# 9 Psychiatric Services

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## Introduction

The current, though still maturing, conception of recovery-oriented services is the derivative of decades of braiding a number of sometimes conflicting developments impacting the mental health system and the individuals needing services from it (Anthony and Farkas 2012; Liberman 2008; SAMHSA 2006). These include the "myth of mental illness" (Szasz 1974), deinstitutionalization, civil rights, consumerism, the general neglect of state hospitals and individual abuses, and professional evidence relative to treatment adherence (Brown and Bussell 2011; Zygmunt et al. 2002). Today, the factors of mental health parity, the Olmstead decision, United States Department of Justice actions relative to the Civil Rights of Institutionalized Persons Act and the United States Supreme Court's Olmstead Decision, highly publicized violent incidents, Center for Medicare and Medicaid Services regulations, peer provided services, inconsistent funding of public mental health systems and, for psychiatrists, the ever present reality of medical liability are among the factors impacting the integration of recovery principles into inpatient psychiatric treatment. The not uncommon dialectic of the "recovery model" versus the "medical model" (e.g., Roberts and Wolfson 2004), in which neither has a clear and consistent definition for individuals, may have facilitated conflict rather than thoughtful integration. Further, the necessity of managing clinical risks responsible for involuntary hospitalizations while maintaining a recovery-oriented focus can produce complexities not easily addressed by "one size fits all" policies or practices.

Given the complexity of development, the continuing evolution of recovery-oriented services, and the potential delicacy of integrating recovery principles into high risk clinical/legal situations, it is not surprising that its translation and consequent challenges lack consistency generally, but also in the specific situation of providing treatment to involuntary or otherwise forensic individuals in inpatient settings. This may be especially so in public state and community hospitals treating individuals who commonly manifest multidimensional challenges related to aggression, self-injury, severe or refractory symptoms, losses relative to employment, family, housing, or medical health, legal charges, and the denial of the need for treatment. It is not the purpose of this chapter to explore any of these factors or developments, just as it will not describe the particulars of diagnosis or psychopharmacology, which are essential functions of psychiatric practice. First, it will focus on how key recovery principles should manifest in the assessment, planning, and treatment activities conducted by

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psychiatrists and other professionals in their roles as treatment team members. Second, it will address how recovery principles should be integrated into tasks primarily conducted by psychiatrists in public inpatient settings.

A psychiatrist in an inpatient setting is typically charged with a number of essential responsibilities. These include admission/discharge, diagnosis, prescribing medication, and making decisions and/or recommendations relative to capacity to consent, involuntary or emergency administration of medications, privilege determinations, and the use of restrictive interventions ranging from special observation to the use of seclusion or restraints. Beyond this, however, many psychiatrists are the designated leaders for treatment teams or are responsible for the individual's overall treatment within the hospital. At the very least, they will be essential members of the individual's treatment team. In this capacity, the necessity of developing an holistic understanding of the individual, the roles the treatment providers need to play in the individual's path of recovery, the interventions necessary to help the individual move forward on that path, and the actions to establish a recovery-oriented environment become essential for all members of the treatment team. For recovery principles to have meaning and effect, they must be integrated into the assessment, treatment planning, treatment interventions, and discharge planning that constitute the essential work of psychiatrists, other treatment team professionals, and direct care staff.

It is a hallmark of inpatient care that safety is the essential "bottom line". Safety has a number of dimensions relative to the physical environment, having an adequate number of staff, completing assessments, implementing plans based on those assessments, anticipating and preventing risk situations, attending effectively to medical conditions and medication risks, examining incidents and medication errors, conducting fire and medical emergency drills, and so forth. What has become clear over the past two decades is that effective attention to the implementation of recovery principles such as hope, respect, choice, connection to others, purpose, and sensitivity to trauma reduce risk in the aggregate. Individuals who feel connected, respected, and included in decisions related to the treatment are less likely to be aggressive or self-injurious. There are obviously exceptions and individuals with serious mental disorders who are unable to absorb or metabolize such approaches are more likely to find their way into state hospitals. However, one of the advantages to such settings is that they typically have the option of more lengthy stays during which there are opportunities for developing more effective treatment strategies, mitigating past traumatic experiences, and establishing more complete connections with individuals consequent to more shared experiences in the treatment setting. Establishing and carefully nourishing a treatment environment in which behavioral events can be treated as exceptions and examined as such is an essential component of a well functioning service. Facilities that default to treating exceptional events as the norm will typically regress to the "us and them", anxiety and fear-driven efforts to over-control individuals that lead to more incidents and compromise the fundamental necessity of a safe environment in which to begin or renew the recovery process.

The most critical source of real and perceived conflict relative to implanting recovery principles centers on individual "choice" and "safety" (Davidson et al. 2006; Hillbrand et al. 2010; Parks et al. 2014). Despite policy statements from SAMHSA (2011, pp. 25–26), such as, "Honoring self-determination, however, does not require, and is not equal to, doing whatever the person wants…. Mental health professionals are bound both by their professional ethics and by their societal obligation to act in the person's and community's best interests, even if that may be in conflict with the person's wishes at the time", these dilemmas do not play out consistently or thoughtfully. Questions, at times offered quite pointedly, such as, "So you want me to let her kill herself if she chooses", "He is going to kill someone if he refuses treatment", or "He will not survive three days if I let him leave like he wants to" reflect the hard, if hyperbolized, edges of the dilemma between self-determination and clinical risk management or between "choice" and required treatment. Less dramatic or more subtle

variants face individuals and clinicians daily in state hospitals:

> George is an individual with congenital deafness committed involuntarily after being found Not Guilty by Reason of Insanity (NGRI) for a rape-murder of an elderly woman who was unable, despite many years of attempted treatment to accept his role in the crime or that the potential risks relative to re-offending had any relationship to him personally. Periodic allegations of unwanted advances persisted. As the population of individuals with deafness declined to the point that operating a special program was no longer feasible (or perhaps legal), he strongly advocated for being placed in a co-ed environment versus in an all-male unit.
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> Alice has been found Not Guilty by Reason of Insanity, has persistent grandiose and paranoid delusions despite taking fluphenazine, and refuses to consider any other antipsychotic agent to the point of threatening to attack anyone who tries to give her a different medication. The content of the delusions precludes her from considering potential discharge placements or other requirements necessary for her to be released.
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> Susan is a young woman with a history of multiple self-injurious events, a substantial trauma history, intermittent substance use, and predilection for entering abusive sexual relationships who demands, after involuntary commitment for the fourth time in two months, to be discharged to live her life the way she wants to live it with her new boyfriend who has multiple psychological and substance use issues.

Two important principles related to choice will be discussed below. These are: (1) that life is a limited menu (for everyone) and (2) that an inability to make one or more choices does not mean that many other choices cannot be made. However, it is important to note in the beginning that self-determination and choice, like the other essential recovery principles of hope, meaning, respect, connection, and sensitivity to trauma does not exist in a vacuum. It is an important aspect to a recovery orientation that has other important aspects. Knitting the various threads together with safety and treatment into a cohesive and consistently applied tapestry is the essential work of creating and sustaining a recovery-oriented service. The specific details to be applied will be determined by the condition, circumstances, strengths and protective factors, predilections, and input of each individual committed for treatment.

In order to provide a foundation for this discussion, it is essential to delineate the essential principles of recovery-oriented treatment that are best applied to and integrated in the processes of inpatient treatment. These are hope, self-determination/choice, purpose or meaning, respect, and a connection to helpful others as well as an assessment of and sensitivity to trauma. As a practical matter, however, the application of three other broad principles provides the framework within which these principles are applied and integrated. First, it is essential to understand the purpose of inpatient treatment relative to an individual's personal recovery journey, even when the individual has not yet conceptualized or initiated such a path. In general, this is to provide the treatment, support, and discharge planning necessary to return the individual to the community with an opportunity to succeed in establishing or reestablishing a more integrated life in that community. The particulars will vary based on individual strengths, symptoms, and circumstances. An individual involuntarily committed consequent to severe, but treatment responsive manic symptoms may require little more than expeditious symptom resolution, support during the crisis, education, and establishing an aftercare plan. A person with serious chronic psychotic symptoms that have responded in limited fashion to medications, lacks effective coping or problem-solving skills, has become estranged from family and other supports, and lacks a place to live will require the implementation of a much more holistic plan of care and discharge planning. An individual ordered into inpatient treatment to restore their capacity to stand trial will require treatment as well as preparation for court proceedings and a plan for "what comes after."

The essential point is that the inpatient treatment should help the person advance their recovery journey with the clear recognition and demonstration that recovery does not end with discharge. Its focus is not to become a successful inpatient. The length of stay or time available for this phase of treatment will obviously hinge on the interface between the individual's legal status and the resolution or mitigation of the risks

responsible for the hospitalization. Nonetheless, the general principle that an inpatient treatment episode is part of a recovery path as opposed to a circumscribed, essentially isolated, episode that concludes with discharge represents a critical change in the framework of inpatient treatment.

> Eli is a young man with Aspergers Syndrome admitted involuntarily after his plan (and preparations) for conducting a mass shooting at a local shopping mall was discovered. Consultations with experts concluded that the risk of his following through with his plan were extremely high, having been foiled only by his father's aggressive efforts to prevent his obtaining weapons. His viscous preoccupation with "all things mass shooting", lack of symptoms of psychosis or affective illness, developmental immaturity, lack of anxiety or distress relative to his plans, inability to manifest anger in any form, and lack of any future orientation with respect to work or relationships presented no obvious options for him or his treatment team.
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> Ultimately, it was determined that a potential path lay in the advantage of his relative youth and immaturity as well as his intelligence, i.e., that if treatment was designed to help him mature emotionally and socially while providing options to exercise his intelligence then he would develop more capacity to discuss and address the issues driving his plans. If so, then there would be an opportunity to mitigate the risks posed by his ideas while having him more prepared to resume college, find employment or other purpose, and improve his opportunities for relationships. Over time, other avenues may present themselves and, hopefully, he will develop more capacity for self-determination toward non-dangerous ends.

In this case, the treatment team had to develop a pathway based on their assessments as a means of getting the recovery process started.

Second, it must be demonstrably understood that each person is an individual as dimensional as "anyone else". A person is not an illness. While the illness may be overwhelming at times, it does not define "who they are" any more than having hypertension, diabetes, arthritis, or hypothyroidism defines a person with any of those conditions. It is common for parents, spouses, and other family members to state, "I have my son back" or "We have our mother back" and in so doing reflect the recovery of an individual from the storms of a psychotic or affective illness. In the end, we are to help the person recover to the point they can begin living their lives and managing their illness. To do so, requires an approach recognizing the person at every stage of treatment.

Third, we must treat each individual as we would wish to be treated or as we would wish a family member to be treated. It may read as a platitude that virtually all clinicians would agree to, but the ultimate test is whether the individual (and family or friends) feel that they were treated in this manner as they prepare to leave. The tyranny of caseloads, behavioral crises, difficult or complicated problems, paperwork, scheduling, and all of the other pressures of inpatient care can and do impede clinicians' capacity for the kind of demonstrable respect, kindness, and clarity of communication we all aspire to.

Finally, as described in the case of Eli above, psychiatrists and inpatient treatment teams must be prepared to take up more of this joint venture when the individual is less able to do so. As Bellack (2006) noted in discussing the management of risks presented by individuals, "… the balance of power may need to shift towards the professional when the consumer is highly impaired and has diminished decisional capacity" (p. 441). This is true for all aspects of recovery-oriented treatment. In simple terms, when an individual is without hope, it is the obligation of the treatment providers to help the individual restore it; when an individual has lost control of their behavior, relationships, purpose, or life in general, it is for the providers to develop a path for him to regain it; when an individual has become isolated, it is the staff's task to help them find connections to others; and when an individual cannot see a life in the community or a life beyond incarceration, it is our job to try to construct one to "see if it fits", recognizing that it will be adapted as the individual becomes more able to engage in the process.

## Forensic Patients

Prior to discussing the central recovery concepts it is worth considering those individuals transferred to state psychiatric hospitals from jails for the restoration of competency, emergency

treatment, or other categories of treatment or evaluation. Many of these individual have a major mental illness and considerable overlap symptomatically with individuals who have been involuntarily detained or committed. The context within which they are to be treated differs, however, in terms of the increased oversight, accountability, security provisions, and stigma commonly related to forensic processes (Simpson and Penney 2011).

The specific parameters placed upon an individual under forensic status must be part of the recovery-oriented thinking that is applied in such cases. First, the legal charges may or may not limit their choices in terms of discharge. Some may be able to return to Court and leave from the next applicable hearing in which case discharge planning is similar to that for civil individuals. Others may face a period of time in jail, the length and eventual outcome of which may not be known. Second, these individuals will typically need to be educated regarding the functioning of the Court, the potential pleas that may be available, and the procedures applicable as they reenter the criminal justice system. Third, the criteria by which discharge or internal privilege decisions are made may be different, the provisions for security on and off the primary residential unit may be different, and there may be different rules governing phone calls, visitation, contraband, patient rights, and so on. At the same time, these differences are relative to the details of an individual's case rather than the general premises of recovery-oriented treatment. All individuals need to adapt to or cope with the external reality which is applicable to them and that does not change. For example, an individual with a recurrent psychotic disorder who will likely be found guilty once restored to competency may be facing some period of jail time. This reality frames what will be necessary to provide him the best opportunity to be successful after discharge differently than someone leaving to go into the community, but the principle of treatment is the same. Another example would be an individual admitted from jail to a unit that requires all of the individuals to wear the same outfit. However, the fact that each individual has no choice in terms of their wardrobe does not convey that they have no choice in what they select for their diet, what groups they may attend outside of those required to restore their competency, what they prefer to be called, or who they choose to spend their time with. Ultimately, they may have a choice relative to their plea or respond to a plea bargain or whether they serve time in jail or state prison, all of which may become an important component in charting their recovery journey. The hope for immediate release may be unrealistic, but the need for hope is present, nonetheless, and may require attention.

For individuals admitted to the hospital after an NGRI decision, the requirements necessary to achieve Conditional Release are very likely to be different than the discharge criteria that would be applied for an individual on civil status. Satisfying the applicable criteria, probably in stepwise fashion, becomes a reality for treatment and an additional component of the eventual discharge plan. It does not change the goal of success in the community, the need for hope, the making of choices, being treated with respect, making connections with people who are perceived to be of help, and receiving treatment sensitive to their applicable trauma history.

## Hope

Hope and optimism is of essential significance in many people's accounts of recovery (Roberts and Wolfson 2004). It is often sufficient to understand hope as it typically is: "I can get better", "I can feel better", "I can be discharged", "I can get a job", "I can be with my family", "I can find a girlfriend", and so forth. Encouragement, statements of confidence, references to the resolution of prior episodes, recognition of strengths, and validating feedback on clinical progress may be sufficient. For some individuals, a clear statement of the plan, its basis, and the clinical steps toward and through discharge are required to give hope some tangible markers to restore the individual's confidence. For each, treatment teams have to determine the language or currency with which hope can be transmitted to and received by the individual.

There are two circumstances, however, in which the foundation for hope has to be reestablished, if not demonstrated, before the individual can connect meaningfully with the therapeutic optimism vital to eventual success. In the first group are individuals for whom their experiences have oppressed any real sense that life can get better. This may be due to persistent psychotic symptoms, psychosocial losses, and limited or evaporative responses to treatment. In certain individuals afflicted with severe borderline personality disorder and the associated trauma history the psychological preparation for, and tolerance of, optimism is lacking. In such cases, a series of successful steps will be required as well a demonstrable commitment from providers to persist in the "hard work" until success is achieved.

> Beth is a young woman treated several decades ago with severe Borderline Personality Disorder who had progressed from short admissions to longer and longer hospitalizations featuring repeated self-inflicted lacerations, occasional overdoses, emotional discord, and gains and losses relative to special observations and privileges. Part of the repeated message given to her was that the time would come when she was not so afflicted by her "emotional storms" (her words), would not feel so compelled to harm herself, and would feel that she was emotionally strong enough to leave the hospital, but that no one could possibly know how long that would take. Well before state hospitals became attendant to recovery principles, she noted as she was leaving that this was an essential part of the treatment.

For a second group, it is necessary to keep in mind that embedded in "hope" is the want or desire for something of meaning or value to the individual. Very few people wish to engage in treatment for the sake of being in treatment. Virtually no one takes medication because they merely want to take their medication. People engage in activities and behaviors that serve a purpose for them. Thus, the treatment must connect to helping the individual achieve or maintain something they value and they must have some hope that they can be successful. Few clinicians who have worked any length of time in a state hospital have not encountered an individual who wants or hopes for no more than they have in the hospital. Such an individual will typically perform whatever tasks are required to maintain the status quo of their current situation, but have no interest in participating in anything that would advance them toward a return to community life. Treatment teams often describe such a person as "hospital dependent", a concept that unfortunately offers no basis for planning interventions tailored to the individual. The individual lacks hope for anything more or different, without which further clinical progress is unlikely. Among the tasks of the treatment is to envision a path that the individual is unable to visualize, attempt its construction, and see if it proves attractive to the individual.

> Dave is a middle aged man with a long history of Schizophrenia who had, for a number of years, been reasonably well compensated from the standpoint of symptoms and was hopeful and contented with the prospect of remaining in the hospital "forever". Repeated attempts to involve him in community activities or show him possible places he could live left him entirely nonplussed and uninterested. He finally connected with one of the Clinical Department Heads who spent many hours with Dave over almost two years, eventually talking about what he might be able to do if he left the hospital. A part of the eventual discharge plan was for him to serve on the local Human Rights Committee as well as to participate in the governance of the local clubhouse program.
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> Kent was a similar gentleman with much more substantial ongoing psychotic symptoms who had refused for a number of years to entertain any thought of leaving the hospital. Over the years, he had acquired a significant amount of musical equipment and his own storage room on the unit. In reviewing the case it was determined, rather obviously, that the hospital was encouraging his remaining rather than helping him realize a more integrated life in the community. An administrative decision was made to eliminate his storage room. From the consequent angst there derived a plan to find an apartment that could hold his equipment and, leveraging that interest, part-time work with Goodwill Industries. A lengthy transition was required, but Kent lived in the community for a number of years pleased with his work and apartment.

## Self-determination and Choice

Operationalizing choice in an inpatient setting for individuals who have been involuntarily detained

and also lack the capacity to make certain decisions related to their treatment can be a source of uncertainty, confusion, and conflict (Mountain and Shah 2008). The ability to make choices over one's life is an essential element of liberty and personal control. Furthermore, the reality is that once a person is discharged most, if not all, more and less important decisions will be theirs to make. To the extent an individual has developed an ownership for managing their illness and recovery and practiced making decisions, the opportunity to achieve success is improved. While legitimately framed as a "right", the practical, clinical importance of improved decision-making is substantial. Developing the skills necessary for decision-making requires the experience of making them. Nonetheless, legal and medical-legal realities as well as institutional limits and efficiency may challenge the best implementation of this principle.

Two important concepts to facilitate navigating these potential ambiguities are that (1) "life is a limited menu" (Barber 2007) and (2) the fact that an individual may lack the capacity or authority to make one type of decision does not mean there are not a number of other decisions that they can make. The first represents a reality based premise that facilitates decision-making and problem-solving while mitigating extreme choice positions that are not supported by law, regulation, clinical judgment, or pragmatism. In truth, no one has a freedom of choice unconstrained by limits related to financial resources, work and family obligations, geography, personal limitations, health, and opportunity. The normal human condition is that "wanting something does not make it so". Everyone has to, for example, wait in line to get a driver's license, vote, or eat in a cafeteria. Each of us can only afford to buy what we can afford, marry someone who agrees to marry us, or work in a job that someone has been willing to hire us to do. Recognizing this, staff may work with an individual regarding the choices that they do have, the choices that can be restored or achieved, and how to work to create better choices in the future. It is also true, and sometimes of motivational importance, that residing in an institution provides fewer choices than living in an apartment or personal home. For example, mealtimes are typically set as are medication times, when groups are offered, and when outdoor and recreational spaces are accessible. Such things may be limited outside the hospital, but typically less so than within an institution.

It is common in state hospital settings for an individual to have been assessed as lacking the capacity to make particular treatment decisions, especially the decision regarding taking antipsychotic medication or when they are ready for discharge. However, such an individual may well be able to determine whether they will take a traditional or atypical antipsychotic agent or take, for example, olanzapine versus risperidone or quetiapine, even if they lack the capacity to refuse medication altogether. A variety of less essential decisions related to food choices, what to wear, when to shower, who to sit with during meals, some group or activity selections, who they will allow to visit them, what they listen to or watch on television, and what information they choose to access from the Internet (within limits as necessary) are generally possible. Encouraging such choices and overtly recognizing them as choices can increase the individual's feeling of control and awareness of making choices as well as serve as building blocks toward more important decisions.

It is worth noting that people make many choices without being aware of doing so. Increasing the awareness of choices made can be of value as it recognizes the individual exerting personal control over their actions and thoughts, whether they are participating in a Cognitive Behavioral Therapy program or not. The institutional rigidity of prior eras was both disempowering and devaluing of the individual, but also poor preparation for the reality of personal decision-making after discharge. Wasting an individual's ability to make or recognize choices by overregulating all aspects of their inpatient experience, "telling them what to do", or denying choices that are neither unsafe nor beyond the hospital's capacity for flexibility have similar effects today. From the standpoint of achieving success after discharge, making choices as a

tangible aspect to self-determination is a more narrowly defined treatment issue as well as a key recovery principle.

At the same time, psychiatrists and other clinicians must provide for an individual's safety and treatment while they are in the hospital. A presently suicidal individual may not be left unsupervised, an actively aggressive individual may require restrictions on where they can be, who they can be with, and how closely they must be supervised, a forensic patient may require a Security presence when outside a locked unit, and an individual with active psychotic symptoms causing or facilitating a risk to themselves or others may require medication whether they choose to accept that or not. Serious injuries, death, prolonging a hospital stay due to elopement, and legal charges, future guilt, or placement limitations consequent to aggression are all impediments to recovery and require declarative action. When such risks are derived from acute symptoms or crisis states, the clinical decision-making is relatively straightforward. However, when the risks are chronic or impulsively episodic, the interface between the empowering personal control of choice and the risks of a "bad outcome" with all the attendant consequences for the individual, clinician, and hospital the matter becomes more complicated and imperfect.

Perhaps the clearest examples are found in the cases of individuals with severe borderline personality disorder, a history of repeated self-injurious behaviors, occasional suicide attempts, and virtually complete external locus of control whose ultimate recovery hinges on the development of improved internal regulation of emotions, making conscious decisions, and developing greater trust in themselves and others. Continuous supervision and restriction of activities promotes the regression that is directly related to risk while the exercise of autonomy, sometimes at a relatively basic level, may produce the anxiety and perceived abandonment that produces an acute, "impulsive" risk. In such cases, clinicians must engage the individual in the dilemma, establish parameters for making decisions based on the individual's history and assessment of the current clinical state, develop plans that can be consistently implemented such that the consequences of safe and unsafe behaviors are known in advance, and document the rationale for decisions made when risks are present with any decision. In such cases, as in others perhaps less dramatically, one cannot divorce choice from the other important dimensions of hope, respect, connection, meaning, and sensitivity to trauma without ill effect.

## Respect

Respect is embedded in the central tenets of recovery practices of self-determination, being treated as an individual rather than an illness, participating in both care decisions and policy development, and recognizing the importance of peer services (Anthony and Farkas 2012). Beyond the well-articulated means of demonstrating respect and treating individuals with dignity there are three further dimensions of respect essential for treatment providers and psychiatrists. The first is the respect for the gravity of an individual's condition and experience. The development of a language applying terms such as "client" or "consumer" to involuntarily hospitalized individuals combined with the necessity of being overtly hopeful and optimistic can result in a devaluing of the person's lived experience. The vitally necessary therapeutic optimism must recognize and validate the seriousness of an individual's condition and experiences which have greatly eroded, if not crushed, their personal hope or optimism that things can improve. Furthermore, clinicians must be sensitive to the individual for whom empowerment and personal autonomy do not (yet) match their feeling of personal competence, which must be met with equal respect.

The second dimension of respect involves practicing at the standard of care. This is discussed in a manner more specific to prescribers below, but it is a measure of respect that all disciplines practice to their standard of care. Doing so encompasses everything from professional boundaries and ethics to conducting psychological testing, to nursing standards of care

with respect to assessment and medication administration, and to conducting therapies by any of the professional disciplines. Practicing safe and effective medicine, and discussing both positive and negative treatment developments, are tangible demonstrations of respect by physicians, but they are no less so for the other professional disciplines.

The third point regarding respect is applicable to only a small number of cases and relates to a treatment colluding with an individual's unrealistic ideas about their treatment or circumstance when doing so precludes the individual from making clinical progress toward discharge and returning to community life.

> Jackie is a woman in her late thirties with a diagnosis of Schizoaffective Disorder who was found Not Guilty by Reason of Insanity for a felony assault with a pair of scissors and had been in the hospital for almost five years. Intelligent, sometimes charming, and creative she disagreed with the NGRI finding and demonstrated an unwillingness to accept the parameters required for advancing through the privilege system to Conditional Release. These parameters basically require an individual to take the medications as prescribed, control any risk behaviors, and demonstrate that they are able to follow the rules in order to demonstrate that they will comply with the parameters of their Conditional Release plan. Jackie's position was that she had been in the hospital many times and had always been able to be discharged without "going through all of this". Thus, her progress was impeded by repeated violations of the hospital's no smoking policy, inconsistent attendance at groups, engaging in sexual activities, failing to return to her unit on time, and engaging in verbal skirmishes with the staff regarding meal quantities, snacks, showers, washing her clothes, and so forth. It came to our attention that her treatment team was overtly agreeing with her that she would have been discharged long ago if she had been a civil patient, making repeated pleas to the privileging committee making a similar argument, and implicitly encouraging her efforts to have her attorney get the NGRI ruling overturned (which was unrealistic even if it were legally possible). The treatment team's stance was clinically inappropriate (because it impeded her making any progress toward release), but was also disrespectful in facilitating her pursuing a false path and essentially wasting her time. After being transferred to another unit with a team that repeatedly held the position that she would have to meet the requirements under the NGRI system in order to gain the release she did badly want. It was a difficult course for much of the next year, but eventually she began demonstrating the required behaviors and was able to achieve her Conditional Release.

A variant of this type of situational impasse created at the interface between the individual and treatment team is demonstrated by the case of Albert.

> Albert is a man in his mid-forties with a longstanding diagnosis of schizophrenia who demonstrated some vague paranoid thoughts and secretiveness, but who presented no behavioral risks. However, after almost two years in the hospital he refused to discuss any discharge plans, instead making references to plans he was making in this regard which he would not share with the team, the unit Social Worker, or his Community Liaison. He refused to take more than a very small dose of medication and had been successful almost a year before in persuading a Special Justice that he could make his own decisions. His case was presented due to his "hospital dependency" and lack of progress. The summary of the consultation was that it was most likely that his refusal to discuss discharge actually reflected persistent delusional ideation about threats he felt would be present in the community and that it was essential for him to have an adequate trial of treatment. The psychiatrist, rather than passively accepting as permanent a judicial decision made a year before that essentially consigned Albert to permanent hospitalization, needed to petition the Special Justice for substitute consent and make it clear that Albert had no future other than living in the institution unless a more effective medication regimen could be implemented. This was done, a more effective medication regimen was prescribed, the psychotic symptoms further attenuated, and a successful discharge was implemented.

In this case, a clinical legal process that appeared to be respecting of the individual's autonomy was, in fact, placing the individual's life at the mercy of psychotic symptoms that could be treated. It is not respectful to waste a year of an individual's life when it can be avoided.

## Connection to Helpful Others

Psychiatrists and other professionals invest significant time and training in learning how to

establish and maintain a therapeutic relationship. Doing so is vital to understanding an individual and collaborating with them in their treatment and highly valued by the receivers of care (Lakeman 2010). However, the connection of importance to the recovery process is the individual's perceived connectedness to another person who is of help or support to them. This may, of course, be a psychiatrist or other professional but is more likely to be a peer, a family member, a friend, a Pastor, or a direct care or support staff member. Feeling connected to others combats the isolation that may afflict individuals with a mental disorder, severe or not, as well as provides a source of tangible support necessary for the recovery process. In addition, such perceived connections decrease the risk of suicide which may be highly correlated with the sense of isolation (Van Orden et al. 2010). The essential point is that it is the connection as perceived by the individual receiving help that is of value in recovery. Professional as well as direct care staff interactions need to keep this important dimension in mind in order to maximize the chance that the individual will feel that others are interested in his well-being and are steadfast in their attempts to understand him and try to help him "get better". In an inpatient setting, it is not possible to anticipate who the individual will most keenly feel a valid and supportive connection with, thus all staff are required to be mindful of this key recovery principle in order to maximize its chances of development.

To achieve recovery-oriented treatment, such treatment must be delivered in a culturally competent manner to convey respect, assist self-determination, and best assure an opportunity for therapeutic connection (The President's New Freedom Commission 2003; SAMHSA 2006). For an individual to experience a confidence that they are being understood, supported, validated, or helped psychologically some understanding on the part of staff regarding their cultural background and traditions will be necessary. This can be a substantial challenge for state hospitals in less diverse areas treating individuals from urban centers and other geographic areas that feature many primary languages and cultures. In addition to training and education programs to enhance staff recognition of and sensitivity to the importance of culture and its impact on individuals, state hospitals have to recognize that the isolation derived from a lack of common language or culture produces additional risk. Such risks may range from suicide when a person feels alone in their suffering to aggression derived from misunderstanding.

In addition to mitigating strategies, such as the use of translation, additional efforts to assure the individual can remain connected to family or friends, direct acknowledgement of not understanding adequately (while continuing to attempt to do so using the individual, family, and other sources of information) state hospital staff must be mindful of communications that are nonverbal. This relates to individual demeanor and expression, but also to how clear hospital routines are within and off the units. The sooner an individual's environment is more predictable to them as far as when things happen, who does what, and where things are the less anxiety provoking, threatening, and isolating it is. Attention to making such routines as obvious as possible "without words" may not just be useful for individuals who do not speak the language, but also for individuals with ongoing psychotic symptoms who may have more difficulty processing verbal information.

## Meaning or Purpose

This aspect of recovery is well discussed by others (Anthony et al. 2002; Anthony and Farkas 2012; Liberman 2008) and requires only a few points to elaborate on in regard to the treatment of severely ill inpatients. First, treatment staff need to demonstrate their understanding that the purpose of treatment is to help an individual live a more satisfying life in the community. Thus, within legal and temporal constraints as applicable for each case, the objectives for the individual and the interventions by the staff are aligned with the goal of discharging the individual with an opportunity to be successful upon return to the community. This is the purpose of the work that the individual is participating in with the treatment staff. Basic

hygiene, proper clothing, safety, attention to physical health, resolving psychiatric symptoms, developing social or problem-solving skills, collaborating with discharge planners, learning Court procedures, and everything else has a purpose with respect to the ultimate goal of successfully living in the community. While this demonstration is not what is intended by this recovery concept it supports and reinforces the individual's sense of purpose.

Second, for an individual in the midst of an acute or ongoing psychotic illness complicated by behavioral, medical, and psychosocial problems the prospect of meaningful engagement, employment or other purpose post-discharge can be easily lost as a consideration. As noted above, the burden may fall more to the treatment providers to recognize its long term importance and bring the matter to attention even if in a preliminary way. As will be discussed later in regard to medications there must be an answer to the question, "Why would this individual accept or engage in the treatment planned or provided?" It may be possible to gain assent and cooperation in an inpatient setting, but this can obscure the larger need for the individual to have meaning or purpose for their life if they are to be motivated to pursue treatment and recovery in the community. If there is no answer to this question, it must become a task for the treatment process, as individuals who lack purpose are likely to require help in order to find it.

Third, one of the substantial, nonspecific improvements in state hospital services has been the implementation of off-unit psychosocial rehabilitation (PSR) groups and activities. In addition to the opportunities to tailor education, practice, problem solving, creative, and recreational activities to the individual, such programs provide a reason for individuals to get up, dress, and eat breakfast if they wish before the work and socialization that accompanies such a PSR program begins. At the least, there is a point to engaging the day, but much more typically the change in location, classroom-type settings, interactions with peers in purposeful conversation or activity, and learning that takes place reinforces the purpose of getting better and preparing for life in the community.

The fourth point relates to the particular challenge of working with that subset of inpatients that have no sense of purpose or meaning in their lives, lack aspiration, and have no genuine hope for living a life any different from what they have in the hospital or have had in the past. Absent a sense of purpose or aspiration, there can be little genuine motivation to engage in treatment or pursue a path to recovery. Two case examples may help illustrate this situation.

> Gus is a man in his mid-forties whose prospects for becoming a lawyer had been devastated by the development of severe psychotic symptoms during his early twenties, extended periods of treatment non-adherence and insufficient responses to medications, and multiple hospitalizations. Once his more acute psychotic symptoms and erratic behavior stabilized, he entered a long period in which he cooperated with treatment, presented no behavior problems, and refused all efforts to engage him in any discussion of discharge. He stated he was "perfectly content" to remain in the hospital. Through patient and painstaking efforts over the course of more than a year his treatment team was finally able to identify that he seemed to enjoy the idea of being of help to others and attract him (very cautiously) to the idea of working with Goodwill Industries and living in his own apartment decorated with his possessions. Still, he refused to sign papers necessary to place his financial affairs in order (which was necessary to allow him to rent an apartment). Months of patiently building his commitment to his work via passes, work with him and his father on their expectations, and, ultimately, the development of a situation in which he had no choice but to "sign or lose access" to his funds accompanied the steady nourishment of the idea of his own apartment, what furniture he might have, in what general location, and what size. After almost two years and a number of trial passes during which he developed a sense of pride in the work he was doing, he was discharged. Two years later, he is living successfully in the community, managing his own affairs, and working part-time with Goodwill.
>
> Earl is an individual of similar psychiatric history, but who was found Not Guilty by Reason of Insanity. While his psychiatric symptoms were relatively stable and he no longer demonstrated the kinds of aggressive behavior that he had in the past, he appeared to have no interest in further progress or discharge. In consulting with the treatment team, who knew him well, they were unable to identify anything that he wanted in the community and were at an impasse as to how to help him. In a lengthy discussion with them, we

were able to establish that it had been many years since he lived outside of an institution, his life had not gone well during prior periods out of the hospital or jail, he was content with his family visiting him at the hospital and had no interest in going to live with them. He appeared to have no real interests other than he did seem to enjoy small mechanical devices or discussing small motors and car engines, about which he had some knowledge and experience. It was determined that the clearest path to living in the community would have to begin with the quiet nourishment of his interest in small engines by finding him some to work on while in the hospital. If that work could be established as a gratifying endeavor then it might be possible to build from that toward a discharge plan that featured working in small engine repair or some similar activity. The task for the treatment team was to take advantage of knowing him well, envision a future that it appeared that he might relate to, and begin taking steps to nourish that vision to see if it would become his own.

## Trauma Informed Care

It is reported that the rates of trauma exposure in individuals with a serious mental illness range from 49 to 100 % (Grubaugh et al. 2011). The principles and growing penetration of Trauma Informed Care in care delivery (SAMSHA 2014) feature significant operational overlap with those of recovery-oriented services. The assessment for historical trauma and sensitivity to minimizing a triggering or reenactment of such trauma constitute important advances for inpatient treatment. It is essential to be mindful of the fact that the circumstances and process of involuntary hospitalization or arrest and subsequent hospitalization may frequently involve further trauma or an emotional activation derivative of prior trauma. At the same time, a small percentage of such individuals will manifest agitated, aggressive behavior or repeated self-injurious acts that, at times, may require the use of seclusion, restraint, or forced medication when the situation is emergent and the safety of the individual or others can be accomplished in no other way. Staff can be uncertain or confused as to how they are to respond when faced with the potential to re-traumatize an individual versus allowing someone to get hurt in the context of their indecision. When there is peer-to-peer aggression, the matter can be more complicated. Obviously, there is no simple answer to such situations, but there are several things that may mitigate the potential consequences.

First, hospitals must acknowledge that such circumstances arise and provide guidance to staff. If the trauma informed care champions and trainers are unfamiliar with inpatient work or are isolated from clinical and risk management staff practices will be inconsistent, organization splitting will occur, and staff will be left “to their own devices”. Staff must be trained in recovery and trauma informed principles and act in a manner consistent with those principles. Seclusion or restraint must be the interventions of last resort when nothing else will achieve safety for the individual or others. They must be competent in utilizing less restrictive interventions to prevent and respond to situations presented the risk of aggression or self-harm as well as in physical techniques to be used when necessary. Treatment teams and psychiatrists must be attentive to the factors that produce risk in an individual and implement treatment strategies and interventions to mitigate such risks. Allowing an individual with an aggressive history, current evidence of ongoing tension and irritability, and paranoia to go without medications in order “not to upset him” is a too common antecedent to an aggressive incident in which the individual and others end up at risk, if not injured. Failing to incorporate known triggers and calming interventions into the treatment plan or failing to educate direct care staff about them is another too common error. If staff demonstrate hope, choice, respect, and sensitivity to trauma consistently, are taught to observe for and intervene early to prevent dangerous escalations, and are competent to handle such emergencies as they occur there will be fewer such escalations and, when they do occur, there will be some mitigation of the potential trauma.

After such an incident it is important for staff to reestablish their demonstration of recovery-oriented interactions, process the incident with the individual, review the current treatment plan, and attempt to learn, with the individual, what could be done should there be a

subsequent recurrence. It must be kept in mind that acts of aggression toward the individual or others delay or impede progress toward discharge and may limit the individual's choices. The fact is that it is also traumatic for other patients as well as staff when one of their peers is threatening, tense and irritable, or behaving aggressively as it may activate fears from their own trauma histories. To add to the complexity, it may also be traumatic to see one of their peers secluded or restrained. For all of these reasons, as well as the fact that being a direct care staff member is among the highest risk occupations, the importance of preventing aggression to avoid the need for restrictive interventions and fear in the milieu cannot be overstated. It is redundant, but important to reiterate that the prevention of aggression does not begin once an individual is agitated or threatening. It begins with establishing the proper treatment environment, thinking ahead about the potential risks an individual may present, and implementing strategies to prevent the development of states and circumstances in which aggression is more likely followed by responding appropriately to acute situations that do develop. It is worth noting that teaching mindfulness to direct care staff has been shown to mitigate aggressive incidents in individuals with intellectual disabilities and may hold promise for behavioral health settings as well (Singh et al. 2009, 2015).

## Peer Provided Services

The penetration, acceptance, and effectiveness of peer provided services have increased steadily during the past two decades (Nelson et al. 2006, 2007; Repper and Carter 2011). The roles available for peers within state hospitals are varied and include conducting group therapies, developing Wellness Action Recovery Plans, operating peer resource centers, providing support to individuals at both admission and discharge, and participating on hospital committees. The effectiveness of peers in reducing hospitalizations, increasing confidence and self-determination, and promoting hope are all reasons that treatment teams need to make use of these resources to help individuals move forward in recovery. In addition, for some individuals, becoming a provider of peer services becomes central to their own recovery, providing a way to derive meaning and purpose from their lived experience. The increasing recognition of the value of including people with lived experience on governmental task forces and policy committees provide further avenues for those individuals who wish to utilize their experiences in contributing to system change and effectiveness.

## Direct Psychiatric Services

To this point, our attention has been how key recovery principles apply in the overall care of psychiatric inpatients, with particular attention to those who have been admitted involuntarily or on forensic status. The psychiatrist is an essential member of the treatment team, if not the assigned leader of the team with responsibility for the overall treatment plan. For inpatient treatment to be effective a consistent, shared commitment to and understanding of how the recovery principles will be implemented and how they intersect with the clinical risk management required for individuals admitted on the basis of behavior deemed dangerous to themselves or others. However, psychiatrists have tasks and responsibilities that are not shared with other professionals. These typically include admission, diagnosis, prescribing medications, monitoring for side effects and medication risks, ordering emergency interventions, and discharge. In addition, the psychiatrist will make decisions, render opinions, or make recommendations to the Court regarding an individual's capacity to make informed decisions related to their treatment.

### Admission

In the case of involuntarily admitted individuals, the actual decision to admit the person is typically made by others, particularly for state hospitals. Thus, the psychiatrist is receiving the

individual for treatment rather than making a decision to admit the person. The admission process varies across facilities, sometimes encompassing several physician assessments so the discussion will relate to the overall process rather than specific details. There are a number of points to be made as to the integration of the basic admission assessment process with key recovery-oriented principles. Some, like other points made above, may seem so commonplace or part of standard practice that their mention is unnecessary. However, their conscious inclusion mitigates taking them for granted or assuming that they are necessarily incorporated on a consistent basis. Depending upon the individual's clinical condition and the circumstances with which they arrive more or less information may be reliably obtained proximate to the time of admission. Nonetheless, it is important to create an opportunity for the interaction and information to be productive, if not satisfying, for the individual to the greatest extent possible. Our job, while collecting the required information as completely as circumstances permit, is to convey, as well as possible, that the hospital is a safe place where individuals are respected, helped, and involved in their treatment. Finally, it is a place from which everyone is expected to be discharged with the goal of living successfully in the community.

The physician assessment will be one of the first interactions for the individual once they arrive. As such, attention is necessary to convey respect and hope as well as creating an opportunity for interpersonal connection and providing choices when possible. Examples of choice might include asking for their preferred name, offering a choice of two chairs to sit in, asking whether they would like a drink of water or to use the restroom prior to beginning, and so forth. It may be helpful to explain that this is a treatment facility and what the next several steps in the admission process will be. Individual capacity for hearing or exchanging information will obviously vary based on the individual, their clinical status at the time of admission, the immediate circumstances of the admission, and a number of other factors. Clinical judgment will dictate the specific means by which to attempt to establish the recovery principles so long as the physician understands this is an important part of the admission process.

The physician must identify any immediate risks to the individual or others. While attention will be paid to behavioral risks, this assessment must include medical risks as well. It is a simple notion, but in the same way that there can be no recovery after suicide, there can be no recovery after a death from a medical complication either. Again, the care with which this is done conveys value and respect in addition to addressing the task at hand with due medical diligence.

In the recovery literature value is placed on the telling of one's personal narrative. Recognition of this fact may allow the physician to combine the taking of the psychiatric and medical history with some opportunity for the individual to tell their story. As a practical matter, time will not permit more than a portion of the narrative, but the impression made by a professional listening with interest and attention can be significant and contribute to restarting (or starting) the recovery process.

The final point would be, in addition to beginning the process of identifying an individual's personal strengths, to try to solicit where the person wishes to go after discharge and whatever details may emerge efficiently from that discussion. This not only begins building the information required for a full, holistic assessment, but also conveys that the individual will get better and leave the hospital. This latter message may get conveyed even if the responses are infected with delusions or other psychotic symptoms.

## Diagnosis

From a clinical standpoint in a recovery-oriented service, the essential importance of making the proper diagnosis is that medications are approved by the Federal Drug Administration primarily for diagnostic indications. It may also serve as a starting point for educational activities for the individual or family related to the individual's

condition. As with medication practices and the monitoring of risks, it is a measure of respect as well as the standard of practice to collect the requisite information and integrate that information into the assignment of the proper diagnosis. Furthermore, when the diagnosis is unclear, it is required to take steps to clarify the diagnosis through further observation, the collection of more history from other sources, the review of prior records, or the utilization of psychological or laboratory testing.

As already noted in different fashion, a diagnosis describes an illness or condition, not a person. The diagnosis is not the person any more than another individual is simply a “hypertensive”, “diabetic”, or “arthritic”. Our task is to attempt to align with the individual to treat or manage the symptoms that they are experiencing, which have resulted in their suffering or impeded their ability to live a satisfying life in the community. This essential point was made at a recent presentation regarding multi-dimensional efforts to prevent psychosis in young people. The presenter noted that, “in the end, it was not so important whether psychosis was prevented so long as the adolescent’s life stayed on its expected trajectory” (Sale 2015). Our purpose is to help the individual get their life on track with treatment of the symptoms of a particular diagnosis subsumed in service of that overarching goal.

## Capacity for Treatment Decisions

With the priority given to empower individuals to take control of their treatment, it is perhaps understandable to find psychiatrists relying on assent for willing patients, despite a lack of true capacity, believing that doing so satisfies this priority. Unfortunately, this practice constitutes a medical-legal risk should complications develop and provides the individual “control” only so long as they go along with the psychiatrist’s plan to “control their behavior”. Too often, should the individual decide to refuse treatment, another assessment is made concluding that they now lack the capacity for such decisions. The clinical-legal process of assuring that a person able to weigh the risks and benefits of treatment is making decisions for the individual is intended as a protection of an individual who is unable to do so. In the situation of using assent as a replacement for consent, the intended protection may be subverted into a coercive process. Furthermore, it does not constitute the kind of active, bilateral engagement in treatment planning or treatment that promotes genuine partnership and, ultimately, ownership. At worst, it can be the equivalent of treatment teams that make sure the individual signs the treatment plan at the end of each review, whether there has been any evidence of the individual participating in the process or not. Failing to clearly address a lack of capacity when it exists will typically delay treatment, cause medication treatment to be sub-therapeutic and, at times, increase the chances that the individual will engage in dangerous behavior, prolonging their hospitalization and reducing their placement options in the community.

Recovery-oriented treatment does not require clinical or legal standards to be attenuated. It does require that treatment efforts be made to help an individual who lacks capacity regain such capacity so that they can make decisions regarding their care. Such efforts may include medications, education related to medications, other treatments, and side effects as well as rehabilitative activities to improve problem-solving or cognitive skills. At the same time it is important for the individual to participate in the processes designing their care, to have the opportunity to make other choices, for staff to highlight those choices as discussed above, and to participate in activities that facilitate decision-making skills. Allowing the individual to express their preference, engaging them in discussions related to their treatment, and providing information about their treatment are all actions that continue despite a formal lack of capacity and treatment decisions being made by others. Recovery is not a matter of pretending, but of a relentless lack of acceptance that the inpatient status quo is “all there is” and persistence in trying to help the individual develop the skills and symptom stability to live in the community.

Once an individual regains capacity for some or all of the relevant treatment decisions such decision-making must be restored to them in a timely fashion. In addition, such achievement should be recognized and used to facilitate other clinical gains necessary for returning successfully to the community.

## Medications

Virtually all of the individuals who are admitted involuntarily will need medication in order to treat their illness or otherwise mitigate symptoms of distress that are impeding their ability to live in a community setting. This reality makes the prescription of medications and ongoing attention to medication risks and side effects a critical function for psychiatrists, physicians, and other prescribers. Medication nonadherence is a substantial problem in all fields of medicine, including psychiatry (Brown and Bussell 2011; Nockowitz 1998).

Practitioners are well aware of this reality, but the focus is often on the reasons individuals do not adhere to the prescribed regimens (Peselow 2007; Zygmunt et al. 2002). In such discussions, attention is consistently given to the complexity of the regimen, side effects, and lack of apparent ill effect when medications are not taken. While interventions have included education, family support, simplifying medication regimens, and managing stress, an important question from a recovery orientation standpoint is, "why would the individual want to take the medication as prescribed?" The medication benefits and risks must help the individual achieve or maintain important aspects of their lives such as work, relationships, feeling better, or relief of distress.

For some problems and medications, the consequences of not taking the medicine are more consistently immediate, e.g., pain medications and hypnotics. In such situations, adherence is likely to be more reliable so long as the medication is needed. However, with many medications, for many people, not taking a prescribed agent makes no readily discernable difference on a day-to-day, week-to-week basis. Most individuals do not notice an increase in their cholesterol level or blood pressure from a symptomatic standpoint. Individuals with bipolar disorder or a recurrent depression are likely to be able to go extended periods of time off of medication without notice.

Given that individuals outside of hospital settings are largely free to choose whether and when to take their prescribed medications, it is important that medications help the individual achieve or maintain things that are important to them, and for them to understand and maintain awareness of how the medication relates to those dimensions of their lives. Being able to work, maintain good relationships with friends and family, and enjoy pleasurable activities as well as avoid losses or disruptions in these areas, future hospitalizations, debts, or legal charges relate more directly to why an individual would choose to adhere to a medication (and any other) treatment regimen. While most people will take medications in a hospital setting in order to "get out", relieve their immediate distress, or because "everyone else does," these motivations will be of little value after discharge. Thus, aside from that group of people who will faithfully do "whatever the Doctor says", if there is no clear reason that would motivate a person to take the medication, it is unlikely that they will consistently do so over time. Telling a person to take their medications because "I said so" or "the Doctor said so" will be insufficient for many people. Likewise, the idea that the medication should be taken to treat "the illness" may be similarly limited in effect. The essential point is that medication is more likely to be taken when doing so helps an individual meet their personal recovery goals and the linkage between the medication and achieving or maintaining those goals must be at the center of medication treatment.

In this context, there are four particular aspects to prescribing medication in a recovery-oriented manner, not including decisions related to emergency treatment that will be discussed below. First, he prescriber is charged with addressing two, often congruent, objectives with medication treatment. Medications are

generally approved by the FDA for diagnostic indications. Thus, in addition to diagnostic fidelity, the medication must be prescribed for an approved indication or deployed "off label" by providing a documented justification based on the literature, specific pharmacological effects, or experience consistent with the standard of professional practice. At the same time, medications need to be prescribed with the goal of success in the community as operationalized for each person. In most cases, relieving the symptoms of an illness resulting in an involuntary admission or legal charges will provide a foundation for making use of other treatments and a path to returning to the community. The two cases below contrast situations in which the successful treatment of the illness per se produced problems for the individual in "real life" in relation to a recovery model of care.

> Sarah is a woman in her late thirties who experienced moderately severe anxiety, depression, and poor sleep leading to suicidal thoughts. She was successfully treated with a combination of an antidepressant and benzodiazepine, but complained of ongoing mild sedation and cognitive slowing that prevented her from completing her work tasks as a newspaper editor and engaging in her previous exercise program resulting in some weight gain. Her treatment was changed to feature a gradual discontinuation of the benzodiapine, with an expedited engagement in mindfulness activities and Cognitive Behavioral Therapy as well as changing jobs to go to work as a magazine editor with less rigorous day-to-day deadlines. With these changes she re-engaged her exercise routines and felt that she had achieved the recovery she desired.
>
> In contrast to Sarah, 30 years ago, Sergio was a young man attempting to develop a career as a pianist when he developed severe symptoms of Schizophrenia accompanied by agitated and aggressive behavior leading to an involuntary hospitalization. He adamantly opposed any treatment with antipsychotic medications due to their effect on his fine motor coordination as this was essential to his being able to play at the level required. He was eventually treated, his symptoms were substantially attenuated, and he was discharged. Unfortunately, no discussion was held regarding the impact of the successful treatment of his illness on his occupational goals.

Each clinical situation is different, but when presented with the problem of being unable to meet both diagnostic and recovery goals at the same time the psychiatrist should: (1) attend to the individual's immediate safety first, (2) treat the illness so as to restore the individual to full decision-making capacity, and then (3) collaborate with the individual on the potential strategies to both treat the illness and achieve the individual's recovery goals. Ultimately, the issue is treatment for a life rather than simply treating an illness recognizing that this process will often require effort after the individual leaves the inpatient setting.

The second intersection between recovery-oriented treatment and medications relates to medication risks and side effects. It is a demonstrable measure of respect to practice at the standard of care in terms of medication risks, and to manifest interest and commitment to working with individuals on side effects that may develop during treatment. This is straightforward with some medications and risks. It is required that white blood cell counts be regularly monitored with clozapine, thus leukopenia can hardly be missed. Likewise, an acute dystonic reaction presents with an urgency that cannot be ignored. However, other monitors require the practitioner to order, conduct, or review at the appropriate frequency, typically defined in the hospital's medication guidelines. Still others, such as weight, BMI, mild cognitive effects, constipation, or restlessness, require unit staff to observe and communicate in order to be effective. This requires the prescriber to communicate with staff and attend to their reports in a timely way to reinforce the integrity of the monitoring system. Attention must be paid to side effects, such as weight gain without laboratory evidence of metabolic consequence or the sometimes subtle cognitive slowing that occurs with a number of psychotropic agents, that may compromise an individual's confidence or feeling about themselves without yet posing a health risk to the individual. The psychiatrist must demonstrate a willingness to discuss these less critical side effects with the individual and make adjustments as necessary. Practicing safe medicine and discussing both positive and negative treatment developments are tangible demonstrations of respect, in addition to being the standard of care.

The third intersection involving medications and recovery relates to the necessity of assuring the integration of medications with behavioral treatment and/or other interventions. This intersection may be more subtle than the others as it relates primarily to making sure that treatment is efficient and that it facilitates the individual achieving treatment objectives to improve confidence and reinforce personal control. For example, with an individual with psychotic symptoms who has a behavior plan for recurrent aggression, it is necessary to assure that the medication treatment is optimized to prevent psychotically driven aggression from impeding the effectiveness of the reinforcement strategy. In another example,

> Sam was an individual with a number of positive and negative symptoms of Schizophrenia hospitalized for the restoration of competency who was identified for case review due to a pattern of staying in bed all morning and missing all of the groups designed to aid in the restoration. Upon review it was clear that his meeting treatment objectives related to group attendance and identifying the roles of various Court officials were being impeded by large bedtime doses of olanzapine initiated consequent to agitation and poor sleep at the time of admission a number of weeks ago. Having made significant clinical improvement with respect to his psychotic symptoms and agitation he had become more sedated, particularly in the mornings when the seminal groups were being held. By making medication adjustments it became possible for him to more consistently (and alertly) attend his groups and make progress toward his restoration goals.

The fourth intersection applies when the inpatient formulary does not match the formulary within the jail or community service in which the individual will receive services after discharge. It also relates to individuals who have Medicare Part D coverage and may have limitations related to their specific Prescription Drug Plan. Unless there are clinical contraindications or other clear reasons to do otherwise the prescriber should utilize medication(s) that will be available after discharge because success after discharge is the preferred purpose of inpatient treatment. To use a medication that will not be available sets up a risk after discharge that the new medication will be ineffective and result in a relapse. Alternatively, the need to change medications prior to discharge to assure that symptom control can be maintained results in a longer length of stay, delaying the individual's return to the community. Neither is consistent with recovery-oriented treatment unless there are strong, competing reasons to do so. That said, when an individual is severely ill and suffering, and does not appear to have responded to medications that would be available after discharge, the priority becomes helping the individual improve symptomatically so that they can fully participate in their treatment decisions. At that point the prescriber can collaborate with the individual on the best course to take. It can also be that the individual, having capacity or not, expresses a strong preference for a particular agent or is unwilling to take any of the to be available agents. Each situation is different, but in such circumstances it can be helpful to reinforce the individual's choice, avoid the potential conflicts related to a different agent that may compromise the therapeutic connection, and expedite the individual improving. Doing so has the potential to provide a much better foundation for the subsequent discussion regarding what medication may be available after discharge and how to address that issue.

A final point related to medications, particularly for individuals with more severe conditions whose symptoms have responded inadequately to standard medication trials and doses, is the need to keep trying to achieve adequate symptom relief until all safe means have been attempted. It is not acceptable to allow a person to remain an inpatient for extended periods of time without making available medication changes to try to help them achieve discharge. The difficulty lies in maintaining appropriate attention to medication risks while continuing to try new agents and combinations to achieve symptom reduction. Central to practicing in this tertiary fashion is identifying target symptoms and measures of success. Too often, in such situations, one medication is added to another, and then another, absent clear evidence of effectiveness or eliminating medications that lack such evidence. The ultimate result is a complicated medication

regimen of inadequate effectiveness, thereby exposing the individual to all applicable risks in return for limited benefit. Thus, it is essential to identify the target symptoms for the medication trial in advance so that the effect can be measured against the desired benefit. If a medication trial does not address the target symptoms effectively then the medicine can be discontinued and another trial instituted. When a new agent is added to a combination of agents successfully, then attention needs to be paid to whether agents in the prior regimen can be withdrawn. The task is that of providing aggressive medication treatment when such is necessary, as well as providing a reasonable opportunity for success after discharge without lapsing into unnecessary polypharmacy that exposes the individual to untoward risks without discernable benefit.

> Rachel is an individual in her early sixties who has been hospitalized for more than a decade under an NGRI order. She has persistent symptoms of paranoia and thought disorganization as well as chronic delusions that impede her ability to make any progress toward Conditional Release or rationally discuss discharge in any fashion. In consultation with the treatment team it became apparent that she has been on fluphenazine decanoate for more than seven years because she "refuses" to take anything else. Even though she is not her own decision-maker, the team did not want to "put her through" the possibility of receiving a different medication over objection.

Unfortunately, this thinking had the effect of sentencing Rachel to life in the hospital, as she clearly could not progress through the NGRI system in the clinical condition she had at present. What the psychiatrist needed to do was identify some of the agents not yet tried (examining the risks in the context of Rachel's current medication conditions), engage the treatment team in how to best work with Rachel to take it, secure consent from her decision maker, and proceed to try to achieve better symptom control.

## Medications in an Emergency

The final intersection between medications and recovery-oriented treatment features the most potential conflict. This is the relatively infrequent need to "force" medication. The circumstances in which medications can be given against an individual's will are the subject of regulations and law, which govern the specific details and vary by setting and state. Given that one of the original strands leading to the modern recovery principles derived from the anti-medication, anti-psychiatry movement, and the much broader importance of choice as a patient right and precursor of the kind of ownership for managing one's illness, the objections to forced medication are readily apparent. Indeed, there are but two exceptions in clinical practice to the general preclusion of medicating a person against their will aside from the Sell decision relating to legal provisions regarding the administration of medication to restore an individual's competency to participate in criminal justice proceeding of compelling interest to the state.

The first, and clearest exception, involves emergency situations in which the safety of the individual or others is in immediate jeopardy and, in the judgment of the physician, medication is required to mitigate that danger. Recovery is not served by an individual harming themselves and it is also not served by them harming others. If a serious injury should occur, there is the additional trauma, the likelihood of remorse, and the reality that future choices regarding placement, work, access to programs, and relationships can be compromised by aggressive actions. Depending on the individual's capacity and motivation legal charges may ensue, further limiting future choices while burdening the recovery process. Any of these developments can complicate the dimensions of hope, connection, and purpose as the individual goes forward. If the hospital has established a recovery-oriented treatment environment, then the potential harm to the recovery process can be mitigated. If the environment is demonstrated to be unsafe, then the maintenance of a recovery orientation is deeply compromised.

The second exception is less clear, may depend on whether the objection is verbal or physical, obviously requires that the individual lack capacity and, in some locations, may be

precluded by regulations. However, in the circumstance in which an individual who lacks capacity presents with such symptoms that discharge is impossible, alternative strategies to persuade or reinforce taking indicated medications have been attempted and failed, and there is a reasonable likelihood that medication treatment will produce sufficient symptom relief to allow progress toward discharge and/or mitigate the risk of future aggression or self-injury, it is reasonable to pursue treatment over objection. When the lack of medication treatment is essentially the equivalent of a permanent sentence to inpatient commitment, likely at some risk to the individual or others, for an individual deemed incapable of making a choice based upon the rational assessment of risks and benefits, such a course is inconsistent with the concept of recovery. It is also inconsistent with the broader purpose of inpatient care to provide the individual an opportunity to live more successfully in the community after discharge.

## Discharge

Psychiatrists or other physicians are responsible for writing the discharge order so that an individual may officially leave the hospital. As a practical matter, with exceptions for discharges driven by Court decisions, the discharging physician will bear the liability that goes with a discharge and, thus, must be satisfied that the discharge is a safe and appropriate one. However, the discharge will typically be the result of the efforts of a number of individuals, will reflect an improvement in symptoms as manifested in a reduction in behavior of risk to the individual or others, will be based in an aftercare plan and placement assessed to be sufficient for the individual's immediate and, perhaps, ongoing needs for treatment, supervision, and support.

When an individual who has been civilly committed can or must be discharged derive from local and state laws and regulations, the available community resources, and work processes as developed for the system in which the individual is being discharged to and from. Despite the variations this involves from one place to another there are some common provisions within discharge planning and discharge that should be present in a recovery-oriented service.

As a matter of respect, self-determination, and hope, it should be made clear to the individual, in language that he can understand what he must do or avoid doing in order to be discharged. This "discharge criteria" should serve to focus the individual and the treatment providers as to what needs to be accomplished during the hospitalization. It should be examined in the context of what is necessary for the individual to be able to do or avoid in order to have an opportunity to live successfully in the community.

Discharge criteria should not describe what the staff will do in order to accomplish the discharge. The criteria should be shaped by the anticipated discharge placement and aftercare services to be provided. For example, an individual whose anticipated placement is a group home with 24/7 supervision and medication administration services does not need to learn to self-administer his medications as a criteria for discharge. An individual returning to live alone in his own apartment may not need to demonstrate an ability to socialize with others. The criteria are likely to be different for an individual leaving to go to an apartment versus one leaving to go to a group home or adult home as these destinations are likely to require different capabilities in order to be successful. It is beyond the scope of this chapter to review discharge planning, but it is essential that the individual know what is expected in order to be discharged, that the discharge criteria be individualized to the person, that they reflect what the individual needs to be able to do or avoid in order to be successful in the community after discharge and that the discharge takes place in a timely fashion upon the individual meeting the discharge criteria. Such a process provides respect, an opportunity to exert and be reinforced for exerting personal choice and control, and establishes a pathway that can help establish and reinforce hope.

## Treatment Team Work Processes and Recovery

Psychiatrists are commonly designated to provide leadership to the treatment team, typically without any real supervisory authority for any of the team members. Many books have been written about leadership, reflecting an inherent elusiveness in our ability to describe and teach what appears to come very naturally to a few (e.g., Collins 2001; Kouzes and Posner 2007). Our focus with this chapter is, fortunately, much more narrow and limited to constructing and maintaining a recovery-oriented treatment environment. To this end, the psychiatrist, as well as other professionals, needs to manifest active attention on the recovery principles of hope, purpose, respect, interpersonal connection, choice, sensitivity to trauma while providing the assessments and treatment necessary to provide the individual an opportunity to be successful in the community after discharge. This attention to recovery principles should also manifest in the working relationships among team members and direct care staff, and in the various meetings necessary to conduct the team's work. It is difficult, if not impossible to produce a recovery-oriented treatment environment absent a recovery-oriented culture that extends into the work environment. It is beyond the scope of this chapter to address the many dimensions of the work environment or the working relationships among various staff members, however, "meeting behavior" is so essential that a paragraph on meetings in relationship to recovery is necessary.

Treatment team meetings are an essential aspect of work in a psychiatric hospital. The manner and spirit with which they are conducted should reflect the same recovery orientation with which treatment is to be conducted. The demonstrable mindset is that the team can help the individual get better and that hope for symptom improvement and success after discharge is possible for each individual. For any particular individual, "getting better" will have its own unique characteristics shaped by the relevant clinical symptoms, behaviors, stresses, strengths, goals, and legal requirements of the hospitalization. Likewise, how the individual would assess or define success after discharge will vary for each case. It is then logically consistent that how a given treatment team will demonstrate their ongoing commitment to recovery principles will be unique as well in order for the commitment to manifest its genuineness or authenticity for any individual. However, within such singularity there are some commonalities. These would include, but not be limited to: an opportunity to participate and contribute to the assessment and treatment of the individuals on their unit, to have an opportunity to provide input to decisions related to individual treatment and the operation of the treatment unit, to have their time respected and not wasted in the conduct of meetings, rounds, or required work duties, and to not be subject to or traumatized by unreasonable job stresses, fear, exposure, or humiliation. As with individuals, there must be the hope that problems, however difficult, can be mitigated if not solved. Ideally, the larger organization allows for the career advancement and encourages such improvement to provide additional dimensions of hope and choice for staff. Creating an environment that seeks to learn from incidents and misfortune rather than blame is the parallel to creating a path for recovery in individual treatment.

Psychiatrists, other professionals and physicians have a substantial influence on the day-to-day, week-to-week environment in which individuals are treated and staff members work. For this environment to support a recovery orientation for treatment, it must support the equivalent orientation in the work processes and working relationships.

## Psychiatrist Administrators

For some psychiatrists, there are administrative or supervisory responsibilities that impact upon the hospital at large, e.g., Medical Directors, Unit Medical Directors, Chiefs of Staff, and Medical Staff Presidents. The nature of the specific position will determine the extent to which the administrative psychiatrist has direct authority

over the clinical operation of the hospital or is simply in a position of influence within the hospital's over all administration. Through the avenues available to them, their efforts and/or influence need to be aligned toward several particular objectives to facilitate a recovery-oriented environment and culture.

First, the vision for a recovery-oriented service needs to drive the development and implementation of policies and procedures so that the policies and practices support recovery principles. This begins with the hospital having a goal of success in the community after discharge for each individual admitted and carries through all of the work processes necessary to accomplish that. Second, they need to help establish a professional and work environment that provides the parallel recovery principles for staff members at each level. Third, they must help hospital administration face directly the difficulties possible when recovery principles intersect with clinical risks so that the necessary clinical practices are consistently and coherently applied. Fourth, the general and specific training to all staff members must reflect the integration of recovery principles into the safety and operational responsibilities of the hospital. Efforts must be made to assure that staff demonstrate on a consistent basis the lessons of such training. Fifth, the psychiatrist must help the hospital have an operational paradigm of learning first and blaming only when thorough examination requires it. Incidents, deaths, and trends in quality or risk measures all provide opportunities to learn and improve. While the multiple regulatory requirements can risk making such exercises bureaucratic, if not perfunctory, the principle of learning and improving applies as well to organizations as to individuals in recovery. Finally, the requisite budget processes within a hospital need to reflect the priorities that are driving the clinical operation in a recovery based direction. The overall objective is that, despite the stresses that accompany the operation of a state or publically funded community hospital, the hospital's mission, recovery orientation, work environment, and budget processes are cohesive and aligned with producing success in the community for those individuals admitted to the facility.

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