Allegheny County Coalition for Recovery

Collaborative for Recovery Dialogues

November 15, 2018

Center for Public Service Psychiatry, Webster Hall

Attendance – 4 service recipients (R), 3 service providers (P)

Note – 2 service recipients also identified as providers (but are recipients for this dialogue) and 3 providers identified as current or former recipients (but are providers for this dialogue)

Facilitators – Bob Marin and Melissanne Myers

Note – Attendance was affected by inclement weather conditions, preventing some participants from attending and delaying the arrival of others. Due to the delayed start, as well as the flow of conversation, there was only one session for the evening (no breaks).

The dialogue began with a simple ice breaker to help everyone settle in and to get energy flowing.

Facilitators welcomed all participants and presented an overview of the dialogue objectives and process, history of dialogues, and guidelines/logistics for the session.

Participants introduced themselves, identified their role in this dialogue, and expressed what they would like to take away from the dialogue.

Facilitator - In the world of behavior health, what does the word "recovery" mean to you? How do you define recovery?

R - Recovery, to me, is the difference between existing and living – existing without care or living in choosing care.

P – Personally, for me as a consumer as well as a provider, it means on a path to, or healing to, living my best life.

P – Not a word I use. In the AA community (Alcoholics Anonymous), it means a process to living life. I don't use it with patience much – I want the patient to define it.

R – I like to think of it as an individual journey. You're either always on the journey or at the end of the road. There is recovery from mental illness – it takes time, and may require maintenance, but there is recovery.

P – Can a person be in recovery when they're not at their best?

R – Are you still in recovery when you slip in AA? As long as there is progress, there is recovery.

P – There are lots of balls to juggle at any given time. If it's not perfect, is it recovery? Is trying your best enough?

R – It's not the same, at all. Recovery is non-linear, moving several steps back and forth.

P – Trying to denote the process here, the dialectic. It is more defined in AA. With depression, not being where I was, but still not at my best, is recovery. The term "getting better" is a more gradient language; it allows for continued improvement.

R – The definition, for me, is not reverting back to old patterns, mental and physical. I didn't think recovery was possible for me. Words like that didn't exist back then. Who came up with that word? Take my meds, check in, and they let me go. It's like a label for old patterns

P – The recovery movement feels like a label.

R – Key tags are a label to be proud of.

P – Is it a failure without a key tag?

R – Do I give back the tag if I slip? Does it further stigmatize? Does incorporating more recovery language still stigmatize?

R – The label of substance abuse is still a label if you give back the badge.

R – Just because you recover and slip, they don't take back the tag.

Facilitator – The term "consumer" came out of the recovery movement to fill a need.

P – It's a term taken up by the community.

P- Recovery is individual. Each consumer defines for themselves. Be true to yourself.

P – Why is "consumer" or "recipient of behavioral health services" better than "patient"?

R – What is a consumer? People who are served. I like to say I'm a person with lived experience.

P – If I see a doctor, I'm a patient…a consumer of services. Should there be a difference between physical health and mental health?

P – Why is language so important?

R – Stigma.

Facilitator – Let's try not to get stuck on a word.

R – I'll tell you the difference. If I tell the receptionist I'm at the hospital for depression, that means I automatically get treated differently - padded room treatment.

R– The brain is part of the body, too, but you get sent to the psych unit, to Western Psych.

P – Intensive care is also special care. If everyone was admitted the same, patients wouldn't get the care they need right away.

P – I think we're still talking about stigma, about being separated out when interacting with the health care system.

R – If I have an ear infection, I go to the regular ER.

Facilitator – Let's not get too hung up on words.

R – It's not so much the separating (to psych treatment), but the not telling people why they're separated. With the psych label, you're treated differently. You're talked around. You're talked about, but not talked to.

P – People are diagnosed in a room. Someone comes to the ER with really high sugar level. He is treated and spoken to in a language (terminology) he understands ("What is wrong?"," This is how can I help you.", "This is what I can do to help you feel better"," Are you feeling better?", etc.). The procedure does not go "around" the patient.

R – It's more prevalent in a mental health diagnosis because people assume you're incompetent.

R – I disagree.

Facilitator – Just a reminder that we all come from different experiences.

R – It is more likely to occur in the mental health system than other facets of health care.

R – In some instances, people can't comprehend. Some people hallucinate, but if the patient is able to comprehend, give them all the information. If the patient is completely out of it – y'all know what to do.

Facilitator – So, language is important.

R – Yes!

Facilitator – Explain….

P – Informed Consent – there are times people can't understand, but you can't always tell if it's a behavioral health issue or a medical issue that is causing it. In listening here, I can hear how important it is to talk about stigma and autonomy in health care. Behavioral health is a leader in that, but patience still has a big beef. On one hand, psychiatry is setting a precedent in the community….but we still have work to do.

R – So much work because of historical monstrosities.

P – We inherit from so many others. Some come to me after seeing a long list of psychiatrists. We inherit patients' issues from many years and have a fifteen minute med check to do it.

P – We inherit people who have a hard time trusting. They sometimes have an acute inability to trust. There are lots of historical atrocities. Psychiatry has, historically, been very paternalistic, and people were told how they felt and what they needed to do. When it doesn't work, trust is lost from the patient.

R – It's difficult to not bombard a new doctor with everything in the past, piling all the hurts and mistrust.

P – When it's a physical issue, it's easy to see how people are incapable. Mentally, it's not so clear. No one wants to intentionally hurt someone. We can be accommodating when enough information is available.

Facilitator – Note that when people are incapacitated by mental health, they require a set of special doctor skills. Reactions may be based on past treatment. Psych symptoms give mental health a different quality.

P – It is so important to be careful and kind when people are most vulnerable, to give the best treatment at that moment. I like inpatient. Not always a sense of agreement, but I listen and do the best I can.

R – There is an inner battle – not wanting to agree because of stigma. Don't know what to say.

P – Wanting to push away.

Facilitator – Pushing away?

R – How do people push away? They block out focusing on things for themselves, crowding out thoughts.

Facilitator – The way people deal with relationships.

R – People in mental health crisis don't want to deal with it. Labelling pushes them away.

P – From a systems perspective – compartmentalizing is the most efficient way of providing service, set up in a certain way.

R – I went to the ER with a swollen tongue - told the ER nurse that I took Penicillin. She saw mental health history in my chart and heard "suicide attempt", which is not what I said. The doctor pulled up the chart and changed the antibiotic.

P – I've actually seen that kind of thing happen. Chest pains don't necessarily mean a panic attack. It could be a heart attack.

R – Treat the condition and tell us why. Don't dismiss symptoms.

P – All doctors go to med school, but no other areas require psych training (except children and neuro).

P – Doctors in other areas often make mistakes when it comes to psych, especially in realizing that people with mental illness/mental health issues can understand and talk.

P – Self-selection – doctors choose their focus, but we have to deal with all conditions.

Facilitator – Well, folks, it's been a recovery night, clarifying what recovery stands for – landing at a place of how we want relationships to work and function for each of us.

Facilitator – It's all about relationships between service providers and receivers.

R – Get to know the individual. Find common ground, big or small. Get to know each other.

Facilitator raised a question of taking a break at this point, but everyone decided to continue.

P – Sometimes it's hard to get to a point to converse. I may not share the feeling of chest pains, but I do share humanity. Look for common humanity.

P – Respect each other as individuals, find commonalities.

R – That goes a long way.

P – Some are troubled by interaction with a mental health provider without feeling human interaction. You want to know who your doctor is, and want more natural conversation besides a symptom check. That troubles me is that psych is still at a point where time is still an issue and we, as doctors, are unable to do this as much as we'd like to.

R – Avoid negative spirals of thought. Try to know your individual possible and probable perceptions.

P – It depends where the patient/doctor are interacting. Fifteen minute med checks are like an assembly line. I'll work with what I'm given, but time is very limited. Tele psych actually allows for asking more questions, and doctors probably need retraining. It is very much individual. We're allowed 45 minutes, right now, but that changes to 20 in January.

P – Definitely does not allow for establishing a relationship as much.

R – I'm listening….20 minutes? So I walk in upset and can't get people to talk to? Personal experience – I don't like to be rushed!

P – There aren't really enough Psychiatrists. There's not enough training, a finite number of spots, it's a chosen specialty, there's stigma, and compensation is an issue.

Facilitator – The system is imperfect and flawed. Do we expect the same things with less time? Time is short; do we want the same treatment in that time?

R – Keep the ball rolling on The Deck.

R – There's a fifteen minute chance to establish a relationship, a rapport. Try to find something in common. If we talk about dogs, and two weeks later you ask how Fluffy is? I'll remember that.

R – Allow for one or two open-ended questions, to learn something about that person.

P – It is possible, sufficient.

Facilitator – Sufficient time.

R – If I feel like the doctor is rushing, I will feel the stressful energy from him.

R – Feel boxed up in an office and sandwiched. What the hell – no chance to speak?

R – Breathe deep before talking with a patient. I can feel rushed energy before you speak. I might think, "Are you trying to cage me in here?".

R – Lots of people feel that way because of past experience. There's trauma upon trauma from psych treatment. People are scared – What the hell am I doing on the deck?

P – Doctors are still human, especially in feeling a 12-15 hour shift. Sometimes, the doctor needs to go home.

R – Feels like judgement can be clouded. All I said was "I'm not feeling well", and suddenly I'm on the 11th floor (Western Psych) and I haven't been fed in hours.

P – I can imagine. It's not so much the judgement, but patience, ability to phrase things appropriately. Doesn't change the outcome, but it does taint the experience for the patient.

R – And makes people reluctant to go back the next time.

P – It is a crap shoot as to who you get and when you get them.

R – How does one (doctor) maintain, knowing an individual has been on the deck for 12 hours?

R – Judgement is clouded. Doc on a dime.

Facilitator – What do you feel?

R – Frustrated, dehumanized.

P – Funny thing, I feel the same on The Deck.

R – Not bothered, but have seen a doctor abused by a patient. How I'm treated in that instance determines my response. I have baggage.

P – Short term outcome does not change, but the long term relationship with psychiatry is.

P – Most people are nice when you're nice to them. The next six patients can be very nice after they see a doctor abused. You get back what you extend (doctors and patients) – wanting to get the best we can.

Facilitator – Have you seen or discovered things doctors do that are helpful in high stress?

R – Slowdown from 80mph situations. Take a breath before the next patient. Exercise good self-care as providers - positive self-talk/inner dialogue. Excuse yourself as necessary if you need a minute to cool down.

P – Worth the talk to explain to coworkers.

R – Establish coping with families. Maintain composure in situations when they don't understand. If family is angry, suggest they wait before discussing/processing.

Facilitator – Our time is coming to a close. What are your responses to tonight's experience?

R – It was a very fruitful discussion regarding both sides.

R – I agree. It was intriguing, open and candid. I hope you take info back with you to help in the future. Think, "Would I want to be treated like this?".

R – Limited time with a little bit to accomplish. Establish rapport and get to know the person – not to be a best friend, but to collaborate. Use inclusive words.

P – I'm really glad I came. I always enjoy hearing different perspectives and bouncing ideas off each other…the group discussion and learning about how doctors are seen in a respectful, kind way.

P – My first dialogue; very respectful and informative. Remember to "breathe" in the 14th hour, and leave documentation to the deck.

P – Only ask the important questions. Find out what's going on with the person.

P – I enjoy the dialogues – I've done them before. We're here because we want to be here, to learn from people who receive care and have lived experience. How do I extend this? Take what I've learned beyond this room.

Facilitator – Take home thoughts?

P – Collaboration and team work – lot me know what I'm doing wrong. Be mindful of how you ask.

P – Realization that The Deck is set up for the convenience of providers/the system. More conversations need to happen on the deck.

P – Talk to other doctors about what we've learned tonight.

R – Try to make good use of peer specialists.

R- Yes, tap into peers! They come with knowledge and support for you.

R – Try to talk to people in other hospitals and resources. Patients are sent home after spending hours there, with info you could have given them in a few minute.

R – All roads lead to the deck and is really hard on patients and families.

R – Remember to give the number to ReSolve.

P – It sounds like we're all on the same page. Now, we need to get the word out to others.

On that note, we ended an evening of great discussion and collaboration.