



New England (HHS Region 1)

MHTTC

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# Guiding Principles for Person-Centered Psychopharmacology and the Promotion of Self-Management



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## Executive Summary

Several forces have converged over the last decade to call for a reconsideration of how to view, discuss, prescribe, and assess medications for effectiveness in the care of persons with serious mental illness and/or substance use disorders. This document briefly reviews these issues and describes the point of convergence as being patient-centered medicine. We offer these six evidence-based principles, illustrated using clinical vignettes, for promoting self-management in individuals with mental illness and/or addictions:

- Elicit the person's and family's perspectives on the concerns bringing them to care.
- Assess the person's and family's perceived needs and priorities, including any cultural preferences (e.g., ethnic, sexual, spiritual).
- Identify the person's short- and long-term goals.
- Identify medication targets that indicate that the person is overcoming barriers to life goals or increasing their quality of life (beyond symptom reduction).
- Prescribe medication as one component of an overall self-management plan that builds on personal and family strengths.
- Identify and address barriers to self-management, including the need for additional supports (e.g., transportation, child care, reminders, environmental modifications).



## Introduction

It has been two decades since the Institute of Medicine first called for practitioners to practice *patient-centered medicine*, which it defined as “care that is respectful of and responsive to individual patient preferences, needs, and values, and ensur[es] that patient values guide all clinical decisions”<sup>1</sup> How, exactly, patient values are to “guide” clinical decisions has yet to be clarified, however, especially within the context of the treatment of serious mental illnesses and addictions. Since that time, other forces converged in clinical practice that call for reconsidering how medications are viewed, discussed, prescribed, and assessed for effectiveness in the care of those with mental or substance use disorders.

First, evidence has emerged that suggests that while some people with serious mental illnesses may require antipsychotic medication for extended periods, others experience significant improvement when medications are used sparingly and primarily in treating acute episodes.<sup>2</sup> Second, while we are beginning to consider whether medications have been overused in the treatment of mental illnesses, we are starting to appreciate how under-prescribed medications are in substance use disorder treatment. Despite significant advances in the development of effective medications for addiction, the majority of persons with substance use conditions

1 Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academy Press.

2 Jobe, T. H., & Harrow, M. (2005). Long-term outcome of patients with schizophrenia: a review. *The Canadian Journal of Psychiatry*, 50(14), 892-900.

are not yet offered them.<sup>3</sup> Third—as a core component of patient-centered medicine—shared decision-making between practitioners and their patients is being advocated as an ethical imperative<sup>4</sup> that also has been shown to increase medication adherence and improve outcomes.<sup>5</sup> Finally, as part of the healthcare reforms currently underway, the Centers for Medicare and Medicaid Services, as well as private payers, are promoting a shift toward self-management of chronic medical conditions, including persistent mental illnesses and addictions.<sup>6</sup> These forces point toward people taking more active and informed roles in their own care, both in terms of collaborating with practitioners in decision-making and in learning how to manage their own behavioral health conditions.

While we welcome patients and their families to take on more active and informed roles in their own care, we also know that mental illnesses and substance use disorders, along with the stigma and discrimination associated with them, can pose challenges to collaborative decision-making. Consider the following two vignettes:



Ms. A has been diagnosed with schizophrenia, for which her psychiatrist had initially prescribed an antipsychotic medication. She reports having auditory hallucinations and thoughts that her neighbor has been spying on her and her two children. She complains that her husband does not take her concerns seriously, and worries that their neighbor is planning to kidnap her daughters. Ms. A does not seem to respond to the medication and after prompting from her psychiatrist, acknowledges that she had not been taking the medication regularly for some time. After gaining 20 pounds and feeling foggy and tired all the time, she had decided to stop taking the medication altogether.

While she is willing to consider other medications, she does not want to gain any more weight and wants to be able to help her daughters with their homework when they return home from school in the afternoon. The voices and thoughts still bother her, but she says that she will not take a medication that makes her obese, sleepy, and unable to concentrate.

3 White, W., Parrino, M., & Ginter, W. (2011, October 11–12). *A dialogue on psychopharmacology in behavioral healthcare: The acceptance of medication-assisted treatment in addictions* [Briefing paper]. Psychopharmacology in Behavioral Healthcare Meeting convened by the Substance Abuse and Mental Health Services Administration. <http://www.williamwhitepaers.com>

4 Drake, R. E., & Deegan, P. E. (2009). Shared decision making is an ethical imperative. *Psychiatric Services*, 60(8), 1007.

5 Davidson, L., Roe, D., Stern, E., Zisman-Ilani, Y., O'Connell, M., & Corrigan, P. (2012). If I choose it, am I more likely to use it? The role of choice in medication and service use. *International Journal of Person-Centered Medicine*, 2(3), 577–592.

6 Resources for Integrated Care. *Self-management support in behavioral health: Organizational assessment tool* [in development]. Centers for Medicare and Medicaid Services.





Mr. B has been taking opioid analgesics, sustained release morphine, and oxycodone for breakthrough pain since shortly after injuring his back while exercising two years ago. His need for pain medication has increased steadily over the past year, resulting in several requests for early refills. A check of the state prescription drug monitoring program showed that Mr. B recently obtained prescriptions for hydrocodone from two other physicians. He told his doctor that he had to see other doctors because the medication prescribed did not relieve his pain. The physician explains that Mr. B has developed the symptoms of an opioid use disorder and wants to discuss his treatment options. Mr. B does not think that this assessment is correct and wants to discuss the reasons why he believes his problem is chronic pain.

What does it mean for a practitioner to practice in a person-centered fashion in cases such as these? What about even more extreme cases, where people are acutely psychotic, deny that they are ill, or are being treated involuntarily? What does shared decision-making look like in real-world practice for people whose illnesses we are treating impair their judgment? While not resolving these complex issues, we developed the following principles to offer practitioners concrete, practical guidance for addressing these and other challenges we face in providing high quality, person-centered, and collaborative care to patients and their loved ones.

We begin by considering the role of medications in treating mental illnesses and substance use disorders within the context of person-centered medical and psychiatric care. Next, we identify six evidence-based principles for promoting self-management and discuss the various roles practitioners play in this new approach. We offer a model of collaborative care that outlines substantive roles for prescribers, other healthcare practitioners, patients, and their family members to ensure that the care offered will be both maximally effective in treating the person's conditions and consistent with their values, preferences, and goals. As prescribed medications that are not taken cannot be helpful, we argue that for medications to be effective over the long-term, they must be acceptable to each person (and in some cases to family members as well), experienced by each person as responsive to their needs, and aligned with each person's efforts to care for themselves as best they can. Vignettes in this section explore and illustrate the key roles that prescribers play in deciding, prescribing, and evaluating medication effectiveness to address these functions.

While many of these principles apply to most persons seen by practitioners for mental illness and substance use conditions, they do not necessarily apply to every situation a practitioner may face or to every setting where they work. Forensic and acute care settings, for example, call for adaptations of these principles to address situations where people may be neither legally entitled nor capable of making their own decisions (at least for specified periods of time). In such cases, we encourage practitioners to minimize conditions requiring coercive measures and limit using those measures only to the time necessary. Since passage of the Dodd-Lieberman Act in 1999, behavioral health practitioners have made significant shifts in lessening their use of restraints and seclusion in inpatient settings. These changes serve as an example of how coercive measures can be avoided at best or minimized at least through changes in practitioner behavior.

When nonetheless necessary, we should take coercive measures in ways that maximize the person's remaining degree of autonomy. In all but the most extreme cases, people will retain rights to make decisions for themselves even within the context of involuntary commitment or prolonged incarceration. We consider it not only an ethical imperative—but also a therapeutic intervention—to protect and promote patient autonomy to whatever degree possible. Having a sense of personal agency and confidence in one's own decisions and efforts are two of the fundamental building blocks needed for people to practice self-management and pursue recovery.

## For many people, medications are only one part of treatment

For many of those we treat who have more serious conditions, medications alone are insufficient to promote optimal recovery. Medications currently in use do not cure serious mental illnesses or addictions. When effective, however, they can reduce symptoms and a person's likelihood of relapse and/or improve the person's quality of life. Thus, medications can offer partial solutions to certain kinds of problems while having little to no effect on other kinds of problems. It is important that we, as well as our patients and their families, appreciate both what medications can do and what they cannot do.

In serious mental illnesses, medications may reduce the more flagrant symptoms such as hallucinations and acute mania, but fail to address the negative symptoms and neurocognitive impairments that are often the more disabling aspects of these disorders. In some persons with schizophrenia, for example, difficulties with concentration, memory, and executive functioning can pose more of an obstacle to community life than the voices they hear when alone. Even in the case of affective disorders where medications can stabilize a patient's mood and protect against relapse, medications cannot repair relationships or help the person identify and plan for managing triggers, such as losses or setbacks.

In addiction treatment, medications may render certain substances less reinforcing or reduce cravings but have no effect on the person's ability to develop new, sober social networks that support their recovery. In this respect, we should avoid conveying the message to our patients that all they need to do is to take the medications we prescribe and that everything will be all right. Recovery requires hard work on the part of both prescribers and patients, and practitioners play a central role in educating people about their role as patients, and supporting them in their efforts to manage their conditions and recover as fully as possible.

With respect to treatment outcomes, it is important to recognize that *quality of life* means different things to different people. What we envision as a better life for a given patient may be very different from the life that they envision or aspire to. For example, we may prescribe a medication to decrease auditory hallucinations, but the voices may not particularly bother our patient who is focused on finding a medication that will allow them to get up in the morning so that they can get to work. We may prescribe a medication because our patient is delusional, but our patient may be uninterested in anything that threatens their closely held beliefs. They would rather take a medication that helps them ruminate less.

As prescribers, we may start from our own point of view and ask our patients to follow our thinking in relation to treating symptoms and illness. A growing body of evidence, however, suggests that we may be more effective if we start from our patient's point of view, taking their values and everyday concerns into account and focusing our efforts on supporting the person in achieving their own goals. For our patients to use the medications we prescribe effectively, we need to expand our role from that of relaying our technical knowledge to applying that knowledge within the context of each patient's personal, everyday life.

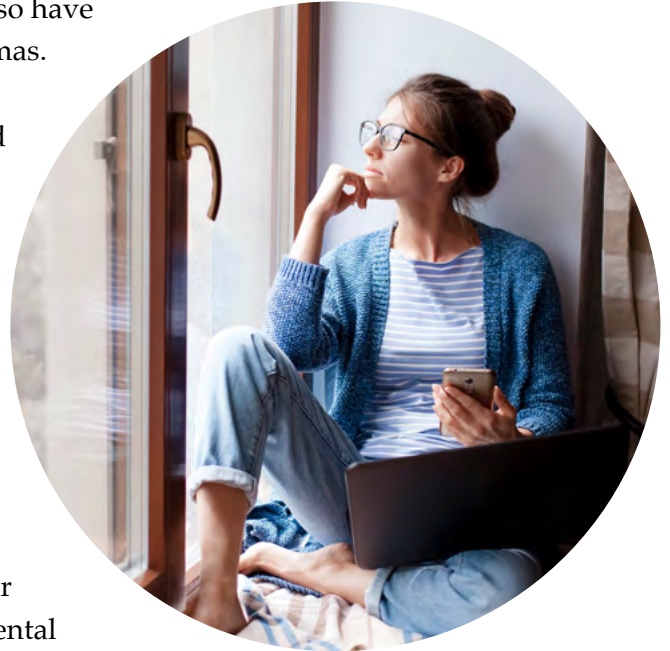


## Medications have costs as well as benefits

While medications can be useful for certain purposes, they also have risks and potential side effects, and may present other dilemmas. Such risks and side effects are not merely annoying or unpleasant, but can contribute to the increased morbidity and premature mortality rates currently experienced by persons with behavioral health disorders. Therefore, we must address risks and side effects, even when a medication is very effective.

Dilemmas associated with medication use may not always be so obvious, such as when the primary cost is the reminder to the person that they are ill or the risk that other people may discover that they are ill. This dilemma represents one way that the continuing stigma that accrues to behavioral health disorders figures prominently as a barrier to adherence. A person is unlikely to take medication for a mental illness, for instance, if they associate mental illness with media portrayals of axe murderers or serial killers. A person also is less likely to take buprenorphine when members of their 12-step fellowship continue to endorse the view that all medications are bad and that recovery requires total abstinence, including abstinence from prescribed medications. The discrimination that continues to accrue to mental illness and addiction in our society is real, influential, and a major factor in many persons' decisions not to take the medications we prescribe.

Because of the inevitable downsides of medications and the power that stigma exerts, it is important that we acknowledge that the decision each person makes each day to take—or not take—the medications we prescribe is a highly personal decision that involves balancing the benefits of a given medication with its risks, side effects, and other costs. No matter how much education we may provide or persuasion we may exert, it remains the person's decision—supported or not by their loved ones—that will determine how consistently they take their medication. A major consideration in many people's silent deliberations about taking a particular medication is what adverse effects that medication will have on their daily life and relationships.





## Beyond symptom reduction to promoting self-management

In the shift to patient-centered medicine and person-centered care, our responsibility shifts from reducing symptoms, cravings, and relapses through a person's compliance with prescribed medications to promoting and supporting patients and families in their active efforts to self-manage these long-term conditions. Since our current medications do not cure the illnesses we treat, it is up to our patients and their families to learn how best to manage these conditions, with our assistance and support, between their appointments. Medication becomes one potential tool along with other tools that they may use to manage their conditions, rather than being the sole focus of care. For patients and their families to undertake such active roles in using tools in the self-management process though, we must do more than provide education, information, and encouragement.



Research consistently demonstrates, for instance, that people are much more likely to implement and follow through with treatments that they themselves have chosen from among relevant options, and are less likely to follow through with treatments chosen for them by others.<sup>7</sup> For patients and families to assume responsibility for self-management, they need to feel confident in their knowledge of what they are managing and in their ability to decide how best to go about doing so. Thus, part of our responsibility becomes laying out the options people and families have from which to make their own decisions, and then respecting those decisions, as we would want others to respect our own.

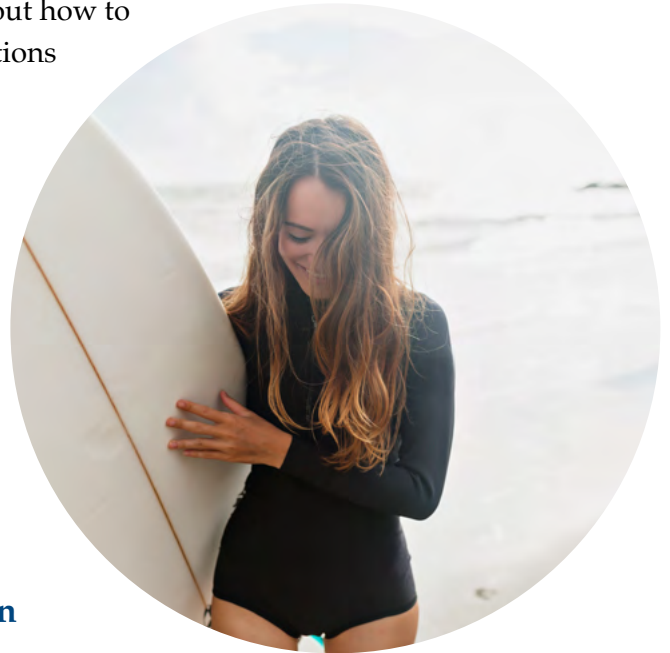
The remainder of this document provides recommendations for how to educate and empower people and their families to assume responsibility for self-management, how to address common barriers encountered in doing so, and how to promote their adherence to the shared decisions resulting from the collaborative relationships you develop with them and the other members of your interdisciplinary care team.

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<sup>7</sup> For a review, see Davidson, L., Roe, D., Stern, E., Zisman-Ilani, Y., O'Connell, M., & Corrigan, P. (2012). If I choose it, am I more likely to use it? The role of choice in medication and service use. *International Journal of Person-Centered Medicine*, 2(3), 577–592.

## Principles for self-management

Researchers have learned much over the last two decades about how to effectively promote self-management of chronic health conditions in patients and their families.<sup>8</sup> Many of these lessons and principles apply as directly to self-management of behavioral health conditions as they do to other medical conditions such as diabetes, asthma, and cardiac disease. Other lessons and principles, though, will need to be adapted to address the specific challenges posed by serious illnesses and refractory addictions. In this section, we discuss and illustrate the key components of the process of promoting self-management of behavioral health conditions, including a model for collaborative decision-making.



### 1. Elicit the person and family's perspectives on the issues that brought them to care.

In addition to assessing clinical severity and functional status, and making a diagnostic formulation, it is important early in a relationship with a new patient to ask about their own and their family's perspective on the difficulties they have been experiencing. Signs and symptoms of behavioral health conditions can be perceived in different ways depending on each person's cultural traditions, family history, and health beliefs. When prescribing a medication for treatment of a behavioral health condition, it is therefore useful to know whether the person and family accept the view that what they have been experiencing has in fact been due to such a health condition, as opposed to being due to other factors (e.g., moral failing, deceased ancestors, existential-spiritual crises, normal adolescent 'storm and stress'). Should a family retain the view that their loved one is 'going through a phase' or under the sway of the devil, for example, they are less likely to support their taking the medications you prescribe.

Once you develop a degree of understanding of the person's and family's perspective, you will have a foundation on which to provide education and information supporting a biopsychosocial view of behavioral health difficulties that, in turn, argues for the use of medications as a part of a holistic treatment approach. We cannot assume that everyone we work with has already accepted or is already familiar with a medical understanding of the signs and symptoms of mental illnesses or addictions. Educating people about this perspective and introducing them to the notion of self-management is thus a key step early in the engagement process.

Not all people or families readily accept a biopsychosocial model for understanding the difficulties they are experiencing, nor must they to derive benefits from medications. It is neither

8 Battersby, M., von Korff, M., Schaefer, J., Davis, C., Ludman, E., Greene, S. A., Parkerton, M., & Wagner, E. H. (2010). Twelve evidence-based principles for implementing self-management support in primary care. *Joint Commission Journal on Quality and Safety*, 36(2), 561–570.

within the prescriber's role, nor realistically within the prescriber's power, to change patients' and families' minds, to tell people how to think, or to require them to agree with the prescriber's point of view. Rather, the situation calls for a collaborative relationship in which both parties respect the other's point of view. In this sense, practitioners do not have to agree or disagree with a person's or family's view. What is important is that the practitioner respect their point of view for what it is (that is, their point of view). When differences emerge between these points of view, as they often do, it requires skill and resourcefulness on the practitioner's part to reframe their recommendations using language that patients and families can accept without pushing them beyond their comfort zone. The following vignette illustrates this possibility.



Ms. C was recently discharged from an inpatient stay to a partial hospital program, which she begrudgingly attends while insisting that there is nothing “wrong” with her. When she meets with the attending psychiatrist, she argues that her obsessive and ritualistic behaviors have religious significance in warding off evil spirits who are intent on torturing her for a sin she committed in her adolescence. She disagrees with the physician's assessment that she has a psychiatric condition, and is skeptical that any medications will be helpful in decreasing what she sees as necessary and self-protective measures she must take because of her youthful indiscretion.

On the other hand, when the discussion shifts to her everyday life concerns, Ms. C acknowledges to the physician that these behaviors “wear her out” and keep her from being able to engage in any of the activities she wants to do, as she can barely make it out of her apartment and when she does make it out, feelings of anxiety and worry overcome her. Ms. C's physician suggests that perhaps she speak with her pastor about ways she may receive absolution from her sin. Without insisting that Ms. C accept a particular diagnosis as an explanation for her difficulties, her physician also suggests that there is a medication that might help her to feel less desperate and less driven, and in turn to worry less. Ms. C could start the medication at a low dose, and she would remain free to take whatever precautionary or protective measures she feels necessary. The physician suggests that Ms. C simply try the medication for a week or so to see for herself whether it is useful in freeing her from the anxiety and worry associated with performing her rituals. After a week's trial, they can assess whether the medication is working.

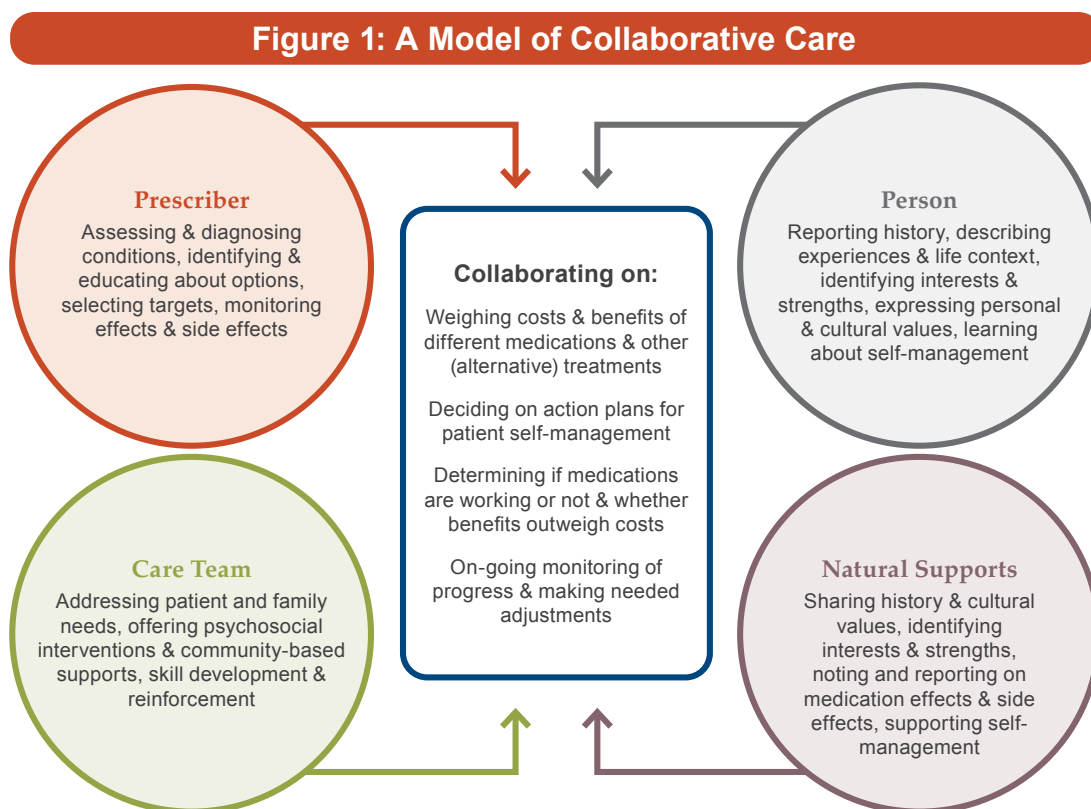
In this scenario, the physician focused on the person's source of distress and—without getting into arguments about what causes that distress—offered Ms. C a “tool” that would enable her to handle this distress more effectively in her everyday life. As a result of this approach, she agreed to try the medication and began to trust that the practitioner was genuinely interested in being helpful to her.

This point brings us to the next component of this process.

## 2. Assess the person's and family's perceived needs and priorities, including cultural preferences (e.g., ethnic, racial, sexual, spiritual).

As suggested in the last vignette, it is important to ask about and identify the person and family's most pressing needs and priorities as well as to understand their perspective on the behavioral health issues they are experiencing. Doing so builds trust between prescriber and patient and their loved ones and suggests to the practitioner the most readily accessible junctures or opportunities for intervention. In other words, patients and families will come to trust a prescriber to the degree that they experience the prescriber as being responsive to the things that concern them most. In the case of Ms. C, it was not the obsessive rituals per se that were her primary concern; it was the anxiety and worry driving those behaviors and draining her of energy that she found incapacitating.

It is often the case when people first present for treatment that what they identify as being of most concern to them is different from what a practitioner might be most concerned about. Patient-centered medicine involves identifying the patient's own most pressing needs and concerns and finding ways to address those as part of a broader care plan that the practitioner and patient develop collaboratively. In a shared decision-making model, all parties bring expertise and information to the table to inform the decisions made about a person's care. In addition to their own perspective, patients and families bring to the table their in-depth knowledge of the person's everyday life and their sense of what is most important for whom. This is crucially important information for a prescriber who wants the medications they have to offer to be most effective and relevant to the patient and their family, for there is little chance of people adhering to medications that are neither effective nor relevant to the difficulties they experience. Figure 1 depicts this model of collaborative care.





Patients' needs and priorities range from the basic (e.g., food or shelter) to the complex (e.g., finding a medication that will reduce chronic pain that does not engender dependency). It's not up to the prescriber alone to address these needs. It is important, though, for the prescriber to be familiar with the patient's needs and priorities and to take these concerns into account. It is highly unlikely, for example, that a woman will be able to reduce her alcohol or cocaine use if she remains homeless, no matter which medications are prescribed. In such cases, prescribers can go a long way to earning the person's trust if the patient knows that the prescriber is part of an interdisciplinary team that is working to help her become housed, as well as being concerned about her substance use.

In addition to garnering resources to address a person's most pressing concerns, practitioners can use these concerns as entry points for discussion regarding available treatments. For many young, single men struggling with psychosis, for instance, a major concern that may interfere with medication adherence is that of impotence. Being able to anticipate such a concern with sexual performance demonstrates to the patient that the prescriber is interested not only in his psychiatric symptoms, but also in his overall quality of life, giving the person confidence in the prescriber's recommendations. The following vignette provides another illustration of this issue.



Mr. D has persecutory delusions and hears voices when he is alone in his apartment. He is convinced that the voices come from his neighbors, who are harassing him and trying to get him to leave the apartment. Unfortunately, he has had the same experiences in two previous apartments, and is beginning to think that the neighbors are following him from one place to the next to continue their harassment. Mr. D's physician has diagnosed him with schizophrenia and would like for Mr. D to begin to take an antipsychotic medication, but Mr. D insists that his problem is with his neighbors and not due to any mental illness. Previous doctors have used the mental illness label

to lock him up against his will and inject medications that made him rigid, knocking him out for days. There is nothing wrong with his brain, insists Mr. D, and therefore no need for medications.

Taking the patient's lead, the physician shifts the conversation to ask Mr. D about his most pressing concerns. Mr. D responds with wanting his neighbors to stop harassing him so that he can sleep in peace. The physician suggests a two-pronged approach: while Mr. D works with his case manager to explore what can be done about the noisy neighbors, the prescriber would like Mr. D to try a medication that might dampen the volume of the voices he is hearing, so that at least Mr. D could get some sleep. The physician does not want to argue with Mr. D about whether he has a mental illness, but is concerned that Mr. D be able to sleep in peace, as he himself suggested. When Mr. D finds the white noise machine recommended by his case manager to be ineffective in drowning out the voices, he agrees to try an antipsychotic medication as an alternative. When the volume of the voices decreases in response to the medication, Mr. D starts to talk with the physician about why the voices might be coming from inside his head instead of his neighbors.

### 3. Identify the person's short- and long-term goals.

In addition to appreciating where the person and family are coming from (their recent past or their perspective on what brought them to care) and what is most pressing for them in the present, it is extremely useful to spend time learning what the person is trying to accomplish and their hopes for the future. One core aspect of person-centered care is that it is goal-directed. Patients' pursuits and actions reveal their values and preferences through what they find meaningful. The only way for a prescriber to use this information in collaborative decision-making and in framing the potential utility of medications is by first learning what the person's goals are in the short- and long-term.

This is not to suggest that practitioners will always agree with patients' articulated goals. Consider comments like "I just want the neighbor to stop spying on me" or "I need more oxycodone" as the opening statements of much more complicated discussions. In such discussions, it is not the practitioner's job to pass judgment on the person's goals either pro or con. Rather, the objective is to find viable goals that they can work toward together. To be viable, these goals must be consistent both with the person's long-term hopes and aspirations and lend themselves to medical intervention. In other words, goals where we and our treatments can make a difference.

In the case of spying neighbors, for example, the patient and practitioner can agree that the person doesn't feel safe in their apartment, and finding ways to feel less vulnerable would be great. In the oxycodone case, instead of increasing a patient's dose, together the patient and prescriber can explore ways to keep the patient's chronic pain from interfering so much with everyday life. The point of exploring both long- and short-term goals is to seek areas of common interest and ways that our interventions can support the person pursuing the kind of life they value. In turn, interventions can motivate the patient's self-management and adherence.

It is often wise to abandon those concerns where agreement seems impossible—at least initially—and only serves as a distraction. It may be easier to suggest alternative short-term goals (such as turning down the volume of voices), when those goals align with the person's longer-term aspirations (such as getting a good night's sleep). In the end, effective treatment flows from shared goals, not from areas where our views are most divergent from those of our patients and their loved ones. It doesn't matter that patients come to see us as being right. What matters is that they see that we can help improve their health and overall quality of life in a meaningful way.



Ms. E has been taking oxycodone as prescribed for back and neck pain for several years. Over the past few months, during a time of increased distress and demands in her life, she has escalated her dose without first speaking with her physician. This increase has caused her to run out of medication early and need new prescriptions before the usual time. When she meets with her physician, Ms. E describes how she has dealt with a family member's serious illness over the past three months and how this illness led to increased demands for her to help to care for this loved one. She also reports feeling inadequate and unable to provide good care for her family, and

describes feeling guilty, sad, and anxious much of the time. She also has had difficulty falling asleep for the last two months and she has used the medication when she cannot sleep. Finally, her pain has increased over this time, thus she has needed more medication to help her to function.

After listening carefully, Ms. E's physician expresses concern over her current situation. The physician then explains that increasing her dose of oxycodone will not be an effective solution to her present difficulties—difficulties that, while significant, might call for other measures. While agreeing that caring for a seriously ill loved one is certainly upsetting and difficult for most people, the physician suggests that given her previous ability to manage adversity in her life, perhaps what Ms. E is beginning to experience may be a form of depression.

The physician offers to connect Ms. E to a clinician for counseling and additional support, if she would find it helpful. The physician suggests that perhaps Ms. E might be willing to try an antidepressant medication as an alternative to increasing her dose of oxycodone. The physician also suggests that perhaps the clinician could recommend ways she might access resources, such as a home health aide, to assist in caring for her ill family member. Ms. E agrees to see the clinician to explore her options, but she wants more time to consider whether she will use an antidepressant medication. Her oxycodone dose is unchanged, and she agrees to return in two weeks to discuss whether she will try a medication for depression, should counseling be insufficiently helpful.

#### **4. Identify medication targets that indicate people are overcoming barriers to life goals or increasing their quality of life over and above their symptom reduction.**

As suggested in our last vignette, there are other ways to talk about the reasons for prescribing medications and their potential utility than symptom or craving reduction alone. Especially since medications often do not totally eliminate symptoms or cravings, it may be useful to identify with the patient and family how you will know when the medications are working in ways you hoped they would. Ask yourself these questions.

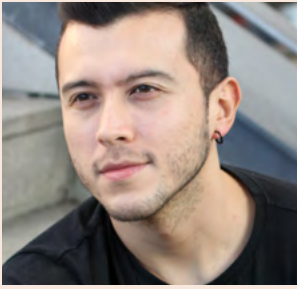
- What are you hoping to accomplish by prescribing a given medication?
- What can the patient hope to experience differently due to taking that medication?
- What can families hope to see because of promoting adherence?

Prescribers must identify specific, concrete targets for the medications they prescribe. To have tangible evidence that the patient is reaching these targets, it's helpful to base them on observable behaviors that others, in addition to the persons themselves, can see that the medications are having desired effects. In treating depression, for example, patients may begin to act differently (e.g., eating more, getting out of bed earlier) before experiencing changes in their subjective sense of mood. Having these changes pointed out by their family or practitioner and understanding that they indicate a lessening of the depression—even if the person continues to feel depressed—increases the likelihood that people will continue taking the medications long enough to derive benefits.

The art of identifying and framing tangible targets related to patient goals and quality of life comes in part from clinical training and experience and in part from discussions with patients and families. As practitioners, we know that for many people the intensity and distress associated with hallucinations and delusions change more in response to medications than do the person's delusional beliefs or the voices themselves. People can have delusions and hear voices without necessarily being distressed by them or acting on them. This suggests that decreasing the intensity of the patient's beliefs or the distress caused by the voices is likely a better target for medication effects than is eliminating symptoms entirely.

Similarly, people with persistent suicidal ideation are more likely to experience a decrease in the thoughts' intensity and frequency than they are their complete absence. Patients expecting elimination of all symptoms will be disappointed by medications offering only partial relief and may discontinue medications with limited efficacy. In contrast, people educated to look for such changes in intensity or frequency, or for behavioral signs such as being able to sit through a movie or get out of bed on time, may feel encouraged by their progress and be more likely to continue taking what they perceive to be effective medications. Consider our next vignette.





Mr. F has taken methadone several times in the past, but always relapsed after only a few days. In his first meeting with his new physician, Mr. F expresses discouragement over his previous attempts to quit using heroin, having little reason to believe that this time will be different. When the physician asks him to describe these prior experiences, Mr. F explains that even after taking methadone, he continued to experience opioid withdrawal symptoms and only found relief by picking up heroin again.

Upon hearing this, the physician first explains that it is common for people to enter treatment multiple times before they experience sustained success, and that the “problem” may not be so much with Mr. F himself as it is with the challenging nature of opioid addiction. The physician goes on to ask Mr. F if he had expected total symptom remission in such a short period. Mr. F responded yes, that he had, and inquired “wasn’t that, after all, the point of taking methadone?”

At this point, the physician explains that methadone seldom eliminates withdrawal symptoms immediately or completely at once; recovery typically happens incrementally and over a longer period. The physician further explains that Mr. F should expect the withdrawal symptoms to reduce and be managed more easily over time. As Mr. F stabilizes on the methadone, the medication may eliminate a few symptoms entirely. Not entirely pleased with this scenario, Mr. F protests and asks the physician what he is supposed to do while he waits for the methadone to “kick in” fully.

In response, the physician asks Mr. F what experiences he has had with counseling or groups. Mr. F replies that he hasn’t tried either, because he doesn’t think he would benefit from talking to anyone. He added that all “those people” do in “those groups” is whine about how hard their lives are. He doesn’t need other people poking around in his business. While appreciating his wish to do the hard work of recovery by himself, the physician suggests that Mr. F might want to try either a therapy or mutual support group before writing them off. The physician says that in her experience, these groups focus specifically and in helpful ways on what people can do to manage persistent withdrawal symptoms.

In fact, she suggests, if he were to try it, Mr. F might be surprised to see how many have struggled with challenges and temptations similar to his own and how generously they support one another and offer suggestions based on their own first-hand experiences overcoming opioid addiction.

## 5. Prescribe medication as one component of an overall self-management plan that builds on patient and family strengths.

Whether or not you consider medication to be a first line treatment for the condition(s) a person has, it is important to ask about what else the person has tried in the past and to educate them and their family about what else they will need to do to manage the condition(s) as effectively as possible. In this sense, behavioral health disorders are both like other chronic medical conditions in several ways while differing from them in others. Knowing when and how to use an inhaler can be crucial for a someone with asthma, as is knowing how to balance nutrition with exercise for the person with type 1 diabetes. Similarly, learning how and when to increase or decrease a dose safely based on life events (e.g., job interview, loss of loved one) and changes in mood or concentration (e.g., not being able to study or sit through a television show) may be an important self-management skill for a person with a behavioral health condition. Alternatively, the detrimental effect of mental illnesses and addictions, and the waxing and waning course of symptoms and relapses, can be more responsive to certain psychosocial interventions than other conditions, such as diabetes or asthma.

There is a robust evidence-base for the effectiveness of cognitive behavioral treatments for both mental and substance use disorders. An underlying component common to these approaches is the power of an empathic, accepting, and trusting relationship where the practitioner shares information and encourages the person to exercise self-care. Even when the prescriber isn't the person offering psychosocial interventions, it is useful for them to collaborate with the patient and family. Together, they can determine approaches to try for certain problem areas, assess how approaches worked or didn't, and determine effects. This collaboration provides the physician with the patient's life context and helps frame what the person needs to address their difficulties, especially those unresponsive to previous efforts.

Offering medications as tools for self-care can be effective in reversing the negative meanings that people have associated with behavioral health treatment in the past. Historically, many patients experienced the administration of behavioral health medications as something that others did to *them*, and it wasn't always clear that these others had the person's best interest in mind. With the shift to patient-centered care, we propose that the decision to take medication becomes something that people do *for themselves*. Making this decision is but one way of taking more control of their lives—lives that too often have spiraled out of their control. Research also suggests that multifaceted approaches are more effective treating these multidimensional conditions than are single-component approaches alone.<sup>9</sup> Finally, identifying patient strengths and expressing confidence in the person's ability to use those strengths to care for themselves is a powerful way to enhance that person's sense of self-efficacy. As we'll see in the next section, a sense of self-efficacy is a centrally important, although commonly diminished, resource required for effective self-management.

The next scenario illustrates how these elements interweave within a patient's life.

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9 Battersby et al., "Twelve evidence-based principles . . ."



Ms. G has used alcohol and cocaine intermittently for many years as one way of managing her mood swings resulting from bipolar disorder. While offered medications for bipolar disorder numerous times, she has not tolerated the side effects well. In addition, she's been reluctant to take medications that would dampen her hypomanic periods of elevated mood and increased productivity. As a result, she has used alcohol to slow herself down when becoming too manic and cocaine to speed herself up when feeling too depressed. Although she feels this approach has worked relatively well for several years, she is presenting for treatment at this time because she recently

lost her job. Her husband is threatening to move out if she doesn't get a better handle on her substance use, which would leave her unemployed and alone.

After taking a thorough psychosocial history, the physician asks Ms. G what her treatment goals are currently. Ms. G states that while she is reluctant to give up alcohol or cocaine, she is worried about losing her husband and needs to secure another job. She is doubtful, however, whether the doctor will have anything to offer her to help, as she has tried mood stabilizers without finding them helpful in the past. The physician explains to Ms. G that she is in a different place now than she was in the past, and makes two observations:

- what has worked for Ms. G in the past is no longer working; and
- it's possible that what didn't work before may now work better, especially if Ms. G is motivated to keep her husband and secure a new position.

The physician also explains that, given Ms. G's history, it is unlikely that taking a mood stabilizer in and of itself will be sufficient to change her long-term pattern of substance use, and that she may need other measures as well.

When Ms. G asks about other available measures, the physician describes an array of services and supports that Ms. G and her husband might try. One example is couples therapy with an addiction counselor who could suggest ways that Ms. G's husband could encourage and support her in discontinuing her use of cocaine and alcohol. Ms. G is reluctant to involve her husband in her care, fearing that this would only add to his sense of burden in the marriage. The physician suggests that Ms. G's husband might be feeling frustrated that there is little he can do to help her dig herself "out of the hole" she has fallen into. To test this hypothesis, the physician invites Mr. G into the session and asks for his perspective on the situation. Mr. G states emphatically that he loves his wife and wants to help, but feels that she has increasingly shut him out of her life as she fell deeper into addiction.

Mr. and Ms. G leave the physician's office with the name and number of an addiction counselor they've agreed to contact. They will return two weeks later, and Ms. G and the physician will discuss the parameters for conducting a new trial of lithium.

## **6. Identify and address barriers to self-management, including the need for additional supports (e.g., transportation, child care, reminders, environmental modifications).**

The final principle is the need to assess potential barriers to self-management that a person and their loved ones might face, and to work closely with them to bypass or overcome these barriers. Such barriers may be material or instrumental (e.g., money for transportation or co-pay for medications); social (e.g., unsupportive family, need for child care); or personal (e.g., lack of confidence and self-efficacy). Referring the person to your interdisciplinary team members may help address barriers. For instance, you could refer to a social worker to address entitlements; to a family therapist to educate and align the family with the patient's care; to sober or supported housing for persons who are homeless; to a psychologist for cognitive behavioral treatment; to a nurse for establishing a medication self-administration schedule and routine. Ensuring that such additional supports are in place will maximize the chance that people can follow through with taking the medicines you prescribe as prescribed, thereby reaping optimal benefits.

Barriers to self-management that may impede medication adherence are directly relevant to the prescriber's role. We addressed one major barrier earlier when we acknowledged the powerful influence that societal stigma and discrimination have on many patients' decisions not to take medications prescribed for them. The need to reject the label of "addict" or "mental patient" frequently becomes enacted in rejecting the medications that symbolize these conditions.

This is not the only way, however, that social forces can effect adherence. Even for those who are willing to accept the diagnosis of a mental illness or addiction, these labels represent the negative experiences of many with these conditions. The discriminatory attitudes patients face both inside and outside of the behavioral health system pose additional obstacles. Labels and prejudicial attitudes can demoralize people to the extent that they lose their confidence and self-efficacy that they once had before the onset of their condition(s). Without confidence in one's own abilities and the belief that one's actions matter in the world, patients are without the most crucial internal resources needed to engage in self-management. Without the sense that their actions may affect change, they lack a reason even to try.

What we have learned over the last two decades about the central role of motivation in behavioral change suggests that people will not do the hard work involved in self-managing their condition if they don't believe that they have any chance of succeeding. They may appear "unmotivated," but this suggests that perhaps they've lost hope for a better life and their confidence that they have what it takes to achieve such a life. Instilling hope and promoting self-confidence, therefore, become significant tasks for prescribers who are educating their patients and encouraging them to self-manage their conditions. As noted at the outset, these tasks may be especially challenging for those patients who are subject to coercive measures, which among other things, convey the potentially damaging message that the person cannot care for themselves. An important role for prescribers in such cases is to identify those domains where a person's autonomy has been and should be preserved. These domains can help the person regain personal control quickly and fully as possible—instead of spiraling downward into despair, resignation, and passivity.



In addition to instilling hope, self-efficacy, and confidence, prescribers may need to “activate” patients who may already have become passive and resigned in the face of their conditions and circumstances. Behavioral activation involves activities such as:

- helping people formulate their own questions and to identify and set their health-related goals;
- planning specific action steps to achieve those goals; and
- addressing barriers not only in relation to behavioral health but in relation to physical health as well.

Ongoing follow up and providing nonjudgmental social and emotional support help sustain self-management behaviors, thereby improving health outcomes while providing people with concrete evidence of their own abilities. It is upon this growing base of evidence that recovery becomes a real possibility that patients can achieve gradually, step-by-step, over time. The following vignette offers an example of what this may look like in practice.



Mr. H has multiple medical and psychiatric conditions and a history of poor treatment adherence as well as poor eating habits and a sedentary lifestyle. As a result of frequent hospitalizations and his family’s advocacy, Mr. H was recently accepted in a supported housing program where staff will closely monitor his medications. When a staff member accompanies Mr. H to his first meeting with the program’s prescriber, the staff member explains that it’s been difficult getting Mr. H to take medications as prescribed during his last hospitalization. Staff had discovered at least one reason for this difficulty.

When they plotted out the seven medications’ prescriptions and dosing schedules, they found that Mr. H would have had to take at least one pill every other hour throughout the day. It was hard enough to persuade Mr. H to take pills twice daily, but there was no way that program staff could spend time on this five or six times a day.

Mr. H’s new prescriber reviewed the medication orders from his last hospitalization and agreed that the dosing schedule was unmanageable for someone trying to learn to live independently. He was equally concerned that the staff might not have any luck persuading Mr. H to take medication even twice daily should he not see the point of taking the pills. At this point, the prescriber turned to Mr. H and asked him if he knew why his provider had prescribed these various medications. Mr. H shrugged his shoulders and suggested that perhaps it was because he had a “chemical imbalance” in his brain.

The prescriber responded that, in part, that was correct, that a few of the medications were meant to restore balance to Mr. H’s brain. In addition, there were medications meant to help his heart work better and keep him alive longer. Mr. H’s response to this information both surprised and concerned the prescriber and residential staff, as Mr. H asked: “What would be the point of that? Why are you trying to prolong this misery?”

With this response, Mr. H's prescriber realized that Mr. H needed more than a revised dosing schedule to improve his adherence and enhance his health. The prescriber, the residential provider, and Mr. H discussed the need for additional supports that might enable Mr. H to have a life that he felt was worth living. These supports included a visiting nurse who could educate Mr. H about the need for and function of each of the prescribed medications and teach him how to use a lockable electronic pill organizer. Mr. H could program this organizer to beep (and open the appropriate compartment) three times a day when it was time for him to take medication. He and the visiting nurse could refill his medications weekly, and the nurse could use this device to monitor Mr. H's adherence.

Free from spending their time trying to persuade Mr. H to take his pills, the residential staff agreed that their primary role would be to help Mr. H learn to cook for himself and do his own laundry. Staff also agreed to talk with Mr. H's family about visiting him regularly and taking him on community outings to explore activities that he might find enjoyable. While initially voicing reluctance about taking responsibility for his medications, Mr. H showed greater interest in this plan after his brother offered to take him to the local VFW [Veterans of Foreign Wars of the United States] Post where he could play cards with other veterans.

## Conclusion

While admittedly simplified for the purpose of illustration, we hope these vignettes make clear that person-centered psychopharmacology is not about simply giving patients whatever they ask for. Nor does shared decision-making diminish, neglect, or override prescribers' clinical and technical expertise or ethical imperatives. Rather, these principles establish a context of collaborative care where prescribers can use their professional knowledge and personal experience effectively and efficiently to the patient's and family's benefit as they learn to live with and manage the complex, multidimensional, and long-term behavioral health conditions for which they seek our help. Accumulating evidence suggests that it is within this context of respectful collaboration that the professional care we offer is more highly valued and appreciated. As we address our patients' and their families' pressing issues, shared decision-making will be beneficial in enabling them to achieve the outcomes that they find most meaningful.



## Useful Resources

- Adams, J. R., Drake, R. E., & Wolford, G. L. (2007). Shared decision-making preferences of people with severe mental illness. *Psychiatric Services*, 58, 1219–1221.
- Alakeson, V. (2007). *The contribution of self-direction to improving the quality of mental health services*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.
- Andrew, M., & Mezzich, J. (2011). The care of the patient and the soul of the clinic: Person-centered medicine as an emergent model of modern clinical practice. *International Journal of Person-Centered Medicine*, 1(2), 207–222.
- Bardes, C. L. (2012). Defining “patient-centered medicine.” *New England Journal of Medicine*, 366(9), 782–783.
- Barry, M. J., & Edgman-Levitan, S. (2012). Shared decision making—the pinnacle of patient-centered care. *New England Journal of Medicine*, 366(9), 780–781.
- Battersby, M., von Korff, M., Schaefer, J., et al. (2010). Twelve evidence-based principles for implementing self-management support in primary care. *Joint Commission Journal on Quality and Safety*, 36(2), 561–570.
- Berwick, D. M. (2009). What ‘patient-centered’ should mean: Confessions of an extremist. *Health Affairs*, 28(4), w555–w565.
- Carlson, B. L., Foster, L., Dale, S., & Brown, R. (2007). Effect of Cash and Counseling on personal care and well-being. *Health Services Research*, 42(1), 467–487.
- Center for Mental Health Services. (2005). *Free to choose: Transforming behavioral health care to self-direction. Report of the 2004 Consumer Direction Initiative Summit* [DHHS Publication No. SMA–05–3982]. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
- Center for Mental Health Services & Center for Substance Abuse Treatment. (2012, October). *Psychopharmacology in behavioral healthcare: Multidisciplinary stakeholders in dialogue* [Meeting report of the Dialogue Meeting]. Substance Abuse and Mental Health Services Administration.
- Charles, C., Gafni, A., & Whelan, T. (1997). Shared decision-making in the medical encounter: What does it mean? (Or it takes at least two to tango). *Social Science & Medicine*, 44, 681–692.
- Dale, S. B., & Brown, R. S. (2007). How does Cash and Counseling affect cost? *Health Services Research*, 42(1), 488–509.
- Davidson, L., Roe, D., Stern, E., et al. (2012). If I choose it, am I more likely to use it? The role of choice in medication and service use. *International Journal of Person-Centered Medicine*, 2(3), 577–592.
- Day, J. C., Bentall, R. P., Roberts, C., et al. (2005). Attitudes toward antipsychotic medication: The impact of clinical variables and relationships with health professionals. *Archives of General Psychiatry*, 62, 717–724.
- Deegan, P. E. (2005). The importance of personal medicine: A qualitative study of resilience in people with psychiatric disabilities. *Scandinavian Journal of Public Health*, 66(Suppl.), 29–35.
- Deegan, P. E. (2007). The lived experience of using psychiatric medicine in the recovery process and a shared decision-making program to support it. *Psychiatric Rehabilitation Journal*, 31, 62–69.
- Deegan, P. E., & Drake, R. E. (2006). Shared decision making and medication management in the recovery process. *Psychiatric Services*, 57, 1636–1639.
- Deegan, P. E., Rapp, C., Holter, M., & Riefer, M. (2008). A program to support shared decision making in an outpatient psychiatric medication clinic. *Psychiatric Services*, 59(6), 603–605.
- Drake, R. E., Cimpian, D., & Torrey, W. C. (2009). Shared decision making in mental health: Prospects for personalized medicine. *Dialogues in Clinical Neuroscience*, 11(4), 455.



- Drake, R. E., & Deegan, P. E. (2009). Shared decision making is an ethical imperative. *Psychiatric Services*, 60(8), 1007.
- Ekman, I., Swedberg, K., Taft, C., et al. (2011). Person-centered care—Ready for prime time. *European Journal of Cardiovascular Nursing*, 10(4), 248–251.
- Elwyn, G., Edward, A., Kinnersley, P., et al. (2000). Shared decision making and the concept of equipoise: The competences of involving patients in healthcare choices. *British Journal of General Practice*, 50, 892–899.
- Epstein, R. M., Fiscella, K., Lesser, C. S., & Stange, K. C. (2010). Why the nation needs a policy push on patient-centered health care. *Health Affairs*, 29(8), 1489–1495.
- Fitzgerald, J., & McCarty, D. (2009). Understanding attitudes towards use of medication in substance abuse treatment: A multilevel approach. *Psychological Services*, 6(1), 74–84.
- Fleck, D. E., Keck, P. E., Jr., Corey, K. B., & Strakowski, S. M. (2005). Factors associated with medication adherence in African American and white patients with bipolar disorder. *Journal of Clinical Psychiatry*, 66, 646–652.
- Freudenreich, O., Cather, C., Evins, A. E., et al. (2004). Attitudes of schizophrenia outpatients toward psychiatric medications: Relationship to clinical variables and insight. *Journal of Clinical Psychiatry*, 10, 1372–1376.
- Hamann, J., Langer, B., Winkler, V., et al. (2006). Shared decision making for inpatients with schizophrenia. *Acta Psychiatrica Scandinavica*, 114, 265–273.
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academy Press.
- Joosten, E. A. G., DeFuentes-Merillas, L., de Weert, G. H., et al. (2008). Systematic review of the effects of shared decision-making on patient satisfaction, treatment adherence, and health status. *Psychotherapy and Psychosomatics*, 77(4), 219–226.
- Koyanagi, C., Alfano, E., & Carty, L. (2008). *In the driver's seat: A guide to self-directed mental health care*. Bazelon Center for Mental Health Law & UPENN Collaborative on Community Integration.
- Lambert, M., Conus, P., Eide, P., et al. (2004). Impact of present and past antipsychotic side effects on attitude toward typical antipsychotic treatment and adherence. *European Psychiatry*, 19, 415–422.
- Noordsy, D. L., Torrey, W. C., Mead, S., et al. (2000). Recovery-oriented psychopharmacology: Redefining the goals of antipsychotic treatment. *Journal of Clinical Psychiatry*, 61(Suppl. 3), 22–29.
- O'Connor, A., Legare, F., & Stacey, D. (2003). Risk communication in practice: The contribution of decision aids. *British Medical Journal*, 327, 736–740.
- O'Connor, A. M., Stacey, D., Entwistle, V., et al. (2003). Decision aids for people facing health treatment or screening decisions. *Cochrane Database of Systematic Reviews*, 1:CD001431.
- Resources for Integrated Care. *Self-management support in behavioral health: Organizational assessment tool* [in development]. Centers for Medicare and Medicaid Services.
- Roe, D., Goldblatt, H., Baloush-Klienman, V., et al. (2009). Why and how do people with a serious mental illness decide to stop taking their medication: Exploring the subjective process of making and activating a choice. *Psychiatric Rehabilitation Journal*, 33(1), 38–46.
- Reuben, D. B., & Tinetti, M. E. (2012). Goal-oriented patient care—an alternative health outcomes paradigm. *New England Journal of Medicine*, 366(9), 777–779.
- Rusch, N., & Corrigan, P. W. (2002). Motivational interviewing to improve insight and treatment adherence in schizophrenia. *Psychiatric Rehabilitation Journal*, 26, 23–32.
- Stewart, M., Brown, J. B., Donner, A., et al. (2000). The impact of patient-centered care on outcomes. *Journal of Family Practice*, 49, 796–804.

- Sepucha, K. R., Fowler, F. J., & Mulley, A. G. (2004). Policy support for patient-centered care: The need for measurable improvements in decision quality. *Health Affairs*, 23(Suppl. 2), 54–62. <https://www.healthaffairs.org/doi/10.1377/hlthaff.var.54>
- Substance Abuse and Mental Health Services Administration. *Treatment Improvement Protocol (TIP) Series*.
- Thomson, R., Kinnersley, P., & Barry, M. (2012). Shared decision making: A model for clinical practice. *Journal of General Internal Medicine*, 27(10), 1361–1367.
- Tondora, J., Pocklington, S., Gorges, A., et al. (2005). *Implementation of person-centered care and planning: From policy to practice to evaluation*. Substance Abuse and Mental Health Services Administration.
- Towle, A., & Godolphin, W. (1999). Framework for teaching and learning informed shared decision-making. *British Medical Journal*, 319, 766–771.
- White, W. (2012). Medication-assisted recovery from opioid addiction: Historical and contemporary perspectives. *Journal of Addictive Diseases*, 31(3), 199–206.
- White, W. (2012). *Recovery orientation in methadone maintenance: A definitional statement*. <http://www.williamwhitepapers.com>
- White, W., Parrino, M., & Ginter, W. (2011, October 11–12). *A dialogue on the psychopharmacology in behavioral healthcare: The acceptance of medication-assisted treatment in addictions* [Briefing paper]. Psychopharmacology in Behavioral Healthcare Meeting convened by the Substance Abuse and Mental Health Services Administration. <http://www.williamwhitepapers.com>