Transformation: Recovering Mental Health Treasures

Herb Bateman

More than 30 years ago, I accepted a job offer, and suddenly I was a "mental health professional" with no mental health experience working for the Mental Health and Mental Retardation Authority (MHMRA) of Harris County, Texas. I learned some big words, like "deinstitutionalization" and "institutionalization." If people had a serious mental illness in the 1960s, they were locked in a psychiatric ward for most of their lives, much like a prison. The patients were pretty much told what to do and what medication to take, with very few opportunities to make decisions on their own.

I visited a few state hospitals in the 1980s, but this was after deinstitutionalization. Even then it was very depressing; I cannot imagine what it was like in the 1960s. Well, yes, I *can* imagine, because my wife worked in a state psychiatric hospital in the 1960s as a registered nurse, and she told me about it each day when she came home. She was in charge of a ward of more than 100 patients. Many of her patients were lined up each morning for shock treatment, casually waiting in line without any protest. There were even a few lobotomy patients.

For the most part, the patients on her ward were treated well. However, she witnessed a case of physical abuse by an orderly. She reported it, but administrators took no action other than to transfer the orderly to another ward. My wife lived with some fear of retaliation.

The community mental health movement was still fairly new when I began at MHMRA in 1977. Traditions and attitudes from the institutionalization period were still active during the newer community mental health phase. Many of the same psychiatrists and mental health professionals who worked in the state hospitals now worked in the community. Newer doctors were often taught the same institutional principles, such as that the doctor knew best, as in "We can do a better job of controlling your life, so sit back, relax and let us tell you what is best. And, if you goof up, we will put you back in the hospital." That is the opposite of patient empowerment.

There was a new tension at work in 1977: deinstitutionalization versus institutionalization. The new and the old were in conflict: "Maybe we can let these patients express an opinion about their treatment." "No, we have always known what is best based on centuries of training."

And so I came on the mental health scene caught up in the swirl of the new and the old, wondering what was going on. Around this time, our agency signed a contract to have Baylor Medical School provide psychiatric services for all of our adult mental health clinics. This "marriage" meant that two different work cultures were trying to merge just when deinstitutionalization and institutionalization (de and in) were trying to work out a "divorce settlement." Yes, 1977 was an exciting year.

I treaded water for a few years, caught in the current of issues, way past my ability to understand the dynamics at play. I had a caseload of approximately 80 clients. For some reason I started questioning things. The word "hope" had not been invented yet in the mental health field. The clients seemed to be trapped in a world of "chronicity" without much hope of getting better. Our focus was on keeping them out of the hospital, which was a pretty low bar for measuring progress. And, yes, we still pretty much told them what to do and what was best for their lives.

Treasure hunt

What about their strengths? As I reviewed the charts, I could not find much, if any, information about strengths. Did our clients not have any strengths? Did they leave all their strengths in the institution? This became a challenge. I was determined to find the strengths of each of my clients. Because I could not find any clues in the chart, I spent most of our individual sessions searching for strengths; it became my treasure hunt.

The clients were a little confused and defensive. They were more comfortable talking about their current symptoms of hearing voices, their history of hearing voices, and their hospitalizations. It took a while, but they finally realized that I was on the level; I really wanted to learn more about their strengths, talents, and hobbies. These strengths really were treasures. It took some trust for them to reveal this part of their lives, a part not touched in years, like a buried treasure. I handled those strengths with care, like a fragile heirloom. During this search, I began noticing that each client had traits of resilience. Even though they had each been through many crisis events, job losses, and family problems, they always seemed to bounce back.

Where there is strength, there is potential. Instead of seeing my caseload as a bunch of patients with chronic mental illness whose main goal was to stay out of the hospital, I began seeing them as people who could live a more

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independent life. "Rick" had been on my caseload for a few years. One of his treasures was a talent for golf. He had been a golf champion on his high school team. He loved talking about his past experiences on the team, and I loved listening to him talk because he seemed to come alive as he shared his story. I really went outside the therapeutic box one day and asked him if he wanted to drive some golf balls instead of meeting for therapy (I had requested and received permission from my boss beforehand).

Something was happening. I was relating to Rick and other clients through their strengths instead of their illnesses. Was I doing something wrong, violating some kind of sacred boundary? I was seeing them not as sick patients, but as people with an illness. Note the word "people" coming before "illness." This was revolutionary for me.

"Ron" was transferred to my caseload. He recently had been discharged from the state hospital after being there for 30 years. The dynamics of "de" and "in" at our clinic were real, and Ron was evidence personified. Because Ron had been locked up for 30 years, he was used to being in a clinic all day. He would arrive before we opened and stay until we closed, even though he had no appointment. Ron would sit in the waiting room every day, staring at nothing. I guess this is what he did in the state hospital. I did not know how to help him.

There was a small kitchen across the hall from the waiting room. One day I asked Ron if he would like to sell coffee to the other patients. He said yes, and we were off to the races. We charged 10 cents a cup. Coffee started selling like wildfire. We soon added Cokes to the inventory. I asked another patient from my caseload if he would like to work in the kitchen. This was not an official program and was not covered in the Policy and Procedure Manual. We called it the "Country Store," as our product line expanded to chips, candy, and sandwiches. Eventually there were about four clients working the store, two on each shift.

Other caseworkers began asking me if I could find something for their clients to do. Within about a year, we had eight to 12 clients doing clerical duties and four working the store. I noticed that other staff members were relating to these clients differently. We all were. They were working and fulfilling responsibilities, and we were relating to them through their strengths.

I also learned about the therapeutic value of responsibility. Responsibility can be as valuable and powerful as medication. As clients would volunteer for jobs, I would assign tasks. Through trial and error, I learned that responsibility needs to be titrated like medication. Too much responsibility often resulted in an increase in symptoms. This required me to closely monitor stress and coping mechanisms, adjusting responsibility up or down before the stress and symptoms escalated to the crisis level. By pushing clients a little past their comfort zone, they developed greater self-confidence.

Recovery

I stayed at MHMRA for 14 years. During that time, a transformation occurred both in the field and in me. When my professional transformation started back in the 1970s, the word "recovery" was not part of the mental health vocabulary. Only in the past ten years has the concept of recovery entered into mainstream mental health. As I read current articles on recovery, I can look back at my transformation experiences and see basic recovery principles at work. I started the job not knowing much and left with a strengths-based focus. I had some good teachers—H. Steven Moffic, M.D., and Rose Childs, M.S.W.—but mostly, my teachers were the consumers themselves.

What did I do with the rest of my life, after leaving the "mother ship" (MHMRA)? I worked for six years at the Mental Health Association of Greater Houston as director of public policy, although I did not direct much—just dabbled. I then became the executive director (ED) of the Gathering Place, a clubhouse program. I learned a lot about being an "ED"—mainly that I did not want to be an ED again. But, while there, I did start another Country Store. I stayed seven years and then went back to the mother ship.

I have been at MHMRA for five years now, as the coordinator of the Consumer Advisory Council (CAC). I found some of my own treasures along the way and still discover more among the consumers who work on the CAC. Guess who my boss is? Ms. Childs, except now she is the deputy director of an agency with 1,600 employees.

The mental health literature I read today shows a balance between managing symptoms and promoting recovery. Focusing on and encouraging strengths development is a step toward recovery; how far we have come since 1977.

Summary

If we agree that mental illness affects a person's self-esteem and self-confidence, then what can we do to encourage self-confidence? Many of the clients I work with do not recognize their strengths and have little confidence in their abilities. The treasure hunt approach not only helps clients discover sometimes long lost or unused strengths but also encourages them to believe in themselves.

A strengths-based focus is more common today than it was 25 years ago. However, managed care and state budgets tend to focus on efficiencies and third-party billing. Is it possible to have a recovery-focused system and generate a sufficient amount of revenue to balance the budget? Can we give equal weight to both? Constantly giving more weight to revenue efficiencies can have unintended consequences. If recovery values are not a priority, we can unintentionally increase the cost of providing mental health services. As more consumers improve in their recovery, they will use fewer and less costly services. To transform a community mental health system toward a balance of recovery and cost-effectiveness priorities is a major undertaking, a tiny bit more complicated than transforming one mental health care worker's perspective. It has been an exciting journey, from lobotomy to recovery, with many treasures discovered along the way.

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