BRIDGES TO RECOVERY

LEADERS IN RESIDENTIAL MENTAL HEALTH CARE

WHEN TO REFER FOR RESIDENTIAL TREATMENT AND HOW TO UNDERSTAND THE PROCESS.

I would imagine that all clinicians at one point or another in their practice have experienced a moment where they felt that a patient had become unmanageable in their practice. My first experience with this type of patient was a young woman referred to me by a psychiatrist for multiple time per week psychotherapy. I enjoyed the patient and found her to be interesting and engaging in the initial portion of treatment and felt that if she had the ability to come frequently, I could contain her acting out and help her to understand her mental state. However, as the work progressed, I found her acting out unable to be contained regardless of the number of days added to her treatment or the outpatient supports I placed into the treatment plan. Her primitive and regressive behaviors caused many a sleepless night as I struggled to find some way to reach her and get her back onto a stable platform. I recall presenting the case to a senior analyst whose opinion I valued a great deal sharing with me that the patient, "…is off the rails and there is no way to stop this train from crashing…" I felt disheartened and impotent and felt as if regardless of the number of days and outpatient supports I added to our work, the patient would continue to spiral downward. It became clear to me that the outpatient model would not work unless I could somehow magically create a 10-day workweek and hours upon hours of groups and monitoring. Luckily, a psychiatrist with whom I was collaborating with had experience working with a residential program on the West Coast who was open to taking this patient into their program and helping her stabilize. I found, with this new opportunity, a tremendous weight was lifted off my shoulders and I was able to help transition this patient to a new environment and a new chance at life. When I admitted the patient into the program, my initial anxiety was that the clinicians at the facility would either misunderstand her presentation or prevent her from returning to my care upon discharge. This belief was based upon hearing "horror" stories from peers of their experiences with residential programs where the referring clinician essentially disappeared from the patients' radar until a few days prior to discharge when a discharge planner would call to set up appointments without any information about what the patient had been working on in treatment or the status of the patient week to week. In my work with Bridges as the clinical director, I wanted to make sure that outside clinicians were an integral aspect of the treatment team and felt incorporated into the patients' care. As such, our team strives to make sure that each clinician is contacted upon admission and then as frequently as desired to feel a sense of connection and continuity with the patient who is in the program.

As the clinical director, I am acutely aware of the complexities of managing a difficult clinical case as I also have a private practice. It is the goal of our clinical team that rather than feeling that the outside clinician loses a patient, the primary therapist in the program (a licensed clinical psychologist and/or training and supervising analyst) becomes a consultant on the case for the outside treating team. Our hope is that the referring clinician will come to the clinical team meeting at Bridges to Recovery when the patient admits and meet the clinicians who will work with their patient and learn firsthand about the areas of concern for the clinician, patient, and the family (when applicable). We find that using this model allows for the clinician to feel confident that they have investigated the program and have a clear sense as to what will and will not occur while the person is in Bridges to Recovery. Further, given that some patients and their families may only know about substance abuse residential programs, visiting the clinical team prior to admission allows the outside team to get a sense as to what happens in residential psychiatric care. As treatment progresses, the primary therapist at Bridges to Recovery becomes the communication hub for the family and outside clinical team whereas they provide weekly updates and facilitate and understanding of the material that is being discussed and processed in the individual and group work. As discharge approaches, we hope that the clinician will come to the final clinical meeting of the patients' stay and hear their progress while in our care as well as have a meeting with the patient to help with any transition anxieties that may occur.

I recall a senior analyst once telling me, "…we cannot believe that we have more impact in a patient's life than we in fact do…we can only try to keep them on a path of understanding as they struggle and help them continue walking when they stumble through our interpretations and empathy…" At Bridges to Recovery, I hope that you will find a local, boutique, exceptional facility where your patients' can find a stable, safe environment to explore those areas of their mind that have felt too terrifying to explore outside of a residential setting and learn the skills necessary to contain those regressive and primitive feelings that arise so they can return to your care to continue on their path to discovery with you. Please don't hesitate to contact me if I can ever be of assistance in working with a complex case or family who is trying to decide if residential treatment is the right choice for them. Thank you for taking the time to read this letter.

Dr. Trevor Small
Clincal Director
Bridges to Recovery