

Dr. Todd Mitchell: Staff Psychiatrist with Berkeley Mental Health

Summarized by Thomas T. Thomas

Todd Mitchell, MD, is a board-certified psychiatrist who joined Berkeley Mental Health (BMH) in 2015. He currently sees patients on the Adult Full Service Partnership (FSP) Team and maintains a private practice in Berkeley. He previously served as the Chief of Psychiatry for University Health Services at the University of California Berkeley. Dr. Mitchell has worked in various community mental health agencies and academic institutions in the Bay Area. He earned an undergraduate degree at Columbia University in New York, his medical degree at Vanderbilt University in Nashville, Tennessee, and took his residency in psychiatry at UC San Francisco.

Dr. Mitchell said that the first two years of medical school were “book stuff” and the second two clinical work. He found that psychiatry was “a natural fit,” but he decided to take a year off after graduating and before completing his residency. His rotation in psychiatry had been too focused on diagnosis, he said, and the symptoms and conditions found in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, rather than on the conditions of real people.

So Dr. Mitchell took a job as a social worker in the psychiatry department of a mental health coop in Nashville. “They were practicing a rudimentary form of Assertive Community Treatment [ACT],” he said. This gave him the chance to participate in homeless outreach and in-home visits, join in 5150-type evaluations, and do psychiatric workups—everything except prescribe medications. “It was an amazing and valuable experience,” he recalled, “going out of the ivory tower and into the street.”

The experience established his interest in community-based, multicultural, and cross-cultural approaches to psychiatry. After his residency at UCSF, he worked at a San Francisco agency similar to Berkeley Mental Health, engaging in citywide case management on the ACT model, again going into the streets and into people’s homes.

Dr. Mitchell described his interests as eclectic, including psychoanalysis, psychodynamics, and psychopharmacology,¹ with an emphasis on severe and persistent mental illness.



TODD MITCHELL, MD

¹ *Psychoanalysis*, founded on the theories of Sigmund Freud, is based on making people aware of their unconscious thoughts and motivations. *Psychodynamics* is an approach that emphasizes the

“Some people say that psychodynamics and psychopharmacology don’t mix,” he said. “It was a joke among my colleagues that everyone thinks our patients are psychotic, but they are also neurotic—and they’re just not getting help with that.” He explained that “neurotic” is not an insult: neurosis is a coping or defense mechanism, a way to solve personal problems. “It’s when the neurosis becomes maladaptive that it causes emotional problems.”

Many of Dr. Mitchell’s patients in the community have both a psychosis and substance abuse. “You can’t treat someone by pumping them full of medications and not dealing with their other issues,” he said. “What other problems are they trying to solve through their substance abuse? You have to approach people holistically, and not just mechanistically as a neurotransmitter imbalance.”

After this introduction, Dr. Mitchell took questions from the audience.

Q. How long were your rotations in medical school?

A. The psychiatric and surgical rotations were each ten weeks. The others, such as OB/GYN, neurology, and pediatrics, were each eight weeks long. “It was during the psychiatric rotation that I came to understand myself,” Dr. Mitchell said.

Q. What exactly is “Berkeley Mental Health”? And how do you fit into it?

A. In most of the country, mental health services are funded and provided on the county level. Berkeley Mental Health is like a county system for the Berkeley-Albany area. We interface with Alameda County’s mental health services, especially when Berkeley people need hospitalization; then they go to the John George Psychiatric Hospital in San Leandro and sometimes to Herrick Hospital in Berkeley. We have a good relationship with the county.

Berkeley is in the middle of a housing crisis, and it’s worse for our clients, most of whom are marginally housed. For adults, BMH offers a Full Service Partnership for the marginally housed and homeless, for people who are least stable, and for those who are marginally engaged in treatment. This team has a chief psychiatrist and two staff psychiatrists, of which Dr. Mitchell is one. “The team goes out to people, talks to them, and asks if they need treatment,” he said. “Our goal is relationship building, on the basis of ‘I might be able to help you with that.’ ”

BMH also has a Chronic Care Team for those who are more securely housed, less likely to need hospitalization, and more compliant with their medication. And finally, for adults, there is a Medication Only Team, for those who are stable but need meds.

In addition, BMH has a Child Full Service Partnership, with its own chief psychiatrist, and a Mobile Crisis Team. In addition, BMH is adding a Homeless Outreach Team, with staff to be hired in the next fiscal year, to go into homeless camps and shelters.

Q. How do you judge success in treatment?

A. Traditionally, it’s been by psychometrics and filling out forms. But Dr. Mitchell believes it should be based on individual assessment. Where is the patient now? Where is he or she trying to go? Where should the patient be going? But these still involve clinical parameters.

systematic study of mental and emotional forces that determine personality and behavior.

Psychopharmacology is the study of the effects of drugs on mood, sensation, thinking, and behavior.

Q. My daughter lists my Berkeley home address as her official residence, but she mostly stays in an Oakland hotel or on a park bench. She hasn't seen a psychiatrist or been evaluated since 2006. Can she still get services at BMH?

A. Yes. She is still a Berkeley resident and can get services if she wants them.

Q. My daughter lives in Arcata but she has to Skype with a psychiatrist in Santa Rosa for her meds, because there's no other doctor closer.

A. Psychiatry is a specialty tied to relationships. It works best when you come face to face with the patient, and Skype doesn't actually do that. On the video screen, you can miss important cues like sweat on the brow or a patient's psychological "tells." It would only work if you know the patient after years in an already established relationship.

Q. Are you open to taking a patient's suggestions about medications?

A. Treatment is a collaboration. The psychiatrist needs to know what's working for the patient. If the patient has suggestions based on what's working for someone else, then it's important to know the other person's diagnosis and situation and how it applies. Generally, however, doctors are presumed to know more about medications and their effects than their patients.

Q. Have you had success with psychotherapy combined with medication versus just medication alone?

A. Psychodynamic treatment is about conflicts and ambivalences, and how conflicts can affect people's relationship with themselves, with other people, and with things. "A pill is a thing," he said, "and people have a relationship with it. The psychiatrist can't ignore that relationship, because a patient's fantasies, expectations, and fears about the pill and its effects can result in the patient not taking it. A purely somatic approach—just medicating the patient—does not get to the *meaning* of the patient."

Q. How do you overcome the fear that a psychotic episode will come back?

A. That may not be possible. We all have feelings. The goal is not to make them go away, but to understand them. Once you have experienced a psychotic break, you have a greater chance of having another. So the fear is real, but you can keep it from paralyzing you.

Q. How many patients do you have at BMH? How much time do you spend with each one?

A. The caseload varies, but a psychiatrist generally sees forty to fifty patients at varying frequencies.

Coming out of residency, Dr. Mitchell used to think in fixed terms of so many sessions of engagement and so many more to see progress. But that's not how it works. "It takes as long as it takes to engage with the patient," he said. "With Assertive Community Treatment, the timing depends on how ill the patient is and how willing he or she is to build a relationship.

"Engaging with a patient is like falling in love. You only know when it happens, when you come to realize, 'Oh, this person trusts me!' And we can't force people to come in for treatment, as in an institution, because our services are all voluntary."