From the beginning I have been one of the few psychiatrists actively involved in the recovery movement. Being an MD gave me some instant credibility and authority and has opened a number of doors for me. Usually it's also brought the inevitable request of, "Can you talk to our psychiatrists? There really not on board with recovery. They'll listen to you since you're a doctor too." There's an amazingly widespread belief that psychiatrists are a major obstacle to recovery and almost as widespread a belief that I should be able to do something about it. In response, I've done a fair bit of thinking about psychiatrists and there are four papers in this section.

My first set of responses was to ask people how they treated their psychiatrists: Were they allocating enough time for their psychiatrists to get to know people well enough to remember their names? If they wanted their psychiatrists to interact with whole people instead of just medicating illnesses, were they interacting with their psychiatrists as whole people or just as prescription writing machines? Did they celebrate their psychiatrists' birthdays like everyone else? Did they know what their psychiatrists' hobbies and interests are? Did they call them by their first names, or have a big wall around them? Were their psychiatrists full members of their teams or hourly workers like the Xerox repair man who you know you need, but don't really want to have to interact with?

Here were my suggestions for where the answers should lead us to.

Let's Include Psychiatrists

(1993)

One of the reasons for the failure of deinstitutionalization is the failure to deinstitutionalize psychiatrists. If we want to have an effective, integrated, community based system of care, the roles of psychiatrists need to be radically changed and they must be developed consistent with our basic principles

1) Continuity of care—the same psychiatrist should be with a person wherever they are from homeless outreach, to clinic, to emergency home visit, to hospital, to substance abuse recovery program, etc. Rather than being program based, psychiatrists should be person based.

2) Team case management—the psychiatrist should be an integral part of the team's internal dynamics, decision making, expertise sharing and responsibility sharing rather than a specialized technician separated from the team.

3) Recovery/empowerment focus—the traditional doctor-patient relationship needs to be replaced with a more adult-to-adult collaborative relationship with both people taking on a variety of roles, blurring traditional boundaries to promote increased self-involvement in treatment and self-responsibility for outcomes, decreasing dependency and chronic patienthood.

4) Community based care—the psychiatrist should see the hospital as serving the community based treatment and not the other way around. We should be actively involved in designing and implementing individualized community based crisis management, respite care, and institutionalization diversion plans.

5) Quality of life focus—the psychiatrist should be helping people instead of treating illnesses in isolation. We should be aware of and involved in all aspects of their lives helping them use medications and other treatments to achieve their own quality of life goals.

6) Cost effectiveness—the cost effectiveness of our clinical treatments is of increasing importance with limited resources, cost containment and even rationing becoming unpleasant realities. Psychiatrists and the case management teams should increasingly be aware of costs, manage costs and take responsibility for the financial implications of the treatment decisions, instead of abdication these decisions and responsibilities to administrator and auditors.

At the MHA Village ISA in Long Beach, a demonstration program, we have actually implemented all these principles and role descriptions. As a result, I have a pleasant, satisfying, effective and integrated job.