Including Psychiatrists in Recovery Advocacy and Planning (2011)

As the recovery movement has gained strength it has moved from being an outsider revolutionary movement to an insider reformation movement. As a result, within the halls of power and within our mental health programs active conflict has broken out repeatedly between recovery advocates, especially consumers, and medical advocates, especially psychiatrists and families. This is both predictable and unfortunate. What is needed for recovery to work, like it or not, is inclusion and collaboration, not conflict. Only a few people will recover without any medical psychiatric treatment and only a few people will recover with only medical psychiatric treatment. The vast majority of people need us to work together. Since I'm a psychiatrist, I'm going to focus on psychiatrists and not on family members or consumer advocates.

Psychiatrists are not very good at including or collaborating with anyone – not with the community, our colleagues, or our patients:

1) Even though we are called community psychiatrists, very few of us are involved in our communities or see our patients outside of our offices. Usually we pretend we don't know any of our patients outside of the office. We protect privacy. The old family doctor making home visits is almost gone.

2) Even though we say we work on teams, we were trained to expect a team to be a group of people who follow our treatment orders. We resist supervisors and bosses. We resist true collaboration. As a result, we're usually excluded from much of the team's interactions. We usually see patients on our own, sometimes in offices separated from other services, with limited coordination fragmenting people's care. We protect autonomy.

3) We don't really collaborate with our patients. We're trained to give them treatment orders and then assess compliance. We are generally not well skilled at outreach and engagement, shared decision making, motivational interviewing, client driven treatment strategies. If our authoritarian methods don't work, we ask for, and sometimes receive, unique coercive powers to treat people involuntarily especially in locked hospitals. We protect power. In psychiatry, the strategy of responding to noncompliance with coercion is justified primarily because the patients are seen to have impaired insight, an inability to see what's wrong with themselves, "anosognosia", but in reality non-compliance is widespread throughout all of medicine, indeed throughout all of life, and lots of people, not just psychiatrists, when faced with someone who won't do what we tell them to do get frustrated and resort to coercion.

Even though our traditional medical system has generally failed to include and collaborate with psychiatrists, the recovery movement must do so if people with the most intractable illnesses are going to recover too. With psychiatrists collaboratively integrated into our system almost everyone, not just those with mild and moderate conditions, can recover.

Psychiatry controls two key elements of our system: 1) Medications and 2) Involuntary treatment, especially hospitalizations. These may seem like relatively small items and planners everywhere have sidestepped and minimized them in their plans to avoid having to deal with them and with psychiatrists. They are not small elements. They are crucial elements. From a financial point of view those two elements use a sizable majority of our entire mental health funds.

From a recovery point of view, despite all the problems with medications, their misuse, the trauma sometimes connected with them, and some consumer's antagonism toward them, medications are still consistently rated as one of the most important contributors to many people's recovery, especially for people with severe mental illnesses. If you find a place that has good collaborative medication services integrated into its overall service delivery, I'd wager you found a place with a good chance of promoting recovery. An integrated recovery approach is a legitimate approach for everyone, especially people with the most severe mental illnesses.

Involuntary treatment, especially hospitalizations, are an even more problematic area. Indeed, the identification of psychiatrists with involuntary treatment and our adamant defense of its necessity, even urging its expansion, causes a great deal of the animosity and conflict. Most psychiatrists won't agree that if we got better at collaborative treatment, worked within a team, and within our communities we'd need a lot less involuntary treatment. In California, a large amount of new resources have been devoted to Full Service Partnerships that enrolled people with pervasive histories of hospitalizations, jailings, and incarceration and gave them team based, community based, intensive services including integrated medications. The outcomes throughout the state averaged a 70% reduction in hospital, jail and homeless days – and that was with some of the most difficult people we could find. That means that creating collaborative, team and community based services that actively include psychiatrists is likely to reduce the need for involuntary treatment by at least 2/3 and probably more. The vast majority of people do not need any involuntary treatment if they are served in a good recovery based system.

On the other hand, most consumer advocates won't agree that anyone ever needs involuntary, coercive treatment. They need to move too, if we're going to collaborate instead of conflict. Some people, with or without mental illnesses, do harm themselves and other people or are very disruptive, destructive, or unable to take care of themselves. We have an entire justice system designed to restrain them. Despite occasional efforts at rehabilitation, that system is fundamentally built on punishment and deterrence. It is cruel and destructive. It's also very expensive and ineffective. Some people with mental illnesses are arrested and confined within our justice system. They are also treated cruelly and destructively. Many people are outraged by that. Personally, I think that the answer is to reform the entire justice system, but most families, professionals, and advocates think that the answer is to divert people with mental illnesses into involuntary mental health treatment to get them "the help that they need". In order to achieve that goal, we must have some involuntary treatment including hospitalizations, addiction facilities, and other locked settings. By its very nature involuntary treatment must include disempowering, traumatizing, and personally destructive elements. We must work together to create the smallest, least destructive involuntary, coercive programs we can. We can't have none or the justice

system takes over. We can't have none and still have basic safety and professional ethics, but we sure can cut back a lot. Sustainable, substantial efforts to create "protective factors" so less people are in crisis and to create appealing voluntary alternatives should be done in collaboration with the present providers of involuntary treatment, not by battling against them.

The recovery framework is comprehensive enough and inclusive enough to include everyone with mental illnesses. It is also comprehensive enough and inclusive enough to include psychiatrists and "brain science" – even medications and involuntary treatment. Just as there should be "nothing about us without us" for consumers, all levels of mental health planning should include psychiatrists, medications, and involuntary treatment. Plans will ultimately be more respected if they include clear collaborative, compromise efforts that generate real solutions than if they maintain ideological purity at the cost of not including either psychiatrists, consumers, or their families.

True hope is based not on ideology, theoretical ideals, or professional dependency and tradition. It is based on facing the realities of suffering and struggles and then working together to build a better future. We are at the point where there are large scale, successful recovery based systems that include psychiatrists, medications, and involuntary treatment, on the one hand, while also engaging and collaborating with people who do not believe they have a psychiatric illness or agree to take medications, on the other. In my opinion, that's the goal, not one side or the other "winning".

Hospice is my favorite example of a successful, person centered, client driven, strengths based revolution in medical care. They have turned what was once some of the most painful, suffering, dehumanizing medical experiences into some of the most humanizing, spiritual, popular experiences in medicine. But why do you have to wait until you're dying to get a person centered approach? Why can't hospice begin at first diagnosis of cancer instead of waiting until "there's nothing else we can do"? Surely the grieving process begins at first diagnosis. Surely the family inclusion, spirituality, personalized caring approach of hospice would be beneficial whether you live or die from cancer. I believe the main reason for the delay is that oncologists weren't able to collaborate with hospice services. In mental health, psychiatrists almost always have something to offer. We're going to have to collaborate better than oncologists do if recovery is going to work.