A brief outline of all the levels on which a good psychiatrist collaborates as part of helping people recover

Collaborative Psychiatry

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I believe that our product is collaborative relationship based personal growth and healing. I believe that psychiatric treatment needs to be integrated as part of that product, not provided separately whenever it is possible to hire a psychiatrist to do so.

Collaborative relationships include:

1) With all members, whether they're on meds or not. All of our members should have multiple staff relationships beyond their PSC. If they don't want to see "the psychiatrist" maybe they'll want to see "Mark" for some other reason if I am appealing enough and have a broad enough range of roles and interests

2) With all the team mate line staff. The services the psychiatrist is providing should be coordinated with those the PSC is providing collaboratively so we're working together - sometimes this involves the PSC being at the med visits, or the psychiatrist and PSC doing home visits or crisis interventions, or goal planning together

3) With the team leadership - the team leader and assistant leader. Psychiatrists have substantial responsibility, both legally and clinically whether they want it or not, this responsibility shouldn't be isolated from other team leadership responsibilities - they should be shared. Often times one of the most important factors in a team's effectiveness is the comfortable collaboration between the psychiatrist and team leaders. This extends to nurturing the team culture together.

4) with other Village programs and staff. There is a need for a collaborative team of psychiatrists and other "medical staff" both for quality management of clinical and administrative processes and for interpersonal support and cohesiveness. Psychiatrists often have need for some interface with a variety of other staff, and vice versa.

5) With other service agencies and the community. Many other service agencies require MD input, including hospitals, social security, Section 8, voc rehab, disabled students office, DMV, public guardian, DCFS, probation, LAC - DMH, Metro transportation, IHSS, meals on wheels. These are not just "papers to be signed". These are actual relationships with agencies our members need over the long term. In addition, psychiatrists often meet family members, landlords, neighbors, lovers, policemen, church representatives and every one of those interactions is an opportunity for community development and stigma reduction.

Psychiatrists need to provide collaborative psychiatric services, including but not limited to medications, to members throughout the range of engagement with psychiatric services (engagement, persuasion, active treatment, and relapse prevention) not just to those who want to see the psychiatrist and take meds and come to appointments and are reliable (very few of our members meet those criteria because they've been selected as people for whom the normal clinic practice hasn't worked). They need to be skilled in welcoming, outreach and engagement, harm reduction, empathy, building trust, connecting medications to goals, working through the meaning of medications and diagnosis including trauma and stigma associated with them, working with ambivalence, motivational enhancement, shared decision making, shared experimentation to learn how to use medications, self help techniques, medication support strategies, increasing self-reliance, and assistance in getting off of medications. Just putting people with all those on "med management" is not a replacement for delivering ongoing, stage based, growth oriented, team based support and skill building services. In surveys the most common item identified as facilitating recovery is medication and yet a relatively small minority of people end up figuring out how to use medications helpfully over the long term. Each failure is important.

Psychiatrists need to know how to integrate medications with self help coping techniques, trauma interventions, CBT and DBT techniques, behavioral therapy and relaxation, differentiating feelings from symptoms, problem solving, interpersonal relationship issues, anger management, and parenting skills. Most of our members do not have a relationship with any other licensed professional that we can expect to provide those services and they can be efficiently and effectively incorporated into "medication visits". (For example, it's important to know when a crying mother could benefit from parenting support vs. when she hasn't picked up her meds from the pharmacy and her illness is returning and to be able to help in both situations. If the services are separated, when the psychiatrist sees someone they're likely to describe lots of situations as illnesses in need of meds and when they see other staff to describe them as emotional issues and overlook the need for meds creating extra conflict on the team and confusion for the member.)

Psychiatrists have a special responsibility to integrate our psychiatric services with 1) psychiatric hospitals, 2) physical health services, 3) substance abuse services, and 4) benefits assistance. They must have substantial expertise in all these areas and be able to move between direct provision, integration, and collaboration. In addition, psychiatrists often have an impact on other services like housing, employment, parenting, educational either informal ways or more often in providing an important supporter of services. (For example, It can matter a lot if the psychiatrist says I think the stress of work may make your symptoms return. Let's wait until you're more stable vs. if he says lets figure out how to best use medications and self help to overcome your symptoms enough to work with them.)

Psychiatrists have a special role in involuntary, coercive services - hospitalizations, conservatorships payee services, medication management, and occasional others (like getting a driver's license back). They need to be able to use coercion sparingly, integrating it with empowering services rather than responding to our frustration and using them as an alternative to empowering services. They also need to be skilled at discontinuing coercive services and welcoming the person to increased self-responsibility as well as processing the likely trauma that results from coercive services.

And they have to do all that is a culturally and spiritually informed way.

It is likely that every psychiatrist will fall short in some areas, either because of inclination, skills, or time available, and like it or not, that's likely to have a negative impact on our member's recovery. That's why I keep trying to improve my practice. We try to compensate for shortcomings, but there's a price to pay. (For example a division in leadership is likely to lead to conflicts, passive aggressive behavior, and staff choosing sides. Having a nurse take over integrating medical care is likely to miss some medical knowledge. Having someone else handle SSI requests for records instead of writing lengthy evaluations will lead to a much higher denial rate.)