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Consumers & Psychiatrists in Dialogue

Introduction

The genesis of this dialogue grew out of the need for greater understanding between recipients of mental health services and practitioners. Melvyn R. Haas, M.D., Associate Director for Medical Affairs, and Paolo del Vecchio, Consumer Affairs Specialist, both of the Center for Mental Health Services (CMHS), initially discussed the topic more than a year before this dialogue took place. Those discussions led to a **Planning** Committee that selected 21 consumers and psychiatrists to represent key and diverse sectors of the two populations in this dialogue.

John Gates, Ph.D., Director of the Carter Center Mental Health Program, Atlanta, Georgia, agreed to serve as facilitator. The dialogue was convened July 24-25, 1997, at the Sheraton Crystal City Hotel, in Arlington, Virginia. Bernard S. Arons, M.D., CMHS Director, delivered the welcoming remarks. The agenda for the meeting was purposely open to facilitate as much dialogue and discussion as possible.

Planning Committee

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Executive Summary

Day One
After welcoming remarks by Bernard S. Arons, M.D., Director of the Center for Mental Health Services, facilitator John Gates, Ph.D., began the dialogue by outlining and explaining the objectives of the meeting. They were:

- to develop better mutual understanding and respect between consumers and psychiatrists in attendance;
- to develop a set of recommendations regarding how consumers and psychiatrists can prepare themselves to achieve better mutual understanding and more therapeutic partnerships; and
- to prepare and distribute a monograph describing both the process and outcomes of the meeting.

As the participants introduced themselves, they revealed their experiences in mental health care. The discussion then launched into the elements of "Personhood and Relationship." The ensuing dialogue focused on respect, dignity, trust, communication, decision-making, recovery, and spirituality.

Respect is a key element in developing a successful consumer/psychiatrist relationship. Mutual respect is fostered when psychiatrists and consumers reach a point of sharing their feelings and philosophies. This level of communication is reached only through a conscious effort by both parties to overcome numerous barriers to cooperation and collaboration.

Meaningful and respectful interpersonal relationships are essential to promote the shared goal of recovery. The challenge is to create an environment within systems of care that fosters the development of meaningful and effective consumer/psychiatrist relationships. The dialogue explored the process of building relationships through active listening---listening to the views of both the consumer and the psychiatrist. Listening promotes understanding and trust. Trust is reinforced when the process of listening involves consumers at all levels of the system.

Establishing trust within the relationship is especially difficult for the consumer who has experienced involuntary treatment. Added to the fears of the consumer are the fears of the practitioner. While some of the psychiatrist's fears stem from the relationship with the consumer (bodily harm, efficacy of treatment, etc.), others are generated by the system (litigation).

The probability of developing a true partnership between consumers and psychiatrists increases when consumers become informed. Informed consumers are better able to participate in decisions regarding the course of their treatment. However, the psychiatrist's respect for and sensitivity to the consumer often determine the degree to which the consumer can participate in decision making. Consumers especially want to be involved in decisions regarding medications---whose efficacy and side-effects vary greatly. In addition, consumers are concerned about individual psychiatrist's competence.

The dialogue on recovery focused on the power of hope, the effects of long-term hospitalization, and the value of peer support. Peer support can be structured as part of the system. This requires psychiatrists' support and advocacy. Psychiatrists can also benefit from their own peer groups. Collaboration with the consumer is enhanced when the psychiatrist is able to network with colleagues who bring fresh perspectives to the consumer/psychiatrist relationship.

Participants also agreed that employment must be an integral part of the recovery process. Psychiatrists are urged to join with consumer advocates in creating an atmosphere which enhances employment opportunities. The following were identified as resources to help foster and support employment efforts:

- Congress;
- States;
- the Centers for Medicare and Medicaid Services;
- private businesses; and
- trainers of psychiatrists.

The discussion segued to "Barriers and Boundaries." Participants identified five hindrances to a successful consumer/client relationship:

- choice of medications (availability, miisuse and overuse);
- limited resources (restrictive budgets and fiscal policies);
- consumer vs. family needs (how these may differ);
- "oppressor" vs. "oppressed" (how the consumer and the psychiatrist are perceived); and
- cultural barriers (race, national or cultural origin, gender, sexual orientation, age, socioeconomic status).

The next topic, "Contexts within which Relationships Exist," focused on the new pressures managed care has put on consumers and psychiatrists, as well as on the relationship between the two. Specifically, consumers and psychiatrists find themselves "outside the loop" when treatment decisions are dictated by corporate concerns of profitability.

For many of the consumers participating in the dialogue, a critical issue is involuntary treatment. It can be demeaning and utterly devastating. However, depending on the condition of the consumer and the constraints of the mental health system, involuntary

treatment often is a psychiatrist's only option. While consumers and psychiatrists desire consistent guidelines on involuntary treatment, both also realize that some cases require action that can not be readily defined by such guidelines.

Day Two
The second day of the dialogue resulted in a number of recommendations to enhance the relationship and collaboration between the consumer and the psychiatrist. Some of the recommendations are targeted to specific groups such as professional organizations, State Mental Health Departments, and managed care organizations. For example, professional organizations are invited to take a more active role as consumer advocates; State Mental Health Departments are asked to recruit, train, and hire consumers in appropriate jobs; and managed care organizations are encouraged to include consumers in determining policy. Other recommendations are more general in nature. For example, all stakeholders are invited to examine the "rules," laws, and traditions that define the consumer/psychiatrist relationship with the goal of determining how they have changed, how they are applied, and how they should be changed.

A complete list of the recommendations can be found at the end of this document. All participants expressed a strong desire to have the dialogue's information promoted and distributed so that more such dialogues will take place in additional settings. As one psychiatrist concluded, "A dialogue such as this is very important. Sometimes it is the differences and confrontations that produce new and creative ideas."

Welcoming Remarks

Bernard S. Arons, M.D.
Director
Center for Mental Health Services
U.S. Department of Health and Human Services

It is a pleasure to welcome such a dedicated group of people to this dialogue. For those of you who may not know, Congress established the Center for Mental Health Services (CMHS) in 1992 to focus on real-world experiences, services, and evaluation. CMHS supports direct services across the country through activities such as administering state mental health block grants; developing programs for homeless individuals with mental illnesses; and overseeing protection and advocacy systems to investigate allegations of abuse, neglect, and rights violations in treatment facilities.

CMHS works to push the system forward. CMHS recognizes that even research-proven, effective programs do not always reach those who need the services. As a result, CMHS takes seriously its responsibility to disseminate information through a number of knowledge-exchange activities.

Among the most exciting knowledge-exchange activities CMHS engages in is to convene highly interactive and groundbreaking meetings such as today's dialogue. And this meeting also addresses a critical emerging issue: to include consumers at every level in a meaningful way. Meetings such as this do not receive the same publicity as our grant programs, but they are extremely important. CMHS uses these opportunities to push the envelope of predictability and take some risks.

Considerable discussion centers around language and what people want to be called. Some people consider themselves "recipients of services," others view themselves as "consumers." It is important to identify ourselves in ways that make us feel comfortable and that realistically reflect our relationship with the mental health system- Mental health professionals also have their views. Today a number of psychiatrists---a sub-group of what we commonly call providers---are present. Some psychiatrists resent being called "providers" and the connotations the term evokes.

CMHS is sensitive to this discussio n and makes every effort to use respectful language. Language should not build barriers to interaction. It should create opportunities for dynamic connection.

This remarkable group is assembled to open uncharted and challenging territory. John Gates, in addition to being the Director of the Carter Center Mental Health Program in Atlanta, recently facilitated some very spirited meetings where he managed to involve everyone in the process and really delve into the nitty-gritty issues. We are delighted he agreed to facilitate this dialogue as well.

We are gathered to exchange ideas, observations, and experiences as equals. The typical interaction between a psychiatrist and a recipient of services is not democratic. It is usually couched in tacit rules of authority that govern the relationship. Although these rules are limiting, they can also provide both the provider and the consumer comfort in knowing how each is expected to act. This meeting goes beyond those rules.

Our goal is to communicate candidly because communication is the key to understanding. We want to develop the kinds of partnerships that are needed to improve mental health services. It is clear that when providers and consumers work separately from one another, the system stagnates and even runs. afoul. We have a mutual interest in improving the quality of care.

It is my desire that, through this dialogue, the importance of hope will emerge. We all hope for a life that is filled with health and strength. But we also hope that, if by chance health does not occur, opportunities for treatment and recovery will easily be within reach.

This is an ongoing process. In addition to the work we have done, we want to build a foundation of sincerity and openness that will lead to future communication, and more importantly, to a mental health services system that truly meets the needs and wants of those it was intended to serve.

Personhood and Relationship

Barriers to communication begin to crumble when both the consumer and the psychiatrist realize that each has responsibilities to the other and to the relationship. Clarifying these responsibilities paves the way for mutual respect and a decision-making partnership.

Personhood goes to the very core of the recovery process, and that process is often impossible in the absence of a working partnership with a psychiatrist. To build such a relationship, it is critical to explore the of personhood and relationship. Among those underpinnings are:

- respect
- dignity;
- trust;
- communication;
- decision-making;
- recovery; and
- spirituality.

Respect

Systems of mental health care can create an unbalanced relationship between the consumer and the psychiatrist. The practitioner often is on one level, and the client, even in the case of client-centered treatment, may be on a much lower level. In the absence of an equal relationship, the consumer tends to perceive the person who attempts to provide needed mental health care as hostile. One consumer said, "I hated my psychiatrist because I came to know him in a completely unbalanced relationship. I despised him. If there was a human in this world I thought was the devil, it was my psychiatrist."

However, the provider can engender mutual respect by sharing his or her treatment philosophy with the client. The consumer gains greater knowledge of the psychiatrist and the reasons for the course of treatment. The psychiatrist's willingness to share the treatment philosophy also indicates his or her respect for the consumer's rights. "After I do the diagnostic session, I usually spend five to ten minutes talking about my treatment philosophy and how I approach things," noted one psychiatrist. "I emphasize that unless an individual poses a danger to himself, herself, or someone else, we will make decisions together."

Consumers recognize the pressure for psychiatrists to appear omniscient. "The key thing that needs to change for psychiatrists," a consumer observed, "is the burden of having to appear as a perfect person, someone who has all the answers and does not need any help. That makes it hard to be a human being.

Many psychiatrists recognize the paradox such supposed omniscient brings into the relationship. In the words of one psychiatrist who described her epiphany, "I began to see this pattern of how people find, in themselves, the process of recovery and healing. Then I began to have a problem with the idea that it was my job to 'treat' them rather than to support them in their recovery. This notion that we have some power is narcissistic.

We sometimes want people to believe in this notion because occasionally it can help. But at the same time, we do ourselves great damage with it. That process of trying to find the spirit in recovery has led me to communicate with a range of consumers."

Another psychiatrist expressed a similar concern. "In this decade of the brain people talk about the revelations of mental illness down to the molecular level. Some suggest that we are going to live in a world in which there is no human suffering-where people exist without any stress. As a result, we are unable to get to the roots of our own vulnerabilities and weaknesses. We bind our anxieties by blaming each other, without acknowledging that we don't have a clue about huge amounts of information. And here's just one example, sometimes I don't know who I have to lock up because I=m afraid they are going to kill themselves. We hold ourselves to a standard of perfection that makes it impossible for us to acknowledge that and makes it impossible for us to live with that uncertainty."

Medical students from the mainstream population often have stereotypical attitudes about patients from minority cultures. As physicians, these attitudes hamper their ability to deliver effective services to members of minority cultures.

The consumer's perception of the psychiatrist can differ in private care and public care. As one consumer described the situation, AI don't think people understand the difference between the two. When a person who has money goes to see an 'analyst,' that's okay. But people from a lower economic status, who have had experience with the public system, tend to see the psychiatrist as a tool of the system."

Dignity

Life changes drastically for the person who is forced to ride to the hospital in the back of a police cruiser. Regardless of station in life or prior achievements, personhood can be shattered and self-image damaged in an involuntary admission. The consumer feels as if everything he or she does is interpreted in the context of an illness. This is reinforced when reintegration into society is hindered by the stigmatizing stereotypes associated with mental illness. The responsibility for eliminating stigma rests with both consumers and the psychiatrists. Both groups must accept the challenge of bringing stigma to the general public's attention and working to eliminate it.

Trust

When a consumer enters involuntary treatment, particularly through adjudication, fear and distrust often result. The system, and everyone involved, becomes the "enemy." As

one consumer put it, AI felt betrayed because I opened up and said some things about myself that later were used against me. I felt like a caged animal. I felt like the doctors were always picking on me. When I was finally released, I harbored this resentment for a long time. I felt I would rather do anything than go back. Consequently, I became homeless." Another consumer related the experience of being terrified of being "picked up" by police or involuntarily hospitalized. She added, "I quickly learned not to put down (in writing) what I felt about myself." The consequence for a psychiatrist attempting treatment is inaccessibility to the consumer.

Consumers are concerned about any individual psychiatrist's competence. Whether the consumer's first experience with a psychiatrist is by referral or through involuntary hospitalization, consumers must trust that when medication is prescribed, it is the right medication in the right dosage. And they also must trust that the empathy exhibited by the psychiatrist is reinforced by sufficient knowledge and experience.

Similarly, many psychiatrists are concerned that their knowledge is inadequate to both help the consumer and avoid litigation. As one psychiatrist expressed, "We're scared to death of the consumers, the people we're helping. We come in with limited knowledge of a situation, and we are required to make big decisions about people. And in the current litigious milieu, we are scared to death about being sued for every decision we make, and every note we write--sued by the very people we serve. Although I see consumers as human beings, in emergency situations my medical/legal training commits them against their will." Providers of mental health services also fear being physically harmed.

Communication

Consumers often used to feel that communication in a consumer/psychiatrist relationship flowed "from patient, to doctor, to God, back to the doctor, and then to the family." As a result, many consumers approached the relationship with a psychiatrist in fear. Much of the rigidity in this relationship has disappeared. To a large extent, an authoritarian model has given way to one that promotes partnership. A lingering fear and a sense of intimidation still exist among some recipients of services. This is especially true among older consumers and those who face language or cultural barriers.

The consumer movement has contributed significantly to reducing communication barriers. As consumers become better educated and more aware of their conditions and illnesses, they are demanding more information from mental health practitioners.

Decision-making

Society creates a dichotomy that puts the psychiatrist and "normal" people in one place and the mentally ill in another. This dichotomy interferes with---or altogether eliminates---the consumer's right to participate in decisions about his or her treatment. For the consumer, the ability to exercise some level of choice during the course of treatment often defines the relationship with the psychiatrist.

When consumers gain information, they are better able to participate in decisions regarding the course of treatment. The ultimate effect is that the consumer and the psychiatrist become partners in the decision-making process. One participant related the following experience: "The day I developed a strategy that could keep me from moving back into crisis, I took back ownership. It was a turning point Now the psychiatrist acknowledges that I have been the master of my recovery." However, the consumer must be realistic in his or her assessment of the psychiatrist.

The psychiatrist must also be cognizant of the consumer's condition when promoting a decision making partnership. According to one practitioner, the psychiatrist has to "determine if it is safe to take such risks during a volatile and tenuous time in the person's life." And, "In order for us to develop a partnership with consumers, it cannot be the kind of partnership where the psychiatrist is assumed to be omnipotent and know everything."

In addition, organized groups of both consumers and psychiatrists must be in on the ground floor as new structures are formed to ensure that consumers are included. "This is a critical moment," one psychiatrist cautioned. "Many states are disassembling the core structures of state mental health departments."

Recovery

"The power of hope in recovery can be transmitted from one consumer to another within a hospital, and the number of days of recovery starts reducing," observed one consumer. In other words, hope translates into dollars saved on prolonged hospitalization.

Long periods of hospitalization can lead to a sense of hopelessness. "There was no life for me. At 21, my life was over. That was the experience of the hospital. I did not feel that way before I went into the hospital. I didn't feel like I could communicate with people. I was completely terrified by that experience," related one consumer about her 10-month hospitalization.

But providers who offer sensitive and respectful care can instill hope and healing. That same consumer, however, added, "Two psychiatric residents worked with me during the time I was in the hospital who, I felt, saved my life. They both listened to me. They respected me. That was probably the most important part. They had confidence in my ability to heal myself "

Relapse is on the rise. Part of the problem is that the system does not allow the depth of family contact necessary to anticipate crises and to reduce the need for and frequency of admissions. In addition, many patients are discharged without appropriate housing alternatives. Homelessness increases the risk of relapse. As a result, some consumers are hospitalized again after they are discovered living on the streets. Further, that person may then be put on stronger medication, which can mask or exacerbate the problem.

Peer Support

A culture of recovery thrives in support groups. As one consumer described them, "Support groups are as necessary to a good recovery as a good psychiatrist and a good relationship with that psychiatrist. Nowhere else provides the kind of empathy, hope, and understanding you find in a group of people who have the same thing you do and understand exactly what you say."

However, support groups and consumer organizations are largely voluntary. In order to have a greater effect on the system and decisions within the system, their funding needs to expand. For example, the Louisiana Office of Mental Health has provided contracts to consumers and consumer groups to supply services within the infrastructure of the Office of Mental Health. These programs hire the parents of children with emotional disorders as parent mentors, give social service contracts to groups to transport consumers to drop-in centers, and hire consumers as case managers.

Drop-in centers play an increasingly important role in the reintegration of consumers into the larger society. Some drop-in facilities have evolved into multi-purpose centers, incorporating programs such as crisis support, meals, over-night shelter, and housing. "Psychiatrists could be helpful in supporting these efforts by referring clients to them. I suggest that we create partnerships to support more of these services," said the director of the office of consumer affairs of a regional health planning council. She also suggested that psychiatrists, through professional organizations, provide financial support for drop-in centers.

Although the consumer immediately comes to mind as the beneficiary of peer support groups, psychiatrists can also benefit from networking. Psychiatrists can enhance their relationships with consumers when they have a forum to share their concerns and disappointments with their peers. One psychiatrist characterized it this way: "In medicine, we are seen as an insecure profession because of stigma and uncertainty as to what mental illness is. Because of the role we are given in social control, we are very likely to be traumatized when the people we take care of do bad things to themselves or to others."

Spirituality

A participant cited recent studies which indicate that people with faith, compared with people without faith, generally have lower blood pressure and heal faster from open-heart. surgery. "If you believe that, why couldn't that same component of a "Higher Power" help you in your time of crisis?" The same consumer/participant also referred to the continued success of 12-step programs and the spiritual component of those programs.

Including spirituality in treatment can present a conflict, particularly in public systems of care. Although many physicians recognize the efficacy of introducing spirituality or other alternative approaches into the treatment regimen, they may be reluctant to tread too closely to a legal/constitutional gray area. Hence, alternative treatments are more likely to be found in private treatment situations, where they do not have to be accountable to public funding sources.

This phenomenon also has implications for the training of mental health care professionals. If alternative treatments are not included in the curricula or experiences of psychiatric residents, knowledge of their possible effectiveness is limited.

Barriers and Boundaries

Despite the best intentions of both consumers and psychiatrists to bridge the chasm which sometimes exists between them, such efforts often fail. The failure to form a collaborative relationship is linked to outside variables and forces. These barriers and boundaries erect both real and artificial walls that separate the consumer and the psychiatrist.

Participants identified five impediments to forming successful consumer/psychiatrist partnerships: choice of medication, limited resources, consumer and family needs, oppression, and cultural barriers.

Choice of Medications

Psychiatric medications sometimes exacerbate the very conditions they are intended to ameliorate. The side-effects of unwanted medications can keep consumers from seeking treatment. "One of the things that kept me away (from treatment) for years, and years, and years, and years," one consumer shared, "was the choice of medications they wanted to give me that I didn't want to take." That consumer did not reenter treatment until a psychiatrist agreed to the consumer's choice of medication on a trial basis. One of the peer counselor's principle roles with the psychiatrist is to provide insight into the consumer's feelings about medications.

Consumers voiced great concern about the misuse or overuse of medications and the long-term effect this practice can have on patients and the society in which they live. As one consumer put it, AThe misuse and overuse of medications is a factory that is tuning out potential mental health clients for the future?

Limited Resources

Departments of mental health face the challenge of setting priorities while working within very restrictive budgets and fiscal policies. Although effective treatments are available, those treatments may not be available to recipients of public mental health services, especially with the advent of managed care. The frustration that develops, for both the consumer and the psychiatrist, can have a negative effect on the relationship. In addition, tighter fiscal policies have led to shorter hospital stays, even though some consumers still need long-term hospitalization.

Consumer vs. Family Needs

The consumer and the consumer's family may expect and want the mental health care system to respond in totally different ways. The needs of the consumer and the needs of the family are often contradictory. The ultimate decision for treatment may be made by the psychiatrist, the mental health care system, or the justice system. The result is that the practitioner and/or the system are often perceived as the culprit by either the consumer or the consumer's family---or both.

Oppressor vs. Oppressed

At times, consumers view psychiatrists as oppressors. Psychiatrists often find themselves perceived as oppressors when they must force a consumer into treatment. Too often, "Psychiatrists are good people caught in an oppressive system," one consumer observed.

Some barriers are built into the specific roles that are dictated by the system. No quick and challenging method exists to alter these traditional or mandated roles. The challenge to change the roles and the perception of the roles--must involve both consumers and psychiatrists. This process ultimately will ve attitudes and perceptions.

Cultural Barriers

"Institutional racism really does affect how people get treated. Studies have demonstrated that people of color are treated very differently from majority people," said a consumer. "This problem will not just evaporate without the conscious awareness of the American society. Until such time that the mental health system addresses these shortcomings, the problem will certainly continue," she added.

Barriers to effective treatment and partnerships between consumers and psychiatrists go far beyond racism. The consumer's gender, culture, age, socio-economic status and sexual orientation also create barriers. "I fight to be seen. I want to be recognized. I don't want to be invisible. I want to be visible. I want to be looked at and recognized in my totality. Added to being a woman, being ill, and being African American, I have age going against me," commented a consumer. Participants agreed that psychiatric residents should be trained in cultural competence/sensitivity to help eliminate some of the biases in the system.

"People who are poor or from disadvantaged populations never receive the same kind of treatment that others from the private sector do." This critical statement came not from a consumer, but from a psychiatrist. He went on to say, "The public sector requires a lot of advocacy and protection coming from the consumers."

Contexts within Which Relationships Exist

Collaboration is as much of a core dynamic within a system as it is of interpersonal relationships. The system defines the roles of the consumer and the psychiatrist, and the larger world limits cooperative efforts. The participants identified four areas that have a

significant effect on the consumer/psychiatrist relationship, as well as on the recovery of the consumer.

Managed Care

Managed care is creating a paradigm shift. For example, in-patient, long-term hospital stays are giving way to community treatment, short-term hospital stays, wrap-around services, drop-in centers, and home health care. Although these shifts provide alternatives for psychiatrists and consumers, they also restrict treatment choices by eliminating or truncating long-term hospital stays and limit the number of out-patient sessions.

Psychiatrists and consumers often find themselves "out of the loop" when managed care organizations make decisions about treatment options. Excluding psychiatrists and consumers from this decision-making process unravels the traditional safety net and replaces it with decisions made in a proprietary/corporate environment. The key to making managed care more responsive is to involve consumers and psychiatrists as decision makers. Ultimately, it is a question of who determines what, and the motivation behind those determinations.

Involuntary Treatment, Seclusion, and Restraints

Although involuntary treatment can promote recovery, it also can be a devastating experience for the consumer. The memory of being taken away in the back of an ambulance or police cruiser and involuntarily committed may arouse fear and terror. It can remain with a consumer throughout treatment and diminish its effectiveness. Most participants, consumers in particular, suggested that alternatives to the traditional means of involuntary treatment and commitment be found whenever possible. "Involuntary treatment is at the core of a lot of the disagreements and feelings consumers have about the profession (psychiatry). They help wield that power over us, and there is no getting around that: You resent the lion tamer---the one who has the threat of caging you," remarked one consumer who had committed her husband for treatment on nearly 50 occasions.

Involuntary treatment is at times both necessary and effective. Given this reality, establishing a fair and consistent framework is desirable, if not always possible. A psychiatrist suggested that should forced treatment become necessary, clear criteria that transcend cultural differences and the power differential (between psychiatrist and consumer) be available. "Who makes the call?" he asked. "Is it the psychiatrist? Is it the consumer? Or is it a combination of both? I think it is the latter." That same psychiatrist related the case of a consumer in the midst of a crisis and unable to make an informed decision: The consumer had a breast carcinoma and she refused treatment and surgery from the oncology team. The oncology team wanted the psychiatrist to take the consumer to court to force her into surgery. The psychiatrist refused. However, the psychiatrist did tell the judge the consumer required psychiatric treatment, which could allow her to make an informed decision about surgery. The judge granted the psychiatrist's request, and the consumer was later able to make her own decision about surgery.

In addition, consumers want consistent guidelines to be established and observed in the use of seclusion and restraints. Just as in the case of involuntary admission, the consumer carries with him or her the memory of such experiences. And those memories can impede recovery.

Employment and Reintegration

"One of the best things we could do is show that consumers are an adjunct to the profession, that they are valued, and that they should be reimbursed if they provide services," said a consumer. Recovery can be thwarted when society stigmatizes the consumer as "insane" and blocks his or her reentry into the community. In addition, psychiatrists sometimes find themselves in the position of asking that a person be certified "one hundred percent disabled," completely eliminating any prospects of employment.

Employment is a critical area for those seeking reintegration into society. Some consumers expressed the sentiment that psychiatrists must more actively promote the role of consumers in consumer affairs and case management. The desired effect is both direct and indirect. Hiring consumers for such positions will provide immediate access to employment What's more, consumers in those positions can help change perceptions and remove stigmas, and ultimately lead to more employment opportunities for other consumers.

In general, psychiatrists were urged to become more involved in helping consumers reintegrate into society. Participants also recognized the effective role support and peer groups have played in furthering reintegration and reasonable accommodation. In addition, the participants identified the following as resources to strengthen the work carried out by peer and support groups to help consumers find employment:

- Congress;
- States;
- the Centers for Medicare and Medicaid Services;
- private businesses; and
- trainers of psychiatrist.

Volunteerism is also a means of reentry. Consumers who find themselves not quite ready to assume employment can ease the transition back to work by volunteering their services to nonprofit agencies and support/advocacy groups. Volunteer work can be a means to regain the skills and confidence essential to recovery.

Training Psychiatric Residents

Psychiatry is increasingly perceived as a traditional science. As a result, the pendulum is swinging from a psychoanalytic approach toward a more biological approach. In turn, the field is at risk of producing new psychiatrists whose diagnostic and treatment options are limited. "How do we help psychiatrists think more broadly than some of my residents

who will tell me when someone commits suicide, 'It was because their serotonin levels were too low'?" commented the director of residency education at a college of medicine. "For some, that is as far as their explanation needs to go," he continued. "We don't like to admit that we make mistakes, and we do not want to be put in situations where we make them. Too often, the knowledge isn't there. This lack of knowledge frequently makes us (psychiatrists) feel insecure."

Another psychiatrist addressed an additional weakness in training. "Any system based on impairments will not concurrently focus on strengths. Therefore, the practitioner does not take into account the strengths of the people he or she is treating," the psychiatrist said. In short, practitioners need to be taught to make two kinds of diagnostic statements--to assess the consumer's impairments and to assess the consumer's strengths.

"A relationship of respect and a 'jointness' to the process are what I like to teach. Therapy, treatment, call it whatever you want, can't take place if that jointness' is absent," asserted a psychiatrist who oversees the training of psychiatric residents at a university medical center.

Specific Recommendations

The honest and open exchange among consumers and psychiatrists resulted in a number of recommendations. Although directed at specific audiences, some recommendations are applicable to one or more additional audiences. In addition, follow-through and ongoing actions are necessary. As one participant stated, "Success is a journey, not a destination."

To Medical Schools and Residency Programs

- $ Emphasize a consumer-centered approach. Training programs must raise the awareness and sensitivity of new psychiatric residents to involuntary treatment, forced medication, seclusion and restraints. Such training could take place during an orientation and before responsibilities for patient care begins. Students should also be allowed to interact with various groups of patients or consumers to counteract the dehumanization which too often occurs in the system.
- Improve respect, understanding, and cultural competence. Training academies could use consumers to train psychiatric residents.
- Recreate this dialogue in booklet form. This booklet could be disseminated to psychiatric residents to raise their awareness and deepen their sensitivity. (A video presentation could serve the same purpose.)
- Develop a new training component for psychiatric professionals where consumers share their experiences. In addition, the Residency Training Directors' Association should receive the report and recommendations of this dialogue.

To Professional Organizations

- Replicate, promote, and enhance activities dealing with consumer issues and the substantial involvement of consumers at the national level. For example, the American Psychiatric Association's (APA) district branches and regional societies could be instrumental in this endeavor.
- Encourage psychiatrists to take a more active role as consumer advocates.
- Establish a higher consumer profile in the APA and its publications. For example, the APA and the American Association of Community Psychiatrists could feature a regular column written by a consumer in their newsletters.
- Encourage the APA to establish a committee of consumers and psychiatrists to promote communication.

To State Mental Heath Departments

- Replicate efforts, such as this dialogue between consumers and psychiatrists, on a State and local level.
- Recruit, train, and hire consumers in appropriate positions/jobs by State mental health systems.
- Develop positions that employ consumers as counselors and evaluators, as well as create strong consumer affairs offices.

To Managed Care Organizations

- Include consumers in policy discussions and decisions.
- Eliminate prior history of severe mental illness as an exclusion to health insurance coverage.
- Make cultural competence an outcome measured by managed care organizations.
- Include a ffill range of effective services, both psychopharmacologic; and psychosocial, in managed cInclude a full range of effective services, both psychopharmacologic and psychosocial, in managed care plans.

To Federal, State, and Local Governments

- Review and alter Federal, State, and local funding policies that may be disincentives to employing consumers.
- Require the relatives of mental health consumers to be involved in designing and monitoring hospital discharge plans and regulations governing managed care organizations.

To the Center for Mental Health Services

- Continue and replicate the work started in this dialogue. One way to do so would be to prepare and disseminate to appropriate publications a synopsis of this dialogue as a press release.
- Coordinate, or serve as a dissemination point to, ongoing dialogues and multi-level partnerships between consumer and professional organizations.

- Disseminate information to relevant agencies in order to replicate this consumer/psychiatrist dialogue in other parts of the Federal government.
- Establish a time-frame to review this dialogue's recommendations and to evaluate any responses to the recommendations.
- Reconvene the participants of this dialogue for the purpose of review and evaluation.

General Recommendations

- Develop a list of references or a bibliography identifying where information may be obtained on consumers' issues.
- Urge philanthropic organizations to provide monetary assistance to consumer organizations and consumer-oriented programs.
- Establish an Internet forum to promote ongoing discourse and exchange among consumers and psychiatrists.
- Create practical how-to materials to foster the replication of consumer/psychiatrist dialogues.
- Encourage consumers, consumer organizations, psychiatrists, and professional psychiatric associations to focus on areas critical to improving cooperation. Topics include:

    - respect;
    - dignity;
    - trust;
    - communication;
    - language;
    - decision-making;
    - peer support;
    - recovery;
    - spirituality;
    - hope;
    - bias resulting from age, gender, race, and sexual orientation;
    - involuntary treatment;
    - medication;
    - managed care; and
    - training of psychiatric residents.

- Examine the "rules," laws, and traditions that define the consumer/psychiatrist relationship to determine how they have changed, how they are applied, and how they should be changed.
- Approach the Carter Center to collaborate on continued consumer/psychiatrist dialogues.