



Weighing the evidence: Risks and benefits of participatory documentary in corporatized clinics



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ABSTRACT

This paper describes the effects of one U.S.-based public psychiatry clinic's shift to a centralized, corporate style of management, in response to pressures to cut expenditures by focusing on "evidence based" treatments. Participant observation research conducted between 2008 and 2012 for a larger study involving 127 interviews with policy makers, clinic managers, clinical practitioners and patients revealed that the shift heralded the decline of arts based therapies in the clinic, and of the social networks that had developed around them. It also inspired a participatory video self-documentary project among art group members, to portray the importance of arts-based therapies and garner public support for such therapies. Group members found a way to take action in the face of unilateral decision making, but experienced subsequent restrictions on clinic activities and discharge of core members from the clinic. The paper ends with a discussion of biopolitics, central legibility through corporate standardization, and the potential and risks of participatory documentaries to resist these trends.

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Introduction

I was driving to the airport when I saw I had a text. It was from Tia, the editor for the video self-documentary group at the psychiatry clinic:

"Can I call you*?? Terrible news..."

Hmm, that is unusual, I said to myself. Maybe we have to reschedule our editing session. After 20 minutes, I saw I had another text:

"Just got bad news from Carla about Larry...He was found dead in his apartment..."

My arms and legs went limp. I pulled over and dialed Tia.

"Oh God. When did you find out? What is Carla going to do? She spent all of her free time with Larry!"

Tia and I went over the signs of trouble. Larry had been tottering on the edge of an alcoholic binge. Two weeks before, instead of talking about his latest pirated video software, Larry talked about

his panic that he had been unable to pay his bills this summer. He reminded us that he was the kind of person who didn't look back once he started drinking. And he had passed out last week in his apartment. Larry waved it off, saying that he had just taken medications and that he could not afford air conditioning.

Larry wasn't the only one in a panic. The clinic that had been his safety net for the past seven years was faltering. Founded in the 1980's by alternative treatment advocates who combined medications with painting, photography, video, yoga class and gardening, it took up the corner of an old hospital building that sheltered people who were recovering from addictions, depressions, manias and psychotic episodes. Decisions were made by a patient government, and lunch was served by patients to patients in a kitchen that doubled as the clinic lounge. Long term patients and volunteer former patients had keys to the supply rooms so that they could roll out a video projector, a sewing machine, or a tool kit whenever the need arose. The leveling of clinical hierarchies and the therapeutic role taken up by patients were reminiscent of the therapeutic communities created by post-war British psychiatrists (Mills & Harrison, 2007).

But over the past three years, hospital managers were forced to make a change. State budget monitors deemed outpatient services too costly. Managed care Medicaid threatened to stop paying for long-term patients, a few of whom had been coming to the clinic for

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over a decade. Counselors were told to start discharge planning for patients who had been in treatment over a year, although there were few community based after-care services in the wake of State cutbacks. Art groups were no longer reimbursable; only one group per day, based on Alcoholics Anonymous principles, could garner a small payment, and was therefore required. Managed care Medicaid paid more for 15 minute medication checks with a psychiatrist than for hour-long psychotherapy visits, so the number of psychotherapists in the clinic dropped by more than one half within a year.

The most fundamental change, however, was that the trusted patients and volunteers who kept cameras loaded for photo group and microphones charged for music group were asked to return their keys. The clinic was shut down daily at four, and patients were not allowed to linger in the art room. The staff was re-educated about the distinction between a patient and a staff member; the staff who were too slow to learn – those who attended barbecues organized by patients in the city park, for example – were transferred to other units in order to “maintain better boundaries.”

Just after his death, Larry's closest friends took note that “we didn't reach out to him like we used to.” A week had passed and no one went to his door when he failed to answer his phone, because his closest friends were preoccupied with their own imminent discharge. The staff was aware of his relapse, and on the mandate of clinic managers to retain only patients who “show they are serious about treatment,” the staff had given Larry an ultimatum that Larry felt he could not abide: voluntary hospitalization in order to return to the clinic.

This shift in administrative tone set up a conflict of therapeutic cultures that inspired participatory documentary-making by a core group of patients. Their documentary was intended to show the importance of creative arts therapies in recovery. Although their self-advocacy through documentary-making was not the only factor leading to the dissolution of the group, their documentary-making brought the conflict into relief as core group members were discharged from the clinic.

Yet, through the process of documentation, the video group members educated themselves about the outside political forces that impinged on clinic walls. And the video project mobilized a group of patients that had a tenuous sense of their own value as persons. On film they portrayed themselves as people with creative talents who were worthy of public investment. They strove for a visual narrative that would raise public awareness of creative arts therapy for mental illness and addictions, in an environment of cutbacks to “non-essential” services in public clinics.

This paper examines the predicament of self-documentarians in the midst of a broad shift in clinical-institutional cultures toward expertise based on “evidence.” Self-documentary gave group members a way to act in their own interests. But it was treacherous to politicize their treatment in a climate of technical expertise. Operating under the rubric of “evidence based medicine”, managerial control undermined the social networks and peer leadership that had developed as a result of less biotechnology-focused, more social and community oriented approaches to treatment.

Methods

This paper describes a participatory, collaborative self-documentary project that unfolded as I worked as a psychiatrist, group therapy volunteer, and participant observer in an outpatient clinic in urban New York State that I studied between 2008 and 2012 as part of a larger ethnographic project on addiction treatment in outpatient clinics: here I provide my own analysis of the events that unfolded from the collaborative project. My data gathering began as a study of corporate and medical professionals' efforts to medicalize addiction, establishing it as a chronic physical illness, rather than a

moral or social disorder, through the widespread use of newly FDA approved addiction pharmaceuticals (Hansen & Roberts, 2012; Hansen & Skinner, 2012). I soon saw the other side of this story, however: the ways that non-pharmaceutical, psychotherapeutic and creative arts approaches to mental health and addiction are being divested. I gathered this data as a participant-observer over a four year period, with a group of dually diagnosed patients (substance dependence plus mood or psychotic disorders), who were shooting a documentary film on the importance of creative arts to their recovery. I participated in this video production group weekly; I saw group members both inside and outside the clinic, at birthday celebrations, at field trips to performances, and at dinners. I was also privy to staff meetings in which patients, therapy groups, and clinic policies were discussed. I wrote field notes on these events, and conducted open-ended interviews with participants to get their interpretation of these events. As a part of the larger study of addiction treatment, I conducted 127 interviews with treatment program administrators and managers, pharmaceutical executives, policy makers, physicians, and pharmacists.

I thematically coded and analyzed narrative data from field notes and interview transcripts using established ethnographic iterative techniques of continuous comparison, and grounded theory development, as well as triangulation with available secondary data and confirmatory interviews with informants (Corbin & Strauss, 1997; Emerson, Fretz, & Shaw, 2011).

This research was conducted with oral informed consent procedures, data storage techniques designed to safeguard the confidentiality of participants' identities, and participant protection from court subpoena of the study's data as provided by a U.S. Health and Human Services Certificate of Confidentiality. These measures were approved by New York University's Human Subjects Investigation Review Board. As a result of these measures, the names, locations and dates of people and events described have been changed to conceal participant identities. However I have tried to accurately represent an ethos of ideological conflict that, while brought into sharp relief in this one clinic, I found pervasive in my conversations with mental health practitioners and site visits to mental health treatment settings across the U.S.

Findings: a clash of clinical cultures – “recovery”, community participation, and “evidence”

In 2004 the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) released their National Consensus Statement on Mental Health Recovery. Written on the basis of their convention of “110 expert panelists [who] participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, State and local public officials, and others”, it led to a series of technical papers and reports (SAMHSA, 2004, p. 1) written in an effort to establish recovery, rather than symptom reduction alone, as the goal of treatment in mental health centers across the country. SAMHSA defined recovery as “a journey of health and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential”, and offered “10 fundamental components of recovery” including self-direction, individualized and person-centered care, empowerment, holistic services, a non-linear path of progress, strengths-based assessments, peer support, respect, responsibility for self-care, and the fostering of hope (SAMHSA, 2004, p. 2).

Psychiatrists and social scientists have described recovery as a development of the prior two decades, a reaction to pessimism and paternalism in mainstream psychiatry (Adeponle, Whitley & Kirmayer 2012). They have defined recovery in various ways, but

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