Problem Overview: Psychiatric Crisis Reform

What is the current situation?

Sometimes, when people who are particularly susceptible get into a situation that causes them a lot of distress, they have a psychological crisis. We have a lot of euphemisms for these experiences but they fall into a handful of categories:

- A person is so distressed they try to kill or seriously injure themselves, or seem to those around them like they are about to
- A person ‘loses touch with reality’ and becomes psychotic, talking and behaving in ways that are extremely unpredictable to those around them, with a higher risk of becoming violent or destructive if they get afraid or distressed
- A person takes a drug that turns down their inhibitions and they become reckless, unpredictable or dangerous
- A person gets into an extremely manic mood that turns down their inhibitions, and they become reckless, unpredictable or dangerous

These descriptions roughly cover the four major types of acute psychiatric crisis--suicidal depression, psychosis, intoxication, and mania. A serious chunk of people experiencing a crisis will be going through more than one of these at the same time--having psychotic delusions that lead them to try to kill themselves, or taking a drug that triggers psychosis or mania. There are many other types of psychological distress (anxiety, depression, obsessive-compulsiveness, paranoia) but generally only these four will lead to someone using crisis services or interacting with the psychiatric crisis system.

What is the psychiatric crisis system? The psychiatric crisis system is an interlocking network of social institutions that respond to and take responsibility for people having these crises. Importantly, once the crisis system is involved, the person in question and their immediate network (family, friends) have much less control over what happens to them than before the system was involved. This network of institutions has important similarities in most countries with Western-style medical systems and local government systems, and a lot of key features such as relevant legislation or expert credential processes are shared or copied across jurisdictions.

Insane asylums have been around for hundreds of years, but the secular mental health crisis response system in place in most Western jurisdictions has been around since roughly the 1960s, which is also when a lot of insane asylums that held people with mental issues for decades were closed down (a process referred to as de-institutionalisation that occured in major Western countries around 1960-1980).

So, what actually happens when the crisis system is called upon? Well, someone makes a call to ask a service for help. Frequently this is not the person in distress; it is more often someone nearby, someone who cares about the person in distress. They most often call 911, although they could call a local suicide crisis hotline, or a local mental health crisis service, or a social services agency. They're more likely to call any of the second kind of service if this type of crisis is frequent or the person is already 'in the system' and there are professionals who already work with them.

When you call 911, the most common thing that happens next is that either paramedics or police or both arrive at your house, attempt to de-escalate the situation, and take the person to hospital if they decide to. Some people can also take themselves or get someone to take them to hospital independently. Neither the paramedics nor the police have specific mental health crisis training (although in some jurisdictions there is some training for some officers) and there are lots of tragic incidents where the police have ended up shooting someone they were called to help, or they deemed someone safe who later went and killed themselves or someone else.

A lot of jurisdictions are working on developing alternative response teams that consist of people with mental health credentials (most commonly social workers) and people with personal experience of these kinds of mental health challenges. This is in part driven by responses to the George Floyd protests of 2020, but some crisis response teams have been around for 30 years. CAHOOTS in Eugene, Oregon is the example most often cited, and they use teams including a medic such as an EMT and a mental health crisis worker to offer emotional, medical and logistical help in situations that don't involve violence or a threat to someone's life. White Bird Clinic (the organisation running it) is now consulting with a lot of other local governments to help replicate their programs in other parts of the US.

In some fraction of cases, the paramedics and/or police decide to take the person to hospital. In some smaller fraction of cases, the person disagrees, and the police take them by force to the hospital (physically restraining them if needed).

The paramedics and/or police take the person to the emergency ward, which, depending on the hospital, may be a psychiatric emergency ward or may be a regular medical ER. The person, and sometimes their family, will then have to wait to be seen by a doctor. Sometimes they wait in the waiting room, and sometimes they get given an ER bed and wait there. In ERs that are not specifically for psych patients or that have long wait times it is often easy for them to escape, particularly if they can fool a nearby nurse into thinking they seem friendly or fine or 'not a risk' to other people. It is very common for suicidal patients to attempt to escape from ERs.

In a psychiatric ER they will be locked into the ward, where no visitors or phones are allowed. It may take up to 12 hours for a psychiatrist to come evaluate them. If they act in a way that seems threatening to any of the ward staff they will be physically restrained (strapped to a bed) by multiple hospital workers and/or given an injection of a rapid-acting antipsychotic such as Haloperidol. The psychiatrist may decide to hold them in the hospital against their will for up to 72 hours.

I don't know what it feels like to be inside a psychiatric emergency ward because they generally do not allow anyone other than patients inside, and there is little to no footage available on the internet. There are some written reports from patients and workers that can give you some idea. However, most people locked in such a ward are either extremely distressed, extremely energetic, or extremely unpredictable, or they have been restrained or sedated or both, and if they have never been there before they are likely to have no idea what will happen to them.

Most of the staff who are present around the clock (nurses, registrars, technicians) are very aloof and don't engage with patients at all. There are other staff (psychologists, psychiatrists, social workers) who interact more with patients but they don't tend to spend too much overall time with them, so most of the time patients have the option of interacting with no one or with other patients (who might be unpredictable, violent, threatening etc). I've found this to be true of four suburban Australian psych wards and one inner city New York psych ward that I've visited.

The treatment plan once someone is transferred to a hospital psych ward (which can take anywhere from a few hours to three days) depends on their diagnosis. Generally the first doctor someone interacts with will do an evaluation and make a diagnosis, even if they only spend 15 minutes with the person. This is generally for billing reasons, although sometimes the doctors can get away with giving a diagnostic code that basically means 'distress for some unknown reason'. People in my family have been given diagnoses of:

- Bipolar I
- Schizoaffective bipolar
- Drug-induced psychosis
- Borderline personality disorder
- Alexithymia with avoidance disorder

Often by different doctors or psychologists in adjacent hospitals for the same cluster of experiences.

After the person is evaluated by a psychiatrist and 'stabilised' if necessary (injected with rapid acting sedatives, antipsychotics, or detox drugs, or they seem to have calmed down on

their own) they will either be discharged (sometimes without informing their family) or they will be moved to a locked psych ward in the same or a nearby hospital. Where they go is mostly determined by where there is space for them, and secondarily whether there is a specialty area (i.e. a detox ward, or a childrens' ward).

It's common for people to languish in one part of the system (i.e. in a bed in the medical emergency ward) because there is no room for them somewhere else, or get discharged from hospital when they're still extremely distressed because there isn't enough room for them in the nearby psych wards. This leads to a phenomenon where some people get discharged from hospital, get back into a situation that is pushing them into acute distress, and end up coming back to hospital again and again being discharged within a few days. These patients are referred to as 'revolving door' patients and it's common for hospital staff to look down on them with disdain or frustration.

If someone does get transferred to a regular psych ward, things become more predictable. Normally the thing determining whether they go and their length of stay is whether a psychiatrist decides to start them on a course of drugs, or change their drugs, and how long they expect it to take to put them on the right amount and watch for unpredictable side effects. If someone has a manic-psychotic episode and is started on second-generation antipsychotics, this stay is generally around two weeks, and in my experience any 'changing meds' stay tends to last on average around two weeks.

Psych wards are pretty unpleasant places to be. The trust between patients and staff is extremely low, and often between different patients, there are a lot of rules (enforced by nurses) and punishments for breaking them, and they are extremely barren (extremely rare access to the outside, nature, phone calls, music, entertainment of your own choosing, or social interactions with people you're familiar with). They look like hospitals, anything potentially dangerous is forbidden (like e.g. musical instruments), the food is boring and bland, and most of the time there is nothing to do. There are sometimes guided activity sessions like art therapy or music therapy but they're often a bit demeaning and run like you would run childrens' craft activities. Some people build good friendships with other patients inside a psych ward but other people find it difficult or impossible, or are too distressed or alienated to want to.

You would think that there would be a lot of cultural variation amongst psych wards in different places but it seems like this isn't the case at least in public hospitals in English-speaking countries. Nurses are badly paid, rarely rewarded for building rapport with patients, and inundated with paperwork. Insurer demands, psychiatric licensing and service licensing demands, and legal requirements severely constrain the variety of structures of public psych wards. For example, in most wards there is an outdoor area, but you must get permission from a nurse, or be accompanied by a nurse in order to use it. Nurses are generally overworked so they resent being asked or say they don't have the time, so it is rare for patients to spend a lot of time outside. Most psychiatrists visit their patients at maximum every 2-3 days, for a brief period. I am not aware of a single public psych ward that regularly and continuously has offered daily high-quality psychotherapy to patients inside the ward, or allowed outside psychotherapists to visit their patients and provide therapy while they're institutionalised, although I have read about this happening in some much older wards (in the UK in the 1980s).

Someone can be held against their will for periods of a month at a time if the psychiatrist and other medical workers ask a mental health judge to involuntarily commit the person. A judge (generally someone with no specific mental health training) will decide whether to allow the team to keep the person in the hospital, in a hearing which generally takes place in the hospital itself. Some hospitals have an assigned patient advocate (not a lawyer) and some patients learn how to navigate these hearings themselves, but most patients don't seem to have any influence at all over the outcome of these hearings. I don't know a lot about the actual structure of the hearing and what the ruling depends on, but it is similar in Australia, the US, the UK and Canada as their Mental Health Acts are all very similar.

Most of the time the person who decides when to discharge a patient is the psychiatrist, sometimes with input from the social worker, who makes sure the person has a safe place to go afterwards and isn't going to be immediately homeless. Sometimes there is no social worker. Generally there is a plan to continue treatment after discharge but the amount of monitoring drastically drops the minute someone walks out of the door. The most common type of follow-up is that either a mental health team will call or visit them a week after discharge and 'see how they're doing', or they are set up with appointments for a psychiatrist in an outpatient clinic starting a week or so after discharge.

Being discharged from a psych ward can be very disorienting, because the amount of control you have over your life and the amount of stimulation you have to deal with goes up immediately and rapidly, and if you had problems that were stressing you out and led to the psych ward stay then you will likely go straight back to them. There have been some attempts in some jurisdictions to create 'stepdowns' or halfway houses for people to stay at to have a bit more autonomy and help getting their life in order, but there is no Western jurisdiction I'm aware of where using these places is standard practice.

It's very common for people prescribed antipsychotics to stop taking them. They cause weight gain in most people, emotional numbness and lethargy, sometimes permanent uncontrollable twitches (in earlier generations of drugs), and can cause rebound symptoms like feeling more aggressive or suicidal in some cases. It's also common for people who are experiencing psychosis to believe that their thoughts, feelings and behaviours are not a problem, and to stop taking them because they either believe they are normal or don't believe their behaviour needs to be changed. It is common for family members to put pressure on the person prescribed the medications to keep taking them, and for psychiatrists to identify refusal to take or forgetting to take medication as evidence of their mental illness, and thus evidence of their continual need for medication. For someone who has been started on medication in hospital, they will be expected to continue taking it indefinitely, even if there's no evidence they will have a second psychotic episode.

Most psychiatric medications cause dependence and people will experience withdrawal symptoms if they stop taking them cold-turkey. Most psychiatrists do not know how to deprescribe medications or do not focus on it, and it is very hard to figure out how to safely stop taking a psychiatric medication such as an antipsychotic or a mood stabiliser on your own.

It is common for people who are actively trying to kill themselves to not have any diagnosable mental illness at all, and there isn't a clear psychiatric medication that stops people from killing themselves. There are some medications that make their emotions less intense (mood stabilisers), or improve their overall mood (SSRIs), or sedate them to make it less likely they will kill themselves (benzos), but some of these medications have the unfortunate rebound side effect of making someone's impulses to kill themselves stronger, and this is particularly a risk when withdrawing from any of these medications. 'Locking people up' is an obvious way to keep someone alive in this situation, but it clearly does nothing to address their impulses to kill themselves, aside from allowing time to pass to give transient impulses time to go away.

I know the least about crisis treatment for acute intoxication or anything related to substance abuse, except that this is the area of crisis treatment where it's most likely that medical doctors will need to get involved (because of risks of poisoning and overdose). In more dense urban areas there will often be dedicated wards and teams for detox and overdose, but in smaller areas they often get treated on medical wards and not on psych wards, or the doctor picks which one to send them to.

This current model of crisis treatment is:

- Scary, unpredictable and overpowering--it takes all control away from the person and their friends and family who might have been managing the situation as best they could and into the hands of a lot of different strangers following made-up rules
- Indifferent to the reasons for the crisis--people are treated primarily as if something mechanical is wrong with their brains, and social and psychological factors are not changed throughout the treatment at all
- Alienating--a person encounters dozens of strangers, often who ask very intrusive things and don't deeply care about the answers, because of burnout or regulation or both
- Secular, materialistic, and individualist--a person's experience is explained as a medical symptom, one that must be controlled or removed. There is no room for explanations that allow someone to find meaning in their experience, or strengthen their relationships through the experience, or their own sense of self and identity.
- Demotivating to mental health workers--mobile crisis team work is seen as low status. Psychiatric nurses are seen as 'not real nurses'. Excellent, caring psychologists and psychiatrists regularly leave crisis work to work in fields where they have more autonomy and are able to develop a more humane and respectful relationship with their patients. The rates of burnout and turnover are extremely high, and recruitment is extremely difficult, even while the pay is not very good.

What would be a better situation to aim towards?

There is a model for responding to psychotic crises developed in Finland, called Open Dialogue. When you investigate it, the core aspects appear to be a set of principles around how to structure services, and not a set of treatments or rules for doctors to use on patients. Within Western Lapland, where the model has been fully implemented for a while now, people diagnosed with schizophrenia recover fully much more often and most people don't have to continue using antipsychotics. A large proportion never need to use antipsychotics at all. The guiding principles are:

1. Immediate help
2. Looking at the problem from the perspective of the whole social network, not just ‘the person with the problem’
3. Fit the response to the needs of the situation--being flexible on time and place
4. The initial point of contact takes charge of the whole treatment, and all issues are discussed openly within the network
5. Psychological continuity--the same team always responds to and deals with the same person; no referrals to other providers
6. Tolerance of uncertainty--being with, without knowing the answers
7. Emphasis on dialogue, and making space for what is as yet unsaid

While this is a set of principles for responding to psychosis, a successful suicide crisis organisation in the UK shares a lot of these principles, while having some key differences. All but no 2. are key features of Joy Hibbins’ Suicide Crisis Centre, and this set of principles shares a lot in common with the principles of psychoanalysis (5, 6, and 7).

This paradigm says nothing about what to do if someone can’t stay at home, and there are alternatives to psych wards that exist and have been tried in the past. The main example is Soterias, which create a specific culture that emphasises principles 5, 6, and 7, while also providing for a person’s basic needs and taking away obvious dangers like weapons, and encouraging healthy sleep and eating patterns, perhaps through the use of sleeping medication. Like Open Dialogue, Soteria patients had an extremely good long-term rate of recovery compared to people given conventional antipsychotic medication+locked psych ward treatment.

The original Soteria experiment housed people who were not immediately given antipsychotics, and the original Open Dialogue also does not immediately give people antipsychotics, but in both cases a person and a psychiatrist may decide to use them several weeks after the initial crisis starts if nothing else works and they want to try it. This strategy is called ‘minimal medication’ but is legally questionable for licensed psychiatrists to use, and almost definitely impossible, legally and practically, for a treating psychiatrist to use for a patient on a crowded and stressful public psych ward.

This paradigm stands in direct opposition to the direction a lot of bureaucratic reforms are heading. They emphasise standardisation, immediate legibility, treatments that can be proven to work (generally through experimental lab research), and place a strong emphasis on minimising the length of time someone is given treatment (through the managed care paradigm from Medicare).

What is currently being done, and by whom?

There is a small but thriving movement of ex-consumers, patients and survivors of psychiatric institutionalisation who have been fighting for reforms for the past 50 years. In particular, they have promoted 1) the inclusion of patients/consumers in decision-making around services and laws and 2) the development of a role within the mental health care system called a ‘peer worker’ who has recovered from a mental health crisis and can encourage and inspire people in crisis, as well as being less intimidating and alienating than

doctors and other mental health professionals. In California there is an organisation called CAMHPRO which is spearheading the development of a training and credentialing system for peer workers, and also promotes or fights upcoming California state legislation depending on whether it protects or hinders patients' autonomy and hope of recovery.

There are also a handful of organizations that focus specifically on legal advocacy for patients' rights, including protesting harmful laws or getting them repealed. PsychRights in Alaska does some of this, as does the Miles Hall organization in California, but unfortunately one of the most prominent organisations of this kind is the Citizens Commission on Human Rights, which is run by the abusive cult Scientology. Scientology is openly anti-psychiatry in its teachings, and unfortunately this has led some ex-patients afraid of the mainstream system to become Scientologists, and also led the anti-psychiatry movement to be associated with Scientology in mainstream culture. One of the most prominent patients' rights advocacy organisations, MindFreedom International, has made some practical progress but has also become unintentionally associated with Scientology in the past through members who were participants in both groups.

There is a movement of ex-patients, clinicians and family members who like and want to promote alternatives such as Soteria and Open Dialogue. They are attending and organising training, and some are starting and funding Soteria houses in different parts of the world. A related type of institution is a peer respite, generally not for acute crises but for recovery, which has a growing movement and network. There is one Soteria House in the US, in Vermont, and a few dozen peer respites--there are three in the greater Bay Area. There are no Open Dialogue-based services in the Bay Area, although there are two first-episode psychosis programs and it's possible they are at least familiar with Open Dialogue.

There are a lot of efforts to create mental health crisis response programs that are alternatives to policing, particularly for black and brown communities who have had historically much more dangerous experiences of encounters with police. In San Francisco there are three mobile crisis teams, one run by the city (SCRT), another run by the city and focused on overdose (SORT), and one run by community activists (CART), although none of them are yet integrated with the 911 dispatch system and they are focused strongly on issues surrounding homelessness and drug use. Oakland just started a mobile crisis response pilot called MACRO, who were trained by the CAHOOTS team from Oregon.

Last year a federal bill was passed to create a dedicated mental health crisis number, 988, akin to 911 but reserved for mental health emergencies. The rollout of this system is being led by a NYC mental health nonprofit with strong ties to the government mental health bureaucracy, Vibrant Emotional Health. In California the rollout is being co-ordinated by a prominent suicide center in Los Angeles called Didi Hirsch, and they do not emphasise any of the Open Dialogue principles in their reform rollout except for principle 1 (immediate help). Both use roughly 'social services' bureaucratic language and organisational structures to describe and implement their programs. They will initially create this system using the existing national suicide hotline network, and then eventually develop processes to do triage, event coding and dispatching emergency services. There is a lot of hope (but no formal public commitments) that this transition will enable the funding and development of a lot more mobile crisis teams, potentially using the CAHOOTS model.

The State Administration for Mental Health and Substance Abuse (SAMHSA) is the peak government body in the US for all mental health institutions. They, as well as Medicaid (who pay for the treatment of most people with serious mental illness), fund innovation grants for groups trying to provide new and better services for the people who tend to need crisis services. However, getting these grants requires relationships with government officials, lots of very legible data, knowledge of how to apply for these grants, and a lot of administrative work to comply with their requirements. In 2012 Medicaid (Medicare?) awarded a $17 million grant to Parachute NYC to implement a mobile crisis team model that implemented Open Dialogue and Peer Support principles, but it was not implemented correctly because of resistance from other parts of the mental health bureaucracy and also because of lack of buy-in from the bureaucratic leaders responsible for championing the project internally.

I have talked to quite a few ex-patients and clinicians with similar motivations as me to create reform in the crisis system, and many have gotten very burnt out from working within the mainstream system, or struggled to get their functioning alternatives adopted within the mainstream system because of legal, cultural or compliance reasons.

What are the key leverage points to affect change?

It is difficult to hire enough mission-aligned mental health workers, particularly ones with credentials, for a reform-minded project

- Create a jobs board or recruiting company that targets existing reform-oriented communities, to make reform projects more visible to reform-oriented clinicians and vice versa
- Investigate why pay rates for frontline workers are so low, and what is stopping them from increasing
- Investigate why reform-minded people drop out study of or avoid getting credentials, and find ways to address that
- Interview a wide sample of clinicians to understand their attitudes and how to de-risk working on reform projects from a reputational perspective
- Investigate what schools reform-minded clinician students choose, and find out why their graduates don't take crisis work
- Investigate and brainstorm about ways to raise the profile of frontline work--by designing new career progressions, by convincing high-profile clinicians to do it, with a Netflix show

Psychiatrists (already conservative by nature) do not want to risk their licenses by pursuing psychosocial or minimal medication approaches to treating crisis situations

- Create a legal fund to defend psychiatrists pursuing a minimal medication approach, and publicise it widely
- Research the legal history of psychiatrists being sued or stripped of their licenses for using alternative approaches, and find out if there are any things that can be done to mitigate it
- Build a forum for reform-minded psychiatrists to talk to each other and discuss this issue
- Fund investigative journalism and reporters who are willing to report on issues of psychiatric de-credentialing

Bureaucratic structures inherent to governments and hospitals make it impossible to get any local system in a Western country to improve the psychological continuity in its crisis services

- Do a literature review on research on psychological continuity in crisis services and publish it, drawing attention to where this issue is understudied
- Interview bureaucratic reformers to find out whether they care about this issue (and staff turnover, burnout etc) and find out what they are already doing about it
- Do research to find out what specific authorities and policies restrict local crisis systems from implementing changes to increase psychological continuity (staffing restrictions, rotation demands etc)

The dominant mindset of first responders and bureaucratic administrators reinforces the individualist, medical model

- Investigate the cultural norms of the CAHOOTS team, and the Open Dialogue team and document how they protect them with recruiting, training, messaging, policies etc in a medical anthropology journal
- Identify the top 10 most important leaders in crisis response in the Bay Area, and the top 10 most reform-aligned leaders in the Bay Area, and target the overlap for messaging/advocacy efforts
- Create a conference with a training arm that accepts all people who work in crisis care and trains people in alternative paradigms
- Write a Netflix show in an alternate universe focused on crisis responders

The Medicaid billing system demands that treatments be documented exhaustively, backed by medical studies, and parceled into defined units of clinician time and effort in order to be reimbursed

- Do investigative journalism on clinician efforts to oppose ‘managed care’ within psychiatry
- Publish case studies about the impact of funder documentation requirements on the development of healthy institutional cultures around crisis care in a major psychiatric journal
- Do a literature review of research on administrative burdens on clinicians over time
- Fund economic/insurance industry research into billing methods for adaptive psychosocial treatments

Most studies of crisis treatments don’t follow up with individuals on a long enough timeframe for the effects of integrative/transformative treatment strategies to shine

- Do a literature review of all the longest studies on traditional versus transformative treatments, from a psychodynamic perspective, and a sociological/anthropological perspective
- Do an interview series with expert crisis clinicians where they are shown longitudinal studies and asked what components are missing, badly specified, or understudied.
- Do a review from an economic perspective on all the funding directed towards people with a serious mental illness in the state of California, combined with case studies of specific individuals, and get it published in a serious medical administration journal

The administrative demands and work culture of government employment tend to attract more conservative, rule-following workers, and push away more intuitive, creative, or highly intelligent workers from frontline work

- Fund longitudinal studies of individual clinicians and organizations, from a personality and organizational culture perspective
- Interview people who left frontline work to find out the reasons they left, and publish them

Most alternative projects are highly dependent on the strength of their vision and leadership, and tend to fall apart or lose funding if they lose a key leader, or a key ally, or the motivation within the group drops

- Search out these existing leaders across the world, create connections between them if they don't already exist, and organise a mentoring program to connect older or retired reform-minded leaders with younger leaders or leaders of new projects
- Create a venture studio-like philanthropically-funded consultancy that offers these leaders high-quality, low-cost or free executive assistants, therapy, emotional support, executive coaching, and transition planning help
- Create a philanthropic fund to support these leaders training other organisations (to cover workshop fees, travel expenses etc)
- Interview a dozen of these leaders and ask what their bottlenecks and risks are
- Run an annual survey of reform-minded projects to ask what resources they need, and match these needs with funding from philanthropic funders

Many alternative projects do not have the skills, time, funding or desire to collect evidence that they work in language that Medicaid, SAMHSA or dominant philanthropic funders would understand.

- Fund the Live & Learn project to offer measurement and evaluation services for all peer respites in the US
- Do an analysis of the key objectives of funders and of project founders and participants to discover the key objectives that are similar and different

It is very difficult for an institution to get credentials to be a locked facility, administer psychiatric medication, or hold someone against their will, and institutions without these affordances tend to not have the capacity to deal with the most acute stage of a crisis, and the institutions that do have these affordances tend to be extremely large, bureaucratic, rule-following and conservative

- Research and write an explainer document about how this works in California, funded by a philanthropic institution or university with a good reputation with the government (to get access to interview subjects)
- Find and interview the academic researchers who study this topic, and publish the interview in Mad in America

There are laws in place that ban the development of alternative facilities, or restrict credentialed clinicians from working in such facilities

- Do legal research to find out what these laws are in California, and publish the report online

Common needed resources:

People

- Academic researchers who can both do meta-analyses and literature reviews within psychiatry
- Academic researchers who can do primary research in medical anthropology, economics, insurance, and epistemology
- Writers to write persuasive, clear content
- Leadership and a team to run events, conferences and gatherings to bring specific groups of people together
- Lawyers who can research the relevant legislation and case law, write bills, represent clients, and advocate for necessary changes

Relationships

- Partnership with legitimate research or philanthropic organisations such as the University of Berkeley
- Connections to publish in Mad in America, and increasingly more mainstream psychiatric and journalistic publications; relationships with good investigative journalists interested in the topic
- Connections inside government agencies such as Medicaid, SAMHSA, and major hospital systems and insurers
- A database of projects worldwide that are aligned with the mission, and regular updates about their needs and resources
- Understanding of and relationships with state and federal legislators who might support or oppose relevant legislation

Funding

- Aligned and flexible philanthropic funders with a desire to make long-term funding commitments

Platform

- A publishing platform and marketing system that can build a reputation over time and target promotion to the right audiences

What are the major roadblocks to affecting change?

Key decision-makers within government are busy, conservative, hard to reach and hard to persuade. It is difficult to even find out who they are, particularly within bureaucratic government departments.

Persuading people that a given plan is a good idea relies on a shared goal, and many people and organisations working on reform within and outside the system have different and competing goals, or place different importance on different values

This subject is socially taboo, hard to look at, and easy to hide, and affects individuals who are different from each other and weak in comparison to the systems that impact them

Local mental health systems are governed by rules developed by central planning agencies and have little leeway to reform or improvise autonomously, so in order to make a local change you may need to get a federal level issue resolved, which is extremely difficult

Individuals within the system are concerned with their own reputations and livelihoods, and activists outside the system are unconcerned with the workers' reputations and livelihoods, so there is more polarisation

There are strong incentives against simplifying, refactoring, or reducing control in any institutional system over time, particularly government ones, and increasing control and adding complexity tend to make the problem worse

The excluded factors that make a person or context conducive to healing and transformation through a psychiatric crisis tend to be illegible or irrelevant within a traditional medical-scientific lens, and advocating for them insults and threatens the identities of many professionals who have made their living and reputation via the traditional medical-scientific methods

What should be done next?

What opportunities exist right now?

What should I do next?