Intramuscular injection and its impact on perspectives in mental health medication, psychotherapy, ethics, peer process, and recovery

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The advent of the three-month injectable intramuscular (IM) injections for antipsychotic medications is a giant step forward in traditional medication management in mental health. This advancement should be a signal to clinicians, and peers in mental health alike, that thinking beyond immediate symptom management and stabilisation needs to be an urgent and necessary shift in the current medication management paradigm. As practitioners in mental health, we set goals and objectives with our consumers and are too often limited by the crisis driven needs of those on oral medications with higher statistics for relapse and a lower medication efficacy. This is an important advancement in delivery systems for this class of medication, signalling that there are more available treatment options for those carrying a diagnosis of schizophrenia and schizoaffective disorders. We need to move beyond the stigma that IM injections are for those just labelled 'non-compliant' but is, in fact, another option for people committed to their mental health. This discussion will hopefully raise a larger conversation and should not be taken as a recommendation to do anything. Instead, it is information to supplement the knowledge of mental health consumers, raise awareness, and provide the importance of choice to a person's treatment carrying these diagnoses.

Keywords: intramuscular injection, medication, mental health, psychotherapy, recovery

BACKGROUND

As a practising psychotherapist, I am looking forward to writing treatment plans for consumers on the new three-month injectable antipsychotic intramuscular (IM) injection with goals that truly capture the desires, hopes, and dreams of all people diagnosed with schizophrenia and schizoaffective disorders. It is my personal and professional experience that IM injections have a greater threshold for efficacy and fewer instances of relapse than oral medication delivery systems for clients suffering from severe and chronic symptoms. Traditionally, psychiatrists only considered IM injections appropriate for patients labelled 'non-compliant' or too dysregulated to manage their own medication.

Now, more and more people carrying a diagnosis of schizophrenia and schizoaffective disorder with a vested interest in their recovery are choosing the more reliable method and route for adhering to their mental health medication and treatment given the IM's greater evidenced and documented possibilities for more successful outcomes. Historically, people on an IM-only option to obtain their medication administration at a hospital ER, or clinic were limited to weekly, then biweekly, and then finally, monthly maintenance appointments.

Now, finally, there is another option that allows people to live their lives in an environment other than ER waiting rooms and mental health clinics in order to adhere to their mental health treatment. For those who have chosen recovery over illness, we now have a medication delivery system that supports our lifestyle, our choice to be successful and happy in our lives, and live beyond the disorder. Unquestionably, the likelihood of consumers achieving their goals and objectives has increased with this shift in medication management and hopefully, will be the beginning of a continuing shift in mental health treatment for this population.

I am not recommending medication or outlining the risks versus benefits. I am instead raising a necessary and often overlooked discussion about what we consider effective medication management in mental health for a population labelled 'untreatable, non-compliant and dangerous' by practitioners and members of the mental health community. This is an important advancement in delivery systems for this class of medication, signalling that there are more available treatment options for those carrying a diagnosis of schizophrenia and schizoaffective disorders.

IMPLICATIONS

Medication Management

Medication monitoring sessions across treatment milieu's in mental health is now challenged with limited face-to-face contact time with consumers, typically 15 minutes per session (Kendrick & Pilling, 2012). Making the situation even more difficult is the increased caseloads which prescribers are tasked with and assigned. Between the limited contact time psychiatrists have with consumers and the increased caseloads assigned to each psychiatrist – on the level of volume alone – doctors and nurse practitioners are finding themselves prescribing more medications with less exposure to each patient's clinical picture.

The management of prescriber face-to-face time, both the quality of time spent with consumers, and the ongoing assessment, evaluation, interpretation, and planning that is involved with each medication monitoring session hinges on more than just the time per session. In fact, it goes beyond the skills of the prescriber too. Today's medication management is not just challenged with limited time, increased caseloads, medication volume, and the limitations of the psychiatrist's ability to interpret the consumer's clinical picture. Medication management with this particular population is challenged above all with negative attitudes towards consumer adherence, and unresolved issues of stigma that

still lingers with patients carrying a diagnosis of schizophrenia and schizoaffective disorder (Vanheule, 2017).

These unresolved issues of stigma and negative attitudes towards consumer adherence are long standing and are enmeshed into the very fabric of research that is involved with consumer adherence to antipsychotic medication and make up the contents of sessions reinforcing adherence using adherence therapies and or medication- focused conversations (Pinto-Coelho, 2017). There is no question that the contents of sessions for consumers on the three- month IM will begin to shift as changes in medication management shape the new therapeutic landscape. This will occur on both on the level of practitioner in terms of attitudes towards consumers, as well as allow the practitioner to reclaim valuable session time on clinical formulations and evaluation of the consumer's clinical picture.

Interventions in psychiatry and psychotherapy

In light of psychiatric hegemony (Relojo, 2017), the impact of the three-month injection on interventions in psychiatry and psychotherapy will be profound. On the level of psychotherapy treatment planning alone, clinician's will have an opportunity to establish goals and objectives that is more realistic, and more attuned with the needs and desires of the consumer. More importantly, therapists can reduce the intensity of adherence therapy, which consumes session time, and functions to absorb time needed to cover a breadth other materials needed for consumers to be successful in their recovery and move forward in their treatment.

Psychotherapy and psychiatric medication monitoring sessions can begin to target tools consumers need to continue on in their treatment. Time can thus be spent on ongoing assessment necessary for clinicians to understand their consumer's clinical picture (Shortell, Bennett, & Byck, 1998), and the development of coping skills, mood regulation exercises, and most importantly, disputing irrational beliefs and cognitive distortions that are so prevalent with consumers carrying a diagnosis of schizophrenia and schizoaffective disorder (Acharya, Pilao, dela Rosa, 2017). Reclaiming session time has infinite possibilities depending on how the clinician will utilise the added time in session from not targeting adherence and routine crisis-driven conversations from oral-based routed medication delivery methods.

Most importantly, consumers will begin to benefit from a shift in attitude toward them and their treatment as discussions of compliance exits the psychotherapy session and full adherence is embraced by consumers. There is no question that stigma and negative attitude toward this population has a significant role in consumer outcomes, success in treatment, and motivation to continue moving forward in recovery. Research suggests that negative attitudes play an important role in consumers allying with their therapists and psychiatrists, establishing an intact therapeutic alliance, and fully embracing the recovery process (Servais & Saunders, 2007). This is extremely important for this population, as paranoia and other symptoms may interfere and complicate the therapeutic alliance, making it difficult for consumers to trust their therapist or summon the energy to make to session at the clinic.

Redefining the peer relationship

Peer specialists in mental health, and the peer movement continues to complicate practices in traditional treatment to this day, as well as play an important role in battling stigma and reshaping the attitudes clinicians have of their consumers. While peer specialists cannot and should not engage in telling consumers to discontinue their medication or recommend a medication to their peer in recovery the three- month injection will reshape conversations in the peer process and dislodge the complexities and ethics from conversations around adherence from the peer process. By eliminating this issue, peers

can continue to focus on support around recovery, and then become a real ally and partner in the recovery process. Conversations between peers can begin to target moving through the mental health system, and not enmeshed around ethically unsound medication-focused discourses, which are, truly, with little exception, outside the role of the peer and primarily assigned to the clinician.

While peers can help consumers establish a voice around their medication concerns to share with their prescriber, there is no question that the peer process is rooted in establishing a mutual relationship to aid consumers in their recovery and move through the mental health system toward recovery. Therefore, the advent of the three-month injection allows consumers engage with their peer in conversations that support the recovery process without complicating the clinical process, but instead, enhancing it, by providing a real space for consumers to connect with their peers without entering ethical and clinical grey areas that can be discrediting to the peer process and derail the consumer's treatment.

Recovery-focused attitudes

Ultimately, now, consumers will be able focus on their recovery and not become dismayed by the limitations of today's medication management. The three-month injections thus opens up a space for consumers time and energy to focus on themselves, their needs for the recovery process, as well to establish a set of expectations for improvement in functioning based on their learned skills in psychotherapy, and from the peer process, instead of externalising and crediting their gains and setbacks to be the product of weekly or monthly changes to their medication, its dosage, or even worse, from lack of adherence.

The recovery process is complex. Full adherence given a consumer's choice to go on an IM further eliminates ambiguity when therapists and psychiatrists are evaluating the effectiveness of medication to manage a consumer's symptoms. Research suggests that a full adherence on an IM increases the efficacy of a medication and decreases instances of relapse (Gaudiano, Weinstock, & Miller, 2008). More importantly, consumers can now focus on goals beyond immediate crisis and symptom stabilisation.

Undoubtedly, consumers engaging in long-term goal setting are more likely to focus less on problematising the everyday problems faced during the recovery process which, research suggests, are short-term issues that resolve themselves with time, either on a stable medication regimen or simply by the passage of time (Epstein & Cluss, 1982). Thus, consumers can begin planning for tomorrow and focusing on taking bigger steps in their recovery without worrying about the present, all the time, which, research suggests, is demoralising for consumers and a definite roadblock in long-term gains in treatment and the recovery process (Dunn, Andersen, & Jakicic, 1998).

Ethical considerations: Dignity and risk and risk of harm

Unquestionably, the spectrum between negligence and overprotection carries with it serious implications in clinical and peer professional practice in mental health. Even in our personal lives, we have friends and family we care for and we wonder where the line is drawn when it comes to caregiving or caring for a friend struggling to maintain their own safety living independently. For therapists, peers, and psychiatrists, the landscape between the two poles of negligence and overprotection is even more unclear, sometimes, and in dispute for interdisciplinary teams with workers from different ethical stances.

Dignity in risk is understood by most practitioners and peers as the chance, choice, or possibility of a patient failing in their goals or capacity to self-manage independently. It means there is a level of self-

worth cultivated by people when they are left to their own devices to make choices for themselves. Call it self-esteem, or self-respect; people generally feel better about themselves when they are given the opportunity to fail at whatever it is they set out to do.

The problem with complete autonomy and 'free will' when you're in treatment is twofold: 1) Treatment is a contract between a provider and patient which carries with it the assumption of adherence and/or active participation in their own care; and, 2) Without any oversight from a provider, therapists, peers, and psychiatrists will run the risk of committing negligence or malpractice should something unforeseen happen to a client that may have been preventable should the client have been monitored and in active treatment.

The disconnect and the limits of the law

The limits of the law are clear. Every state in the US has a regulatory body that decides where this line is drawn between negligence and dignity of risk for therapists and psychiatrists. Peers professionals too, are working on actively drawing up plans to manage risk more effectively to reduce the likelihood of harm to clients and collaborate more closely with their clinical counterparts.

The law is written and very clear on paper so we abide by it in practice. The liminal space between theory and practice or praxis is where the line gets blurred when deciphering what to do with a client when their risk of homicidal or suicidal behaviour is unclear, or unable to be assessed.

In situations like this, besides your 'gut' feeling, on which side of the negligence versus overprotection spectrum do your instincts tell you to side? What will inform your choice: 1) Will it be the relationship you have with your patient; 2) their apparent mental status; 3) their level of mental distress; or 4) the level of trust between you and your client? More importantly, what does it say for you as a practitioner when you make your decision?

Forced treatment: An ethics of hope for people with severe and persistent mentally illness

By and large, we need to articulate the challenges with treatment of individuals with severe and persistent mental health illness (SPMI) who are non-adherent to the clinical recommendations of their providers. It is the intent of this article to outline why it is so important to seek out available treatment early on before symptoms worsen to the point where reality, judgement, and impaired insight preclude the afflicted individual from buying into available treatment options to experience relief from what could become chronic and persistent symptoms.

The available options for a course of treatment targeting chronic mental illness of course becomes more limited and more restrictive as the degree of chronicity increases and insight and judgement decrease to the point in which capacity is lost by the patient. In this article, the open dialogue approach will be evaluated for its limitations and benefits for SPMI populations as well as two available courses of forced treatment in both in patient and community-based settings.

In the recovery movement today, the open dialogue approach to treatment is showcased and renowned as the most effective treatment for SPMI populations and argued to be the only approach that works for producing long-term positive lasting outcomes. It is an approach that stresses a shared conversation between consumers and providers about forming a treatment pathway and medication regimen that is acceptable to all parties to promote adherence and reduction of non-compliance.

This really needs further unpacking because if an individual is in need of an extremely high level of care their symptoms may be so serious and chronic that relief or remission is often not realistic. This has

been evidenced by research time and again (Lynn, 2001). I have even experienced it as a patient with lived experience during multiple in patient hospitalisations and as a clinician practicing in the community.

There is no question the open dialogue approach is effective, humane, and appropriate for those who are accepting of their condition and have the insight and judgement to move forward in their recovery, but these are people who are adherent to treatment and on board with treatment recommendations from the onset of diagnosis so of course their rate of experiencing improvement in their condition is expected.

I have seen first-hand in state and local hospitals where people are placed in long-term care indefinitely because they refuse medication and all other treatment recommendations, experience no relief from their symptoms and are in turn too dysregulated to maintain their own safety in the community. Forced treatment in certain severe cases would provide many people, people like myself and others like me with a chance to live in the community again and 're-regulate' enough to continue their care and perhaps experience further improvement on an outpatient basis instead of locked away in a state ward for years or maybe decades.

Forced treatment can occur in an in-patient hospital as medication over injection or in the community with Assisted Out Patient (AOT) treatment in which the county mental health department monitors specific high risk individuals through a series of paper trails and reports which are reviewed every year or so to determine if the person can return to a lower level of care and voluntary treatment. AOT is usually provided by Assertive Community Treatment (ACT) teams and providers which conduct home visits as this population experiences issues with connectivity to clinics and benefit from closer monitoring from community-based treatment team

CONCLUSION

The impact of the three-month antipsychotic IM to social work is immense, layered, and profoundly important to the improvement of treatment for schizophrenia and schizoaffective disorder. Above all, the three-month injection signals that the importance of choice in consumer treatment is being taken seriously by clinicians during the treatment of these disorders which for so long have carried with them stigma and negative attitudes. More importantly however this advance remarks upon the rising numbers of consumers choosing adherence, and recovery over illness.

Ultimately, clinicians and peers will begin to reclaim much needed space in the treatment process for just that, treatment, which, for these disorders, will be a vital and much needed change to the execution of psychotherapy practices and medication management. Hopefully, the days of clinicians referring to consumers carrying a diagnosis of schizophrenia and schizoaffective disorder as 'untreatable, and non-compliant, or even dangerous' will be a distant voice of the past in mental health treatment.

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