Victorian Mental Illness Awareness Council

Submission

Senate Select Committee on Mental Health

Strategy (a) It is the view of the VMIAC that the National Mental Strategies developed since 1992 have been successful in some areas and failed in others.

Achievements: There have been many positive achievements in Victoria. We have completed de-institutionalisation and we now provide the following structure and services for adults.

Clinical:

Crisis Assessment and Treatment teams;
Inpatient units;
Step up, step down facilities (undergoing pilot trials);
Mobile Treatment and Support Teams;
Community Care Units;
Secure Extended Care Units;
Continuing Care Teams;
Case Management;
Shared Care services;
Primary Mental Health & Early Intervention services;
Statewide Forensic inpatient and out-patient services;
Statewide Eating Disorders units;
Statewide Mother and Baby units.

Non-Clinical:

Psychiatric Disability Support Services that include:
Home Based Outreach Support services;
Rehabilitation and Support services;
Mutual Support and Self Help;
Supported accommodation;
Drop-in services.

Legal & Advocacy: Under the Mental Health Act people with a mental illness are entitled to have a lawyer represent them. Consumers are also entitled to have an advocate. Provision also exists for the Community Visitor program that works out of the Office of the Public Advocate (OPA). The Guardianship and Administration Act also provides for the appointment of advocates. However, due to the high rate of guardianship appointments, which is an issue in itself, little advocacy is carried out by OPA.

In Victoria there are three main advocacy services that people with a mental illness use; that is, Legal Aid, the Mental Health Legal Centre and the VMIAC. While there are other advocacy and legal services in the State, their clientele tend to be those with intellectual, physical or sensory disabilities. The VMIAC is the only specialist, "all of life" (non-legal advocacy service and covering all aspects that the consumer identifies as an advocacy issue) in the State.

Consumer Participation: The right of consumers to participate in their own care and treatment, in statute and policy at a national, State and local service delivery level is well documented.

Each area mental health service has been provided with funding to appoint local consumer consultants, establish consumer advisory groups and have consumer representatives on national, State and local committees.

In summary, Victoria has achieved a great deal in regard to changes to the physical environment where people with a mental illness receive their treatment and care. Additionally, most people with a mental illness live in the community, attend their general practitioner for on-going medical support, or receive their treatment via the Community mental health clinic. Many live in either private accommodation with their family, partner or live alone. Others live in supported accommodation or in boarding houses.

We have seen a plethora of policy development to support the changes.

In essence, what we have done is make all the changes important to everyone, except the people on the receiving end of the services. In some instances the changes have been so superficial they appear to only exist on paper. (See later comments)

Barriers: As can be seen by the above, Victoria's mental health service have undergone significant changes since the first National Mental Health Plan.

Unfortunately, the greatest impediment to policy implementing has been the failure of government to provide adequate funding so that what is written as policy actually can happen in practice. Indeed, there is no component of clinical and non-clinical service delivery as outlined in policy that has not been impeded by funding restrictions for example, crisis assessment and treatment teams, mobile treatment support teams, case management, consumer participation (individual, group and systemic) at a local, state and national level, access to psychiatric disability and rehabilitation programs etc.

Another barrier to achieving the Mental Health Strategies is the attitude of politicians from all political persuasions. Mental health is a social problem and a very serious one for the Australian community. Unfortunately for politicians it is a political issue where political parties, in particular the Liberal and Labor parties, (National and State) spend much energy competing with each other and even using tragedies to score political points. It is a sad refection on this country’s leaders when decisions are driven by what will win votes and what will protect the party from criticism, rather than what is best for the community in particular those most vulnerable in our community.

Because of this perceived need for politicians to protect their government and or their political party, politicians have developed expertise in using defensive reasoning practices to address all matters pertaining to our community. The end consequence of this is to only provide sufficient funding to look like you are doing something when in actual fact you are doing very little. Positive and proactive leadership is bereft. A good example of this is this inquiry. For some years, many of us have been complaining about the lack of funding to mental health and the tragic consequences of it. Governments and politicians have known for years that mental health issues constitute 20 percent of the total health burden, yet mental health is only funded at around 7 percent of the overall health budget. Requests to address the funding shortfall have largely been ignored. It is only when a tragedy occurs and **becomes public,** where the government may come under criticism (lose votes) or is embarrassed that we get any action and even then it is limited to what the government can get away with.

Last year, I wrote a letter to the Prime Minister expressing concern about the lack of funding and its impact on people not only being able to access a service but to receive a standard of service delivery that was in keeping with agreed professional standards. I provided an anecdotal example of a young woman who suicided during her first admission to hospital. I included the anecdote so that it would be clear to the Prime Minister the consequences of government inaction regarding appropriate funding. The letter in response was pure defensive reasoning. In other words, all my expressions of concern were completely ignored to the point where I am unable to show the letter to the young women’s parents as it would only add to their distress.
See Appendix 1 (a & b)

Let me be very clear, Ms Rau is not the first mental health patient who has been picked up and placed in a detention centre in the most uncaring and indefensible way. I advocated for a man last year who has lived in this country for over 20 years, has a diagnosis of schizophrenia, receives a disability pension, has a Department of Housing flat and an Administrator to manage his finances. The reason for his detention – he didn’t fill out an extension of visa application 22 years ago. There was no consideration of his level of disability or his capacity.

While there are many consequences of the lack of positive leadership and funding, the most tragic is the level of preventable deaths through suicide. In Victoria we have an average of 350 reportable deaths a year, that is to say, people who have died while in the care of the public mental health care system. While not all the deaths would be through suicide, the writer believes most would be. Indeed the Director of Mental Health, Dr R Vine reported that 21 people suicide annually within 5 weeks of discharge from hospital.

Another issue that has impeded positive change is the lack of positive leadership in management at an organisational level in the health sector.

Failures: Some 15 years ago, as a general nurse I was seconded to work in the Department of Human Services Mental Health Branch for 2 years, as the Mental Health Director at the time Dr Peter Eisen stated, "To help clean up psychiatric services."

During the period of secondment one of the tasks given was to conduct a ministerial statewide audit of each of the 19 psychiatric hospitals to ascertain the standard of clinical practice.

My role in this audit was to interview patients about their experiences of hospitalisation. Given that this was my first exposure to people with a mental illness, if someone had told me before I heard from them and in some instances saw for myself that this is standard practice; that this is the way you treat people with a mental illness, I would not have believed them.

The consumers raised as issues of concern 15 years ago the following:

Attitudes of clinicians (no change)
Seclusion practices (no change)
Lack of respect for rights (no change)
Nurses staying in the in-patient office (no change)
Not knowing which nurse is looking after you (no change)
Lack of continuity of care (no change)
Everything being pathologised (no change)

The one thing that consumers persistently provided as positive feedback was the gardens (we got rid of them).

In summary, Victoria has addressed many issues to improve the situation for mental health services. The one thing that hasn't been done is addressing the issues important to consumers.

Put simply, the major impediment to effective positive change from the consumers perspective is the attitude that exists at all levels of government that "Doctor knows best."

Modes of Care: (b) As indicated previously, Victoria has a structure that with appropriate funding, should meet most of the important needs of the consumer community. It is almost impossible to objectively evaluate the modes established when government has never provided the funding to adequately and safely implement the modes of care.

Crisis Assessment and Treatment teams (CATT) are probably the best example of what happens when governments fail to adequately fund services.

From the consumer perspective CATT would be the most disliked and criticised service in mental health. Consumers refer to the service as the Can't Attend Today Team or the Call Again Tomorrow Team. When you have an objective moment about CATT you realise that in fact the service bears the brunt of blame for the government. They have never been funded adequately so that they can attend to consumer needs in a timely manner or even play a preventative role in the consumers' deteriorating mental state.

Funding (c): As discussed in previous section and in HREOC submission.

NGO Sector (d): Based on feedback from consumers, the NGO sector plays a major role in providing an environment and opportunity for the individual to receive support and rehabilitation. However, consumer feedback also suggests that staff who work in the NGO area hold attitudes and values similar to those found in the clinical sector and that this is increasing as the clinical and NGO sector work more closely together.

While much positive feedback is provided from consumers regarding individual services, unless management hold dear the organisations values, it would seem that the larger the service becomes, the greater the risk of losing the values of the organisation. Anecdotal feedback from consumers suggests that this is occurring in some of our larger organisations.

The role of the NGO sector in Victoria has been outline at the beginning of this report. Feedback from consumers indicates that "Drop In" services are the most effective and play a major role in their recovery. Interestingly, reports indicate that this is the most undervalued and least funded aspect of NGO services.

Social Supports: (e) The lack of funding provided by government for social supports for people with a mental illness can only be described as a disgrace. Many people with a mental illness are homeless, unemployed, forced to beg in the street, in some instances engage in prostitution in order to buy food, are generally isolated and alone. The impact these stressors have on the person's mental health should be self-evident.

Additionally, while respite services exist for carers (albeit inadequate) even less is available for consumers and those consumers who do not have a carer can miss out completely.

Special Needs: (f) Comments on this section should be left for others with expertise in the area. It suffices to say that current services are inadequate. Regarding dual disability, I would recommend that Self Help Addiction Resource Centre (SHARC) be contacted.

Primary Carers: (g) The responsibilities placed on primary carers for their loved ones since deinstitutionalisation have been significant and in some instances far beyond what should be expected of any individual.

In effect in many instances the constant stress resulting from these responsibilities has led some carers to become consumers.

While much has been done and achieved in providing carers with education, training and support I dare say that most would argue that it has been grossly inadequate as with all other services in the system.

Primary Health: (h) Much of the responsibilities of primary care in mental health have been handed over to general practitioners and local primary care and early intervention teams. In some services shared care arrangements exist where the local mental health service and GP service work together.

Regarding the effectiveness of these services in promoting, preventing and enabling early interventions along with providing chronic care management we have received no feedback from consumers and are therefore unable to comment.

However, from time to time we do receive comment from consumers that the attitudes of some GP's are far from ideal and that when the consumer is unwell the GP's lack of knowledge is worrisome.

Iatrogenics (i): **It needs to be stated from the very beginning of this section that the only people who believe the mental health care system is not as bad as most consumer say is those who have never been on the receiving end the public mental health care system.**

Having worked in the public mental health care system for some 15 years, I am yet to meet a patient of mental health who has not been damaged by the way he or she was treated and cared for. Indeed, consumers will often say that it takes a good 12 months to recover from hospitalisation just because of the way they were treated.

Unfortunately we have this terrible culture where once you have been diagnosed as having a mental illness every expression of thought or feeling is pathologised. Demonstrations of empathy for what the patient may be going through are almost non-existent. Feelings including feelings of terror when a person is in a psychotic state are ignored – all the person will get is medication. Care and treatment for the feeling side of suicide is also confined to medication. The individual clinicians that do not go along with this neglectful culture are so few in number they stand out like lighted beacons. In some instances, our lighted beacons are punished rather than rewarded for their respect for patients. Last week for example I was told about a nurse who was pulled up in the car park by colleagues and was told in no uncertain terms to stop showing the rest of them up. All she was doing was spending time with her patients rather than being in the office.

The writer could provide numerous examples of where staff have been punished for standing up for their patients and those who have neglected their patients rewarded and promoted.

Reducing the level of iatrogenesis can only be achieved with a change in the current culture and getting back to the basics, that is, you should do your patient no harm. There will never be a quick fix to this problem, but it can never be fixed while those **not** on the receiving end of care and treatment fail to recognise that if they were treated the same way they would be equally upset. As with any change, it needs to take place slowly, needs to be planned, needs all affected by the change actively involved in all aspects of the change process including the assessment, planning, implementation and evaluations. If people do not have a sense of ownership about the process the change will not be effective or sustainable.

In practice I would start the process of a change in culture in an organisation as follows:

Establish a committee to oversee a change to the culture.

Establish meetings with consumers to ascertain what are the positive and negative components of care, treatment and the service generally and why.

Establish meetings with staff at all levels and ask them to articulate what it is they want for their patients and themselves in relation to their work. What they think is good and negative about the service from a patient and staff perspective.

All of the above would be documented.

From the documentation I would set about establishing a philosophy and objectives for the organisation, a set of values, code of ethics etc. All the documents necessary to support and guide a positive culture. (At the moment, these documents sit in folders or hang on walls so that the organisation looks good. Rarely are they used to guide day to day practice. As a consequence staff can by quite cynical about them).

Both staff and consumers would at the same time undergo some education about how to document philosophies, objectives etc.

Once the organisation has developed draft documents as outlined above, they would be presented to all stakeholders for comment and adjustment. When the document have been approved, I would then have each area of service, based on the organisation- wide documents and their own wishes for patients and staff, write their own philosophy, objectives etc. Once completed, these documents establish the protocols to guide all actions. In other words, the plan for change is established from the information all stakeholders have provided. The stakeholders then identify the priority areas and the strategies to be used to implement the change. Keeping in mind that any effective and lasting changes to an organisation's culture is going to take at least 5 years, the time lines established need to be practical. Throughout this whole process the management need to demonstrate positive leadership, an open door policy, a democratic and inclusive management style and constantly demonstrate a commitment to the changes. Positive practice should always be recognised and rewarded (non-monetary). Evaluation of the organisation's progress needs to be constant.

Recovery, Consumer Participation, Peer Support: Consumer Operated Services:

TheVMIAC is the peak consumer organisation for people who have experienced a mental illness or emotional problems. It as been our observation and experience that the knowledge and skill gained through the "lived experience" is invaluable with regard to assisting other consumers not only when people are quite unwell, but also in the recovery and rehabilitation phases of their illness.

Unfortunately, our observations would suggest that the skill and knowledge consumers gain through their own experiences are not valued by decision makers at a State or local level. As indicated, we have consumer participation activities at a statewide and local level. Consumer consultants are employed in each of the 21 area mental health services and most have a local consumer advisory group. It is a sad reflection on services that little has been achieved to change culture. In other words, services use consumer input only to respond to the agenda of the service. No one ever asks consumers what they would like on the agenda. Until such time as this changes, consumer participation can only ever been classified as tokenistic. Notwithstanding this, consumer participation has never been funded adequately. A good example of this is our own organisation (VMIAC). The State provides funding for 4 staff who provide individual, group and systemic advocacy and education and training (consumers, service providers and the general community) across the State. While there has been a demonstrable increase in demand for all components of our service applications for an increase in funding have been ignored for years.

In essence, what the VMIAC has demonstrated over the years is that consumers can operate services quite successfully. For some years now, knowing the knowledge and skill level of many consumers, we have dreamt about expanding our services to drop in, rehabilitation, home based outreach, establishing a cabinet making and furniture repair business, garden maintenance, etc, etc. We at the VMIAC know that consumers can do it. It just needs the decision-makers to step outside the square and give consumers a go.

Corrections (j): At the moment, Victoria is undertaking research in to the prison system and the extent to which people with a mental illness are being held in prison. Currently the prison system has 30% women and 23% men being held in custody who have significant mental health issues. Notwithstanding this, the large majority of patients in the State's forensic hospital would simply not be there had they been able to get the care and treatment they required at the time they needed it. To date, no government has been made accountable for this.

Additionally, it needs to be stated that there are many women who have children who fear contacting services for help when they are becoming unwell because of their fear of losing their children. For example, if a mother falls over and fractures her leg, child protection are not notified, but if you have a mental illness and become unwell, child protection will often be the first call made.

Seclusion (k): According to the Mental Health Act, seclusion can only be used if there is immediate and imminent risk to the safety of the person or others or there is a risk that the person may abscond.

Given that the Act also requires that a "least restrictive environment" should be used, one could argue that seclusion should be a "last resort" measure; that clinicians should engage in therapeutic interventions that reduce the risk of a person requiring seclusion. Unfortunately, it is a sad indictment on clinicians that this is not so. The abuse and misuse of seclusion practices remains the same as it was some 15 years ago when concerns were expressed about it and recommendations made to improve and reduce its practice. While the Department of Human Services, in particular the Office of Chief Psychiatrist have developed practice guidelines, anecdotal reports from consumers would suggest that senior management at local services have never ensured that these guidelines are adhered to.

In order that you understand how the right to seclude people is abused and misused the following example is a typical lead up to a person being secluded.

It needs to be kept in mind that most people in an in-patient facility are involuntary patients and therefore meet all of the criteria under the Mental Health Act namely, the person appears mentally ill, requires immediate treatment, requires treatment for the protection of themself or others, the person is unable to agree to treatment or is refusing same and treatment cannot be given in a less restrictive environment. In other words, the person is quite sick.

The patient will go to the ward office and knock on the door. The office is usually in the centre of the ward and is encased with glass. Therefore, the patient is able to see the nurses inside the office. The patient may knock regularly on the door for quite some time and will be totally ignored. After about 10 minutes the patient will lose their temper. They will then have the nurses' attention. The patient will usually be grabbed, forcibly taken to seclusion, held down, injected, stripped naked and left in the seclusion room. There have been a number of instances where consumers have told us, contrary to the Act, that they have been forced to urinate on the floor because the nurse has refused them toilet facilities. The legal notations required under the Act will be written up stating the patient was a danger to themselves, others, or an absconding risk. No consideration will be given to the fact that the behaviour of nurses is a major contributing factor to seclusion levels. Accountability is non-existent because their documentation is the only written evidence and they write it up to be consistent with the Act and psychiatrists go along with this appalling "habit of practice."

In one particular case (the consumer has provided approval to use her example) the medical notations outline the physical injuries (head, back, shoulder and leg) and resulting physical limitations the person sustained in a motor car accident, as well as constant physical pain and sensitivity to noise. The person is in her 50's and was experiencing her first admission to a psychiatric ward (had been admitted because she was suicidal). Because of the noise, she went to the nurse's station and asked for cotton wool for her ears. Her request was refused and she was ordered to go back to her room, which she did. She phoned her husband who suggested she must have got it wrong and told her to ask again. She did. This time she was not only refused her request, but also told off and again ordered back to her room. This is despite the care plan stating she would need "support and should be encouraged in a respectful way" and that current treatment/strategies for dealing with her physical injuries should continue as they were prior to her admission. To cut a long story short, my client experienced seclusion which included being grabbed, held down, injected, stripped, (provided gown, but no underwear) and being forced to urinate on the seclusion floor several times. My client sustained bruising and a compression of her 7th cervical disc. (See attached photos).

In closing this section of the submission, it needs to be stressed that the anecdotal examples provided are not one off situations, but have been provided so that you can obtained a clearer understanding of what occurs.

Detention: As with seclusion, detaining people with a mental illness is misused and sometimes abused. According to the Act for involuntary detention you must meet all of the criteria. There is no requirement to document in a person's medical file how the person meets all of the criteria and it is often very clear that the person does not meet all of the criteria. The Mental Health Review Board in reviewing involuntary detentions also often fail to follow their legal responsibilities required under the Act. Indeed at a recent hearing the Board upheld the involuntary status of my client even though the Board member (lawyer) agreed with me that my client did not meet all of the criteria of the Act. The ease with which involuntary detention can occur is similar to seclusion; that is, it has become an appalling habit of practice where rationalisations are made to fit legal requirements.

While many clinicians argue that involuntary status allows the clinician to develop a therapeutic relationship with their patient, and establish engagement, this is nothing more than defensive reasoning. It is impossible to develop a relationship of mutual respect and trust when one is coercing the other and the only interest shown during the consultation is whether you are taking you medications or not.

Education (l): While much has been done to educate the community about mental illness and reduce the stigma, very little has been done to reduce the stigma in mental health services. Consumers, when asked if they could wave a magic wand and change something about the mental health care system, will mostly say that they would change professional attitudes, in particular those of psychiatrists. Consumers have been very clear for a long time. They believe the stigmatising attitudes of clinicians are far worse than what they experience in the general community. Clearly good clinicians exist who do not display prejudice, but unfortunately they do not form the majority.

Additionally, education and training for consumers and their carers is lacking, in particular when the person is first diagnosis and commences treatment. While care plans will outline the need for education, the progress notes and consumer feedback indicates that the education is not taking place.

On a systemic level, as an organisation we provide education to our consumer groups and on invitation to carers and service providers.

We would like to devote more time to education and training so that consumers could develop expertise in becoming consumer educators, but our limited funding prevents this.

Accountability: (m) As an organisation that provides individual, group and systemic advocacy for and with people who have a mental illness, the scenario of blaming the victim and shooting the messenger is very much alive and well in the mental health care system. Thus, accountability is only limited to the few things governments, organisations, managements and staff cannot get away with. By way of example, the Mental Health Act states in Section 82 (3) (C)“A person who is kept in seclusion must: -be supplied with bedding and clothing which is appropriate in the circumstances;…” Despite the Mental Health Act, despite the Chief Psychiatrists guidelines which clearly indicates it is unnecessary to remove the patient’s clothing, despite accreditation processes and audits of each area mental health service by the Office of Chief Psychiatrist the practice continues to this day.

The writer could provide numerous anecdotes of consumer experiences of seclusion where the Act, guidelines and standards are ignored.

Basically we have a defensive reasoning culture whereby everything is about protecting organisations and the people who work in them at the expense of truth, justice and genuine learning from our mistakes. Defensive reasoning exists at government, bureaucratic and management level. If you refuse to support this culture of cover-ups, then you will find yourself with a very negative reputation similar to what you experience in the “shooting the messenger” scenario – very similar to what happens to whistleblowers. It is a shocking and quite unethical culture and until such time as we address it accountability will always remain a word that is often used but rarely put in to practice.

Research (n): The writer could not make informed comment on the adequacy of mental health research generally, its level of funding, or its ability to influence practice. Having said that, the writer is aware that Beyond Blue receives millions of dollars from government to conduct research into depression and its related issues. While research is an essential component of the mental health services, it is hard to justify the amount of money being spent on research into depression when we have members of the community being turned away from accessing clinical services and taking their life. Clearly there needs to be a better balance.

Additionally, the VMIAC would highly recommend a broadening of the research being undertaken to include the issues important to those on the receiving end of the services. Research on attitudes, models of practice, consumer experiences with mental illness etc. The VMIAC also believes that consumer led research is grossly lacking and needs further development and funding.

Data Collection: (o) If government were as obsessed about standards of practice as they are about data collection there probably would not be any need for this inquiry.

Currently there exists written and agreed upon standards of practice for the clinical and non-clinical sector. They have existed for many years. They are written to cover all aspects of service delivery and therefore at the workface the criteria as written have little practical value, in other words, compliance would be very difficult to measure. They do however have use in providing a guide for individual services to adjust them so that they can be used to measure standards of practice at a local level. Apart from the VMIAC I have no knowledge that any service has attempted to use the standards and criteria to develop local practice standards and audit same on a regular basis.

In defence of services, each professional group, for example, psychiatrists and nurses, have a professional body responsible for establishing their profession’s standards and both professions have done so. Unfortunately governments have taken over, establishing standards of practice far lower than the professions have set. Governments have done this by failing to provide the funding necessary to ensure you can deliver a standard of practice agreed to by the professional bodies. Put simply, when you are short of staff and the ward or clinic is busy, clinicians will “cut corners” to save time. What has happened is that the shortages of clinicians and the business of the wards/clinics has existed for so long that these “cut corners” have now become the normal standard of practice. As a psychiatrist aptly put it, “If there is any area mental health service claiming to provide holistic assessments and treatment they should be certified, because they are clearly delusional, there simply isn’t enough time.”

Consumer : Outcomes: The failure to either understand or respect the principles of consumer participation is perhaps best demonstrated by the introduction of consumer outcomes.

Consumer outcomes have been introduced in some clinical and non-clinical services. Consumers in the psychiatric and disability rehabilitation sector were given a choice of measures. What the services failed to do was provide consumers with the education necessary to make an informed decision. Thus, services got the measure they preferred.

At one point, consultants were hired by the Commonwealth to ascertain consumer views on consumer outcomes. The results indicated they would like to develop their own measure. While there has been a commitment to revisit the need to develop a new tool, the writer doubts this will ever occur because there are too many services providers committed to the current ones.

Links: The VMIAC does not support the notion of linking funding to compliance with standards for the following reasons:

Victoria has conducted a number of consumer and carer satisfaction surveys that were originally linked to funding. The strategy encouraged services to cheat with some putting pressure on consumers to be positive because if they were not, funding would be reduced and therefore services.

Another possible negative result is that we currently have a culture where consumers are often afraid to complain because they may be punished by the service. Therefore, a high level of consumer complaints may very well demonstrate more respect for the rights of consumers to complain than those with low levels of complaints.

Modes (p): The VMIAC has no issue with examining possible changes to the structure of the mental health care system. Indeed the writer understands that Victoria is currently looking at the matter via a Ministerial Advisory sub-committee. What the writer does have issue with however, is that the current structure has never been appropriately funded and therefore has never been given a fair chance to see if it can effectively meet the needs of consumers.

Regarding models of care, the VMIAC would support and indeed would be prepared to beg for a change from the medical model approach to care and treatment to a more holistic approach where the maintenance of the personhood of the consumer is seen as paramount.

Unfortunately, current practice relegates all statements and feelings that consumers express to symptoms of their mental illness. In other words, normal everyday human emotions are pathologised.

Little to no consideration is given to the emotional impact of having a mental illness or the feeling side of the symptoms consumers experience. For example, if a person is experiencing a psychotic episode where voices are constantly telling the person that they are useless, and they should just kill themselves, you will not find any documentation in the person’s medical file that gives consideration to the impact this might be having on them and how they feel. This is despite the fact that it is the feeling side of the psychosis that will lead to a person attempting suicide. Basically the only therapeutic intervention they will get is medication and containment until the medication takes hold.

If we are to ever reduce the number of preventable deaths that occur, mental health services desperately need to revisit their therapeutic intervention model to encompass a holistic, humanistic and empathetic approach, that is, it needs to be more than just the provision of medication.

The difficulties of providing continuity of care and treatment are also of concern and more importance should be placed on the positive impact this can have on consumers.

A review of the appropriateness of having people with a mental illness presenting to emergency departments needs to occur. Currently people who are very emotionally distressed are expected to sit in the waiting areas for hours only to be observed and heard by others patients waiting to be seen.

Isabell Collins
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