

The Consumers' Atlas to Mental Health

CONVERSATION STARTERS

Vol. 1: The Medical Model

Vol. 2: Entering the labyrinth: Balancing care and risk in clinical services

Vol. 3: Stigma: The precarious balance between social and personal identity

Vol. 4: Where mental health is made: Personal autonomy and social regulation

Vol. 5: Mad Studies

Vol. 6: Musings about the National Disability Insurance Scheme (NDIS): Are we in or out?

Vol. 7: Holding ourselves together in time and space: Living in community

Vol. 8: In the news: The wider context of mental health and illness

Our Consumer Place is Australia's Mental Health Resource Centre run entirely by people diagnosed with 'mental illness'



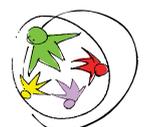
ourconsumerplace.com.au

RESOURCE CENTRE FOR MENTAL HEALTH CONSUMERS

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ourcommunity.com.au

Compiled by Merinda Epstein in partnership with Jacques Boulet

The Consumer's Atlas to Mental Health

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The Consumers' Atlas to Mental Health

CONVERSATION STARTERS

*Vol. 2: Entering the labyrinth: Balancing care
and risk in clinical services*

The Consumers' Atlas to Mental Health

1. Purpose and intentions of the Consumers' Atlas to Mental Health:

Conversation Starters is a set of eight volumes each containing 15 statements, intended to initiate and energise conversations about mental health. They are not statements of 'fact'; rather, they are tentative opinions to stimulate insightful conversations about the ways we understand madness, health and other services, community and mad people's politics. We hope they will assist in exploring issues concerning mental health through conversation, supported and informed by materials ranging from the experiential, the narrative and descriptive through to research-based and theoretical work.

The choice of the assembled materials is, of course, biased; some references are controversially 'conservative' whilst others are controversially 'radical'. We included them because they are all part of the full story. We have, therefore, spent less time accumulating 'mainstream' medical material because this is easier to find and many readers would already have absorbed a great deal of this discourse in their everyday interactions with the institutions of psychiatry or, indeed, through information from mass media and other sources.

2. Eight Volumes

Vol. 1: The Medical Model (published and available)

Vol. 2: Entering the labyrinth: Balancing care and risk in clinical services

Vol. 3: Stigma: The precarious balance between social and personal identity

Vol. 4: Where mental health is made: Personal autonomy and social regulation

Vol. 5: Mad Studies

Vol. 6: Musings about the National Disability Insurance Scheme (NDIS):

Are we in or out?

Vol. 7: Holding ourselves together in time and space: Living in community

Vol. 8: In the news: The wider context of mental health and illness

3. Each volume is organised as follows:

1. A series of fifteen conversation 'starter kits';
2. Each kit has three sections:
 - **Entry Section:** A set of five interesting, quizzical, provocative and sometimes controversial short statements accompanied by cartoons. This is the first, most direct and simplest way to enter the conversation.
 - **Middle Section: 'Wikipedia entries to madness'**, offering 30 initial definitional understandings of the issue or the dimension of madness proposed as the main theme of the conversation.
 - **Annotated Reference Section:** References to about 15 articles, discussion papers, academic debates, research, professional psychological or psychiatric literature, newspaper and other journalistic work, different discourses, antipsychiatry literature, medical literature and associated debates.

4. General: Also available and covering all eight volumes are:

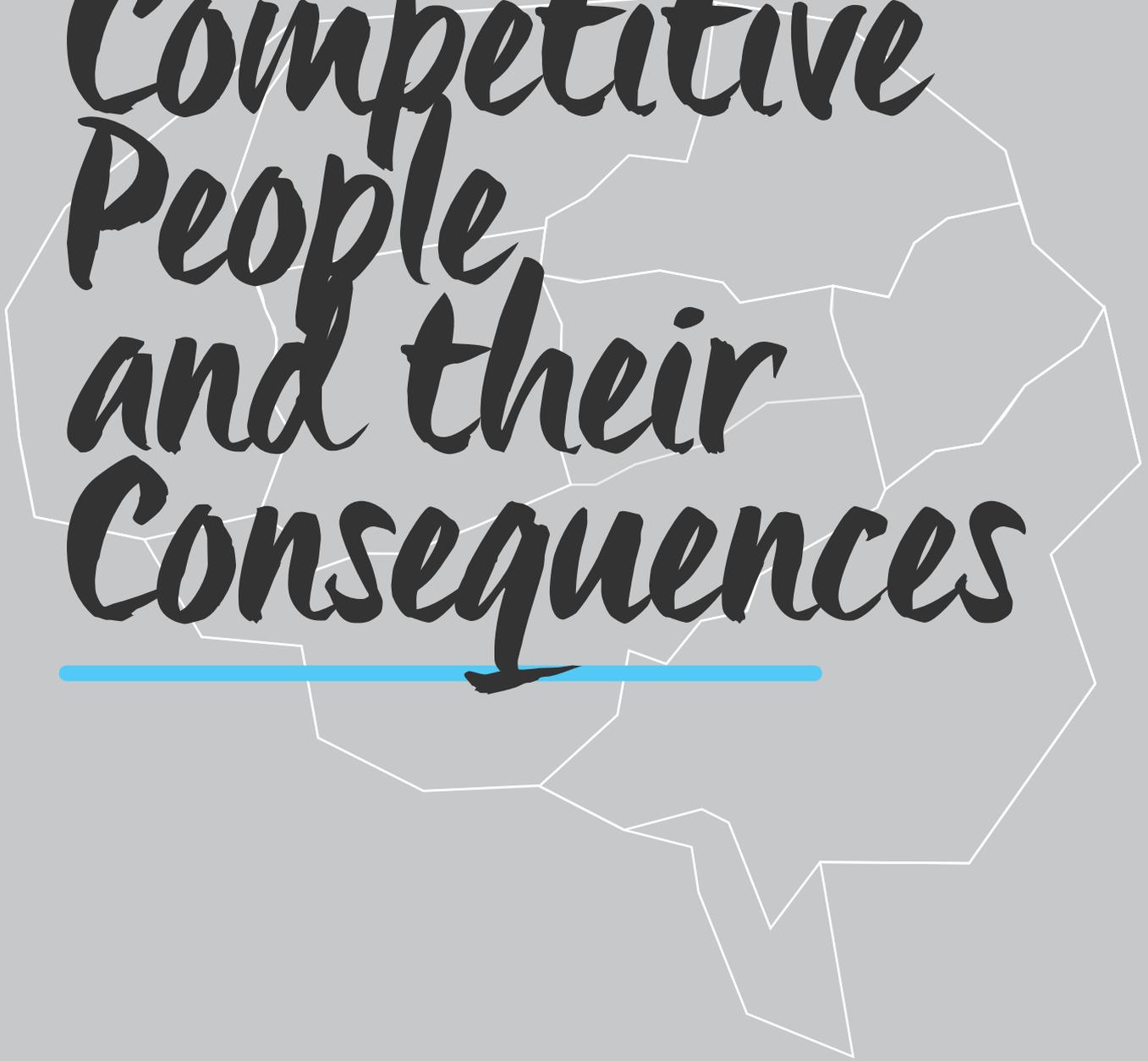
- a more comprehensive explanatory introduction to this material; and
- a substantial reference collection with hundreds of references, ordered in 100 'thematic entry-points' to be posted on the *Our Consumer Place* website.





1.

Competitive
People
and their
Consequences



1. Competitive People and their Consequences

DO WE HAVE A PROBLEM?

In mental health, the interacting meritocracy ranges from the most socially marginalised (homeless, older Australians, survivors of torture, refugees and many more) to professors of psychiatry and a group of 'Policy Heavyweights', including famous consumer survivor-thrivers. Between these extremes exists a gradation of (often opposing) camps of expertise.

MEDICINE AND PSYCHOLOGY ATTRACT COMPETITIVE PEOPLE

In each discipline, students are forced to compete amongst themselves and between disciplines. Many thrive in this environment – proven under pressure. Of course this affects their capacity to relate with those around them, the hoi polloi, their patients and clients. Clinicians need to try and disengage this competitive reflex. Unless remedied, the early competitive reflex may lead to troubling delusions.

STUDYING IN SILOS

There is a lack of trust in and respect for other clinical groups, even lacking understanding of what others actually do. Each discipline has very little contact with the others during their preliminary training; continuing education is too often discipline-based and when multidisciplinary, certain groups, or one group, often feel exempt from team working, whether in reality or in their collective head space. This severely curtails coordinated care..

STAGE MANAGERS

Doctors assume responsibility for leadership for which, some believe, they should be rewarded with status. Perhaps they do deserve some compensation for potentially being in the firing line, but is this important enough to risk losing the support and understanding of their colleagues? Social workers, counselling psychologists, occupational therapists, counsellors, psychiatric nurses and consumer employees jockey for leverage.... and then there's the managerial class...

FALSE FACTS FIGHTING FOR TERRITORY

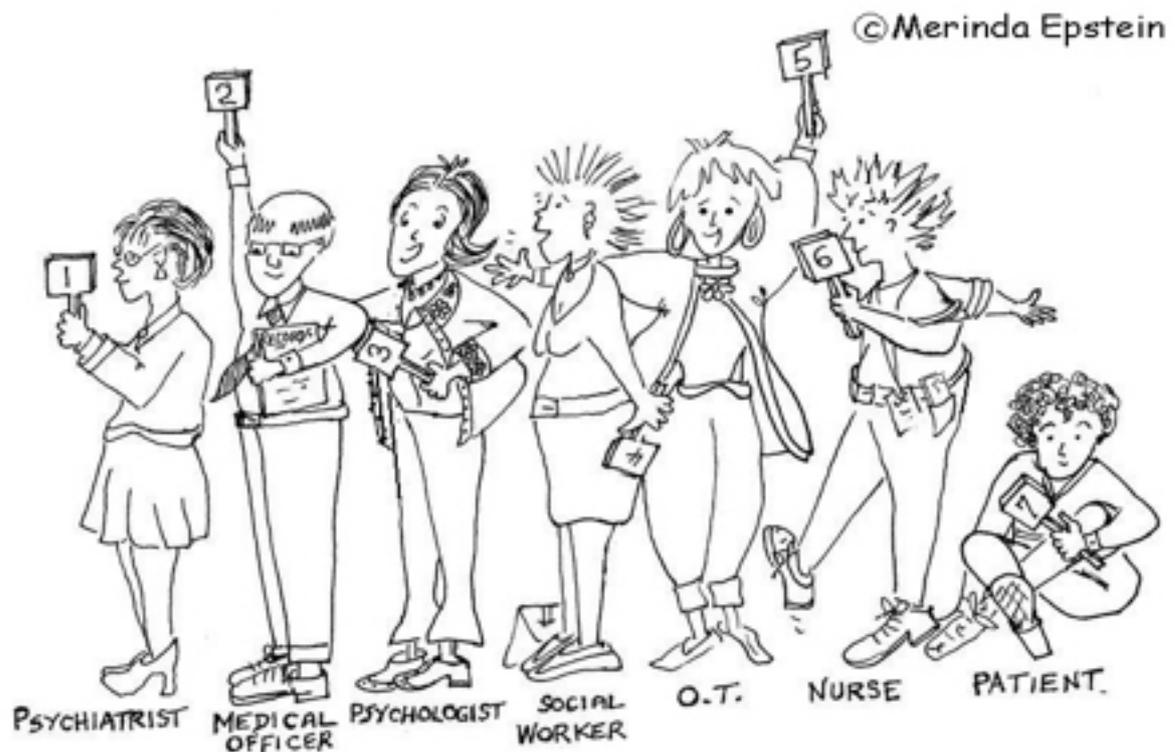
Here comes the community sector: psychiatrists sit imperiously on Boards as do other high profile clinicians. Other clinical groups can end up anywhere, competing with peer workers and 'old fashioned' community workers. Fighting for territory here is fierce. What happened to 'community' in all this?



A WIKIPEDIA ENTRY TO MADNESS

1. ATAR (Australian Tertiary Admission Rank): https://en.wikipedia.org/wiki/Australian_Tertiary_Admission_Rank
2. BIOPOLITICS: <https://en.wikipedia.org/wiki/Biopolitics>
3. BULLYING: <https://en.wikipedia.org/wiki/Bullying>
4. CRITICAL MASS (SOCIO-DYNAMICS): [https://en.wikipedia.org/wiki/Critical_mass_\(sociodynamics\)](https://en.wikipedia.org/wiki/Critical_mass_(sociodynamics))
5. CLINICAL PSYCHOLOGY: https://simple.wikipedia.org/wiki/Clinical_psychology
6. DANIELLE OFRI: https://en.wikipedia.org/wiki/Danielle_Ofri
7. FEMINISATION OF THE WORKPLACE: https://en.wikipedia.org/wiki/Feminisation_of_the_workplace
8. FEMINIST PEDAGOGY: https://en.wikipedia.org/wiki/Feminist_pedagogy
9. HAZING: <https://en.wikipedia.org/wiki/Hazing>
10. INTERDISCIPLINARITY: <https://en.wikipedia.org/wiki/Interdisciplinarity>
11. INTERPROFESSIONAL EDUCATION: https://en.wikipedia.org/wiki/Interprofessional_education
12. LATERAL VIOLENCE: https://en.wikipedia.org/wiki/Lateral_violence
13. MEDICAL ANTHROPOLOGY: https://en.wikipedia.org/wiki/Medical_anthropology
14. MEDICAL EDUCATION IN AUSTRALIA: https://en.wikipedia.org/wiki/Medical_education_in_Australia
15. MEDICAL EDUCATION: https://en.wikipedia.org/wiki/Medical_education
16. MEDICAL ETHICS: https://en.wikipedia.org/wiki/Medical_ethics
17. MEDICAL STUDENT'S DISEASE: https://en.wikipedia.org/wiki/Medical_students%27_disease
18. MULTIDISCIPLINARY APPROACH: https://en.wikipedia.org/wiki/Multidisciplinary_approach
19. OVERACHIEVEMENT: <https://en.wikipedia.org/wiki/Overachievement>
20. PRIVILEGE - SOCIAL INEQUALITY: [https://en.wikipedia.org/wiki/Privilege_\(social_inequality\)](https://en.wikipedia.org/wiki/Privilege_(social_inequality))
21. RESIDENCY: http://images.pps.console.com.au/resize/portplus/storage/3785/3785_3094246_300816043629_5904.jpg?width=249
22. ROSENHAN EXPERIMENT: https://en.wikipedia.org/wiki/Rosenthal_experiment
23. SOCIAL STRATIFICATION: https://en.wikipedia.org/wiki/Social_stratification
24. SUICIDE AMONG DOCTORS: https://en.wikipedia.org/wiki/Suicide_among_doctors

25. THE BIRTH OF 'THE CLINIC': https://en.wikipedia.org/wiki/The_Birth_of_the_Clinic
26. THE MEDICAL GAZE: https://en.wikipedia.org/wiki/The_Birth_of_the_Clinic
27. TRANSDISCIPLINARITY: <https://en.wikipedia.org/wiki/Transdisciplinarity>
28. UNIVERSITY OF NEWCASTLE SCHOOL OF MEDICINE & PUBLIC HEALTH: https://en.wikipedia.org/wiki/University_of_Newcastle_School_of_Medicine_and_Public_Health
29. WORKPLACE BULLYING: https://en.wikipedia.org/wiki/Workplace_bullying
30. WORKPLACE VIOLENCE: https://en.wikipedia.org/wiki/Workplace_violence



mental health services triage arrangements

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Zick-Varu M. Talcott Parsons, the Sick Role and Chronic Illness, *Psychiatry and Society* 2010 July 5:72-94 <https://ore.exeter.ac.uk/repository/bitstream/handle/10871/15021/Talcott%20Parsons%20the%20Sick%20Role%20and%20Chronic%20Illness.pdf?sequence=4&isAllowed=y>

(This paper re-examines the contentions of Talcott Parsons in relation to changes in doctor-patient relationships, the move in the late part of the twentieth century and early 21st century towards lifestyle analysis and prevention and whether 'sick role theory' is still (as) useful. He concludes that whilst what happens in medicine is cocooned in a moral economy of values, it is still a useful concept. Talcott Parsons was a major force in American sociology, the school of sociology he belonged to was relatively conservative. He was born in 1902 and died in 1979. Much of his writing dates from the 1950s and 60s when the social and political environment encouraged critical questioning of medicine. Parsons developed the 'sick role' theory framed in 'functionalist sociology,' arguing that being sick "means that the sufferer enters a role of 'sanctioned deviance'. This is because from a functionalist perspective a sick individual is not (functioning) as a productive member of society." (Sociological Perspective on health and Illness) <https://courses.lumenlearning.com/boundless-sociology/chapter/sociological-perspectives-on-health-and-illness/> Functionalism is one of the three main schools of sociology at the time, the other two being Symbolic Interactionism and Conflict theory. <https://lailima.hawaii.edu/access/content/user/kfrench/sociology/the%20three%20main%20sociological%20perspectives.pdf>)

2.

Bayne K. Health Privileges, Centre for Progress in Health, July 28, 2016 https://centerforhealthprogress.org/blog/health-privileges/?gclid=CjwKCAiA9f7QBR BpEiwApL GUivCRROuGqKcV8xUTZ32zT9f9wMcV3OgkQPwukWfIVzrMCvCE09-VHhoCwSYQAvD_ BwE

(This is a brief personal reflection as Katie explores her own white privilege and the institutional power and authority she holds because of it. She suggests that all of us with privilege need to recognise it and do something about it. It is a very short, easy to read piece.)

3.

McIntosh P. White Privilege: Unpacking the Invisible Knapsack, Working Paper 189 College Center for Research on Women, Wellesley MA 0218 <http://www.ywca.org/atf/cf/%7B6EDE3711-6615-4DDD-B12A-F9E0A781AE81%7D/White%20Privilege%20Unpacking%20the%20Invisible%20Knapsack.pdf>

(This essay is a much quoted classic; it is also easy to read and short. McIntosh writes: "I was taught to see racism only in individual acts of meanness, not in invisible systems conferring dominance on my group." She includes a list of simple things her white privilege enables her to do and be. It is a bit confronting because these are such everyday things that

most of us take for granted. McIntosh is an American writer so the race issue is in your face but it applies equally here in Australia. The first six points (of fifty) are:

- I can if I wish arrange to be in the company of people of my race most of the time.
- I can avoid spending time with people whom I was trained to mistrust and who have learned to mistrust my kind or me.
- If I should need to move, I can be pretty sure of renting or purchasing housing in an area which I can afford and in which I would want to live.
- I can be pretty sure that my neighbours in such a location will be neutral or pleasant to me.
- I can go shopping alone most of the time, pretty well assured that I will not be followed or harassed.
- I can turn on the television or open to the front page of the paper and see people of my race widely represented.)

4.

Campbell D. Why hospitals need more generalist doctors and specialist nurses in The Conversation October 9th, 2014 <https://theconversation.com/why-hospitals-need-more-generalist-doctors-and-specialist-nurses-18899>

(Don Campbell is a General Physician and Director of General Medicine at Monash Health. As health-care costs are rising inexorably due to our ageing population, he argues that as we age we need the general practitioner role as a coordinator of diverse specialist services. But that role will become untenable and the ratio of generalists to specialists will need to be increased particularly in areas of chronic illness like heart disease, depression, dementia and osteoporosis. At the same time there is, he argues, a need for more nurses to specialise and take over some of the roles that are presently performed by specialist doctors who attract large fees. He is talking as someone who is both a doctor and academic interested in how we fund health services. He concludes: "In order to create the radically different hospital to meet the needs of the rapidly ageing population over the next 20 years, we need to create new roles for health-care workers and challenge traditional siloed professional practice." The article has links to several interesting sites.)

5.

Roberts M. The production of the psychiatric subject: power, knowledge and Michael Foucault; Nursing Philosophy 2005 Jan; 6(1): 33-42 <https://www.ncbi.nlm.nih.gov/pubmed/15659088>

(Michel Foucault was born in October 1926 and died in June 1984. He was a distinguished French philosopher and historian who radically changed the way we interpret social and cultural life (https://en.wikipedia.org/wiki/Michel_Foucault). He was particularly interested in the conceptualisation of power and in 'discourse analysis' https://en.wikipedia.org/wiki/Foucauldian_discourse_analysis; this is an imperative idea when thinking about where the consumer is located in competing knowledges in psychiatry. Instead of thinking about power as discrete and wielded, he saw it as 'embodied' and 'enacted'. This means that those of us who have power live it and often don't even know that we are doing so. He argued that power is not just coercive but rather that power is used with varying degrees

of authority. In the situation of psychiatry, for example, the discourse of the medical model enables psychiatrists to live and be agents of considerable power whilst consumer workers, despite having some power given they are employed, have much less.

In this paper Roberts refers to the work of Foucault as applied to psychiatry, psychotherapy and psychiatric nursing. He explores what he describes as intimate relations between power and psychiatry. In this paper he suggests how patients are made into 'subjects' and how 'psychiatric identities' are formed, concluding that Foucault is still important in discussions about power and knowledge and to test the theories behind diagnosis and therapeutic process. The article is not hard to read but there are a lot of references to work with which you may be unfamiliar. Ignore this in a first reading and go back to any that have held your interest. We should probably all be familiar with the work of Michel Foucault!

6.

Samson C. The fracturing of medical dominance in British psychiatry? *Sociology of Health and Illness* Vol. 17 No. 2 1995 <http://onlinelibrary.wiley.com/doi/10.1111/1467-9566.ep10933403/pdf>

(In this interesting work, Samson explores medical dominance and the idea that at that time (1995) it was starting to fracture. He argues that its dominance (and loss of dominance) was not only, or necessarily, driven by the medical profession for which there are other historical examples. He talks about 'occupational privileges' in history and that are economic, political and cultural. He argues that managerialism and the present move in mental health interventions into community services influences a period of waning psychiatric privilege. "Knowledge claims and medical procedures that have legitimated the dominant position of psychiatry within the mental health services - a medico-eclectic ideology, a view of doctor superiority over other mental health professionals and the extensive use of physical treatments - are outlined and contrasted with the conflicting ideas and authority structures of community care and health service management.")

7.

Cameron D. I. see managerialism as a virus, *The Guardian* (Australian Edition), 6th April 2002 <https://www.theguardian.com/society/2002/apr/05/publicvoices4>

(This is a short, reflective and interesting piece by a retired psychiatrist who specialised in drug and alcohol psychiatry. Cameron reflects on some services in Britain that were before their time, radical and successful. He notes that in England these sorts of services are now seen as better practice and they are re-introduced often by people who had no historical knowledge. At the time in the 1990s, as is too often the fate of somewhat experimental but 'successful' ideas with committed people and a mission, attempts 'tame them', 'control them', 'make them accountable' too often destroy them. There are examples in education, community services and other areas of psychiatric practice. In these situations, there is a genuine need for those who might be destined to carry institutional power to realise it. The only way for proponents of the service to be heard was to utilise the institutional power of the most senior staff, even if they did not want this role. This is an example where the maldistribution of power within a practice was less important than a collective politic about the idea and its importance.

This is just one person's reflection, but it raises very interesting questions about what makes a 'good' service and who knows and how do they know and how to talk about this in ways that appease the concerns of those responsible for spending taxpayers' money.

Having people with a competitive streak who have lots of institutional authority and are not afraid to wield it might, paradoxically, bring daring ideas home. Or not...)

8.

Farooq K. et al Why medical students choose psychiatry; a 20-country cross-sectional survey, BMC Medical Education 2014, 14(12) <https://link.springer.com/article/10.1186/1472-6920-14-12>

(There is a lot on the internet about how medical students don't want to do psychiatry and what can be done about it. There is also a lot on the internet about psychiatry being seen as low status compared to other specialities. There are various reasons posited for both. Whether students do or don't value psychiatry ranges from prejudice, fear, feeling they would be judged, not make enough money, not scientific enough, through to personal experiences with mental illness. The attitudes of non-psychiatric doctors are important; prejudice and intolerance likely not attended to in undergraduate education can manifest itself in practice. This is a comment from an emergency specialist (followed by a succession with the same sentiment) from Emergency Physicians, National Institute of Clinical Excellence 2014): "Any A&E doctor could tell you that in psychiatry, crisis management means rolling up at 10am the next morning, latte in hand, when the blood and vomit have been cleared away and the patient is no longer drunk and abusive." This is an overview and there is scope to find many articles that go deeper and less wide.)

9.

Cutcliffe J. & Happell B. Psychiatry, mental health nurses and invisible power: Exploring a perturbed relationship within contemporary mental health care. Int J Ment Health Nurs. 2009 Apr;18(2):116-25 <https://www.ncbi.nlm.nih.gov/pubmed/19290975>

(This article focuses on the power mental health nurses have over their patients and is particularly interested in the subtle, sometimes linguistic taken-for-granted ways of relating. Invisible power and control is a theme. This article is not easily accessible to non-academics and consumers not employed in an organisation. We have tried not to use articles which are not easily accessible. We do so to include discussion about nurses and power to complement the many on doctors and power.)

10.

Schindler F.E. et al A study of the causes of conflict between psychiatrists and psychologists. Hospital and Community Psychiatry, 1981 April 32(4):283-6 <https://www.ncbi.nlm.nih.gov/pubmed/7227987>

(This is a relatively old document but, from a consumer perspective, this doesn't make it any less relevant. No doubt, members of both of the groups in question will claim, 'all has changed'. Perhaps... perhaps not... Social workers and nurses were included in the study design so they could reflect on psychologists and psychiatrists. This is interesting. As an historical marker from times when ideas were allowed to be more candid and radical it makes interesting reading. Make your own judgement of its importance today and perhaps try and find materials that are asking the same questions but are more contemporary. It would be an interesting comparison. If you can't find any, this says something too. Read between the lines and you may see the diminishing authority of psychotherapy. Perhaps this is economics dressed up as a scientific method issue. Your call...)

11.

Pilgrim D. & Rogers A. Survival of its discontents: the case of British psychiatry *Sociology of Health & Illness* Vol. 31 (7) November 2009:947-961 <http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2009.01166.x/full>

(David Pilgrim and Anne Rogers are eminent sociologists in the field of psychiatry. They have written widely together. This is wide ranging paper of great interest. Amongst other things, it refers directly to the power differential between different groups in the psychiatric workforce. Using the works of Habermas and other social theorists, this is a peek at psychiatry as a profession, its internal angst as its job moves from silo institutions to co-ordinated ways of practicing, between factions, pressure from consumers and other clinical groups in the sector and the challenge of keeping the community safe at the same time as providing caring that keeps patients engaged. Worth a read!)

Code 2.

Critical:
Conditions
for Caring!

2. Code Critical: Conditions for Caring!

THE UBIQUITOUS SECURITY GUARDS

'Code grey' means security guards approaching (plus other interventions). It's sad when in emergency departments people are dumped by crisis teams to spend quality time with guards. Sometimes there is a solid cube inside the otherwise open plan maze of cubicles. It's justified of course, but it remains a monument to community prejudice.

YOU'RE NOT KIDDING ANYONE

Security guards frequent psychiatric units responding to 'incidents'. An incident indicates a violence spike. We're not deceived. We know what 'an incident' is and it just seems silly to use a euphemism that has the effect of eroding trust further.

STAFF MEMBERS CAUSE INCIDENTS TOO!

Some staff members in acute units have been there too long. Others thrive on action. It keeps them awake. In some consumers' minds there is no doubt that in many incidents the focus should be on the behaviour of staff rather than that of consumers.

EXCUSE FOR USING FORCE AND SECLUSION

Some staff as well as some consumers harbour force. Anger and violence are horrible for everyone and an acute unit might be a hostile place for staff to work in but they are paid to protect patients. This might be a radical idea. Maybe it is a matter of gender as much as it is a matter between staff and consumers. Both dynamics are about power.

FLOOR(ed) PLANNING:

Psychiatric units are not prisons but there are some with floor plans that resemble correction facilities. Some units in general hospitals have security guards on permanent placement at the main unit door. Fear and mistrust (on both sides) are too often built in but we are not deceived by a 'control-by-pastels' approach either. 'Colour psychology' is a discipline actually ripe for (expensive) consultation.



A WIKIPEDIA ENTRY TO MADNESS

1. ASSERTIVE COMMUNITY TREATMENT (ACT): https://en.wikipedia.org/wiki/Assertive_community_treatment
2. AUTHORITY (sociology): [https://en.wikipedia.org/wiki/Authority_\(sociology\)](https://en.wikipedia.org/wiki/Authority_(sociology))
3. AUTONOMY: <https://en.wikipedia.org/wiki/Autonomy>
4. CHEMICAL RESTRAINT: https://en.wikipedia.org/wiki/Chemical_restraint
5. COERCION: <https://en.wikipedia.org/wiki/Coercion>
6. COMPASSION FATIGUE: https://en.wikipedia.org/wiki/Compassion_fatigue
7. DIVERSION PROGRAMS: https://en.wikipedia.org/wiki/Diversion_program
8. DUAL DIAGNOSIS: https://en.wikipedia.org/wiki/Dual_diagnosis
9. EMERGENCY PSYCHIATRY: https://en.wikipedia.org/wiki/Emergency_psychiatry
10. FORENSIC PSYCHIATRY: https://en.wikipedia.org/wiki/Forensic_psychiatry
11. HOSPITAL EMERGENCY CODES: https://en.wikipedia.org/wiki/Hospital_emergency_codes
12. LIST OF POLITICAL IDEOLOGIES: https://en.wikipedia.org/wiki/List_of_political_ideologies
13. MEDICAL RESTRAINT: https://en.wikipedia.org/wiki/Medical_restraint
14. MEDICAL ETHICS: https://en.wikipedia.org/wiki/Medical_ethics
15. MENTAL DISORDERS VIOLENCE: https://en.wikipedia.org/wiki/Mental_disorders_and_gender
16. MENTAL HEALTH LAW: https://en.wikipedia.org/wiki/Mental_health_law
17. MENTAL HEALTH TRIBUNAL: https://en.wikipedia.org/wiki/Mental_health_tribunal
18. OCCUPATIONAL VIOLENCE IN NURSING: http://www.health.vic.gov.au/__data/assets/pdf_file/0008/17585/codeblackgrey.pdf
19. PATIENT-INITIATED VIOLENCE: https://en.wikipedia.org/wiki/Patient-initiated_violence
20. POWER (SOCIAL & POLITICAL): <https://en.wikipedia.org/wiki/Politics>

21. PSYCHIATRIC (STATE) APPARATUS: https://en.wikipedia.org/wiki/Ideology_and_Ideological_State_Apparatuses
22. PSYCHIATRIC ADVANCED DIRECTIVE: https://en.wikipedia.org/wiki/Psychiatric_advance_directive
23. PSYCHOLOGICAL ABUSE https://en.wikipedia.org/wiki/Psychological_abuse
24. RESTORATIVE JUSTICE: https://en.wikipedia.org/wiki/Restorative_justice
25. SELF-DETERMINATION: <https://en.wikipedia.org/wiki/Self-determination>
26. SHARED DECISION-MAKING IN MEDICINE: https://en.wikipedia.org/wiki/Shared_decision-making_in_medicine
27. SOCIAL EQUALITY: https://en.wikipedia.org/wiki/Social_equality
28. STRUCTURAL VIOLENCE: https://en.wikipedia.org/wiki/Structural_violence
29. UNITED NATIONS COMMISSION ON HUMAN RIGHTS (UNCHR): https://en.wikipedia.org/wiki/United_Nations_Commission_on_Human_Rights#Human_rights_and_mental_health
30. VICARIOUS TRAUMATISATION: https://en.wikipedia.org/wiki/Vicarious_traumatization



ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Ruffalo LCSW Mental Illness as Metaphor, Medicalisation and Psychiatry Psychology Today, September 2nd 2016 <https://www.psychologytoday.com/blog/mental-illness-metaphor/201709/power-paternalism-and-psychiatry>

(This is a short article, clearly argued. It endeavours to explore the role of compulsion and control in community mental health settings. This piece argues that authoritarian practice emanates from several places including the history of the organisation, individual staff preference and culture. Some authoritarian attitudes (with a trickledown effect) come from senior staff who have an authoritarian world view and authoritarian personality traits. This paper is a result of the examination of literature. The author warns of practices becoming habitual and eventually staff experiencing them as 'normal'. This paper reiterates other research which suggest there are widespread differences both internationally and in Australia in how compulsion has developed, particularly in non-hospital situations.)

2.

Power, Paternalism and Psychiatry: Authoritarian versus libertarian psychiatry; Psychology Today, Sep 2, 2017 <https://www.psychologytoday.com/blog/mental-illness-metaphor/201709/power-paternalism-and-psychiatry>

(This is a short accessible piece written for the interest of a wide readership. It argues that there are two 'types' of psychiatrists emanating from different traditions. The first is an authoritarian tradition coming out of the big institutions of the 19th and 20th centuries. The second is a libertarian tradition coming from Freud and the psychoanalytical tradition. Control, power, obedience and submission (compliance) are the code of authoritarian psychiatrist typology whereas "the libertarian psychiatrist may not agree, personally or morally, with his patient's conduct, he is not going to engage in coercion to change the patient, insisting that it is the patient's own responsibility to change himself.")

3.

Baptcare Social Policy Position Paper March 2016 Abuse and violence in family and other carer relationships, March 2016 https://www.baptcare.org.au/__data/assets/pdf_file/0009/12141/AbuseViolenceFamily-SocialPolicyPapaer-final.pdf

(This is a relatively new report which looks into issues of intimate family violence. The section that is of particular interest is Baptcare's look into family violence against people with disabilities. This is often covered up and/or justified. This discussion is on pages 10 – 13. The following section on violence against the elderly is important. As the community ages more emphasis in psychiatry will need to be on older people. This applies to the consumer movement as much as anywhere else. The word is already out that there is family violence in this area.)

4.

Kulkarni Jayashri Sexual assaults in psych wards show urgent need for reform The Conversation May 17, 2013 <https://theconversation.com/sexual-assaults-in-psych-wards-show-urgent-need-for-reform-14265>

(This is a really important contribution by one of Victoria's most well-known psychiatrists interested in the wellbeing of women in psychiatry. Kulkarni reports on a survey which suggests that many women feel unsafe in psychiatric units. She looks at the history of psychiatric services which moved from large single sex wards in the old institutions to very short stay in and out units today. She comments how policy since the 1990s has meant that acute units now have become pits of despair and violence where perpetrating violence and defending against violence is the norm; where the amount of angst and violence has also escalated because of illicit drugs. This is a short, easily consumed piece written with insight. There are two particular reasons this piece is important: it names gender as a significant contributory factor in understanding violence and Kulkarni focuses on patients and the effects of violence on them whereas most literature is concerned with the effect of violence on staff.)

5.

Allan C. Mixed-sex wards are more complicated in mental health: The Guardian, January 23rd 2009 <https://www.theguardian.com/society/joepublic/2009/jan/23/mental-health-mixed-sex-wards>

(Clare Allan is a consumer (service user) novelist and a writer of a regular column in the Guardian. I have included a list of her columns <http://journalisted.com/clare-allan?allarticles=yes> She writes widely but there is a theme about women's mental health including about gendered personality disorder labels. Here she has a look at the issues around sexual violence and argues that it may be a bit more complicated than it may appear. She cites a trial in the UK where many of the women involved wanted to return to mixed sex wards. She concluded that this area is one that needs a lot more attention. This is a short column that might lack substance but may give us ideas we might wish to explore.)

6.

O'Donoghue B. et al Perceived coercion in voluntary hospital admission; Psychiatry Research Vol 215(1) 30th January 201: 120-126 <http://www.sciencedirect.com/science/article/pii/S0165178113006641>

(This is an academic article. Unfortunately, accessing it depends on being at a university or working for an organisation in mental health, but once obtained it can be copied. It caught our attention initially because it used words that are flags to consumers. Prefixing consumer knowledge with the term 'perceived,' calling people 'individuals' (the language of police amongst other things). The argument is that the amount of (perceived) violence experienced by voluntary patients in acute settings is equal to or more than the (perceived) violence against people held involuntarily. This is interesting stuff and consumers may recognise situations where people, even though they are voluntary, find themselves in the midst of significant violence. Whether or not the authors have the understanding from a consumer perspective to truly 'get it' is for readers to explore.)

7.

Sartorius N. Iatrogenic stigma of mental illness, British Medical Journal 2002, June 22:P 324 (7352): 1470-1471 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1123430/>

(Norman Sartorius is famous. He writes from within the tradition of mainstream psychiatry but he also runs a critique. In this article he writes about how psychiatrists stigmatise

in-patients and how stigmatisation creates new and/or augments old mental illness. Iatrogenic (or iatrogenesis) is a good word for people to know; it means illness caused by doctors or more generally as illness caused by health systems and their physical environments. Sartorius speaks about labelling and how this can make people sick. He also speaks about side effects and how these will "mark the person as having a mental illness more than the original symptoms of the illness." He adds that this is exacerbated in countries where regimes go for cheap or for genuinely poor countries, for example through the use of old drugs where the side effect profile is significantly worse. Medical practitioners accept such policies, although it is clearly their duty to fight such regulations and ensure that their patients receive the best treatment, which is often not the cheapest. He puts forward the interesting idea that creating legal protections for some patients (based on diagnosis) can lead to stigmatization by doctors who ideologically or in their fight for resources systematically (and sometimes publically) cause greater and significant distress [and sometimes suicide] for others, based on crude information about diagnosis. This is short, old and worth reading.)

8.

Glenys D. et al Iatrogenic harm from psychological therapies – time to move on; British Journal of Psychiatry, March 2011, 208(3) 210 – 2012 <http://bjp.rcpsych.org/content/208/3/210>

(Usually, when we talk about violence and harm, we are talking about psychiatric interventions, use of physical treatment, over-use of powerful medications, vicarious danger and violent situations. This article notes the failure to systematically study and understand iatrogenic harm that may emanate from psychological interventions. The writers note that searching for harm in psychiatry is relatively straight forward, but searching for literature about harm caused by various different strands of psychological intervention is much harder. They also note that the disparity between the many testimonials of patients on the internet adds to the dearth of information in published papers. I am pleased to see no mention of 'perceived harm' here; they describe the posited risk factors for negative outcomes and possible mechanisms for harmful therapy, including: "Damaging interactions between therapist and patient and unresolved ruptures in the therapeutic alliance; poor fit between therapist and client that the therapist won't admit for whatever reason; suboptimal provision due to large case-loads and organizational pressure to take on patients beyond one's competence." This is an important invitation to do further research; the category of 'potential risk' reflects a rather professional way of looking at things. Collaboration with consumers may produce different categories of harm or, at least, the rethinking of the ones mentioned in this article.)

9.

Pelto-Piri V. et al Paternalism, autonomy and reciprocity: ethical perspectives in encounters with patients in psychiatric in-patient care; BMC Medical Ethics 2013; 14:19 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4029406/>

(This is a research paper; unlike most research papers it is available on-line for free. The writers identify three archetypical approaches to clinicians' approach to treatment:

Paternalism: 1) promoting and restoring the health of the patient, 2) providing good care and 3) assuming responsibility.

Autonomy: 1) respecting the patient's right to self-determination and information,

2) respecting the patient's integrity and 3) protecting human rights.

Reciprocity: 1) involving patients in the planning and implementation of their care and 2) building trust between staff and patients.

The authors explored each approach in relation to the commentary of participant clinicians, the most common approach being paternalism. There was some support by staff for approaches that could be described as respecting autonomy, but very little evidence of reciprocal approaches which would involve patients in the planning and implementation of their treatment in meaningful ways.)

10.

Molodynski A., Rugkasa J. & Burns T. Coercion and compulsion in community mental health care in British Medical Bulletin 20120: 95-105 <https://www.ncbi.nlm.nih.gov/pubmed/20501486>

(This paper argues that in several countries the use of compulsion in community services is expanding and that this cannot be completely explained by the rise in the community component of mental health delivery. It is under researched. The authors did a meta-study of peer-reviewed literature, perceived to be 'gold standard' as the process of collection, examination, interpretation of the results and writing up is monitored and enhanced by other professionals who are experts in the same area. It's a process of validation that academics and clinicians often think is the most rigorous. The authors found much debate between different camps of knowledge. They argue that the evidence is small but there is increasing interest. Compulsion seems to be taken more and more for granted and justified as used in community psychiatry. The concept of 'informal compulsion' is a slippery one. The results from different researches are conflicting with regional variations.)

11.

Malcolm L. When Your Mind is Not Your Own: Community Treatment Orders, Saturday 27th February 2010 (podcast) <http://www.abc.net.au/radionational/programs/allinthemind/when-your-mind-is-not-your-own-community-treatment/3120438>

(This is a podcast and worth a listen. It is an interesting program with Steven Segal and Mary O'Hagan about Community Treatment Orders. Steven is a social work academic from the University of California, Berkeley Campus <http://socialwelfare.berkeley.edu/faculty/steven-p-segal> and he has worked with this issue. His perception is that Community Treatment Orders may be much better than pundits declare. He argues that being kept in a locked ward of a hospital is far worse than being in the community, no matter by what means and such restrictions may enable people to stay 'better' and live longer. Mary O'Hagan <http://www.maryohagan.com/blog/tag/compulsory%20treatment> is a well-known, informed, articulate activist who has worked for many years to improve the lot for people with mental illness. Occasionally, she draws on her own experience but mostly she enables others who may not have her experience. She argues the need to overhaul the idea of community detainment and that given the right resources, people won't need these orders. She does argue for compulsory orders but her version of these is that they require services to provide decent care. People cannot be held responsible for the deficiencies of the mental health system. That is, instead of doctors going to the Mental Health Tribunal to get an order to restrict a person's human rights, a patient might be able to go to the Mental Health Tribunal to get an

order to make the service system do its job properly and provide optimal care. This may be a fanciful idea (for now) but it resonates with many people with mental illness, particularly those who have experienced community force and advocates who have tried to support them. The third person interviewed was 'Stephen', a man with a diagnosis of schizophrenia, telling his own story about community treatment orders. He was great and it was really interesting to listen to how the presenter was able to be attentive and genuine with him which she couldn't with Mary O'Hagan who was cut off several times. I found the presenter's approach disingenuous but it also reveals a problem that is widespread. It seems we are allowed to be a story but when we stray into commentary many find us more difficult to deal with. See what you think. Have a listen.)



3.

Duty of
Care and the
Dignity of
Risk

3. Duty of Care and the Dignity of Risk

DUTY

What is this duty of care? Clinicians sometimes have an ingrained 'duty of care' reflex to just about everything. People employed in the system must do their duty not only to consumers (as they see it) but also under the ethics of their profession and the demands of their workplace. But in what order? When situations get tough and consumers don't agree with the judgements of others, 'duty of care' is often invoked. Perhaps it would be wiser to say 'duty of treatment' or 'duty to be seen as doing something' or 'duty to my boss, the system or family carers' or just: 'I'm afraid'.

SUSPENDING CARE

Sometimes we may need to be protected in ways we do not want. It just doesn't feel very caring. Duty of care often involves suspending care as it is recognised by patients. This is linguistically problematic. Can genuine caring emanate from medical force, from clinical behaviour experienced as harmful, dehumanising assumptions and tragic defiling of people's character?

DUTY TO CARE

Staff have a 'duty to care' in ways patients seek caring. Even an acute unit is a community and inter-relationships carry across boundaries, personalities and roles. Force humiliates, punishes, shames and begets more force. Trauma is carried in the body as well as the mind; caring in places of high stress, violence, force and odd interactions drifts in and out of focus. Sincere, authoritative debriefing with community-acknowledged, experienced (non-clinically trained) listeners who have the power to instigate real processes for formal apology seem to be what is desperately needed. Iatrogenic trauma helps no one.

RISK?

General community attitudes drive service delivery. Angry men, poverty, psychosis, unpredictability, homelessness and overt signs of difference influence community attitudes to and perceptions of risk. Clinical unions such as the Australian Medical Association (AMA) and the Australian Nurses and Midwifery Association (ANMA) are in there too, fighting for the safety of clinicians. The community is often inclined to believe that risk-containment is the most important thing for successful service delivery (particularly in the public sector). The government listens to medical unions - especially the ones of doctors - but it is public incidents, portrayed or amplified, that get to the Minister's minders.

DIGNITY

Taking risks will make life a whole lot better for many consumers. It will also kill some. The difference is that deaths can be easily counted and dignity cannot. This is one area where consumers and carers sometimes come asunder in individual relationships and from lobby group to lobby group...



A WIKIPEDIA ENTRY TO MADNESS

1. ADHERENCE (MEDICINE): [https://en.wikipedia.org/wiki/Adherence_\(medicine\)](https://en.wikipedia.org/wiki/Adherence_(medicine))
2. ASSESSMENT OF SUICIDE RISK: https://en.wikipedia.org/wiki/Assessment_of_suicide_risk
3. AUBREY LEVIN: https://en.wikipedia.org/wiki/Aubrey_Levin
4. AUTONOMY: <https://en.wikipedia.org/wiki/Autonomy>
5. BODILY HARM: https://en.wikipedia.org/wiki/Bodily_harm
6. CHELMSFORD ROYAL COMMISSION: https://en.wikipedia.org/wiki/Chelmsford_Royal_Commission
7. DECLARATION OF GENEVA: https://en.wikipedia.org/wiki/Declaration_of_Geneva
8. DE-ESCALATION: <https://en.wikipedia.org/wiki/De-escalation>
9. DEFENSIVE MEDICINE: https://en.wikipedia.org/wiki/Defensive_medicine
10. DOCTOR PATIENT RELATIONSHIP: https://en.wikipedia.org/wiki/Doctor%E2%80%93patient_relationship
11. DUTY TO PROTECT: https://en.wikipedia.org/wiki/Duty_to_protect
12. DUTY TO WARN: https://en.wikipedia.org/wiki/Duty_to_warn
13. ETHICAL ISSUES IN PSYCHIATRY: https://en.wikipedia.org/wiki/Ethical_issues_in_psychiatry
14. ETHICS OF CARE: https://en.wikipedia.org/wiki/Ethics_of_care
15. GRAHAM'S HIERARCHY OF DISAGREEMENT: https://en.wikipedia.org/wiki/De-escalation#/media/File:Graham%27s_Hierarchy_of_Disagreement-en.svg
16. HIPPOCRATIC OATH: https://en.wikipedia.org/wiki/Hippocratic_Oath
17. INFORMED CONSENT: https://en.wikipedia.org/wiki/Informed_consent
18. MEDICAL ERROR: https://en.wikipedia.org/wiki/Medical_error
19. MEDICAL MALPRACTICE: https://en.wikipedia.org/wiki/Medical_malpractice
20. MENTAL DISORDERS AND GENDER: https://en.wikipedia.org/wiki/Mental_disorders_and_gender
21. MENTAL HEALTH LAW: https://en.wikipedia.org/wiki/Mental_health_law
22. MENTAL STATE EXAMINATION: https://en.wikipedia.org/wiki/Mental_status_examination
23. NEGLIGENCE: <https://en.wikipedia.org/wiki/Negligence>
24. NIGHTINGALE PLEDGE: https://en.wikipedia.org/wiki/Nightingale_Pledge
25. PHYSICIAN-PATIENT PRIVILEGE: https://en.wikipedia.org/wiki/Physician%E2%80%93patient_privilege

26. PSYCHIATRIC SCREENING: https://en.wikipedia.org/wiki/Psychiatric_assessment

27. RISK AVERSION: [https://en.wikipedia.org/wiki/Risk_aversion_\(psychology\)](https://en.wikipedia.org/wiki/Risk_aversion_(psychology))

28. STANDARD OF CARE: https://en.wikipedia.org/wiki/Standard_of_care

29. THE AGITATED/VIOLENT PATIENT: https://en.wikibooks.org/wiki/Textbook_of_Psychiatry/The_Agitated/Violent_Patient

30. TRAUMA RISK MANAGEMENT: https://en.wikipedia.org/wiki/Trauma_risk_management



ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Dean J. et al Duty of care or a matter of conduct: Can a doctor refuse a person in need of urgent medical attention? Diagnostic challenges; Volume 42, No 10, October 2013: 746-748 <https://www.racgp.org.au/afp/2013/october/duty-of-care/>

(This is about doctors and the duty of care in public places with people who are not their patients. It mainly refers to doctors where a physical health issue arises but it would also pertain to psychiatrists. If the doctor does not want to be involved they can:

- actively deny being a doctor,
- passively avoid identifying themselves as a doctor, or
- Acknowledge being a doctor, but refuse to render assistance.

There are ethical and legal considerations whatever the doctor chooses. This paper discusses them.)

2.

Gray A. The Liability of Providers of Mental Health Services in Negligence; The University of Western Australia Law Review, vol. 40: 163 – 198 <http://www.austlii.edu.au/au/journals/UWALawRw/2015/45.pdf>

Gray looks at a famous case; a man was discharged from a public hospital and taken home by a friend whom he later killed. One of the issues was whether the discharging doctor and the service had a legal duty of care to protect the public and the patient's family. The decision was made that neither the doctor nor the hospital had this duty. Another issue was the contributing role of public policy. "Clearly, there is strong public interest in upholding high standards in medical endeavours, and legal principle should reflect community expectations. Individuals expect governments to take reasonable steps to protect their safety. When a duty of care is imposed on virtually all other professionals, it is hard to justify what effectively seems like a new immunity in the area of mental health service providers. Recognition that a duty of care exists can have positive benefits in terms of encouraging high standards and appropriate care..."

3.

Shircore M. Shoot First, Establish Liability Later: The Duty Of Care Owed To Mentally Ill Persons; Journal of the Australasian Law Teachers Association. <http://www.austlii.edu.au/au/journals/JIALawTA/2012/21.pdf>

(Mandy Shircore is a Senior Lecturer at James Cook University. There is a keen literature on the legal implications of Duty of Care. In this paper the writer uses case examples from a legal perspective to look at the problems of police power and a lack of responsibility for the vulnerability of people with a mental illness. It is an important issue. It is written in 'legalise' so some might find it a bit difficult. On the other hand, case examples mean that it is about stories of real people and this is compelling for many. It is Australian and New Zealand so this makes it relevant.)

4.

Ranieri V. et al Caregivers perceptions of coercion in psychiatric hospital admission; Psychiatry Research 2015 Aug 30 288(3) 380-5 <https://www.ncbi.nlm.nih.gov/pubmed/20501486>

(This is an interesting piece of research that aimed to look at the difference between inpatient understandings of experiences of coercion in an in-patient admission compared to the perception of family and other lay carers. The aim was to compare what patients experienced (using patient report) and their care-givers perception. Sixty-six caregivers participated in this study and the majority were parents. Seventy one percent of service users were admitted involuntarily and nearly half had a diagnosis of schizophrenia or schizoaffective disorder. Caregivers of involuntarily admitted individuals perceived the service users' admission as less coercive than reported by the service users. Caregivers also perceived a higher level of procedural justice in comparison to the level reported by service users. The researchers conclude that: "Reducing the disparity of perceptions between caregivers and service users could result in caregivers having a greater understanding of the admission process and why some service users may be reluctant to be admitted.")

5.

Desai N.G. Responsibility of psychiatrists: Need for pragmatic idealism; Indian Journal of Psychiatry 2006 Oct-Dec, 48(4): 211-214 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2915590/>

(This is a short discursive piece that is clearly written and easy to understand. The Indian Journal of Psychiatry produces some material that is not inaccessible which is good. In this paper Desai looks at the multiple responsibilities of psychiatrists and how individuals and groups can balance competing demands without getting totally overwhelmed which he does contend is a possibility. He names the following competing forces:

- Professional Responsibilities
- Ethical Responsibilities
- Social Responsibilities
- Legal Responsibilities.

Desai makes a claim that too often it is the social responsibilities that are not taken as seriously as they should be in this balancing of the impossible. He argues that this is a particular issue in developing countries. This is a paper written by a psychiatrist for psychiatrists. Because of this, it does at times read a little bit pompously. Take it or leave it.)

6.

Høglund P. et al Accountability and psychiatric disorders: how do forensic psychiatric professionals think? International Journal of Law in Psychiatry, 2009 Nov-Dec: 32(6):355-361 <https://www.ncbi.nlm.nih.gov/pubmed/19811835>

(Unfortunately, this is an academic paper that is not available free on the internet, but you may get it through a health organisation. How do clinicians figure out which patients do and do not have the capacity to be accountable for their actions? This is a paper about research conducted in Sweden but it seems to have relevance. Clinicians (psychiatrists

(30), psychologists (30), nurses (45) and ward attendants(45)) from five different services were interviewed to judge patient accountability:

- By diagnosis;
- By assessing accountably in five case studies;
- By listing further factors they regard as relevant to the ways they make assessments of this kind in their own practice.

Results showed convergence in decision making: "consistently found most types of mental disorders to reduce accountability, especially psychotic disorders and dementia. Other factors thought to be relevant were substance abuse, social network, personality traits, social stress, and level of education.")

7.

Brumbles D. & Meister A. Psychiatric Elopement: Using Evidence to Examine Causative Factors and Preventative Measures. Archives of Psychiatric Nursing, vol. 27, No 1 (February), 2013:3-9 [http://www.psychiatricnursing.org/article/S0883-9417\(12\)00129-X/pdf](http://www.psychiatricnursing.org/article/S0883-9417(12)00129-X/pdf)

(Elopement is a pretty interesting term; it means running away from a service – absconding. I like elopement better. The authors describe a project where they spoke to clinicians about policy, practices and learnings about elopements from public, locked psychiatric units. In some ways this is both insightful and disappointing. The disappointment comes perhaps from the fact that it is written for nurses (primarily) by nurses and so the orientation of the conclusions and the results are nurse-centred rather than patient-centred. The exploration of reasons why patients elope is really interesting. Some of the reasons given were:

- Boredom
- Frightened of the other patients
- Feel trapped and confined
- Have household responsibilities they feel they must fulfil
- Feel cut-off from friends and family
- Worried about the security of their home and property
- Impulsivity or anger about not being discharged
- Patients describe a "sense of meaninglessness" when referring to their hospitalization
- Stigma of being on a psychiatric unit
- Disliking the staff or the food
- Medication side-effects
- They feel neglected by staff
- Desire to use drugs or alcohol

- Feeling unsafe on the unit
- Dealing with other patients that get into their personal space
- Be at home to protect their belongings.

Many of these are if not admirable certainly understandable. The report vacillates between what seems to be a patient-sensitive approach to the data and a containment narrative, which seems to lose the texture of the complex material found in the research. It's of interest if one picks through some of the judgemental language carefully.)

8.

Department of Health, Victoria Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units; Chief Psychiatrist's guideline; October 2009. Updated June 2012 [file:///C:/Users/Merindz/Downloads/inpatient_sexualsafety_cpg_glines%20-%20PDF%20\(1\).pdf](file:///C:/Users/Merindz/Downloads/inpatient_sexualsafety_cpg_glines%20-%20PDF%20(1).pdf)

(This is an easily accessible document produced by the Victorian Chief Psychiatrist. It reads like the report it is which some readers will find really useful and others will find boring, depending on disposition. The reason for its inclusion is that duty of care issues around sexual behaviour on acute units is important and is central to issues around single sex units, for example. These guidelines are useful because it reduces the need for individual staff (and unit authorities) to make a call based on a lack of substance in policy. The guidelines include 'Responding to disclosures of a past history of sexual abuse.' This is good to see. Obviously there are also issues to do with people who are manic making decisions they later regret.)

9.

United Nations, Human Rights, Office of the High Commissioner "Dignity must prevail" – An appeal to do away with non-consensual psychiatric treatment; World mental Health Day Saturday 10 October 2015 <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16583>

(Psych. survivors (and some consumers) have been emphasising the tragedy of force in psychiatric institutions for a considerable time. Some get heard and many are classed as ratbags. However, things start to change when this human rights issue becomes the concern of the United Nations. GENEVA (8 October 2015) – "The United Nations Special Rapporteurs on the rights of persons with disabilities, Catalina Devandas-Aguilar, and on the right to health, Dainius Pûras, today called on States to eradicate all forms of non-consensual psychiatric treatment.")

10.

Saxena S. & Hanna F. Dignity- a fundamental principle of mental health care; Indian Journal of medical Research 2015 Oct; 142(4):355-358 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4683817/>

(This is short and easy to read. It offers a well-argued plea that we in mental health should take the issue of people's dignity more seriously. It is argued that "to treat

someone with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals". There are many people-who-have-been patients who will attest to this not happening in many practices. The authors describe two components of this:

- Dignity is the self-worth as experienced by the person, and
- Dignity is the worth of the person as reflected in the respectful attitudes and practices of others.

The paper identifies four principal areas that need our attention:

- Dignity and mental health governance
- Dignity and liberty
- Dignity, recovery and community integration
- Dignity as a human right.

"Many people with mental disorders are deprived of their right to be treated with dignity as valued members of society. They are not only discriminated against, and marginalized in their communities but also in the mental health service context where they should be receiving care and support. Governments, national and international partners of health care provision must ensure that all laws, policies and practices in mental health care promote dignity and respect for people with mental health conditions on an equal basis with others.")

11.

Parsons C. Dignity of Risk: The right to self-governance for people with mental illness
OPENFORUM 4th April 2017 <http://www.openforum.com.au/dignity-of-risk-the-right-to-self-governance-for-people-with-mental-illness/>

(Another easily accessible document which reiterates what people diagnosed with mental illness have been saying for a very long time. People deserve the right to take risks. People deserve the right to make mistakes. People deserve the right to explore themselves and the world just like anyone else. How else will they learn and grow as people? This means that families, services, clinicians and authorities have to change too. "Every endeavour has an element of risk, and every opportunity for growth carries with it the potential for failure. All people learn through a process of trial and error; often learning as much from their mistakes as from their successes.")

4.

Ferocious
Services:
Tame Them

4. Ferocious Services: Tame Them

ASSAULTIVE PLACES

A patient was sexually and physically assaulted in an acute unit by another patient. When she wrote a letter of complaint she was told that the assaults were due to the fact that the hospital was situated in a growth corridor and could not keep up with demand for beds. The link between overcrowding and violence is perhaps a true one, but the lack of services does not seem to be the patient's fault and assaults are wrong.

WHAT SCARES CROWS

Accepted wisdom suggests people leave psychiatric hospitals with long-term adverse effects due to the severity of their symptom. Some consumers ask: "Who conducted this research?" Our analysis is that – possibly - the long-term deleterious consequences are a product of the way we were treated in the service unit and the iatrogenic trauma we experienced there.

GOOD GRIEF!

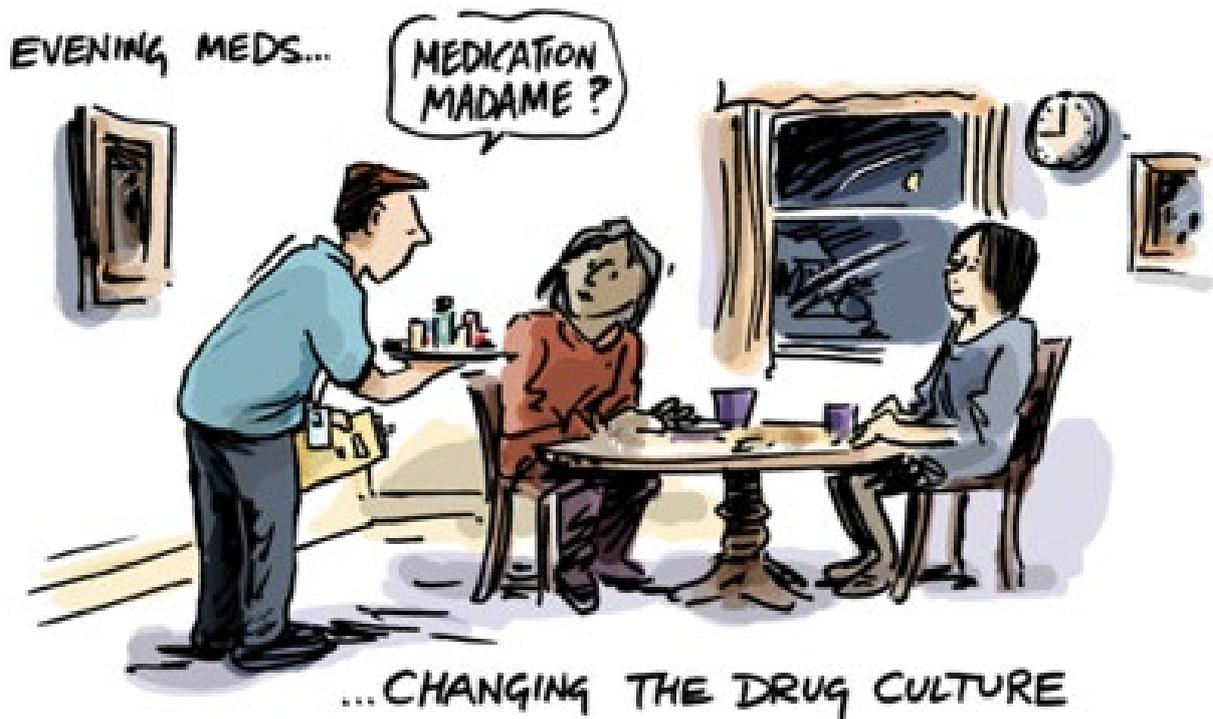
Well, bad grief actually. Services often take away opportunities for self-determination and rob us of our lives. We lose confidence, become scared of autonomy, lock ourselves inside and lose hope for life or we get really angry and reinforce for staff the mythology that already surrounds us: a tiny fragile bird or a snake hissing. In both cases we are usually scared and powerless and not our true selves. Of course we grieve the loss of self.

WE HAVE TO DO IT

Clinicians say: "people say thank you after they are no longer locked up in hospital against their will". They are very grateful; however, for every person who says 'thank you' another three run away (hoping never to return) and another two are put on a Community Treatment Order and they are usually not very thankful at all.

TRIESTE

Services can run without so much fear; Trieste, Italy, has been marketed as exemplary. Even ignoring the hype, the regional centre of Trieste continues to set an example. Led by pioneering psychiatrist, the late Franco Basaglia, Trieste has become a model of how psychiatric services might be less driven by crisis, less punitive, more holistic, and an essential part of the city's sense of identity rather than shame.



A WIKIPEDIA ENTRY TO MADNESS

1. ABUSE: https://en.wikipedia.org/wiki/Abuse#Medical_abuse
2. ASSAULT: <https://en.wikipedia.org/wiki/Assault>
3. BASAGLIA LAW: https://en.wikipedia.org/wiki/Basaglia_Law
4. CONFLICT RESOLUTION: https://en.wikipedia.org/wiki/Conflict_resolution
5. DEMOCRATIC PSYCHIATRY: https://en.wikipedia.org/wiki/Democratic_Psychiatry
6. DUE PROCESS: https://en.wikipedia.org/wiki/Due_process
7. HEALTH COMPLAINTS COMMISSIONER: <https://hcc.vic.gov.au/>
8. HEALTHCARE IN AUSTRALIA: https://en.wikipedia.org/wiki/Health_care_in_Australia
9. HEALTH PROVIDERS WATCHDOG: <http://www.theage.com.au/victoria/watchdog-with-teeth-to-name-shame-and-ban-dodgy-health-providers-20170131-gu25eq.html>
10. IATROGENESIS: <https://en.wikipedia.org/wiki/Iatrogenesis>
11. INDEPENDENT MENTAL HEALTH ADVOCACY: <https://www.legalaid.vic.gov.au/about-us/what-we-do/independent-mental-health-advocacy>
12. INSTITUTIONAL ABUSE: https://en.wikipedia.org/wiki/Institutional_abuse

13. MEDIATION: <https://en.wikipedia.org/wiki/Mediation>
14. MEDICAL ABUSE: https://en.wikipedia.org/wiki/Professional_abuse
15. MEDICAL SCHOOLS AND WIKIPEDIA: http://journals.lww.com/academicmedicine/Fulltext/2017/02000/Why_Medical_Schools_Should_Embrace_Wikipedia_.22.aspx
16. MEDICAL STUDENTS PSYCHIATRY: <http://theconversation.com/stigma-about-mental-illness-steers-medical-students-away-from-psychiatry-34298>
17. MEDICARE REBATES FOR PSYCHOLOGY (Australian Psychological Society): https://www.psychology.org.au/medicare/fact_sheet/
18. MEDICARE: [https://en.wikipedia.org/wiki/Medicare_\(Australia\)#Medicare_levy](https://en.wikipedia.org/wiki/Medicare_(Australia)#Medicare_levy)
19. MENTAL HEALTH INEQUALITY: https://en.wikipedia.org/wiki/Mental_Health_Inequality
20. NEGOTIATION: <https://en.wikipedia.org/wiki/Negotiation>
21. PATIENT ABUSE: https://en.wikipedia.org/wiki/Patient_abuse
22. PATIENT-INITIATED VIOLENCE: https://en.wikipedia.org/wiki/Patient-initiated_violence
23. PHYSICAL ABUSE: https://en.wikipedia.org/wiki/Physical_abuse
24. ITALIAN PSYCHIATRIC REFORM: https://en.wikipedia.org/wiki/Psychiatric_reform_in_Italy
25. SEXUAL ASSAULT: https://en.wikipedia.org/wiki/Sexual_assault
26. AUSTRALIAN PSYCHOLOGICAL SOCIETY: https://en.wikipedia.org/wiki/Talk%3AAustralian_Psychological_Society
27. THE MENTAL HEALTH LEGAL CENTRE: http://www.communitylaw.org.au/clc_mentalhealth/cb_pages/the_legal_centre.php
28. TRIESTE (ITALY): <https://en.wikipedia.org/wiki/Trieste>
29. VICTORIAN MENTAL HEALTH COMPLAINTS COMMISSIONER: <http://www.mhcc.vic.gov.au/>
30. WORKPLACE SAFETY IN HEALTHCARE: https://en.wikipedia.org/wiki/Workplace_safety_in_healthcare_settings



ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Mental Illness as Metaphor, The Political Uses of Psychiatric Labels: The psychiatrisation of political differences, Psychology Today, July 27th 2017 <https://www.psychologytoday.com/blog/mental-illness-metaphor/201707/the-political-uses-psychiatric-labels>

(This is an addition to conversations about diagnosis, diagnosing and force. It starts with reference to the 'Goldwater Rule' which enshrines the principles of medical ethics, stating it is unethical for psychiatrists to give a professional opinion about public figures they have not examined in person, and from whom they have not obtained consent to discuss their mental health in public statements. The article look at the work of Thomas Szasz https://simple.wikipedia.org/wiki/Thomas_Szasz. Unlike physicians from other specialties, psychiatrists - and, by extension, nonmedical mental health professionals like psychologists and social workers - occupy a unique position at the interface of medicine and the legal system and wield a great deal of power to treat their patients coercively. This is not accidental; it highlights psychiatry as an agent of social control. In the Soviet Union dissidents were 'en masse' labelled as having 'creeping schizophrenia and dealt with by the state. There is no such thing as 'creeping schizophrenia'. This paper ends with a warning note about using the DSM and other instruments to diagnose those with whom we have differing politics or don't like. Like most of the contributions from Psychology Today this piece is very readable and has links to important concepts and events.)

2.

Poulsen B. Revisiting the Myth of Mental Illness and Thomas Szasz: Avoiding the pitfalls of social control and radical libertarianism, *Psychology Today*, September 12th 2012 <https://www.psychologytoday.com/blog/reality-play/201209/revisiting-the-myth-mental-illness-and-thomas-szasz>

(This article starts with a quote from Thomas Szasz: In the animal kingdom, the rule is, eat or be eaten; in the human kingdom, define or be defined. Thomas Szasz died in 2012 at the age of 92. His 1961 book, The Myth of Mental Illness, was famous and both loved and hated. He was seen as a radical and libertarian. He fought against the use of force, the role of psychotropic medications to control people and many psychiatric institutions. He saw diagnostic systems and the medicalisation of morality in a critical light. It is argued by many that Szasz (the libertarian) went far too far. This paper looks at the argument for and against Szasz's political, moral and ethical positions. It suggests that it is advisable to try and steer a middle path. Like above, this piece is very readable offering links to important concepts and events.)

3.

MIND (England). What is Complex Post Traumatic Stress Disorder? [https://en.wikipedia.org/wiki/Dissociation_\(psychology\)](https://en.wikipedia.org/wiki/Dissociation_(psychology))

(This is an introduction. Complex Post Traumatic Stress Disorder originates with childhood trauma and re-presents itself in adults in different ways, including dissociation [https://en.wikipedia.org/wiki/Dissociation_\(psychology\)](https://en.wikipedia.org/wiki/Dissociation_(psychology)) and other symptoms similar to Borderline Personality Disorder. Many clinicians don't know or understand Complex PTSD and because of this, Borderline is over-diagnosed. Borderline is a diagnosis that attracts prejudice, anger and abuse in services. When this happens to people carrying the scars of childhood trauma, service refusal, service control, even service anger and contempt are experienced as re-triggering and violent. People (usually women) can experience both borderline and complex post-traumatic stress disorder. Public adult services are under-equipped and sometimes ongoing (intense) psychotherapy is needed. This is a respectful article. The issue that some consumers might have to contend with is a suggestion that one must have experienced the very worst childhood trauma and abuse in order to justify this diagnosis. This is not true; however, just reading it will re-trigger people, which is not fair. It is also descriptive and has some advice. It will be a relief to many people who have been diagnosed with borderline. Naming complex post-traumatic stress disorder, as a diagnosis, will hopefully guide acute services to behave responsibly with people who have, in essence, been traumatised twice. For a more clinician focussed (perhaps less empathetic) analysis, see Cloitre M. et al: Distinguishing PTSD, Complex PTSD and Borderline Personality Disorder: A latent class analysis <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4165723/>. It might be useful but it is technical, and, more importantly, it still clouds all this discussion with the overt judgement that surrounds borderline. It leaves the reader with an important question: is this debate trying to produce a better class of borderline, one which somehow deserves more respect from services? Check it out.)

4.

Lantta, T. et al Violent events, ward climate and ideas for violence prevention among nurses in psychiatric wards: a focus group study; *International Journal of Mental Health Systems* 2016 10(27) <https://ijmhs.biomedcentral.com/articles/10.1186/s13033-016-0059-5>

(Patient violence against nurses in their work environments is a widespread global concern, particularly in the field of mental health care. A high prevalence of violent events has an impact on the well-being of nurses and may also impair overall ward climate. However, it has been proposed that nurses use limited techniques to prevent patient violence and, therefore, more comprehensive methods for dealing with patient violence are needed. This study aimed to explore nurses' experiences of violent events in psychiatric wards, give insight into ward climates and examine suggestions for violence prevention. This study followed a descriptive, exploratory design using focus groups. There are some really interesting quotes from nurses about the way they see things. There is a commentary about nurse cynicism and how certain nurse behaviors and reactions can become habituated. The study found that psychiatric nursing education (and nursing practice) offered a limited pallet of suggestions as to how to cope with violence. The nurses in this study avoided saying they were afraid. They talked about de-escalation but with no clear understanding of what this might mean. A Finnish study cited argued that de-escalation as it is now understood had limited effect. This study looked at ward climate in relation to violence, but the needs and preferences of an individual patient in both prevention and management of violent events were hardly discussed by the nurses. Nurses may act based on given organizational instructions and customs, regardless of a patient's individual needs but patients rarely (if ever) being asked. The study concluded that, 'new tools are needed to relieve the overburdening of wards and climates of cynicism... De-escalation training programs should focus less on skills of physical restraint and more on competent interactions respecting patients' perspectives.)

5.

Goulet M. & Larue C. Post-Seclusion and/or Restraint Review in Psychiatry: A Scoping Review; Archives of Psychiatric Nursing Vol 30(1) Feb 2016:120-128 <https://www.sciencedirect.com/science/article/pii/S0883941715001934>

(This is technical. It is also interesting and it is available on line in full. The purpose is to analyse the literature around Post Seclusion and Restraint Review (PSRR). Overall the evidence is insufficient and contradictory. The authors note that there is considerable history of debate about what works and what does not "... reference to the notion of debriefing in psychiatry and psychology immediately conjures up the harsh criticism leveled in this regard in the Cochrane analysis (Rose et al., 2009). This vociferous debate in the scientific community and the accretion of new dimensions are likely the reason so many and such conceptually vague terms are used to refer to the various forms of intervention conducted after the seclusion of psychiatric inpatients." The scoping review revealed that there are numerous forms of PSRR. The authors propose a "typology based on the target of the intervention, that is, whether it is focused on the patient, the treatment team, or both." They conclude: "When the issue of SR [seclusion and restraint] is approached in a holistic fashion, when the interaction between clinician and patient is placed at the centre of therapeutic care, it is evident that any proposed solutions must involve both patients and care providers, especially nurses.")

6.

Goulet M. et al Evaluation of seclusion and restraint reduction programs in mental health: A systematic review; Aggression and Violent Behavior, Vol 34, May 2017: 139-146 <https://www.sciencedirect.com/science/article/pii/S1359178917300320>

(This paper will cost you money if you're not affiliated with a university or a health organisation; perhaps affordable. It is a specialist paper for people who have an interest in public psychiatry, restraint and seclusion policy and practice. It is a recent (2017) review of the literature on this subject. The three key conclusions the authors have reached:

- *Six key elements are predominant in seclusion and restraint reduction programs*
- *Leadership is core element of seclusion and restraint reduction programs*
- *Seclusion and restraint reduction programs enhance the quality and safety of care.)*

7.

Slemon A., Jenkins E. & Bungay V. Safety in Psychiatric Inpatient care: The impact of risk management culture on mental health nursing culture; *Nursing Inquiry*, Vol 24 (4) October 2017 <http://onlinelibrary.wiley.com/doi/10.1111/nin.12199/full>

(This paper is free on line. It's a report on research undertaken by researchers interested in the discourse of safety in acute psychiatric units and how the subtexts in this discourse influence practices which are ineffective. It's an interesting and relatively non-techno-jargon read. It is referenced widely offering extra opportunities to pursue the issues raised. The authors postulate five taken-for-granted assumptions around safety that need exploration:

Constant Supervision. This is a taken for granted, usually non-problematized part of patient 'care'. The authors posit that constant observation can be a deterrent to safety because of the understandable angst about loss of privacy, disempowerment and the cloying surveillance leading to a feeling of incarceration – something that some patients understandably react to. They conclude: "This practice, though widespread in its use, is unsupported by a substantive evidence base demonstrating efficacy in preventing suicides and can be conceived of as unethical in its harmful impact on the patients it is intended to protect."

Risk to Others. Seclusion and restraint continue to be a common course of action despite international attempts to restrain the use of it. Looking at the available material this paper suggests that the primary cause of violence is patient-staff conflict. The practice of seclusion makes this worse. The authors write: "that the line between necessity and convenience is frequently blurred and that seclusion is often utilized outside of its construction as a "necessary" intervention for upholding safety."

Risk to the public: absconding and door-locking. There is a long history of locking people up because the public is frightened. Multiple research studies report no evidence that door locking reduces absconding. These authors make the point that there are sometimes necessary or sensible reasons for 'absconding' but these are badly understood and rarely treated sensibly by staff. These include fear, boredom, lack of privacy and concerns surrounding responsibilities at home.

The hyperfocus on risk management and prevention obscures the complexity of causes of absconding from psychiatric inpatient units: rates of absconding are significantly higher on units that aren't working properly. While door locking continues to be upheld as a necessary safety measure for protecting the public, the practice is ineffective and contributes to dehumanizing and indeed less safe care environments.

Risk to professional responsibility. Psychiatric nursing happens within a macro climate of public liability and threat. Some nurses (like some doctors) are scared about how society's

agencies will treat them if something goes wrong. Hence, defensive practice that makes patients (and nurses) less safe. "... nurses described the difficulty of weighing a patient's therapeutic needs against the pervasive "potential for blame in the organizational culture of risk management.")

8.

Manhous C.A. Labor unions in medicine: the intersection of patient advocacy and self-advocacy; Med Care 2014 May 52(5): 387-92 <https://www.ncbi.nlm.nih.gov/pubmed/24709850>

(Medical groups have unions. Doctors' unions claim not to be unions but rather associations who lobby governments and advocate for 'their' patients (clients) and the needs of both sick people and the sector. Groups with less power, nurses for example, organise in more formal ways. For all these groups there is a tension between organising for their own rights and perceived civic duty. Sometimes this is solved by associations of clinicians refusing to recognise their self-interest. The authors conclude: "Although labor unions have been a means of counterbalancing unchecked discretion of corporate management, conventional labor unions may run afoul of medical ethical principles. Reconsideration and innovation, to address this ethical dilemma, could provide a solution that aligns both clinicians' and patients' welfare.")

9.

Portacolong E. et al A Tale of Two Cities: The Exploration of the Trieste Public Psychiatry Model in San Francisco, Culture Medicine and Psychiatry; May 2015 <https://www.ncbi.nlm.nih.gov/pubmed/25998781>

(The Trieste model is one of the most famous and most libertarian in the world, applauded by the World Health Organisation. The movement towards change in Italy was inspired and led by an Italian psychiatrist, Franco Basaglia. In this model, the degree of force is reduced to a minimum and the amount of choice is heightened. The acute hospital is relatively unimportant and community is central and well supported. This paper describes an attempt to reproduce the Trieste model in the USA; San Francisco, California. This process revealed a number of obstacles to such a translation; cultural, societal, theoretical and historical.)

10.

Tucker I "This is for Life": A Discursive Analysis of the Dilemmas of Constructing Diagnostic Identities in Qualitative Research Vol. 10(3) Art. 24 – September 2009 <http://www.qualitative-research.net/index.php/fqs/article/view/1376/2872>

(Basaglia was a psychiatrist and a health administrator. He was radical and an important reformer. His most famous work was done in the Italian city and region of Trieste. Although many in the west talk about the Trieste model with some awe, few people know about the crucial role played by Basaglia, who was determined not only to dismantle the huge asylums of the past but to create communities where mutuality, reciprocity, choice and 'lives worth living' would replace forced treatment, bound bodies, isolation from the community and low expectations. This article provides a short introduction to the life and work of Basaglia who is little known and often misunderstood

in the English-speaking world. "This article will seek to address this by highlighting Basaglia's significant role in the struggle for both deinstitutionalisation and the human rights of those incarcerated in Italy's asylums during the 1960s and 1970s.")

11.

Do the right thing: how to judge a good ward: Ten standards for adult in-patient mental healthcare June 2011 http://www.rcpsych.ac.uk/pdf/OP79_forweb.pdf

(This is a position paper put out by the Royal College of Psychiatry in London in 2011. The full text is available. Here is a good start to 'taming' services. We need to know what we want when they are tamed. Their ten areas of concern are:

- Bed occupancy rates of 85% or less;
- Ward size maximum of 18 beds;
- A physical environment that is fit for purpose;
- The ward is a therapeutic space;
- Proportionate respectful approach to risk and safety;
- Information-sharing and involvement in care planning;
- A recovery-based approach: Links with the community and other agencies;
- Access to psychological interventions;
- Personalised care: Staffing and daily one to one contact;
- Providing socially and culturally sensitive care.

Each of these is discussed in depth. Reading the document I wondered what psych. nurses would think of it given that they are on the front line. Also, how to get the resources to do this as doctor bodies in psychiatry haven't proved to be particularly effective lobbyists.)



5.

Flowers -
Just
Fripperies?

5. Flowers - Just Fripperies?

FLOWERS AS MISSILES

Nobody gives flowers in public psychiatric hospitals. Flowers are perhaps the symbolic difference between physical and mental illness interventions. In many public mental illness settings, they are simply 'projectile potential' and confiscated. If there is an amnesty, staff have to nip next door for a urinal to put them in.

BEST IN SHOW

Perhaps the more humble the flower, the more healing the gift. Many private hospitals have huge displays in the foyer shop - these are there to impress funding and hospital registration bodies. They may be an institutional response to collective fear.

FLOWERS SPEAK

When lonely, some of us can share our lives with flowers in the same way we do with pets. They are our community. We nurture them as we sometimes struggle to nurture ourselves. When they die, as they will, we do not die. We pick another and put it in a vase. In the old days, we were surrounded by a paddock: plants, grass, flowers, meandering walking places and trees to hug. They called it an institution.

METAPHORICALLY SPEAKING

The cycle of plants is a metaphor for life – life that we sometimes struggle to live. In our society, cultural meanings have entered our language: 'children blossoming' and pregnant women having a 'rosy glow,' for example. There seems to be little beauty in psych. hospitals. Could a simple flower help or is this naïve?

DISSSENT BY FLOWERS

When there's nowhere to put flowers in a public psychiatric unit, getting friends to send more of them is empowering. It is the cumulative effect which leads to staff being forced into a flower defence position as the nurses' station fills up. Bulk flowers create a critical mass of dissent. It's hard (but possible, we acknowledge!) to admonish a flower when there are many other flowers watching.



A WIKIPEDIA ENTRY TO MADNESS

1. YOU DON'T BRING ME FLOWERS ANYMORE' <http://www.nhs.uk/news/2009/12December/Pages/Hospital-flowers-not-harmful.aspx>
2. CHAIN STORE RIP-OFF IN OUR HOSPITALS: <https://www.theguardian.com/commentisfree/2015/aug/28/hospital-phone-television-charges>
3. DEEP ECOLOGY: https://en.wikipedia.org/wiki/Deep_ecology
4. DIVERSIONAL THERAPY: https://en.wikipedia.org/wiki/Diversional_therapy
5. DO BLOOMS SPREAD GERMS? <http://www.dailymail.co.uk/news/article-2591250/Flowers-ccccccccccccccccban-9-10-hospitals-concerns-blooms-spread-germs.html>
6. ETYMOLOGY: <https://en.wikipedia.org/wiki/Etymology>
7. FLOWER CHILD: https://en.wikipedia.org/wiki/Flower_child
8. FLOWERS IN MYTHOLOGY: <http://www.mythencyclopedia.com/Fi-Go/Flowers-in-Mythology.html>
9. FRESH CUT FLOWERS. HOW TO MAKE THEM LAST: <http://www.goodhousekeeping.com/home/gardening/advice/a19818/mistakes-cut-flowers/>
10. GARDENING LEAVE (CHARITY): [https://en.wikipedia.org/wiki/Gardening_Leave_\(charity\)](https://en.wikipedia.org/wiki/Gardening_Leave_(charity))
11. GIFTS IN PSYCHOTHERAPY AND COUNSELLING: <http://www.zurinstitute.com/giftsintherapy.html>
12. HEALING ENVIRONMENT: https://en.wikipedia.org/wiki/Healing_environments
13. HERBALISM: <https://en.wikipedia.org/wiki/Herbalism>

14. HORTICULTURAL THERAPY: https://en.wikipedia.org/wiki/Horticultural_therapy
15. LANGUAGE OF FLOWERS: https://en.wikipedia.org/wiki/Language_of_flowers
16. MEANING (EXISTENTIAL): [https://en.wikipedia.org/wiki/Meaning_\(existential\)](https://en.wikipedia.org/wiki/Meaning_(existential))
17. METAPHOR: <https://en.wikipedia.org/wiki/Metaphor>
18. NO FLOWERS IN THE PSYCH. WARD: <https://www.theatlantic.com/health/archive/2012/11/no-flowers-on-the-psych-ward/264923/>
19. NOSEGAY: <https://en.wikipedia.org/wiki/Nosegay>
20. PARABLE: <https://en.wikipedia.org/wiki/Parable>
21. PLANT SYMBOLISM: https://en.wikipedia.org/wiki/Plant_symbolism
22. PSYCH HOSPITAL RULES & WHAT TO BRING/NOT BRING: <http://keepupthefight.tumblr.com/post/125225465379/psych-hospital-rules-what-to-bring-not-to-bring>
23. SAINT-PAUL ASYLUM, SAINT-RÉMY (VAN GOGH SERIES): [https://en.wikipedia.org/wiki/Saint-Paul_Asyllum,_Saint-R%C3%A9my_\(Van_Gogh_series\)](https://en.wikipedia.org/wiki/Saint-Paul_Asyllum,_Saint-R%C3%A9my_(Van_Gogh_series))
24. SYMBOLIC REPRESENTATION: https://en.wikipedia.org/wiki/Symbolic_representation
25. THE HISTORIC STORY OF GIVING FLOWERS: <http://intuitivemeaning.com/2010/07/the-historic-story-of-giving-flowers/>
26. THE RETREAT: https://en.wikipedia.org/wiki/The_Retreat
27. THERAPEUTIC GARDEN: https://en.wikipedia.org/wiki/Therapeutic_garden
28. TIPS FOR CHOSING GET-WELL FLOWERS: <http://www.proflowers.com/blog/tips-for-choosing-get-well-flowers-for>
29. WHAT TO SEND A FRIEND IN A PSYCHIATRIC HOSPITAL: <https://alphamom.com/your-life/life-relationships/smackdown-gift-guide-what-to-send-a-friend-in-the-mental-hospital/>
30. WHITE FLOWERS: <http://www.flowermeaning.com/white-flowers/>



ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Rachel A. & Borofsky H.A. No Flowers in the Psych Ward; The Atlantic Nov 8th 2012
<https://www.theatlantic.com/health/archive/2012/11/no-flowers-on-the-psych-ward/264923/>

(This is an interesting short piece by a clinician working in a locked ward in the criminal justice system. "Perhaps I was naïve to think that healing was the intention, but on the ward, I find only its absence. The hospital functions as a holding cell for people not safe on the streets and not safe in jail. People rotate through. One of the regulars, an African-American man who whistles loudly tells me, "I was born in a zoo, and I'll die in a zoo." I tell myself otherwise, but it's hard not to feel like a zookeeper." ... Psychiatric hospitals have no flowers. Visitors do not bring them. They usually bring toothpaste, deodorant and underwear. I ask my supervisor if I can bring leftover flowers from the shop. "Glass vases," he shakes his head. I find plastic vases and sneak in de-thorned pink roses. A patient asks, "Can I give one to my girl?" The next day, the flowers and plastic vases vanish.)

2.

Conellan K. et al GARDENS OF THE MIND nature power and design for mental health, Diversity and Unity, Flinders University http://www.academia.edu/1375232/GARDENS_OF_THE_MIND_nature_power_and_design_for_mental_health

(It is always refreshing when you come across material that seems to be written from left field. This piece comes from a faculty of architecture and design. The purpose of the work (which comes from Britain) is to describe an acute unit in South Australia which is experimenting with incorporating good garden design into the unit. It's fascinating. The authors are addressing acute units, which is novel and interesting: "We situate the discussion within the context of contemporary debates. We also bear historical examples in mind, especially in relation to power relationships that are designed into spaces. However our focus is the contemporary purpose-built mental health unit." It's a shame that this article is not available in full to lay people who can't afford to pay for it.)

3.

Hickman C. Cheerful prospects and tranquil restoration: the visual experience of landscape as part of the therapeutic regime of the British asylum 1800-60; History of Psychiatry 2009 vol20(4) 425-441 <http://journals.sagepub.com/doi/abs/10.1177/0957154X08338335>

(This is not available in full text unless you have access to a tertiary institution or are associated with an organisation that can purchase the document. The authors contend that many historians have studied the big institutions of the 19th and 20th Century with criticism. However one consistent advantage has been recognised: the land surrounding the buildings. They note that generally the advantages have been described in active terms: the opportunity for productive work (manual), exercise and other recreational activities. None of these are easily possible within contemporary psychiatric acute units. The authors in this article look at passive advantages and passive therapeutic opportunities of these grounds: the beauty and expanse of the grounds themselves just to sit in and be with. The

grounds (with their flowers and trees and hedgerows and insects and the rural scene and sometimes small animals) were on their own, without any intervention, therapeutic without the need for clinical intervention. This was a therapeutic design that has been much maligned (big bin on the hill) but here it is argued that this has advantages not enjoyed in contemporary mental health acute units.)

4.

Epstein M This is Not Catharsis. My Time in HDU, Health Issues Centre 2011, <http://healthissuescentre.org.au/images/uploads/resources/This-is-not-about-catharsis-my-time-in-high-dependency-unit.pdf>

(In this paper (written in 2011), I describe a three week admission to the Mercy Hospital in Werribee where I ended up in High Dependency. The experience exercised my senses most of the time. Most of these were bad ones. It was also barren and cold and angry and unkind. It was lonely and, at times, frightening. For me, the absence of flowers is a powerful metaphor. Flowers smell nice (usually) and are soft and delicate and kind. Flowers mean the opposite of what I was then experiencing. The fact that people are afraid of flowers saddens me so much. It seems the ultimate foreboding of these places. Maybe it's a reality that the harsh environment with violence, ill-tempered staff and the assumption that people don't deserve small indulgences means that my flower dream will never eventuate. In the end, the staff with whom I was able to relate were the ones who helped me rescue my flowers.)

5.

Collins J. et al Lost landscapes of healing: the decline of therapeutic mental health landscapes; Landscape Research; vol. 41 (6) <http://www.tandfonline.com/doi/abs/10.1080/01426397.2016.1197192?journalCode=clar20>

(An interesting paper that is only available for purchase if you are not affiliated with a university or an organisation that is registered. This is a pity because it is another interesting article about the loss of landscape in the middle- to end-20th Century as deinstitutionalisation and governments keen to sell off the real-estate of the old institutions replaced them with mainstreamed, isolated, mental health units, subscribing heavily to the medical model. This looks at the demise of therapeutic landscapes with their flowers, trees, rural land, grass to lie on, ants to study, bees to concern one. "Through the conceptual framework of therapeutic landscapes, this article explores this nexus with a focus on changes which transpired during this period eventuating in the demise of institutional landscapes for mental illness.")

6.

Wiener A. et al "You don't give me flowers anymore": an analysis of gift-giving to medical and psychiatric inpatients Social Psychiatry and Psychiatric Epidemiology, April 1999, Vo 34(3):136-140 <https://link.springer.com/article/10.1007/s001270050124>

(This paper sought to investigate the gift-giving attitudes and behaviour of family and friends to relatives in psychiatric hospitals compared to family and friends in psychiatric hospital. This is a different emphasis than the work looking at differences in the way

physical and psychiatric hospitals receive gifts for patients. This was a research project. It is interesting to think about the symbolism of the words in the beautiful love song in the title ('You don't bring me flowers anymore' with Neil Diamond and Barbara Streisand <https://www.youtube.com/watch?v=450Unsb5BCw>), reminding me also of the other song, 'He used to give me roses' which was the theme song for the 1970s hit soapie 'Prisoner' – an anthem to incarceration which is very much relevant to this paper (Lynne Hamilton https://www.youtube.com/watch?v=vAUTaL_HBfM). This research found that there are differences in the attitudes of family and friends towards gift-giving amongst friends and family of people with mental illness in acute settings: "The results suggested that during hospital admissions, the behaviour of relatives and friends of mentally ill patients is rejecting. The authors suggest that more education for relatives may help to improve this picture." This is a 1999 paper so there may be differences now. I could not find a replication...pity!

7.

Chow W.S. & Priebe S. Understanding psychiatric institutionalisation: a conceptual review; BMC Psychiatry 2013:169 <https://bmcp psychiatry.biomedcentral.com/articles/10.1186/1471-244X-13-169>

(This is a classic. Great cartoons and raises the issues about diagnoses simply and informally. If you haven't seen it, have a look.) (This paper is available on line for free. It is a comprehensive review of the literature on institutionalisation and is an attempt to understand issues related to being institutionalised. It differs from much of the work in this area with its concentration on institutionalisation and not deinstitutionalisation. It is well signposted with clear headings, making it a bit easier to read. The research team argue that there are four underlying concepts of institutionalization:

- bricks and mortar of care institutions;
- policy and legal framework;
- clinical responsibility and paternalism in the clinician-patient relationship; and
- patients' adaptive behaviour to institutionalised care.)

8.

Spain E. Healing Plants Inspire New Compounds for Plants for Psychiatric Drugs – Scientists look in Nigeria to develop better therapies for mental disorders; North Western Now, May 11th 2015 <https://news.northwestern.edu/stories/2015/05/healing-plants-inspire-new-compounds-for-psychiatric-drugs>

(This is a small piece that is indicative of how learning sometimes originates from the way that peoples around the world have used plants for centuries. In this case, it's a specific region of Nigeria. There is hope that plants used here might be developed into new medications for people living with schizophrenia and bipolar. As you read it, you just have to hope like mad that the drug companies aren't ripping of the centuries-learnt insights and capabilities of the Nigerian villagers. It is horrible if they are. I don't know. Nonetheless, the role of plants here is also important.)

9.

Kinda P.T. et al Medicinal Plants Used for Neuropsychiatric Disorders Treatment in the Hauts-Bassins Region of Burkina Faso; Medicines 2017, 4(32) file:///C:/Users/Merindz/Downloads/medicines-04-00032.pdf

(This study introduces real knowledge of neuropsychiatric disorders in the traditional medicine of the Hauts Bassins Region in Burkina Faso in Western Africa. This report is free and available on line. It is a report for budding scientists, as there is a lot of data, mostly presented in detail. Much of it is of complex (for me anyway) chemicals and compounds. It is also fascinating and you can jump the detail if you want to. This study made it possible to report 66 plant species belonging to 51 genera or alike groups and 32 families of plants which share attributes. They were all used in the local communities for the treatment of neuropsychiatric diseases. Roots and leaves were the most commonly used, usually mashed into a liquid and then processed into required consistency and with required strength. Medicines were swallowed. Plants identified were quoted to possess psychoactive properties and some chemical contents which could justify the conclusion of the report: "Traditional remedies suggested in this study are a real interest in the fight against neuropsychiatric disorders. Then, further researches will be necessary to identify psychoactive compounds from these plants and their acting mechanisms for neuropsychiatric diseases treatment." It's an interesting paper particularly for those who have a scientific bent and a fascination with biological/pharmaceutical interventions in psychiatry.)

10.

Detweiler M. et al What is the evidence to support the Use of Therapeutic Gardens for the Elderly? Psychiatric Investigation 2012 Jun; 9(2): 100 – 110 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3372556/>

(We are an aging society. With more people living longer, mental illness in the elderly will gain greater prominence. Dementia is already a major challenge. This paper looks at the role of therapeutic gardens in caring for older people, particularly those with dementia. This paper is an ambitious study of the literature and attempts to rigorously evaluate claims that have not, they say, been adequately tested. The therapeutic garden is specific and discrete. It is not a couple of plants here and there. It is not an indoor plant in the corner of the dining room. There are gardens and therapeutic greenhouses. One of the most important features is that therapeutic gardens need to mimic gardens, paths and grates that elderly people may have experienced when they were young and then at intervals through long lives. They are all about sensory experiences and work best when there are daily routines.)



6.



People, Profit
& Pretty
Pamphlets

6. People, Profit & Pretty Pamphlets

SILENCING DISSENT AND THE ROLE OF PROFIT

Few people talk about oppression and private psychiatric services; patients often know it, however. We searched in vain for resources to assist us in this. This is telling... when searching the web using words like 'power abuse', 'over-servicing', patient autonomy or 'intimidation' correlated with private hospitals, for example, searches came up empty. Everything led back to glossy pages advertising private hospitals. How could this be? Perhaps information in this marketplace is strongly controlled?

LEARNED HELPLESSNESS

It can happen to any of us. Being a vassal to medicine's power and being rewarded for it leaves some people unsure of their own agency and sometimes weak in the face of authority. This is not a 'fault' thing; it is about social control and medical dominance.

IN CONCERT WITH PRIVATE HEALTH INSURANCE COMPANIES

What a powerful combination! Insurance companies have a lot of power and influence in the private sector. Hospitals can only provide services the patient is covered for in their insurance. This may mean kicking a person out the minute their insurance cover runs out.

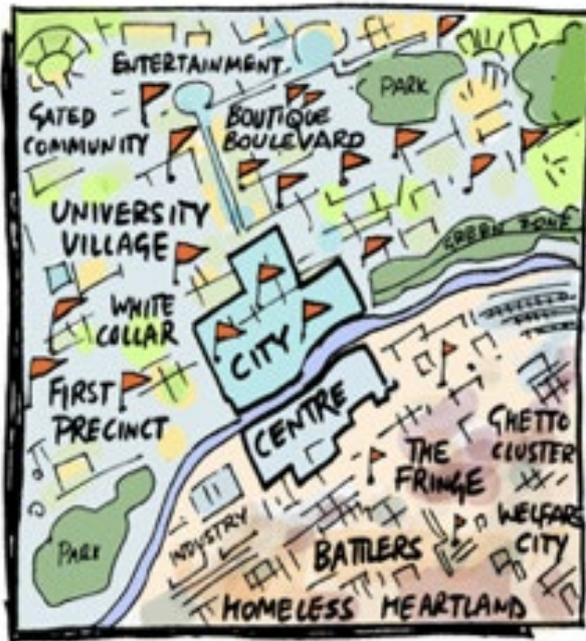
GROUPEES

In the public system, consumers get bored and testy when in hospital. There are often few programs. In the private sector there are, according to many consumers, too many 'therapeutic' interventions. Many patients find these unnecessary, paternalistic, potentially health assaulting and contrived. This is because they are contrived. Health Insurance companies insist on a patient attending a certain number of programs for the hospital to be paid.

ACTING OUT (OF HERE)

In private hospitals, the consequences of not complying are sometimes psychological fearmongering, shame, provocations, assaults on status, intimidation, infantilisation, threat of public exposure or threats to be removed and deposited in the locked wards of the public sector. People are often afraid; whether or not forced relocation is enacted is largely immaterial. The deep tragedy occurs when 'leaving hospital successfully' is perceived as needing to be formally taught to people in a program.

PSYCHIATRY : PRIVATE PRACTICE COUNTRYWIDE



PRIVATE PRACTICE

NATURAL HABITAT

UNIVERSAL COVERAGE

A WIKIPEDIA ENTRY TO MADNESS

1. ADHERENCE MANAGEMENT COACHING: https://en.wikipedia.org/wiki/Adherence_management_coaching
2. BETTER ACCESS TO MENTAL HEALTH CARE INITIATIVE: https://www.psychology.org.au/medicare/better_access/
3. BROCHURES (Private healthcare in Australia): <http://www.privatehealth.gov.au/footer/brochures.htm>
4. DOCTOR-PATIENT RELATIONSHIP: https://en.wikipedia.org/wiki/Doctor%E2%80%93patient_relationship
5. FOR-PROFIT HOSPITAL: https://en.wikipedia.org/wiki/For-profit_hospital
6. HUMAN CAPITAL FLIGHT: https://en.wikipedia.org/wiki/Human_capital_flight
7. IATROGENESIS: <https://en.wikipedia.org/wiki/Iatrogenesis>

8. INFORMED CONSENT: https://en.wikipedia.org/wiki/Informed_consent
9. INFORMED FINANCIAL CONSENT IN THE PRIVATE HEALTH SYSTEM: https://www.collaborateandlearn.hadsco.wa.gov.au/cal/Resource%20files/Report-Informed_Financial_Consent_in_the_Private_Health_System.pdf
10. JOANNA MONCRIEFF: https://en.wikipedia.org/wiki/Joanna_Moncrieff
11. LIST OF AUSTRALIAN PSYCHIATRIC INSTITUTIONS: https://en.wikipedia.org/wiki/List_of_Australian_psychiatric_institutions
12. LOOPHOLES FOR HEALTH INSURANCE (CHOICE): <https://www.choice.com.au/money/insurance/health/articles/mental-health-and-health-insurance>
13. MARKETING COLLATERAL: https://en.wikipedia.org/wiki/Marketing_collateral
14. MEDICAL INDEMNITY: https://en.wikipedia.org/wiki/Medical_indemnity
15. MEDICARE – A QUICK GUIDE: http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1617/Quick_Guides/Medicare
16. MEDICARE (Australia) [https://en.wikipedia.org/wiki/Medicare_\(Australia\)](https://en.wikipedia.org/wiki/Medicare_(Australia))
17. MEDICARE SERVICES: <https://www.humanservices.gov.au/customer/subjects/medicare-services>
18. MENTAL HEALTH TREATMENT AND PRIVATE HEALTH INSURANCE OMBUDSMAN: <http://www.ombudsman.gov.au/publications/brochures-and-fact-sheets/phio/mental-health-treatment-and-private-health-insurance>
19. PRIVATE HEALTH INSURANCE OMBUDSMAN: <http://www.ombudsman.gov.au/about/private-health-insurance>
20. OUTLINE OF PSYCHIATRY: https://en.wikipedia.org/wiki/Outline_of_psychiatry
21. OVER-MEDICATION: <https://en.wikipedia.org/wiki/Overmedication>
22. PAYING FOR MENTAL HEALTH CARE (SENATE): http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/c12
23. PHILOSOPHY OF HEALTHCARE: https://en.wikipedia.org/wiki/Philosophy_of_healthcare
24. MOTIVATIONAL INTERVIEWING: https://en.wikipedia.org/wiki/Motivational_interviewing
25. PRIVATE HEALTH INSURANCE POLICIES FOR PSYCHIATRIC CARE: https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-91-Private-Health-Insurance-policies-for-psychi.aspx
26. PRIVATE HEALTHY INSURANCE - ACCC: <https://www.accc.gov.au/consumers/health-home-car/private-health-insuranc>

27. PSYCHOLOGICAL ABUSE: https://en.wikipedia.org/wiki/Psychological_abuse

28. TWO-TIER HEALTHCARE: https://en.wikipedia.org/wiki/Two-tier_healthcare

29. UNECESSARY HEALTH CARE: https://en.wikipedia.org/wiki/Unnecessary_health_care

30. WHICH IS BETTER - PUBLIC OR PRIVATE HOSPITALS? <http://theconversation.com/which-are-better-public-or-private-hospitals-54338>



ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Quiggin J. Why can't our leaders learn from 30 years of failure in health and education? The Guardian (Australian edition) Friday 23rd September 2016 <https://www.theguardian.com/commentisfree/2016/sep/23/why-cant-our-leaders-learn-from-30-years-of-failure-in-health-and-education>

(Easy read, reputable media source, this article is a simple introduction to the arguments against increasing efforts to privatise essential services such as health and education. There are advocates of privatisation (sometimes blind privatisation); Quiggin is not one of them; he argues that those jockeying for a purely privatised economy use arguments like: "...if the profit motive works well in providing something as vital as food, it must work well everywhere." The latest instance of this blind faith, argues Quiggin, is the Australian Productivity Commission's call to privatise public health and housing. <https://www.theguardian.com/australia-news/2016/sep/22/productivity-commission-calls-to-privatise-public-health-and-housing>)

2.

Epstein M. Getting What You Need; The Company We Keep, Our Consumer Place, Chapter 3 pp 75-104 <http://www.ourcommunity.com.au/files/OCP/CompanyWeKeep.pdf>

(This is a very honest account from a consumer perspective about the difficulties in the mental health arena of trying to get what you need. Even if people have money to purchase services, this does not necessarily translate into effective 'shopping'. Many people are confused and hunting is extremely difficult when too little information is in the public domain.)

3.

Epstein M Troubleshooting - difficult decisions for patients seeing private clinicians; Our Consumer Place <http://www.ourcommunity.com.au/files/OCP/CompanyWeKeep.pdf>

(This is a consumer perspective account. The assumption that there is either 'choice' or 'no choice' in mental health services is challenged. Many people who may 'seem to have' choice can end up having to decide between 'bad' and 'dreadful' or getting caught up in insidious power games where they, as the 'relatively powerless', have to make decisions in uneven and very difficult situations.)

4.

Harley K. et al Constructing health consumers: Private health insurance discourse in Australia and the United Kingdom; 12th October 2010 <http://www.tandfonline.com/doi/abs/10.5172/hesr.2011.20.3.306>

(When we searched for a critical analysis of the private sector in mental health very many dead ends were reached. Almost every search led to ads for private health insurers or private hospitals. The role of capitalism not only in health care but also in control of information on the internet became apparent. This paper is not about psychiatry but it is about the privatisation of health care and about the creation of 'the private patient'. It is a comparative analysis between Australia and the United Kingdom and looks at the messages promulgated by the health insurance industry. The authors conclude "Our analysis highlights adoption by private health insurers of neoliberal discourses of choice and individual responsibility, partnership and healthy lifestyles. In these respects, similarities between the discourses over-ride national differences." For psychiatry, there is thus an emphasis on personal attributes (choice and responsibility) which are circumscribed by shame and which also provide fertile ground for adverse medical commentary. Political rhetoric is important, especially when it is potentially damaging.)

5.

Richardson J. Australia's 'unsustainable' health spending is a myth in The Conversation, May 12, 2014 <https://theconversation.com/australias-unsustainable-health-spending-is-a-myth-26393>

Richardson J.R. Can we sustain health spending? Medical Journal of Australia 2014; 200 (11): 629-631 <https://www.mja.com.au/journal/2014/200/11/can-we-sustain-health-spending>

(Political debate is fierce within (and beyond) the health sector. This is a primer and both articles by Richardson argue that Australia can sustain its health spending. There are those who disagree. These are short pieces but they underline some of the ideological schisms which divide advocates around health funding. There are more articles to be found:

- https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BriefingBook44p/FundingHealthCare
- <https://www.mja.com.au/journal/2014/200/11/can-we-sustain-health-spending>

Fundamental...? Point One: mental health doesn't get enough money compared to existing need. Other more 'sexy' areas of health do better. Why? <https://theconversation.com/mental-health-funding-in-the-2017-budget-is-too-little-unfair-and-lacks-a-coherent-strategy-77470>

Some important considerations: Most things which are described as facts in order to attract funding are actually opinions (research influence depends on many things some of which have less to do with research and more to do with politics). <https://www.economist.com/blogs/babbage/2012/11/qa-samuel-arbesman>

- *How ideology works:* https://en.wikipedia.org/wiki/List_of_political_ideologies
- *How political policies are 'sold' to us:* <https://theconversation.com/people-will-accept-unpopular-decisions-if-they-understand-the-need-turnbull-36994>
- *The historical context of neoliberalism:* <http://folk.uio.no/daget/neoliberalism.pdf>
- *Trickledown economics and its limitations:* <https://www.thebalance.com/trickle-down-economics-theory-effect-does-it-work-3305572>

These issues must also be understood within the context of industrial lobby groups; here are a few: The Australian Medical Association (AMA); Private Health Insurance Lobby; Private Hospitals; Pharmaceutical Companies. <https://blogs.crikey.com.au/croakey/2009/06/03/a-whos-who-of-lobbyists-in-health/>

Also, history is important, including:

- *The 1973 introduction of universal health cover by the Whitlam Government:* [https://en.wikipedia.org/wiki/Medicare_\(Australia\)](https://en.wikipedia.org/wiki/Medicare_(Australia))
- *The whittling down of this coverage incrementally usually by conservative governments:* https://b.domainstatic.com.au/w800-h533-2013277487_1_pi_161209_093009
- *Propping up public systems by money from private sector:* <http://www.theaustralian.com.au/national-affairs/health/private-health-insurance-propping-up-public-system/news-story/7549718353882d705a79daf0306a799c>
- *Propping up private health insurance agencies with taxpayers' money:* <https://www.theguardian.com/australia-news/2017/apr/20/propping-up-private-health-insurance-is-like-putting-lipstick-on-a-pig>
- *Also, the role of government in an Australia Federation where State and Federal Governments attempt to cost-shift by forcing their counterparts to foot a greater share of the 'burden':* https://ahha.asn.au/sites/default/files/docs/policy-issue/rotf_issues_paper_3_-_roles_and_responsibilities_in_health.pdf

https://b.domainstatic.com.au/w800-h533-2013277487_1_pi_161209_093009

For mental health there are some extra things to think about. Here are three of them.

The First National Mental Health Strategy and its ongoing legacy: http://www.health.wa.gov.au/mhpr/docs/Rhetoric_or_Reality_15years_of_mental_health.pdf

- Forced treatment is only carried by State and Territory Governments;
- There are economic complications where drug and alcohol services cross-over between sectors;
- Moving services into the community and the funding of the National Disability Insurance Scheme also fudge the boundaries.
- Cost shifting to jails: http://pubmedcentralcanada.ca/pmcc/articles/PMC1361075/pdf/hesr_00295.pdf)

6.

Menadue J. Propping up private health insurance is like putting lipstick on a pig. The Guardian (Australian edition) Thursday 20th April 2017 <https://www.theguardian.com/australia-news/2017/apr/20/propping-up-private-health-insurance-is-like-putting-lipstick-on-a-pig>

(See above for a more comprehensive analysis. This article looks at attempts to prop up the private health sector in Australia by using tax incentives. It is an interesting article with a great headline. The argument follows that propping up private health insurance is like throwing good money after bad.)

7.

Why seek a second opinion? Second Psychiatric Opinion Service; <https://www.secondopinion.org.au/about-us/>

(This is the closest the public sector really gets to a fancy pamphlet. The attempt is to write it in plain (or easy to read) English so that everyone gets a chance to understand. This is practical information about getting a second opinion in Victoria. It would be easy to think by the first paragraph that this is a service available for many when in fact it is a service available to very few:

On a Temporary Treatment Order or Treatment Order;

A security patient; or

A forensic patient.

There are also provisos such as the fact that the psychiatrist offering a second opinion cannot suggest an alternative diagnosis. This is clearly stated. This hesitancy of public sector advice material to be out there and honest about the limitations of their service in a way those not eligible are able to understand might be that nuance and multiple audiences gets lost in an attempt to use plain English especially in headings. There are similar descriptive limitations in some material put out by The Office of the Complaints Commissioner and Independent Mental Health Advocacy.)

8.

Epstein M. Our Consumer Place HOW MONEY (or lack of it) AFFECTS A CONSUMER'S CHOICES, <http://www.ourconsumerplace.com.au/consumer/article?id=5630>

(This piece is easy reading and raises issues that are relevant to consumers using private services. There are many traps for the unwary. The private sector in psychiatry is not easy to navigate. Because of very limited access to public services, many consumers are forced into the private sector even when they can't afford it. Many get into debt which puts additional strains on their mental health. Other adults rely on parents to pay for services and if there are demons from the past, this can be catastrophic. We know of one woman who is stealing money and couch surfing to pay for private health insurance because public services have refused pleas for help. Perhaps, private psychiatric hospitals are not geared for providing advice and support for options other than their own.)

9.

Better access to mental health care and the failure of the Medicare principle of universality; Medical Journal of Australia 2105; 202(4):190-194 <https://www.mja.com.au/journal/2015/202/4/better-access-mental-health-care-and-failure-medicare-principle-universality>

(Unfortunately this is one of those quality pieces of research that is not available freely to the public. Nonetheless it can be obtained through academic institutions and sometimes through mental health organisations. Expect graphs, numbers, boxes of data and sometimes complex analysis. This research is a detailed dissection of 'objective' data. Always with these types of documents, read the summary, the introduction and then the conclusion. Fill in the middle parts as needed. Once past the method, it is interesting but not surprising. Private (Medicare funded) mental services are mal-distributed with poor people and people in regional and remote areas being under-served. This is a 2105 publication by quality researchers so should be a useful resource for anyone wanting to make a case for redistribution of private practitioners. See this for a summary: <https://www.monash.edu/medicine/news/latest/2015-articles/huge-gaps-in-mental-health-care-study.html>)

10.

Sharma V. Those who need it most don't get psychiatric care. It's a mental health crisis. The Guardian (Australian edition) Thursday 7th December 2017 <https://www.theguardian.com/commentisfree/2017/dec/07/those-who-need-it-most-dont-get-psychiatric-care-its-a-mental-health-crisis>

(This is a short article by a Victorian psychiatrist. It looks at the crisis-driven nature of service delivery and the messages people get about the need to create crisis in order to be given priority. It's a commentary on an over-burdened system of health care but it is also a commentary on the criteria that are systematically applied to 'sift the chaff from the wheat' (my phraseology, not his). As a psychiatrist, he cannot say this. Where do we, as citizens of this state, look for answers to these multiple political and economic dilemmas in psychiatric care?)

11.

Australian Psychological Society: Code of Ethics <https://www.psychology.org.au/Assets/Files/APS-Code-of-Ethics.pdf>

Royal Australian and New Zealand College of Psychiatry: Code of Ethics https://www.ranzcp.org/Files/Resources/College_Statements/Practice_Guidelines/code_ethics_2010-pdf.aspx

- Babic A. (2015) *Ethical Dilemmas Experienced by Occupational Therapists Working in Private Practice*; Thesis submitted as a component of the Master of Occupational Therapy Program University of Sydney <https://ses.library.usyd.edu.au/bitstream/2123/14209/1/MOT%20Thesis%20A%20BABIC%2017%2012%202015.pdf>
- Nanasaheb J. *Dilemmas in Private Psychiatric Practice*; *Indian Psychological Medicine* 201; 33(2):149-152 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3271489/>

(Most written material on professional ethics seems to come from clinical psychology. Perhaps this is because interpersonal relationships in this field may more often be ethically challenging. Organisations representing clinical psychologists are also active. The emphasis tends to centre on the obvious types of ethical considerations such as confidentiality, boundaries, sexual relationships between client and psychologists, multiple relationships and more. Worth a read! It is good to know what we should expect of those we interact with. As a consumer, you can't help wondering what a list of ethical standards might look like if we wrote them. To start, with we probably wouldn't condone the use of the term 'termination' for mutually agreed conclusion of therapy sessions. I suspect we might also focus a bit more on power, misuse of power and the role of money and profit... Thinking about these issues is important. Whilst, as part of the organised consumer movement, we don't pay full attention to the private sector: seduction, control and potential disablement, we miss opportunities to make things better for many. Angela Babic's thesis gives insight from a slightly different perspective and, importantly, compares professional ethics within the public sector to professional ethics in private practice. It's interesting to compare the two codes from the peak bodies in psychiatry and psychology. They are similar, but again, the almost trivialisation of the profit motive as an ethical consideration is concerning. Power comes from knowledge but it also comes from uneven relationships and in this situation there are important questions about money changing hands.)

12.

Rosenberg S. Mental health funding in the 2017 budget is too little, unfair and lacks a coherent strategy, May 11, 2017 <https://theconversation.com/mental-health-funding-in-the-2017-budget-is-too-little-unfair-and-lacks-a-coherent-strategy-77470>

(Analysis of the most recent budget by a reputable commentator.)

13.

Australian Government - Australian Institute of Health and Welfare: Mental Health Services in Australia – last updated 12th December 2017 <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary/prevalence-and-policies>

(Every seven years the government contracts the Institute of Health and Welfare to

conduct two important surveys. One looks at issues to do with high prevalence illnesses, such as depression and anxiety, and another looks at low prevalence illnesses such as schizophrenia and psychosis. Knowledge is then gleaned to help develop future policy and how our taxes are spent. One of the problems with this process is that the methods used in the two surveys are completely different. There is a strange bias due to the fact that the low prevalence surveys are completed by people already utilising public services and therefore intake policy plays a major role. The bureau of statistics is involved with the high prevalence survey. There is an ethical issue, firstly because stigma means that people under-describe their experiences but also the Bureau of Statistics is very tuned in to the required length of such a survey. It is too long, so people switch off. However condensing it has a degree of arbitrariness in what gets included and what does not. There is a bias towards those experiences that have 'bigwig' clinicians who will fight for their inclusion, because they know this process will eventually attract dollars. From a consumer perspective, the problem is not so much that it is arbitrary but rather that everyone pretends it is not. It includes the latest figures from the Australian Institute of Health and Welfare.)

14.

Sweet M. The psychological backlash against Hickie and McGorry, Crikey November 30th 2011 <https://www.crikey.com.au/2011/11/30/mind-games-the-psychological-backlash-against-hickie-and-mcgorry/>

- Sweet M. *Mind Games: the long road travelled on mental health reform*, Crikey November 29th 2011 <https://www.crikey.com.au/2011/11/29/mind-games-the-long-road-travelled-on-mental-health-reform>
- Sweet M. *Mind Games: Better Access for some, but reforms put others offside*, Crikey, December 1st 2011 <https://www.crikey.com.au/2011/12/01/mind-games-better-access-for-some-but-reforms-put-others-offside/>
- Sweet M. *Mind Games: what are the lessons from the mental health minefield?* Crikey December 2nd 2011 <https://www.crikey.com.au/2011/12/02/mind-games-what-are-the-lessons-from-the-mental-health-minefield/>

(For anyone wanting to understand the debates in mental health funding policy in the most recent decade, here is a good place to start. Many of us have heard of Ian Hickie, Patrick McGorry and John Mendoza, but who are they really and what is their agenda - overt and hidden. Why the angst? What drives protagonists in reform and why are they targets for so much criticism? Melissa Sweet calls it a mental health mind-field and in these four articles she tries to tease out the issues that make them so. These are a bit dated but it doesn't matter. Policies might have changed and, for example, The National Disability Insurance Scheme - something McGorry does not support (The Australian April 6th 2017) - changes policy parameters, nonetheless, the fundamentals have not changed and Melissa Sweet does a good job of outlining some of the main issues. There will be some of us who do not like her interpretation but these are important issues to discuss.)

15.

Universal Healthcare for all Australians ACTU Annual Congress 2015 <http://www.actu.org.au/media/801469/11-universal-healthcare-for-all-australians-final-policy.pdf>

(The Congress of the ACTU constructed this document in 2015, setting out the health agenda for the Australian Council of Trade Unions – the umbrella organisation for the trade union movement in Australia. Below are their recommendations in mental health. It is always some balancing between the mental health needs of all unionists with mental illness (and/or severe distress) and the mental health needs of the nursing (and other) workforce in mental health. Below are the recommendations. It is interesting to see the priority on preventative measures, which is different from some mental health debates. They note in their recommendations that this should not happen with money being taken away from acute health. Herein lies a dilemma with shrinking health budgets; a big debate within mental health only briefly mentioned.

- *A substantial increase in funding for mental health services, focused particularly on delivering quality community and preventative services. This funding must not be based on any reduction in the funding of acute mental health services;*
- *An emphasis on programs aimed at supporting and promoting good mental health and well-being and policies which encourage Australians to access mental health care early;*
- *Measures to ensure that people experiencing mental illness can access more and better coordinated services, both clinical and non-clinical, and work towards improving the lives of those that are the most disadvantaged and socially excluded;*
- *A national workforce plan aimed at addressing the critical shortage of specialist mental health workers through training, recruitment and retention of a quality workforce;*
- *Programs aimed at keeping and returning workers with mental ill health to their preferred occupations in supportive working environments;*
- *The reestablishment of the National Mental Health Commission as an independent organisation to ensure effective and independent monitoring, assessing and reporting on the efficiency of the mental health system;*
- *The Federal Government's ongoing commitment to, and extension of, primary care mental health programs provided by health workers, including nurses, through programs such as the Mental Health Nurse Incentive Program (MHNIP).*

16.

GP Salary Australia: Recruitment Specialising in GP jobs across Australia; <https://www.astermedical.com.au/outside-of-australia/doctors-salaries-australia/>

(This is interesting. Which doctors earn how much? Psychiatrists are not at the top of the salary scale.)

7.

Sorry You're
Out Of Order:
First Agree
And Then We'll
Negotiate

7. Sorry You're Out Of Order: First Agree And Then We'll Negotiate

GETTING ALONG WITH THE SYSTEM

Understanding from a consumer or patient perspective is vital for everyone involved in healthcare; but this wisdom is often hard to glean if one has not been taught to value consumers' body of knowledge. All organised social systems have shared understandings, even rules – both norms and mores. Social acts and interactions are only ever 'real' or 'true' from the point of view of the actors or observers. Bodies of knowledge are relative but some have institutional power and others do not. Learning the rules of the most powerful groups might be galling, but it may also be pragmatic.

RUN OFF OUR FEET!

We know that clinicians occasionally write our documents in the first person and then blackmail us into signing them. We also know what happens if we kick up a fuss about it - which we usually don't. It's actually appalling practice and the standard staff defence is both ideological (it's a stupid idea that they want you to write your own report in the first place) and pragmatic (too much time and resources). Sometimes we fight for self-determination, but this is so inappropriately interpreted by services and systems that it often does more harm than good.

TRUST IS CONDITIONAL

Getting our files through Freedom of Information (FOI) is educative. Sometimes it is reassuring... often it is horrifying ... for many it reaffirms fears of duplicity. Memories of times and conversations and systemic violence are often lost in clinical translation. Files can be redacted (blacked out); they can't be changed by us even if they are factually incorrect and just interpretations from a consumer's (and sometimes intimidated clinician's) point of view. Adding to them is allowed but be warned: don't use red ink, don't underline or capitalise and don't add exclamation marks either, or you may gain an extra line in your diagnosis.

LIVID EXPERIENCE No 22

A university student was seeking help from a doctor on campus, who decided to refer her to a psychiatrist. She was reluctant, but referral in hand, she rolled-up the psychiatrist's rooms. His first words were: "I require you to commit to ten sessions to demonstrate that you will take your treatment seriously". He then said nothing for the rest of the half hour. The student left psychologically scrambled, wondering why she was referred to this particular person.

INFORMED REFERRAL

Often GPs will refer to a list (perhaps constructed by the College of Psychiatrists (RANZCP) or the Australian Psychological Society (APS)) These lists tell almost nothing about the practice or methods of those on the listings. Maybe GPs have a bit of contact with a specialist or he/she finds someone whose 'book is not full' or a specialist another patient seemed to 'like' but... Perhaps we need to go back to doctors advertising their wares. Ethically questionable it may well be, but at least we would know what we are buying. Maybe?



A WIKIPEDIA ENTRY TO MADNESS

1. ADVANCE PSYCHIATRIC DIRECTIVE: https://en.wikipedia.org/wiki/Psychiatric_advance_directive
2. ARGUMENTATION THEORY: https://en.wikipedia.org/wiki/Argumentation_theory
3. DOMINANT IDEOLOGY: https://en.wikipedia.org/wiki/Dominant_ideology
4. ESCALATION OF COMMITMENT: https://en.wikipedia.org/wiki/Escalation_of_commitment#Leadership_norms
5. ETHICAL DILEMMAS FOR PROFIT ENTERPRISES IN HEALTHCARE: <https://www.ncbi.nlm.nih.gov/books/NBK216766/>
6. FREE MARKET HEALTHCARE: https://en.wikipedia.org/wiki/Free-market_healthcare
7. FREEDOM OF INFORMATION (FOI): https://en.wikipedia.org/wiki/Freedom_of_information
8. GASLIGHTING: <https://en.wikipedia.org/wiki/Gaslighting>
9. INTERNALISATION: [https://en.wikipedia.org/wiki/Internalisation_\(sociology\)](https://en.wikipedia.org/wiki/Internalisation_(sociology))
10. MEDICAL ETHICS: https://en.wikipedia.org/wiki/Medical_ethics
11. MEDICALIZATION: <https://en.wikipedia.org/wiki/Medicalization>
12. PSYCHIATRY ADVANCE STATEMENT: https://www.vmiac.org.au/wp-content/uploads/2017/02/vmiac_guide_to_advance_statement.pdf
13. MORES: <https://en.wikipedia.org/wiki/Mores>
14. PARADOX OF CHOICE: https://en.wikipedia.org/wiki/The_Paradox_of_Choice
15. PHILOSOPHY OF HEALTHCARE: https://en.wikipedia.org/wiki/Philosophy_of_healthcare
16. PHRONESIS (PRACTICAL WISDOM) : <https://en.wikipedia.org/wiki/Phronesis>
17. POWER (SOCIAL & POLITICAL): [https://en.wikipedia.org/wiki/Power_\(social_and_political\)](https://en.wikipedia.org/wiki/Power_(social_and_political))
18. PRIVATE HEALTHCARE: https://en.wikipedia.org/wiki/Private_healthcare
19. PROFIT MOTIVE: https://en.wikipedia.org/wiki/Profit_motive
20. REFERRAL: [https://en.wikipedia.org/wiki/Referral_\(medicine\)](https://en.wikipedia.org/wiki/Referral_(medicine))
21. RELATIVISM: <https://en.wikipedia.org/wiki/Relativism>
22. RHETORIC OF THERAPY: https://en.wikipedia.org/wiki/Rhetoric_of_therapy
23. SELF-DETERMINATION: <https://en.wikipedia.org/wiki/Self-determination>

24. SHARED DECISION MAKING IN HEALTHCARE: https://en.wikipedia.org/wiki/Shared_decision-making_in_medicine
25. SOCIAL ACTIONS: https://en.wikipedia.org/wiki/Social_actions
26. SOCIAL INSTITUTIONS: <https://en.wikipedia.org/wiki/Institution>
27. SOCIAL NORM: [https://en.wikipedia.org/wiki/Norm_\(social\)](https://en.wikipedia.org/wiki/Norm_(social))
28. SOCIALISATION: <https://en.wikipedia.org/wiki/Socialization>
29. STRUCTURE & AGENCY: https://en.wikipedia.org/wiki/Structure_and_agency
30. ULYSSES PACT: https://en.wikipedia.org/wiki/Ulysses_pact

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Farrelly S. et al Barriers to shared decision making in mental health care: qualitative study of the Joint Crisis Plan for psychosis; Health Expectations, Vol 19(2) April 2016: 448-458
<http://onlinelibrary.wiley.com/doi/10.1111/hex.12368/epdf>

(This report from a qualitative research project is available in full on line; service users is the general term used in Britain. Ninety-five people were involved in a qualitative research project into joint decision-making. Fifty were clinicians and 45 were service users. The success of the exercise in shared power was limited; the researchers suggested four reasons:

- *ambivalence about care planning;*
- *perceptions they were already fully sharing planning with service users;*
- *concerns regarding the clinical appropriateness service user's choices;*
- *needing to set close barriers around service users choices.*

The researchers suggested that there was a strong commitment to the idea of shared planning but limited commitment to the practice or misunderstandings or a limited capacity to envisage a radically (to clinicians) different approach. Clinicians believe they were already practicing democratically. Clinicians described their model of Shared Decision Making as: "...making a suggestion, asking for agreement from service users and then recording this. Directing the flow of information in this way could be considered more consultation than SDM [shared decision making]." The idea of inviting service users to make an Advance Directive was not popular with the clinicians in this study: "I'm all for patients having power but this is more than that..." Implementation of Joint Care Planning had limited success... clinicians approached the intervention thinking it required little effort or consideration of their behaviour.)

2.

Sharac J. et al Nurse and patient activities and interaction on psychiatric inpatient wards: a literature search; International Journal of Nursing Studies 2010 Jul; 47(7): 909-917
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4018996/>

(As always, Bettina Arndt is controversial. This is an opinion piece in the Australian newspaper. How it is received by consumers might depend on whether they are a parent and/or whether their childhood traumas – perceived by them as big or small – have impacted on their adult lives in significantly bad ways. For many in the latter group, this might just be a breath of fresh air.) (This is a review of the literature; pulling together as much previous work on the subject as possible. It is useful to look at the summary, the first part of the discussion and the summary and conclusion. This will give you an idea about whether you might like to explore further. Previous research indicated:

- on average around 50% of staff time is spent in contact with patients;
- the more senior the staff member, the smaller amount of time spend with patients;
- amount of time spent delivering 'therapy' is probably in the region of 4-20%;
- relatively little patient time is spent in contact with staff and much is spent in isolation;
- staff time with patients is reducing over time.

The lack of structured activities and patient contact indicated in this literature review is thought to be due to a variety of issues:

- a more severe patient-mix so that staff members spend more time 'containing' than offering activities to patients;
- staff shortages of psychologists and occupational therapists; and
- a trend over time of nurses spending less of their time interacting with patients and more of their time on non-patient activities such as administrative duties.

Some options to improve social engagement and participation in group activities are:

- activities could be offered that are able to be led by unqualified staff or unqualified staff could be trained to lead some groups;
- efforts could be strengthened to recruit volunteers onto the wards to lead activities;
- the introduction of information technology onto the wards might be used to streamline administrative duties and paperwork to free up time for nurses to devote more time to caring for patients on a one-to-one basis.

One conclusion is that as community treatments have increased in importance and the money has moved from acute care into community provision, the capacity of acute units to provide meaningful occupation has reduced. Although not an occupational therapist, I'm somewhat surprised that the recommendations would appear to undermine their professional expertise. Other occupation groups would not like this. I also noted that the activities suggested are not of the 'therapeutic' type run by clinical psychologists. This is possibly appropriate given the short stays in acute units these days.)

3.

Boland S. (2016) Guardedness in Communications between People Experiencing Acute Psychosis and Mental Health Nurses; a thesis presented to Dublin City University for the Degree of PhD [http://doras.dcu.ie/21413/1/Guardedness_in_Communications_between_Nurses_and_People_Experiencing_Acute_Psychosis_2015_\(3\).pdf](http://doras.dcu.ie/21413/1/Guardedness_in_Communications_between_Nurses_and_People_Experiencing_Acute_Psychosis_2015_(3).pdf)

(This is a doctoral thesis. As such it is long and, may look daunting. Use the table of contents. It has good headings to guide. It is a good idea to read the abstract, introduction and conclusion first. It will help you to make a decision whether it will be useful for you. The author used 'Grounded Theory' to study the tenor of communication between people experiencing acute psychosis and nurses with the purpose of improving communication and therefore nursing practice. The theory developed the idea of guardedness on both the part of nurses and service users, depending on the degree of risk, attempts to ease distress, or considerations that it is advantageous to raise or lower their guard. They note: "This was a complex and interactional process which was influenced by past experiences, current events, contexts and how nurses and service users presented when communicating. This guardedness in communications also facilitated a sense of ownership and control over what they say and do. It is proposed that mental health nurses and service users can use appropriate guardedness to establish what they consider are permissible communications at a moment in time.")

4.

Dahlqvist-Jönsson P. et al Service users' experiences of participation in decision-making in mental health services; Journal of Psychiatric Mental Health Services, 2015 Nov; 22(9): 688-97 <https://www.ncbi.nlm.nih.gov/pubmed/26148016>

(This is an academic article but is reasonable easy to read. Unfortunately, it is not available in full (and free) on the internet. The people interviewed are people diagnosed with psychotic disorders. The researchers contend that most of the material available on joint decision-making has been studies from the point of view of clinicians. This paper combines two ideas:

- Concrete and specific ways of 'doing' joint decision making need to be developed;
- The intelligence that is needed to make this happen is the knowledge and worldview of service users

The study concludes that:

- People with "Serious mental illness" struggle to be seen as competent.
- Service users have good concrete ideas to make shared decision making could work.
- Mental health nurses have the responsibility to implement shared decision making as part of a recovery approach to care.)

5.

Hibbins J. I'm reinventing mental health care by putting patients in charge The Guardian Monday 25th September 2017 <https://www.theguardian.com/healthcare-network/views-from-the-nhs-frontline/2017/sep/25/reinventing-mental-health-care-putting-psychiatric-patients-in-charge-suicide-crisis-centre>

(This is a compelling read. Introduction: If you've spent any time in the public mental health system, you know that folks diagnosed or labeled as having serious mental illnesses are poor. If you've been poor or worked with poor folks, you know that many poor folks suffer from affective and cognitive disorders or, to quote Bentall, "complaints" (1,2). But what comes first, the poverty or the presumed mental illness? Does poverty play a role in causing a person's mental illness or does a person become ill and simply drift down the socioeconomic ladder into poverty? And how many people are we talking about?)

6.

Epstein M. This is not about catharsis! My time in HDU by Merinda Epstein; Our Consumer Place <http://www.ourcommunity.com.au/files/OCP/ThisIsNotAboutCatharsis.pdf>

f forced treatment, High Dependency, misuse of power, violence and trying to stay safe. It's also showing the incapacity of clinicians to recognise differences between 'patients' and negotiate or even discuss important issues around gender and fear. Dominant themes are poor communication, staff closing ranks, staff assuming there were shared meanings, degradation and disrespectful approaches to treatment, poor follow-up of assaults, infantilisation and lack of resources. There are also examples of things that were good.)

7.

Roberts M. The production of the psychiatric subject: power knowledge and Michel Foucault; Journal of Nursing Philosopher, 2005 Jan 6(1):33-42 <https://www.ncbi.nlm.nih.gov/pubmed/15659088>

(Those who know firsthand the pernicious effects of being bullied know that it often has very serious consequences and sometimes destroys relationships and lives. In Australia if you have no money, it's not treated seriously until it festers into mental illness – often (not always) the kind that don't get treated seriously either. There are other ways... but you have to have the networks and resources to find them. This paper argues that bullies suffer too.)

8.

Roberts M. Critical thinking and contemporary mental health care: Michel Foucault's "history of the present"; Nursing Inquiry 2017 April 24(2) <https://www.ncbi.nlm.nih.gov/pubmed/27862651>

(This is another article that is only available on line and has to be paid for. Free access can be gained through university affiliation or sometimes through organisations. This article uses Michel Foucault's (https://en.wikipedia.org/wiki/Michel_Foucault) work. Michel Foucault was a French theorist and thinker whose ideas about society dominated during the 20th Century. His work is still, profoundly influential. Amongst other things, he theorised about knowledge and power and discourse. In this paper a slightly different tack is taken: the authors want to explore how instead of what: how did Foucault think, theorise and made new sense of the world in a way that was at the time unique. The authors suggest that for evidence-based, collaborative work between clinicians and those who use mental

health services, professionals need to start to develop exceptional skills in critical thinking. The term Foucault used was “the history of the present” (<https://www.ncbi.nlm.nih.gov/pubmed/27862651>). He was pragmatic regarding ‘theory’ as a collection of think-processing tools and these might change depending on context and need. This approach meant that his “theory” was a toolbox of more or less useful instruments, each conceptual tool designed as a means of working on specific problems and furthering certain inquiries, rather than as an intellectual end in itself or as a building-block for a grand theoretical edifice.)

9.

Roper C. research and academic papers https://www.researchgate.net/profile/Cath_Roper

(Cath Roper is an academic in the Department of Nursing at Melbourne University, working on the Consumer Perspective in Mental Health. Cath’s interests lie in the field of force, eradication of seclusion and restraint as well as in supported and collaborative decision making. Her work is so relevant to this topic that I have linked to her resource page.

- Consumers' and their supporters' perspectives on barriers and strategies to reducing seclusion and restraint in mental health settings. *Australian Health Review* 40 2016 <http://www.publish.csiro.au/ah/pdf/AH15128>
- Telephone survey of service-user experiences of a telephone-based mental health triage service. *International Journal of Mental Health Nursing* 22 2013 <https://www.ncbi.nlm.nih.gov/pubmed/23360561>
- Gaining Strength: Consumers’ experiences of case management with the Strengths Model. *St Vincent’s Mental Health*. 2012 http://recoverylibrary.unimelb.edu.au/_data/assets/pdf_file/0009/1406979/gaining-strength.pdf
- Identifying the ‘right patient’: Nurse and consumer perspectives on verifying patient identity during medication administration. *International Journal of Mental Health Nursing* 20 2013 <http://onlinelibrary.wiley.com/doi/10.1111/j.1447-0349.2010.00739.x/abstract>
- The active participants in mental health services. *Mental Health in Australia: Collaborative Community Practice*. Oxford University Press 2007 <https://eprints.utas.edu.au/5551/>
- Reflection without shame - reflection without blame: towards a more collaborative understanding between mental health consumers and nurses. *Journal of Psychiatric and Mental Health Nursing* 14 2005 <https://www.ncbi.nlm.nih.gov/pubmed/17244010>
- Wanting to be heard: Mental health consumers' experiences of information about medication. *International Journal of Mental Health Nursing* 13 2004 <https://www.ncbi.nlm.nih.gov/pubmed/15660592>

10.

Buch-Gudde C. et al Service users’ experience and views of aggressive situations in mental health care: a systemic review and thematic synthesis of qualitative studies; *Journal Multidisciplinary Healthcare* 2015 8:449-462 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4599636/>

(These papers describe a totally different ethical problem in which pharmaceutical companies are exposed and it includes psychiatric drugs. The two issues here are that of companies pushing up the price of pharmaceuticals by manipulating patents. The second article is about clashes over BigPharma's refusal to sell cheaper, generic drugs to poor countries.) (This is a review of the literature (looking at all that has been done and written on the subject before). Service users' knowledge was treated respectfully as real knowledge. Themes:

Violence is more likely when;

- *patients experienced the ward as custodial rather than caring;*
- *patients needed protection from other patients;*
- *there were no meaningful activities;*
- *patients felt powerless over their lives or to change anything;*
- *patients felt ignored;*
- *in need of a caring relationship with staff that was not forthcoming;*
- *treatment was degrading;*
- *The experience of inner violation as a human being;*
- *Lack of opportunities for dignity;*
- *Aggression as self-defence (when inner being attacked and subjugated)*
- *Lack of opportunity to share their feelings with staff who genuinely cared;*

Some of the explanations offered by patients. Patients had a need for:

- *Real dialogue with staff;*
- *Real user involvement as a preventative strategy.*

The literature review concludes: "From a patient perspective, this study highlights the importance of staffs' knowledge and skills in communication and collaboration with patients to prevent aggressive encounters. Therefore, a major ethical requirement and professional challenge is to develop relationships with patients based on sensitivity, respect, and collaboration."

8.

Hospital
Trauma:
To see or
not to see

8. Hospital Trauma: To see or not to see

SHARED LIVES, SHARED TRAUMA

People are traumatised not only by what happens to them in acute units but also by what happens to others. Vicarious trauma may be very high and wide-spread. When there is a failure to debrief or a lack of capacity to debrief, the effects of traumatic incidents can become permanent impairments.

BLAME GAME

What happens when the forces of society (and its institutions) corrupt the relationships of those with least power? We turn inwards and start to blame each other. Those responsible for this disunity win. We are all much easier to control if we are fighting one another. Those traumatised by the mental health system sometimes find it easier to blame other patients or clients for the sins of oppressive systems: the State, the ideology of meritocracy, compromised welfare systems, doctor power, administrative pettiness; everyone's anxiety and fear and lawmakers ... even the institution of the nuclear family...

TRAUMATISED STAFF

Sometimes staff members are traumatised not only by what they see but also by what they are asked to do or say, or not say. Some will harden and become emotionally brittle, reactive and defending. They become scary and sad... Others will develop greater empathetic acuity and may feel impotent, maybe feel responsible beyond their capacity to act and compassion-weary. Despite all these things, the difference between traumatised staff and traumatised patients remains: clinicians are paid and patients are not.

PLEASE LEAVE THE GATE AS YOU FOUND IT

The trouble with trauma-informed care as presently conceived is that it doesn't challenge the gate-keeping processes of the public mental health system. It's fantastic to move public sector clinicians towards recognising childhood trauma and its enormous impact on adult lives, but it doesn't help people who are presently 'locked out' of the public system.

BRINGING IT HOME?

People with histories of trauma can be re-traumatised by anything, from locks on fridges to other participants'/residents' sexual advances to bad staff doing bad things to someone carrying a camera. Never judge. What is trivial to one may be terrifying to another. Two words that should go from the lexicon of caring are 'just' and 'only'... no experience is ever 'only' anything. Thinking about trauma needs to be sophisticated; sometimes life courses can be so awful that they must be considered with special observance. These are not necessarily stories of childhood sexual abuse.



A WIKIPEDIA ENTRY TO MADNESS

1. CHILD SEXUAL ABUSE: https://en.wikipedia.org/wiki/Child_sexual_abuse
2. COMPLEX POST-TRAUMATIC STRESS DISORDER: https://en.wikipedia.org/wiki/Complex_post-traumatic_stress_disorder
3. COPING: [https://en.wikipedia.org/wiki/Coping_\(psychology\)](https://en.wikipedia.org/wiki/Coping_(psychology))
4. CRITICAL INCIDENT STRESS MANAGEMENT: https://en.wikipedia.org/wiki/Critical_incident_stress_management
5. DEBRIEFING: <https://en.wikipedia.org/wiki/Debriefing>
6. DISABILITY: <https://en.wikipedia.org/wiki/Disability>
7. DISSOCIATIVE DISORDER: https://en.wikipedia.org/wiki/Dissociative_disorder
8. EXISTENTIAL CRISIS: https://en.wikipedia.org/wiki/Existential_crisis
9. FEAR: https://en.wikipedia.org/wiki/Psychological_trauma
10. FLASHBACK: [https://en.wikipedia.org/wiki/Flashback_\(psychology\)](https://en.wikipedia.org/wiki/Flashback_(psychology))
11. HYPERVIGILANCE: <https://en.wikipedia.org/wiki/Hypervigilance>
12. INSTITUTIONAL ABUSE: https://en.wikipedia.org/wiki/Institutional_abuse
13. INSTITUTIONAL BETRAYAL: https://en.wikipedia.org/wiki/Institutional_betrayal

14. INSTITUTIONAL SYNDROME: https://en.wikipedia.org/wiki/Institutional_syndrome
15. MILITARY SEXUAL TRAUMA: https://en.wikipedia.org/wiki/Military_sexual_trauma
16. PHYSICAL RESTRAINT: https://en.wikipedia.org/wiki/Physical_restraint
17. POST-TRAUMATIC STRESS DISORDER: https://en.wikipedia.org/wiki/Posttraumatic_stress_disorder
18. PRINCIPLES OF TRAUMA-INFORMED CARE: http://www.mhpod.gov.au/assets/sample_topics/combined/Trauma_and_Mental_Health/objective2/
19. PSYCHIATRIC DRUGS AS AGENTS OF TRAUMA: http://www.darkpharma.nl/uploads/7/3/2/8/7328594/psychiatric_drugs_as_agents_of_trauma_intl._journal_of_risk_safety_in_medicine_vol_22_number_4_2010.pdf
20. PSYCHOLOGICAL ABUSE: https://en.wikipedia.org/wiki/Psychological_abuse
21. PSYCHOLOGICAL RESILIENCE: https://en.wikipedia.org/wiki/Psychological_resilience
22. PSYCHOLOGICAL TRAUMA: https://en.wikipedia.org/wiki/Psychological_trauma
23. SHELL SHOCK: https://en.wikipedia.org/wiki/Shell_shock
24. STOCKHOLM SYNDROME: https://en.wikipedia.org/wiki/Stockholm_syndrome
25. SURVIVOR GUILT: https://en.wikipedia.org/wiki/Survivor_guilt
26. THE TRAUMA OF INVOLUNTARY TREATMENT: <http://thecaregiverspace.org/the-trauma-of-involuntary-treatment/>
27. TRAUMA MODELS OF MENTAL DISORDERS: https://en.wikipedia.org/wiki/Trauma_model_of_mental_disorders
28. TRAUMA TRIGGER: https://en.wikipedia.org/wiki/Trauma_trigger
29. VICARIOUS TRAUMATISATION: https://en.wikipedia.org/wiki/Vicarious_traumatization
30. VICTIM BLAMING: https://en.wikipedia.org/wiki/Victim_blaming



ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Cusack K.J. et al Trauma within the Psychiatric Setting: A Preliminary Empirical Report, Administration and Policy in Mental Health, Vol. 30 No. 5, May 2003 (© 2003) <file:///C:/Users/Merindz/Documents/10.1.1.554.8727.pdf>

(This is a PDF file which means it is easily accessible to all and is free off the net. It is also dated. Sometimes these two attributes go hand in hand. Despite its age, it talks to contemporary issues. As the authors point out, there is a dearth of material taking a broad-sweep look at acute unit induced trauma. It is a research study which used in-depth interviews to try to understand the experience of trauma from 'inside' a traumatised patient. There was resistance to this research especially from clinicians who believed it might disturb and harm patients to talk about their trauma. The researchers found quite the opposite. Also, an argument was mounted that trauma was the result of symptoms of illness rather than experiences of service. This was scuttled by the research findings. The authors went to some length to differentiate between 'just harmful' and traumatic experiences so as to dispel the inevitable critique that they were inflating 'trauma' and 'just fanciful' story' and to not delegitimise traumatic experiences. The DSM IV definitions of significant trauma were utilised. The authors use the concept of 'sanctuary trauma' to describe the idea that the acute unit should be a safe place. Society wants to keep believing it is a safe place of refuge. Sometimes patients and families want to believe it is a safe place and yet it so often is not. In reality, for many, it is a highly charged dangerous, harmful, and for some traumatic experience. The authors chose to study more than seclusion and restraint which they posited may be the most obvious but not necessarily the most insidious forms of trauma in acute settings. Less empirical attention has been paid to traumatic experiences other than seclusion and constraint. There is also a lot of literature around staff safety and staff experiences of vicarious trauma but little attention paid to inpatient consumers' experiences. This research was also interested in routine procedures and events that can be deeply traumatic. In conclusion, the patients reported that the following experiences were most traumatising, in order of frequency:

- Institutional events and procedures
- Sexual or physical assault
- Coercive measures
- Witnessing traumatic events
- Verbal intimidation/abuse from staff and other patients)

2.

Procter N. et al Trauma-informed approaches in mental health: A practical resource for health professionals, 2017 University of South Australia, SA Health, Adelaide <http://search.ror.unisa.edu.au/media/researcharchive/open/9916119990401831/53142939230001831>

(This is a very recent Australian resource written for clinicians working in forensic services about trauma-informed care. It claims to be about finding ways in which both staff and consumers can work in empowering ways. The assumption is that very many forensic patient ways of being and living bug providers and this leads to interactions that are traumatic retriggering past trauma. The premise is that abusive and/or traumatic early

experiences – leave scars. Trauma-informed care works to avoid re-traumatisation by empowering consumers and staff in decision-making, safety, trustworthiness, choice and collaboration as well as building of strengths and skills. The approach recognises seemingly obnoxious 'behaviour' might have a reason, a sound one given circumstances. The authors use the term 'trauma informed lens' in a similar way that consumers use the term 'consumer perspective lens'. These are particularly important ways of understanding behaviour which may in the past have been described as 'deliberately difficult' or 'uncooperative'. A trauma-informed approach is one that works from the fundamental principles of trauma awareness. Consideration of behaviour through a trauma-informed lens means seeing 'deliberately difficult' or 'uncooperative' ways of relating differently.

See also:

- Graham J. Identity Stress and Vicarious, Secondary, Indirect Trauma in Nurses, Ausmed 18th January 2017 <https://www.ausmed.com/articles/stress-trauma-nurses/>
- Sabin-Farrell et al Vicarious traumatization: implications for the mental health of health workers? *Clinical Psychology Review*, 2003 Vol. 23(3): 449-480 <http://www.sciencedirect.com/science/article/pii/S0272735803000308>
- Andes M. et al An exploration of the meanings of space and place in acute psychiatric care. *Issues in Mental Health Nursing*, 2006, 27(6), 699-707. Taylor and Francis: <https://pdfs.semanticscholar.org/7122/1a0a535ab76f7ddfdb4f8a3170cdd81c9d15.pdf>

3.

"Empowerment - noun (definition) Getting through the staff only door using collective skulduggery. (In MadQuarry Dictionary: A consumer's guide to the language of mental health, July 2012 p. 10)

(In the above entry in MadQuarry Dictionary an insightful consumer describes his/her idea of empowerment and it is about ownership of spaces and authority over spaces in an acute unit. It is also about collective action. This is a good introduction to this article. Samuels and colleagues comment: "Human reality is charged with spatial relations and a history of man is a geography of men in search of their places, articulating their alienation and their concern for relationship." A particular focus here is the geography of the acute unit and the relationship in time and space between psychiatric nurses and patients. The contention is that both groups need private space but that this is hard to find. In the days when smoking was allowed, this effectively defined a space that was as much as possible 'patient controlled' and relatively private. The assumption is that since smoking has been disallowed, this privacy has been absent for both patients who smoke and others who don't. On the other side, nurses have always had the 'nurses' station' – privacy and authority. Much of this paper talks about the role of the 'nurses' station'; the authors write: "In this paper, we have explored how the meaning of the nursing station can affect relationships between nurses and patients. It is possible that on acute psychiatric units, the nursing station is a metaphor for nurses' existential dilemma to distance themselves yet relate to patients."

The space and place of the nursing station may alienate psychiatric nurses from patients, as it may patients from nurses. This includes discussing the role of clerical duty, legitimate needs for 'our' space and ways this place is used to control patients. This is not a unique debate. Teachers have similar issues with staff rooms. The authors argue that the unique characteristics of psychiatric acute units and psychiatric illness makes issues of privacy qualitatively different from the also very real privacy issues for people with physical illness in hospitals. This is a preliminary discussion.)

4.

Goulet M. & Larue C. Post-Seclusion and/or Restraint Review in Psychiatry: A Scoping Review; Archives of Psychiatric Nursing, 30 (2016): 120-128 https://ac.els-cdn.com/S0883941715001934/1-s2.0-S0883941715001934-main.pdf?_tid=c5335f4c-dc95-11e7-ba20-0000aacb362&acdnat=1512792336_47fcda02c94b6c3a71e5134636130af7

(This article is about trauma experienced in hospital. In the author's purview is a study of methods for reflection following seclusion and restraint. It is a scoping review which means that the authors are bringing together similar and disparate research and discussion in this area with the purpose of looking for consistencies and differences. Each of the different pieces of research is tabulated. This is quite useful. However for a piece of work that claims to be interested in terminology and language, it grates on occasions when acronyms are over-used and where people are described as 'targets'. The paper argues that the development of good relationships with nurse performance emanating from a place of reflection reduces the risk of aggression and staff resorting to controlling behaviour which aggravates many situations. In conclusion, the authors argue that a review of the literature reveals a paucity of PSRR (Post Seclusion and/or Restraint Review) evaluation studies and they recommend that more work is needed.)

5.

Holmes D. et al The mentally ill and social exclusion: a critical examination of the use of seclusion from the patient's perspective; Issues in Mental Health Nursing 2004 Sep 25(6): 559- 578 <https://www.ncbi.nlm.nih.gov/pubmed/15371143>

(Patients' experiences of seclusion and restraint are more likely to occur in the nursing literature and very rarely in the preferred journals of doctors, which is interesting given the impact of seclusion and the authority of medicine. The research methods used (in a phenomenological tradition) 'a semi-structured, non-directive interview format with a total of six participants is preferred by many nurse researchers and consumer researchers who understand the importance of deep questions, deep probing and deep knowing. This is not a tradition in medical research. The 'content analysis' (making sense of what people –patients were saying) seems to have involved only nursing researchers. There was no sign of patients/consumers helping to make sense of the data. The analysis revealed three themes:

- *People's (patients') experience of seclusion as a deeply emotional time;*
- *People's (patients') experience of seclusion as a useful intervention; and*
- *Information about how people (patients) 'do' seclusion.*

The researchers report on major themes they could identify:

- *Patients' experienced seclusion as punitive;*
- *Patients' experience seclusion as an attempt at social control;*
- *Patients' experience seclusion as an intensifier of already existent negative feelings (powerlessness, exclusion, rejection, abandonment and isolation).*

See also:

Ling S. et al Understanding Mental Health Service User Experiences of Restraint Through

6.

Wadson H. & Carpenter W. Impact of the seclusion room experience; *Journal Nerv. Ment. Dis* 1976, 163(5): 316-28 <https://www.ncbi.nlm.nih.gov/pubmed/789819>

(This is a fascinating article. Like so much material written in the generally more open, experimental, less bureaucratic and perhaps more creative period in the history of psychiatry (1960s and 70s), the discussion is less formulaic and the idea interesting. Inpatients from an acute unit were invited to represent their experiences of seclusion using art (drawings) as a means to communicate. It's important to remember that this period was at the end of an era of institutionalisation so people were likely to spend longer periods in acute settings and would have had a chance to get to know staff and researchers alike. All the inpatients invited to participate had schizophrenia. The art work was analysed by non-consumers which reflects its historical position (Malcolm L. All in The Mind (Radio National) Art in the Asylum: orphans of the art world? Part 1. The Cunningham Dax Collection, 13th October 2007 <http://www.abc.net.au/radionational/programs/allinthemind/art-in-the-asylum-orphans-of-the-art-world-part-1/3230500> The authors concluded that the nature of the pictures fitted into the following categories:

- *frightening delusions connected with the experience of seclusion;*
- *strong non-delusional feelings about being in seclusion (often the picture of the psychiatric illness was a representation of the seclusion room experience);*
- *special focus on the staff member in attendance outside the seclusion room door;*
- *pleasurable hallucinations occurring while in seclusion.)*

7.

Goettlich A. Power and Powerlessness: Alfred Schutz's theory of relevance and its possible impact on a sociological analysis of power, *Civitas*, Porto Alegre 2011 v 11(3):491-508 <http://www.redalyc.org/pdf/742/74221624009.pdf>

(This is all about power, power as it applies to many and multiple relationships all of us must negotiate every day, every place, every site of decision-making, every place of service delivery and in all our work – paid and voluntary. Goettlich heads his paper with the following reference to some famous thinkers: "Bertrand Russell declared "that the fundamental concept in social science is Power, in the same sense in which Energy is the fundamental concept in physics" (Russell 1957, p. 10). Later on, Robert Dahl stated that "the concept of power is as ancient and ubiquitous as any that social theory can boast" (Dahl, 1957, p. 201). Norbert Elias claimed that "balances of power ... form an integral element of all human relationships" (Elias, 1978, p. 74), and Heinrich Popitz argued "that the bacillus power is inherent in all human relationships" (Popitz, 1992, p. 21)1. From the standpoint of systems theory, Niklas Luhmann conceived of power as a "symbolically generalized medium of communication" (Luhmann, 1979)."

This is a theoretical paper that needs concentration. Goettlich compares an individual approach to understanding social power (comparing the experiences of those who wield power with those who are subject to power-over) to a societal analysis of power relationships through social institutions, discourse analysis (Michel Foucault. <http://www.>

massey.ac.nz/~alock/theory/foucault.htm) and other understandings that take power seriously as a social phenomenon. It is important to read this, especially for those who do not have a background in understanding, mental health and illness in its social context. Psychiatry is flooded with individualistic, psychological explanations of 'reality'. Perhaps this needs balancing.)

8.

Ten Houten W. D. The Emotions of Powerlessness, Journal of Political Power 2016 vol. 9(1):83 - 121 <http://www.tandfonline.com/doi/abs/10.1080/2158379X.2016.1149308?src=recsys&journalCode=rpow21>

(Ten Houten is concerned about the social construction of power. His work is an attempt to revisit "alienation theory, to establish a linkage between alienation theory and the sociology of emotions, and to analyse power hierarchies. He compares Anglo-Australians and Aboriginal-Australians and compares gender and cultural differences in those experiencing powerlessness." What is it like to experience powerlessness? How does powerlessness lead to feeling like a victim? What is it about us – those who often feel powerless? What is it about a group that experiences powerlessness? Ten Houten writes, "After briefly considering cognitive aspects of powerlessness, we propose that the affective basis of powerlessness is comprised of four primary emotions:

- acceptance/acquiescence;
- anticipation/expectation;
- sadness; and
- fear.

From this, six secondary emotions associated with powerlessness are articulated: fatalism, pessimism, resignation, anxiety, submissiveness and shame. This article is about experienced powerlessness.)

9.

Sadan E. Empowerment and Community Planning, Chapter One: Theories of Power http://www.mpow.org/elisheva_sadan_empowerment_spreads_chapter1.pdf

(For all consumers and clinicians who believe they can empower a client, patient, colleague or friend, this is an important read. In order to understand empowerment, and disempowerment, it is beholden on us to understand power as a social and political reality. This is an introduction. It is useful. It teaches us that language can seem deceptively straightforward and misunderstandings can arise when those with more social power and authority use language, like 'empowering' without understanding its complexity and the complexity of the social systems in which it sits. In this introduction Sadan talks about the history of ideas around 'power', competing theories and important theoreticians such as Giddens and Foucault, social mechanisms for using (and misusing) power, power and politics of everyday situations, power and conflict, power hierarchies and the politics of empowerment. Sadan also sketches attempts to research power. This is a refreshing sociological approach to looking at society, power and social institutions. Psychologists also have theoretical ideas about power seen in an individualistic and relational way which sometimes puts intrinsic value on the 'empowered' and the 'disempowered' and creates interventionist responsibilities on clinicians to intervene in the lives of those who

are deemed disempowered. It can run close to coaching the presumed disempowered without adequately understanding the role of social institutions (including health systems, capitalism, meritocracy...) in creating the 'other'. There is much literature from psychology on 'power'. In this summary, however, the central tenet is the central role played by social circumstances. Sadan reminds us that with all the good will in the world we can't (individually) pre-plan and control all the factors necessary for our social interactions. He quotes Dreyfus and Rainbow "People know what they do; they frequently also know why they do what they do; but what they don't know is what they do does In other words, people are not conscious of the by-products and the implications of their deeds." (Dreyfus & Rainbow, 1982:187))

10.

Gimson K. et al Developing a Trauma Informed Therapeutic Service in the Australian Capital Territory for Children and Young People Affected by Abuse and Neglect 2014, https://www.communityservices.act.gov.au/__data/assets/pdf_file/0003/642828/Discussion-Paper-Trauma-Recovery-Centre-September-2014.pdf

(Regardless of the geography, this is important. It is also of contemporary importance in Australia as it comes as we are being reminded of multiple injustices that have taken place, some of them institutional, from Aboriginal youth in Darwin being treated in ways that disgust us, the stolen generation report recommendations not being enacted, the ten year stocktake from the 'Closing the Gap' report, the suffering of the stolen children, and their children <http://www.aljazeera.com/news/2018/02/10-years-apology-stolen-aboriginal-children-180213102513521.html>

At the same time the Royal Commission into Institutional Responses to Childhood Sexual Abuse published its findings and they were explosive with churches, schools and charities all humbled and shamed not only by the accusations that they harboured paedophiles over many years, but also that they attempted to protect their reputations at the expense of the children.

*This is the time to reassess not only services for children who have experienced overt trauma and abuse but also for adult survivors not just of abuse but also, and even more importantly perhaps, those whose trauma is less obvious, less easy to name, less easy to find blame, less in your face. This is a report leading to a policy in the ACT. This is a particular way of writing: report writing. It has its place but it's a blunted form of communication. For those whose interest stretches beyond the prosaic there is material which explores ideas of 'trauma Informed Care'. If you're interested, a starting place might be: Bath H. The Trouble with Trauma, *Scottish Journal of Residential Child Care* 2017 – Vol.16, No.1: 1478-1480 http://traumebevisst.no/program/etgodthjem/filer/Bath_H_The_Trouble_with_Trauma.pdf*

White, middle class services are not always the right place for children from other cultures or for working class kids no matter how oriented towards traumatic backgrounds.)

11.

Sweeney A. et al Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal*, Vol 21(3): 174 -192 <http://www.emeraldinsight.com/doi/full/10.1108/MHRJ-01-2015-0006>

(This paper is authored by trauma survivors and staff in mental health services. With present priorities in Victoria, this would be called co-production... or would it? It is, in fact, set in the UK but situations are similar and the broad discussion is relevant to Australia. The importance of this paper to consumers is that it is a peer reviewed journal, contemporary (2016) and links childhood trauma to re-traumatisation in mental health systems. The authors, including consumers (known as 'service users' in the UK), discuss issues to do with principles of trauma-informed care, attributes of acute settings (in particular) which systemically re-traumatise, evidence of the effectiveness of trauma-informed services, and a discussion of the attributes that enable and/or create barriers to approaching services from a point of trauma mindfulness. It is available in a PDF file. This is great. It can be downloaded without any cost or need to be affiliated with an educational institution or services.)

12.

Schuetz B. The Trauma of Involuntary treatment, The Caregiver Space, April 27th 2015
<https://thecaregiverspace.org/the-trauma-of-involuntary-treatment/>

(This short piece is written by a woman who describes herself as a 'caregiver'. It is journalistic in style and very easy to both read and read with compassion. The basic tenet of her writing is to make a case for mental health services to stop traumatising those who need help. In her piece she describes the admission of a 'friend' and none of us who have been through admission to a psychiatric hospital would question the way she describes in small detail the acts and rituals of admission that shame us and confuse and blame and distort our communication. This is a good place to start.)



9.

Crisis: Let
them think
they know
more than you

9. Crisis: Let them think they know more than you

THINGS YOU DO AND DON'T SAY TO CRISIS TEAMS

If we are likely to receive uninvited guests, there are things to learn. Sometimes it isn't possible, but if we know their triggers it is possible to steer their thinking. Remember it is not just words. They are watching us too. The best thing to do may be to learn from experienced people who have been through it all before. There will be a systemic refusal to share coffee offered in reciprocal good will, as they seem to have every confidence in saliva-borne transferable mental illness!

TAKE THE INITIATIVE AT YOUR OWN PERIL

The Acute Community Intervention Service (ACIS) is designed to take control perhaps calling it negotiated. Although it is our home it is their gig. Being forward, confident and intelligent does not seem to work. Talking about consumer politics is definitely not helpful. Standing up for ourselves is perilous. The general rule is, if you want the service to take your pain seriously, they won't. If you want them to leave you alone, they will probably intern you.

POVOCATEUR

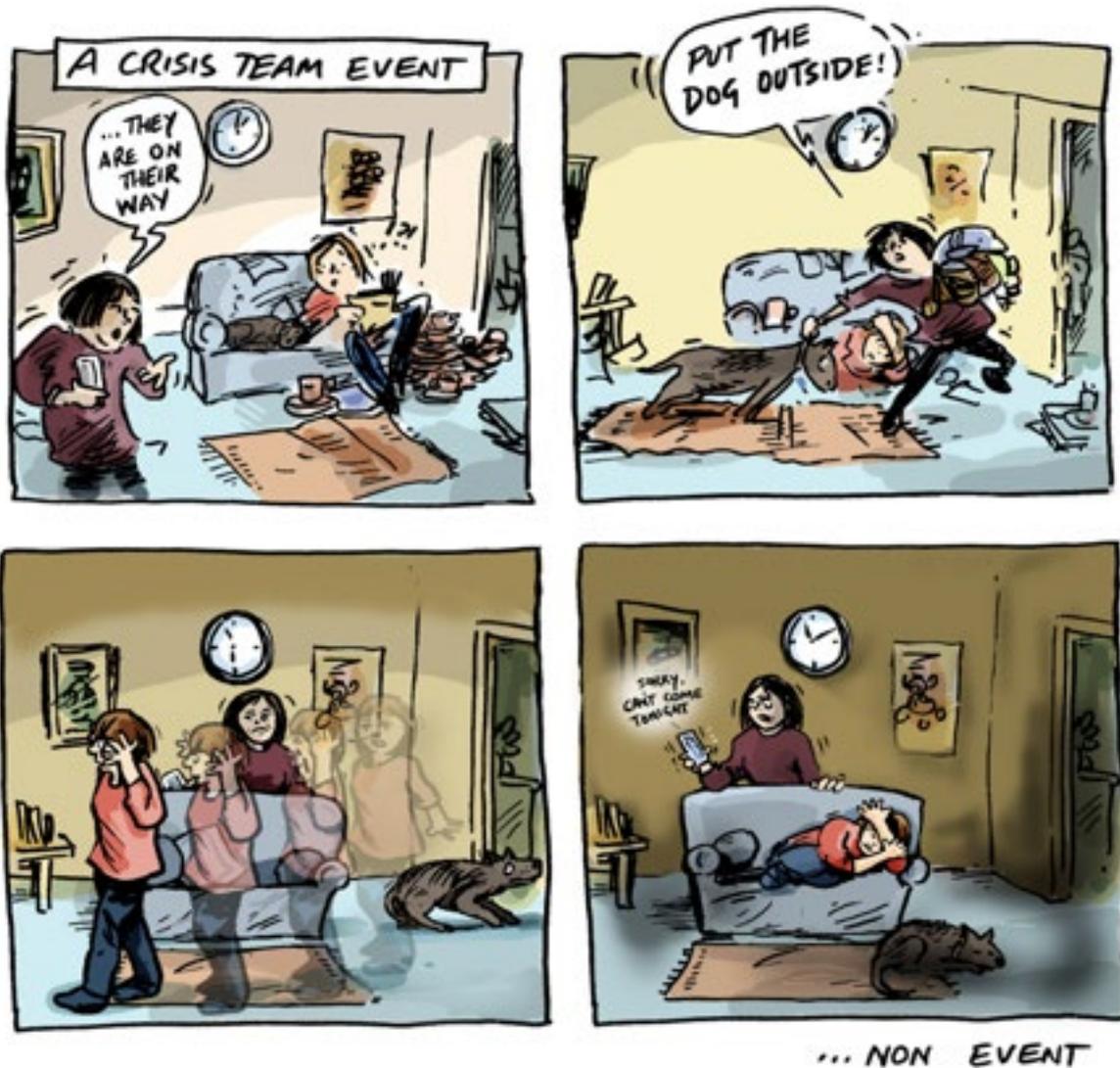
Reciting the Mental Health Act is perhaps not such a good idea. We may know it better than the clinicians who want to use it to detain us. That wouldn't do. Try not to get a name for yourself – unless it's a good one. People are still punished for their activism. We forget that we can be seen as frighteningly well-connected as well as frightening in more obvious ways.

CONSTRUCTING CRISES

Crisis teams are crisis driven. It becomes a way of life. The triage staff work hard to sieve out the crises from the rest. The dramatization of experiences is promoted through this process. Triage and crisis team behaviours give some consumers clear messages that they are worthless unless they can generate a crisis. This is not healthy and in spite of the fact that it is usually generated by services, patients are blamed.

FEEDING TIME

Crisis teams can surprise.... One duo went two suburbs away (on route to another patient) to feed a beloved dog for a patient they were visiting. It was a lovely act of generosity but it was also therapeutically outstanding. The rotten part is when best practice precariously moves closely to what is deemed 'weak boundaries', even 'unprofessional'. In this instance the consumer was fearful that these good, thoughtful people might be sanctioned in some way, but she still sent a card of thanks to the service. Fear of sanction is real, but these two were gratified that their practice was publicly acknowledged.



A WIKIPEDIA ENTRY TO MADNESS

1. ACCUTE COMMUNITY INTERVENTION SERVICE (ACIS): <https://www2.health.vic.gov.au/mental-health/mental-health-services/support-and-intervention/acute-community-intervention-service>
2. ADULT PREVENTION AND RECOVERY CARE (PARC): <http://www.health.vic.gov.au/mentalhealthservices/parc.pdf>
3. AGENCY PHILOSOPHY: [https://en.wikipedia.org/wiki/Agency_\(philosophy\)](https://en.wikipedia.org/wiki/Agency_(philosophy))
4. ASSESSING SUPPORT FOR CLIENTS-AT-RISK: <https://www.suicideline.org.au/health-professionals/assessing-support-for-clients-at-risk/>
5. BODY LANGUAGE: https://en.wikipedia.org/wiki/Body_language
6. BOUNDARY CROSSING AND DUAL RELATIONSHIPS: <http://www.zurinstitute.com/boundariesbrochure.pdf>
7. CRISIS IN EMERGENCY: <http://www.modernhealthcare.com/article/20131116/MAGAZINE/311169992>
8. CRISIS INTERVENTION: https://en.wikipedia.org/wiki/Crisis_intervention

9. CULTURALLY COMPETENT CRISIS RESPONSE: https://www.schoolcounselor.org/asca/media/asca/Crisis/cc_crisis.pdf
10. EMERGENCY DEPARTMENTS AND CRYSTAL METH: <http://www.tandfonline.com/doi/abs/10.1080/01612840.2016.1251516?src=recsys&journalCode=imhn20>
11. EMERGENCY DEPARTMENTS AND SUICIDAL IDEATION: <http://www.goodtherapy.org/blog/five-lessons-i-learned-from-visiting-er-with-suicidal-ideation-0920137>
12. EMERGENCY PSYCHIATRY: https://en.wikipedia.org/wiki/Emergency_psychiatry
13. FACIAL EXPRESSION: https://en.wikipedia.org/wiki/Facial_expression
14. INPATIENT & CRISIS SERVICES (SENATE INQUIRY INTO MENTAL HEALTH) http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/c08
15. MANAGING THE ACUTE PSYCHOTIC EPISODE <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1839209/>
16. MENTAL HEALTH ACT 2014: <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014>
17. MENTAL HEALTH FIRST AID: https://en.wikipedia.org/wiki/Mental_health_first_aid
18. MENTAL HEALTH TRIAGE: https://en.wikipedia.org/wiki/Mental_health_triage
19. MENTAL STATE EXAMINATION: https://en.wikipedia.org/wiki/Mental_status_examination
20. MINI-MENTAL STATE EXAMINATION: https://en.wikipedia.org/wiki/Mini%E2%80%93Mental_State_Examination
21. NON-VERBAL COMMUNICATION: https://en.wikipedia.org/wiki/Nonverbal_communication
22. PATIENTS IN EMERGENCY WITH ACUTE SEVERE BEHAVIOURAL DISTURBANCES: http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2015_007.pdf
23. POLICE AND MENTAL HEALTH: https://www.mind.org.uk/media/618027/2013-12-03-Mind_police_final_web.pdf
24. PROFESSIONAL BOUNDARIES: https://en.wikipedia.org/wiki/Professional_boundaries#Nurse-client_boundaries
25. PSYCHIATRIC ASSESSMENT https://en.wikipedia.org/wiki/Psychiatric_assessment
26. PSYCHOLOGICAL EVALUATION: https://en.wikipedia.org/wiki/Psychological_evaluation
27. SUBACUTE MENTAL HEALTH SERVICES: <https://www2.health.vic.gov.au/mental-health/mental-health-services/services-by-type/subacute-mental-health-services>
28. SUICIDAL IDEATION: https://en.wikipedia.org/wiki/Suicidal_ideation
29. SUICIDE TERMINOLOGY: https://en.wikipedia.org/wiki/Suicide_terminology
30. MENTAL HEALTH TRIAGE VICTORIA: <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/service-quality/mental-health-triage-service>

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Wessely S. The real crisis in psychiatry is that there isn't enough of it; The Conversation October 23rd 2014: 55-57 <https://theconversation.com/the-real-crisis-in-psychiatry-is-that-there-isnt-enough-of-it-32076>

(This article is one of many in a debate about whether we do or do not need more psychiatry. Many of those who write about the dangers inherent in psychiatry argue that it's not that people don't need more support but rather that that support ought not be predominantly medical and need not be predominantly serviced by psychiatrists who extract a lopsided amount of money through Medicare. These writers often talk about psychiatric imperialism. This term especially refers to Western medicine being an occupier in developing countries <https://www.psychologytoday.com/blog/hide-and-keep/201510/psychiatric-imperialism-exporting-western-mental-disorders> or about the apparent rise and rise of dubious psychiatric diagnoses <http://www.academyanalyticarts.org/moncrieff-psychiatric-imperialism>

This article challenges both the arguments put forward above. The author postulates that psychiatry is an easy profession to 'beat up' stating that: "Not for us the simplicities of some other parts of medicine. Here is a cancer – take it out. There is a bug – kill it. In psychiatry, the ability to tolerate uncertainty is an essential skill. Because we have to negotiate fuzzy boundaries – between eccentricity and autism, between sadness and clinical depression, between hearing voices and schizophrenia – and there will always be boundary disputes." He argues that the worst of the problems are caused not by an expansionist psychiatry but rather by the lack of funding for psychiatry and the strain and tensions that evokes for clinicians and patients; that the crisis is really psychiatry being treated with less seriousness and less respect rather than with too much.)

2.

Watson A.C. & Fulambarker A.J. The Crisis Intervention Team Model of Police Response to Mental Health Crises: A primer for Mental Health Practitioners, Best Practice in Mental Health, 2012 Dec. 8(2):71 <https://www.ncbi.nlm.nih.gov/pubmed/24039557>

(Watson and Fulambarker argue that with certain sorts of mental diagnoses, mental health and law enforcement become entangled and this needs to be understood, because it is both about both the mental illness influencing law breaking and law breaking influencing mental health. The Crisis Intervention Team (CIT) Model is a collaborative approach to:

- *Link people to services; and*
- *Divert them from the criminal justice system.*

This paper includes discussions on the limitation of the model and searches ways to create an evidence base to support this way of viewing police and patient interaction.)

3.

Watson A.C. & Angell B. Applying procedural justice theory to law enforcement's response to persons with mental illness, Psychiatric Services, 2007 Jun 58(6): 787 – 793 <https://www.ncbi.nlm.nih.gov/pubmed/17535938>

(This article argues for the introduction of 'procedural justice' in relationships between people diagnosed with mental illness and police. It looks at how officer behaviour has an effect on people being either 'cooperative' or resistant to police interaction. "Key components of a procedural justice framework include participation (having a voice), which involves having the opportunity to present one's own side of the dispute and be heard by the decision maker; dignity, which includes being treated with respect and politeness and having one's rights acknowledged; and trust that the authority is concerned with one's welfare." Implications and cautions for efforts to improve police response to persons with mental illness and future research also are examined. This is worth reading in relation to crisis intervention.)

4.

Balaratnasingam S. Mental Health Risk Assessment: A Guide for GPs, Australian Family Physician June 2011 Vol. 40(60):366-369 <https://www.racgp.org.au/download/documents/AFP/2011/June/201106balaratnasingham.pdf>

(Interested in how GPs assess risk? Here it is. Well, in principle anyway; an easy read about the role of one of the primary gate-keeper professions in mental health. Many people rely on GPs to manage their mental health and often GPs complain of struggling to organise 'secondary referrals' <http://healthissuescentre.org.au/consumers/health-care-in-australia/> understanding-our-health-care-system. This seems to be a respectful piece.)

5.

MIND (UK) Listening to experience: An independent inquiry into acute and crisis mental healthcare; 2011 pp3-52 https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf

(A project run by MIND in England. Unlike the advocacy body MIND in Australia, the British MIND has played a major role in mental health politics for a long time and has been a progressive force in mental health policy and practice for many decades. This is a project instigated to research the efficacy of crisis care across the country. This project takes consumer knowledge very seriously and respects knowing that comes from people's experience of crisis 'treatments'. It asks the following questions:

- *What do people in mental health crisis need?*
- *What is good about existing acute and crisis services – what would you like to protect or have more of?*
- *What are the problems in acute and crisis care? If services in your area are being reorganised, what impact is this having on acute and crisis care (if you know)?*
- *What changes in acute and crisis care do you want this campaign to achieve?*

6.

State-wide mental health triage scale Guidelines; A Victorian Government Initiative

© State of Victoria, Department of Health, 2010 <http://cedd.org.au/wordpress/wp-content/uploads/2015/04/Triage-guidelines1.pdf>

(This is a policy document. As such it sets out in 'clear' point form the guidelines in relation

to mental health triage. Although some of us find these sorts of documents difficult to read, people who like a point form, direct, instructional style of communication (and even those who find this boring) will gain a lot from having a look. The advantage is that you can 'point hop' to the bit that is relevant, put the document away and then come back when different information is needed. It is useful to know the criteria for triage and why you may or may not be provided, or, be forced to receive treatment you may not want. This is a formulated scale for the whole of Victoria and as such it may have a very important role to play in our lives. It feels 'funny' to have so little control over the judgements others have over our lives particularly when they are formulaic. These sorts of scales often leave the person out of the formulaic and this means people sincerely searching for empowerment (supposedly a personal asset seen through institutional eyes) by working out how he/she can get what he/she need by working towards either the goals of getting a service or the goal of staying free. There is a chapter told from the perspective of consumers and a chapter told from the perspective of family carers. They are different.)

7.

Lakeman R. Mental State Examination © 1995 http://www.testandcalc.com/richard/resources/Teaching_Resource_Mental_Status_Examination.pdf

(This is slightly old. It doesn't matter. Some things don't change that often. The Mental State Examination (MSE) is central to so much in psychiatry and this short document is a primary guide. One of the important things a MSE tells us is that we are being watched, even studied, not for symptoms of illness as we would be if examined in another medical discipline, but rather for who we are – with the symptomatology entangled with this. If we are asked questions, it is not necessarily because anyone is particularly interested in our story. It is because of the way we tell it. Sometimes it is an act of watching whether the way we behave matches the story we tell. We will be seen differently depending on what diagnosis we carry: "The main thing diagnoses are good for is sussing out what your shrink thinks of you – Bipolar Affective Disorder means they like you. Unipolar means you're boring. Borderline Personality Disorder means they hate you and Schizophrenic means you scare the shit out of them because they can't keep up with your thinking." (Persimmon Blackbridge, consumer painter & writer of Prozac Highway.) The Mental State Examination influences clinical perception often way after its use-by date. Well done it is useful but if it is judgemental, badly recorded or too definitive, it can cause harm. The MSE can be completed formally or informally. This article is brief, readable and people will make of it what they will. Consumers need to know how to do one to understand some of the behaviour that is directed towards them.

- *Mental State Examination:* https://en.wikipedia.org/wiki/Mental_status_examination
- *History of the Mental State Examination:* <https://emedicine.medscape.com/article/293402-overview>
- *The Mini-mental State Examination:* <https://www.ncbi.nlm.nih.gov/pubmed/17078433>
- *Transcultural Relevance of the MSE:* <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.571.9787&rep=rep1&type=pdf>
- *The Geriatric Mental State Examination:* <https://www.ncbi.nlm.nih.gov/pubmed/12211122>)

8.

de Cates P. & Price J. Expert Review of The Mental State Examination The Journal of Clinical Examination 2007 3 15-21 <http://quantosis.com/journals/3/15-21%20de%20Cates%20and%20Price%20-%20Mental%20State%20Examination.pdf>

(This is a much more detailed examination of the different aspects of completing a MSE. It is written by doctors presumably for a medical audience. It is interesting for consumers because it is a look behind the curtain at the medical discourse in which such a discussion sits.)

9.

Sawyer A. Risk and new exclusions in community mental health practice, Journal Australian Social Work, 2008 Vol 61(4): 327-341 <http://www.tandfonline.com/doi/abs/10.1080/03124070802428183?src=recsys&journalCode=rasw20>

(Sawyer argues that the preoccupation with risk over two decades has led to many things, some detrimental to the health of people and communities. She bases her paper on personal experience in crisis team work in Melbourne between 1991 and 2008. She laments that researchers from overseas have taken on board a need to find out more about the consequences of a preoccupation with risk and yet researchers in Australia have produced little. A reflective piece, she analyses the effects on services of a constant context of hypersensitivity to the possibility of risk and the turning of services into risk-averse institutions. She argues that one of the particularly negative attributes of the shift in priority has been "... the narrowing of service provision and that "low-risk" clients are newly disadvantaged, often excluded from service."

- Royal Australian and New Zealand (RANZCP) Rethinking Risk to Others: <https://www.rcpsych.ac.uk/pdf/CR150%20rethinking%20risk.pdf>
- Problems with Risk-Averse Services: <http://www.independent.co.uk/voices/comment/our-risk-averse-mental-health-system-is-wasting-money-and-harming-recovery-8471518.html>
- Risk Distortion and Risk Aversion: https://www.pccs-books.co.uk/downloads/Risk_Distortion_and_Risk_Aversion.pdf

10.

Craze L. et al Recognising and responding to deterioration in mental state: A scoping review, Australian Commission on Safety and Quality in Health Care July 2014 <https://www.safetyandquality.gov.au/wp-content/uploads/2014/07/Recognising-and-responding-to-deterioration-in-mental-state.-A-scoping-review.pdf>

(Leanne Craze has put together a report for the Australian Commission and Safety and Quality in Healthcare. By the nature of this organisation and the brief Craze was given, it is inevitable this report is not challenging risk-aversion practice. The questions this report addresses are:

- How often are adverse outcomes associated with deterioration in patients' mental state reported? And where are they reported?

- *What is in place to support early recognition of deterioration in mental state in acute care facilities? Guidelines and frameworks of relevance to assisting early recognition?*
- *What is in place to manage potential adverse outcomes associated with deteriorating in mental state?*
- *How are these strategies evaluated? How successful have these strategies been?*
- *What are the gaps that need to be addressed to reduce the risk of adverse outcomes associated with deterioration in a patient's mental state?)*

11.

Crisis Teams, Rethink Mental Illness, October 2016 https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0020/273422/situational-ppt1.pdf

(This is worth reading but perhaps with a critical perspective. Emergency departments make a demarcation between 'mental illness' and people in a 'situational crisis'. Although it is mostly not stated, the implication is that people in only a 'situational crisis' are less deserving and shouldn't be there. It's fascinating to see a presenter (this is a PowerPoint) trying so hard to not discriminate whilst doing so; something which is perhaps picked up even more keenly by consumers who have been on the receiving end of practice that has been deemed negatively. For example, the authors write that clinicians are careful not to pathologise people just because they have had a bad day. This is far from simple. The use of the word 'just' names and labels people as much as a diagnosis may. Also, the word 'mad' intended here to differentiate between people who are normal but distressed, labels people with real mental illness 'mad' in a way the authors probably did not intend. Even how a simple line liked this, if picked up by students in a way that influences them, can be a seed for thoughtlessness. There are many more examples in this document which give away an underlying judgement of people with 'situational crises'. There is a hidden message of 'get your act together' and the suggestions for practice are problematic, including a throwaway line about providing referral. Consumers who have been in this situation know emergency clinicians don't have the skills or the aptitude to follow through with this. It's good that the 'case studies' have been included, because they don't support the thrust of the presentation. All of them are serious situations, very real and deserving of respect. Perhaps the question might be, 'how can health services in complex societies better attend to the needs of people whose authentic psychological distress doesn't meet stereotypes of authentic health-seeking?')





10.

Saying 'Yes'
When We
Mean 'No'

10. Saying 'Yes' When We Mean 'No'

THE SERIOUS INCURSION OF FEAR

Michael Leaning's famous poem tells us that there are only two feelings, love and fear and only two languages, love and fear. Fear plays such a central role in psychiatric services, particularly acute ones. Some people rear up and hiss at the danger, other people curl up into a ball. Some people say 'yes' when they mean 'no' because they're afraid to say 'no'... other people say 'no' because they're afraid to say 'yes'....

LIKE ME! PLEEEEAASE!

Many consumers are desperate for the love needed to replace their fear. We all need people in our lives and we all need to be held in esteem and be needed. Treatment is too often called 'care', a language pretence that can be devastating for those who need real relationships and real caring in their lives. Misunderstandings are almost always systemic, a response to institutional and linguistic shortfalls or laziness. These systemic deficiencies are too often seen as patient/client inadequacies and to be treated...

PRIVATE LIVES!

Ostensibly, private hospitals where money changes hands should be places where patients are prepared to say 'no'. It depends, of course, but sometimes it doesn't work this way. When we are told we are not adult enough, not intelligent enough, not good enough decision makers, not ready to make the decisions we need to make, it is still hard to say 'no'.

THE TYRRANY OF BEING A 'GOOD' PATIENT

Judi Chamberlin, a famous survivor from the US wrote: "Well, I've been a good patient, and I've been a bad patient, and believe me, being a good patient helps to get you out of the hospital, but being a bad patient helps to get you back to real life."

IT'S NOT WORTH SAYING 'NO'!

Who can be bothered? It's not really a question most of the time. At a loss, we turn to our manipulation skills. Manipulation is a craft. It's not a flaw. The chaos of acute units limits everyone's capacity to even approximate assertiveness. The system is blind to 'real' ways of communicating need and power. If we are bad at manipulation, we have a limited palette of communication tools. Empowerment often emerges from skilled manipulation. Ironically, manipulation works best at times when we don't simultaneously need to 'seek attention'. Of course, we are punished if we are caught doing either.



A WIKIPEDIA ENTRY TO MADNESS

1. ABANDONMENT (EMOTIONAL) [https://en.wikipedia.org/wiki/Abandonment_\(emotional\)](https://en.wikipedia.org/wiki/Abandonment_(emotional))
2. ASSERTIVENESS: <https://en.wikipedia.org/wiki/Assertiveness>
3. ATTENTION SEEKING: https://en.wikipedia.org/wiki/Attention_seeking
4. AUTONOMY (MEDICINE): <https://en.wikipedia.org/wiki/Autonomy#Medicine>
5. COLLECTIVE INTELLIGENCE: https://en.wikipedia.org/wiki/Collective_intelligence
6. COMPLIANCE: [https://en.wikipedia.org/wiki/Compliance_\(psychology\)](https://en.wikipedia.org/wiki/Compliance_(psychology))
7. CONDITIONED EMOTIONAL RESPONSE: https://en.wikipedia.org/wiki/Conditioned_emotional_response
8. COVERT CONDITIONING: https://en.wikipedia.org/wiki/Covert_conditioning
9. CRITICAL THEORY: https://en.wikipedia.org/wiki/Critical_theory
10. CULTURE OF FEAR: https://en.wikipedia.org/wiki/Culture_of_fear
11. DEFENCE MECHANISMS: https://en.wikipedia.org/wiki/Defence_mechanisms
12. DOMINANCE & SUBMISSION: https://en.wikipedia.org/wiki/Dominance_and_submission
13. EMPOWERMENT: <https://en.wikipedia.org/wiki/Empowerment>
14. EXISTENTIAL CRISIS: https://en.wikipedia.org/wiki/Existential_crisis

15. FALSE CONSENSUS EFFECT: https://en.wikipedia.org/wiki/False_consensus_effect
16. FEAR: <https://en.wikipedia.org/wiki/Fear>
17. CULTURAL THEORY OF RISK: https://en.wikipedia.org/wiki/Cultural_Theory_of_risk
18. FIGHT OR FLIGHT RESPONSE IN HUMANS: https://en.wikipedia.org/wiki/Fight-or-flight_response
19. INTERPERSONAL COMMUNICATION: https://en.wikipedia.org/wiki/Interpersonal_communication
20. MIND GAMES: https://en.wikipedia.org/wiki/Mind_games
21. PASSIVE-AGGRESSIVE: https://en.wikipedia.org/wiki/Passive-aggressive_behavior
22. PROFESSIONAL ETHICS: https://en.wikipedia.org/wiki/Professional_ethics
23. PSYCHOLOGICAL MANIPULATION: https://en.wikipedia.org/wiki/Psychological_manipulation
24. SELF-DEFENCE: <https://en.wikipedia.org/wiki/Self-defense>
25. SELF-PRESERVATION: <https://en.wikipedia.org/wiki/Self-preservation>
26. SELF-VERIFICATION THEORY: https://en.wikipedia.org/wiki/Self-verification_theory
27. UNCONDITIONAL POSITIVE REGARD: https://en.wikipedia.org/wiki/Unconditional_positive_regard
28. UNCONSCIOUS COMMUNICATION: https://en.wikipedia.org/wiki/Unconscious_communication
29. VERBAL SELF-DEFENCE: https://en.wikipedia.org/wiki/Verbal_self_defense
30. HOW EMPHASIS ON RISK MANAGEMENT CHANGES HOSPITAL CULTURE: <http://onlinelibrary.wiley.com/doi/10.1111/nin.12199/full>

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Writing a Psychiatric Case History: General Instructions https://www.fmhs.auckland.ac.nz/assets/fmhs/som/psychmed/docs/writing_a_psychiatry_case_study.pdf

(This is instructive. It's a model (one assumes therefore good) way to take a psychiatric case history. For those of us who have seen our files and know the terrible things that have been written in them can read this and get a better idea about what was:

- *A careless or incompetent or prejudice-laden effort by an individual; or*
- *What is more institutional as set out in this document.*

The thing I noticed first was that it definitely isn't 'joint' decision-making. It's good to find out the thinking that is being encouraged when the perspective is a clinical one.)

2.

Muskett C. Trauma-informed care in inpatient mental health settings: A review of the literature, *International Journal of Mental Health Nursing* (2013) <http://staging.mhcc.org.au/media/25362/muskett-2013.pdf>

(For years after the big institutions were closed and emphasis swung around to a biomedical model of understanding mental illness, not terribly much attention was paid to trauma. In a literature search from 2000-2011, Muskett analysed practices that had been put in place to enable trauma-informed care in inpatient settings. Muskett's summation of the literature is both honest and cynical. It's not particularly encouraging. This is about mental health nurses grappling with how you do trauma-informed care in practice. She argues that the trauma-informed care 'lobby' have only been able to suggest the exclusion of seclusion and restraint as practical methods. It is then argued that this is utopian. So, the author asks, "where to from here?" The question is not directly answered but there is a plea for a better way for people, "especially with significant abuse histories.")

3.

Slade M. Implementing shared decision making in routine mental health care, *World Psychiatry* 2017, 16, 146-153 <http://onlinelibrary.wiley.com/doi/10.1002/wps.20412/pdf>

(Mike Slade is well known in Australia; he gave a keynote address at the 2017 Mental Health Services Conference (the MHS), summarised by Amy Coopes <https://croakey.org/profiling-a-paradigm-shift-in-mental-health-reporting-from-themhs2017/>. This article is a more academic one which is recent and in a 'prestigious medical journal' which might either make it good or indecipherable for people to read. Slade frequently uses the acronym SDM (shared decision making). He argues that the ethical case for shared decision making is strong but the scientific one is not (yet). He suggests that there are usually two reasons posited to support shared decision-making; the first is that it leads to better outcomes and the second is that it is ethically right. Slade argues that the empirical (observation and experiment) evidence that it leads to better outcomes is inconclusive. The ethical reason is that it should be practiced because it is the right thing to do. Slade's argument is that "clinicians need to balance the biomedical ethical principles of autonomy and justice with beneficence (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3342811/>) and non-maleficence (<http://www.alzheimer-europe.org/Ethics/Definitions-and-approaches/The-four-common-bioethical-principles/Beneficence-and-non-maleficence>). As well, shared decision making has been recommended in mental health at policy level. Yet implementation remains limited. Why? He argues that there are (ward) cultural reasons why policies are not enacted on the ground. There are also technical issues. Finally he suggests three strategies to overcome the impasses to practice:

- *Creating widespread access to high-quality decision support tools;*

- Integrating shared decision-making with other recovery-supporting interventions;
- Responding to cultural changes as patients develop the normal expectations of citizenship.)

4.

Stacey J. et al A critical narrative analysis of shared decision-making in acute inpatient mental health care *Journal of Interprofessional Care*, 2016 30(1):35-41 <http://www.criticalvaluesbasedpracticenetwork.co.uk/wp-content/uploads/a-critical-narrative-analysis-of-shared-decision-making-in-acute-in-patient-mental-health-care-1.pdf>

(This is available in full text. The authors argue that the idea of shared decision-making is supported by many professionals and many professions. They observe, however, that any decision-making (within any sector) must take on board clinicians' personal and professional values and beliefs, including their relation to education and power. Clinicians are educated in silos. Different professional groups within the sector have different experiences of professionalism, different expectations of their roles and different cultures of practice. Also, there are other players who play a part in decision making, for example, managers, consultants, consumers & carers. Different groups have widely different amounts of institutional power. Expert (or specialist) knowledge, the authors suggest, helps to create differences including different relationships toward decision-making. Each group constructs a precious identity that separated them. This is about power-over ways of practicing, education, accreditation (organisation of knowledge) and following very different career paths – some more rewarded financially than others. Specialisation has the effect of further distancing clinical groups and making decision-making styles even more disparate. In conclusion the authors write that: "In summary, this study has presented a CNA of multiple perspectives of how decisions are made about patient care. Very real power hierarchies exist and have powerful effects on actors within the hierarchy. This suggests that the current structures may at best obscure and at worst actively obstruct new ways of working. Until the role and identity of the professional groups are understood in the context of power, a practical implementation of shared decision-making, as advocated in policy and literature, will be illusory.")

5.

Zablocki L. Inpatient: A Psychiatric Story – an interactive novel on survival in the psych system 2017 <http://www.inpatientgame.com/play.html>

(This game is a simulation of a mental health crisis and the patient experience of psychiatric hospitalization. The people in this game are fictional, but the situations have been inspired by real-life experiences - looks interesting. There is, however, a warning that some people may be re-triggered.)

6.

Thibault C.A. et al Understanding the Milieu Experiences of Patients on an Acute Inpatient Psychiatric Unit, *Archives of Psychiatric Nursing*, Aug 2010 Vol 24(4):216-226 <http://www.sciencedirect.com/science/article/pii/S0883941709000983>

(This is an important paper which decides a research project using phenomenological method. Two of the researchers were consumers and their expertise was called upon heavily in the analysis of the data. The method was long, in-depth interviews with six

patients from an acute psychiatric ward. The interest was to find out what is now happening in the life of an acute psychiatric ward when so much has changed. The hypothesis was that short stays, sicker patients and psychosis caused by illicit drugs would make a substantial difference to the communal life on the ward (milieu) and that this would impact negatively on people's experiences. The analysis, however, found that it was not this straightforward. The authors found all sorts of paradoxes. These patients were finding something therapeutic from the ward community. The authors described "... patients' embodied, dialectical, and often paradoxical experiences of fear and affirmation, alienation and connection, and abandonment and healing. The authors share selected narrative accounts to generate new understanding of patient experiences and suggest that the inpatient psychiatric milieu remains an important but often neglected component of psychiatric treatment.")

7.

Stenhouse R.C. They all said you could come and speak to us': patients' expectations and experiences of help on an acute psychiatric inpatient ward. *Journal of Psychiatric Mental Health Nursing* 2011 Feb 18(1): 74-80 <https://www.ncbi.nlm.nih.gov/pubmed/21214687>

(This is oldish but goo(This paper focuses on the experience of inpatient care in the psychiatric system. There were thirteen participants and the method was unstructured interviews. The aim of the study was to gain insight into the experience of being a patient on an acute inpatient psychiatric ward. The style was narrative. Reading of the holistic analyses yielded themes of help, safety and power running across the participants' experiences: "The patient experience was characterized by dissonance between expectation and experience, the search for a nurse-patient relationship and the development of strategies to cope with being on the acute ward... their expectation that they will receive help through the development of relationships with the nurses, and their experience of the barriers to this. In response, participants developed strategies to support each other." The authors isolated one issue – patients' understanding of what the word 'help' meant to them in an inpatient setting. They spoke of expecting and needing 'help' in the inpatient settings but when that was not always forthcoming patients helped each other. This is of no surprise. People have been doing this forever. There are some questions for consumer theorists and practitioners.

- What do you do with such an insight?
- Do you turn this into an individual therapeutic opportunity to encourage a patient to be more self-directed?
- Do you use it as community building?
- Do you keep out of it and let a good process continue (recognising the limits of staff relationships)?
- Do you understand it as an industrial issue and demand patients are paid for the work?
- Do you see a potential to start milieu therapy and make a prediction of milieu-readiness?

Here is another article by the same author: Stenhouse R.C. 'Safe enough in here? Patients' experience of feeling safe in an acute psychiatric inpatient ward, *Journal of Clinical Nursing* 2013 Nov.22:21-22 <https://www.ncbi.nlm.nih.gov/pubmed/23876128>)

8.

Cappleman R. et al Experiences of ward rounds among inpatients on an acute mental health ward: a qualitative exploration, *British Journal of Psychiatry Bulletin* 2015, Oct, 39(5):233 – 236 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4706194/>

(This document is in full text on the web – free. Ward rounds are conducted regularly on acute units. These are opportunities for staff and students to check out how a patient is going, review medications and tell students (medical) all sorts of curious things about ‘a case’. It is sometimes led by a consultant psychiatrist who generally takes the lead. This is one of the interactions on acute units where some patients say ‘yes, I’ll be part of this’ because they are afraid to say no or because they are intrigued or because they want to find stuff out or because they are bored. This study used in-depth interviews to find out more about what inpatients thought about ward rounds. Doctors tend to think ward rounds are very important but information about what patients think of them is scarce. “Patients report not being listened to and feeling that information is withheld from them. Many patients also feel inadequately prepared for ward rounds by staff.” Participants in the study made the following recommendations for staff:

- *Allow patients access to ward round records and the power to negotiate additions to them.*
- *Invite a smaller number of staff into patients' initial ward rounds and increase the number gradually.*
- *Be open about when patients are being assessed on particular areas of their mental state and why.*
- *Utilise patients' one-to-one time with named nurses so ward rounds can be prepared for.*
- *Issue patients with a booklet about hospital procedures on admission, including information about ward rounds. This would serve as an aide memoire for patients to return to, so they can remind themselves of ward round procedures.*

*Also see: Swenne C.L. & Skytt B. The ward round patient experiences and barriers to participation, *Scandinavia Journal of Caring Science*, 2014 Jan (2):297 -304 <https://www.ncbi.nlm.nih.gov/pubmed/23808650>*

9.

Miletic T. et al Guidelines for Working Effectively with Interpreters in Mental Health settings; Victorian Transcultural Psychiatry Unit 2006 http://www.vtmh.org.au/docs/interpreter/VTPU_GuidelinesBooklet.pdf

(This is vital for consumers working in mental health settings as well as for administrators and clinicians. There is an art to working with interpreters and the starting point is humility. Don't pretend it's straightforward and don't pretend you know what to do without any training. Consumers know, for example, how tenuous communication is on an acute psychiatric ward. How much more difficult it must be for people who don't speak English. I would hate it. Imagine knocking on the glass door of the nurses' station for twenty minutes knowing that when someone eventually comes you have no way of telling them what you need. It's an extra layer of disadvantage. People sometimes use the word intersectionality: that place where mental illness meets linguistic and cultural disadvantage. This is a thorough guide

and, like all such documents, it's not an enthralling read but it is an organised one. Don't use children to interpret for their parents. It is not fair, not ethical; besides they need to be at school.)

10.

A Brief Discussion of Privilege in Equity Matters, <https://asusequity.wordpress.com/equity-101/a-brief-discussion-of-privilege/>

(This is brilliant (and all on web). It's so brief. The writers ask us to think about our own privilege by listing a heap of questions about what we can and cannot do. If we answer 'yes' this is a tick for privilege. The importance of this is not just that it is interesting but also that it reminds us of our own comparative privilege when maybe we didn't recognise that we do have power and can live in world where are not always subjugated and we have the means (financial, educational, moral and cultural) to make decisions that many others could not. This particular piece looks at:

- White Privilege,
- Heterosexuality Privilege; and
- Ableist Privilege.)

11.

Rosenhan D. L. On Being Sane in Insane Places <http://www.bonkersinstitute.org/rosenhan.html>

(This is a famous experiment. It leads to deep thinking about the nature of psychiatry, the difficulties psychiatry has that other specialities of medicine don't have about the clarity of science. It is dated now but it remains important. These days no ethics or research committee would allow it to take place. So, it's both historic and totally contemporary. Rosenhan, a psychologist, organised for a handful of healthy students to be admitted to psychiatric units. How they got on will fascinate you. The temptation to use research like this to bash psychiatry should perhaps be considered carefully.)

11.

The Medical
Model:
Consumers
and Exclusion

11. Patients Perceive and Clinicians Know

GUESS WHAT?

People with 'mental illnesses' know many important things; perhaps knowledge that clinicians may never learn or have the privilege to implement in practice. Clinicians know stuff too. No denying that. However, guessing is their standard currency. It is in part their job. Mostly clinicians avoid saying this publically. Society sanctions this and the medical ethos reinforces this because it must. The more autocratic the clinician, the more disguised their guessing becomes.

RESIDENT REPRESENTATIVES

None of us can truly represent another. This is as true for those who head up a consumer organisation as it is for those who have just had their first hospital experience. All of our views are influenced by what we value, what we respect, which ideas we want to interrogate, which people we choose to associate with and listen to. Being expected to always represent is precarious, leaving us open to accusations of being non-representative when others challenge our opinions. Saying 'no' to the concept of representation does not imply our knowledge base is not a collective one.

THINKING YOU ALWAYS HAVE TO KNOW IS OPPRESSIVE

This language defines relationships between clinicians and 'their' patients. The onus of knowing falls on doctors (and other medical professionals). The community drives this. Society applauds expertise. Clinicians of all kinds work under considerable pressure to appear (and be) authoritative. It often takes the exceptional clinician to publicly express uncertainty. Knowledge is limited, emergent and absolutes are rare.

REAL KNOWLEDGE

The difference between being institutionally expected to 'know everything' and being institutionally expected to 'know nothing' is enormous. This leaves clinicians empowered by a designated knowledge base and even the best politically and experientially credentialed consumers stuck in cycles of relativity and accused of having only individual, subjective stories open to commentary by the knowledgeable professional. This is a significant knowledge demarcation. Clinicians know and consumers perceive. Really?

THE CONSUMER BODY OF KNOWLEDGE

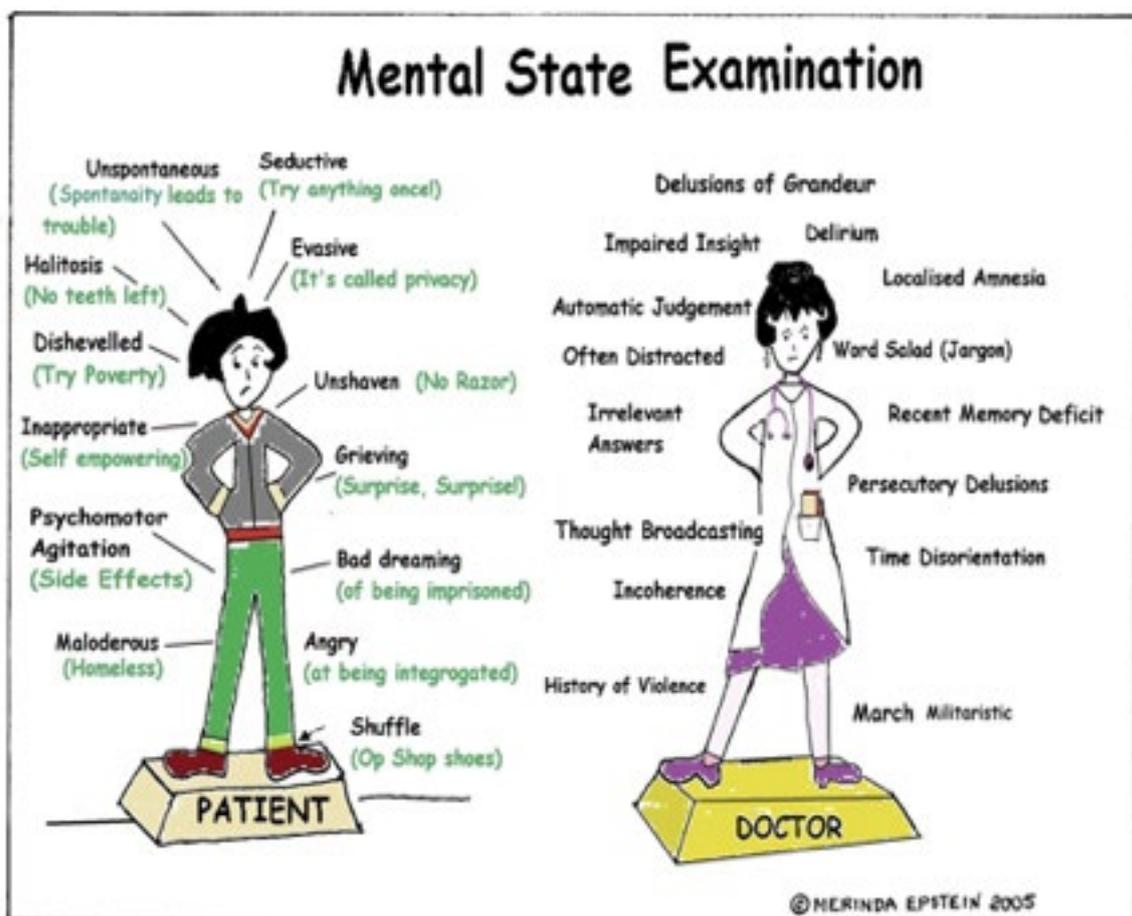
On top of the knowledge every person brings when they visit a doctor or other clinicians, mental health consumers have developed a perspective, a theory and an epistemology which is authoritative and challenges other discourses. Knowledge is power: if you don't respect my knowledge, you don't respect me. If you don't recognise I have knowledge, you certainly can't enable me to find my power. Knowledge is not some bland icing on the cake of educational achievement. Of course it's political.



A WIKIPEDIA ENTRY TO MADNESS

1. ABSTRACT AND CONCRETE THINKING: https://en.wikipedia.org/wiki/Abstract_and_concrete
2. ARISTOTLE'S THREE TYPES OF KNOWLEDGE: <http://www.applitude.se/2011/02/aristotle%E2%80%99s-three-types-of-knowledge/>
3. BODY OF KNOWLEDGE: https://en.wikipedia.org/wiki/Body_of_knowledge
4. CARPER'S FUNDAMENTAL WAYS OF KNOWING: https://en.wikipedia.org/wiki/Carper%27s_fundamental_ways_of_knowing
5. CLOSURE (SOCIOLOGY): [https://en.wikipedia.org/wiki/Closure_\(sociology\)](https://en.wikipedia.org/wiki/Closure_(sociology))
6. COLLECTIVISM: <https://en.wikipedia.org/wiki/Collectivism>
7. CULTURAL CAPITAL: https://en.wikipedia.org/wiki/Cultural_capital
8. EMPIRICAL EVIDENCE: https://en.wikipedia.org/wiki/Empirical_evidence
9. EPISTEMOLOGY: <https://en.wikipedia.org/wiki/Epistemology>
10. EXPERIENTIAL KNOWLEDGE: https://en.wikipedia.org/wiki/Experiential_knowledge
11. FACTUAL RELATIVISM: https://en.wikipedia.org/wiki/Factual_relativism
12. HALF-LIFE OF KNOWLEDGE: https://en.wikipedia.org/wiki/Half-life_of_knowledge
13. IDEA: <https://en.wikipedia.org/wiki/Idea>
14. INDIVIDUALISM: <https://en.wikipedia.org/wiki/Individualism>
15. OBJECTIVITY: [https://en.wikipedia.org/wiki/Objectivity_\(philosophy\)](https://en.wikipedia.org/wiki/Objectivity_(philosophy))
16. ONTOLOGY [https://en.wikipedia.org/wiki/Ontology_\(information_science\)](https://en.wikipedia.org/wiki/Ontology_(information_science))

17. PHENOMENOLOGY: [https://en.wikipedia.org/wiki/Phenomenology_\(psychology\)](https://en.wikipedia.org/wiki/Phenomenology_(psychology))
18. PHILOSOPHY OF SCIENCE: https://en.wikipedia.org/wiki/Philosophy_of_science
19. POLITICISATION OF SCIENCE: https://en.wikipedia.org/wiki/Politicization_of_science
20. POSITIVISM: <https://en.wikipedia.org/wiki/Positivism>
21. POSTPOSITIVISM: <https://en.wikipedia.org/wiki/Postpositivism>
22. PROFESSIONALIZATION: <https://en.wikipedia.org/wiki/Professionalization>
23. REIFICATION (KNOWLEDGE REPRESENTATION): [https://en.wikipedia.org/wiki/Reification_\(knowledge_representation\)](https://en.wikipedia.org/wiki/Reification_(knowledge_representation))
24. PROFESSIONALISATION: <https://en.wikipedia.org/wiki/Professionalization>
25. SUBJECTIVITY: <https://en.wikipedia.org/wiki/Subjectivity>
26. TACIT KNOWLEDGE: https://en.wikipedia.org/wiki/Tacit_knowledge
27. THE MYTH OF OBJECTIVITY: <https://www.psychologytoday.com/blog/political-intelligence/201206/the-myth-objectivity>
28. THE SIX TYPES OF KNOWLEDGE: <https://blog.udemy.com/types-of-knowledge/>
29. WISDOM: <https://en.wikipedia.org/wiki/Wisdom>
30. WORLDVIEW: https://en.wikipedia.org/wiki/World_view



ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Lützen K. et al Moral Sensitivity in Psychiatric Practice; Nursing Ethics, November 1st 1997 <http://journals.sagepub.com/doi/abs/10.1177/096973309700400604>

(This was a study using questionnaires. It is a bit old but the topic is perennial. What drives psychiatrists to what they perceive to be good moral decision making. It is published in a nursing journal which is interesting. The analysis is based on 754 completed questionnaires. Primarily it looks at the moral code used when psychiatrists make decisions. What are the attributes of their practises they regard as the most important moral drivers. Lützen gives an example of a difference between male and female psychiatrists: "[Male psychiatrists] agreed to a greater extent that medical knowledge was most important in deciding what was best for the patient [whilst]...female ...psychiatrists thought that the relationship with the patient was most important in psychiatric practice. Reading this paper I started thinking about consumers of psychiatrists practice (patients) and whether there are gender differences between the way we judge the behaviour of psychiatrists in relation to the morality of their practice.)

2.

Isaac R. The Ethical Private Practitioner - Ethical Issues in Counselling and Psychotherapy Practice: Walking the Line Bhola P & Raguram A (eds.) 2016; Chapter Two: 19-35 <file:///C:/Users/Merindz/Downloads/9789811018060-c2.pdf>

(This is a full text which is great and as it is part of a descriptive conversation it is written in language which is quite commendable compared to much that comes out of the discipline of psychology. The following paragraph is indicative of the style of writing in this chapter: "As a private practitioner, sitting alone in my room, far away from everybody else, I felt truly out in the cold. I was cut-off from the support system I had grown used to. Just being a good therapist was suddenly not enough. On the other hand, I had a lot more say in the type of clients I chose to work with, on my timings, on the space that I occupied and in how I chose to proceed with the therapy. Clients came to see 'me' and felt freer to ask about my training and qualifications. They looked around my room and observed and inferred what they might. There was no one looking over my shoulder. No judgement; but no help either. Private practice offers more freedom and flexibility with work, but also a greater burden of clinical and ethical responsibility (Brennan 2013)."

This material is of great interest to the profession of psychotherapy in particular and clinical psychology and counselling psychology in general. This is the audience. There is no shortage of material. This is just one study. In looking at the method and the many qualifications to what is meant by the term 'psychotherapist' and what is meant by the term 'ethical' data is collected, the author hopes, that will mean practitioners will get to understand more about ethical practice. As a consumer reader, the most obvious flaw in attempting to draw out ethical practice without including the knowledge of the people who are being practised on is precisely that. There appears to be no attempt to include 'clients' knowledge but rather there is ample evidence of the author implicitly making recommendations based on his perception of what he and fellow psychotherapists believe 'people-who-they-call-clients' think. They would say that they have empirical evidence. By such exclusion of one or many 'knowledges' an ethical problem arises. Having outlined the critique above, this chapter is good for many reasons and its accessibility is a bonus. It's easy to read, it's about ethics which is interesting (if only to check it past the clinicians we

might personally see), it's about private practice and psychotherapy both of which are not experienced by mainstream public patients, it enables consumers to get into the heads of clinical psychologists and, importantly, this is an area of practice in mental health which is in the political doldrums (out of fashion); so this gives us all an opportunity to hear more critically medical model attacks on what is, perhaps, an art rather than an evidence-based science.)

3.

Robertson M. An Overview of Psychiatric Ethics, Health Education & Training Institute (HETI) <http://www.heti.nsw.gov.au/Global/HETI-Resources/psychiatry/An%20Overview%20of%20Psychiatric%20Ethics.pdf>

(If you want something good on psychiatric ethics, here it is. This is for those of us who really want to understand the ethical deliberations psychiatrists are required to understand and follow. We all know that they don't all behave ethically and that sometimes there are bureaucratic, financial, political or personalities things that get in the way of ethical practice. Like in all groups, some psychiatrists won't even know what's in these guidelines and won't care. Others will care passionately and may get stuck where there are ethical grey areas and dilemmas. Whether in private or in public services practice, ethics is important. Ethical decision-making is important in all medical disciplines; however, psychiatry presents a unique set of circumstances. Rarely does anyone think that consumers (or individual patients) can actually play an important role in helping psychiatrists get through the tangle of conflicts that often make decision-making onerous. Patients have an experiential knowledge of their own about ethical practice. Sometimes they are too afraid to talk about it, especially if the ethical issue applies to a psychiatrist with whom they have a personal and powerless relationship. Get a copy of this. It will be a useful document to have at hand.)

4.

Epstein M. Pluck, acceptance, defiance and fortitude: telling mental illness stories to change the world, Our Consumer Place, February 2016 <http://www.ourcommunity.com.au/files/ocp-stories2016.pdf>

(This is a 2016 publication from Our Consumer Place. For those interested in story and those interested in consumers' body of knowledge, this is important. It cuts through the dichotomy between consumer educators telling their own story and other consumer educators working towards enabling others to tell stories or following the pursuit of developing the consumer body of knowledge. This is a new contribution. It blends these two ways of educating together in some sort of theorised way. Some of the themes are.

- *Story is not just personal account;*
- *Creative and inventive ways to build a consumer knowledge base;*
- *Story and education of clinicians;*
- *The dominant archetype messages told through story;*
- *Using story as narrative;*
- *The dominant medical metaphors: war and science;*
- *Personal account in the education of clinicians;*

- The roles of story in business, science, economics, politics etc.;
- Story and tokenism;
- Representation and expertise in consumer knowledge;
- Clinicians and others coaching consumers to tell stories in certain ways.

Section 2: Sociological Conceptualisation of medical Knowledge and power in Concepts of Health and Illness; including: Concepts of Health, Wellbeing and Illness, and the Aetiology of Illness: Health Knowledge <https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4a-concepts-health-illness/section2>. This is from a textbook. It is basic but important and written in an instructive way. There is easy access to the whole document. It describes why the sociological interpretation of health and illness is different from the dominant biomedical model. A step by step approach is taken here. For all people unfamiliar with the work of sociologists, this is a must read. It is very short.

I have coupled with Epstein's booklet a paper looking at story, narrative and knowledge written from a more general (and more powerful) perspective. The two papers support each other. The fundamental point of difference is that the Dein's work is keen to understand and theorise about healing and recovery (from a sociological but also non-consumer) point of view. Epstein seeks to understand narrative, archetype, story and knowledge from a consumer perspective. Dein S. Narratives and Healing: Implications for Psychiatry and Psychotherapy; *Anthropology* 4:162 <https://www.omicsonline.org/open-access/narratives-and-healing-implications-for-psychiatry-and-psychotherapy-2332-0915-1000162.php?aid=70904>)

5.

Rayner S. Uncomfortable knowledge: the social construction of ignorance in science and environmental policy discourses; *Journal of Economy and Society*, Vol 41(1), 2012 <http://www.tandfonline.com/doi/abs/10.1080/03085147.2011.637335?src=recsys&journalCode=reso20>

(Forget that this is ostensibly about environmental issues and, instead, concentrate on the idea that ignorance can be created and is created by powers within society to achieve certain political outcomes. This is as relevant to mental health/illness as it is to environmental beliefs. Unfortunately, it is only a summary and to obtain the whole article it is necessary to purchase it if you are not affiliated with a mental health service or university. This is not a research article so it is much easier to navigate. The ideas are compelling. It starts by looking at the nature of society and identifying that in order to make sense of the world, institutions (and individuals) reduce it to create ideas that seems consistent and more reliable. Then the author articulates how institutions do this and how the people who create and maintain these institutions do this. He argues that we get rid of the tensions and contradictions. The paper discusses four different methods we use to do this:

- Denial;
- Dismissal;
- Diversion; and
- Displacement

In order to do this institutions and people seek to exclude ideas that don't fit with their worldview, abandoning knowledge which isn't 'easy' and which contradicts itself and is messy. Then they need to justify this abandonment with public rhetoric. People and institutions seek to tick-off simplified public messages. Social, cultural, economic and political authority join together. Safe renditions of life, of the truth, of knowledge have appeal. Life without tensions and contradictions is appealing to many. Versions that don't fit are expunged. The author calls these ways of knowing 'uncomfortable' knowledge. It's obvious that within the mental health/illness discourse consumer knowledges (and some understandings by consumers in particular) might well be understood as uncomfortable by those who ascribe to a packaged dominant theory.

Similar ideas are canvassed in the following article. It is also worth a read. Again, if you are unconnected to a university or workplace in mental health, it has to be purchased. McGoey L. Strategic unknowns: towards a sociology of ignorance, Journal of Economy and Society, Vol 41(1), 2012 <http://www.tandfonline.com/doi/full/10.1080/03085147.2011.637330>

6.

Prideaux J. The Age of Unreason, The Economist, <https://www.economist.com/news/special-report/21657023-world-grows-richer-and-older-mental-illness-becoming-more-common-john-prideaux>

(This is fantastic. It is both a written document and spoken as audio. Please have a go at this one. I think it is important that we all do. It covers a huge spread of issues at surprising depth. It is in 'The Economist', so unsurprisingly, the author is interested in funding mental illness, judging seriousness and preferred priority and an orientation towards science dependence as described often as evidence-based practice. Even if you have some qualms about this it is worth reading/listening-to. It covers (amongst other things):

- *Historical underscoring of contemporary ideas about who is responsible about knowing what;*
- *Expertise historically – the family;*
- *Medical knowing relatively recent and differing according to country and population;*
- *Big moves in ideology;*
- *Our aging population;*
- *World trends;*
- *Rich countries' mental health needs and why questions about mental illness are socially constructed;*
- *Developing a country's understanding of mental illness;*
- *Prejudice;*
- *Different ways of describing mental illness;*
- *Relativism and mental illness;*
- *Transatlantic differences in describing mental illness – example, autism (syndrome or illness);*
- *The future of treatment.)*

7.

Laugharne R. et al Psychiatry, postmodernism and post-normal science, Journal of the Royal Society of Medicine 2002 Apr. 95(4):207-210 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1279521/>

(This is available in full text on the web; it is helpful. Laugharne argues that to understand the way that different knowledge bases and understandings interact it is useful to look at the ideas of postmodernism. He refers to the 19th Century philosopher Friedrich Nietzsche (https://en.wikipedia.org/wiki/Philosophy_of_Friedrich_Nietzsche) who said, in a famous quote: 'What, then, is truth? A mobile army of metaphors, metonyms and anthropomorphisms—in short, a sum of human relations, which have been enhanced, transposed, and embellished poetically and rhetorically, and which after long use seem firm, canonical and obligatory to a people; truths are illusions of which one has forgotten that this is what they are; metaphors which are worn out and without sensuous power'. In a mental health context, this is in some part equivalent to the ideas of different perspectives (consumer, bureaucracy, family carers, services, psychiatrists etc.) which have different and often competing discourses (<https://en.wikipedia.org/wiki/Discourse>). How do we know the truth? Laugharne describes three identifying characteristics of postmodernism:

- Suspicion of metanarratives (traditional religions can be seen to have metanarratives);
- Criticism of science;
- Post-normal science.

The rest of the article describes the arguments the author uses to claim that contemporary psychiatry can be seen (perhaps more than any other medical speciality) as postmodern in its practice. I think it's a bit of a stretch, but if you are interested in knowledge, in competing claims to knowledge, psychiatric discourse or the way psychiatry juggles different truths or creates facts (or fact-likeness), read this piece and make your own decision.)

8.

Living Knowledge: Indigenous Knowledge in Science Education http://livingknowledge.anu.edu.au/html/educators/02_questions.htm

(This is essential reading if we want to include the oldest and perhaps most important scientists of this land. Knowledge, for Indigenous people includes: Beliefs and understandings acquired through long-term association with place and based on social, physical and spiritual knowledge. Indigenous knowledge is known variously as:

- Traditional Ecological Knowledge (TEK);
- Indigenous people's Knowledge (IPK); or
- People's Knowledge.

While Indigenous knowledge sometimes contrasts with scientific knowledge, it can also be complementary and provide supplementary information about the world:

- What is Science?
- What is Indigenous science?
- What is the relationship between Indigenous knowledge and science?

Although this paper is written for secondary school students, it is easily accessed. It is an introduction to understanding the different ways Aboriginal peoples create knowledge. Knowing and respecting Indigenous knowledge is much more than an Indigenous issue. In mental health, Indigenous groups hate the term mental illness. It doesn't make sense as they intrinsically know things holistically, spiritually, creatively, in narrative and in all sorts of ways that many in this country do not understand, so therefore don't appreciate. Indigenous communities (if they are still whole and still healthy) understand 'social, emotional and cultural wellbeing' a holistic and inclusive term rather than 'mental illness'. This term also reflects the importance of place and kin. The importance is that non-Indigenous consumers can learn from Aboriginal ways of doing knowledge; knowledge that has been practiced through thousands of years of grounded theory. This is also more than bush medicine. It's about an attitude to health. In mental health terms, it could be argued that 'closing the gap' is about opportunities for us as Indigenous people diagnosed with mental illness to explore better ways of understanding health in a much more rounded, nuanced and sophisticated way. We still have a long way to go. Our language, knowledge and culture, our history, are all imbedded in white imperialist ways of being. When we are nurtured in and, at the same time, judged by, a medicalised definition of self, it is sometimes hard to see what's outside. People are often scared to explore difference.)

9.

Dove E.S. et al Beyond individualism: Is there a place for relational autonomy in clinical practice and research? *Clinical Ethics* 2017 Sep, 12(3): 150-165 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5603969/>

(This is a full text available on the web, therefore easily accessible to anyone who has a computer and WiFi capacity. This is a generalist medical article and not specifically about mental health. The authors juxtapose the values of individuality and autonomy (independent, self-interested, rational, gain-making, decision-makers) against the ideas associated with 'relational autonomy'. Proponents of this view argue that we are always also shaped by our relationships with others. The writers suggest that, despite the critique of individualism, there is no creditable evidence to show that the 'relational autonomy' critique has had much influence in clinical ethics or research thus far. The authors utilises 4 case studies to argue that, "certain forms of relational autonomy can have a tangible and positive impact on clinical practice and research. These solutions leave the ultimate decision to the person most affected, but encourage and facilitate the consideration of this person's care and responsibility for connected others." The subtext in this article is perhaps psychiatrists trying to find a way to colonise the idea of 'relational autonomy. Is this about clinical power? Readers need to interrogate it for themselves.)

12.

It's My Leg
That's Broken:
Musings On A
Life Sentence

12. It's My Leg That's Broken: Musings On A Life Sentence

THE CURSE OF MEDICAL HISTORIES

Consumers with different needs and lives have differing relationships with their 'case histories'. Some people hate having to repeat their story ad nauseam and lobby for devices such as electronic records to be universal. Others are terrified of this happening and the consequence of non-involved doctors further stigmatising them. From one perspective, records are simply a way of crafting a picture to aid and streamline future interactions with medical professionals. It is the accuracy of entries and inclusion of important information that is important. For others, the whole document is heresy and too often puts in stone a series of untruths that are profoundly defamatory.

DOWN ON THE FARM

In rural and remote situations, people with psychiatric histories are often known to everyone. Although what is written about them can be rotten, it is sometimes not that that matters so much. News travels even faster outside than it does inside the system. The emergency department will be well and truly informed long before consumers have any crisis at all. A broken leg is never just a broken leg for someone with mental illness in small country towns or even regional centres. Prejudice hurts harder.

ACUTE HUB

Emergency Departments in general hospitals have a lot to deal with. This is not denied. However, all is not OK in the ED. From a psychiatric perspective it is the EDs that need reform. Too often mental health consumers leave unravelled and unhelped, exposed and demeaned; for some, traumatised by the use of force. It's weird to have bunkers in a hospital space: declaring war on us, making our difference even more obvious... and then forgetting we're there.

MY FRIEND, MR SECURITY

Consumers have surprising stories sometimes. The accounts of the honourable policeperson and the very special security guard are worth hearing. These stories can't be generalised, but they can be studied to find out what makes these relationships work. Sometimes relationships with the most unlikely are fuelled by an innocence that gets trained-out of clinicians and other professionals.

LIVID EXPERIENCE No. 45

Take one acute psychiatric unit and a patient with a physical disability (nobody ever said it was only the sane who have to cope with physical disabilities!). Take a walk around the perimeter of the hospital. It's called... 'Something-or-other Therapy'. The patient with limited physical capacity is chastised by a staff member for manipulating other patients by her refusal to walk in a timely way. She is told not to use her disability as an excuse. No staff member challenges the nurse involved. Thankfully, several other patients start hobbling as well.



A WIKIPEDIA ENTRY INTO MADNESS

1. CHARACTER ASSASSINATION: https://en.wikipedia.org/wiki/Character_assassination
2. CLINICIANS AND MORAL JUDGEMENTS ABOUT PATIENTS: <https://peh-med.biomedcentral.com/articles/10.1186/1747-5341-5-11>
3. COLLECTIVE INTELLIGENCE: https://en.wikipedia.org/wiki/Collective_intelligence
4. CONFIDENTIALITY: <http://pb.rcpsych.org/content/31/4/153.2>
5. DEFAMATION: <https://en.wikipedia.org/wiki/Defamation>
6. DUAL RELATIONSHIPS: https://en.wikipedia.org/wiki/Dual_relationship
7. ELECTRONIC HEALTH RECORDS: https://en.wikipedia.org/wiki/Electronic_health_record
8. FOREIGN DOCTORS' OBSTACLE COURSE: <http://www.smh.com.au/national/foreign-doctors-obstacle-course-a-disgrace-20111119-1nonl.html>
9. FREEDOM OF INFORMATION: https://en.wikipedia.org/wiki/Freedom_of_information

10. HEALTH EQUITY: https://en.wikipedia.org/wiki/Health_equity
11. INTEGRATED PERSONAL HEALTH RECORDS: <https://bmcmeginformdecismak.biomedcentral.com/articles/10.1186/1472-6947-8-45>
12. LIAISON PSYCHIATRY https://en.wikipedia.org/wiki/Liaison_psychiatry
13. MEDICAL HISTORY: https://en.wikipedia.org/wiki/Medical_history
14. MEDICAL PRIVACY: https://en.wikipedia.org/wiki/Medical_privacy
15. MEDICAL RECORD KEEPING: https://en.wikipedia.org/wiki/Medical_record
16. MENTALISM: [https://en.wikipedia.org/wiki/Mentalism_\(discrimination\)](https://en.wikipedia.org/wiki/Mentalism_(discrimination))
17. PREJUDICE IN MEDICINE: <http://pb.rcpsych.org/content/31/4/153.2>
18. RURAL MEDICINE PRIVACY: https://en.wikipedia.org/wiki/Australian_College_of_Rural_and_Remote_Medicine
19. PSYCHIATRIC HISTORY: https://en.wikipedia.org/wiki/Psychiatric_history
20. PSYCHIATRIC PATIENT BOARDING: <https://www.hindawi.com/journals/emi/2012/360308/>
21. PSYCHIATRIC PATIENTS IN EMERGENCY DEPARTMENTS: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4786237/>
22. PSYCHOLOGISTS' RECORDS (APS): <https://www.psychology.org.au/Assets/Files/Management-ownership-access-psychologist-records.pdf>
23. REDACTION: <https://en.wikipedia.org/wiki/Redaction>
24. RURAL GENERALIST MEDICINE: <http://www.acrrm.org.au/the-college-at-work/rural-generalist-medicine>
25. RURAL HEALTH: https://en.wikipedia.org/wiki/Rural_health
26. SMALL COMMUNITY PSYCHIATRY: <http://www.racgp.org.au/afp/2014/july/generalism-in-rural-australia/>
27. SOCIOLOGY OF PUNISHMENT: https://en.wikipedia.org/wiki/Sociology_of_punishment
28. TELEPSYCHIATRY: <http://www.acrrm.org.au/the-college-at-work/rural-generalist-medicine>
29. WHEN DO ICTOR'S DISCRIMINATE: <http://www.nytimes.com/2013/08/11/opinion/sunday/when-doctors-discriminate.html>
30. WHY CONSUMERS WANT THEIR HEALTH RECORDS: <https://rockhealth.com/why-consumers-want-their-health-records/>

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1

Tsirigotis K. et al Gender differentiation in methods of suicide attempts; Medical Science Monitor 2011, 17(8) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3539603/>

(This article is on line free for all; the authors refer to a concept they describe as 'Gender Paradox'. That is, 3 times as many women as men attempt suicide and yet men are four times more likely to die from such attempts. Thus women are the attempters and survivors of suicide attempts [and therefore more likely to be of interest to emergency departments and the dominant – often negative - values of emergency medicine.] The authors describe women who attempt suicide as the "attempters" and "survivors". Over half the sample of people who sought out suicide had major depression. None were diagnosed with psychotic disorders. Women are twice as likely as men to be diagnosed with major depression. The authors put forward three possible explanations for this: Men highly value independence and decisiveness, and they regard acknowledging a need for help as a weakness and avoid it whilst women value relationships and friendships and are more likely to speak to friends with whom they explore their feelings. Men choose more drastic measures to suicide; maybe men just want to die more: "...the underlying reasons [for the Gender Paradox' continue to be debated... An answer to the question of how many of suicide attempters were desperately "crying for help", especially among women, and how many suicide attempts were actual suicide intentions, may be the subject of further research]." This research did not use a sampling method which picked up other social factors such as social class, education levels, sexual orientation, cultural background, and ethnicity. There may be important and useful knowledge to gain about suicide from the intersection of these important factors.)

2.

Kesby A. & Murchie F. Situational Crisis in Emergency Departments https://www.aci.health.nsw.gov.au/_data/assets/pdf_file/0020/273422/situational-ppt1.pdf

(Power points sometimes don't work as documents to be read because they leave out all the information which often is important to enable meaning. This one is a case study of an educator trying to teach emergency staff about (a) person(s) 'presenting' to an emergency department in a 'situational crisis'- potentially a euphemism for 'time waster'. The educators, in point form, tick off the things that need to be done for good practice. They offer advice that sounds very reasonable on its own, but, if taken in the context of emergency department culture, seems limited precisely because it does not confront that culture directly including feelings, fears, anger of staff and systems. The reality is that these people are covertly chastised and unilaterally not liked and the presentation may be an attempt to make life a bit better for them.

Some of what they say seems paradoxical; they ask to not pathologise these people, which sounds good; but then they suggest that they probably just 'have had a 'bad day", which is a judgement, especially when one puts it beside the reality of the case studies. There is also a lot of 'give the patient a pamphlet and then they'll go away'. We know experientially that this doesn't work but, in addition, that it alienates people and is likely to increase tension rather than reduce it. It is also difficult to take seriously the idea that emergency staff could 'help people find their own strengths'. They are neither qualified nor, if experiential knowledge is

anything to go by, likely to be helpful because an 'emergency manner' won't be authentic for this purpose.

This presentation should remind us that this sort of education should be done in partnership with people who have been on the receiving end. The case studies offer a very powerful message: all three people had major social issues which, of course, profoundly influenced their mental state. They are obviously legitimate if one takes a holistic view of mental distress and wellbeing. The emergency department might not be the right place, but if the way we care for and about people, where else do they go? That's an issue for institutions as much as it is an issue for those in pain. People who are deeply distressed but have no 'legitimizing' mental illness bring up anomalies in care for emergency departments.

This case study of an education intervention reveals a hidden agenda that needs to be better understood.)

3.

Pobile B. My brush with suicide and the shame of not being a good enough man; Sydney Morning Herald May 7th 2017 <http://www.smh.com.au/lifestyle/health-and-wellbeing/ben-pobjie-the-shame-of-male-suicide-20170501-gvw2bi.html>

(This is an easy-to-read newspaper article written in the first person; Ben Pobile found life overwhelming and this escalated into an attempt to take his own life. In a short period of time he experienced police intervention and psychiatric hospital for the first time. This is a story of profound shame.)

4.

Record Keeping Guidelines: American Psychological Association <http://www.apa.org/pubs/journals/features/record-keeping.pdf>

(As consumers we sometimes do need to find out the conditions under which treating clinicians are required to practice. Sometimes it is really important, because we feel something is wrong that needs redress. In this case, we also have to further explore. In Australia much of this information comes from the Australian Psychological Association: Code of Ethics: <https://www.psychology.org.au/Assets/Files/APS-Code-of-Ethics.pdf>)

5.

Australian Health Complaints Regulatory Board <http://www.ahpra.gov.au/publications/tribunal-decisions.aspx>

(Sometimes reading guidelines is not so immediate. It gives us a feel around applied professionalism and perhaps helps us communicate when tricky situations occur and clients/patients don't want to lose negotiating without equal access to the most important information. Importantly, this is not about clinical practice per-se. It is about keeping records and this is an important distinction especially for psychologists working in institutional settings, where what they write is passed on to others and likely to move more and more from opinion to fact as it is passed along over time. Records in private clinics are less potentially damaging, but what we commit to print cements our thinking regardless of what story we tell. Diagnoses and even 'traits' should be handled with care.

By carefully looking at these guidelines, you will learn as much from what's not there as

from what is there, notwithstanding that there are 13 guidelines. In emergency departments people can so easily misread and misuse files; should there be a guideline about offering personal information to a health professional who does not directly need it? Where is the clinical guideline about writing and sharing information that psychologists know a client would not like shared or a guideline which reminds clinicians that some language is judgemental and unacceptable? Or where is shared decision-making or allowing a client to take their own files to an emergency department? This is all part of a hidden curriculum and of maintaining the status of the respective professions. Often these documents serve to reinforce this. There are three things about this document which are important to know:

- It's from the US;
- It is clearly articulated giving readers a sense of this kind of document;
- The Australian one will be similar.

(It is using the profession of clinical psychology as an example but applies equally to other clinical groups.)

6.

Gutheil T.G. Empty Words in Psychiatric Records: Where Has Clinical Narrative Gone? Psychiatric Times, December 16th 2011 <http://www.psychiatrictimes.com/risk-assessment-0/empty-words-psychiatric-records-where-has-clinical-narrative-gone>

(The author bemoans the loss of the narrative in history-taking, also critiquing the over-use of acronyms that make little sense to clinicians working in psychiatric settings but potentially dangerous when psychiatric files are sent to other settings, including Emergency Departments. He also asks some searching questions of computer generated history-taking for psychiatric patients. He believes that careful clinical judgement needs to be able to be recorded with clarity: "...judgment cannot be captured through a host of checkboxes, especially when the checklists are designed primarily for recording individual symptoms or signs rather than complex mental processes." He draws attention to psychiatric emergency admissions and the inability of such templates to adequately record psychiatric rather than physical presentation. In this short, easy-to-read piece the author offers a couple of examples of the shambles a record can become when there is an overreliance on templates and electronic gadgets.)

7.

Australian Medical Association, Guidelines for Doctors on Disclosing Medical Records to Third Parties 2010 <https://ama.com.au/article/guidelines-doctors-disclosing-medical-records-third-parties-2010>

(This is comprehensive and possibly predictable. It is also a document designed to cater for all doctors, specialists and generalists.

- Consent for Disclosure of Medical Records
- Patients who are minors
- Patients with impaired decision-making capacity
- Patients who are deceased

- *Where Disclosure of Patient Records to Third Parties is Authorised By Law Regardless of Patient Consent*
- *Where Disclosure of Patient Records to Third Parties is Required By Law Regardless of Patient Consent*
- *Fees For Providing Copies of Medical Records*

Three things struck me:

- *There seems to be no mention of confidentiality and records going between medical practitioners; is there an unwritten agreement that there is doctor club which is so trustworthy that sharing information is, by definition, acceptable? This is a bigger question and an informed guess would probably suggest that mostly personal information gets transferred via (in these days generated) letters or on the phone. Nonetheless this seems an obvious gap.*
- *Inpatient and emergency settings seem not to be on the radar. Perhaps these are areas where there is greatest risk especially when professional ethics is challenged by managerial requirements.*
- *Finally, I was fascinated that doctors retain copyright over their records even if patients have the right to see them. This seems a strange idea to me.)*

8.

Zun L. Care of Psychiatric Patients: The Challenge to Emergency Physicians, *Western Journal of Emergency Medicine* 2016 Mar. 17(2): 173-176 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4786237/>

(Leslie Zun has a particular interest in emergency departments. If you have an interest in this area it is worth following Zun's work, mostly opinion pieces which are easier to read and appraise in terms of ideas and logic. They are all referenced and several are contemporary. Zun's argument is that people with psychiatric illness or distress are neglected in emergency departments where there is prejudice and fear on the part of clinicians; she argues that they are not treated like 'ordinary patients' and lists the following:

- *For what other patient types do we have consultants outside of our medical facility come to evaluate the patient and determine the need for admission?*
- *For what other patient types are emergency physicians (EPs) uncomfortable ordering their home medications?*
- *What other patient types have to wait for an inpatient bed or to be transferred to another facility without receiving any treatment?*
- *What other patient type do our attitudes affect their outcome so significantly?*
- *Why do we focus on improving care for trauma, cardiac, stroke, paediatric, geriatric patients but not psychiatric ones?*

Zun concludes: "Is this an issue of benign neglect, lack of outcome satisfaction, unpleasantness of these patients, countertransference issues or something else that compels us to limit our interest in patient care, research, and learning more about these patients?")

9.

Shah S.J. et al Literature review: Physical assessment of patients presenting to emergency department with a primary mental health problem; The Journal of Emergency Medicine, 2012 Vol 43(5) <http://www.health.nsw.gov.au/wohp/Pages/literature-review.aspx>

(There are two issues that inevitably crop up in discussions about (or with) people with mental illness in emergency departments and they are the opposite of each other. The first one is that emergency department staff become preoccupied with the psychiatric issues that too often emergency clinicians fail to screen properly for or listen attentively for indications of physical illness. Sometimes people aren't believed. This article and the ones below discuss this issue.

I learnt a new term, relatively commonplace it would seem in emergency departments: medically cleared means that all the possible physical reasons for the patient's distress have been tested and cleared before taking further psychiatric steps. There is no special word for, nor is it easy to find literature on, emergency clinicians' failure to listen to or be able to hear what people with a diagnosis of mental illness are describing as their physical symptoms.

- Parmar P. et al Value of mandatory screening studies in emergency department patients cleared for psychiatric admission, Western Journal of Emergency Medicine, 2012, Vol. XIII(5), <https://www.ncbi.nlm.nih.gov/pubmed/23359831>
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- Prospective medical clearance of psychiatric patients; Primary Psychiatry, March 2008 <http://primarypsychiatry.com/prospective-medical-clearance-of-psychiatric-patients/>
- What does "Medical Clearance" really mean? Journal of psychosocial nursing and mental health services, Vol.48, Issue 8, 2010 <https://www.healio.com/psychiatry/journals/jpn/2010-8-48-8/%7B28f5118d-9f37-4a60-8533-a31f5c218e66%7D/what-does-medical-clearance-for-psychiatry-really-mean>
- Reeves R.R. et al Unrecognised physical illness prompting psychiatric admissions; Annals of Clinical Psychiatry, Vol 22(3) 2010 <https://www.ncbi.nlm.nih.gov/pubmed/20680191>

10.

Shefer G. et al Diagnostic Overshadowing and Other Challenges Involved in the Diagnostic Process of Patients with Mental Illness Who Present in Emergency Departments with Physical Symptoms – A Qualitative Study, PLOS one 2014 9(11) <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0111682>

(Whilst a patient being medically cleared is an action, an aspect of sound emergency department practice, 'overshadowing' is the attitudes and beliefs which makes emergency clinicians more likely to miss physical diagnoses. In a sense, the institutional and clinical thinking is being effectively restrained by prejudice as well as unfamiliarity with and a fear and suspicion of mental illness. This might be a fear of drama and the potential for violence or a fear or anticipation of and judgemental suspicion reflex - fraud and manipulation.)

This was a small qualitative research involving 18 doctors and 21 nurses from emergency departments, who were asked about cases in which mental illness interfered with diagnosis of physical problems and about other aspects of the diagnostic process. Interviews were transcribed and analysed thematically. Interviewees reported various scenarios in which mental illness or factors related to it led to misdiagnosis or delayed treatment with various degrees of seriousness. The results of the data presented from the interviews with emergency clinicians fell into two groups:

- The presentation of the patient and the behaviour of the patient made it extremely difficult to identify physical diagnoses. These causes were attributed to the patient. They were described as direct causes.*
- The second group of complicating factors were those grouped as environmental. The clinicians reported that the chaotic nature of emergency departments, staff prejudice, staff just not being interested and other aspects of staff behaviour also means that people's physical illnesses get missed.)*

11.

Van Nieuwenhuizen A. et al Emergency Department staff views and experiences on diagnostic overshadowing related to people with mental illness Epidemiological Psychiatric Science, 2013 Sep 22(3): 255-62

(This is another piece of research trying to identify how staff could do their jobs better across emergency departments and psychiatry. The conclusion is that the two disciplines should work more closely together. The research method did not include the customs of this enterprise. It is very hard to find research that asks consumers how they experience overshadowing in emergency departments and the effect this has on their lives. Having experienced emergency departments as a patient, it is difficult to see solutions which sweep past, but do briefly mention, the attitudes and failings of staff. Even in conclusion, these authors say there is a hierarchy of causes with the behaviour of the patient on the top. Maybe 'fair cop' from a clinical perspective, but this piece of research was not designed to hear from the experiences of patients which is slightly ironic given that the problem that is being studied - in part at least - indicates a failure to listen to the consumer. It is disappointing that the emergency departments' distaste for people known as only 'fraudulently sick' or 'frequent flyers' is not challenged.)

13.

Don't you dare
say 'thank you':
Self-harm
and Moral
Judgement'

13. Don't you dare say 'thank you': Self-harm and Moral Judgement

IT'S JUST BEHAVIOURAL

Psychiatry differentiates between 'real' and 'not real' suffering; 'real' and 'not real' illness; 'real' and 'not real' experiences. The accusation 'just behavioural' is not a term of affection, nor does it denote a good outcome – not a terrible illness, thank goodness. The term implies some actions are self-serving. The sick role trumps the seemingly senseless act.

THE AGE OF ENLIGHTENMENT

Self-harm scares people partly because it is inexplicable to many. When professionals who are paid to know find themselves mystified and feel powerless, they often don't know what to do. This evokes fear, anger and judgement. It is called countertransference. Perhaps it's just inadequate training and unexplored prejudice. The reality is that consumers often know why they self-harm. To be enlightened, all that is needed is respectful inquiry.

LET'S CLIMB A MOUNTAIN

Those who 'indulge' in dangerous sports to fulfil needs both known and unknown and fully aware of the costs are no less responsible for their actions than those who lacerate their wrists or take non-life threatening overdoses. Those who climb Mt. Everest and lose their limbs become heroes; those who repeatedly overdose or cut themselves are debased. Apart from gender, the pragmatic difference is that some of us seem to give psychiatric services and emergency departments the shits.

JUST TO LET THE PAIN ESCAPE

In adults, self-harm is frequently connected with childhood trauma. Sometimes people say they can deal with the external, physical pain but the internal suffering is unbearable. They cut to massage their lives. Sometimes, those who self-harm question the fact that they are even real. The blood helps ground them. Sometimes, consumers who have never self-harmed, judge with the same language and arguments used by others; they want distance because they think 'this behaviour' taints them too. All this is unlikely to be helped by publicity about teenage self-harm spread around by social media.

10. EMERGENCY MEDICINE: https://en.wikipedia.org/wiki/Emergency_nursing
11. EMERGENCY PSYCHIATRY: https://en.wikipedia.org/wiki/Emergency_psychiatry
12. GENDER DIFFERENCES IN SUICIDE AND INTENTIONAL SELF-HARM: https://en.wikipedia.org/wiki/Gender_differences_in_suicide
13. INTENTIONAL SELF-HARM AND SUICIDAL BEHAVIOUR IN CHILDREN: <https://www.humanrights.gov.au/our-work/childrens-rights/projects/intentional-self-harm-and-suicidal-behaviour-children>
14. INVISIBLE SELF-HARM: <http://pb.rcpsych.org/content/pbrcpsych/31/7/255.full.pdf>
15. MEDICAL & SURGICAL CARE OF PEOPLE WHO HAVE SELF-HARMED: <https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0015742/>
16. MENTAL HEALTH TRIAGE TOOL (EMERGENCY MEDICINE): <http://www.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-mh>
17. NON-SUICIDAL SELF-INJURY DISORDER: https://en.wikipedia.org/wiki/Nonsuicidal_self-injury_disorder
18. PSYCHOLOGICAL NUMBING (EMOTIONAL DETACHMENT): https://en.wikipedia.org/wiki/Emotional_detachment
19. PSYCHOLOGICAL TRAUMA: https://en.wikipedia.org/wiki/Psychological_trauma
20. SELF-HARM & SUICIDE: https://en.wikibooks.org/wiki/Textbook_of_Psychiatry/Self-harm_and_suicide
21. SELF-HARM AND THE EMERGENCY DEPARTMENT: <http://www.bmj.com/content/353/bmj.i1150/rapid-responses>
22. SELF-HARM, SERVICES AND SHAME: <http://www.ourcommunity.com.au/files/OCP/ShameTraumaAndSelf-harm.pdf>
23. SELF-HARM: http://images.pps.console.com.au/resize/portplus/storage/3785/3785_3094246_300816043629_5904.jpg?width=249
24. SELF-EMBEDDING: <https://en.wikipedia.org/wiki/Self-embedding>
25. SEXUALITY AND SELF-HARM: <https://www.psychologytoday.com/blog/the-scarred-soul/200911/the-relationship-between-self-injury-and-sexual-orientation>
26. SUBSTANCE-INDUCED PSYCHOSIS: https://en.wikipedia.org/wiki/Substance-induced_psychosis
27. SUICIDE TERMINOLOGY: https://en.wikipedia.org/wiki/Suicide_terminology
28. TRAINING FOR DOCTORS IN SELF-HARM: <https://www.sciencedaily.com/releases/2010/09/100927083903.htm>
29. TRIAGE: <https://en.wikipedia.org/wiki/Triage>
30. YOUNG PEOPLE AND SELF-HARM: <http://www.themix.org.uk/mental-health/self-harm/telling-someone-you-self-harm-5682.html>



ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Epstein M. Shame, trauma and self-harm: when self-harm is a sane response to an insane world; Our Consumer Place <http://www.ourcommunity.com.au/files/OCP/ShameTraumaAndSelf-harm.pdf>

(This is a power point presentation. I have tried to fill in some of the bits between each slide to make it more coherent There is a problem with shame. Several different threads are woven through this presentation. They include:

- *Stigma against people who self-harm by the medical profession, particularly emergency clinicians;*
- *A comprehensive glance at why people self-harm (84 explanations and they are all listed – some are similar and are included to show that these types of reasons are thematic);*
- *What emergency departments say about why people self-harm (14 and they are all horrible);*
- *UK 'National Institute of Clinical Excellence' put out two comprehensive guidelines on self-harm and emergency services. It dug up a veritable hornets nest where people who self-harm (for whatever reasons) were attacked (metaphorically) by emergency clinicians who were offended by the NICE report;*

- *Clinical language in relation to self-harm;*
- *Harm minimisation;*
- *Bill of Rights for people who Self-Harm.*

And, if you're interested in compassion, see below:

- Engel B. *How Compassion Can Heal shame from Childhood: The Antidote to Shame Psychology Today July 14th 2018* <https://www.psychologytoday.com/blog/the-compassion-chronicles/201307/how-compassion-can-heal-shame-childhood>
- Au T.M. et al *Compassion-Based Therapy for Trauma-Related Shame and Posttraumatic Stress: Initial Evaluation Using a Multiple Baseline Design, Behavioural Therapy, 2017 Mar 48(2): 207-221* <https://www.ncbi.nlm.nih.gov/pubmed/28270331>
- *Childhood trauma and shame Trauma Counselling Brisbane* <http://traumacounsellingbrisbane.com/childhood-trauma-and-shame/>

2.

Grey F. How can we talk about this http://www.ourcommunity.com.au/files/OCP/Flick_BPD.pdf

(This is a terrific small piece based on personal experience; Flick Grey asks some questions about how we talk about trauma, shame, diagnostic categories and the messiness of it all. Real experiences do not lend themselves to platitudes; short, beautifully written and worth reading. Also look at Flick's keynote at the 2017 Mental Health Services Conference and her interview with Lynne Malcolm from All in the Mind, Radio National, the next reference.)

3.

Malcolm L. Lived Experience in Mental Health Care – An interview with Flick Grey, All in the Mind, Open Dialogue Sunday 5th November 2017 <http://www.abc.net.au/radionational/programs/allinthemind/lived-experience-in-mental-health-care/9107916>

(Lynne Malcolm interviews Mike Slade and Flick Grey who describes herself as a 'mad studies academic'. Both Slade and Grey gave keynotes at the 2017 MH Learning Network Conference in Sydney. Flick is at the same time remarkably erudite and remarkably honest. She talks about suicidal feeling which, for her, are chronic. She talks about self-harm and her somewhat ambivalent relationship with the diagnosis, Borderline, which she believes does describe her experiences but also brings judgement from others and which she describes as an invitation for others to say bad things. She describes this as cruel. She speaks about the ethical challenge to speak authentically from personal experience whilst at the same not being trapped by this. She talks about childhood trauma and says to Lynne Malcolm that she does not want to name her trauma because there is already a competitive field where some people believe their trauma is not big enough to count, leaving them with little option than further shame. She talks a lot about shame. Flick says that it is very hard to find a language of shame and that dissociation is complex and on a continuum. She describes her deep relationship with suicide. Suicide sometimes makes sense. She concludes by talking about ecological metaphors which include understanding that there are no monocultures. To have everyone in the same box with the same experiences and the same ideas would be limiting. What Flick Grey would like to see in mental health provision is a functioning ecosystem that includes experience of marginalisation and where diversity

is embraced and applauded and people can find their ecological niche. This is really worth making time to listen.)

4.

Epstein M. The Emperor's New Clothes: On Being Invisible and Neglected Within the Mental Health System - A Gendered Perspective from a "Borderline Pioneer". Our Consumer Place http://www.takver.com/epstein/articles/emperors_new_clothes_themhs_2006%20.pdf

(This is a keynote at the Mental Health Services Conference in 2006. Since the publication of the First National Mental Health Strategy in 1993, Australian mental health policy has prioritised services for people diagnosed with psychotic illness. There is unanticipated fallout from this approach. Certain groups of people are systemically locked out of services through a justifying rhetoric that denies the seriousness of their distress. This paper looks at the vulnerability of women labelled as having Borderline Personality Disorder (BPD) to this approach and this rhetoric. It looks at the use of the Diagnostic and Statistical Manual (DSM) as a political tool and the systemic, diagnosis-based discrimination within services, as well as hierarchies of legitimacy and shame. How does a fight for people's right to 'be seen' sit within a consumer critique of psychiatry's apparent thirst to create more and more categories of pathologised person? This paper names the 'borderline' dilemma as a gendered issue. It also names it as a socially constructed one located in the politics of childhood trauma.)

5.

Epstein M. Eighteen Reasons why Emergency clinicians think people self-harm and 84 reasons why people said they self-harm in Shame (not published), Trauma and Self-harm when self-harm is a sane response to an insane world; Our Consumer Place <http://www.ourcommunity.com.au/files/OCP/ShameTraumaAndSelf-harm.pdf>

(There is a huge mismatch between the reasons people give for self-harming and the reasons posited by emergency physicians. It's fascinating, as there are many reasons given which make sense within the context of their lives and their past. Some are very honest. Emergency staff have a very restricted understanding of the possibilities – and they are all judgemental.)

6.

Sullivan P.J. Should healthcare professionals sometimes allow harm? The case of self-injury, Journal of Medical Ethics, 9th Feb 2017 <http://jme.bmj.com/content/43/5/319>

(This paper is part of a debate in medicine about the professions' approach to self-harm. As part of this debate, much discussion about harm minimisation has occurred. Harm-minimisation is providing people (usually women) who self-harm as a strategy for living with the tools and knowledge to self-harm as safely as possible. They will self-harm because it is a strategy for life, at this stage. But they need skills and the technology to do so as safely as possible. It's a little bit like safe injecting rooms for people who are addicted to heroin and ice. Part of it is about knowledge and practice and part of it is about non-judgemental, kind and accepting environments. Sullivan argues for harm-minimisation and Pickard and Pearce (below) are concerned about it. Sullivan notes that although harm-minimisation has been studied and debated the ethical issues around it

a less well understood: "I will argue that harm-minimisation should be supported on the basis that it results in an overall reduction in harm when compared with more traditional ways of dealing with self-injurious behaviour. It will be argued that this is an example of a situation where healthcare professionals sometimes have a moral obligation to allow harm to come to their patients." Only an abstract of this article is available free on the internet unfortunately.)

7.

Pickard H. & Pearce S. Balancing costs and benefits: a clinical perspective does not support a harm-minimisation approach for self-injury outside of community settings British Medical Journal; Journal of Medical Ethics 2017 vol. 43(5) <http://jme.bmj.com/content/43/5/319>

(Unfortunately this paper is not available free on line. It is a more traditional article which gets stuck on issues to do with free choice. Some of us would argue that the free choice was all used up when we were raped by our fathers as children or by priests in institutions. Nearly always with these sorts of articles, they produce a throwaway line about how vulnerable we are as though vulnerability is our only virtue or how 'impulsive' we are as if impulsivity is the last card we have in our hand - an excuse. It's all a euphemism for 'it's all your fault'. They also produce the standard fare about people who self-harm not being properly mentally ill. Do they not realise that most people KNOW this; it's often why they self-harm. It's called blame and shame: defaming everyone who self-harms - well everyone that does it in certain sorts of ways - or unless one is 'genuinely mentally ill'. They do state they can see a purpose for harm-minimisation in community settings, concluding: "The situation is different, however, with respect to both secure and non-secure inpatient settings. It is also different when we consider some of the other forms of harm-minimisation that Sullivan advocates, namely the provision of self-harming instruments alongside education about anatomy and physiology." Their argument might be a bit more palatable if it wasn't written in a way that will simply make things so much worse. The time is over for having to justify an argument by attacking the integrity of women who aren't vulnerable of their own making; ever.)

8.

Gutridge K. Safer self-injury or assisted self-harm, Theory Medical Ethics, 2010 Feb, 31(1):79-92, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2847158/>

(This article is available free on-line. Psychiatric patients may try (or express a desire) to injure themselves in hospital in order to cope with overwhelming emotional pain. Some health care practitioners and patients propose allowing a controlled amount of self-injury to occur in inpatient facilities, so as to prevent escalation of distress. Is this approach an example of professional assistance with harm? Or, is the approach more likely to minimise harm, by ensuring safer self-injury? In this article, it is argued that health care practitioners who use harm-minimisation can be considered to be helping physical injury to occur, although they do not encourage the act. It considers why there are compelling reasons to believe that a patient who self-injures is not maximally autonomous in relation to that choice.)

9.

Martinson D. Self-injury: Beyond the myths, Secret Shame <http://www.psyke.org/history/200003/selfinjury/secretshame03.html>

(Deb Martinson is an expert over many years of activism for people who self-harm. She comes from a perspective of experiencing what it's like to self-harm but this is not a 'personal story'. This is the writing from an elder in relation to self-harm. It must always be respected. See also: Martinson D. Bill of Rights for People who Self-Harm ©1998-2001 Fort Refuge <http://www.fortrefuge.com/SelfInjuryBillOfRights.html> This is Deb's signature document. It needs promoting even more. Have a look if you are unfamiliar with it.)

10.

National Institute for Clinical Excellence (NICE) Self harm June 2017 - includes NICE Guidelines 2004 and NICE Guidelines 2013 <https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-behavioural-conditions/self-harm>

(In 2004, the National Institute of Clinical Excellence in Britain commissioned a substantial report about the short-term care of people who self-harm. 2004 was early days in the new ways of thinking about self-harm. NICE was, in that way, before its time. When the report came out, it included some recommendations that emergency staff needed education in order to improve the work they were able to do with women who self-harm. Emergency clinicians from around England erupted in indignation. Dreadful vitriol against women from both men and women erupted. This document is very important as much for what it wrought as for what was written within it. A NICE report into longer-term ways of caring for people who self-harm was published in 2008 and updated in 2014.)

11.

Watts J. Why do people self-harm? You asked Google – here's the answer The Guardian 6th September 2017 <https://www.theguardian.com/commentisfree/2017/sep/06/google-autocomplete-why-people-self-harm>

(This is an informative and sympathetic article in the Guardian. The Guardian is good to read because it does not tend to be sensational and is often well-researched. At the same time it is not a long academic piece that is hard to understand. It refers to young women and searches for understanding rather than for reasons to blame and shame. Watts is empathetic and inquisitive rather than judgemental. "Most westerners believe that skin is the boundary between "me" and "not me". Cutting – by far the most common form of self-harm – can serve to reassure someone that this boundary still exists and that they are present in the here-and-now. This function is especially important when an individual has experienced interpersonal violence or when unusual perceptual experiences are violating the experienced body boundary. Self-harm can also help to reinitiate time. In this sense, it is not so different from the function of notches to mark the days on a prison wall; inscriptions allow the individual to mobilise a sense that a different future might one day come in an environment where one feels imprisoned by internal or external persecutors.")

74.

'Care' - Full
with that
Treatment

14. 'Care' - Full with that Treatment

HEALTHCARE VERSUS MEDICAL CARE

Health is not just the absence of disease. To enjoy mental health is way beyond having an absence of mental illness. Indeed, it is theoretically possible to both have a chronic mental illness and enjoy good mental health. Consumers are divided by experience and linguistic purpose. It is in the interest of some to champion mental illness systems and dub mental health a peripheral concern.

INSTITUTIONAL CARE - AN OXYMORON?

People both create and are created by the institutions of society. Psychiatry is socially understood to be about the kind treatment of people distressed souls. However, society also expects psychiatry to protect 'ordinary' people from the perils of its deviant members (monsters). This is a tall order and the institution of psychiatry labours under the responsibility. No other area of health is challenged like this.

FORCE, TREATMENT & CARE: DOUBTFUL COMPATIBILITY!

Some consumers say that forced 'treatment' is never 'treatment'. They say that force negates any benefit from what is being done to them' even if it is in the name of alleviating symptoms. Some consumers also say that using the terms 'treatment' and 'care' interchangeably is dishonest. The concept 'treatment' denotes doing 'on' and 'to' people, whilst care is about the quality of the relationship. The lack of clarity in the way these terms are used can create hurt and confusion.

CO-SEDUCTION: WHY THE STATE MUST LIE

It's in the interest of governments, bureaucracies and services for mistakes to be covered-up, contradictions ironed-over, public relations to be thrown into gear and bureaucrats muzzled. This might all happen at the same time, as such systems are proudly promoting 'inclusion', 'recovery', 'empowerment'; 'full participation' and now 'lived experience in decision-making' and 'co-production of knowledge'. Many of us want to believe in our authority to make a difference. The ways we try to do it against such institutional barriers differ enormously.

BEDSIDE MANNER

In psychiatry, more than in any other medical discipline, the quality of the relationships is primary to health-making. Promoting conditions for multi-relational, reciprocated healing is central. This is why a physician's bedside manner

ought not to be ignored. "In fact, there is some evidence that people who can speak more fluently receive better medical care. We are embodied, but our minds order the brokenness around us by imposing vocabulary on it." Whilst 'bedside manner' is relegated to an extra add-on to the 'real' practice of medicine, health outcomes will continue to suffer.



A WIKIPEDIA ENTRY TO MADNESS

1. CLINICAL HANDOVER: https://en.wikipedia.org/wiki/Clinical_handover
2. SEMIOTICS: <https://en.wikipedia.org/wiki/Semiotics>
3. CLINICAL SUPERVISION: <https://en.wikipedia.org/wiki/Whistleblower>
4. COMMUNICATION THEORY: https://en.wikibooks.org/wiki/Communication_Theory/The_Frankfurt_School
5. DISEASE: <https://en.wikipedia.org/wiki/Disease>
6. DOCTOR/PATIENT RELATIONSHIP: https://en.wikipedia.org/wiki/Doctor%E2%80%93patient_relationship
7. RECIPROCITY: [https://en.wikipedia.org/wiki/Reciprocity_\(social_psychology\)](https://en.wikipedia.org/wiki/Reciprocity_(social_psychology))
8. ELECTRO CONVULSIVE THERAPY: https://en.wikipedia.org/wiki/Electroconvulsive_therapy
9. EMOTIONAL FIT: <http://news.stanford.edu/2015/04/02/doctor-patient-emotion-040215/>
10. EMPATHIC PRACTICE: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5299383/>
11. GRAND ROUNDS: https://en.wikipedia.org/wiki/Grand_rounds
12. HOW DOCTORS THINK: https://en.wikipedia.org/wiki/How_Doctors_Think
13. PHYSICIAN-PATIENT PRIVILEGE: https://en.wikipedia.org/wiki/Physician%E2%80%93patient_privilege

14. MENTAL STATE EXAMINATION: https://en.wikipedia.org/wiki/Mental_status_examination
15. NARRATIVE MEDICINE: https://en.wikipedia.org/wiki/Narrative_medicine
16. NURSE-CLIENT RELATIONSHIP: https://en.wikipedia.org/wiki/Nurse%E2%80%93client_relationship
17. OXYMORON: <https://en.wikipedia.org/wiki/Oxymoron>
18. POWER AND DUTY: <http://theconversation.com/power-and-duty-is-the-social-contract-in-medicine-still-relevant-3941>
19. LEARNING FROM ANTI-ROLE MODELS IN MEDICINE: <https://members.aamc.org/eweb/upload/300Quaintance116.pdf>
20. THE INVENTION OF 'BEDSIDE MANNER': <https://www.psychologytoday.com/blog/anatomies-the-human-body/201506/the-invention-bedside-manner>
21. THE MADQUARRY DICTIONARY: <http://www.ourcommunity.com.au/files/OCP/MadQuarryDictionary.pdf>
22. THE ROLE OF EMPATHY AND WISDOM: <https://www.hindawi.com/journals/jbe/2013/923810/>
23. THE ROLE OF ROLE MODELS: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1124228/>
24. THE SOCIAL CONTRACT: https://en.wikipedia.org/wiki/Social_contract
25. THEORIES MEDICAL COMMUNICATION: https://en.wikipedia.org/wiki/Doctor%E2%80%93patient_relationship#Bedside_manner
26. WHAT HAPPENS WITH JUNIOR DOCTORS? <https://www.theguardian.com/healthcare-network/2015/aug/14/what-happens-junior-doctors-start-work-nhs-patient-care>
27. WHAT IS BEDSIDE MANNER? <https://www.ncbi.nlm.nih.gov/pubmed/2710920>
28. POSITION OF TRUST: https://en.wikipedia.org/wiki/Position_of_trust
29. RELATIONSHIP MAINTENANCE: https://en.wikipedia.org/wiki/Relationship_maintenance
30. POST-SECLUSION AND RESTRAINT: <http://www.sciencedirect.com/science/article/pii/S0883941715001934>

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Grant V.J. & Briscoe J. Everyday ethics in an acute unit; British Medical Journal; Clinical Ethics 2002 28:173-176 <http://jme.bmj.com/content/medethics/28/3/173.full.pdf>

(This is an older paper but in some ways that's good; much of the literature written earlier has a discursive quality that more modern literature seems not to have. This paper looks at ethics in an acute unit through the minutiae of interpersonal communications. It draws

on three stories about people who experienced acute unit life very differently but who all had simple but very important needs, all authentic and all ethically interesting. There was also an analysis that some things can't be done even when patients know what is needed. There are conflicting priorities and other reasons that things that would be really good simply aren't possible. It was refreshing that these stories were not called 'case studies' or 'vignettes', a language that seems respectful. They are illustrative of the fact that small things matter in acute care. Some things have changed. There is mention of a smoking room in Ron's story. Some points of concern/interest may be that:

- the psychiatrists aren't considered enough part of the milieu to have their interactions analysed;
- I'm not sure people stay in hospital long enough these days to still have Community Ward Meetings – but I was pleased that at long last this idea is being critically considered;
- Weekend leave in public hospitals ditto (in private hospitals it's common.)

There are three concrete themes from these stories but they are not really the essence of the ethical considerations. It is the relationships around them that are important:

- *Boredom.* How do staff interact with Ron who has rightly concluded he is bored and that he needs to get outside and do something physical. I would have liked the therapeutic value of the non-medically trained 'drink-vendor-man' to be considered as it seems to be an interesting and common experience. Therapeutic opportunities presented 'the bloke next door' just doing his job and being inclusive and respectful.
- *Social Context.* Mr Craig is a Principal of a school who ends up in an acute unit. He's appalled at a string of things because his outside status is being ignored and perhaps denigrated by staff. He's older than all the other patients, he can't tell nurses from patients, he wants to deal with doctors only but his health status means he can't. And on it goes. What small interactions would make this better? Start with staff not calling him 'tommy' when his name is Mr Thomas Craig.
- *Weekend Leave:* Nancy doesn't yet understand the culture of acute units. She is scared. She is timid. Along comes a Community Ward Meeting where Nancy misinterprets the signs and feels exposed. She read the cues incorrectly not because she was sick but rather because she didn't have the ward-culture experience or knowledge.)

2.

Roper C., Grey F., & Codagen E. Co-Production Putting Principles into Practice in mental health contexts http://recoverylibrary.unimelb.edu.au/__data/assets/pdf_file/0010/2659969/Coproduction_putting-principles-into-practice.pdf

This is a must read for every consumer who is seeking to work with those with more power. It gives examples of good practice; creative and grounded understandings of the role of power in practice. It addresses common failings in attempts at democratic decision-making in mental health contexts and the impact of bureaucratic, professional, institutional and psychological barriers which drive unhelpful assumptions. It's about the overt barriers and the hidden ones. It is very new and very exciting. There is a strong consumer voice because there is a strong consumer presence in the writing team and a lot of knowledge that comes from experiences of previous attempts at getting it as 'right' as possible. It does not take the issue of relative power lightly or tokenistically. This is a great document. Read it if you can. It's not too long either.

3.

Filipe A et al The co-production of what? Knowledge, values, and social relations in health care, PLOS May 3rd. 2017 <http://journals.plos.org/plosbiology/article?id=10.1371/journal.pbio.2001403>

This analysis is not set in a mental health context but the questions raised by the authors can be transferred. It is a discursive piece. The authors describe it. "Co-production" is becoming an increasingly popular term in policymaking, governance, and research. While the shift from engagement and involvement to co-production in health care holds the promise of revolutionising health services and research, it is not always evident what counts as co-production: what is being produced, under what circumstances, and with what implications for participants. We discuss these questions and propose that co-production can be understood as an exploratory space and a generative process that leads to different, and sometimes unexpected, forms of knowledge, values, and social relations. By opening up this discussion, we hope to stimulate future debates on co-production as well as draw out ways of thinking differently about collaboration and participation in health care and research."

4.

The Pseudo Study: Mind changers, Mind Changers, BBC Radio (podcast) 27th July 2009, <http://www.bbc.co.uk/programmes/b00lmy48>

(This is a BBC program about the famous Rosenhan experiment where a handful of psychology students were admitted to different psychiatric hospitals. There was nothing wrong with them. It was engineered by psychologist, David Rosenhan. What happened next is fascinating. Worth your time to find out if you don't know the story.)

5.

Kertchok R. Ethical Issues and Moral Distress in Psychiatric and Mental Health Nursing: a Literature Review, Journal of Health Research, Vol 29(3) May-June 2015 <https://www.tci-thaijo.org/index.php/jhealthres/article/view/97177>

(This article is about nurses who come across situations in the work that challenge them morally and ethically. How do they deal with profound dissonance and what effect does this have on their practice and interactions with others including patients. Moral and ethical distress is different from professional distress (or work stress) which might be around professional status and operational issues (as examples).)

6.

Freedman R. et al Conflict of Interest – An Issue for Every Psychiatrist, American Journal of American Journal of Psychiatry 2009 Mar 166(3) 274 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4430107/>

(The American Psychiatric Association is perhaps the most conservative body of psychiatrists in the world. This is an editorial signed-off by a cast of thousands. It is a good litmus test of just how pervasive drug companies have become. In this editorial, influential psychiatrists demonstrate they are concerned that drug companies have too much influence over psychiatrists or, at least, potentially have. There is a call for more controls but there is also an argument that drug companies are important for research money,

teaching opportunities and that they provide hope for new treatments. In this editorial, the APA notes that there are two groups of psychiatrists who must be super cognisant of transparency:

- Psychiatrists with academic positions and the capacity to influence students and who also often need research money; and
- Psychiatrists involved with developing new treatments working in partnership with drug companies.

At the level of experience of patients, there are stories of particular clinicians, usually in the private sector in Australia, who somewhat blatantly obtain favour for their practice through their relationships with pharmaceutical companies. There seems to be little indications to patients that these relationships produce good practice. There is more evidence that they are probably unethical.)

7.

Sociological Conceptualisation of Medical Knowledge and Power in Concepts of Health, Wellbeing and illness and the Aetiology of Illness, <https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4a-concepts-health-illness/section2>

(Power is one of those things people seem to write about. People are interested in who has power, even making heroes out of people who wield power in heavy-handed ways like Donald Trump. One of the 20th Century's most influential theorists, Michel Foucault, changed our understandings forever with his writing about a more subtle way that power and discourse might be present in everyday interactions and related intimately with knowledge. (https://en.wikipedia.org/wiki/Michel_Foucault). Consumers talk about power a lot, or if not 'talk' they 'get it' in ways they don't necessarily have the language to describe. Certainly the adage about 'people with power often don't know they have it and the people without power certainly do' is lived experientially all the time. This is a chapter of a book that is easy to read about the relationship between power and knowledge in relation to health and wellbeing. It's an easy read and it raises fundamental issues about power in an area where different sorts of knowledge are treated very differently and doctors generally have the responsibility of knowing what is culturally ascribed the knowledge most important to know.)

8.

Kaba R. & Sooriakumaran B. The evolution of the doctor-patient relationship, International Journal of Surgery (2007) 5 57-65 https://ac.els-cdn.com/S1743919106000094/1-s2.0-S1743919106000094-main.pdf?_tid=476ab822-dd7a-11e7-801b-00000aacb35f&acdnt=1512890479_ecfd3fc21422566fcdf72f6a2a604246

(This is a fascinating account written by surgeons rather than psychiatrists. The authors talk about changes in values around the doctor-patient relationship, however they continue to only use the male pronoun. They follow the path of medicine through:

- Ancient Egypt (approximately 4000 to 1000 B.C.);
- Greek Enlightenment (approximately 600 – 100 B.C.);
- Medieval Europe and the Inquisition (approximately 1200 to 1600 A.D.;

- The French revolution (late 18th Century);
- Doctor-patient relationship (1700 – present day).

The authors are interested in issues such as passivity and activity in decision-making by patients. The challenge for knowledgeable mental health consumers is to situate this document in the discourse of health professionals who have not explored some of the issues around participatory democracy in health as much as we have. In a sense, this is not their expertise; however, the story they tell going right back to Ancient Egypt is fascinating. The authors conclude: "Previously, patients were most often considered to be too ignorant to make decisions on their own behalf. Thus, informing patients about the uncertainties and limitations of medical interventions served only to undermine the faith that was so essential to the therapeutic success. Doctors felt comfortable in making decisions on behalf of their patients. Later on, doctors ... became separated from their patients politically, economically, and socially. The distance between the doctor and patient widened. Little social mingling remained and the doctor-patient relationship became impersonal and remote, based upon negotiation and financial transaction."

9.

Robertson M.D. & Walter G. Many faces of the dual-role dilemma in psychiatric ethics Australian and New Zealand Journal of Psychiatry 2008 42(2): 228-235 https://www.researchgate.net/profile/Garry_Walter/publication/5605426_Many_Faces_of_the_Dual-Role_Dilemma_in_Psychiatric_Ethics/links/00b7d52127f7a5e50b000000.pdf

(This is a problem for psychiatry; it is issue not faced or not faced keenly by physicians, surgeons and general practitioners. Our society has given psychiatry responsibility for both keeping us safe from crazy, mad, frightening people and at the same time the responsibility to treat and care for some of the most marginalised and needy people in the community (amongst others). This has always been a tension for the profession; conflicting obligations, these authors argue, are more than about a conflict of interest. Both tasks are huge and totally contradictory. This dyadic description is useful but a bit unsophisticated; the authors point out that there are multiple groups in the community with members who might not agree and group positions might have different points to make on the civic task. These include family carers, police and more. The authors draw a conclusion that in some ways the practice of psychiatry has to take its cue from community values: "This tension illustrates how the discourse in psychiatric ethics is embedded in the social and cultural context of the situations encountered. It appears that as society changes in its approach to the value of liberal autonomy and the 'collective good', psychiatrists may also need to change.")

10.

Crossman A. Deviance and Mental Illness Thought Co. March 18th 2017(updated): <https://www.thoughtco.com/deviance-and-mental-illness-3026266>

(This is easy reading about an important debate. Is psychiatry an instrument to control a population of deviants or is it about caring about illness and treating individuals with compassionate care? It is full of links which sometimes makes it difficult to follow the argument, but it does mean that it is a document that expands and this expansion is controlled by the reader. It is a short blog but a good start. The starting premise is that "...deviance and mental illness often go hand-in-hand. While not all deviants are considered mentally ill, almost all mentally ill persons are considered deviant (since mental illness is not considered "normal").)

11.

Khullar D. The Trouble with Medicine's Metaphors: Using military terms like 'battle' and 'fighter' to help patients conceptualise their illness can sometimes harm more than it helps The Atlantic, August 7th 2014 <https://www.theatlantic.com/health/archive/2014/08/the-trouble-with-medicines-metaphors/374982/>

(This short (relatively) piece written in lay language explores the use of metaphors in medical practice and how there are different reactions to such a process. The author refers to several studies to back-up his contention that metaphors help doctors to communicate and are a favoured communication style in research into patient opinions about the communication styles of doctors. The most famous work on metaphor is Susan Sontag's 'Illness as Metaphor'; she dealt with her own cancer by being matter of fact and assertive. (https://monoskop.org/images/4/4a/Susan_Sontag_Illness_As_Metaphor_1978.pdf). Metaphors were counterproductive; she argued against dressing illness up and covering up grave possibilities with metaphor. She believed in science and that was her idea of medicine. Later, many people, from survivor groups to academics, refuted her approach. In the article there is a much less black and white picture about metaphor and the author names many. Within the consumer movement, there are many people who hate being told they are 'brave' or they are 'on a journey' or 'fighting' on or any of the terms they believe are disrespectful. Read the paper. It will be interesting to see the diversity of views. Also it might be challenging but informative to read this Our Consumer Place booklet: Epstein M. Pluck, acceptance, defiance and fortitude: telling mental illness stories to change the world, Our Consumer Place, February 2016 <http://www.ourcommunity.com.au/files/ocp-stories2016.pdf>.)

12.

Burridge K. et al Euphemisms and Language Change: The Sixth and Seventh Ages; Euphemisms and the World Formation Process, LEXIS- Journal of English Lexicology, Vol. 7, <http://journals.openedition.org/lexis/355#tocto2n8>

(This article is written by linguists which gives it a different flavour from articles on metaphor written by activists or medical professionals. It is not looking at mental illness but rather at old age. It doesn't matter. The same issues exist. The argument about words is an important one. Linguists look at words differently. The argument is that metaphor is commonly used when other phraseology is taboo and when language is unstable and likely to keep changing. The authors note that the very unstableness also makes the words powerful. The paper looks at euphemisms and how they function and "the different linguistic strategies that are used in their creation." The authors focus on the idea of linguistic creativity around old age and taboo as well as the linguistic connotations of naming and being named.)

13.

Dabby L. et al Explicit and Implicit Attitudes of Canadian Psychiatrists toward People with Mental Illness; Canadian Journal of Psychiatry 2015 Oct 60 (10): 451-459 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679121/>

(This article is available in full text and describes the attitudes of medical students and psychiatrists to people with mental illness. This is a common theme although the two groups, medical students or lay people change as does the particular group of

professionals. The research design matters here. Self-reporting your own actions and/or attitudes is problematic. The two aspects of bias that are common in these studies are explicit and implicit attitudes. Implicit measures are generally tested by scales and other psychological inquiry tools measuring biased attitudes and may enhance predictions of behaviour. Explicit stigma is self-reported and occurs with conscious awareness, whilst implicit occurs outside of conscious control. Therefore, research into professional attitudes usually involves two things:

- A comparison between two groups one of which the 'ordinary person' would expect to have less bias because they are clinicians; and
- A comparison between implicit and explicit bias within each group.

The researchers acknowledge that some of the data seeming to indicate that a certain group has quite 'good' attitudes towards people with mental illness may be the result of research participants simply feeding back what they think they should say. Here are three other papers in the area:

- Peris T.S. et al *Implicit and explicit stigma of mental illness: links to clinical care*, *Journal of Mental Disorder*, 2008 Oct 196(10): 752 – 60 <https://www.ncbi.nlm.nih.gov/pubmed/18852619/>
- Laura G. *Implicit and Explicit Stigma of Mental Illness: Attitudes in an Evidence Based Practice*, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4031039/>
- Kopera M. et al *Evaluating Explicit and Implicit Stigma of Mental Illness in Mental Health Professionals and medical students*, *Community Mental Health journal*, 2015 July 51(5): 628-634 <https://www.ncbi.nlm.nih.gov/pubmed/25535045>

14.

Johansson I.M. et al *The meaning of care on a locked acute psychiatric ward: Patients' experiences*, *Nordic Journal of Psychiatry* 2009 Nov 63(6):501-507 <https://www.ncbi.nlm.nih.gov/pubmed/19688635>

(This study is only available free if you work for an organisation or are undertaking tertiary study. Otherwise you have to pay for it which is a pity. It's an interesting study, looking at the ways in which inpatient consumers, both voluntary and involuntary, define care. The results are ambivalent with some patients seeing caring as including the conditional withdraw of freedoms, which seemed to mean a sort of maternal (looking after) approach to care. For others, this was not the case. A significant finding was that many inpatients believed that the care they received from other patients was as important as or more important than the care from staff.)

15.

Locked In?
Locked Out:
System
Gatekeeping
and its
Language

15. Locked In? Locked Out: System Gatekeeping and its Language

MAYBE IT'S THE RHETORIC THAT HURTS

In all health policy announcements, the allocation of funding is relative. Invariably, policy decisions lead to some getting access to resources and others dipping out. Resources are finite; needs are not. Honesty in conveying allocation decisions to the public is rare; as a society, we don't want to know that funding isn't straightforward. Authorities seek justification by creating a rhetoric of 'comparative need', 'responsibility', 'worth', 'value', 'justice' and fault.

ONE PERSON'S PRISON IS ANOTHER'S CASTLE

It is easy to feel bad about yourself when it comes to being mentally ill; the experiences are bad enough and community prejudice makes it worse. Services too often harm; recovery can be elusive. Added to this is the harm we inflict on each other: when speaking in absolutes and becoming too confident in our own judgement. It's OK to understand psychiatry as fundamentally evil; it's also OK to look at it as salvation. It's especially OK to meander down in-between paths and passageways ... exploring.

GENERAL PRACTITIONERS (GPs) AT THE CROSSROADS

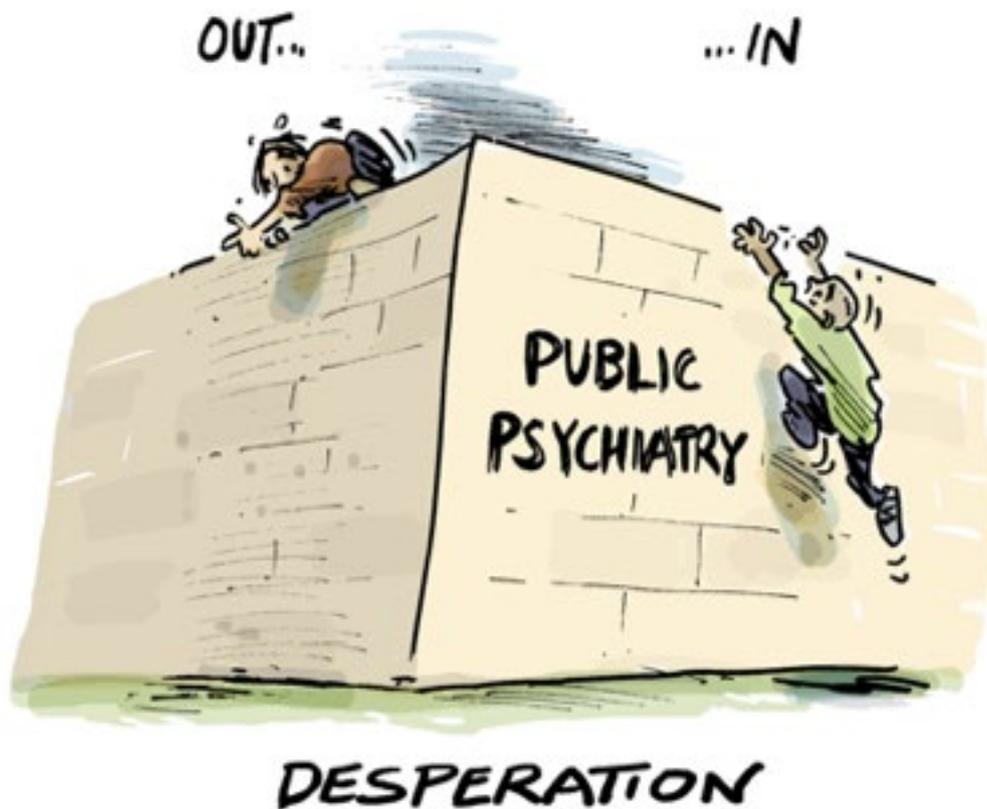
GPs are the frontline defence against the (putative) patient imposter – the 'time waster', the 'frequent flyer', the 'lonely', the 'only behavioural' and the 'just-attention-seeker'. GPs are sentinels: gate-keeping health budgets and patients. Some learn to judge harshly and many are stuck with rigid definitions of health and illness. These do not always work well for mental health and patients know it. This is why we have to work so very hard to be heard.

WHAT IS THE CLINICAL ICEBERG?

This term refers to hidden illness. There is much debate about what gets treated and what does not in psychiatry and elsewhere in medicine. Under the surface, many illnesses are underreported and symptoms leading to more serious illness are missed. Over-servicing can also harm. Treating prodromal psychosis (in young people before it 'becomes' psychosis) is controversial and stigma-driven hesitance to report mental distress all indicate the complexity.

DON'T SLAM THE SICK ROLE: LEARNING TO 'DO SICK' PROFICIENTLY

When sociologists write about the 'sick role,' they refer to acceptable ways of 'being sick' within a given social context. It was sociologist Talcott Parsons who developed this theory in the 1950s, using 'sick role' to describe socially sanctioned deviance. However, whether the sickness is medical, psychological or psychiatric, such 'sanctioned deviance' must still be socially policed and is the socially designated task of the medical profession. Many people think the sick role relates to 'learned helplessness'; it might just as easily be 'learned resourcefulness'.



WIKIPEDIA INTRODUCTION TO MADNESS

1. 2014 VICTORIAN MENTAL HEALTH ACT IN COMPARISON: https://en.wikipedia.org/wiki/Involuntary_commitment_internationally
2. ANTI-PSYCHIATRY: <https://en.wikipedia.org/wiki/Anti-psychiatry>
3. CHEMICAL RESTRAINT: https://en.wikipedia.org/wiki/Chemical_restraint
4. COMMUNITY MENTAL HEALTH SERVICE: https://en.wikipedia.org/wiki/Community_mental_health_service
5. COMMUNITY TREATMENT ORDERS: <https://www2.health.vic.gov.au/mental-health/>

practice-and-service-quality/mental-health-act-2014-handbook/compulsory-treatment/treatment-orders

6. DISEASE MONGERING: https://en.wikipedia.org/wiki/Disease_mongering
7. DOCTORS' STEWARDSHIP OF HEALTHCARE FUNDING: <https://ama.com.au/position-statement/role-doctors-stewardship-health-financing-and-funding-arrangements-2016>
8. GENERAL PRACTICE AND INVOLUNTARY TREATMENT ORDERS: <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/compulsory-treatment/treatment-orders>
9. GOD SYNDROME: <https://www.psychologytoday.com/blog/mood-swings/200810/god-syndrome>
10. IATROGENIC: <https://en.wikipedia.org/wiki/Iatrogenesis>
11. INTAKE: https://en.wikipedia.org/wiki/Intake_interview
12. INVOLUNTARY COMMITMENT INTERNATIONALLY: https://en.wikipedia.org/wiki/Involuntary_commitment_internationally
13. LEARNED HELPLESSNESS: https://en.wikipedia.org/wiki/Learned_helplessness
14. MANAGEMENT OF MENTAL DISORDERS IN GENERAL PRACTICE: <https://bmcfampract.biomedcentral.com/articles/10.1186/1471-2296-13-19>
15. MANAGING CHALLENGING INTERACTIONS WITH PATIENTS: https://en.wikipedia.org/wiki/Sick_role
16. MANAGING MEDICALLY UNEXPLAINED ILLNESS: <http://www.racgp.org.au/afp/2015/september/managing-medically-unexplained-illness-in-general-practice/>
17. MEDICAL RESTRAINT: https://en.wikipedia.org/wiki/Medical_restraint
18. PHILOSOPHY OF HEALTHCARE: https://en.wikipedia.org/wiki/Philosophy_of_healthcare
19. PHYSICIAN-PATIENT RELATIONSHIP: <http://depts.washington.edu/bioethx/topics/physpt.html>
20. POLARISATION OF MENTAL HEALTH CONSUMERS: <http://www.tandfonline.com/doi/abs/10.5172/jamh.7.3.15>
21. PRODROME: <https://en.wikipedia.org/wiki/Prodrome>
22. PUBLIC POLICY: https://en.wikipedia.org/wiki/Public_policy
23. REVOLVING DOOR PATIENTS IN GENERAL PRACTICE: https://www.researchgate.net/profile/Ian_Shaw5/publication/8355265_Doctors_Dirty_Work_Patients_and_Revolving_Doors/links/0c96052ce795c27f9c000000/Doctors-Dirty-Work-Patients-and-Revolving-Doors.pdf
24. RHETORIC OF MEDICINE: https://en.wikipedia.org/wiki/Rhetoric_of_health_and_medicine
25. SHARED DECISION-MAKING IN MEDICINE: https://en.wikipedia.org/wiki/Shared_decision-making_in_medicine

26. SICK ROLE: https://en.wikipedia.org/wiki/Sick_role
27. SOMATIC SYMPTOM DISORDER: https://en.wikipedia.org/wiki/Somatic_symptom_disorder
28. TALCOTT PARSONS: https://en.wikipedia.org/wiki/Talcott_Parsons
29. THE ICEBERG REVISITED: <https://academic.oup.com/ije/article/42/6/1613/736811/Commentary-The-iceberg-revisited>
30. WIKIPEDIA SYSTEMIC BIAS: https://en.wikipedia.org/wiki/Wikipedia:Systemic_bias

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Australian Healthcare System, Conference Paper @ International Sociological Association World Congress Yokohama-Japan July 2014 https://www.researchgate.net/publication/263945821_To_Choose_or_Not_to_Choose_Questions_About_the_Role_of_Gatekeepers_in_the_Australian_Healthcare_System

(This paper explores whether people, regardless of status as voluntary or involuntary patients, have any real choice about their healthcare service needs. The authors argue that wealth, education and geographic location are influential determinants. [It makes one think about a crazy irony that some wealthy families with adult children with 'Serious Mental Illness' might be facing public health systems they would, under any other circumstances be able to avoid as they would have high purchasing advantages to purchase prime health services as a product of educational capital, geography and wealth.] In this paper the emphasis is on the gatekeepers who guide certain people and or groups of people in ways which enhance or limit the choices they can make in the 'health services maze'. The paper looks at the roles of both private and public gatekeepers in wealthy and poor suburbs, using qualitative in-depth interviews with people in gatekeeping roles. The study sets out to avoid a tethering of all medical practice decision-making to the concept of professional self-interest. A more complex picture emerges. It is well backed up by theory. Worth a read!)

2. ROSENHAN

Here follow a number of papers describing the famous Rosenhan experiment; it's a treasure in part because ethics and research committees will probably never allow anything like this to happen again. It's a must read for anyone who doesn't know about it. The 'experiment' consisted in presenting a handful of psychology students to different psychiatric inpatient facilities as patients; they were perfectly normal people with no mental illness. What happened next? It's history and you'll need to read the original paper by David Rosenhan (Rosenhan D.L. On Being Sane in Insane Places <http://www.bonkersinstitute.org/rosenhan.html>)

(To accompany that initial paper, here is some commentary, the last one a podcast:

- Quartet E. *The Study That Shook The Psychiatry World: The Rosenhan Experiment*; OneDio, 19th July 2016 <https://onedio.co/content/the-study-that-shook-the-psychiatry-world-the-rosenhan-experiment-11254>
- *The Rosenhan Experiment examined* <http://frontierpsychiatrist.co.uk/the-rosenhan-experiment-examined/>

- *The Pseudo Study: Mind changers*, BBC Radio (podcast) 27th July 2009, <http://www.bbc.co.uk/programmes/b00lny48>)

3. CHELMSFORD

Another important piece of psychiatric history; it has different meanings for different people especially for the patients involved. (One man's nightmare; medicine for profit: Personal account of Deep Sleep Therapy; Chelmsford, Green Left Weekly July 24th 1996 <https://www.greenleft.org.au/content/one-mans-nightmare-medicine-profit>)

(Chelmsford was a private psychiatric hospital in Sydney. During the 1970s, doctors experimented with a sort of therapy called 'Deep Sleep Therapy'. It went terribly wrong and patients died. There are messages: 1. about the lack of regulation in the private sector; 2. about not all the bad things being around force and that the power of medical persuasion should be further explored; 3. about the practice of psychiatry in the 1970s; 4. about experimentation; 5. about avoidable death; 6. about atrocity; 7. about the susceptibility of needy people to get abused. A Royal Commission was held into the Chelmsford tragedy. Here are further references:

- Walters C. *Chelmsford victim gets a legal ray of hope, but it's 36 years overdue*; Sydney Morning Herald, September 7th 2009 <http://www.smh.com.au/national/chelmsford-victim-gets-a-legal-ray-of-hope-but-its-36-years-overdue-20090906-fcu3.html>
- CHELMSFORD ROYAL COMMISSION (Wikipedia): https://en.wikipedia.org/wiki/Chelmsford_Royal_Commission
- *Chelmsford Scandal: Aftermath and Scandal* <https://chelmsfordblog.wordpress.com/aftermath-of-the-scandal/>)

4.

Senate Select Committee into Mental Health (Australia); Tabled 28th October 2006 Chapter 6 - Access to mental health services. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/c06

(This was a wide-ranging Senate committee born out of a public demand to explore the floors in service provision. Chapter 6 was interested in access to mental health services. It is worth a read primarily because not all that much has changed. A major thread of discussion was the maldistribution of services. Country, regional and remote populations were badly serviced right throughout Australia with a high turnover of staff. Areas in the poor suburbs, such as western Sydney and Melbourne, had many fewer private psychiatrists and fewer services than their counterparts in the wealthier suburbs. Suburbs on the rim of State capitals had a mixed picture but mostly underserved.)

5.

Brown P. *Psychiatric intake as a mystery story*; Culture, medicine, and society June 1993 Vol. 17(2): 255-280 <https://link.springer.com/article/10.1007/BF01379328>

(This is a terrific paper. It's a pity it is not more easily accessible. There doesn't seem to be a lot written about the intake process. The authors suggest that there is much more going on than we are told. What we are told is that it's a benign, non-political, non-problematic activity; a simple act of the service taking on people who are the most deserving according to policy. It is argued in this paper that the referral source influences the way staff see

people, as does the type of illness and the 'illness' behaviour, but also staff's idiosyncratic interpretations of this behaviour. It is also argued that the institutional arrangement of the service, a need for institutional control to be maintained and larger policy drivers like the ascendancy of bio psychiatry are all powerful determinants behind decisions made in intake. The idea that the process of intake is negotiated is an interesting one. This paper looks at clinicians and prospective patients as giving and withholding information to improve their case – whatever that might be. It is argued that this form of interaction leads to: "... excessive reliance on a question-and-answer mode of engaging, staff interpretation of patient behaviour and motivation, and control by staff of information."

6.

Weavell W. Are Mental Health Treatment Orders Out of Order? The University of Melbourne: PURSUIT <https://pursuit.unimelb.edu.au/articles/are-mental-health-treatment-orders-out-of-order>

(Wayne Weavell writes for the University of Melbourne, Social Equity Institute. He argues here that people who are locked in to the psychiatric system via the back door – Community Treatment Orders (CTOs) - are a special group to be considered when thinking about what it means to be 'locked up'. He tells the story of William who was almost forgotten about, withering on a CTO despite protestations and repeated attempts to go through the Mental Health Tribunal, with his order automatically renewed. Eventually William asked for a review by the Victorian Civil and Administrative Tribunal (VCAT). VCAT found that he did not meet three of the four criteria needed for a CTO. The order was revoked but the process must be questioned. Are CTOs being used simply to control people?)

7.

Ryan C. Should we be forcing people with severe mental illness to have treatment they don't want? the Conversation 2 Sep 2016 <https://www.sbs.com.au/news/insight/article/2016/08/31/should-we-be-forcing-people-severe-mental-illness-have-treatment-they-dont-want>

(This is another paper about Community Treatment Orders (CTOs). This is basic and simply describes some of the terms and structure. It's Australian so this gives more legitimacy for an Australian readership. It is also contemporary.)

8.

Vognar D. We Need to Expand Involuntary Treatment for Severe Mental Illness? Huffington Post, 7th May 2012 https://www.huffingtonpost.com/david-vognar/involuntary-treatment_b_1652151.html

(In this article, Vognar describes the plight of a friend who eventually drove his car into two other cars, killed himself and hurt others. This is a common sentiment for family, friends and carers. In this case, it's difficult to tell if Vognar is arguing for expanding the diagnoses included in the conceptualising of serious mental illness (his friend has depression) or whether he is arguing for the public mental health services to grow and in so doing, that the level of acuity needed for compulsion would drop. When talking about involuntary treatment, it is important to acknowledge the call by family and friends to better care for those they love.)

9.

Mackler D. Therapy Without Force: A Treatment Model for Severe Psychiatric Problems, Mind Freedom <http://www.mindfreedom.org/kb/mental-health-alternatives/therapy-without-force>

(For those who don't know, MindFreedom is a radical survivor group in the USA. Having said this, it does not disqualify them from useful commentary any more than conservative psychiatrists should be disqualified from opinion pieces. Nonetheless the articles chosen to put on the website reflect the values of MindFreedom which are largely anti-psychiatry. This interesting piece is written by a therapist interested in democratic psychiatry. In addressing the topic Mackler asks: "In the midst of a system laced with coercive mores, how can a therapist behave non-coercively and thus therapeutically?" In the article, Mackler struggles with how to be a non-coercive therapist amongst a dominating coercive treatment worldview, supported by many. First he names the different forms of coercion and discusses each and then goes on to explore alternatives.

- Types of Coercion
- Forced Medication
- Forced withdraw from medication
- Forced hospitalisation
- Forced therapy
- Force used to prevent suicide)

10.

Shaw I. "Revolving-Door" Patients: "Dirty Work" Patients, and "Revolving Doors" ; Health Research, October 2004 https://www.researchgate.net/profile/Ian_Shaw5/publication/8355265_Doctors_Dirty_Work_Patients_and_Revolving_Doors/links/0c96052ce795c27f9c000000/Doctors-Dirty-Work-Patients-and-Revolving-Doors.pdf

("Using information from research into the phenomenon of "revolving-door" psychiatric patients, the author explores general practitioners' perceptions of difficult patients and the consequences for patient management. He first considers the concept of "good and bad" as a possible subtype of dirty work. He then presents the evidence of medical irritation with patients from interview data and explores the rationalizations for the way in which patients are subsequently managed. In line with previous studies, the author argues that the construction of patients as difficult and the subsequent dynamics of exclusion lie in the breakdown of the "normal" doctor-patient relationship coupled with the doctor's need to get on with the day's workload. Moral judgments formed a part of the exclusion process.")

11.

Webb D. Is Involuntary Psychiatric Treatment – Reasonable, Necessary, Justified and Proportionated? http://www.communitylaw.org.au/mentalhealth/cb_pages/images/MHLC-Forum-Paper%20David%20Webb.pdf

(This is a knowledgeable argument against forced treatment. It juxtaposes Victoria's Charter of Human Rights and Responsibilities against the legal structures that provide systems and services in Victoria the right to hold people with mental illness against their will. "Victoria's new Charter of Human Rights and Responsibilities seeks to protect the basic civil and political rights of people in Victoria. One of the most fundamental of these is the right to be protected against medical treatment without consent. Despite this, involuntary psychiatric treatment remains the foundation of Victoria's Mental Health Act, without which there would be no need for the Act at all." Webb is interested in the law because it is the law that is the lynch pin. This is quite readable and useful, especially for those who want to understand the debate, those affected by forced treatment and those who are interested in human rights and mental health law. There is a push through the United Nations for involuntary treatment to be dealt with as torture. This is controversial. Webb explores this. The author concludes that holding people against their will is not reasonable, necessary or justified.)

12.

Sjöstrand M. et al Ethical Deliberations about Involuntary Treatment: interviews with Swedish psychiatrists, BMC Medical Ethics, 2015 16: 37 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4446957/>

(This is an unusual and welcome addition to the literature. Usually studies about practice ethics derive from the knowledges of clinicians or, sometimes ethicists, historians, anthropologists or sociologists. In this example, the researchers interviewed patients, respecting their knowledge. The patients' views about practice related to forced treatment was nuanced and mixed and didn't fit neatly into broad categories. In conclusion, the patients concurred that: "organisational factors sometimes led to decisions about compulsory treatment that could have been avoided, given a more patient-oriented healthcare organisation.")

