This is not about catharsis! My time in HDU by Merinda Epstein

Several months ago I spent three and a half weeks in the tiny, suffocatingly inward facing High Dependency section of a public psychiatric unit in one of the poorer suburbs of Melbourne. I was not there by choice – far from it. I want to write about this experience, terrible as it was. When I told my psychiatrist this, she said, "Are you sure you're ready? At the right time it might be cathartic. It could be quite good to get it off your chest."

Well, no, actually. I am not wearing that experience on my chest. I am wearing it in my heart. I am wearing it in my body. I am wearing it where anger comes from, anger strong enough to drive change. This has nothing to do with personal catharsis. It has everything to do with demanding that what happened to me doesn't continue to happen in that service, in Victoria, in Australia and – dare I even wish it – anywhere else in the world where I know only too well far worse atrocities happen daily.

'Mania'

The first inkling I had that I was being constructed as 'manic' was from my psychiatrist. She was very serious when she told me she was going to ring triage in my local public mental health service. She jumped up and went to the phone. I was surprised. Later, after it was over and I returned to see her – still harbouring some resentment – she got down her copy of the Diagnostic and Statistical Manual and went through the criteria for mania pointing out that I had had, in her eyes on that day, a tick next to every indicator of 'mania' except grandiosity. She told me that with my personality grandiosity was unlikely. I decided to take that as a compliment. Later my G.P., who I like and trust, looked at me nonchalantly and said, "believe me, you really **were** 'manic'". I didn't feel manic. It seems like everyone was in agreement except me.

My psychiatrist said she always knew the CATT team would put me in hospital when she sent me home that day but she didn't tell me because she was worried I might do a runner. Wise. I remember she said goodbye at the door as I left her rooms, adding "drive home very carefully". Why did she say that? I thought I always drove pretty carefully.

The Crisis Assessment & Treatment Teams (CAT Teams)

The CAT team is such an interesting and complex institution. The decisions CAT teams make depend enormously on the skills and attitudes of individual clinicians. This time I think I drew the short straw. There was no doubt about my madness in the eyes of the team that came out to my house that afternoon. It was a horrible encounter. It felt like I was being interrogated by a machine – a female machine that rarely looked up from the paperwork that seemed to be occupying her time in between asking questions that needed no answers because it was blatantly obvious that the decision to lock me up had already been made. In the wake of this machine her male partner said nothing. She talked at me. I remember she said to her colleague, "This woman can be quite a nice lady. I've come across her before." Lady I'm definitely not but how reassuring it was to know I could be nice.

Did you know that knowing the Mental Health Act is now a symptom of madness? When I wondered out allowed whether I actually fitted the five criteria for being held against my will, I was immediately threatened with the police. It worked. There was no way I wanted my neighbours involved. I didn't feel bad or sick but I was very confused with which the rapidity life altering decisions were being made. When I'm really miserable or desperate for help with feelings I can't deal with and a life that feels like it's reeling out of control the CAT Team usually aren't interested. And here they were after my blood when life felt OK to me. It's such a curious thing. I was scared of them – intuition had kicked in.

For the next thirty minutes I was 'managed'. Oh! How I hate the way this word is used in psychiatry. I just wanted the talking machine to leave me alone. She confused me and frightened me. I ended up needing help to get out of the house. It was medically constructed incompetence. "Get this, grab that, where's your toothbrush? Show me your pills." And then as an aside, she commented to her partner – a statement that was really meant for me – "this is just a big mess with pills everywhere. I don't think she has any idea what she's taken!" I told her I had fed the dogs. This was my major concern. Not hers. I phoned my sister. There was no way I was going anywhere without knowing the dogs would be safe. Obviously I wasn't that mad.

I remembered to make a phone call to a friend to cancel something and this private moment was followed by a stream of question from the talking machine: who was it? Why did you ring them? Were you organising to run away? This was ridiculous – the mention of police had already defeated me. I was moving into acceptance that this peculiar affair was a reality. However seeing that I was being managed, the talking machine should, at least, have told me to put on shoes without laces. The one thing that I was determined to bring was my drawing materials – an insistence which showed superior (not impaired) judgement. I drew myself through the next three and a half weeks.

The Admitting Consultant

I found her to be rude, arrogant and full of her own self importance. I was pleased when she said she was just assessing me and wouldn't be 'managing my case'. Good. She said I was definitely mad because I was mucking around with a piece of string when I was being drilled. I admit to being nervous, agitated, cranky and maybe even reactively difficult but mad I did not believe I was!! My judgement seemed to disagree with everyone else. Eventually I got to see 'my' consultant – a man I saw so rarely and for such a short period of time that I have little recollection of him. He was in attendance when I was discharged (unusually) straight from the High Dependency Unit (HDU – what happened to the language of Intensive Care in the psych. end of the health system?).

Medical Staff

The first few days were spent in the general ward. There were two registrars. A young woman was taking over from a young man who was being rostered off somewhere else in the medical ether. I was very pleased that it would be the young woman I would have to deal with. They were both very young and awfully inexperienced. The difference was that the young woman knew it and the young man did not.

I did my best to help the young registrar who was being brave in a brand new and somewhat scary job. She was genuinely open to my suggestions. For example the beds in High Dependency Unit were really low and there were no chairs that weren't attached to the floor (potential missiles of course) so she came and talked to me, looking down on me from a great height. This is no way to have a conversation and I pointed it out. She said she felt uncomfortable too and we tried to think up some alternatives together.

She was still battling to come to terms with the incongruence between what she saw and heard when she talked to me and what she was being taught. Several times she aborted quite silly exercises that weren't working and said, "this is a waste of time". I agreed with her. One time she got mixed up between whimsy and mania after I told her that one day I'd like to get a pony and gig and learn how to drive. I think she documented this as a grandiose thought given I was poor, rather than a nice dream to have when I was stuck in a horrible place. Another time she accidently taught me how to more successfully self harm. She didn't mean to and was horrified when she realised what she had done. She was young and inexperienced but I liked her. I gave both her and 'my' consultant a copy of Our Consumer Place's booklet – So you've got a mental illness? ... What now? and hoped they might learn something. I think she will read it. I'm not so sure about the consultant.

This is Not a Punishment

I'm in the open ward. There is a nurse standing at the door of my room watching me. She repeats my name several times and I wonder why and then she goes away. She comes back with a senior nurse who very strangely says, "this isn't a punishment, do you understand what I'm saying? This isn't a punishment. We are just worried about your safety". Punishment for what? I had no idea what was going on as I was led away towards the door that led to the High Dependency Unit where I would spend the next three and a bit weeks.

The High Dependency Unit (HDU)

I was to learn a great deal more about confinement. It was built like a prison. It was about restriction and surveillance. They took away my shoelaces so I wouldn't hang myself and with my disability my left foot kept coming adrift from my left, lace-less shoe. I stumbled around as best I could. The food was good in HDU. During these weeks there were only ever two lots of two days where there was another woman in the HDU. It was a masculine highly charged environment.

Warped Communication

It was a really difficult place to function in. In order to get my needs met, I might have joined in the dominant culture and become threatening, angry, verbally abusive, potentially violent, and in your face constantly. But it probably wouldn't have worked. These guys didn't get their needs met either and I don't want to judge them. They were caught in the same net as me. They were reacting as best they could (in a man sort of way) to a situation that bewildered them and where they had forcibly lost control of their lives and often felt they were left no alternative but threatening violence. It's just that they scared me. I hid. In the three and a bit weeks I burst into angry tears only once and this was after I had been assaulted.

There were several young men who could have flipped out at any point and we all knew it. Unfortunately there were also some staff who seemed to thrive on violence and mayhem. It was sometimes difficult to watch as staff spoke, wrote on the whiteboard and handled people in ways that successfully stirred everyone up. Sometimes this was in reaction to patients' deliberately and successfully rousing the staff – a game of sorts. The difference was that one group was paid and the other was not.

Safety

I kept hearing the senior staff member's voice in my head, "This is not about punishment. We are just wanting to keep you safe …" Most of the time I experienced the fear of violence in my body, my breath, my senses, my soul and it was this fear that paralysed me. It was a seething undercurrent of violence in the environment. At no time in that unit did I feel safe.

Mania and Complex Post Traumatic Stress Disorder

I understand how complex I must seem to clinicians. Hospitals elicit complicated reactions from me. This applies to all hospitals and not just psychiatric ones. Hospital stays can bring up demons from the past that often play themselves out in nasty flashbacks, dissociation (detachment from my emotions) and self harm. Dissociative voices are not the same as psychotic ones but when I tried to explain this no one 'got it'. I couldn't seem to successfully explain this disjunct between trauma-based experiences and the 'mania' for which I was admitted. In the end I gave up. But one thing I knew and that was that the self harming way of being in that hospital was a guardian against self-destruction and not a path towards it. I was never at any risk from myself. Sometimes things are just too difficult to explain.

Drawing

Thank goodness I draw and was allowed to have my drawing materials with me – kinder scissors notwithstanding. I hid in my room (door open, of course) and drew cartoons. I feel very keenly for others who might not have a distraction such as this. It was interesting how boredom was not tackled. There was this strange game, a word game, on the whiteboard. Every morning, dutiful staff would put the game up and then nobody except the staff would play it. In three and a half weeks, not one patient was the slightest bit interested but I guess it proved useful for bored staff. Very weird.

Cigarettes

The hospital still allowed smoking. Good on them. I estimate that half the nursing staff time in that HDU was given over to using cigarettes as currency and, sometimes, punishment. Staff members were constantly busy distributing, refusing to distribute, locking and unlocking the cigarette cupboard, negotiating the purchase of cigarettes and creating complex rules about not sharing cigarettes which seemed only to lead to violent confrontations which needed 'managing'. It was unquestionably a 'cigarette culture'.

For the entire time I was the only person who didn't smoke. I was free to watch. It was definitely a major way that control was maintained by staff. Without access to cigarettes, however, I am absolutely sure that those who were already close to the edge level of violence would have escalated beyond the capacity of the existing staff to maintain control. I fear what is happening in other hospitals where the ban on all smoking still stays in place.

Using Seclusion as a Mechanism to Control Others

I also watched control being re-established when it looked like open violence was on the edge of erupting by making an example of one patient and recruiting security personal to take him off to a seclusion room and forcibly inject him. It did have the 'desired' effect of quietening things down but at what cost to the person dragged away in such a manner?

The time I became most distressed was when this was done to a teenager who was least able to protect himself and the least difficult male in the bevy on the Unit. He was very creative young man and it felt to me like the staff were making an example of him -he didn't resist – in order to gain control over those who were much more likely to ignite than he was.

I still wonder whether this constitutes assault by staff.

I Was Assaulted.

Whilst I was in the HDU I was assaulted twice. There is no way I will ever totally recover from this and the lack of action that followed both incidents. It was by the same large, middle aged man. He'd been there for ages.

As I write this I wonder whether I should be more compassionate, even forgiving – but I don't feel it. The first time, he cornered me in my room whilst I was getting dressed. He was standing between me and the doorway and he pulled down his tracksuit pants and his underclothes and, jiggling his genitalia, he walked towards me stating over and over again; "I'm goin' to fuck you luv ... I'm goin' to fuck you luv … I'm goin' to fuck you!" I was pinned against the wall with horror and immobilised mentally. Somehow I managed to get past him. I can still smell him.

When I told a staff member what had happened, the man was chastised, “you’re a naughty boy! You know you’re not allowed in other people’s rooms now go and sit down on that chair”. I couldn’t believe that absolutely nothing was said to me. Nothing! I felt sick with the intrusion in my room and the threats to my body and safety. Nothing was asked about my welfare, nothing was asked about whether there was anything I needed. This is where I was supposed to find safety? So much for that!

The day then blew out into a terrible fight for control between four young men and the staff. All attention focused on maintaining some sort of discipline within the Unit. What happened to me lost any importance at all – if it had any in the first place, which I doubt. I retired to my room dry retching and crying inside for someone to come and help me.

De-brief (a little) at Last

Two days later I was allowed to have some time in the ordinary ward and a very young male Occupational Therapist was able to do what all the nurses before him had been unable to do – talk to me. He was angry on my behalf and he apologised on behalf of the institution which employed him. We walked around the unit, outside for the first time in three weeks, and he kind of said sorry. It wasn’t enough but it was real.

The Second Assault

The following day the same man again invaded my room. He was in my ensuite shower. I was there and he was yelling, “I’m goin’ to piss on you luv … piss on you luv … piss on you luv … piss on you luv!” It made me feel sick. He came out of my shower still fully dressed dripping water and piss. He then walked all over my room. This time he got roundly chastised and chased back into his room to get changed. The staff member did speak to me. He said, “just be grateful it was just in your shower. Last time he pissed on a woman in this Unit, she was asleep in her bed and it woke her up”. He smiled. I was supposed to understand this humour. I didn’t “get it”. It wasn’t funny. Firstly, that’s rotten for that poor woman. Secondly, how come this guy’s still pissing on people? Thirdly, that comparison did nothing to make me feel less sick or safer. The staff might all be used to this guy but I wasn’t! I felt violated. I had been violated. I turned on the shower and left it on to run and run and wash him away. I got towels and tried to clean him out of the only little bit of personal space I had.

Too Scared to Change my Clothes or Sleep in Night Clothes

After my room was invaded twice I didn’t shower again for the rest of the time in that place. I didn’t change or even take off my clothes at night. I couldn’t. My room was in the corner of the small unit. Stupidly there was a couch along the wall just outside my bedroom and the man who assaulted me kept lying along the couch where he could hold out a long arm and grab at me every time I walked into my room. Once again I constantly implored staff to move him on. They mostly didn’t. At least during the last few days I was allowed out to roam in the open ward. Mostly I just kept drawing.

Flowers

During my stay in HDU three different organisations sent me wonderful sheaths of flowers. I’m a flower girl. I was excited but the arrival of these ‘weapons’ caused considerable consternation. It was absolutely unprecedented to have flowers in HDU. The solution was to hide them in the nurses’ station where they remained unloved and unwatered. I was allowed daily visitation rights (through the window). Eventually one lovely clinician, who I knew had secretly started to tend them, just brought them out and put them on the bench in my room ignoring the protestations. More consternation and disagreement. Just how dangerous can a flower be? They were already starting to give up the ghost in the rarefied environment but what was left of them remained with me. Guess what, not one flower harmed anyone during the rest of their stay.

The Last Days

The time seemed interminable. Eventually I was told I was to have a family meeting. A what? Here was another hurdle I had to jump. My friend took a day off from work and my 86 year old mother travelled from one end of Melbourne to the other by public transport to get to the hospital. We created a makeshift family but it was a big demand on Mum. The Mental Health Act actually says that I could have refused that meeting (and should have been asked whether I agreed to it) but I wasn't going to jeopardise potential freedom by threatening anyone else with my knowledge of the Mental Health Act, so I said nothing.

We spoke with the consultant and the registrar. There was an inquisition about just who my friend was and why she was there which made me cross. It really wasn't important. The meeting was short. I told them what they wanted to know just to make sure the trajectory was the way I wanted it. I knew it was unusual to be discharged straight from HDU. My guess was that it was just a bed allocation issue but I was going to make sure it ended well. Yes, I could go home. At last!

The nurse on duty and available to help me escape was impressive. He was furious that so many of my belongings, put in the hospital trust for safe keeping, had been lost –especially the mobile phone. He did his utmost to search the building and find those responsible for the loss of the phone. The CAT team member on duty that day was also great. My friend was particularly taken with him and they shared a smoke together – a good bonding opportunity that was in my interest. In the end, unfortunately, the staff forgot to give me my medications and we had a very long car drive circumnavigating Melbourne to drop Mum off and get back to the hospital to pick up the medication before landing me back home.

The Good News

The good news at this stage is that the Office of the Public Advocate has managed to convince the Unit Manager to reimburse me for the cost of my mobile phone. I waited for the cheque. My long brown shoelaces, removed for safety reasons, still haven't found their way back to me, nor my children's scissors which I asked my brother to bring in for me thinking that if they were OK for four year olds they'd be OK for me. Not the case I'm afraid. They were banished never to reappear.

When the cheque arrived for my replacement phone, some personal assistant had written on a slip of paper reimb. mobile @ sim card encl. That was it. How silly was I to expect an apology for the inconvenience caused or maybe, just maybe, contrition for having lost it in the first place.

The After CATT

When I think about the role of the CAT Team I often think of this well known rhyme:

The Grand Old Duke of York,
He had 10,000 men,
he marched them up to the top of the hill
and he marched them down again again.
When they were up they were up,
when they were down they were down,
and when they were half way up
they were neither up n'or down.

After discharge from hospital you and the CAT Team are now at the bottom of this hill. The mission has been accomplished. Their single remit now is to get rid of you as quickly as possible. Oh, so different from three and a half weeks earlier when we were all teetering dangerously at the summit! Afterwards they only ever see you a couple of times and this is to do very practical things like making sure you have enough medication. The machine woman came to visit again and she was equally entranced by her paperwork and continued to talk at me. Dare I ask her for an apology for forcing me into a situation where I was assaulted, belittled, dehumanised and hurt?

I desperately needed an apology from someone but I wasn't going to get it from the CAT Team. It's not their brief to talk to you about your experiences although that would seem a logical responsibility to right minded observers. This is something I needed and is exactly what I couldn't get. So, as the institution dictates, I felt stupid for having these inappropriate needs. Instead I stood at the front door, turned the outside lights on, shook hands, thanked them as freely as I could muster and ushered them, for the last time for now, up the front path to their government car which, thankfully, these days doesn't have red plates.

The Final Edition

The day after the last visit from the CAT Team my very old washing machine blew up. I packed up two baskets of clothes and made my way to the nearest laundromat where I settled with a book and some knitting. It was not that much later that the competent and personable CAT Team man who was on duty when I was discharged walked through the door lugging his washing. We were awkward for a minute and then laughed. There was something very health-giving about this unplanned encounter. It was about us both being truly human, the dignity of an adult to adult encounter, personal acceptance and a frustration that we were both forced to use the inconvenient laundromat – shared subjugation to the fallibility of white goods was the nearest I got to an apology for this episode. It felt good.

Conclusions

1 **HDUs traumatise:** It is naïve and ahistorical to continue to believe that High Dependency Units (HDUs) are places of healing or even safety. People both sustain trauma and are re-traumatised.

2 **HDUs are not safe:** HDUs are designed both physically and functionally to be places of containment and surveillance and yet they are not safe. We desperately need substantial change, whether it is using them with much greater discretion, exploring the idea of single sex HDUs, redesigning them architecturally, re-thinking staff ratios, employing staff who specialise in trauma, providing staff with access to education provided by consumers or all of the above.

3 **Assaults should never go unnoticed in HDUs:** If HDUs are truly built to enhance surveillance, as unpleasant an idea as this might be, then stuff as dreadful as sexual and physical assault should never go under the radar.

4 **Staff must be trained to respond to assaults:** All staff working in HDUs should be trained to support people, physically and emotionally, who have been terrorised by someone, assaulted and/or abused. Sometimes this may require direct and immediate intervention of hospital management so people know they are being listened to, believed and responded to.

5 **People who don't express their needs loudly still need support:** Creatively exploring new ways to respond to need expressed in less aggravated, less violent, less outwardly demanding ways is important. Careful listening to people who speak the quietest is essential.

6 **Allegations of assault must be followed up:** Allegations of assaults and abuse (whether they be by made against other patients or staff) may require police intervention or the intervention of the following authorities: the Chief Psychiatrist, the Public Advocate, the Health Complaints

Commissioner, the Mental Health Legal Centre or the advocacy of the Victorian Mental Illness Awareness Council. They must be followed up.

7. **Reports of assault must not be "explained away":** Reported assaults must be handled seriously and without judgemental explanation or dismissal based on diagnosis or circumstances of either the person alleging the assault or the alleged perpetrator.

8. **Smoking laws must be reconsidered:** The new bans around smoking on psychiatric acute units must be reviewed. Even though smoking is (of course!) bad for our physical health and the rituals around it take up a lot of staff time in HDUs, the potential for even more aggravated states of violence, where smoking is denied, must be considered.

9. **There must be opportunities for de-briefing after assaults:** Despite really stretched resources in the public mental health system and the multiplier effect of this in poor and rural areas, something must be done to build in post-hospital opportunities for debriefing for people who have been assaulted and/or abused whist in hospital. Without this, the chance of people developing Post Traumatic Stress Disorder is unacceptably high, especially for people who already have a history of abuse and/or trauma.

10. **The role of CAT Team must be better explained:** The role of CAT Teams both before and after stays in hospital should be written down in simple (but not patronising) language. These short documents should be jointly drafted by staff and consumers. People need to know what they can and can't expect so they can negotiate the relationship from a point of strength, not embarrassment.

11. **There needs to be better communication between public and private psychiatry:** The nexus between private psychiatrists and public psychiatry should be strengthened allowing for better communication between the private and the public sector where it so greatly affects both the efficacy of people's stay in public hospital but also to reduce the likelihood and effect of harm

12. **There needs to be better communication post-treatment in a public hospital:** The follow up from public hospital to private psychiatry is often poor and neglected – one phone call from a CAT Team member and an often delayed, ineffectual, report written by a very junior registrar. This is unsatisfactory. Communication, including communication with 'the patient', is vital in recovery from traumatic incidents.

13. **Private clinicians need to take responsibility for their part:** Private clinicians have a responsibility to (1) believe 'their' patients who describe injurious traumatic experiences, (2) provide opportunities to de-brief, (3) take responsibility for their role in the incarceration of their patient and in as least defensive way as possible explore why decisions were made, (4) stop behaving like a psychiatrist for a while and genuinely try to appreciate the totality of the powerlessness of HDUs; (5) treat the abuse and trauma of some hospital experiences not only with compassion but also with overt intent to advocate for their patient about the wrongs that have been done.

14. **Senior medical staff in public hospitals need to take responsibility for hospital culture, including the lack of safety:** Consultants in public hospitals should understand the importance of communication, especially where things happen in the hospital setting that will affect the ongoing wellbeing of 'the patient.' Because of their status it is the responsibility of senior medical staff to actively work with management to fight for the rights of those who have been traumatised by hospital experiences and/or practices. They must take a lead in 'taking on' disabling hospital culture, dissuading staff from fobbing problems off as the result of 'the patient's illness / symptoms / lack of…' and genuinely lead for changes to be made that increase opportunities for all patients to achieve health safely.