Anecdotal examples of public mental health clinical and non-clinical practices

Case 1:

Trish (not her real name) was an involuntary patient in a psychiatric in-patient unit of a metropolitan hospital. Trish was admitted following an overdose of medication. She requested and was granted leave to attend the Victorian Mental Illness Awareness Council (VMIAC). During the interview with Trish, she indicated that the reason she was suicidal was that she had been raped a fortnight prior to her admission to hospital. On asking Trish if she had told her psychiatrist or contact nurse about the rape she indicated, no. When asked why not, Trish said that if you get upset and cry in front of the clinical staff all they do is increase your medication. Trish feared that all the clinical staff would do was give her drugs to sedate her and she felt that if she was to ever work through the issue then she needed time to cry and grieve and this would not be possible if she was "drugged out of her mind."

The advocate suggested to Trish that she relay her concerns to her psychiatrist and her wishes to get emotional support to work through the incident. Trish agreed to the suggestion and the advocate indicated she would visit her the next day. When the advocate visited Trish, Trish could hardly stand up and was unable to have a conversation she was so sedated.

After the consumer was discharged from hospital, the advocate arranged for Trish to attend the Council Against Sexual Assault (CASA) for counselling and support.

Case 2:

A 24 year old man called Mathew (not his real name) was admitted to a private hospital following an attempted suicide. Mathew was homosexual and was in a stable relationship with another man called Tim (not his real name). During visiting hours Mathew and Tim were sitting in the visitors' lounge holding hands and talking. A registered nurse entered the room, told them that their behaviour was offensive and if they did not stop holding hands then Mathew's partner would have to leave. While both men were quite upset about the nurse's attitude, Mathew was very distressed and remained so. Eventually Mathew was discharged from the private hospital and on the same day of discharge he took a significant overdose of his medication. Mathew was subsequently admitted to an intensive care unit (ICU) of a public hospital. He spent some time in the ICU and was later transferred to a medical ward where he was "certified." When Mathew had recovered from the physical impact of the overdose of medication he was transferred to the in-patient psychiatric unit. Despite Mathew's history of making 2 very serious attempts on his life and despite his parent's explicit expressed concerns that their son was still quite suicide, Mathew was discharged and transferred

to a private hospital where, less than 24 hours after his admission he left the ward and took his life.

The advocate read all three of Mathew's medical files and could not find any evidence of any interactions between Mathew and the clinical staff where Mathew's feelings were explored. There were no notations regarding what he was feeling, why he was feeling the way he was, why he wanted to die; there was simply nothing despite the fact that it is the feeling side of suicide that leads people to take their own life. The only clinical intervention was medication and containment. At the time of Mathews death, he was on 15 minutely sightings by the nursing staff because he was regarding as at risk of suicide. The latest time Mathew was noted to have been seen on the ward was 1000 hours, but Mathew had been run over by a train at 0910.

The Coroner's Inquest basically found no fault with the way Mathew was treated. This is despite the fact that the nursing staff in all three hospitals failed to carry out contemporary nursing practice and failed to comply with their own profession's Competency Standards which are a requirement for registration and practice.

Case 3:

Cheryl (not her real name) a twenty year old woman was admitted to a public psychiatric in-patient unit as a voluntary patient. In her diary she indicated that she wanted to go to hospital because she needed support. Cheryl had been receiving treatment from a private psychiatrists on and off for some years since being "pack raped" on her way home from high school. This was Cheryl's first hospitalisation for her psychiatric illness.

Cheryl's medical file notations indicate that she was assessed by a psychiatric registrar and later seen by the consultant psychiatrist. The consultant psychiatrist wrote four lines in Cheryl's medical file which suggests that her assessment of her patient was grossly inadequate especially given that psychiatry is not an exact science and that she was seeing this patient for the first time. Nonetheless, Cheryl was given a diagnosis of schizophrenia and treated accordingly.

After a few days of hospitalisation, Cheryl indicated that because she was not receiving the support she came in to hospital to get, she wanted to go home. According to the medical file, Cheryl was then told that if she attempted to leave hospital she would be made an in-voluntary patient. Cheryl committed suicide on the ward eight days later.

There is not a single notation in Cheryl's medical file ascertaining how she felt, how she felt about being given a diagnosis of schizophrenia, why she was feeling suicidal, what she meant by needing support, what might be helpful to her, etc, etc. The only therapeutic intervention Cheryl received was a hasty diagnosis and medication.

Most consumers who have experienced hospitalisation in a public psychiatric in-patient unit will tell you that it is the most terrifying experience of their life, especially their first admission. The terror patients feel is not uncommon knowledge, but the reality of these feelings of terror along with other feelings associated with the person's illness are more often than not completely ignored by clinical staff.

Case 4:

A 50 year old Muslim man named Doddi (not real name), married with 2 teenage daughters presented to a public hospital emergency department requesting assistance for his depression and feelings of anger. Doddi worked as a computer programmer and had been experiencing discrimination in the workplace since the attack on America in 2001. It was also noted in his medical file that he had been held and tortured as a political prisoner in his country of origin.

Doddi was subsequently admitted to a public psychiatric in-patient unit as a voluntary patient.

While the patient care plan indicated that Doddi was to be provided with "various therapeutic strategies" to help him cope with his depression and anger, the type of therapeutic strategies were not articulated in the plan, and the progress notes suggest that no therapeutic activities other than medication were initiated. Notwithstanding this, there were no notations in Doddi's medical file to suggest that any clinician spent any time with Doddi to ascertain how he was feeling as a regular therapeutic or even one off strategy.

Additionally, the patient management plan and progress notes would suggest that Doddi's Muslim culture was not given any consideration.

After a couple of days of admission, Doddi expressed concern about a number of issues. While many of the matters were noted in his file they were largely not acted upon. Indeed his increasing frustrations at not having his concerns attended to were pathologised, and he was told it was simply part of his illness and accordingly, he was offered medication. As a result, Doddi as a voluntary patient informed his doctor and the nurse that he had decided to leave. He packed his belongs and went to the nurses station to say goodbye. He was grabbed by a

group of nurses, taken to seclusion held down, injected, stripped to his underpants and left their. Doddi was made an involuntary patient. The legal documentation indicated that he was insightless, refusing medication etc. At no stage did the nurses document any resolutions to Doddi's concerns about his care and treatment. The next day morning Doddi was made voluntary and he was discharged from hospital requiring no follow up.

This impact of Doddi's experience with the public mental health care system has been profound. His depression has markedly worsened, he feels totally humiliated, suffers from flashbacks and he has lost all faith that the system is there to care for people.

Case 5

A middle aged man called David (not his real name) who came to Australia over twenty years ago was picked up by the police and taken to an immigration detention centre for having failed to fill out an extension of visa application some 23 years prior. No account was given to the fact that the man had a diagnosis of schizophrenia that his illness was such that he was on a disability support pension, had a department of housing flat and an administrator to manage his finances. On meeting David, in the detention centre (he had been there for 4 days) he seemed to have no understanding of why he was there. He expressed concern about being late with his medication and having no change of clothes or toiletries. On speaking to the detention centre's nurse, there appeared to be no knowledge of his illness or requirement for medication.

The Department of Immigration indicated that David would need to pay some $10,000 to be released. Additionally Centrelink were to be notified to stop his pension. Luckily, the Department of Immigration staff member the advocate dealt with was helpful and David was released from the detention centre. The $10,000 was waved, the administrator gave a written assurance to "keep an eye on David until his case could proceed legally and Centrelink agreed not to stop his pension. David's case to remain in Australia continues.