

## “Safe times: 11.30am–12.00 and 4.30pm–5.00”

Merinda Epstein

RECENTLY I WENT to visit a friend in a public psychiatric unit. I had quite a long wait as she was being brought out of the High Dependency Unit. As I was sitting there I was staring at the nurses' station when I spotted the sign attached to the wall. It simply said, “SAFE TIMES: 11.30am–12.00 and 4.30pm – 5.00”. I laughed. As a veteran of acute psychiatric wards it seemed absolutely appropriate that two half-hour slots were the only times that the unit staff felt confident to claim that safety for patients could be anticipated.

Eventually I worked out what it really meant. Of course, silly me, these were the times the safe would be unlocked and you'd be able to get your money out!

When I have told this story to groups of consumers it engenders great mirth. Many of us think it is totally appropriate that these places, so often holding us against our will, should be characterised in this way. These are not safe places for many consumers much of the time and an unintended admission of this consumer reality by those in power strikes many of us as particularly humorous.

When I have told the story to groups of people working on acute psychiatric units many think that the fuss I am making is quite ridiculous because for them it is all so familiar and so obvious. Following this practice for years, they have a set of justifications for this apparently inflexible routine and can not imagine the sign meaning anything else.

However, when I have told this story to groups of outsiders who are neither consumers

nor clinicians in the mental health field — members of society who have had no experience of acute unit life — the reaction has been confusion and, for some, horror. They are stunned that “mental patients” are still so dangerous that visitors can only be assured of their safety during two half-hour periods each day.

### The first person account<sup>1,2</sup>

People listening to me describe this sign hear something different depending on their relationship to mental health services. Wadsworth\* graphically captures this often gaping fissure between what professionals see and what patients see happening to them and around them.

Here then is the source of the gap — sometimes more and sometimes less — between consumers' ways of seeing and staff's ways of seeing. What may have been experienced by some consumers as “abuse, humiliation or neglect, emotional blackmail and atrocity” may instead for some staff have been “limit-setting, standard treatment, individual service-planning and an incident”. What might be for some staff “safe seclusion, necessary medication, a successful treatment option in x% of cases, unavoidable duty of care and behavioural modification” can be for some consumers, “being locked up, forcibly injected, electrically shocked till you lost your memory, being assaulted and treated like an animal”. What can be for some consumers “frightening powerlessness and terror”, can be for some staff “therapeutic restraint and temporary ideation”.

These different perspectives do not carry the same power or authority. This is a vital under-

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\*The idea of “consumer perspective” has been well documented in *The essential U&I*,<sup>3</sup> page 175.

standing and one the consumer movement has been anxious for others to understand. From our perspective, commentary from the first person is not “just personal storytelling”. The evidence base for consumers comes from the aggregation of our personal experiences that gives our way of knowing a rigour that is often misunderstood by others in the health industry. This does not mean that we all experience the same things, share or don’t share pro-medical model beliefs or make the same decisions about our own health journeys. Rather, it means that there is a perspective that is uniquely ours. Third person analysis will never capture all that health systems need to know, regardless of how neat and “scientific” it might at first seem. The first person account is fundamental and important — too often the imperative missing link in systems’ attempts to improve health care delivery and outcomes for “sick” people.<sup>†</sup>

### **Forced treatment and patient perspective**

The delivery of mental health “care” fundamentally differs from all other areas of health service delivery because it can be forced on people against their will. Therefore the experiences of mental health patients can never be subsumed within a broader context of patient experience. With few exceptions, no other patient can ever be forced to undergo anything. It is against the law.

### **Accident and emergency (A&E) departments**

A&E departments are the interface flashpoint between physical health delivery institutions

and the mental health system. They are frequently fraught places for people with “mental illnesses”.

I remember one occasion vividly. It involved an overdose and me waking up in A&E at 3 am totally covered in black tar (which they give you as a chucking agent), bewildered and desperate to flee. However, instead of finding a reassuring face I looked up to see a woman (who turned out to be a nurse) yelling at me and challenging me not to touch her because she objected to the tar on my hands. My clothes had been confiscated (so I couldn’t escape). I was met by glares everywhere. I am not a bad person. What appeared to clinicians to be “attention seeking” was just me trying desperately to apologise to the staff. I had obviously inconvenienced and angered them, and despite the fact that I was still terrified of what was happening in my head I wanted to say “sorry”; but they were unable to hear me. My husband was summoned, against my will, and ordered to take me in his land rover to a psychiatric unit at another hospital. His terror and helplessness combined with the lack of information forthcoming from the A&E department fed his fury with me. Still affected by drugs and lurching towards the car I was conscious that the hospital gown, which was all I had to wear, didn’t meet at the back. I felt fat and exposed. John shoved me up into the high, 4-wheel drive passenger seat, working against gravity and my arthrodised (straightened) left leg. I fell backwards. He was embarrassed and accused me of falling on purpose. It culminated in him taking me to the wrong hospital because he had not waited for more detailed instructions which were slow in coming. I was still semi-conscious when we eventually reached the appointed psychiatric unit over three-quarters of an hour later.

Unfortunately, I hear consumers report similar incidents worryingly frequently. It is tragic. At the risk of sounding mistrustful, I sometimes wonder whether the refusal to transport me by ambulance was a deliberate act to make me take responsibility for my own actions —

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<sup>†</sup> I have just finished reading the Mental Health Council of Australia’s recent report, *Not for service: experiences of injustice and despair in mental health care in Australia*.<sup>4</sup> I commend this report because it is a genuine attempt to capture the lived reality of people who have been diagnosed with “mental illness”, and carers, as they experience mental health services in this country. (See page 261.)

some sort of strange pay-back for having taken an overdose.<sup>‡</sup>

I have now read accounts by A&E clinicians about their frustration with people with “mental illnesses”, especially people who overdose and cut themselves. Perhaps the best illustration is a *Letter to the Editor* I found written by Rachel James, an A&E clinician.<sup>5</sup> Not only is she angry with people with “mental illness”, but she is also angry with psychiatrists:

Any A&E doctor could tell you that in psychiatry, crisis management means rolling up at 10am the next morning, latté in hand, when the blood and vomit have been cleared away and the patient is no longer drunk and abusive.

She vents her frustration further:

It is hard not to get frustrated: people who self-harm do have a choice, although it may not seem like it at the time. They could not do it, or they could do it and stay at home to deal with the consequences. Just please don't lacerate yourself, come to hospital and then complain about it.<sup>5</sup>

There is much work to be done in healing at this interface. Rachel James steadfastly argues that education for clinicians is not the answer. Not only do I not agree, but I think much of it should be provided by consumers.

‡ Australian Capital Territory MHS (Mental Health Services) base their management approach of people with borderline personality disorder on a [misinterpretation of] the text of Watson and Krawitz (*Borderline personality disorder: a practical guide to treatment*, Oxford University Press (UK), 2003) which essentially argues that:  
— institutional care is not appropriate for people with borderline personality disorder; and  
— there needs to be immediate consequences for their actions. (ACT Disability, Aged and Carer Advocacy Service (ADACAS), ACT, Submission # 139. *Not for service report*, as cited above, page 703.)

§ My present psychiatrist, who feels she has to constantly reassure me that this was a wrong call in a hit and miss game of diagnosis in mental health service delivery, often implores me, “Why have you got to talk about being labeled as having BPD in public? You've got a perfectly good psychotic diagnosis to use in public!” I laugh and tell her, “This was the worst one. This is the one that taught me I was evil. How many other women out there now believe they are evil too? This is the one that others won't or can't talk about.”

Perhaps the emergency culture attracts professionals who thrive on being decisive and have the necessary skills and attitudes. My guess is that many of these people are the least blessed when it comes to listening rather than doing, checking to make sure that something that has been said in an unconventional way has been understood, or defusing difficult situations.<sup>6</sup>

## Crisis and assessment teams (CAT)

CAT teams have received bad press. They work under enormous pressure and have considerable responsibility for deciding who gets into hospital and who does not. They can be easy whipping boys when things go horribly wrong. My experience is that, on the whole, give and take personality clashes and just plain slack practice by some, they treat me well enough or diabolically, almost entirely depending on my diagnosis at the time.

Since working with my present psychiatrist to understand and accept (mostly) that despite fourteen dubious prior diagnoses I am in fact struggling with a “real psychotic illness”, much has changed. Mostly now, the local CAT team has been acceptable: respectful, accommodating, supportive and non-judgemental, provided, of course, I can handle being patronised. This is so different from when my primary diagnosis was, for example, borderline personality disorder (BPD).<sup>§</sup>

Recently, I had a serious episode and the CAT team visited me frequently. Living on my own poses challenges at times like this. Many weeks before, my sister had arranged to go bushwalking and I had committed myself to driving to her property, half an hour away, to water her plants and feed her two dogs. She was away when I got “sick”. I was beside myself with worry about the dogs, who were not getting fed because I was not well enough to drive. On the Thursday night two members of the local CAT team arrived. I was very anxious. After about half an hour listing to my anxiety about the dogs they checked my medication and left.

They must have gone out to caucus because five minutes later they returned saying they had a

patient in the same town as my sister and that if I gave them the address and the dog food they would feed the dogs for me. This was the most therapeutically useful thing they could possibly have done.

I am a bit wary about retelling this story, because although it was for me a truly professional, creative, healing act, I know that systems often can't appreciate laterality, and these two caring people could well be seen as either deploying their labour inadvisably in terms of their triage responsibilities or having troubles with their professional boundaries. This is devastatingly sad. As a consumer who has been actively listening to stories from people diagnosed with "mental illness" for over 15 years perhaps the most propelling reality is that the very best practitioners are, frequently, the ones who push the boundaries, and this can sometimes be dangerous for them. This is not an argument for less "professionalism", rather, it is an argument for consumers always being actively involved in the evolving process of defining and redefining what professionalism and ethical practice actually mean in the context of contemporary mental health practice.

### **The acute unit**

Many people in the consumer movement argue that "treatment" that is forced on us is not "treatment" at all. We argue that obligatory containment and the terror associated with forced injections and the effects of extraordinarily potent, mind-altering drugs given without our consent is one of the most frightening things that can happen to people. My present psychiatrist and I are both aware that she is, in part, treating me for posttraumatic stress disorder (PTSD) stemming directly from the way I was treated during one forced admission 15 years ago. The fact that the effects of such trauma can last so long and be so debilitating is frightening. The level of iatrogenic illness remains unacceptably high, and the industry must put greater effort and more resources into preventing further harming those who come before it in the name of "care".

On the other hand, the acute unit has sometimes been a false god in my life. Distressed and desperate, I have sought voluntary admission unsuccessfully or

have found my way in only to be totally disillusioned by the reality that I have found there. Sometimes my disillusionment is of my own making — my own unrealistic but desperate hope of finding a healing place within an institution created by 20th century medicine. In my experience acute units are no longer places of asylum. Unfortunately, they are too often places where you are infantilised and patronised, and where many compulsory ward programs are excruciating. I have also experienced first hand the insidious creep of institutionalisation, witnessing it overwhelming many of my friends. Sometimes it takes as little as 2 weeks for institutionalisation to impact on people's confidence and capacity. This scares me. Too many people diagnosed with "mental illness" are being compelled to undertake "therapeutic" programs that are supposedly about taking greater control of their lives within institutions that habitually take such control away. Nonetheless, acute units have their place for some. Friends tell me they have sometimes found succour in such places and I am forever amazed at the stories of inspiring clinicians who seem to emerge despite the environments in which they so often find themselves.

A few weeks ago I was visiting a friend who was a voluntary patient in an acute unit in a large metropolitan hospital. She was telling me about an incident that she had witnessed earlier in the day where a very disturbed male patient was gently induced to calm down by a male nurse sitting quietly on the floor beside him for over an hour and a half as other staff wisely kept their distance.

From a consumer perspective there were two things of note here. The clinician very successfully persuaded the man to have some quiet time and take medication orally, avoiding the need for him to be manhandled either by staff or the now obligatory security guards. Because of this quiet approach there was no need for forced injections of powerfully sedating drugs — no need for the dreaded Seclusion Unit. My friend was impressed that this was achieved, however it took ages and this impacted on other patients who were, at one stage, forced to stay in their rooms. She felt that she wasn't adequately briefed on what was happening and said that some

## The French lady

*Five years later I still remember the French lady  
and the smell of pink nylon.*

*She would have been a fairy too when she was little,  
dancing in pink on tippy-toes.*

*We could have clapped her then  
encouraging more.*

*Instead, we drop our eyes  
pretending she's not there, not real,  
not really one of us.*

*Sometimes we glance sideways and  
share a knowledge that only the French lady  
does not know.*

*Or, that's what we thought.*

*She smokes my cigarettes  
(grabbing them straight from my mouth)  
and smiles.*

*I smile back and awkwardly place myself  
between my visitor and the grabbing hand  
glancing down at my own fat and bandaged wrists.  
I am scared.*

*At night she clambers into bed. My bed.*

*I get up then feeling ashamed.*

*She's taken my purse and my money has been hidden  
in strange hiding spots and down the air conditioning  
flue.*

*Someone finds my silver ring stuffed up the plumbing  
in the bathroom.*

*The French lady smiles.*

*I smile back thinking I know her better now.*

*It takes four of them to protect me and my things.*

*They grab her and I can feel them.*

*Eight hands pulling at me —  
holding me down now and my nightie is ripped off my  
shoulders*

*as I keep struggling for a while . . .  
and then . . .*

*— undignified, naked, defeated I find myself lying  
bewildered on the hospital floor.*

*They take her away and I am left feeling grotesque.*

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of the other patients had been talking among themselves about people being rewarded for being violent and aggressive. This, some people felt, was unfair, particularly for women.

Balancing diverse needs in such a fraught environment is a challenge, however, my experience is that ninety percent of the time patients understand the dilemmas staff face and do what they can to help. The situation is exacerbated by the ridiculous situation in Victoria where we have no women-only units, so the many women diagnosed with "mental illness" who live in violent relationships and/or have histories of child abuse find themselves constantly retriggered and terrified. I was very frightened of "the French lady" until I got to know her better (see Box).

## Record keeping and discrimination

Getting access to my psychiatric file under "freedom of information" legislation was one of the most therapeutically useful things I have ever done. When I put in an application to get my files I was excited, but I was also very nervous. Being labelled as "mentally ill" immediately implies that your perceptions and beliefs are deemed inaccurate and your reasoning is, also by definition, unreliable. Over time, unless you really fight this dominant medical idea, you start to lose faith in your own judgement as well. So, for me, getting my records, and evidence that my fears about what was written in them were well founded, was emancipating.

The records contained many descriptions of me being "manipulative", "calculating", "attention seeking", "dependent", and "hysterical". The consumer movement has worked really hard to come up with alternative ways of describing people's distress that are infinitely less judgemental. This is not so hard to do, so it is annoying that these problems have not been solved. A good example is the dreadful term "attention seeking". To take away the venom all you have to do is to turn the words around. To suggest that someone is trying to "seek some attention", particularly if it is couched in a statement that such attention was not easily forthcoming because there were not enough staff on or it was handover etc, turns something that is a destructive and futile

comment into a constructive statement about what needs to change in ongoing unit practice.

Also within my records was a direct quote from a private telephone conversation I had with a friend and colleague. In this instance, the phone — as is very common — was placed right opposite the nurse's station. There was no privacy, and I guess we all knew that you took your private life into your hands every time you made a call. Sometimes I got so desperate for contact with the outside world I took a risk. I knew it was a calculated one.

It's amazing to me that this private conversation was actually recorded in a file and no one subsequently reading the file (day after day after day) seemed to have had the ethical drive to black it out and bring it to the attention of those with authority within the unit. This was even more shocking given the fact that what I had said that was so worth recording was something that I believe was entirely sensible. I had asked my boss not to tell too many people that I was an inpatient in a psychiatric unit. To this day I have no idea why this was seen as an example of me being "manipulative with a work colleague".

Also recorded is a discussion between my admitting doctor and several staff about my homosexuality. My problem with this is, in part, that I don't think my sexuality has much to do with my mental health, but also that this commentary was going on behind my back. My admitting doctor on one admission described me as "a rather plain looking woman . . ." If he had described me as anxious, distressed, distracted — any of these things — I would have understood it as part of the process of

careful observation — a skill taught to medical students. However, his judgement about my looks was redundant and unprofessional. My beauty or lack of it was, surely, totally irrelevant.

There were many more specific instances of troubling record keeping, but the thing that most amuses me was the prolific use of exclamation and question marks.<sup>¶</sup> My records were full of them. On one occasion I was escorted on a group walk (yuk!). Every member of staff knew that I have a physical disability — an arthrodised (permanently straightened) left leg. In my file it reads "She claimed that she can't bend her knee!!!"

Precisely because I have experienced record keeping which is of poor quality, lazy and sometimes unethical, I have strong views that further accessibility of records across state and territory borders or between different health institutions should be discouraged. I do not want what I consider to be defamation spread any further — especially not to mainstream health providers.\*\*

## Conclusion

Consumers and services need to collaboratively explore what is possible given the paradox that underscores mental health practice. Social expectations are that mental health services are responsible for both providing "care to the sick" and protecting society from "scary social deviants".<sup>3</sup> At the same time, funding constraints and misinterpretations of the idea of community care, have turned many public psychiatric acute units into little more than psychotropic drug pumping stations. Clinicians know this and consumers know this. No wonder morale is low: clinicians are leaving without their positions being filled and consumers do not feel safe.

I often wonder about what happens when groups of professionals are feeling progressively irrelevant because they can't do what they are trained to do and are under significant public pressure to solve social problems while working in an area of health that is perhaps the least sexy and the most underfunded. Could there be a tendency for some people who are workers in such a situation to feel more useful and even indispensable when the unit is alive and vital with crises? I am not suggesting that most

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¶ My guess is that they might be being used more now that we can all get hold of our records and directly defaming accusations might possibly become the topic of defamation suits.

\*\* The consumer movement has collected information that demonstrates that some of the worst discrimination comes from mainstream health institutions and their workforce. For example: — Frank Small and Associates. *Attitudes of Health Professionals Project*. National Mental Health Strategy, 1998.

— National Community Advisory Group on Mental Health. *Let's talk about action*. Mental Health Section, Commonwealth Department of Health and Ageing, April 1994.

— Meadows G, Singh B, editors. *Mental health in Australia — collaborative community practice*. Melbourne: Oxford University Press: 16.

clinicians deliberately stir things up, but I do believe that sometimes there is a cultural imperative for action. Certainly consumers not infrequently complain of a culture where “things escalate easily” and where some staff fail to recognise their own role in promoting this escalation.

The metaphor that I have used now for some time is the parable of “the canary down the mine”. In the 19th century miners took canaries down the coal mines because these sensitive little birds would die as soon as the air became polluted enough to badly affect the miners. The death of the bird would be a signal to get out. Acute psychiatric hospital units can be seen to be like 19th century coal mines. For many (both clinicians and consumers), they are experienced as toxic. Sensitivity of staff to this toxicity must start to be seen as a valuable contribution to the safety of the unit for all, rather than a “deficiency of skills”, or “over identification”, or “promoting dependence” or “being manipulated” or whatever other language is used to frame such acts of affinity negatively. In order to bring about this profound change in service culture consumers must become increasingly involved in selection of staff and promotion; evaluation and accreditation of services as well as the education and training of all

those who work across the many health services that interact with people diagnosed with “mental illness”. Staying safe for everyone may depend on it.

## Note

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