

Breakdown

A story of mental illness mismanagement

By Sarah Russell

Recently, I had a mental breakdown. It all happened so quickly. One day I was a contented postgraduate student with teaching responsibilities. Three days later I was having a psychotic tantrum.

Spending three weeks as a certified patient in Larundel introduced me to some of the problems that sufferers of mental illness face: appalling health care services, discrimination in the work place and the loss of friendships.

The saga began when I became unduly concerned about a work colleague. She was depressed and I became worried that she was contemplating another suicide attempt. It was the anniversary of a friend's suicide and I felt that I could not let it happen again. I began having terrible dreams, waking up terrified in the middle of the night. For weeks, I tried to talk to my colleague about my fears but she had other things on her mind. Eventually, I wrote her a note which she resented: "You are not my mother".

I became too upset and angry to sleep. Instead, I stayed up all night writing her a ten page, honest letter. I asked for a response. When I received none, I left messages on her answering machine. The next day, my fears for her safety returned and the quantity of the answering machine messages increased. There was no malice in these messages; there was simply a lot of them. I had completely overreacted.

After three nights of not sleeping, I recognised that I was overwrought. I went to a 24 hour clinic and requested some sleeping tablets. A prescription was written by a medical practitioner, no questions asked. My intention was to come home and spend a few days sleeping it off. My brother, however, soon put a stop to that. Rather than contact my local doctor, he contacted the cavalry. The Crisis Assessment and Treatment Team were at my door when I arrived home from the clinic and it was all downhill from there.

The Crisis Assessment Team was my introduction to the contemporary Mental Health Care System. A psychologist and a psychiatric nurse came to my home and, after a brief assessment, they recommended that I take a major tranquilliser. I demanded to see a qualified psychiatrist and was told that there was none available on the weekend. I refused to take the medication and angrily insisted that they leave my home.

There is no doubt that this altercation contributed to my decline. I became furious that unqualified people were recommending psychotropic medication. Surely sufferers of mental illness deserve the same standards of care as other people who are sick. We deserve to be treated by qualified medical practitioners, even on a Sunday.

Crisis Assessment and Treatment Teams are part of the current shift of mental health services to the 'community'. We are told that this shift will improve the quality of life of sufferers of mental illness. Yet, this improvement will only occur if there is a commitment to allocate sufficient resources to make it a success. Unfortunately, this is not happening.

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Crisis Assessment and Treatment Teams are largely staffed by psychiatric nurses and allied health professionals. Although there is one medical officer, psychiatric registrar or consultant psychiatrist employed on each team, she cannot possibly attend all the home visits. Instead, phone orders are frequently given and medication is often written up by the doctors after it has been dispensed. On the weekends, there are no medical practitioners on many teams. It was unfortunate, therefore, that I became acutely unwell on a Sunday.

The Crisis Assessment and Treatment Team left me at home in the care of two friends who had no understanding of manic behaviour. Even though the team had decided that I required treatment with medication, they left me alone without that medication. Would a patient with chest pain, requiring morphine and oxygen, be left alone with friends? Of course not. A doctor would be notified immediately (even on a Sunday).

Leaving me at home with two friends highlights yet another problem with current community care policies. They are being used to transfer responsibility for the care of sick people onto unpaid and unqualified labour. Nowadays, psychiatric nurses visit patients for half an hour a day; the other twenty three and a half hours of care is provided by relatives, friends and volunteers. Although this is cheaper, it can have serious implications for both the patient and their carers. In my case, it caused irreparable damage to two friendships.

Witnessing acute illnesses can be very upsetting. Severe asthmatic attacks or epileptic convulsions, for example, can be quite devastating to observe. Watching a friend or relative gasping for breath or seeing them thrashing around on the floor can be a very traumatic experience. Yet, it is common to feel compassion for the sufferers of physical illnesses. In my case, however, my friends felt only anger.

I have only a vague memory of that fateful Sunday afternoon. As the day progressed, I deteriorated. Sleep deprivation became psychotic anger. I was angry with my brother for interfering in my life; I was angry with the CAT team for being the CAT team; I was angry with Kate for killing herself; I was angry with my colleague for not returning my calls. My behaviour probably resembled someone on a bad acid trip; I was completely out of control. My friends had never witnessed psychotic behaviour before and they found the whole experience very distressing. They saw me throw clothes out my window, smash Kate's vase and jump over my back fence.

Jumping over my back fence brought an end to my liberty. The CAT team returned with the police and I was forcibly removed from my home (still without having been examined by a doctor). I was transferred to Larundel in the back of a police divisional van. Although ambulances are commonly used for health care emergencies, punitive action is taken when a person is suffering an acute mental illness. This humiliation of being "arrested" was enough to tip me deeper into a crisis.

I arrived at Larundel angrily demanding to see a psychiatrist. Instead, I was initially assessed by a young medical officer. I was rude, angry and hysterical. It did not take long before I was held down by the nursing staff and given medication against my will.

I spent several days refusing medication. As a consequence, I was frequently held down and given intramuscular injections. I spent some of that time in solitary confinement - in a room six metres by three with a mattress on the floor. On one occasion I was forced to urinate on the floor

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because no other arrangements had been made.

After ten days, I realised that a change of plan was required. I realised that the only way to get out of this hell-hole was to be docile and compliant. I became "good". On one occasion, an arrogant male nurse patted me on the head and said "there's a good girl". I felt like kicking him in the balls but I feared the repercussions. He had the power to put me back into solitary.

I was alarmed at the extraordinary lack of resources at Larundel. One morning, I was forced to dry myself with face washers after a shower because there were no towels. There was even a restriction on the amount of milk I could drink. These complaints seem trivial, however, compared to the terror I felt towards some of the psychotic male patients. On one occasion, a male patient wandered into the bathroom when I was in the shower (there was no lock on the door). He asked me to fuck him. I was terrified but was able to calmly ask him to leave. Surprisingly, he did.

There is one memory of Larundel that stands out: the heavily medicated patients lying around, some on couches, some on the floor, while the nursing staff sit in the office observing through a glass window. A few of us paced up and down a corridor, forty four paces in each direction. There was nothing else to do; it was either the couch or the corridor.

At Larundel, despite a white board in the corner that suggested otherwise, there was no diversional activities, no therapy group discussions, no relaxation classes. Nothing. There was not even a social worker. Here people are admitted during a crisis, made docile with medication, then discharged into the same social circumstances. It is not surprising, therefore, that there are so many readmissions.

At Larundel, the only therapy was four hourly medication. At the appointed time, I would queue for my pills and swallow them before watchful eyes. Here drugs were dished out but no information accompanied them. No-one told me about the side-effects, the foods to avoid, how much alcohol to drink or whether it was safe to drive a car. It was not until after discharge that I found the answers to these questions.

It took fourteen days of docility and compliance to gain my freedom from Larundel. To get out, I had to play the game of being a "good girl". When the game was over, the anger re-surfaced. I was not only angry with my brother for locking me up, but I was also angry with myself. How could I have let this happen? How could I have let so many nights pass without sleep?

I kept asking myself: If I had been left alone to take those sleeping pills, could the crisis have been averted? There were so many "what if's. What if my colleague had spoken to me weeks earlier, reassuring me that she was not suicidal, and the nightmares had stopped disrupting my sleep? What if I hadn't cared so much?

It was pointless to go on and on with all these "what ifs. I had spent three weeks in Larundel and that was that. Although it was important to write letters to the Chief Psychiatrist and the Health Services Commissioner, it was also important to get on with my life.

Unfortunately, this has not been easy.

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The first thing I needed to do was to apologise to those people who had been affected by my mental illness. I felt very remorseful and ashamed for my irresponsible behaviour when I was sick and I hoped for forgiveness. I regretted making all those absurd phone calls to my colleague and smashing Kate's vase. I rang my friend but, upon hearing my voice, she hung up the phone. I was devastated. At a time when I desperately needed compassion, I found hostility.

I anticipated that returning to university would be uncomplicated. During my few years in the department, I had supported many colleagues in times of stress and sickness and felt sure that they would do the same for me. During times of crisis, some had even used my family's beach house. Yet, when I returned to the department, these same people ignored me when I passed them in the corridor.

I was astonished to learn that my friend had spoken about my "Psychotic Sunday Behaviour" to my academic supervisor. I had asked for her help as a friend, not as a work colleague. My irresponsible behaviour occurred in my own home on a Sunday; it had nothing to do with my work. The boundary between personal and professional became further blurred when my colleague complained of "harassment". Couldn't she have just picked up her phone and told me to bugger off? Then, at least I would have known that she was not lying in a gutter somewhere full of valium and panadol.

The harassment complaint transformed my private illness into a major departmental issue. As a consequence, my privacy and confidentiality were completely violated. My breakdown was announced at a staff meeting and many postgraduate students were interviewed to determine whether my behaviour had upset them in any way. During this series of interviews, some postgraduate students complained that I was "direct, honest, articulate and outspoken". I explained that this was not the behaviour of a "manic-depressant"; this was me.

I was sick for two days, not two years. During those two days, the only departmental contact I had was with an answering machine and a woman who I thought was a friend. Nevertheless, a group of postgraduate women in my department formed a delegation to complain to my supervisor that they had been profoundly affected by my behaviour for the past two years. These women used the lens of a mental illness to re-interpret my behaviour and their relationship with me. They complained that I was the "self appointed organiser of social activities and reading groups". Due to my mental illness, my contribution to departmental life was portrayed as me being a megalomaniac.

The complaints were never investigated through any formal process and I was not given the opportunity to defend myself against these allegations. Yet they were documented on my academic file and reported to senior university personnel. Due to my mental illness, my supervisor simply assumed that the allegations were true. At the departmental staff meeting, the academic and general staff were told that I had a mental illness and had harassed and bullied a number of students. Staff were advised to keep a weather eye out for any such future behaviour.

So much for mental illness being treated just like a physical illness! If I had HIV, for example, would my supervisor have announced my illness at the staff meeting? If I had broken my leg, would my supervisor have jumped to the same conclusions?

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During my few days back at work it became clear that my colleague had not explained the context in which the alleged harassment took place (my fear that she may be contemplating another suicide attempt) nor the behaviour that constituted this 'harassment' (numerous phone calls to her answering machine on a Saturday). She had simply complained of 'harassment'. This lack of knowledge about the nature of the harassment allowed imaginations to run wild. Was it sexual harassment? Were other postgraduate students victims of my harassment?

On several occasions, I was asked whether my colleague and I were lovers. I should have responded that this was none of their business, but such an answer creates misunderstandings. There had already been far too many misunderstandings in this saga. It was even thought that I had contributed to a Masters student's decision to defer her course simply because her deferral occurred around the time of my breakdown.

Amongst academics, it seems nothing is sacred. News of my illness spread to my other workplace where it was widely circulated by the receptionist. Here, however, the response to my illness has been compassionate, not cruel. Here, people have even helped me to find some humour in this most extraordinary saga. Colleagues have left numerous messages on my answering machine, hoping I will not lodge an harassment complaint.

It has been suggested that I take my case to Equal Opportunity lawyer because I have been discriminated against on the grounds of a mental illness. If I had HIV, for example, would all the postgraduates have been interviewed to determine who had shared my coffee mug? Would I have been asked about my sex life.