

Response to the Draft Report on Mental Health from the Productivity Commission

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The draft report is a comprehensive document that recommends a number of initiatives and changes in practice to improve mental health outcomes.

I believe I am in a good position to comment on the draft report both through my work as a psychiatrist for more than 40 years, and as a former secretary of the RANZCP where I was involved in broader policy development. I have worked with children, adolescents, families and adults. I have also worked in both the public and private systems and in prisons.

Most recently I have been assessing claimants regarding workers compensation claims, transport accident claims and personal injury claims. I have also been involved in training psychiatrists in this field.

I have interviewed more than 30,000 people during my career.

My concerns about the draft report are with regard to 8 main areas:

1. How do we define a mental health problem?
2. Research issues.
3. Comorbidity especially involving drug and alcohol issues.
4. Mental illness and incarceration.
5. Victims of trauma.
6. Claimants regarding worker's compensation and transport accident psychological injuries and other traumatic events such as natural disasters.
7. Privacy legislation.
8. Cost estimates.
9. Workforce

1. HOW DO WE DEFINE A MENTAL HEALTH PROBLEM?

Is somebody grieving experiencing a mental health issue? Is somebody who failed to gain an expected university placement dealing with a mental health issue? Is somebody caught for drink-driving experiencing a mental health issue?

In my view these are legitimate questions. If people in the above categories are regarded as having mental health issues then all of us, whenever we experience any setbacks would fall into this category. This becomes so all-encompassing as to involve everybody in the community and ultimately those who actually do have serious mental health issues may be even more disadvantaged by the flood of demand for mental health services. Where do we draw the line between normal responses to life's vicissitudes and people whose capacity for coping has been impaired?

In my experience people with mental health issues fall into two main groups. There are those who are dealing with the vicissitudes of life and are either temporarily or permanently affected. The

second group is those who have a severe mental illness such as schizophrenia, bipolar disorder, generalised anxiety disorder and so on.

The draft report does allude to this distinction but in my view makes little of it.

This distinction is a very important one. The needs of the first group can generally be met by general practitioners, psychologists, mental health nurses and other mental health workers.

These people have become distressed by loss or perceived loss. The usual losses that lead to distress include loss of health, loss of wealth, loss of a loved one, loss of a relationship, loss of a job, loss of a home, loss of self-esteem and loss of love. No matter what the cause, these experiences are familiar to us all. We can all empathise with the ensuing grief, sadness, fear, loss of sleep, loss of appetite, self-medication with cigarettes, illicit drugs and alcohol with the resultant problems arising from such self treatment. This is the group that is the 1 in 5 each year. In the normal course of events most people recover with or without treatment. They usually require some period away from work and benefit from symptomatic treatment for sleep, psychological counselling to ventilate and to learn strategies for managing.

The second group are those with mental illness. Their symptoms may be present in childhood but predominantly occur in adolescence. These people have a chronic disorder that usually fluctuates and is frequently disabling. They require specialist psychiatric treatment and may need periods of hospitalisation. These people are seen in both the public and private health systems. People in this group constitute 3% of the population. A study I did in 1993, the Solomon Buckingham Epstein Report, estimated that 50% of people in this group received no treatment. The subsequent ABS study in 1997 confirmed that impression and the more recent ABS studies have noted that that trend has continued. There are many reasons for this including reluctance to seek treatment by individuals affected, workforce maldistribution, inadequate resources, amongst others.

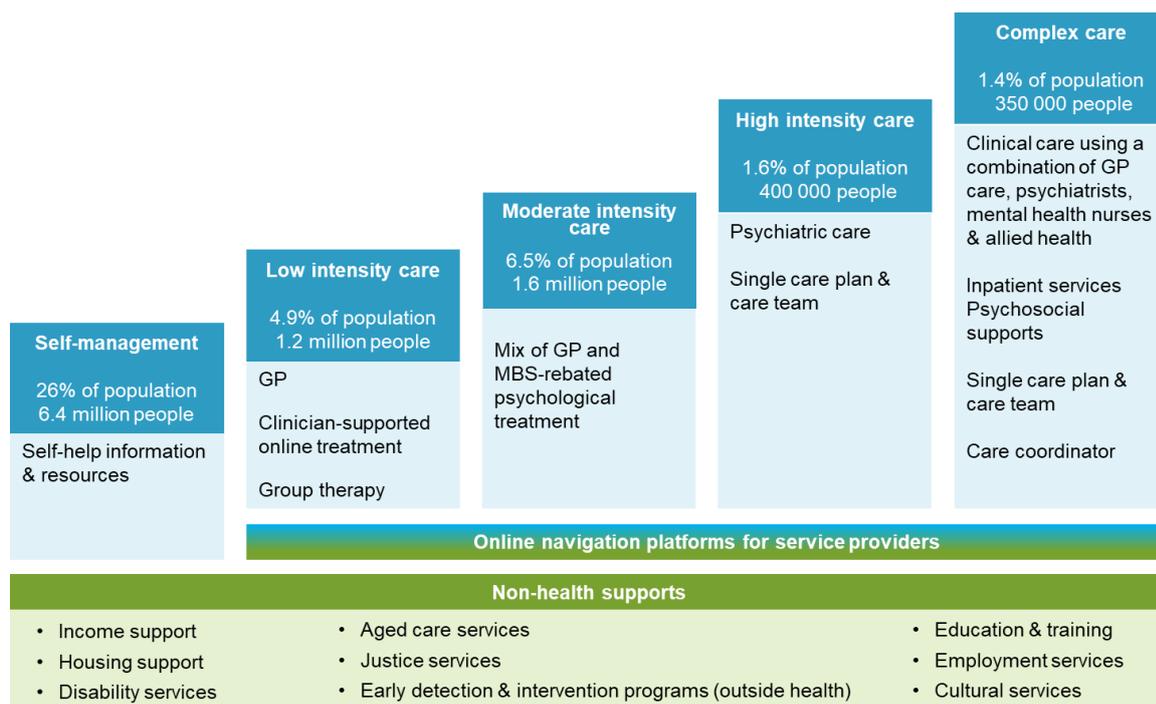
There is a third group. This group consists of a small minority of people in the first group who have not recovered and have merged into the second group and who remain severely disabled.

Although we can all identify and empathise with the first group. It is much more difficult to identify and empathise with people with severe mental illness. Very few of us know of the experience of paranoia, hallucinations, delusions. Well-meaning people try to relate to people with a bipolar disorder or a major depressive disorder but have no real understanding from their life experience of the pain of these mental illnesses.

Although there have been many attempts to reduce stigma, some successful, nevertheless people with severe mental illnesses such as schizophrenia, bipolar disorder, panic disorder, obsessive-compulsive disorder and generalised anxiety disorders frequently receive little sympathy and certainly limited understanding. In my experience they remain severely stigmatised.

I have seen some people who have not wanted or sought mental health treatment and a significant number whose mental health has deteriorated as a result of mental health treatment. Mental health treatment is not a panacea. I have provided 2 case summaries to illustrate these points (see appendix).

Most people do not need specialized mental health treatment or long term treatment. A small group require lifelong treatment sometimes including short term in-patient stays and long term supported accommodation.



I note the Commission recommendations with regard to phased treatment. It is not clear whether or not this relates to private psychiatric practice. As a matter of routine private psychiatrists should work as part of a team including psychologists and mental health nurses, and other mental health workers including home visits.

Supported care for people with a chronic disabling psychiatric illness must be available. This does not need to be in a hospital setting or even in a psychiatric unit. It has always been a paradox that we put people who are acutely mentally ill in accommodation with Allah suffering similar problems, I have always questioned how that can be beneficial. It seems a warehousing approach. Some years ago I recommended that consideration be given to private home care. Private home care would allow for a person with a serious mental illness to be in a more normal environment, the caregivers would be trained, paid and supported such an approach would reduce the stigma of being in a hospital and provide for more personalised care, probably with a significant cost saving.

We all know that people suffering from psychiatric issues (mental illness and related problems) have complex clinical needs that vary over time that may require different levels of treatment and support. We also know that being employed is very important for us all in terms of having a sense of purpose, a reason to get out of bed in the morning and a sense of identity.

In my view it is important for the commission to have a clear definition of mental illness and acknowledge the wide variety of manifestations of mental health concerns.

My concern is that the Productivity Commission recommendations do not separate out these different groups.

Consider a similar Productivity Commission Report on physical illness. One would expect that physical illness would not be taken as a whole but would be sensibly responsive to broad categories of physical illness. For example, respiratory disorders, cardiovascular disorders, endocrine disorders and so forth.

It is disappointing that the Productivity Commission Report does not make a similar distinction with regard to Mental Health Issues such as described above.

2. RESEARCH INTO TREATMENT OUTCOMES

For many years there has been extensive research on various aspects of mental health issues both in Australia and internationally. Much of this has been ad hoc in response to the interest of a particular researcher and with regard to the availability of funding.

As a result of the report I contributed to in 1993 funding was provided to assist private psychiatrists to provide more services to people with severe mental illness. This was a well-funded program but there was little benefit.

I mention this because at the time I realised that there was no systematic approach to either mental health research or mental health research funding.

I envisaged a type of three-dimensional matrix. One dimension would involve various types of mental illness, one dimension would involve stages of mental illness, one dimension would involve people with a similar illness being treated in metropolitan, rural and remote areas.

It seemed that there was no global way of looking at what worked in the context in which that approach had worked. Neither was there any systematic way of looking at what had not worked and the reasons for that.

Its worthwhile having a network of psychiatry research centers and draw upon the huge talent pool of private psychiatrists.

This seemed to be a way of prioritising research into treatment outcomes so that what worked does not have to be duplicated and can be implemented and what has not worked should be assessed with different approaches tried.

Such a systematic approach should inform all mental health service providers, research funders and researchers.

3. COMORBIDITY

DRUG AND ALCOHOL ISSUES

In the early stages of a severe mental illness many people resort to self-medication with illicit drugs and/or alcohol leading to further problems. This is especially the situation with regard to people who become dependent on cannabis. These people are often very passive and resistant to reducing their cannabis use despite the adverse effect on their mental illness of their continuing consumption. This is a much more serious problem for those who are addicted to methamphetamine (ICE) who are notoriously difficult to treat for various reasons including their unreliability, their unprovoked aggression and their alienation from family members because of their violence and stealing.

There are also many people who develop a mental illness in the context of their illicit drug use. Their treatment is often made more difficult by their continuing drug use.

We need to have much greater coordination between drug and alcohol services and mental health services.

INTELLECTUAL DISABILITY

There is also difficulty in dealing with mental illness in people with an intellectual disability. Intellectual disability services and mental health services rarely provide a combined approach.

PHYSICAL ILLNESS

People with physical health problems have a much higher rate of mental illness especially depression for understandable reasons. These people also tend to be insufficiently treated with regard to their mental health issues. Sometimes medication used to treat their physical illness has an adverse effect on their mental state. Consultation/liason psychiatry is a component of most inpatient general Hospital services, usually in the context of an acute illness but consultation/liason psychiatry has a much broader role to play as part of the team managing people with complex chronic physical conditions.

4. MENTAL ILLNESS AND INCARCERATION

This section of the report is to be commended. The report notes the significant incidence of mental illness in our criminal justice systems. Many people have a combination of intellectual disability, illicit drug use and antisocial behaviour associated with complex and difficult to treat mental health issues. Mental health services in prisons are poorly funded and the very experience of incarceration is known to exacerbate mental illness.

It is interesting to note that those who advocate for removal of asylum seekers from detention centres because of the adverse mental health issues involved rarely mention the adverse effects of incarceration, a situation much closer to home.

5. VICTIMS OF TRAUMA

Victims of trauma of whatever cause usually experience significant complex and long-term mental health issues. We see this in victims of childhood physical, emotional and sexual abuse but also in people who have been tortured and first responders who become overwhelmed by their exposure to violence and experience severe vicarious trauma. Many of these people become permanently psychologically disabled and their capacity for coping becomes much more limited. Their prognosis for improvement is poor and they need significant help in navigating daily life together with some symptomatic treatment.

6. WORKER'S COMPENSATION/TRANSPORT ACCIDENT/ NATURAL DISASTERS AND PSYCHOLOGICAL INJURIES.

I have both assessed and treated people with work-related mental health issues and for people who have suffered mental health problems arising from various traumatic events including transport accidents.

I am pleased that the Productivity Commission has considered work-related mental health issues in some detail.

There are 4 types of mental health problems that arise from workplace injury. The first involves a physical injury that becomes associated with a psychiatric injury. In many situations employers have a positive attitude to these workers and many workers do not blame the employer for their injury. In that context and appropriate return to work is more easily navigated. However that can then lead to the second type of work related mental health problem. This is when a worker returns to work but is

not given appropriate duties even within the context of the work limitations. For example repetitively sweeping a factory floor for an injured fitter and turner. This is demeaning and workers complain that they feel unwanted and a nuisance. They complain that they feel the employer is trying to get rid of them and in that context become angry and depressed.

The third type of mental health problem arises from workplace conflict that is poorly dealt with by management. Too often management appears ineffectual in resolving workplace disputes. Too often the victim is blamed. This inevitably leads to a breakdown in the relationship with the employer and often to long-term psychiatric disability.

The fourth type of mental health problem is where there is a back down in trust between the employer and the employee, this is particularly so in small workplaces where an employer has learned that an employee has complained to others of an injury at home but then makes a WorkCover claim claiming the injury occurred at work. The claim may well be accepted and the employee eventually returns to work but shows little interest in maintaining employment. One question is whether or not there is actually a mental health issue.

The gold standard of workers compensation is the return to work rate. For at least the last 10 years the Victorian WorkCare authority has attempted to improve the return to work rate having tried a number of different strategies with little evident benefit. This is a very difficult issue.

Workers compensation is a complex socio-/medico/political environment. An example will illustrate this point. A number of years ago the number of WorkCover claims by Victorian police officers dropped by 50% in one year. At the same time the Emergency Services Superannuation Scheme became much more liberal and the number of claims on that scheme in the same year increased by 250%. The impression was that police officers were choosing the superannuation exit rather than the workers compensation exit because of the reduced stigma and the reduced bureaucracy.

I turn to the recommendations of the Productivity Commission.

Recommendation 19.1 is *“Psychological health and safety should be given the same importance as physical health and safety in workplace health and safety (WHS) laws”*. I have no argument with that recommendation. However this raises 2 issues.

The Paradox is that it is government policy to improve mental health outcomes and reduce stigma

It is also government policy to discriminate against claimants with a psychiatric injury!

For example. ReturntoWork South Australia.

- benefits for permanent impairment
 - physical impairment threshold 5% **PLUS** a lump sum payment
 - psychiatric impairment threshold 30% (only Pure Mental Harm) and **NO** lump sum payment!

Similar discrimination is present in the workers' compensation legislation in the Commonwealth and in all states and territories.

Furthermore, Recommendations 19.3 and 19.4 propose policies that positively discriminate for people with work related mental health issues to the possible detriment of physically injured workers.

Recommendation 19.3

Workers compensation schemes should provide lower premiums for employers who implement workplace initiatives and programs that have been considered by the relevant Workplace Health and Safety authority to be highly likely to reduce the risks of workplace related psychological injury and mental illness for that specific workplace.

and

Recommendation 19.4

Workers compensation schemes should be amended to provide clinical treatment for all mental health related workers compensation claims, regardless of liability, until the injured worker returns to work or up to a period of six months following lodgement of the claim. Similar provisions should be required of self-insurers.

Should physically injured workers receive such immediate treatment whether or not liability is accepted!

Further comments

Draft finding 19.1 reflects the comments I have made earlier.

Draft finding 19.2 is correct as far as it goes however it ignores the complexity of the background to many workers compensation claims.

Draft recommendation 19.4 sounds worthy but in my view has significant issues with regard to who eventually pays if the claimant's later rejected and what is the equity if a person with a mental health issue has six months of treatment (or less) but a work who claim is not yet been accepted with regard to a physical injury does not receive the same consideration.

Draft finding 19.3 with regard to Employee Assistance Programs Is correct although it is important to bear in mind that some fine little benefit in these programs if there has been conflict with the employer as they are uncertain as to the relationship between the counsellor or psychologist and the employer and become concerned about the confidentiality. an employee assistance program should provide funding for a psychologist or counsellor chosen by the employee rather than by the employer.

Information request 19.3. Many superannuation policies contain provision for income protection payments.

Workplaces

REFORM OBJECTIVE:

Develop and support mentally healthy workplaces

draft Recommendation 19.1 — psychological health and safety in workplace health and safety laws

Psychological health and safety should be given the same importance as physical health and safety in workplace health and safety (WHS) laws.

In the short term (in the next 2 years)

The model WHS laws (and the WHS laws in those jurisdictions not currently using the model laws) should be amended to ensure psychological health and safety in the workplace is given similar consideration to physical health and safety.

All WHS legislation should clearly specify the protection of psychological health and safety as a key objective.

Necessary amendments should be made to ensure that the relevant legislation and regulation addresses psychological health and safety similarly to physical health and safety.

draft Recommendation 19.2 — codes of practice on employer duty of care

In the short term (in the next 2 years)

Codes of practice should be developed by Workplace Health and Safety authorities in conjunction with Safe Work Australia to assist employers meet their duty of care in identifying, eliminating and managing risks to psychological health in the workplace. Codes of practices should be developed to reflect the different risk profiles of different industries and occupations.

draft Finding 19.1 — return to work is more difficult in smaller businesses

Return to work for those with a psychological injury or mental illness is difficult if the injury or illness was related to personal conflict or wider cultural issues in that workplace that have not been addressed prior to return to work. These difficulties are more acute for smaller businesses operating from a single location, as unlike larger organisations that have multiple sites, the business is unable to provide return to work at a different location.

draft Recommendation 19.3 — lower premiums and workplace initiatives

In the medium term (over 2 – 5 years)

draft Recommendation 19.3 — lower premiums and workplace initiatives

Workers compensation schemes should provide lower premiums for employers who implement workplace initiatives and programs that have been considered by the relevant Workplace Health and Safety authority to be highly likely to reduce the risks of workplace related psychological injury and mental illness for that specific workplace.

draft Finding 19.2 — the role of workers compensation in addressing mental health

Workers compensation arrangements can most effectively deal with mental health claims and improve outcomes for employers and employees by providing for:

early intervention

early treatment

successful return to work.

draft Recommendation 19.4 — no-liability treatment for mental health related workers compensation claims

In the short term (in the next 2 years)

Workers compensation schemes should be amended to provide clinical treatment for all mental health related workers compensation claims, regardless of liability, until the injured worker returns to work or up to a period of six months following lodgement of the claim. Similar provisions should be required of self-insurers.

Information request 19.1 — How should the treatment be funded?

How should the clinical treatment for workers with mental health related workers compensation claims (irrespective of liability) be funded until return to work or up to a period of six months?

draft Recommendation 19.5 — disseminating information on workplace interventions

In the medium term (over 2 – 5 years)

WHS agencies should monitor and collect evidence from employer initiated interventions to create mentally healthy workplaces and improve and protect the mental health of their employees. They should then advise employers of effective interventions that would be appropriate for their workplace.

draft Finding 19.3 — Employer assistance programs (EAPs)

Employer Assistance Programs (EAPs) are reported to be highly valued by at least some employers and employees. The type and level of EAP services an individual business requires to meet its needs and those of its employees is best determined by the business itself.

The services provided by EAPs, as well as concerns around the reliability of services and the reputation of providers, would be enhanced through further evaluation of their outcomes. To facilitate this, the EAP industry could:

develop mechanisms to enable individual businesses and EAP service providers to evaluate outcomes for that business

invest in research to improve external evaluation and benchmarking of best practice in the wider provision of EAP services.

Information request 19.2 — personal care days for mental health

Would designating a number of days of existing personal leave as ‘personal care’ to enable employees to take time off without medical evidence to attend to their personal care and wellbeing improve workplace mental health and information on absenteeism due to mental ill-health? If so, what would be needed to make this provision effective?

Information request 19.3 — barriers to purchasing income protection insurance

Are there any barriers to employers — in sectors where there is a higher risk of workers developing a work related psychological injury or mental illness — purchasing income protection insurance (including for loss of income relating to mental ill-health) for their employees on a group basis to enable their employees to access this insurance at a lower cost?

Information request 19.3 — barriers to purchasing income protection insurance

7. PRIVACY AND FREEDOM OF INFORMATION LEGISLATION

Privacy and Freedom of information legislation are both important components in maintaining transparency and confidentiality. However such legislation can have some unfortunate adverse effects.

In particular privacy legislation requirements may make it difficult or even impossible for clinicians to communicate with parents of an adult child with a severe mental illness. Since the main burden of care for that person falls on the parents such legislation is not only counter-productive it also leads to loss of faith in clinicians and the mental health system. It seems obvious that for parents and other nonclinical caregivers to look after a person with a severe mental illness they need to know what they are dealing with, they need to know what treatment is being provided, medication used, the frequency of medication, the risks of non-compliance with medication, appointment times and so forth.

An unfortunate adverse effect of Freedom of information legislation is that confidential conversations with clinicians by parents and other caregivers become available to the identified patient. It is not uncommon for this to lead to a breakdown in the relationship between the prime caregiver and the person with mental illness, for example if the prime caregiver has arranged for the person with mental illness to be assessed by a CAT Team and admitted to a mental health facility as an involuntary patient.

8. THE COST TO THE COMMUNITY OF MENTAL HEALTH ISSUES

I note that there is a comment in the draft report stating that the cost of mental illnesses between \$41-\$51 billion per year and that the additional cost to the community may be as high as \$130 billion.

Cost of diminished wellbeing (for those living with mental ill-health or self-inflicted injuries, and/or dying prematurely, including those who die by suicide) **130**

Other costs that overlap with (and cannot be added to) the above

Costs to the economy of suicide and suicide attempts (excludes the costs of pain and suffering of the individual and their family and friends) **16-34**

Such estimates are always reliant on a good deal of guesswork and these figures, taken out of the context of other costs sound enormous.

It is difficult to reconcile the figure of \$16 billion-\$34 billion with regard to the costs to the economy of suicide and suicide attempts when, In 2018, preliminary data showed a total of 3,046 deaths by suicide (age-specific suicide rate 12.2 per 100,000). According to data from the Australian Institute of Health and Welfare in 2016/2017 \$9.1bn were spent on all MediCare related mental health services.

However, large as these figures appear to be, we live in a country with a GDP of over \$275bn. It can bring these figures into proportion when we look at other costs. For example the cost of personal care days for mental health (information request 19.2).

The November 2019 figures from the ABS show that the Workforce numbers in Australia were 12,996,500.

The Average Weekly Earnings for all employment for the third quarter of 2019 was \$1238.30, the average daily wage (assuming a five-day workweek) was \$247.66.

If all Australian workers took one personal care day each the cost to employers, only in terms of wages with no production, is about \$3,22 bn.

The report states *“Across those reforms for which benefits have been estimated, total benefits were estimated to be up to \$11 billion per year as a result of the increased economic participation of people with mental ill-health — noting that this does not take into account the costs incurred to achieve these reforms”*.

The report appears to have some certainty with regard to the economic benefits and it is surprising that the costs incurred to reap these benefits are not similarly estimated.

Furthermore there is some naïveté in the notion that provision of more targeted mental health services for mental health problems will lead to a significant increase in productivity. Is it suggested, for example, that a person who experiences a bereavement could be “treated” and therefore have fewer days off work and in general be less distressed?

At the time of writing this response we are experiencing intense bushfires over widespread areas with some loss of life and many people have lost their homes, their belongings, their memories and for many their employment. There is no doubt that people have experienced and will experience varying levels of traumatisation from these fires and their experiences. We know that some require long-term treatment and some may never recover fully. I would be surprised if mental health treatment of whatever sort significantly reduces the morbidity associated with this traumatic situation.

In my view there is also further naïveté with regard to comments about children with “mental health problems” falling behind academically with regard to their peers. What are the mental health problems referred to here? There are a small number of children who have significant mental health problems that do not appear to be related to environmental factors. Most however, experienced sadness, anxiety and depression in the context of family trauma, separation, emotional, physical and sexual abuse for which there are no clear-cut answers. These are multifaceted issues that appear to be more societal rather than particularly mental health related.

The recommendation that people who have work-related mental health issues should receive treatment for six months or a shorter period if the condition resolves is very problematic.

As a simple matter of equity why should people who do not have work-related mental health issue have more restricted access to mental health services? Why should people with mental health issues receive such treatment when people with work-related physical health issues do not receive similar treatment.

Furthermore, the issue raised in the report about who will be liable for the cost of this treatment is not resolved. If the claimant’s claim is rejected then the insurance company should be reimbursed for the cost of such treatment. Who will do that?

9. WORKFORCE

The recommendations in the draft report will require a marked increase in workforce. One wonders if this issue has been thought through. There are significant constraints on training psychiatrists, psychologists and other mental health workers.

For example under the heading ‘Prevention and early intervention’ mention is made of

‘provision in all schools of an additional senior teacher dedicated to the mental health and wellbeing of students and maintaining links to mental health support services in the local community’.

As of 2019 there were 10,584 schools in Australia. The report further states *‘the introduction of wellbeing leaders in schools will involve identifying, training and deploying a relevant workforce and developing resources for these leaders’.*

If this recommendation is followed either new teachers will be required or current teachers will need further training. Who will do this? Furthermore, what will these teachers do? The suggestions are so vague as to be meaningless, *‘dedicated to mental health and wellbeing of students’*, whatever that means and *‘maintaining links to mental health support services’*. If this recommendation was enacted then there is likely to be an increase in referrals to mental health services and hence a further need for a larger mental health work force. How many?

Presumably the comments with regard to Productivity savings is an attempt to indicate that these extra costs will be more than covered. I am not holding my breath. A further issue with regard to the recommendations is maldistribution of the mental health workforce.

It is generally recognised that it is inappropriate for a mental health worker of whatever discipline to be the sole mental health worker in a small community. There needs to be at least two and possibly three mental health workers both to provide support to each other and also to be able to provide ongoing treatment when mental health workers are on leave.

As described earlier there should be some clarification about the role of private mental health teams.

CONCLUSIONS

The draft report on mental health of the Productivity Commission is a very important and worthwhile endeavour. From my extensive experience both as a clinician and to some degree as a policy advisor has led to me questioning some aspects of the report. I have concerns about the lack of clarity about the identified targets of this report, the supposed productivity savings if the recommendations are implemented, I am concerned that the issues of comorbidity, and victims of trauma are not dealt with more comprehensively.

The recommendations with regard to workers compensation are worthy but naïve and appear to be mere jargon and do not recognise the complexities.

I am also concerned about the failure to recognise the adverse effects of privacy legislation and Freedom of information legislation on the effective management of people with mental illness.

I am also concerned about where this increased workforce will come from, who will train them, how this will be funded and how maldistribution issues will be addressed.

The impression come through that, in the words of Monty Python, “society is to blame”.

My comments, although critical at times are an endeavor to improve the recommendations of the Commission. This is an important and difficult task and the report is impressive in its scope..

APPENDIX (Case studies de-identified)

Case Study 1

John is a 37 year old single clerical worker in a state government department. He lives with his widowed mother. He made a workers compensation claim for “stress” arising from some work overload issues leading to the development of a rash. He was unkempt, unshaven and grossly obese. During the course of the interview it emerged that he was experiencing persecutory auditory hallucinations, paranoid delusions and ideas of reference. He believed that his mother was trying to poison him, people were trying to push him from the bus and fellow workers were conspiring to murder him, all dais in a matterof fact bland manner with no evident concern. He had been with his employer from the age of 17 and had a good work record. At the age of 20 he was taken to the emergency department of a hospital because of concerns about his paranoia and hallucinations. He left after two hours as he was “sick of waiting” and has had no further contact with mental health services. He lives a very limited lifestyle and despite his belief that people are trying to kill him, nevertheless, he did not appear concerned.

If he had received treatment it is likely that he would have been placed on long-term antipsychotic medication. This may well event interfered with his work capacity. He would have been known to his employer and family as having a psychotic illness. It is likely that he would not have remained in the workforce with all the consequences of chronic unemployment. One question is whether or not he would have been better off with treatment.

Case Study 2

Peter is a 26 year old married father of twin girls living in a rural city who was an electricity linesman. He suffered devastating electrical burns during the course of his work effectively destroying his arms. He had been referred to mental health workers and psychologists but had refused to go. His explanation was “I feel like I am circling a dark hole and they will want me to go into it and I am frightened that if I do so I will never come out.”

I have heard similar but less eloquent responses from others who have experienced severe trauma.