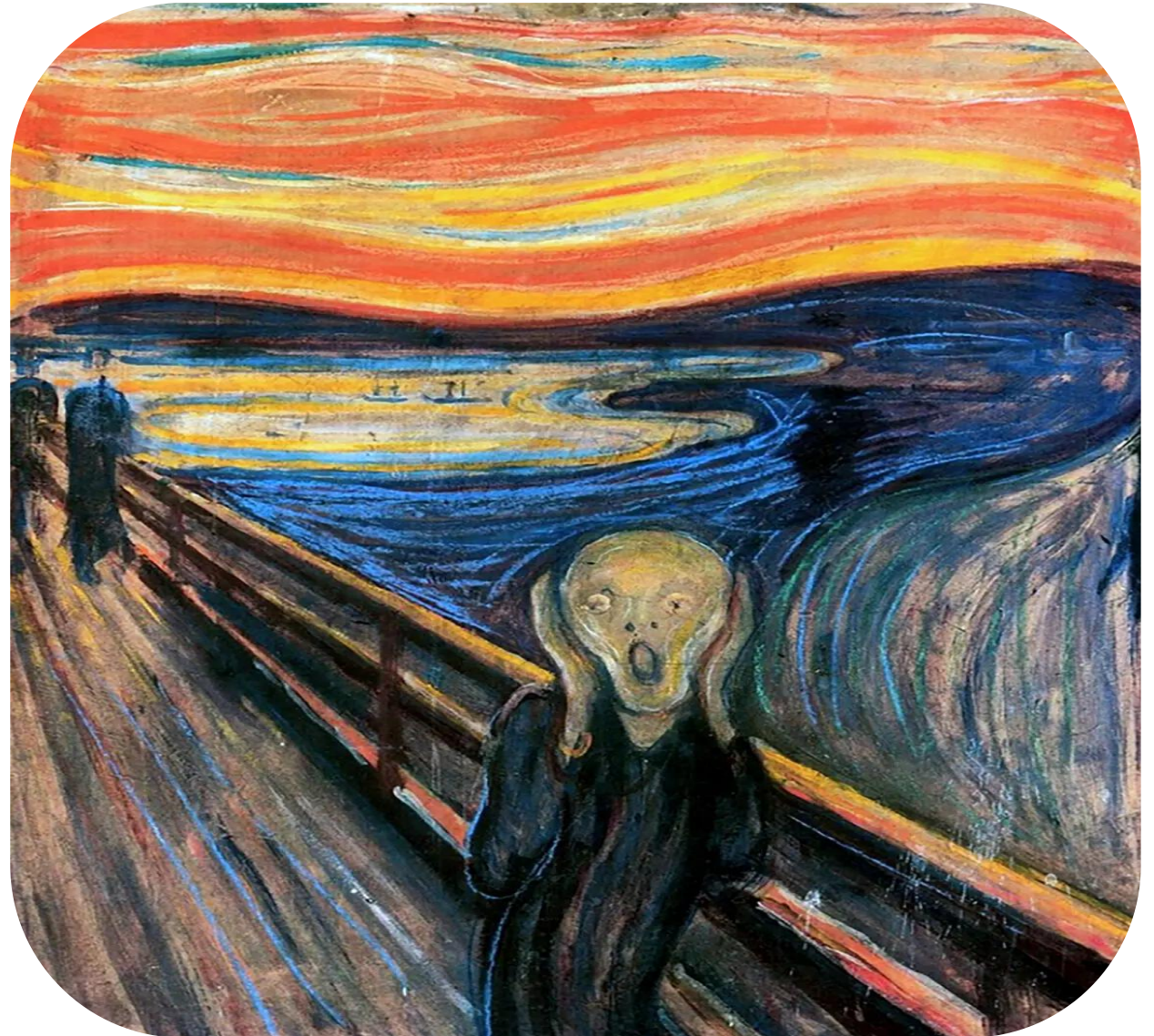


BEYOND THE WHINGE:

Impacts of a changing society on how we recognise schizophrenia

Andrew Carroll



Centre for Forensic
Behavioural Science



Acknowledgement

- Dr Calum Smith



OUR CURRENT MALAISE...

**SOCIETAL CHANGES AND
SCHIZOPHRENIA**

THE EPISTEMIC SHIFT

**HOW FORENSIC PRACTICE CAN
LEAD POSITIVE CHANGE**



OUR CURRENT MALAISE...

British psychiatry on the brink

Underfunded and with bad incentive structures, the industry needs rescuing.

By Penelope Campling



06 NOVEMBER 2025

AUSTRALIA'S MENTAL HEALTH SYSTEM 'THIRD WORLD'

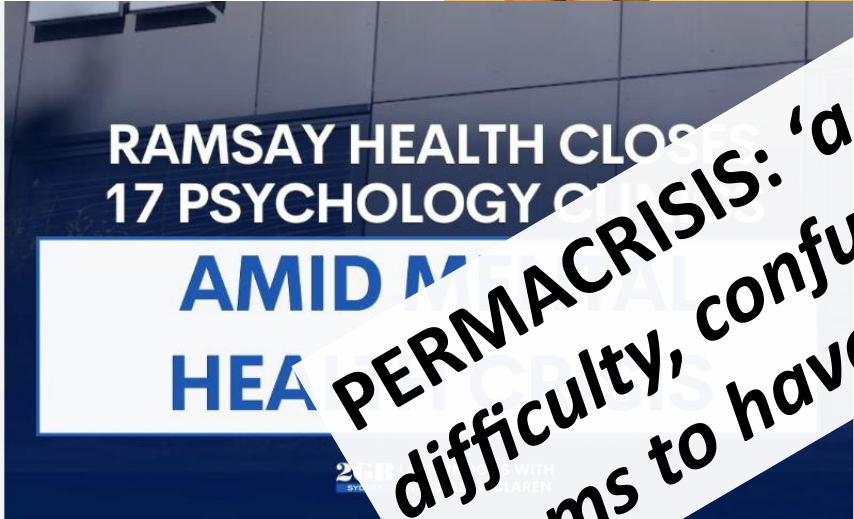
12 MINUTE READ

AMA MENTAL HEALTH PUBLIC HEALTH

By HELEN TOBLEP

2025 Public Hospital Report Card — Mental Health Edition

PERMACRISIS: 'a long period of great difficulty, confusion or suffering that seems to have no end'



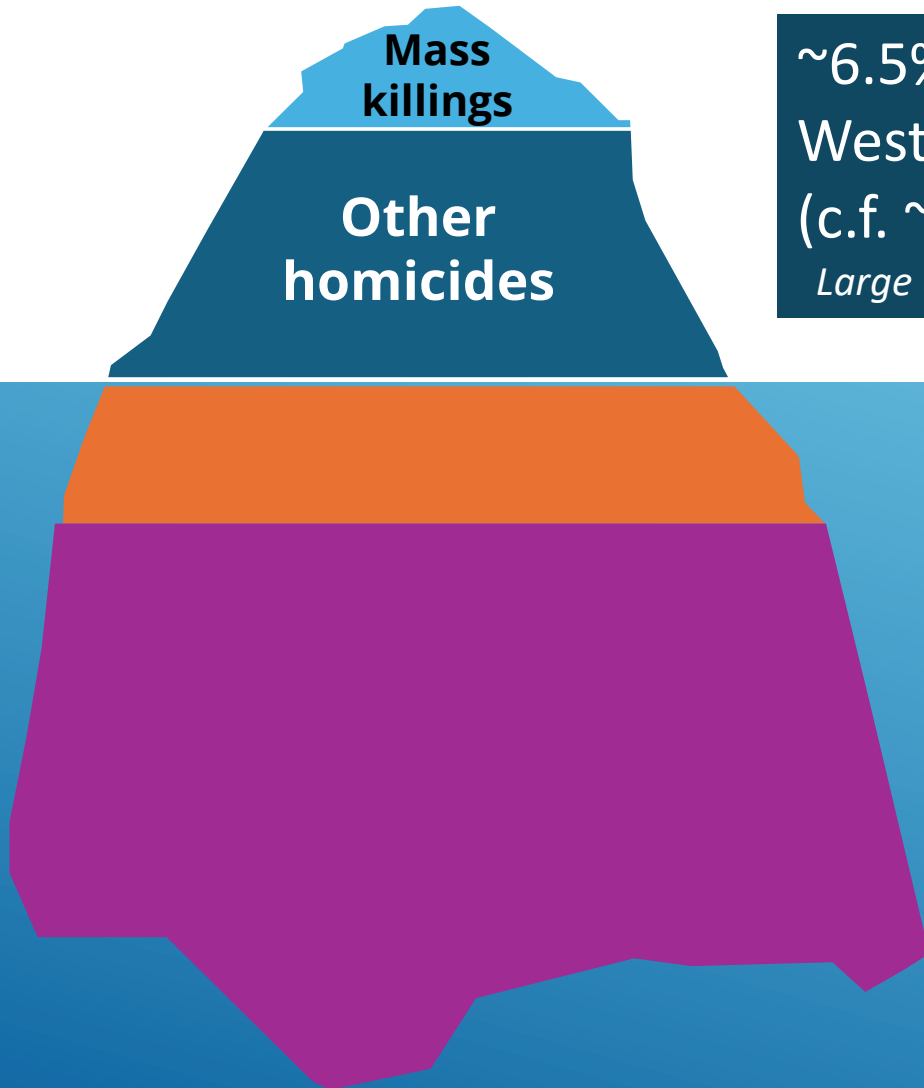
- Become a psychiatrist
- Training, exams & assessments
- Guidelines & publications
- Membership
- Events & learning
- Grants, awards & giving
- News & analysis
- Contact

Home > News & analysis > 2025 > November > Record mental health ED wait times a symptom of system-wide failure

Record mental health ED wait times a symptom of system-wide failure

OUTCOMES OF INADEQUATE CARE FOR SCHIZOPHRENIA

VISIBLE

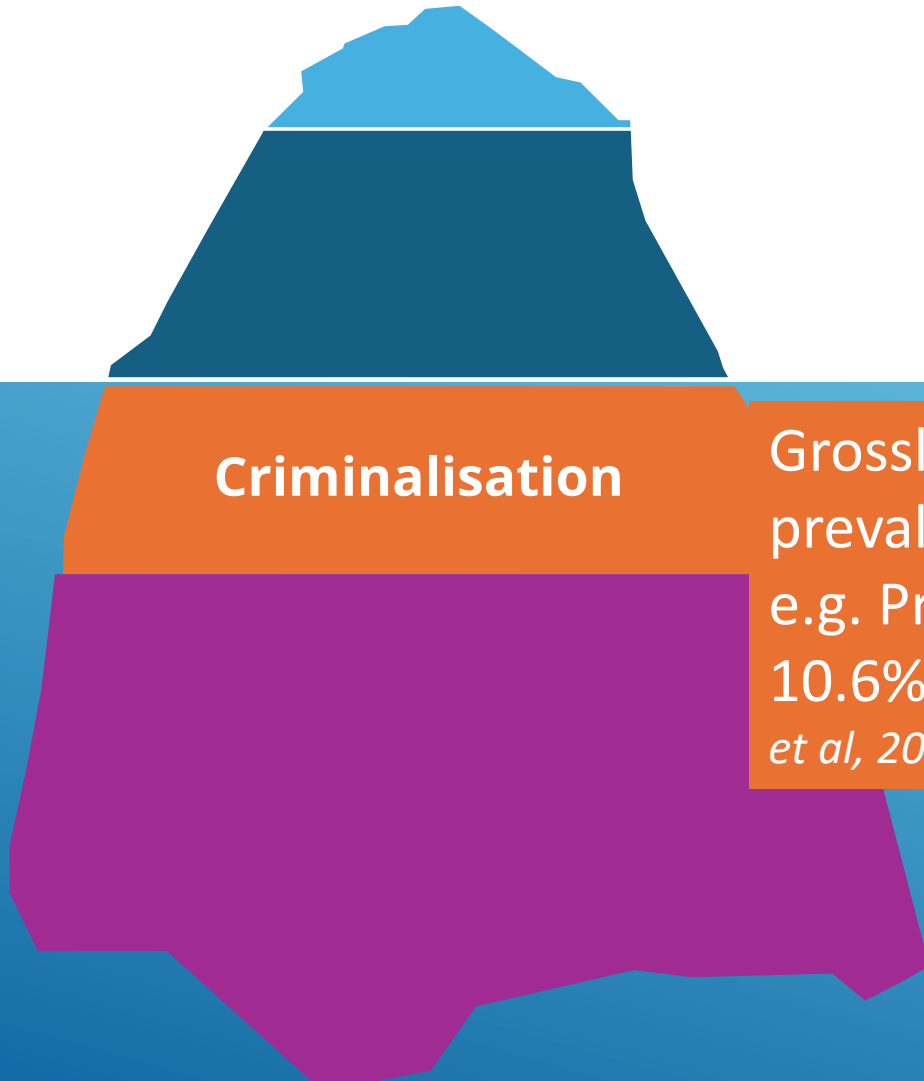


~6.5% of all homicides in Western societies
(c.f. ~0.5-1% of population)
Large et al, 2009

OUTCOMES OF INADEQUATE CARE FOR SCHIZOPHRENIA

VISIBLE

**INVISIBLE TO
GENERAL PUBLIC**



Criminalisation

Grossly disproportionate prevalence amongst prisoners
e.g. Prisoners in NSW:
10.6% “*established psychosis*” (Yee et al, 2025)

OUTCOMES OF INADEQUATE CARE FOR SCHIZOPHRENIA

VISIBLE

**INVISIBLE TO
GENERAL PUBLIC**

**THE BIGGEST IMPACT OF
INADEQUATE CARE**

- **Poor quality of life/function**
- **Impact on others inc. carers**
- **Early death: physical illness /
suicide / misadventure**

Mortality:

- **Average death ~15-20
years earlier** *Jia et al, 2022*

Homelessness:

- **>20% psychotic illness**
Ayano et al, 2019

***Is this merely about
“inadequate funding” or is
there more to it ?***

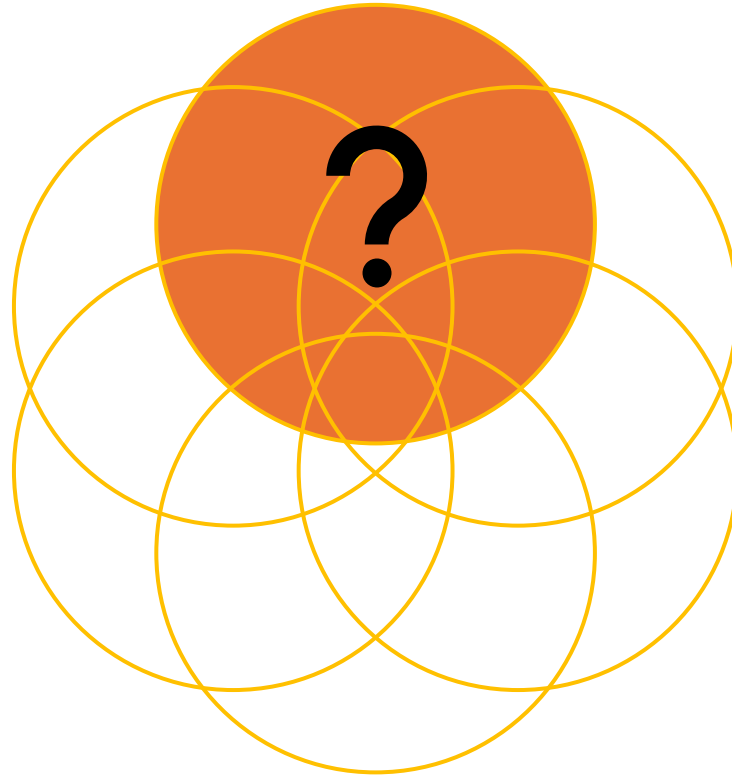




OUR CURRENT MALAISE...

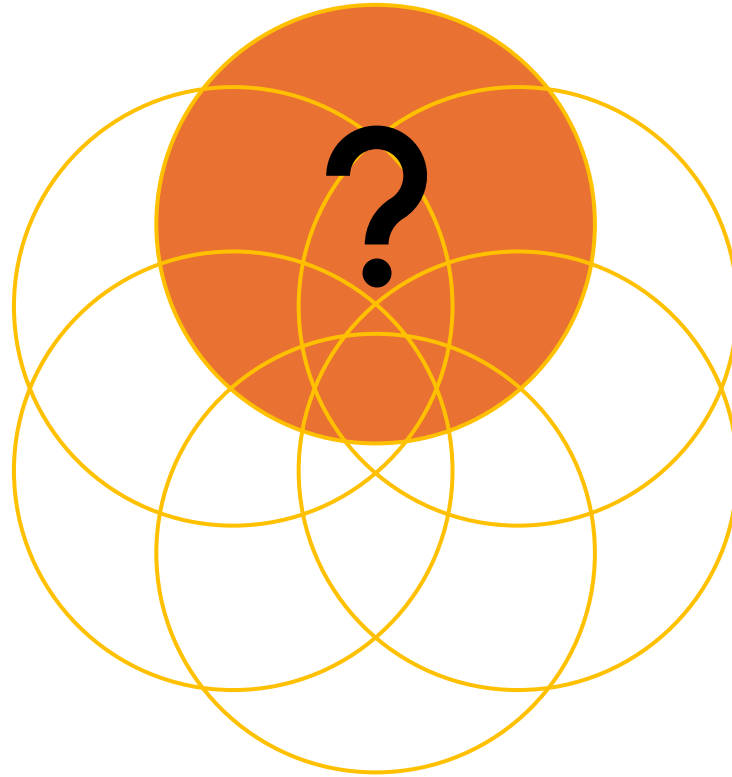
**SOCIETAL CHANGES AND
SCHIZOPHRENIA**

*Where should care
be delivered?*



*Where should care
be delivered?*

*Large specialist hospitals →
mainstreaming and care in
the community*



THE OLD



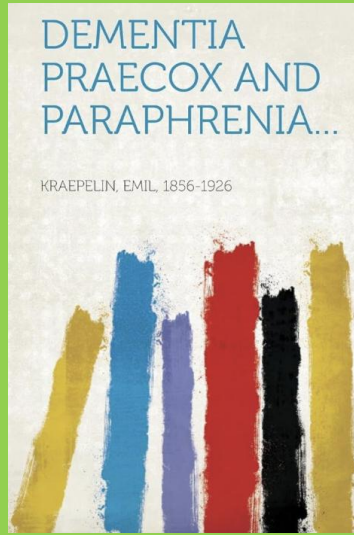
Large, isolated
'asylums'

Long admissions
(months / years)

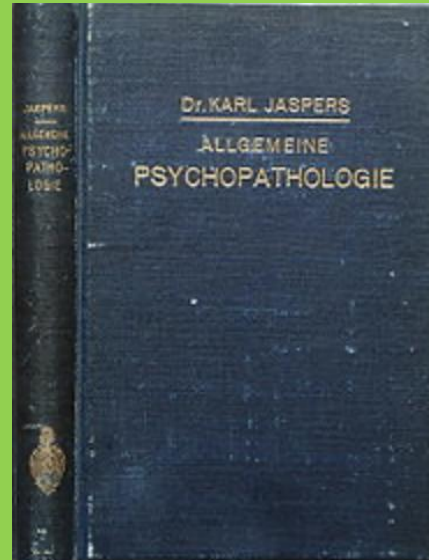
Ready access to
extra staff to
control disturbed
behaviour

All aspects of life
integrated

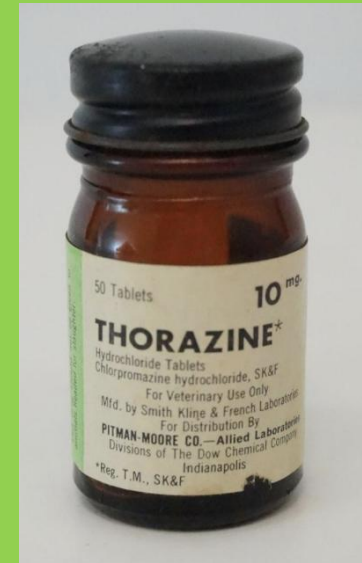
Long-term clinical observation of large numbers (“The psychiatric gaze”) gave birth to:



- diagnostic categorisation



- descriptive psychopathology



- treatments - some proved helpful

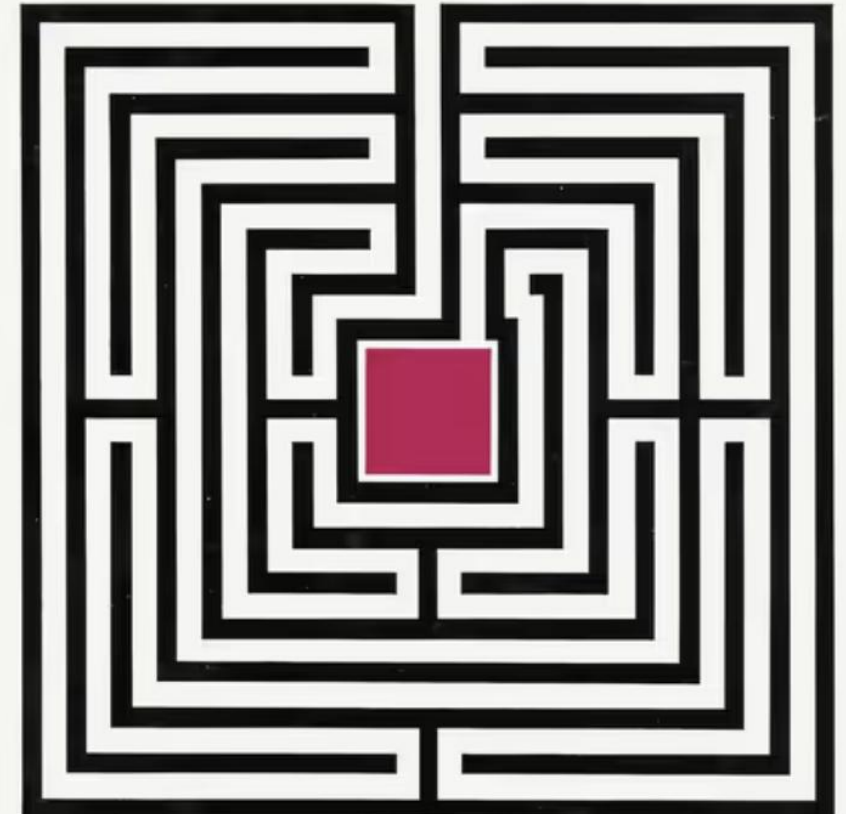


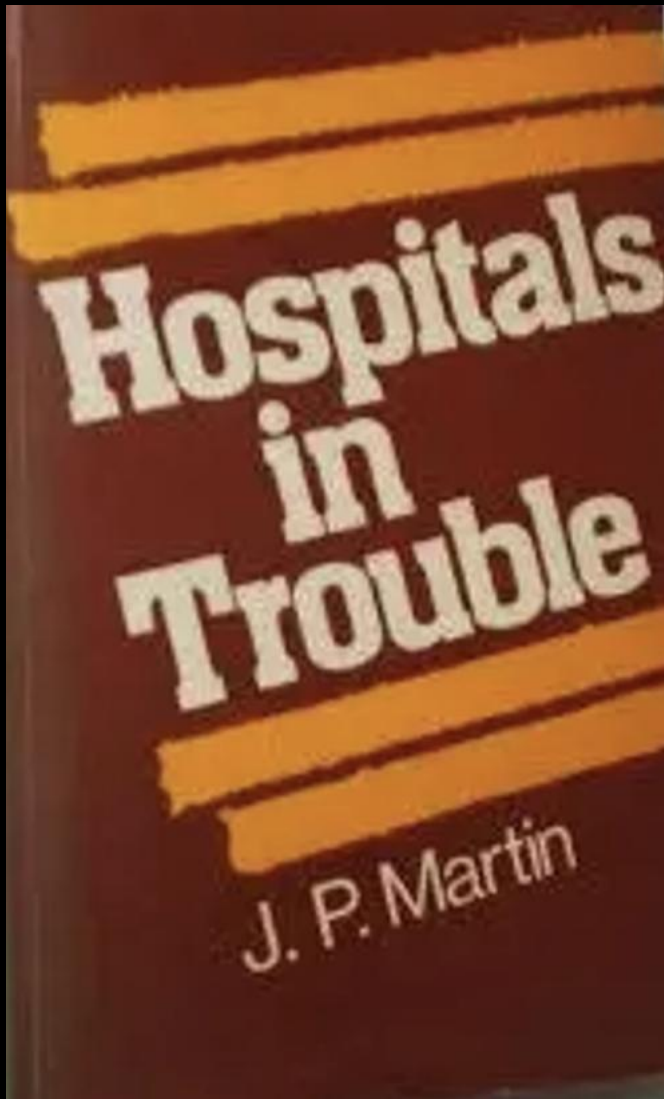
THE OLD

- Lost dignity: structural stigma
- 'Institutionalism': dark side of tightly integrated care
- *“the total institution”*



Erving Goffman
Asylums
Essays on the Social
Situation of Mental Patients
and Other Inmates





THE OLD

- Isolation
- Limited external scrutiny
- → prone to **abuse**



Surgery
Cardiology
Neurology
Emergency
Intensive Care
Infectious Diseases

Mental Health
Fracture
Rheumatology
Radiation
Respiratory
Sleep Labs
Cancer Centre
Ophthalmology
Admitting
Genetics
Internal Medicine
Dental

Obstetrics
Maternity
Pediatrics
Social Services
Family Medicine
Ultrasound

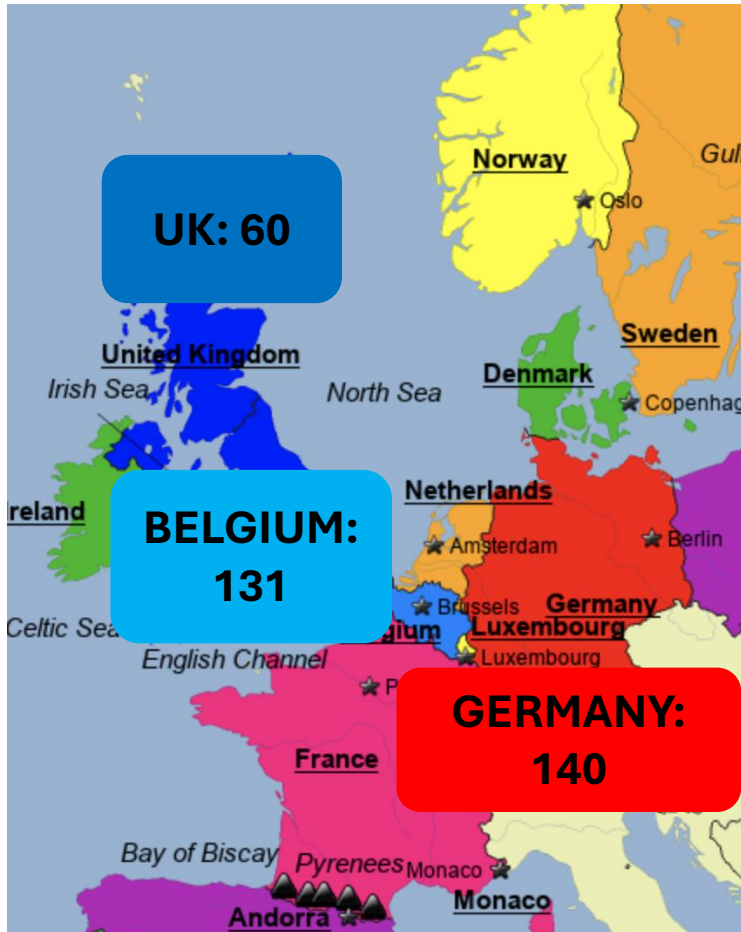
SHORT-STAY MAINSTREAMED UNITS IN GENERAL HOSPITALS

- MUCH fewer beds → MUCH shorter stays
- No 'extra' nursing staff to call on in crisis
- Rehabilitation mainly by non-clinical services in community: 'psychosocial' imperfectly integrated with 'clinical'



THE NEW

PUBLIC PSYCHIATRIC BEDS /100,000 POPULATION



OECD AVERAGE: 65-69

**RECOMMENDED MINIMUM
FOR ADEQUATE CARE: 50**

THE NEW



High **churn**: short
length of stay

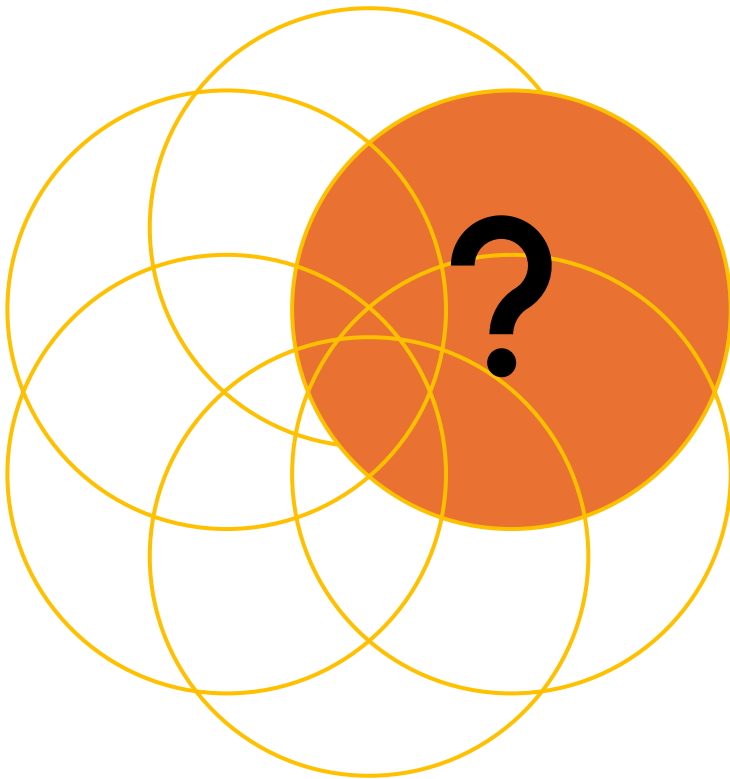
Inpatient 2025 Victoria (Australia):

- Average length of stay*: **10 days**
- **13% re-admitted** within 28 days of discharge

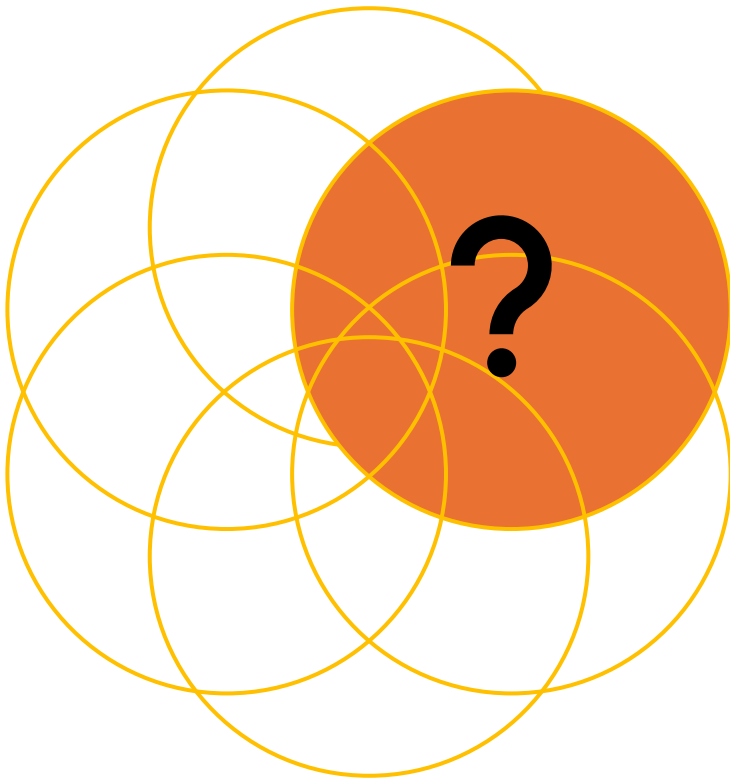
*Excludes outliers >35 days

THE NEW

What ethical value dominates decisions about compulsory care?



What ethical value dominates decisions about compulsory care?



paternalism
→ *autonomy*

THE OLD



*“... it is the job of a caring health service sometimes to protect the mentally disturbed from the consequences of their own actions, always provided of course that such a **paternalistic** arrangement is properly monitored and open to independent discussion.” Gunn, J. (1977)*



THE OLD



- Impacts on dignity/ morale/ status
- Trauma of coercion under-appreciated

***“...repeal provisions
which allow for
involuntary
commitment...”***



UNITED NATIONS
HUMAN RIGHTS
OFFICE OF THE HIGH COMMISSIONER

THE NEW

Mental health, human rights and legislation

Guidance and practice



World Health
Organization



UNITED NATIONS
HUMAN RIGHTS
OFFICE OF THE HIGH COMMISSIONER

THE NEW

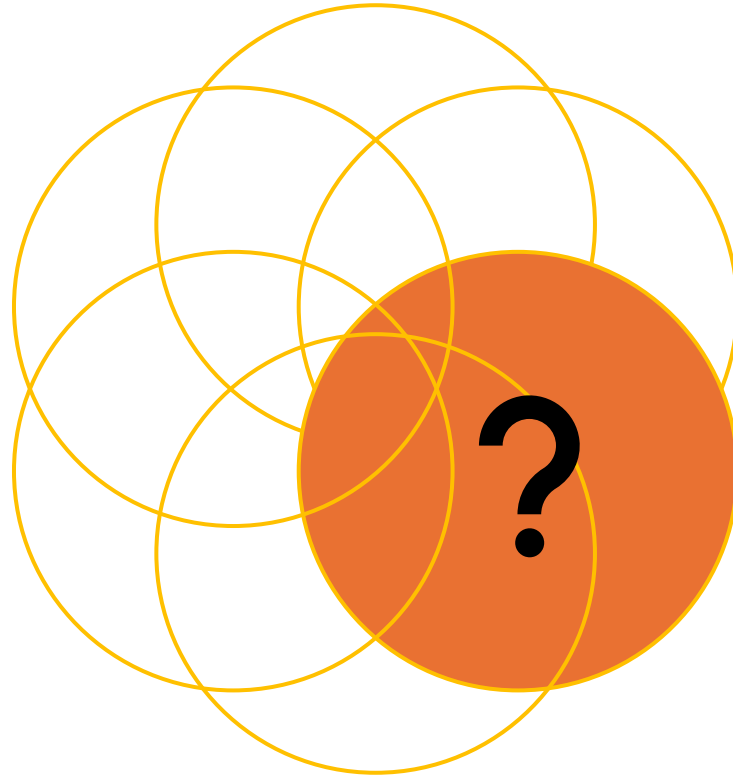


Mental Health & Wellbeing Act 2022 (VIC)

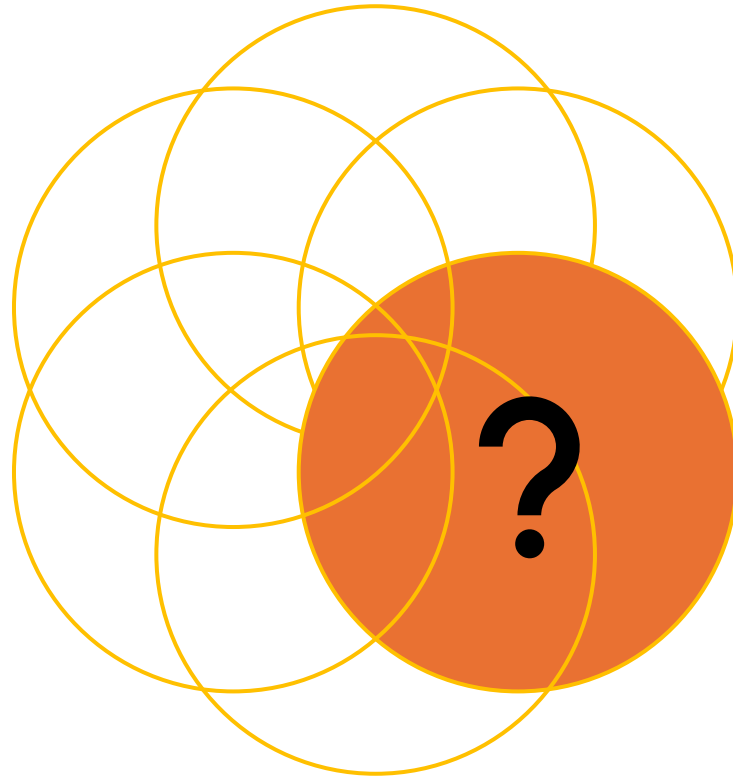
*“...this Act has the following objectives...enable a reduction in the use of seclusion and restraint with the aim of **eliminating** its use within 10 years.”*

→ **No** restrictive practices (even bodily restraint) by 2032

*How do we determine
funding for services for
schizophrenia?*



*How do we determine
funding for services for
schizophrenia?*



*collectivism →
consumerism*

THE OLD

Social welfare

State support
imposed on those
poorly equipped
to seek it



Neoliberalism:

- “...**competition** is the defining feature of *humankind*.”
- “...casts us as **consumers** rather than citizens.”
- *Supply/demand theory: every purchase made is someone else’s sale and vice versa.*



THE NEW

BUT schizophrenia often → difficulties with insight / motivation / organisation →

may not seek or may struggle to access treatment at times of highest need.

→ **'HELP-SEEKER' CONSUMERIST**

MODEL IS PROBLEMATIC

SUPPLY →





*“...the promise of further growth and investment ...was broken...**neglect** set in, with a slow dismantling of the **assertive** community mental health system...”*

Pat McGorry quoted in ‘Out of the Madhouse’

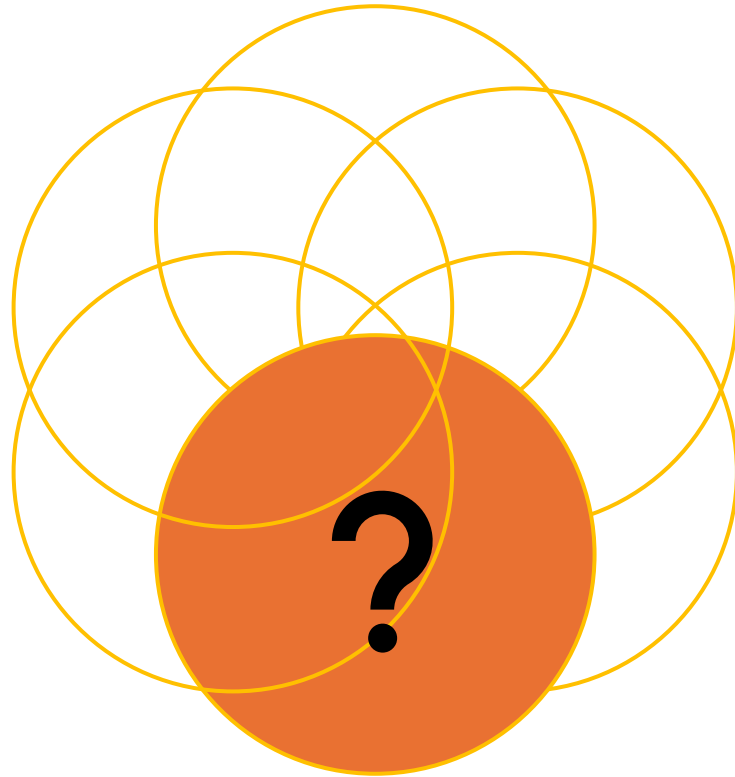


THE NEW

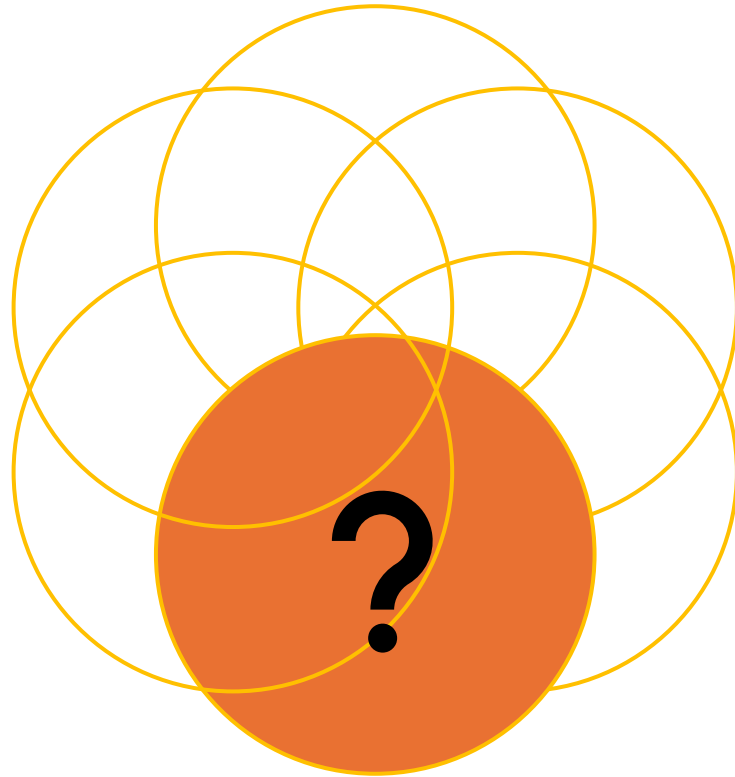
ACTIVITY BASED FUNDING:

- A rational economic model
- Incentivises short-term focus: “the churn”/ short stays / early discharges

***What kind of thing is
schizophrenia?***



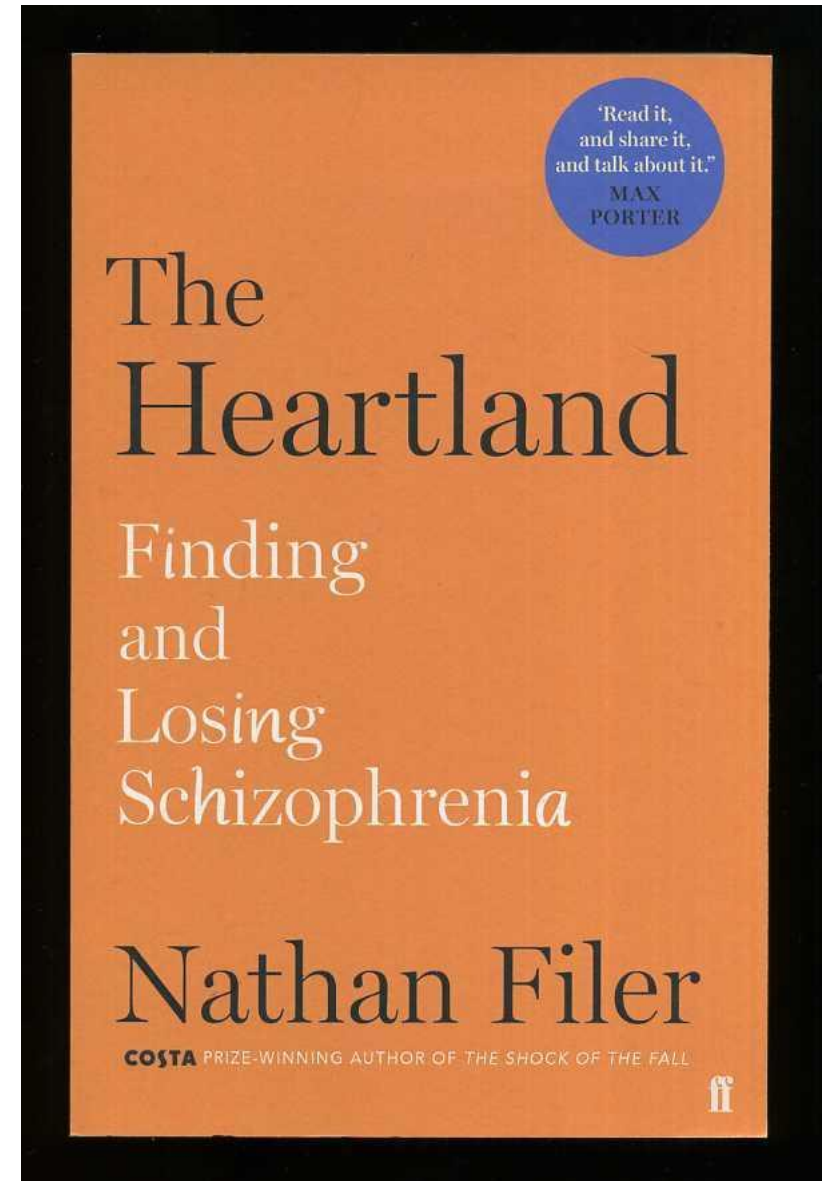
*What kind of thing is
schizophrenia?*



*mental illness →
'psychological distress'*

THE OLD

- Schizophrenia: a **mental illness**
- Potential downside of this:
 - Othering
 - Stigma

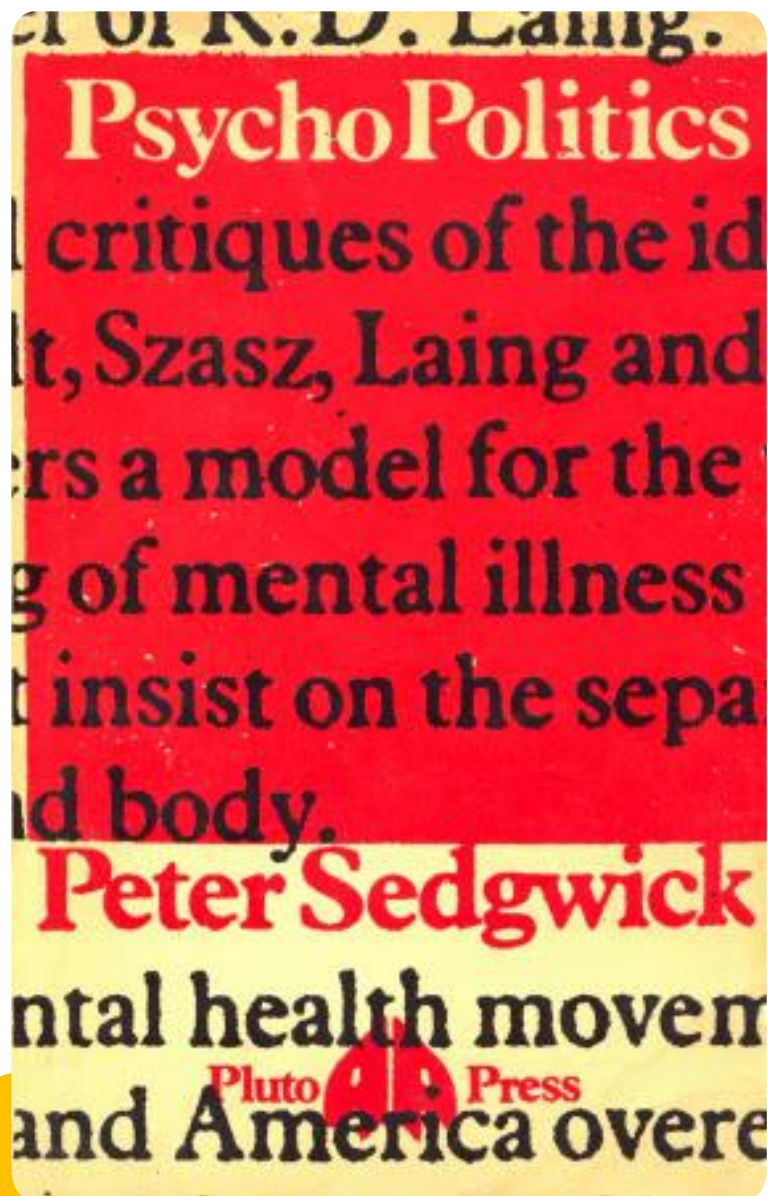


*“Getting a **diagnosis** was the moment that saved my life - it opened the door for treatment and medication and resources.”*

Kody Green



THE OLD



*“...without the concept of **illness** – including that of mental illness...we shall be unable to **make demands** upon the health service facilities of the society in which we live.”*

Peter Sedgwick, 1980

THE OLD

Post-medical:

- 'Knowledge' not limited to “experts”.
- Schizophrenia *as* medical illness is contested (“sane-ism”).
- Merely part of a homogenous melange of “mental health and wellbeing issues”





THE NEW

Mental Health and Wellbeing Act: update and engagement paper

June 2021

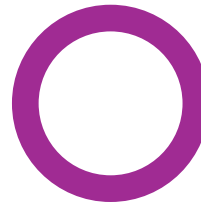
OFFICIAL



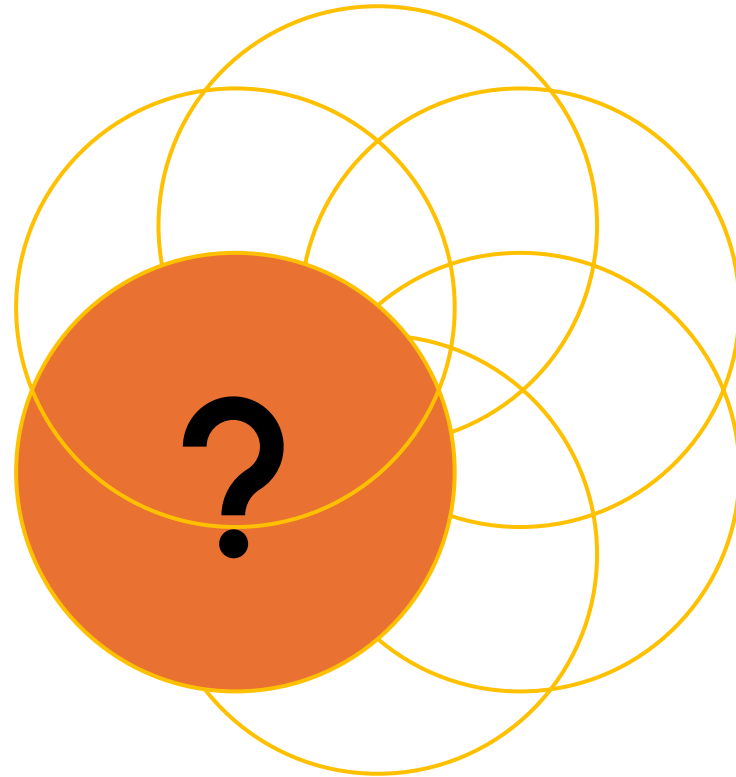
*“The criteria for compulsory treatment will change... replacing reference to ‘preventing serious deterioration in the person’s mental or physical health’ with ‘preventing the person experiencing serious **distress**’...”.*

“We, as a society, have never talked more about mental health than we do now...But when you look at the chatter, it is mainly about depression and anxiety, which most people can relate to... There is a hierarchy of what is acceptable to talk about in public. And psychotic experiences are at the bottom of the pile...”

Sandy Jeffs, 2025 (LinkedIn)

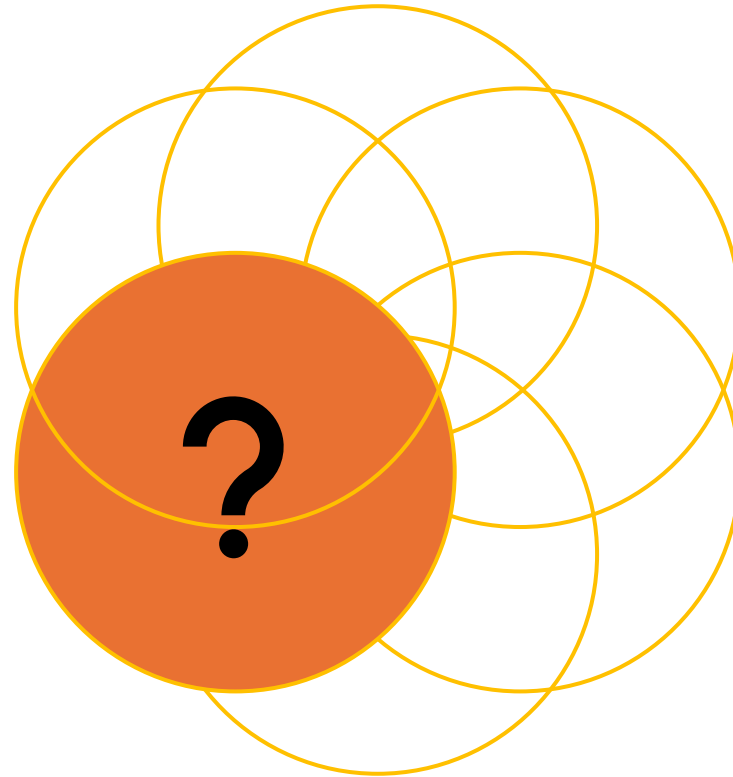


*How should we make
sense of violence by
people with
schizophrenia ?*



*How should we make
sense of violence by
people with
schizophrenia ?*

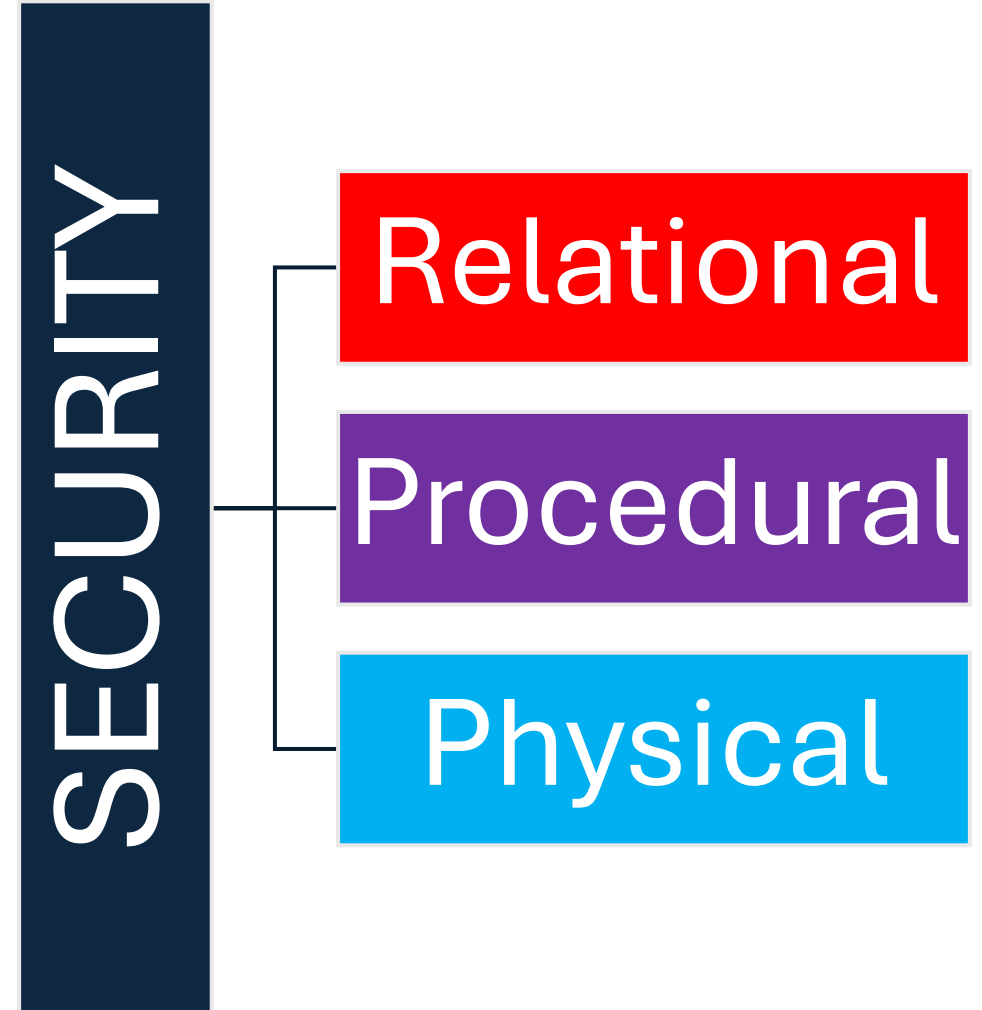
*clinical challenge
→ moral failing*



THE OLD

Behavioural disturbance a recognised complication of illness in some people, some of the time.

→ Managing this - therapeutic use of security - recognised as a **core clinical skill**.



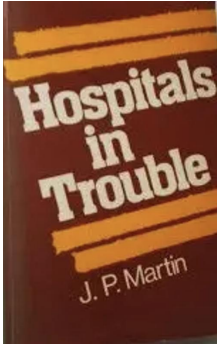


THE OLD

Under-recognition of staff burnout / injury



Physical abuse of patients



THE NEW

ZERO TOLERANCE

**USE OF PROFANITY,
VERBAL THREATS
OR ANY ACT OF
VIOLENCE
WILL NOT BE
TOLERATED**

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“It's behavioural!”

Denial of service to patients who are aggressive, even if unwell.

Criminalisation.

Progressive de-skilling.

Increased use of police in hospitals and community.

“...the more health professionals withdraw from assertive and involuntary treatment ... the more likely that police and others operating outside the mental health system will be called on to assume a coercive role.”

Australian and New Zealand Journal of Psychiatry 2008; 42:177-182

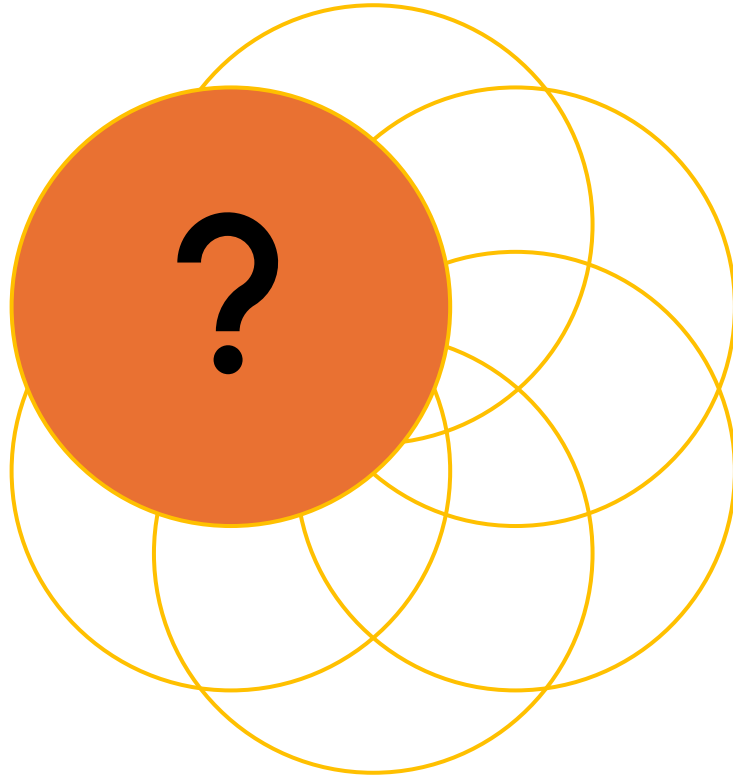


Recovery-based practice: do we know what we mean or mean what we know?

Tom J. Meehan, Robert J. King, Pam H. Beavis,
Jacqueline D. Robinson

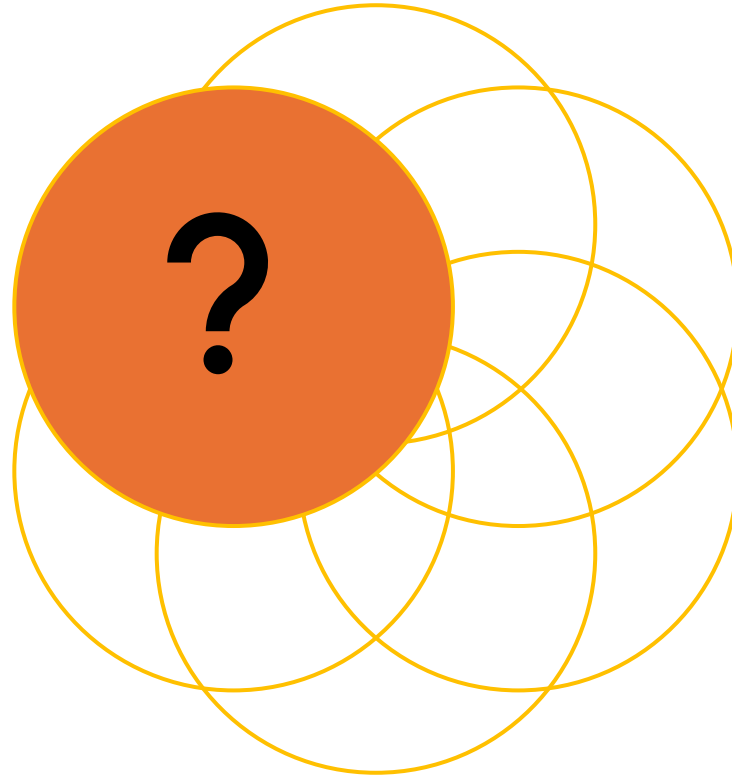
THE NEW

*What is the
foundation of clinical
care?*



**Holistic
formulation →
reductionist
triaging**

**What is the
foundation of clinical
care?**



“In 1990, I had time to talk to my patients, engage them psychotherapeutically where appropriate and, despite the time pressure, attempted at least to maintain a holistic, biopsychosocial approach.”

Deahl, 2023



BIO

PSYCHO

SOCIAL

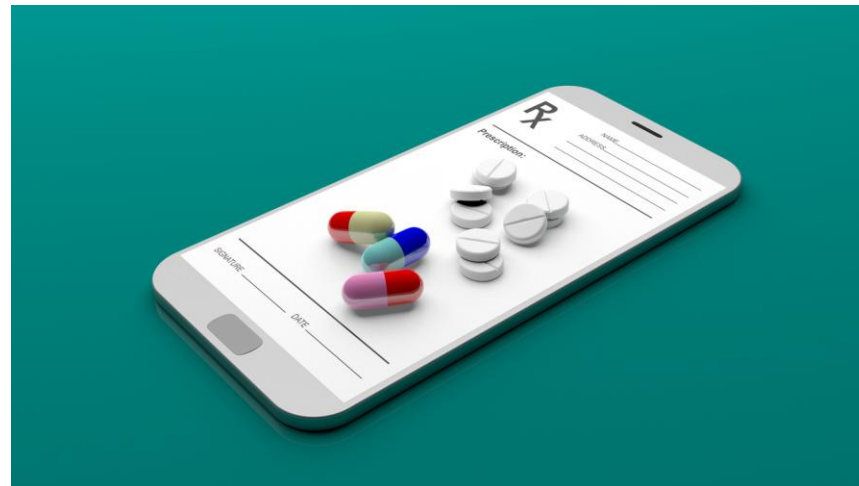
THE OLD



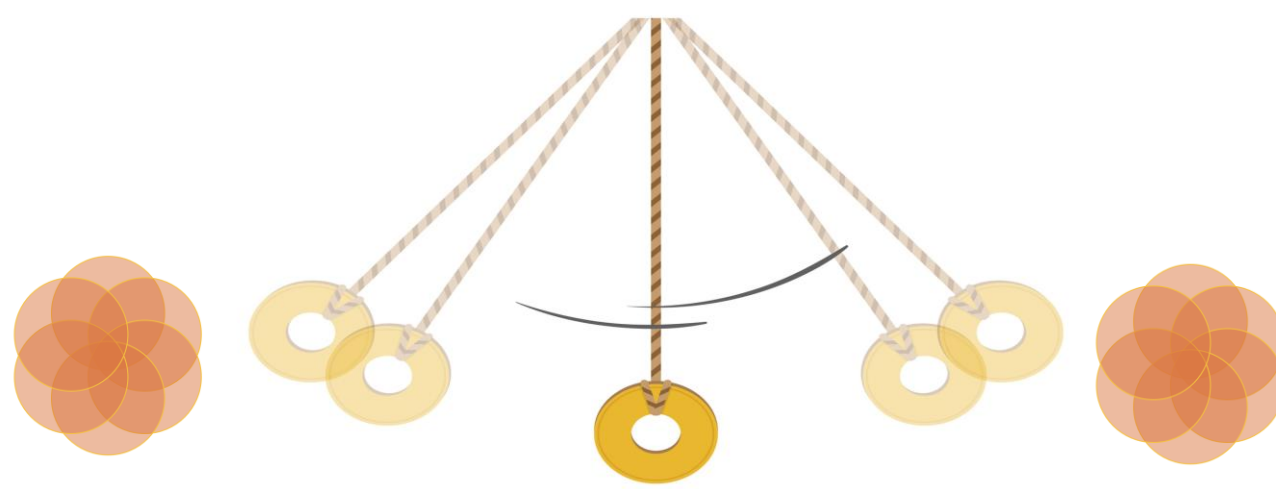
“Now I feel my job has been reduced to little more than a prescribing machine.”

Deahl, 2023

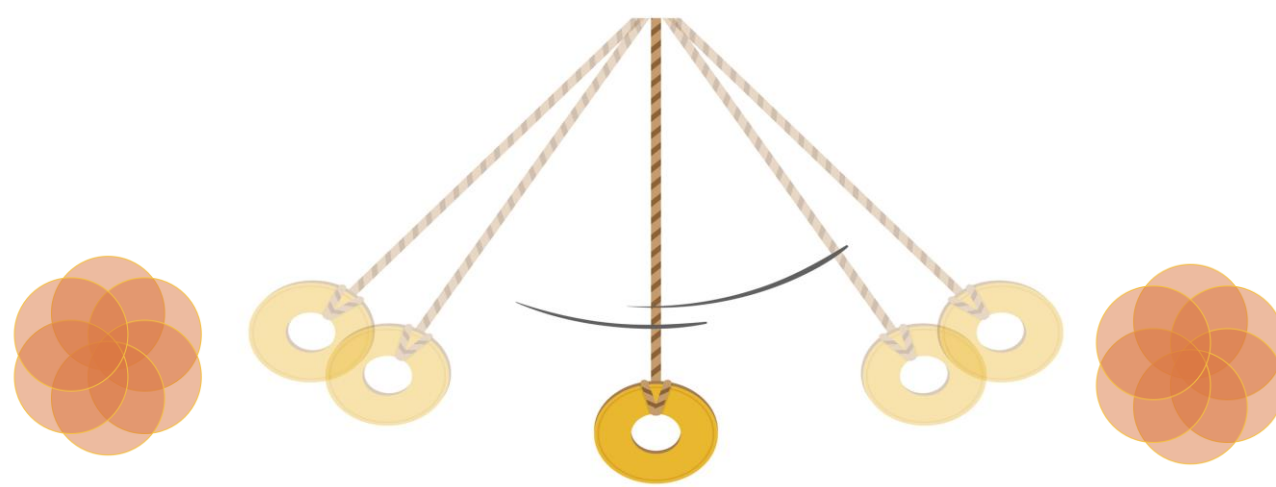
From true *‘Medical Model’* to a corrupted *‘Medication Model’*



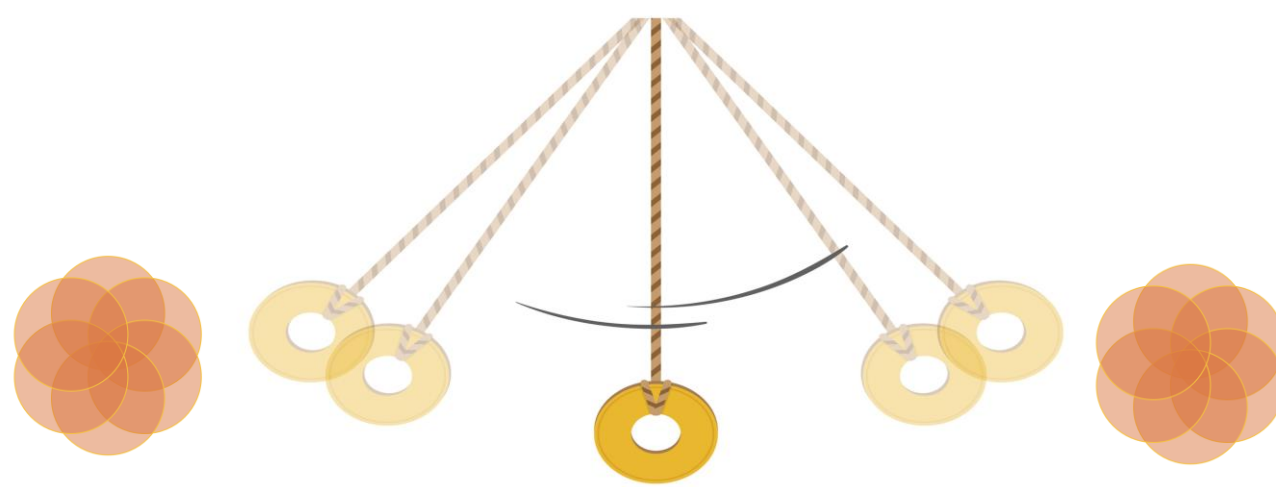
THE NEW



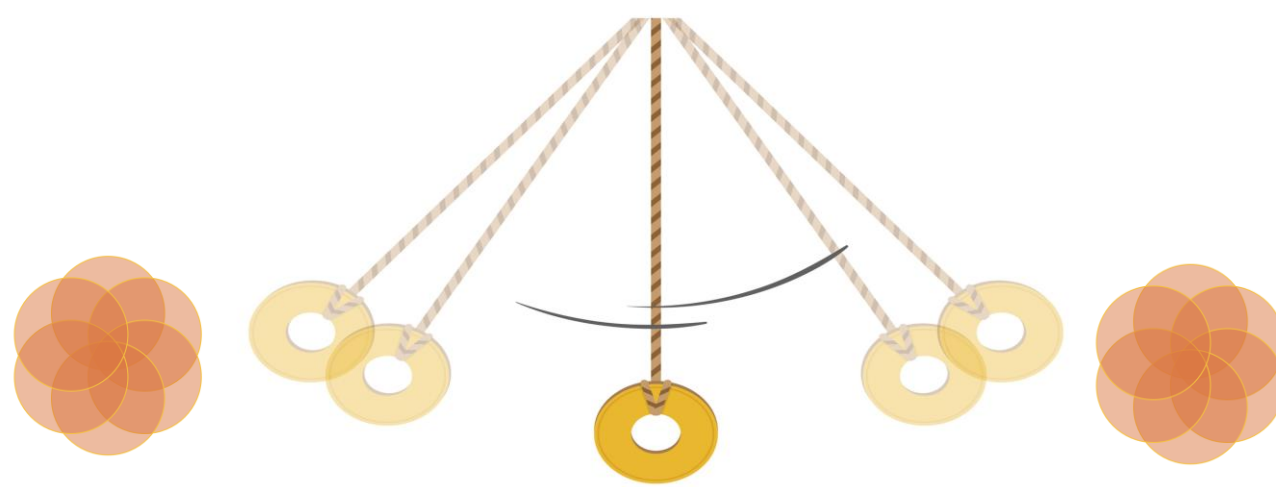
- Our answers to these key, complex questions have **shifted to extremes**, largely based on ideologies, without adequate consideration of trade-offs.



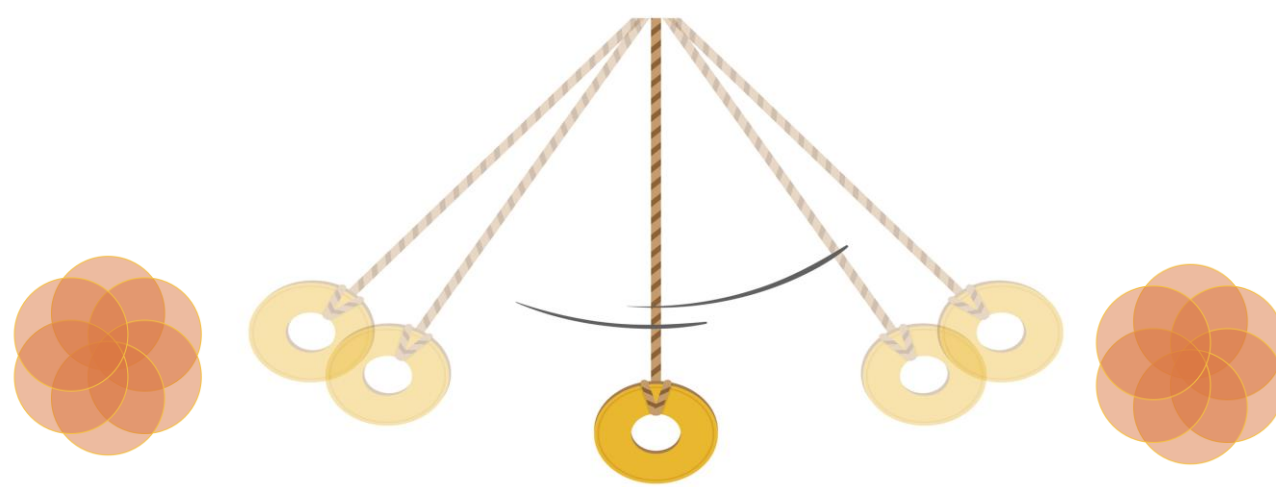
- Our answers to these central complex questions have shifted to **extremes**, largely based on ideologies, without adequate consideration of trade-offs.
- Net effect of the shifts (and synergies between them) → now impossible for general public mental health services to adequately service many people living with schizophrenia.



- Our answers to these central complex questions have shifted to **extremes**, largely based on ideologies, without adequate consideration of trade-offs.
- Net effect of the shifts (including synergies between them) → now impossible for general public mental health services to adequately service people living with schizophrenia.
- ***How have services coped with this ?***



Services (and the systems that fund them) have coped by fundamentally changing the way we ***think about*** schizophrenia...



Services (and the system that funds them) have coped by fundamentally changing the way we think about schizophrenia...

→ we now think about schizophrenia in a way that misses some key elements



OUR CURRENT MALAISE...

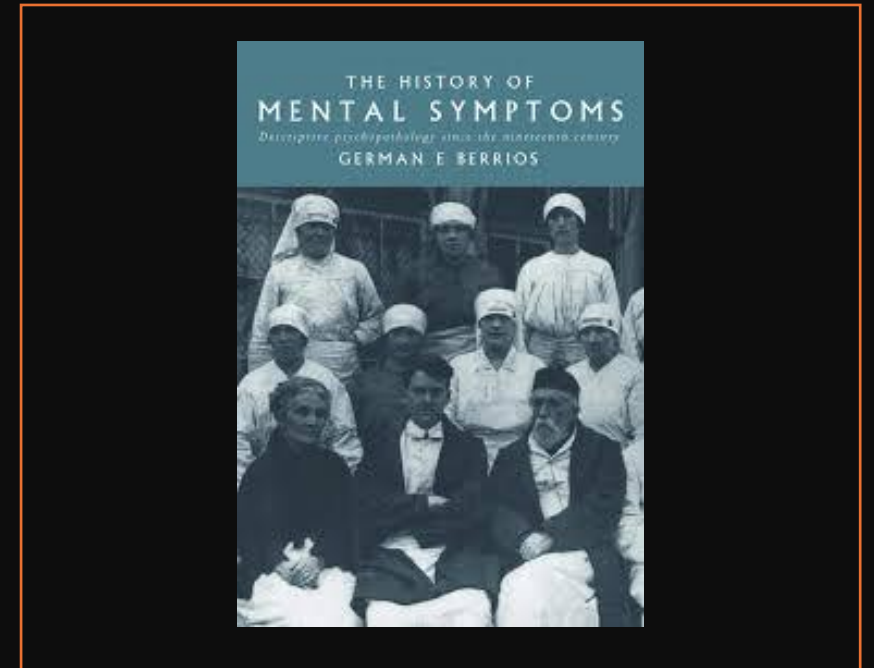
SOCIETAL CHANGES IN HOW WE ANSWER
THE KEY QUESTIONS ABOUT
SCHIZOPHRENIA

THE EPISTEMIC SHIFT

'episteme' :

"the way observers are instructed by their culture to perceive mental disorder."

German Berrios, 1996



EPISTEMIC SHIFTS:

*the way we think about schizophrenia
is subject to periodic changes...*



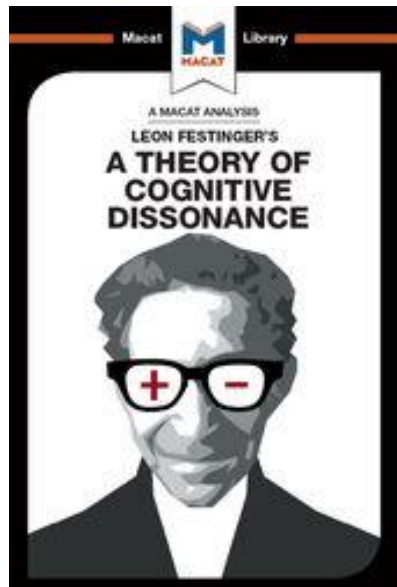
- **Divine punishment for sin**

- *A serious medical illness*

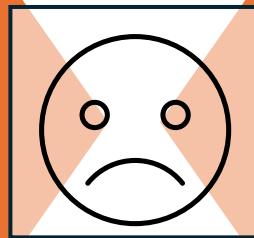
- *A 'rump' episteme...*

The 'rump' episteme has emerged by a process of cognitive dissonance:

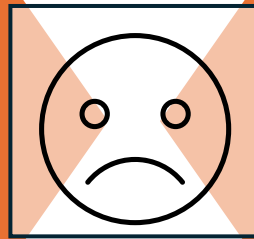
When two ideas are not consistent with each other, we do all in our power to change them until they become consistent...



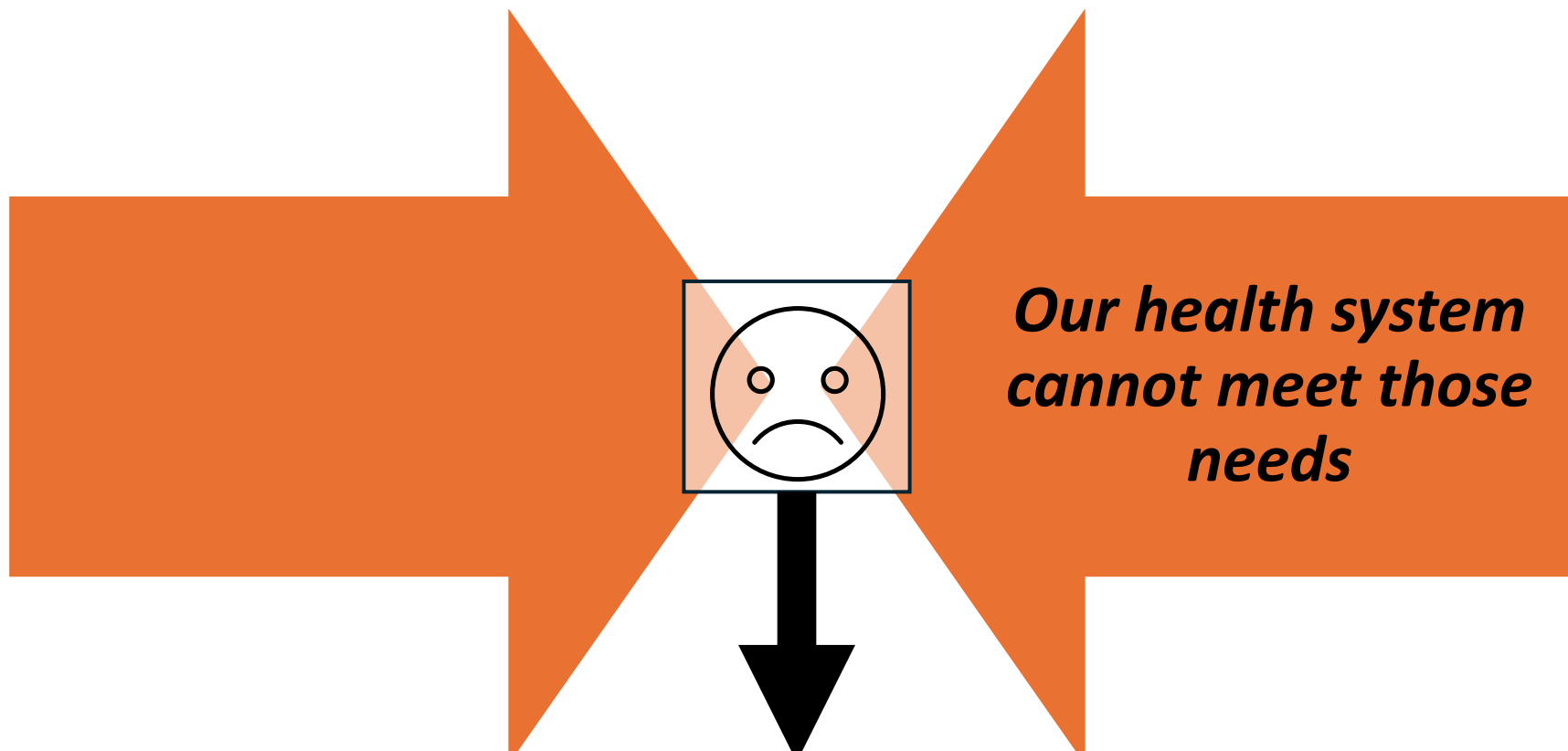
This person
has health
needs



This person
has health
needs




*Our health system
cannot meet those
needs*



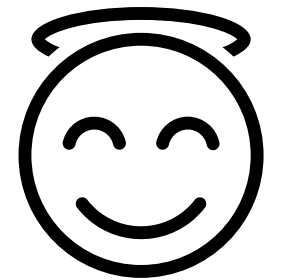
*Our health system
cannot meet those
needs*

**MOST OF THESE NEEDS ARE NOT
HEALTH ISSUES AFTER ALL...**



*Our health system
cannot meet those
needs*

**MOST OF THESE NEEDS ARE NOT
HEALTH ISSUES AFTER ALL...**



***WHAT DOES THE 'RUMP' EPISTEME OF
SCHIZOPHRENIA FAIL TO RECOGNISE ?***



**DEPTH OF
PSYCHOPATHOLOGY**



Neurocognitive and 'negative' symptoms :

- Sustained evidence-based clinical treatment and care now unlikely to be available, despite these being the main source of long-term disability.



Disorganisation of thought and behaviour:

- Recast as ‘personality disorder’ or ‘behavioural’.



**DURATION OF
PSYCHOPATHOLOGY**

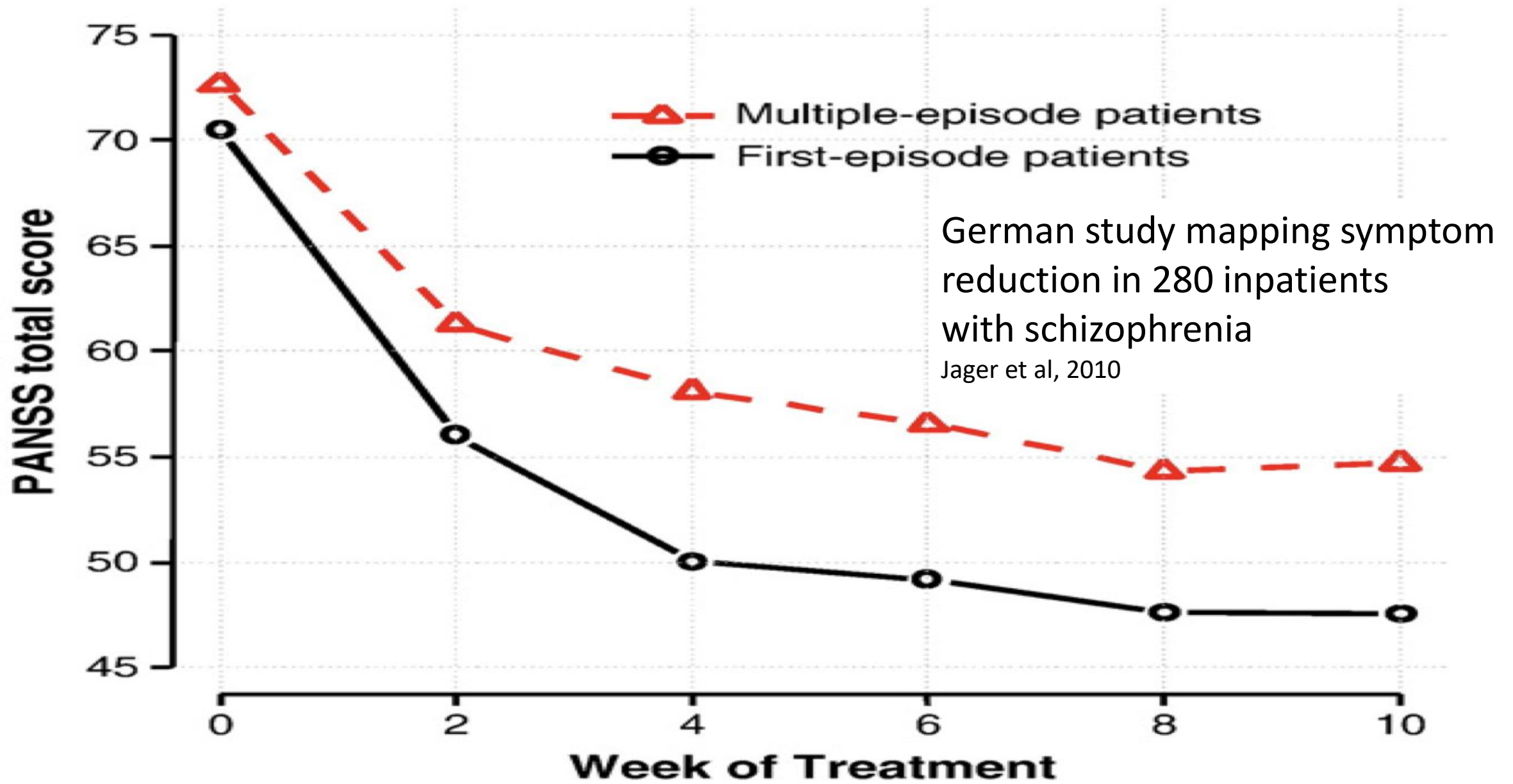


Fig. 2. PANSS total scores during inpatient treatment: first-episode patients compared with multiple-episode patients (LOCF).

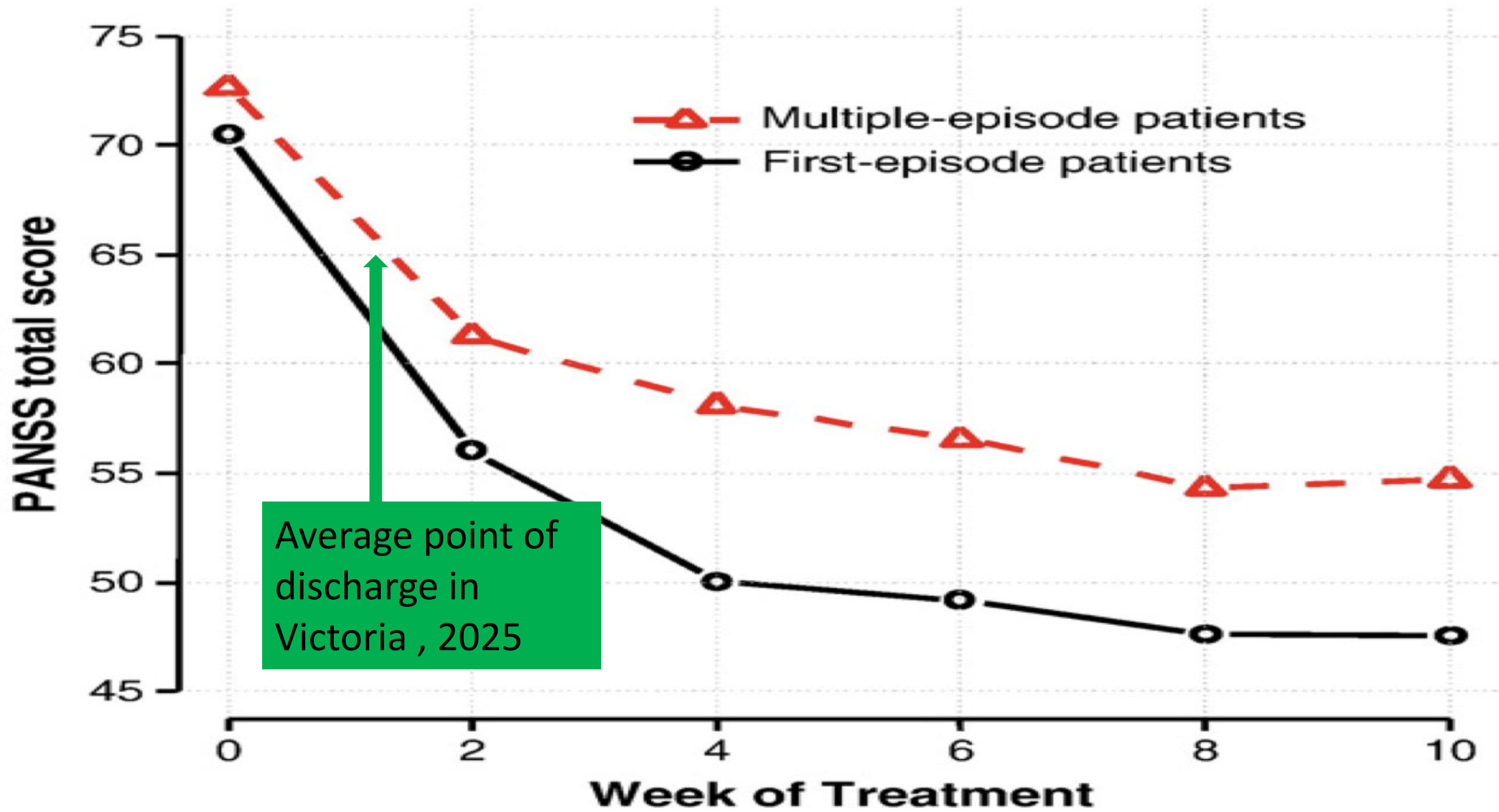
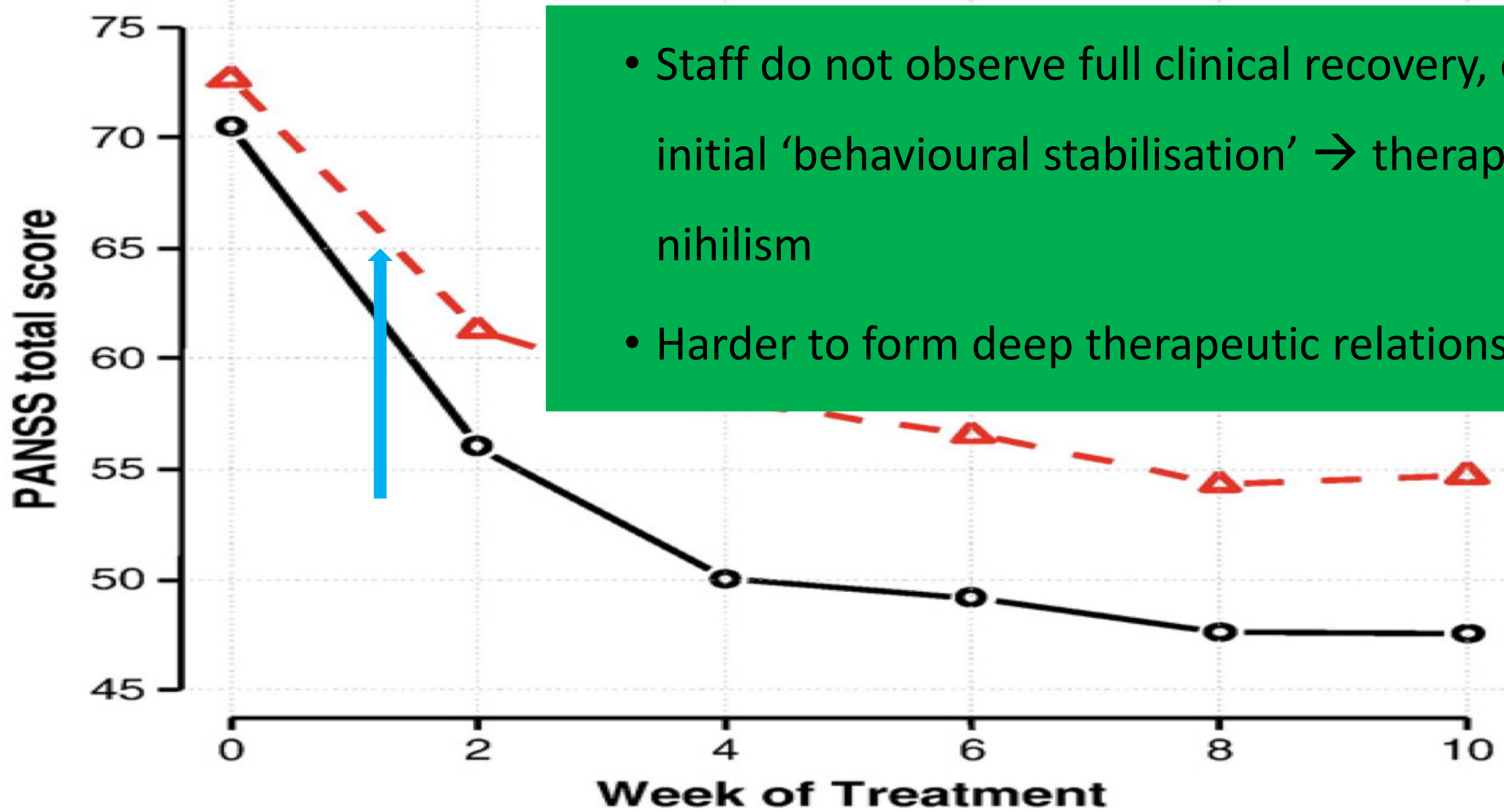


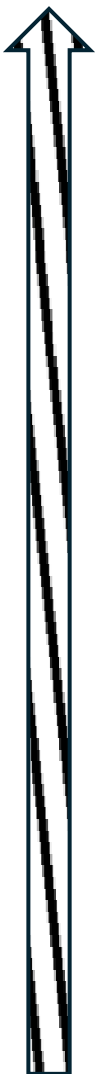
Fig. 2. PANSS total scores during inpatient treatment: first-episode patients compared with multiple-episode patients (LOCF).



- Staff do not observe full clinical recovery, only initial 'behavioural stabilisation' → therapeutic nihilism
- Harder to form deep therapeutic relationships.

Fig. 2. PANSS total scores during inpatient treatment: first-episode patients compared with multiple-episode patients (LOCF).

Impairment



1



One episode only—
no impairment

16%

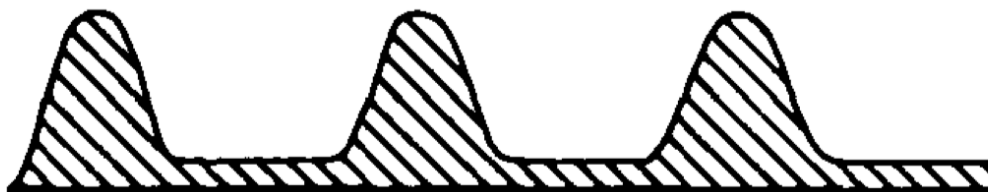
2



Several episodes with no
or minimal impairment

32%

3



Impairment after the first
episode with subsequent
exacerbation and
no return to normality

9%

4



Impairment increasing
with each of several
episodes and
no return to normality

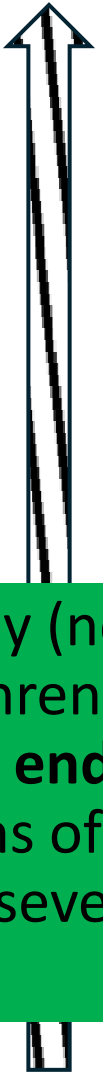
43%



Time (2 ½ years)

*Katz et al, 1983: 5 year patterns
of course of illness based on
107 patients with schizophrenia*

Impairment



1



One episode only—
no impairment

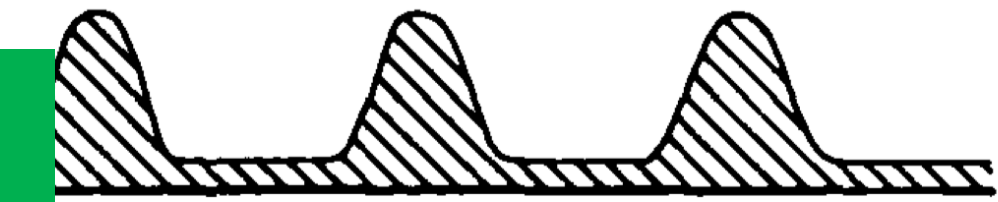
16%

2



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Impairment increasing
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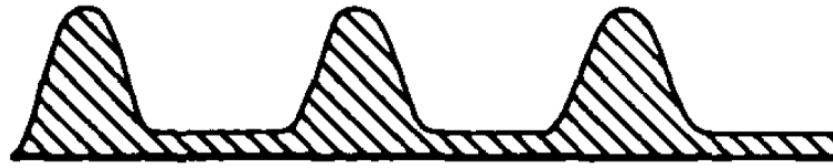
43%

For many (not all), schizophrenia involves **enduring** problems of a clinical level of severity.



Time (2 ½ years)

Katz et al, 1983: 5 year patterns of course of illness based on 107 patients with schizophrenia



Impairment after the first episode with subsequent exacerbation and no return to normality

9%



Impairment increasing with each of several episodes and no return to normality

43%

This **persistence of vulnerability** is now usually neglected:

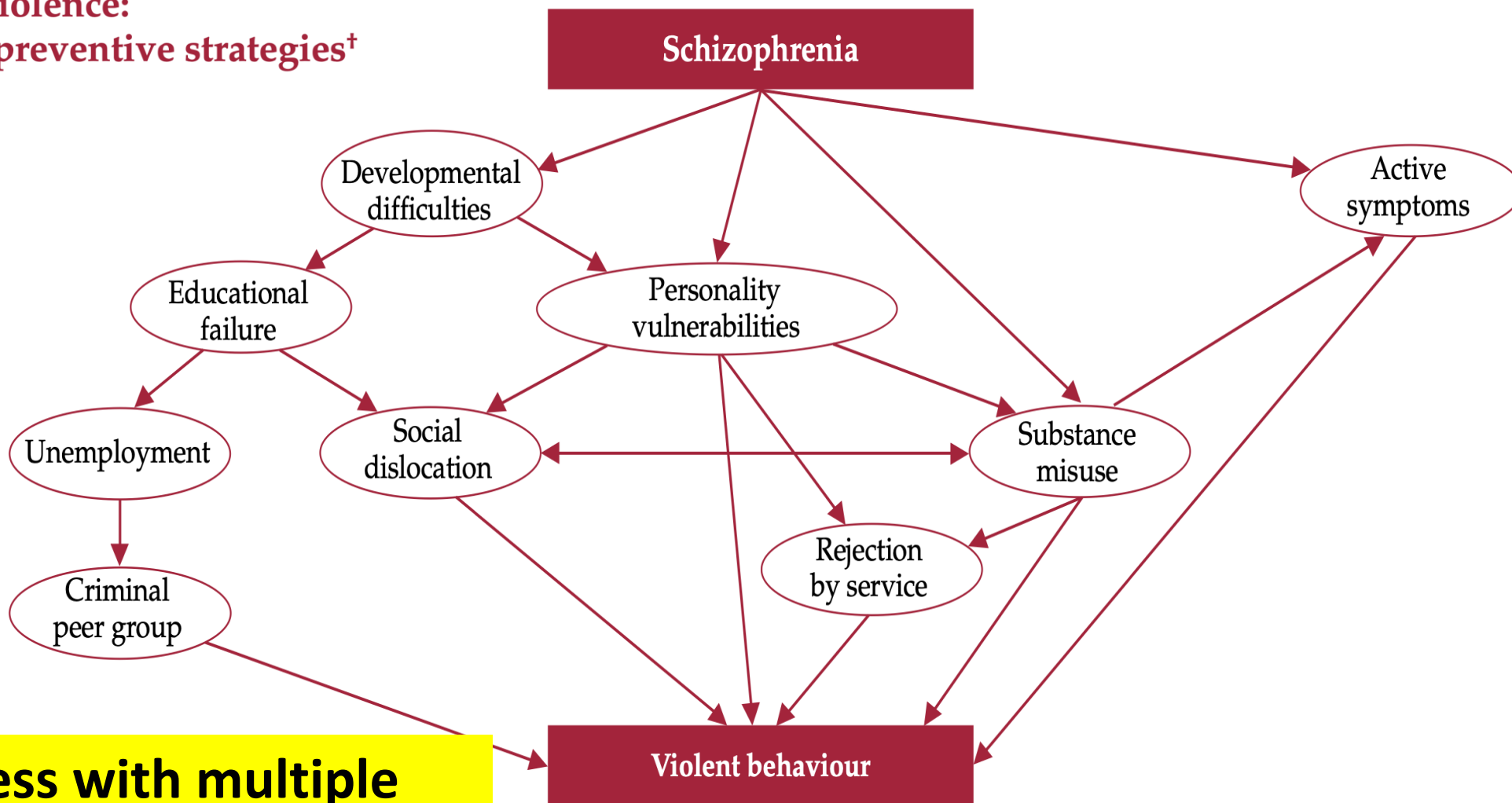
- A 'set and forget' model: back to GP +/- psychosocial input (NDIS if lucky) without even periodic specialist reviews →
 - a complex illness managed without specialist input
 - missed opportunities to enhance QoL / safety / wellbeing / physical health over long term
 - excess mortality and morbidity (a 15-20 year mortality gap!!!)



**COMPLICATIONS OF
PSYCHOPATHOLOGY**

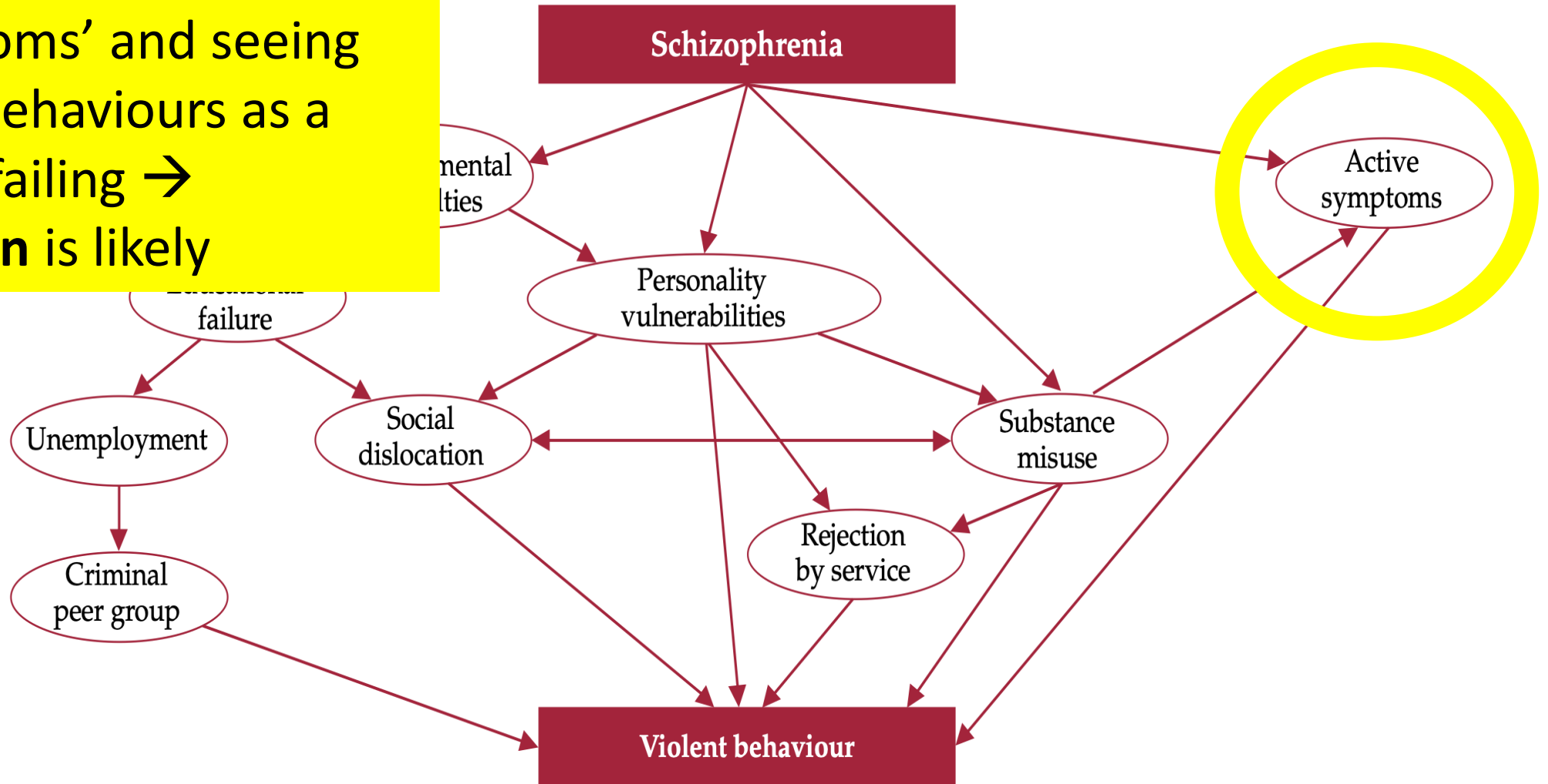
Schizophrenia and violence: from correlations to preventive strategies[†]

Paul E. Mullen



A complex illness with multiple psychosocial consequences that heighten risk of problematic behaviours.

Only recognising episodic 'active symptoms' and seeing problematic behaviours as a purely moral failing → **criminalisation is likely**



WHAT THE NEW 'RUMP' EPISTEME FAILS TO RECOGNISE...



**DEPTH OF
PSYCHOPATHOLOGY**

**DURATION OF
PSYCHOPATHOLOGY**

**COMPLICATIONS OF
PSYCHOPATHOLOGY**

What remains? A 'rump' episteme...

Schizophrenia only reliably recognised and deemed worthy of treatment if:

- delusions & hallucinations evident even on brief interview (**'overt'**) **AND**
- associated **high arousal** and hence a perceived 'imminent risk of serious harm'.



c. 2000 AND BEYOND:
'THE NEW'

This 'rump'
episteme has
emerged...

- Gradually
- Not based on evidence



The new 'rump' episteme reinforces our comfort with how we have answered the 6 questions:
a vicious cycle...

The 'rump' episteme



- Mainstreamed community care
- Very high threshold for compulsory care
- Market-driven funding
- De-medicalising
- Rejection of violent
- Triage as treatment

?



OUR CURRENT MALAISE...

SOCIETAL CHANGES AND
SCHIZOPHRENIA

THE NEW EPISTEME OF SCHIZOPHRENIA

**HOW FORENSIC PRACTICE CAN
LEAD POSITIVE CHANGE**

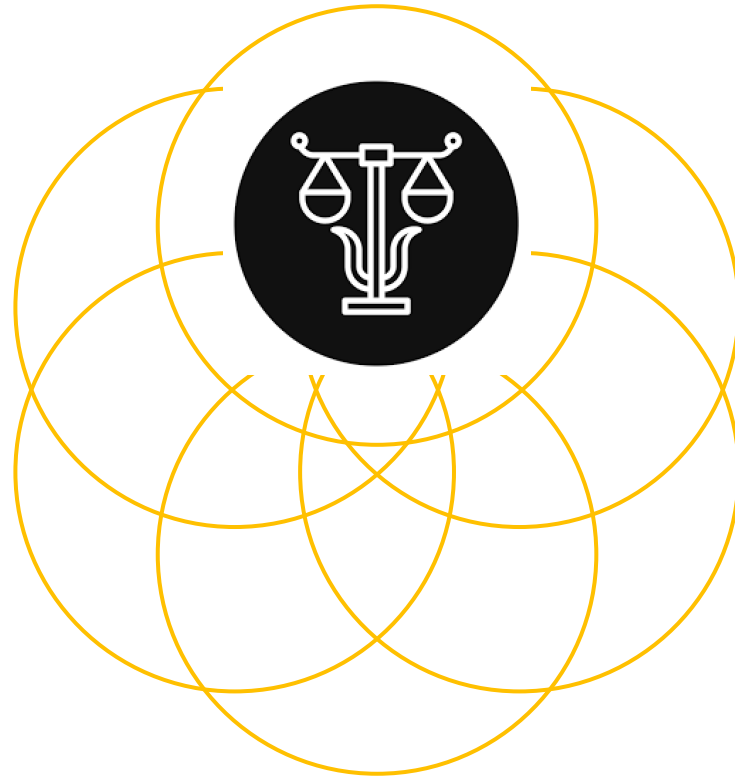


AFTER serious offending, IF a person with schizophrenia is granted the identity of 'forensic patient' (as opposed to 'prisoner'):

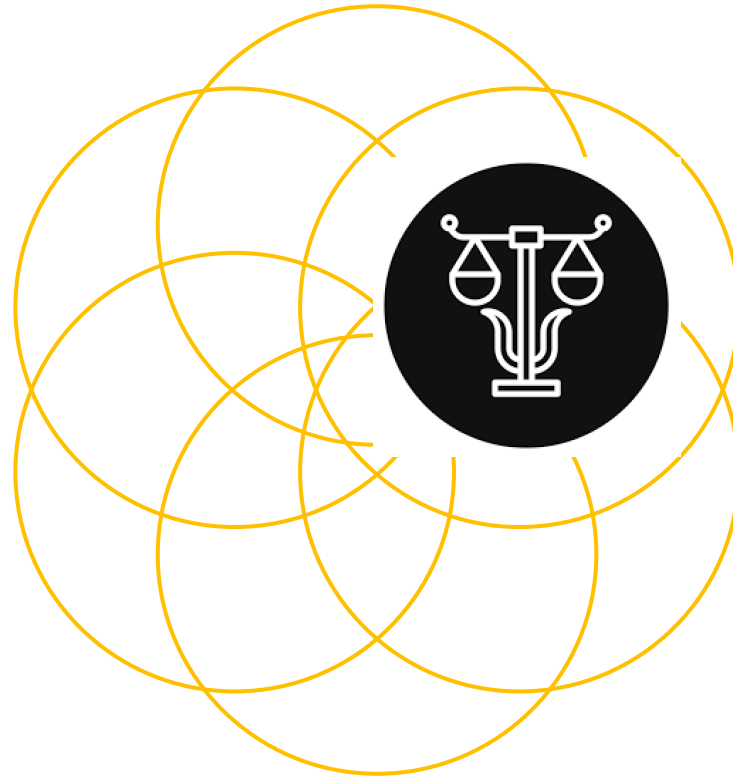
- The broader aspects of psychopathology **are** treated
- The indefinite duration of vulnerability **is** recognised
- The behavioural complications of schizophrenia **are** acknowledged as core business of (forensic) mental health service

The rump episteme no longer holds sway and the way we answer the key 6 questions is different...perhaps more nuanced?

Specialist hospitals : not too large,
subject to external scrutiny and
ideally not remote

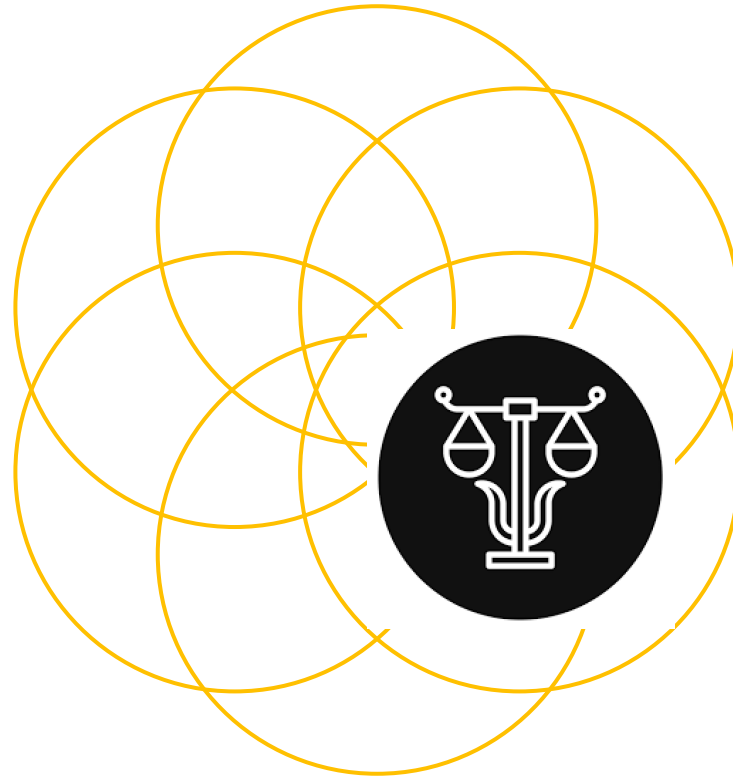


Specialist hospitals : not too large,
subject to external scrutiny and
ideally not remote



*A rehabilitative journey from
compulsory control back to
autonomy*

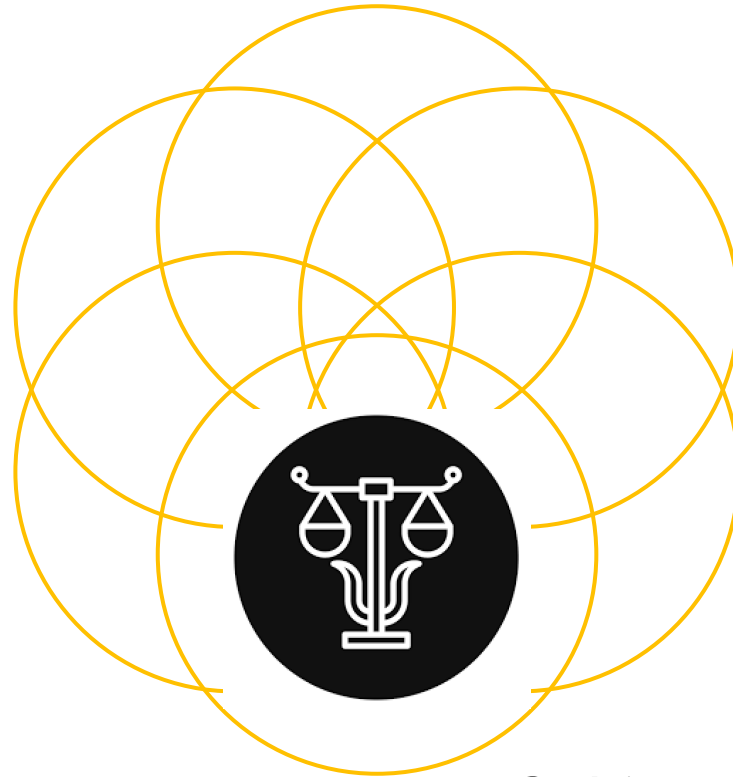
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*A rehabilitative journey from
compulsory control back to
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*Well-funded services that are
proactively provided to the
'service user'*

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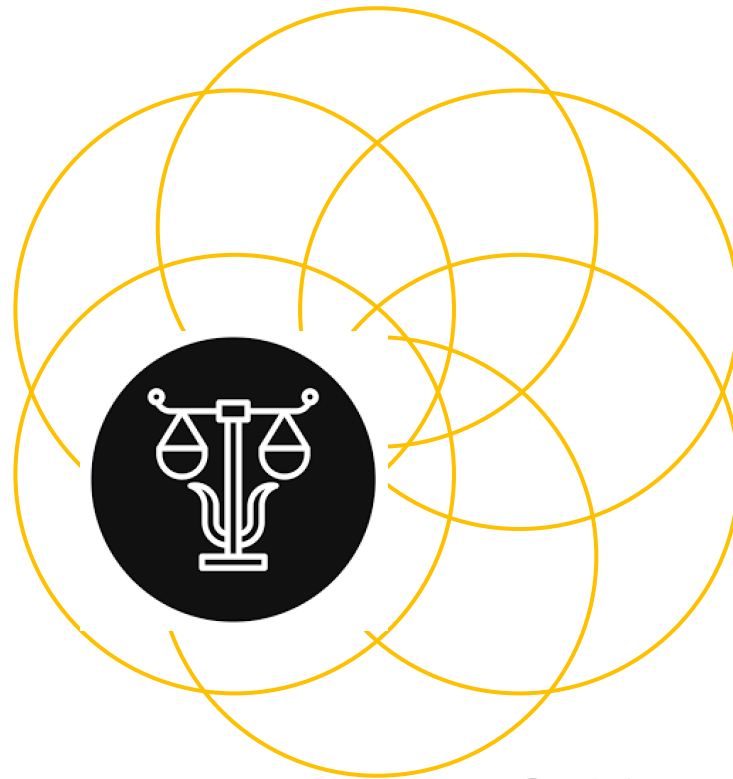


*A rehabilitative journey from
compulsory control back to
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*Well-funded services that are
proactively provided to the
'service user'*

***Schizophrenia is an illness that has
deprived person of moral
responsibility for a serious crime***

***Specialist hospitals** : not too large,
subject to external scrutiny and
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*A rehabilitative journey from
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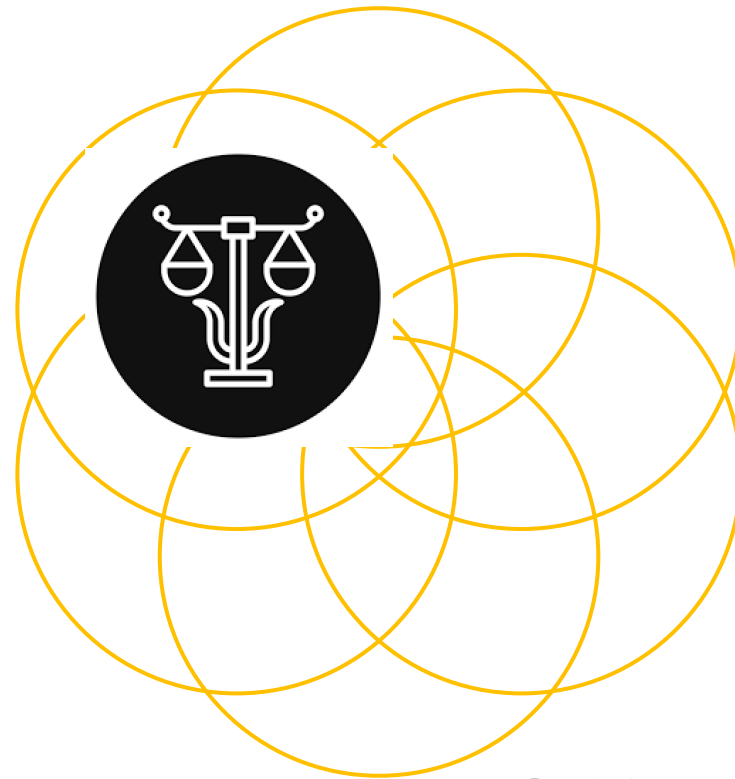
*Well-funded services that are
proactively provided to the
'service user'*

*Violence is a **clinical**
challenge (discharge from
service for bad behaviour
isn't an option!)*

*Schizophrenia is an **illness** that has
deprived person of moral
responsibility for a serious crime*

***Specialist hospitals** : not too large,
subject to external scrutiny and
ideally not remote*

*Long admissions permit time
for formulation-based
biopsychosocial care*



*A rehabilitative journey from
compulsory control back to
autonomy*

*Well-funded services that are
proactively provided to the
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*Violence is a **clinical**
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Forensis: “of or
pertaining to the market or
forum” (multiple voices)



Forensis: *“of or pertaining to the market or forum”* (multiple voices)

Forensic practice in hospitals and post-discharge is subject to high level of scrutiny by Courts / Tribunals / media / government

→ multiple perspectives are brought to bear on the work

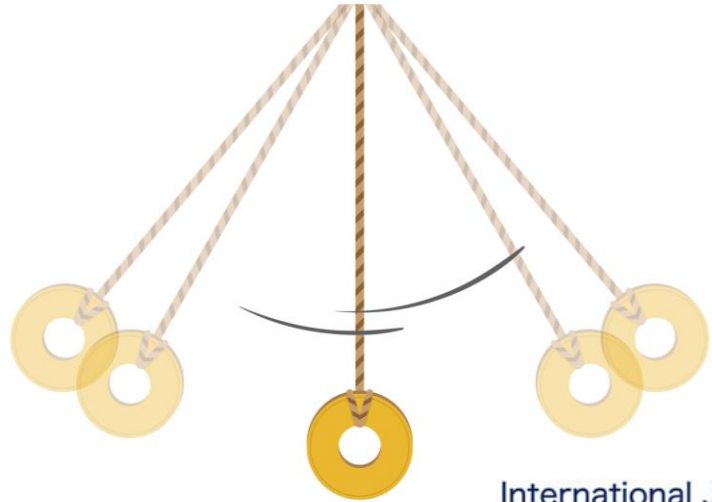
→ **Dialectical thinking** is required





DIALECTICAL THINKING

- A style of thought that seeks to integrate opposing viewpoints to find a new synthesis or balance.
- From "either/or" thinking towards "both/and"...



THE FRUITS OF DIALECTICAL THINKING:

- The swings of the pendulum are dampened
- “Third ways” incorporating aspects of each side may



ANZAPPL

Care and containment in forensic psychiatry



THIS IS WHAT WE ALWAYS RETAIN CONTROL OVER --- EVEN WHEN DECISIONS ABOUT CARE PROVISION ARE OUT OF OUR HANDS...

- “The pendulum always ‘overplay its hand’”: extremes are avoided
- Solutions are less ‘tidy’ and ‘final’ but are contested, dynamic and messy!
- Regarding schizophrenia: this allows room for a richer and more complex **way of thinking**



**HOW WE THINK
ABOUT THE NATURE
OF THE PROBLEM**

***LET'S STOP LETTING THE TAIL WAG
THE DOG!***



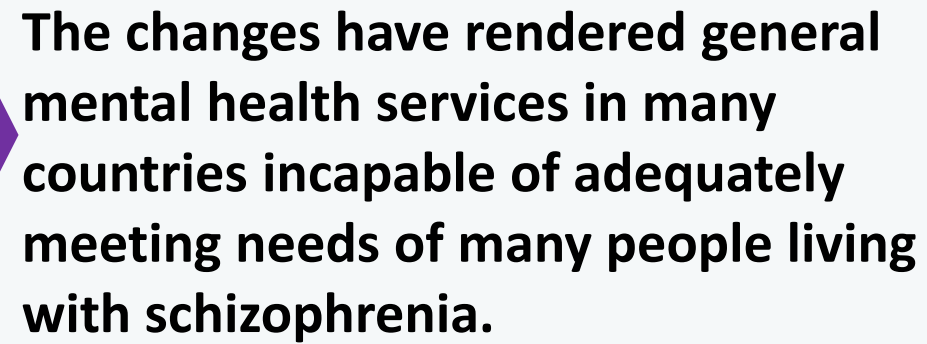
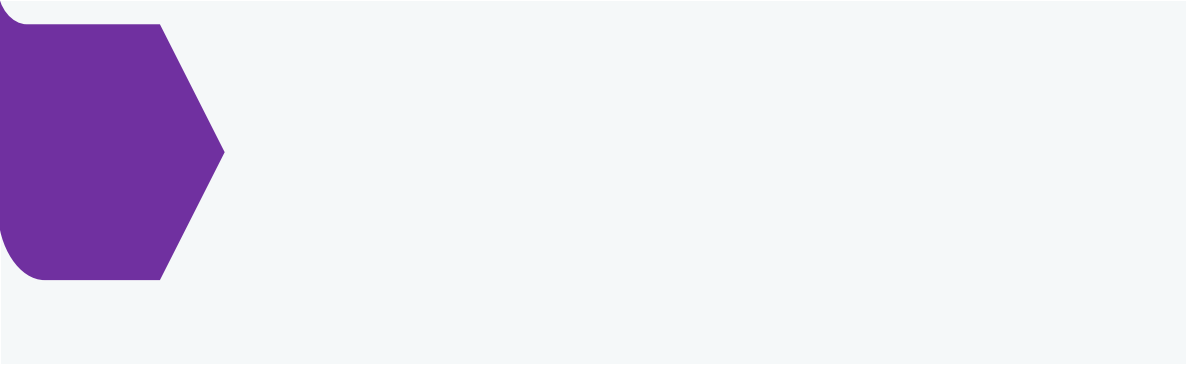
**WHAT SOCIETY IS
WILLING TO FUND**

THE LESSON FOR THE 2030s...



Schizophrenia has always challenged us as a society. 21st century societal shifts have profoundly changed how the challenges are addressed.

THE LESSON FOR THE 2030s...



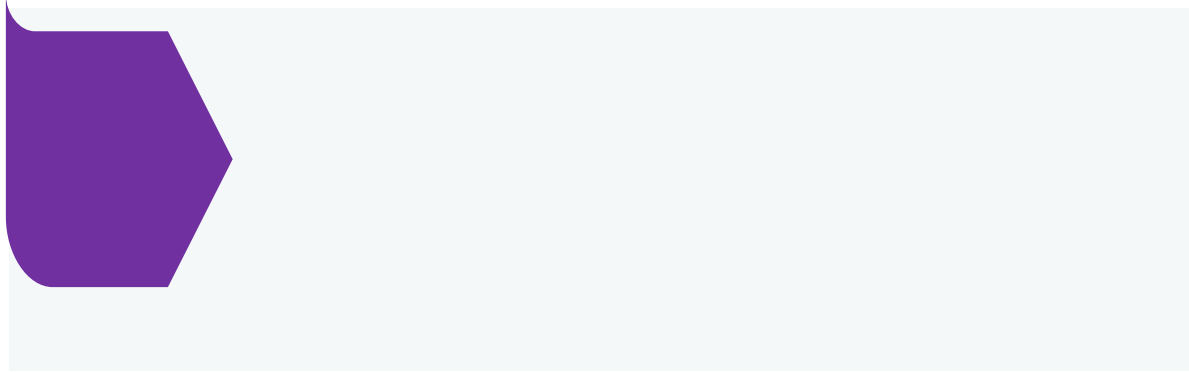
The changes have rendered general mental health services in many countries incapable of adequately meeting needs of many people living with schizophrenia.

THE LESSON FOR THE 2030s...

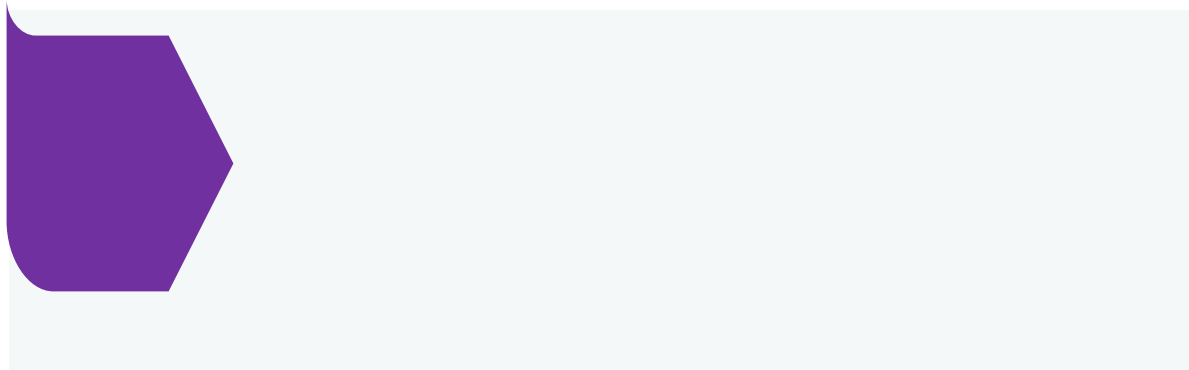
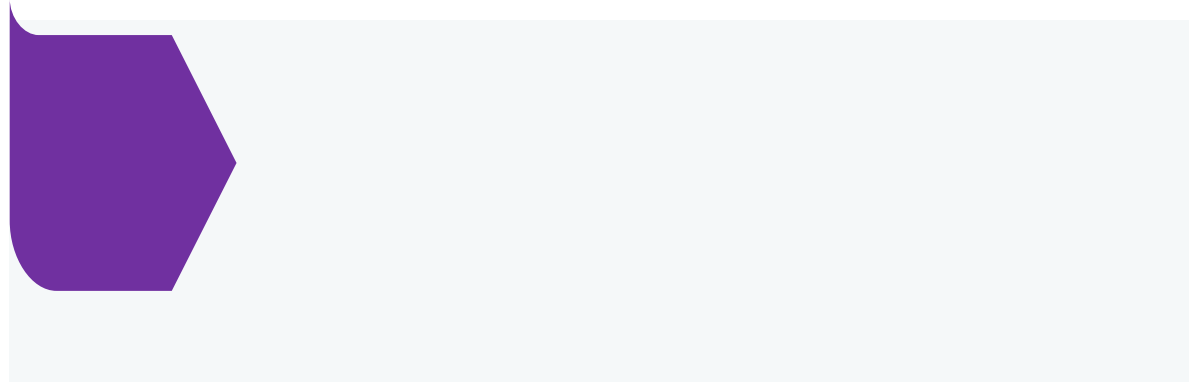


The system has coped by an epistemic shift: our new model of schizophrenia is an oversimplified 'rump'.

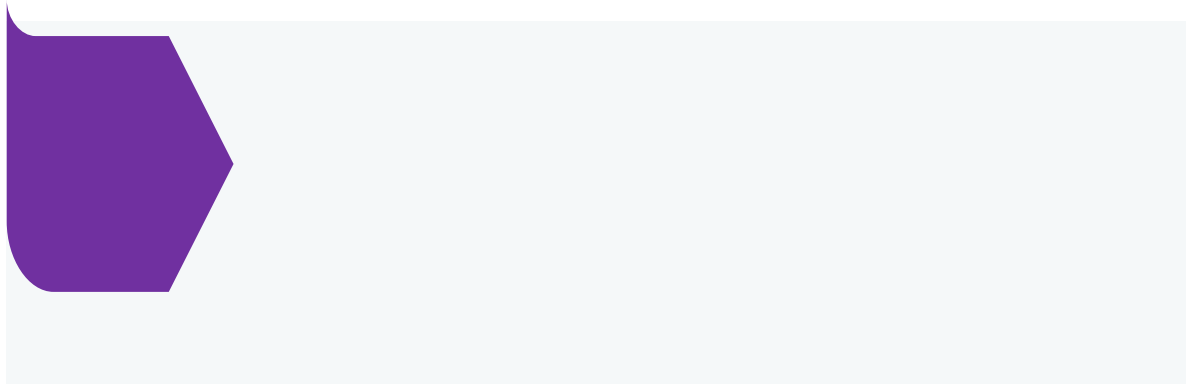
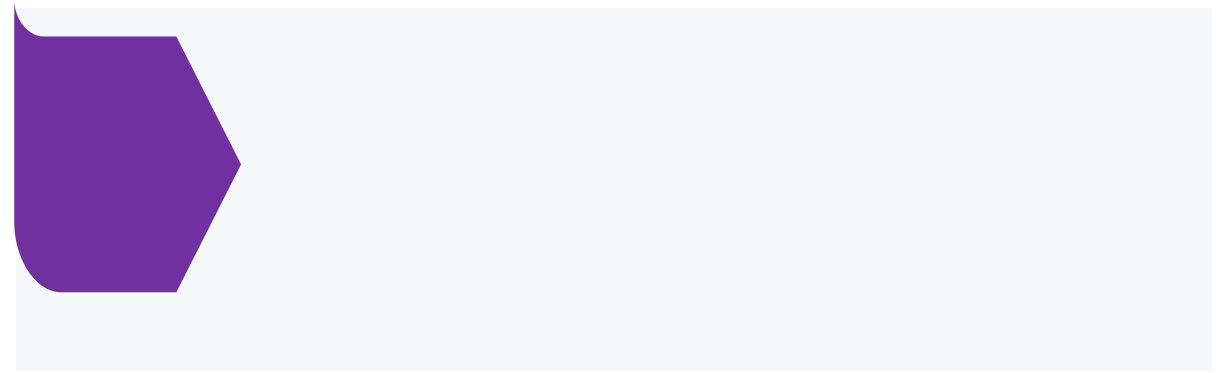
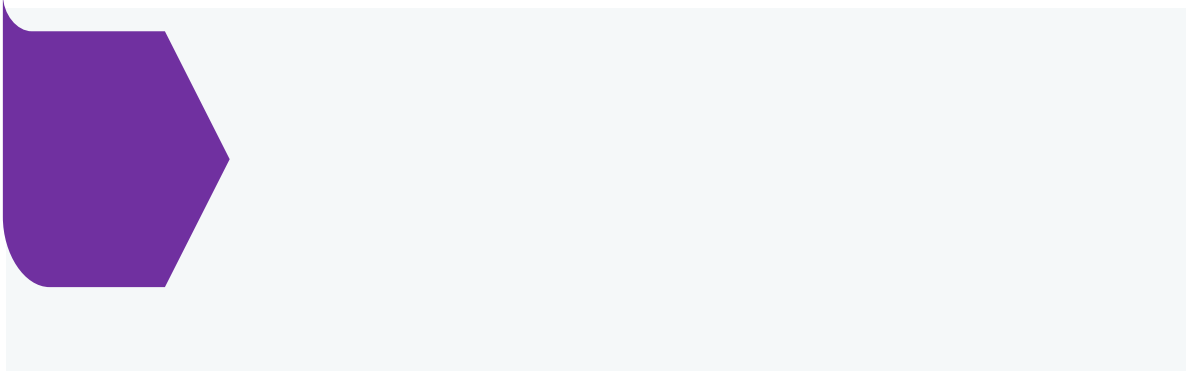
THE LESSON FOR THE 2030s...



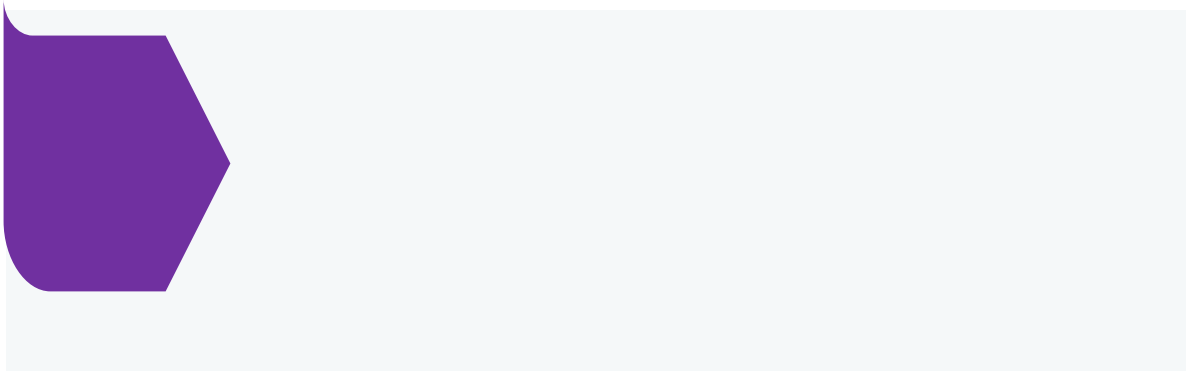
If this continues, care for schizophrenia will remain inadequate, even with more funding for “mental health”. *The whinge for more resourcing is not enough!*



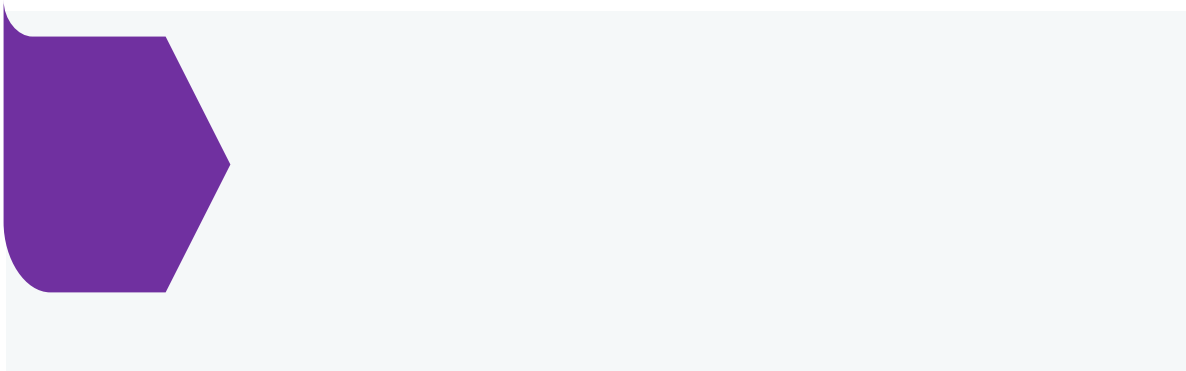
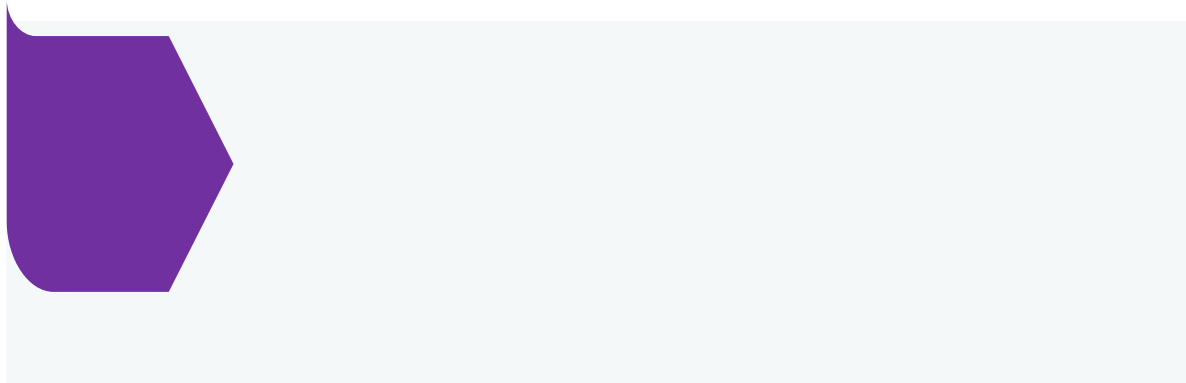
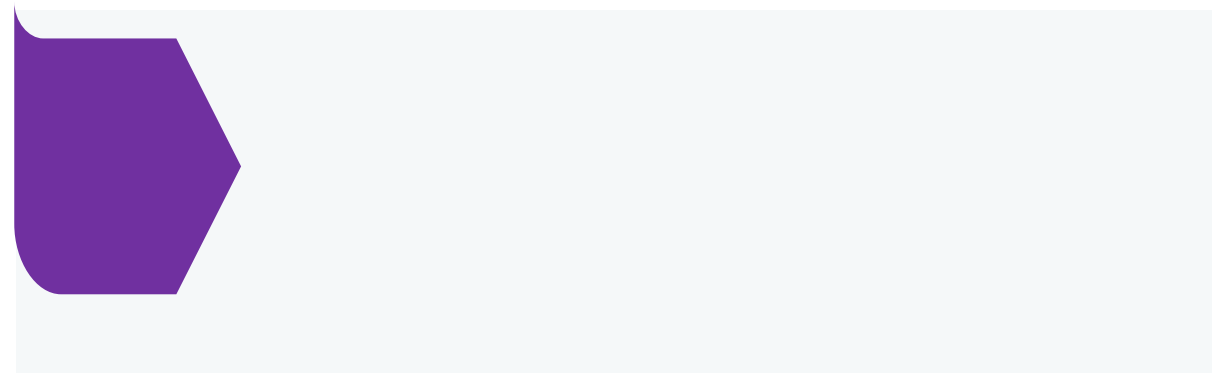
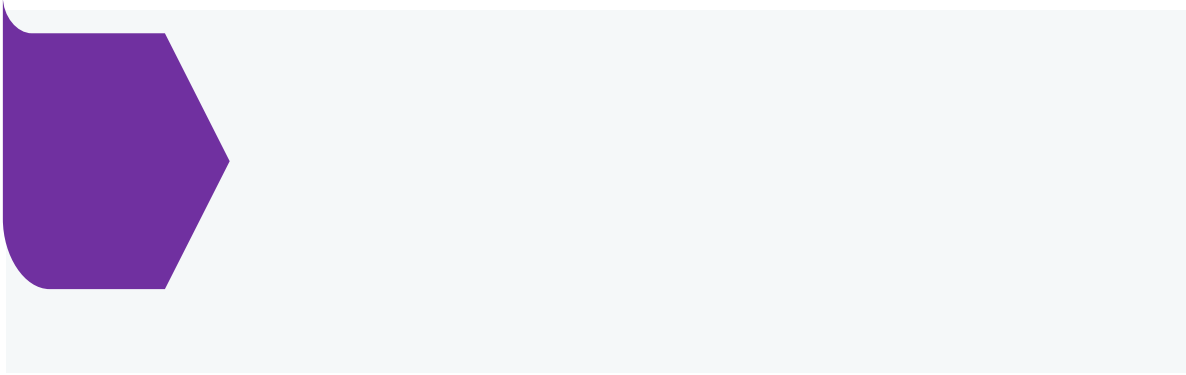
THE LESSON FOR THE 2030s...




Forensic practice in hospitals and community is forced to embrace dialectical thinking and has partly resisted the epistemic shift.



THE LESSON FOR THE 2030s...



*Becoming more open to dialectical thinking might enable the rebirth of a more adequate model and support
THE SCREAM...*

The background of the slide is a reproduction of the painting 'The Scream' by Edvard Munch. It depicts a turbulent, colorful sky with horizontal bands of red, orange, and yellow, transitioning into a dark, swirling sea. In the foreground, several figures are visible on a bridge, looking out at the sea. The overall mood is one of intense emotional distress and mental anguish.

***Let's provide care
for schizophrenia
based on need,
not legal status!***