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# Mental health diagnosis: Axioms, continuum, and future directions

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The present work is intended to create a space of support and safety for people with a mental health diagnosis. However, readers should never coordinate a response to an immediate clinical emergency unless they have state-licensed credentials issued by a local office of professions. Anyone requiring immediate medical attention should call 911 or proceed to a local emergency room. The central aim is to develop a community of individuals willing to establish a new culture surrounding the delivery of mental health services and the manner in which treatment, advocacy, and community psychoeducation is rendered by systems of care and prepared for consumption in our communities. Twenty-first century treatment for people with a mental health diagnosis is advancing, largely driven by new trends in research and policy reform. These policies, for better or worse, prescribe and map a course for new treatment pathways and models for delivering best practices in mental healthcare. To build on earlier research requires that clinicians successfully challenge less effective treatment milieus, evidence a need for further data, and ultimately, carry out studies that demonstrate and provide better outcomes for patients. Without question, rising violence can be partly attributed to a broken mental health system.

Keywords: diagnosis, mental health, mental health diagnosis, psychotherapy, trauma

## BACKGROUND

Rising insurance costs emphasise the need for urgent reform and further advancement of research in mental health. This need for immediate change translates into revamping the mental health delivery system by correcting the systemic and institutional gaps in a broken system that allows patients to fall through the cracks of treatment and continue carrying a mental health diagnosis. Evidence-based treatments and outcomes in current best practices signal that this shift in mental health treatment is necessary if people are to experience a full and lasting recovery (Anthony, 1993). Deinstitutionalisation has, in fact, stalled, and today's neo-institutionalisation of people carrying mental health diagnosis has overtaken decades of progress in providing full community access and integration. Ultimately, we are here to change the paradigm.

Too many people carrying a mental health diagnosis in higher education are subject to discrimination, unfair and disproportionate disciplinary action, and premature expulsion from campus life. While colleges have services for people with mental health disabilities, treatment programs, and on-site consultation for community vendors providing assistance, the problem persists. People with mental health diagnoses continue to battle institutional and systemic stigma that corrupts the ground floor of higher education.

As a student at Binghamton University in New York, I struggled internally against my battle with schizophrenia and outwardly against my college, which was mishandling my application to graduate school. While my particular circumstances are unimportant, the college's misinformed decisions on how to interact, support, and hear my voice as a student with a disability illustrates of the depth of the void in adequate accessibility in higher education. A closer look at several incidents at Binghamton highlight how college services currently treat students with mental health diagnoses and the need to level the playing field in administrative actions so that a mental health diagnosis does not stigmatise the student and manifest itself in extreme disciplinary action for minor infractions. One learning moment from my college experience occurred during course registration. These catastrophes are everywhere in higher education. As a clinician, I hear countless stories, all with the same causal and proximate root. I am recommending measures be put into place immediately to counteract and mend the damage inflicted upon students with disabilities.

Such measures begin with additional services and support, but ultimately, accessibility requires that a college adapt its culture and change its stance on mental health. Although I believe firmly in change from within, now more than ever third party consultants need to be brought in to work closely with campus departments and incident aversion teams to assist with cases that strain existing support systems and services. Colleges can no longer operate in isolation and diffuse their incidents internally. Colleges must immediately open their doors to mental health awareness before further harm is done to our youth.

In doing so, practitioners must continue to discuss, define, and set up an ongoing dialogue that focuses on what recovery means for people battling a diagnosis (Windell, Norman, & Malla, 2012). We all have eccentricities. Some of us are moody; others are negative and cynical. These character traits make us what we are – humans. When a person first receives a mental health diagnosis and enters the mental health system, it is easy to forget the humanity behind the diagnosis. At the onset of treatment, everyday quirks and eccentricities can easily be dismissed as part of the problem requiring medication or therapy.

I recommend further exploration of key strategies for differentiating the person from the diagnosis and providing tools to spread psychoeducation so that the stigma in everyday life is dismantled for students, parents, and other family members. People diagnosed later in life can easily remember who they were before they became. But people with severe and persistent mental health issues that are diagnosed early

in life can easily forget life before treatment. I encourage you to think back to a time when you were naive and happy, and the mental health system was totally off your radar.

However, even then, even before any symptoms were present and active in your life, you probably still had problems that you considered normal for your stage of development. For example, you may have loved to stay up all night. Probably, nobody called your behaviour manic. Were you strange or goofy at times growing up? Even bizarre? I bet no one called you schizophrenic or delusional.

People reserve certain language and descriptions of behaviour for people with a mental health diagnosis. But the truth is that people with and without a diagnosis can behave the same way, but only the person with the diagnosis is perceived as symptomatic. This a huge problem for the recovery movement and an even bigger problem for people in recovery who are trying to figure out if the issue they are struggling with is symptomatic or a normal reaction to life's stresses (Deegan, 1988). For example, if you are carrying a depressive disorder diagnosis, when is it acceptable and normal to be sad? If you are bipolar, when is okay to be energised and feel on top of the world?

The answers are complex and should signal the focus of recovery: the healing of the person diagnosed rather than just the alleviation of the symptom. Recovery needs to begin with identifying who you were, assessing where you are at now, and planning a course of treatment for getting you to where you want to be. When treatment focuses on the problem, or the symptom, the person becomes the diagnosis (e.g., he or is schizophrenic, bipolar, depressed). Too many people in treatment forget that some problems and issues are normal, need to be experienced, and are a part of life. Problematising every little issue in life and associating it with your diagnosis is the first and best way to perpetuate the revolving door to hospitalisations and the mental health system (Le Boutillier, et al., 2011).

Undeniably, our support systems, both natural, and artificial, play a vital role in our health by enabling our capacity to heal from sickness and reducing the likelihood of revolving through the mental health system. Supports play several important roles in our recovery and ability to problem-solve difficult situations without incident. Given my professional experience as a clinician, mental health therapist, and peer struggling with a mental health diagnosis, I can affirm that we are only as strong as our weakest support. Whether the 'weak link' is a friend or service worker (e.g., case manager or therapist), people carrying a mental health diagnosis and persons seeking better health and healing alike need to be able to identify helpers and be sure to find players who have a vested interest in your mental health.

My term for overwhelming support is 'too big to fail'. In my recovery and healing, I have always been blessed with a litany of helpers to guide and oversee my journey through the mental health system. When I was first diagnosed, family visited me in the hospital regularly and ensured there was no mistreatment by staff members when I was in the state hospital. In addition to their participation in treatment, my family was a large part of my discharge plan back to the community and my rehabilitation from unresolved symptoms. I had the opportunity to witness countless patients without the same family support. I witnessed patients without visitors, friends, or outside professionals and without a home in the community to be released to after their recovery in the hospital.

Whatever the problem was, whatever the complaint from the hospital staff regarding my behaviour and treatment progress, I had family with which the staff could lodge their complaints. I had friends visiting from time to time to make sure I was not mistreated by hospital staff, and I was relatively comfortable in the hospital. These supports and friendly visitors became unofficial members of my outpatient treatment team. When I re-entered the community and began outpatient treatment, my team was always there to advocate for me and facilitate. In addition to family and friends, I leaned on professional contacts to push the system along during 'stuck moments' and holding patterns – times when many people either slip through the cracks or become subject to relapse and re-entry into the system.

My landscape of health and healing has never included failure or a sense of defeat and isolation because my horizon reaches beyond my immediate personal space into a large, unending pool of resources. I continue to draw on them when I feel that my progress is too slow. My support system can also fix external mechanisms so I can continue to heal and recover. This is why your helpers should be more than motivated; they should be proficient in the system and your struggle so they can operate without your immediate supervision and act when you might not be available given your first priority is healing.

'Too big to fail' means you have so many people in your corner you can fall back into a learning moment without losing ground. It also means your problems reflect on the problems of a larger stakeholder in the system, so your issue becomes, in turn, the system's issue. People can move the system to work for them. Their interests and the people who espouse them can be motivated to squash 'noise' and complaints out of fear that patients might relapse without extra support or create an unseemly public display. These events would jeopardise the veneer of hope the system is supposed to create for those it serves.

Ultimately, there are limits to leaning on your helpers for support. Calling friends or family to do everything is not only unrealistic, it can become abusive. Put boundaries in place with your helpers so their work does not ever negatively impact your case or cause more harm than good. Your helpers should be understanding and accepting of your limitations. The next phase of your healing should not be down the avenue of learned helplessness. In the end, healing is a product of your strength and should reflect predominantly your work in recovery and not that of your helpers.

#### Critical mass: Defining the urgency

New policy must include 'Full community access and integration: Dislodging lockdown from Treatment'. We need to systematically apply and introduce new knowledge to mental health treatment through a deep belief that care needs to exist beyond the confines of a locked unit in a psychiatric warehouse. It is time we charge our university system with the task of envisioning full community integration and system-wide ward closures of state psychiatric facilities. The social work and psychology departments of the New York State Office of Mental Health will draft a proposal for Ward Closure Teams that will plan, assess, and implement the dismantling of locked long-term care units across the state and identify gaps in community care and access at the local level.

The community of mental health practitioners and peers needs to establish a new culture surrounding the delivery of mental health services and the manner in which treatment, advocacy, and community psychoeducation is rendered by systems of care and prepared for consumption in our communities. Parties with a vested interest in healthcare and social welfare stakeholders can begin to levy reform by opening the conversation. Hopefully, this will result in a document that helps establish a culture in which all people involved in mental health will expect major shifts in outcomes. The road ahead presents many obstacles to universal access to treatment, but these challenges must be met head on if we are to move mental health treatment forward.

Members of the mental health community should search for allies and advocates who will lobby for community-based services, so they can expand further and will have the resources to take up our cause and incorporate it into the very structure of their organisations. This needs to be a living document. Community members should update, adapt, and revise it as further research and emerging discourses inform the manner in which mental healthcare is packaged, consumed, and presented for debate by this community and its members.

### Interdisciplinary parity: Eliminating the disconnect between the peer and mental health practitioner

As a mental health professional with lived experience, I had to choose between peer work and social worker. Dualities and binaries: Mental health has both. There are no specific answers to unpacking every aspect of the complexities, but they are a little more black and white than deciphering good from evil. It's about conflict, values, and ethics. It's personal, it is professional, and it is individual. It is global, with every intersection revealing the liminal space between two worlds. Undoubtedly, being a peer and mental health professional has its challenges, especially in negotiating boundaries with co-workers, friends, allies, and consumers. When does disclosure become overexposure and unprofessional in the clinical realm? Living as a peer and practising as a professional, means mutuality. It means disclosing your life in the most open manner. This may require discussing lived experiences, which can create complications and conflicts with the boundaries that set the standard for clinical practice in mental health.

This struggle sets the stage for today's dilemma in mental health: How to be transparent, authentic, and real in the best interest of the consumer's care, including proper treatment, respect for dignity, and the right to the best practice and options. So, how do peers and professionals handle this complexity? This can be achieved through building empathic connections with clients and colleagues. We know what it is like to be ill. We know what it is like to treat that illness. Bridging that gap is fundamental to providing the best possible care. We all have our histories, but authentic peers are comfortable with their journeys and the journey of clients (Deegan, 1996). They can create a most intimate and supportive relationship in a system which is centred on suffering and deep pain. Fundamentally, it is about restoring the human aspect of care in human services. And, it is about time. But we are not there yet. To get there, the relationship between peer professionals needs to shift. We need supervisors, clinicians, and administrators who understand this duality and nurture, its delicate and complex layers. Ultimately, with support and openness, holding space, and challenging fear of the unknown, the gap becomes a bridge to the best possible care. Mental health professionals must choose to which world they want to belong: (i) a world that discredits and places sanctions on uses of self-disclosure (Relojo, 2017); or, (ii) one that practices mutuality and can create conflict when the peer enters the real world and finds that regulations and rules can complicate equality and freedom of choice.

Natural connections, supports, and understanding what it means to be a colleague affect how professional people relate to the mental health system. As a social worker, support and consultation will look and feel different than the counselling I receive from a peer who is practising mutual support. This seems odd since we are all doing the same thing. Call it treatment, case management, or peer support; we are all looking to resolve the mental health issues of our clients and patients. Labels make us realise that how we see each other and how we understand our role is different because of stigma and the evolution of the mental health system. The system creates identities for people enrolled in its institutions and labels us as something less than or other than a professional. Until stigmas are dislodged from the mental health paradigm, we cannot expect to see outcomes that reflect the importance of peer work or mutuality as an intervention that creates a lasting space for change that can resolve mental health issues. This paradigm shift means every mental health provider will be able to practise mutual support without removing the human element that occurs when social work is practised without peer support. Human connections are made by identifying ways of reducing the human struggle and divisiveness in our population that makes mutuality more distant and difficult to practise. This is because our interests and human connection derive from stigma.

We want counsellors, therapists, and peers to be authentic. But what does that really mean in the context of systems of care? Authenticity means being true to one's own beliefs or being without pretensions. How can someone be authentic in a system that pushes its own values, ethics, and prescribed regulations for treatment? How can a consumer ever hope to be treated without bias or

judgement in a system that categorises, assesses, and diagnoses you with prescribed manuals? I am suggesting that if we had authentic therapists or peers, then the empathy and connection made with you during treatment is really a negotiated form of the word. It does not meet the platonic, pure definition of authentic, and, I would hazard to say, has been commoditised for reimbursement from insurance companies and not-for-profit (but really, for profit) agencies. The clinical regulations of the New York State Office of Mental Health (under NY Article 31), and those of other states with state regulatory commissions for mental health treatment include rules for participation in treatment. I have never heard of rules in an authentic relationship. A relationship, if it espouses authentic values, will inherently develop from the input and energy invested in the connection. But this is not how treatment plays out in the modern clinic, where it is prescribed and very much based on funding streams and 'anchors of care'. These denote which practices take priority over others and which interventions are 'in' and which are 'out'.

When you first enter a clinic and come under its gaze, you, the consumer, are immediately assessed for risk of harm and safety. You receive a diagnosis that supposedly helps practitioners map a pathway and strategy for your treatment. But hold on; that does not sound authentic. Why are consumers of mental health treatment assessed, marked, and essentially ticketed for retail value for reimbursement by insurance companies? Because, if we are honest, when you are given a diagnosis for insurance purposes, the clinic is basically forwarding your projected cost given the 'medical necessity' of your diagnostic label. This means, for example, if you are diagnosed with acute anxiety, most managed care insurance companies will want to know your progress toward your 'goals' or readiness for discharge. On the other hand, if you are lucky enough to receive a diagnosis of chronic schizophrenia, you are eligible for Medicaid and other catastrophic coverages that pay for long-term care, because, that is your value and worth in systems of care. So, where in all of this are the authentic relationships? It rests in the negotiated 'back-and-forth' dialogue between you and your practitioner. Is your practitioner willing to drive treatment forward and justify your continuing care at the clinic? This care depends on various factors, including: (1) your needs as a consumer; (2) the cost of keeping you in treatment; (3) the pressures of a rising caseload; (4) the risk of harm as a level-of-care issue; and, (5) participation in treatment. If you meet these criteria, your care cannot be terminated without a complex and systematic formula justifying your discharge. Although authenticity has no space when the system determines your medical value, it does hold space in the consumer's active participation. To keep moving forward, you need to justify your ongoing treatment by willingly and actively participating in your care. The rules for Article 31 clinics are clear. State regulatory bodies want to know if you are involved and vested in your treatment or if you are simply not worth the cost of your state and insurance psychiatric rehabilitation.

Unless you are a freelance, privately contracted peer, or consultant, you are also part of a larger system of care. Understanding the peer's authentic value to the consumer is even more problematic in this context. But it is a value. I am suggesting that the peer, too, has been assigned a rate for services. By adding peer services to the consumer's treatment, an identified need has supposedly been met. But, the integrity of peers aside, consumers of services are duped into thinking their voices are heard by their peer advocates and that their peers will address any problems they are having moving through the system. This thinking is fallacious and should be addressed by peers working in all systems of care, which, as have already been suggested, are also traded among agencies like commodities and packaged under the disguise of mutual support. This is extremely problematic for consumers who are truly disorganised in their thinking and actively delusional or psychotic. In most of these cases, the voice of the peer is silenced, and the legal system goes to work. Thus, if you are so ill that you cannot differentiate 'right' from 'wrong' and are at an acute risk of harm, it is not your peer's voice that will be heard by the treatment team when you are unhappy with your care. Instead, it will be the lawyer's voice, above all, that either justifies your continuing care on a voluntary basis or your commitment to forced treatment with a change of legal status to involuntary.

I have not always been a peer. I did not rise through the ranks of the movement. However, my research does not reveal many courtroom peers challenging judges to convert a consumer's legal status to voluntary. Why are peer advocates not in the courtroom? Just follow the money. Peer work, as a commodity to be traded for peer support, has no value in the legal system when it intersects with a consumer's treatment within systems of care. This means, essentially, it is the voice of the lawyer, psychiatrist, and perhaps therapist that has primacy over the peer. This is because its legal worth can be justified on a level that satisfied the court's concern over-risk and harm to others. I am not suggesting that peers should be assessing for risk or making legal decisions regarding their clients. Nor am I saying clinicians should fly by the seat of their pants and forgo prescribed treatment practices because on a philosophical level it does not satisfy the definition of authentic treatment. Instead, I am signalling the mental health community that we have a long way to go before consumers will begin to accept their therapists' advice as truly empathetic and the peers' voices as their equal in systems of care. With this said, we can continue to evaluate funding streams and question the reimbursement practices of insurance companies that classify assign consumers of care treatment based more on money and worth than on society's drive to end disparities in treatment practices.

### The re-rising of community mental health

For most of us served under its auspices, we just call it the system. Many systems serve consumers with services and 'benefits' (e.g., social security, social services, etc.). Some systems are more distressed and outmoded than others, but no system is as complex, repressive, isolative, feared, and misunderstood as the mental health system. As a clinician who works within the community mental health model, I am recommending reform of specific aspects of the mental health system at the local level. My experiences are based on serious delinquencies in person-centred care and the limited opportunities available to me to move forward and escape the system's revolving door. As a provider and peer, I have witnessed different attitudes toward consumers, most of which were not person-centred. By that I mean, a stance toward consumers that allies with their recovery and creates a culture in which service recipients feel safe, have a voice in their treatment, feel supported, and are made aware of their rights. I have worked at various levels of the mental health system in my locality: the clinic, community centres, schools, and people's homes. Thus, I have had an opportunity to interact with various systems that intersect the mental health system to an effort to connect consumers with other services and benefits.

Surprisingly, I discovered that the most person-centred attitudes held toward consumers came from other systems (e.g., DSS, Social Security, schools, and other community organisations) and not from the so-called person-centred mental health system and its staff, whose members work directly with consumers with a diagnosis. As community practitioners and peers, we like to think our person-centred perspective is the most advanced, but we have not yet reached the upper limit in practice. The most egregious flaw in the mental health system is how difficult is the struggle to leave the system in an 'improved' position without relapsing. The main reason is the challenges in connecting to other services because of insurance/Medicaid or working disabled issues. In addition, when giving up disability status, the consumer is left to his or her own devices to succeed without any support. Consumers, practitioners, and peers have all encountered the system's forked road. Either (1) take the path of living as 'working disabled' with its many restrictions in insurance coverage and assistance; and/or, (2) or choose no system support, which makes it all too easy to rebound into the system. Is anyone really shocked that people are rebounding? After years of support, people carrying a mental health diagnosis improve and are dropped from services to survive without support. They lose years of conditioning, including, in some cases, hand-holding, and in others, benefits and services.

Does the working disabled path provide any greater chance of success? As a working disabled consumer, I found the hardest part of this path was not feeling healthy enough to work, but rather

navigating the complex system of benefits that comes with the status so I can stay connected to treatment and deal with the backward Medicaid system that covers people with this status. Where we live, grow up, work, and spend our time impacts our chances for success and, ultimately, survival. The person versus the environment question is an age-old debate that focuses on whether aspects of our success and/or failure can be attributed to where we live. Nature versus nurture also seeks to evaluate the protective factors (e.g., good parents, shelter, etc.) and weigh them against factors that put people at risk of potential harm. Studies and ongoing research continue to struggle with answering this question when it comes to mental health. Threats to a person's safety potentially harm his or her mental health on various levels. Possible safety threats include scarcity of resources, poverty, and homelessness. Although secondary to personal safety, they can sometimes be just as lethal, particularly when environmental issues become more complex and hard to identify. However, the possibility of survival is lower for a person without healthcare and a home than it is for an affluent person with the best mental health insurance coverage money can buy. But the environment consists of much more than a collection of people and their financial status. How mental health intersects the macro and micro aspects of our humanity is even more complex. So, what is important when it comes to our personal mental health when thinking about the larger world around us? Access to goods and supplies, hospital networks and medical/psychiatric care, and even transportation contributes to our community Environmental Mental Health Index (EMHI).

The EMHI is a self-administered tool that evaluates if our environment is helping us thrive or just survive. To use the tool, simply answer a few key questions using your internal barometer to reveal thoughts and feelings about where you live and the larger world beyond your immediate surroundings. Community brings with it a collective mental health status beyond our personal mental health narrative. Both intersect and complicate what defines mental health on both macro and micro levels. Social apparatuses, such as feelings attached to being a part of something larger than ourselves, something unique, affect our feelings about where we are and how we got there. Both the 'where' and the 'how' may not reveal macro threats and protective factors, but they do inform how we feel about where we live. Using this technique will make you more cognizant of your surroundings and how they impact your feelings on a daily basis. It is the first step to understanding how where you live affects why you feel and think the way you do. Local community mental organisations need to begin to evaluate similar scales to identify and mark which of their programmes are effective and which require additional funding because of counter-therapeutic environmental interference.

#### The problems with diagnostic labels in person-centred care

Clearly, peers and clinicians are divided on the issue of diagnosis. As a peer and clinician, I suggest a bi-party solution to this age-old divisive question. At the root is an issue of language. It is about roles and responsibilities to carry out treatment. Ultimately, it is about identifying the condition or problem so the patient can progress to a less harmful pattern of thinking or behaviour.

This argument builds on a multidimensional lens for deconstructing the intersections that complicate the health systems and treats mental illness as a category 'different' from mental health. The evolution of society's concept of mental illness means that psychiatry as a hegemonic apparatus functions at the micro and mezzo levels of society. Institutionalisation now exists in the minds of those battling in community neo-institutionalisation. This suggests we are working with an institutional framework for language to discuss and talk about mental health problems in the community context. Mental health care raises our hopes for a cure beyond what medication can fix and moves patients toward greater solvency and a working image of the self.

Dated institutional language talks a lot about reform, recovery, and getting 'better' or adjusted. But in the evolving and shifting community, people want to do more than adjust or get better. They want to



discover a solution to their problem and move on and live life. Unfortunately, the language of diagnosis does not allow people to move on. Diagnoses follow consumers; sometimes forever.

### The neo-institutionalisation

Neo-institutionalisation is covert and insidious; it must be stopped. I have already suggested that state of mental health treatment has fallen under the shadow of something more dangerous to the consumer of services than ever before in community mental health systems across the US. The term community mental health evolved from the vacuum left after de-institutionalisation. At first, people were genuinely excited about this new turn. It promised more person-centred care in mental health treatment. Decades later, however, this movement has stalled and become an ageing system set up to meet the needs of consumers from a distant era. In New York State, each county answers to the Office of Mental Health. Other states follow similar regulatory structures for providing treatment. The county mental health office, the most local unit in the community mental health system, has become nothing more than an office to lodge complaints and keep records of its failing services. We need to turn the system on its head, first by re-establishing the consumer's voice in treatment. The system is still run by so-called experts and autocratic practitioners, who traded their noble ideal of a helping profession for commercial benefit. These 'clinician-crats' now dominate the system and make up the ruling or decision-making elite in community mental health offices and local government. The only exception to this dominating stakeholder is the peer professional. Unfortunately, to do business with these 'clinician-crats', the peer profession has been reduced to dollars and cents on the state budget plan. To truly reform the system, it needs to be restructured to match the needs of consumers by offering programmes and services that reflect the values of community mental health that once enabled people to leave the hospital system for full access and integration into the community. Full access and integration is the freedom once realised by the psychiatric survivors of the 1970s and 1980s. It means more than ramping up points of entry into local community health networks; it also means connecting mental health treatment to all goods and services targeting healing and health-related issues. The rise of the Modern Health Home and the fall of the silos, illustrate the system's attempt at integrating care, but, as with most new treatments, the outcomes reflected the clumsy practices of the care management philosophy and regulations. Now, instead of one service at a shop or agency, we have several services intersecting with health and wellness. However, like most products assembled hastily, the quality of care reflects a degradation of skills across the states. The concept worked, but the fine tuning in hiring practices and billing overshadowed the worthwhile and beneficial programmes.

Ultimately, the hospitals are still open. Long-term out-patient programmes still exist and are more abundant than before. I am suggesting we remove the 'levels' from our systems of care and end top-down forms of treatment in which patients are granted access to freedoms based on their success in treatment. The level-of-care philosophy made sense years ago, but does it make sense today? Our goal is to pave the way to ending long-term in-patient treatment and funnel consumers back into the community for the long term in their roads to recovery. Instead, we are feeding a system that privileges restriction, seclusion, and isolation from the community. If treatment and services were all considered at the same level of care, there would be no complaints from consumers that treatment is not centred on their needs and did not exist simply maintain and justify its own upkeep. The rules encompass the way we document patients and carry out treatment. They even bleed into the philosophy of care and implementation of practice at our workplaces. No doubt, a set formula for the way operations and treatment is carried out in the mental health setting is paramount for establishing the foundation of care necessary to get treatment off the ground. But is prescribed treatment necessary to care for a full range of diagnostic, social, systemic, and institutional problems? The benefits are obvious: predictability, consistency, and evidence-based practice requires that treatment be reliable and reproducible if treatment venues are to conduct house research. Research and evidenced-based treatment are vital, but is prescribed treatment a must to drive quality and effective treatment forward in mental health?

## CONCLUSION

I am a clinician with lived experience who has been exposed to a number of treatment settings as a peer and professional. What's missing is that special touch, that lining to the golden thread that jars the system, turns it on its head, and yet returns unscathed. I call it *special projects*. It is a division of care that dares to explore the irrational and the unknown and has the confidence to justify billing to keep the programme running and eligible for state funding. This is done by asking a few questions reflectively: (1) Why is treatment the same here as down the street? (2) What can I offer my client that stands apart from services of past providers? (3) Who am I working with, and how do the regulations of OMH complicate the best care possible for my client? (4) How do I make it all work? First as an individual, then as a team, and ultimately with your clients and their families.

At its root, this is a person-centred philosophy and practice that keeps the uniqueness of people at the heart of treatment. It is a choice to be different from the cookie cutter clinic. I do not know about you, but I did not train to work on an assembly line unless that process was going to cure my client. But in reality, people are all different, so we need to find the right fit for your clients using special projects guided work. We need to advance research to demystify the lasting and long-term implications of neo-institutionalisation. Expanding definitions of discourses that intersect with mental health should challenge today's ineffective systems. Research needs to use a multidimensional lens to deconstruct the intersections that complicate the health systems and define mental illness as a category 'different from mental health'. In the future, further work should deconstruct categories of medicine, psychiatry, and social work and encourage strength-based approaches that will supplant neo-institutionalisation and create a new gold standard in treatment and social work.

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