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Submission to the Mental Health Select Committee: Inquiry into the opportunity to improve mental health outcomes for Queensland

My Background:-

I am a mental health nurse, an associate professor of mental health and a Masters prepared psychotherapist with over 12 years of fulltime education in mental health and over 32 years of experience in the field. I coordinate a highly successful Masters of Mental Health programme. I have worked in Europe, New Zealand and Australia in the mental health field including for Queensland Health in senior clinical roles in emergency departments, in assertive community treatment teams as well as in the NGO sector and in the provision of private psychotherapy. I am considered a leader in mental health in any other place but my home of Queensland (and have delivered dozens of keynote addresses). I have endured over 30 inquiries into mental health systems in Australia in my career. I have also written and had published over 100 peer review publications and many book chapters exploring how to improve outcomes and providing commentary on how the system can be improved.

The problem:-

- In my career I have never encountered anywhere and at any time such a demoralised, underutilised, underappreciated, and disempowered mental health nursing workforce as I have in Queensland at this moment. I also note that both State and Federal Governments now spend more than ever before on mental health but any measure of mental health outcomes remains rigidly poor. The reasons for this are complex but relate to:
    - a medico-centric (rather than person centred system). In this system nurses are always positioned as subservient to medicine and by and large treated as ignorant 'hand maidens' regardless of their credentials or experience; No inquiry has addressed this problem or even noted it. That the terms of reference of this inquiry are framed around "mental illness" assumes that most people who access services have a medical problem which requires a medical solution. This is not the case and spending an hour in any emergency room in any Queensland hospital for an hour or more on any Friday night will lead any reasonable person to wonder why most people are brought coercively to an emergency department for a "medical" assessment.
    - We have one of the most coercive mental health systems in the world. Nowhere outside of totalitarian regimes are so many people forced to receive assessment and treatment. Over half of all 'mental health' bed days in Australia are under coercion (a Mental Health Act) and a good many more are under duress (the risk of coercion). Queensland is also embarrassingly one of the few places on earth that mandates that we lock people in. There is no evidence that this is effective at improving the mental health of Queenslanders (none at all).
    - The system privileges antiquated models of care basically unchanged for decades. These again are medico-centric, risk obsessed, increasingly protocol driven (the computer system dictates how one should do one work). It relegates most clinicians to being cogs in a machine. This would be fine if the output was improved mental health or even effective treatment for serious mental illness. It isn't. This system creates chronicity and blames the patient and their families for

being ‘treatment resistant’ when they don’t get better even though people are not even offered treatment in most instances.

- Trauma is the underpinning issue for most people who present seeking help as recommended or under coercion to emergency departments and often non-specialist generalist medical services. The treatment for trauma is not medicine. It never has been and not for want of trying to find a medical treatment (medicine and quick fixes have been extensively explored) there is no medical treatment for trauma. Psychotherapy is the treatment (if primary prevention fails… and there is none in Queensland). However, State services don’t generally offer psychotherapy and neither do federal programmes such as ‘Better Access’. So, people are encouraged or forced to be assessed and receive ‘treatment’ which they don’t receive, and their problems are rarely resolved. Again, please note that the usual response by guild lobbyists here is for more money to do more of the same i.e. more beds, more psychology, more training positions, more doctors, more medicine, more non-evidence based but exotic and expensive treatments such as TMS. None of these things are the treatment for the problem.
- Most people who present with suicidality or depression are never offered any psychotherapy or lifestyle interventions, yet these are the recommended first line treatments for high prevalence problems such as ‘mood disorders’. I invite any committee member to visit any Queensland Health ECT clinic and ask the recipient whether they have every received psychotherapy. It is rarely if ever the case (I have never met someone being offered ECT who was given the opportunity to try a decent dose of anything but medicine).
- Highly qualified and experienced psychotherapist which include any mental health nurse who might have 3-5 years of specialist psychotherapy training on top of their post-graduate qualifications cannot practice their skills in either the State system or under medicare. They are banned for life to access ‘focused psychological strategies, which also mean they can’t access other medicare items such as those for ‘eating disorders’. This is not for want of trying. I

collected 5500 signatures on a petition to at least allow such people the same access to medicare as a GP with 16 hours of training, but this has been ignored by both sides of the federal political divide (Greg Hunt and Mark Butler). It is embarrassing that these highly qualified people can work in the UK NHS, in Germany as registered psychotherapists, in Ireland as Clinical Nurse Specialists in psychotherapy but in Queensland their best shot of a liveable wage is undertaking risk assessments in an emergency department.

The Solutions:-

- Qualified psychotherapists but particularly APHRA registered professionals such as Credentialed Mental Health Nurses need to be able to access the same medicare rebates as clinical psychologists in Better Access and other programmes. Urgent reform to the Federal MBS should be sought.
- State mental health services need to offer psychotherapy and high-fidelity psychotherapeutic programmes if they are recognised as the treatment of choice for the presenting problem.
- Immediately overturn the mandate to look acute inpatient doors and set targets to reduce coercion of any kind. It is worth considering that every treatment authority be subject to the scrutiny of a magistrate within 24hours (as is the case in New South Wales).
- The existing power structures in State health services which see medicine as being the arbiters of everything need to be reviewed and the expertise of specific disciplines valued for the contribution which they can make. For nurses this means, senior mental health nurses are responsible for managing the ward environment in acute services (not junior doctors) and they should minimally be able to determine whether a door should be unlocked or not!

The evidence: -

Please allow me to table some documents which support my propositions:

Most of these papers can be found here, amongst many more:
https://working4recovery.com/mhn/

Please first consider the petition: Unlocking the potential of Mental Health Nurses by enabling access to the MBS

Credentialed Mental Health Nurses (MHNs) in Australia are highly skilled, and educated Mental Health Professionals. All have postgraduate qualifications and many are experts in the provision of psychotherapy including working with those with the most complex health issues (see: 1, 2, 3). Successive Governments have failed to recognise the expertise or potential of MHNs. What was formerly known as the Mental Health Nurse Incentive Programme (MHNIP) offered some of the most vulnerable in the community access to medium to long term psychotherapy (see: 4,5) despite this not being officially recognised (see: 6). The MHNIP was handed to the Primary Health Care Networks (PHNs) as part of their flexible funding pool and any reference to the therapeutic capability of MHNs removed from the guidance notes on 'Stepped Care' (see: 7). Some PHNs have prevented MHNs from continuing to provide care to those in need. MHNs have been locked out of providing care under the Medicare Benefit Scheme including COVID-19 funding for tele-health measures (see: 8, 9). MHNs should have full access to the MBS, and their therapeutic skills recognised by all funders of mental health services.

The following may be accessed via the hyperlink provided:

Lakeman, R. (2021). 'All animals are equal but some are more equal than others': A discussion of guild capture of psychotherapy and the cost, Psychotherapy and Counselling Today. 3(1), p.24-28

Lakeman, R. (2021). Why a billion dollars won't buy Australia improved mental health, Hospital & Healthcare, Friday 16th July, https://www.hospitalhealth.com.au/content/aged-allied-health/article/why-a-billion-dollars-won-t-buy-australia-improved-mental-health-1152920572

Lakeman, R. (2021). Mental Health Nurses are still not 'all in this together', Hospital & Healthcare, Thursday 20th May, http://hospitalhealth.com.au/content/nursing/article/mental-health-nurses-are-still-not-all-in-this-together--498623979#ixzz6vSd1CB9X.

Gill, N. S., Parker, S., Amos, A., Lakeman, R., Emeleus, M., Brophy, L., & Kisely, S. (2021). Opening the doors: Critically examining the locked wards policy for public mental health inpatient units in Queensland Australia. Australian & New Zealand Journal of Psychiatry, 55(9), p. 844-848. 00048674211025619. https://doi.org/10.1177/00048674211025619

Lakeman, R. (2021). Psychology belongs to everyone, but what about psychotherapy? A discussion of the undervaluing and professional capture of psychotherapy in Australia. *The Science of Psychotherapy Magazine*, Feb 2021, 41-77.

Hurley, J., & Lakeman, R. (2021). Making the case for clinical mental health nurses to break their silence on the healing they create: A critical discussion. International Journal of Mental Health Nursing, 30(2), 574-582. https://doi.org/10.1111/inm.12836

Lakeman, R. (2020). Sisyphus and the struggle for recognition of Mental Health Nursing (Feature Article), Summer News 2020, Year in Review. The Australian College of Mental Health Nurses, p.3-9, Online: https://testandcalc.com/Richard/resources/Sisyphus_and_Mental_Health_Nursing_2020.PDF

Hurley, J., Lakeman, R., Cashin, A., & Ryan, T. (2020). Mental health nurse psychotherapists are well situated to improve service shortfalls in Australia: findings from a qualitative study. Australasian Psychiatry, 28(4), 423–425. https://doi.org/10.1177/1039856220924326

Lakeman, R., Cashin, A., Hurley, J., & Ryan, T. (2020). The psychotherapeutic practice and potential of mental health nurses: an Australian survey. Australian Health Review, 44(6), 916-923, doi.org/10.1071/AH19208

Hurley, J., Lakeman, R., Cashin, A., & Ryan, T. (2020). The remarkable (Disappearing Act of the) mental health nurse psychotherapist. International journal of mental health nursing, 29(4), 547-750. Doi:10.1111/inm.12698

Lakeman, R. (2017). Mandated locked wards and mental health nursing. ACMHN News, Summer 2017, 18-19.

Thank you for your consideration. I have many other papers and stories to share and would be happy to do so.

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