SUBMISSION TO THE MENTAL HEALTH SELECT COMMITTEE OF THE QUEENSLAND PARLIAMENT

From Dr J D Thompson

To

The Committee Secretary

Mental Health Select Committee

Parliament House

George St

Brisbane

Qld 4000.

I am Jeffery David Thompson, a Medical Practitioner with General Registration and Specialist Registration as a Psychiatrist with the Medical Board of Australia. I was Medical Superintendent of Baillie Henderson Hospital in Toowoomba for over twenty-one and a half years and was acting Superintendent for four and a half years, as well as Clinical Director of the District Mental Health Service for five and a half years. I still do some part time work there.

I have been a psychiatrist for forty years and was a trainee for five years before that, mainly in the UK. My qualifications and experience are listed at the end.

I have a long interest in, and qualifications in, Health Policy.

I regard myself to be experienced in Adult Psychiatry, Forensic Psychiatry, Schizophrenia, Affective Disorders, Brain Damage, Intellectual Disability and Rehabilitation Psychiatry.

I support the RANZCP Qld Branch Submission

I agree with everything it says but I have chosen to make my own, based on my own experience and to highlight the areas I think most crucial.

Do we need more beds and an increase in funding?

As an advocate for my profession, and its patients, I shall say ‘Yes” but part of the question involves how we define Mental Health, where we place the limits of the concept and what results we can reasonably hope to gain from use of these resources.

I support the call for more money, more staff and more beds but am aware this might not be easy to provide.

More importantly we need to look at the best way we can direct our resources, for best results.

I think that the Productivity Commission Mental Health Report can help us to look at the economic issues.

I know that governments are frequently asked for money and that Covid has hit the economy and the health budget.

What is Mental Health?

I began practicing ‘Psychiatry’ as a young doctor and increasingly have found myself in ‘Mental Health’ This rightly recognised the role of nonmedical professionals. At the same time the scope of the field widened, and ‘mental health’ came to include all varieties of depression, human reactions to adversity and stressful life events. Can we fix these? The answer is often ‘No’ but sometimes we can help.

So, there are wider and narrower views of mental health.

Ultimately, the question is should we take a narrow (high intensity, low prevalence) or wide (includes low intensity, high prevalence) view of mental health, and how much should go to each.

Professor Gordon Parker of the University of NSW and Dr Allan Francis Chairman of The DSM IV of the American Psychiatric Association have warned against over medicalising human adversity.

On the other hand, some say that mental health resources should be used to prevent self-harm and to reduce mental distress

Diagnosis is important. Psychiatric disorders are classified in two widely accepted systems

The International Classification of diseases from the World Health Organisation.

The Diagnostic and Statistical Manual of the American Psychiatric Association.

A listing in either of these does not necessarily imply that the condition is a treatable disease.

In previous decades mental health was seen as being mainly about those with major mental disorders, including organic conditions and was somewhat dismissive of those with “Personality Disorders” and “Addiction”. Some of these were labelled “Not for Service” and there was a backlash against this with a demand for more services for these supported by Hickie and others. We do need to provide for these, but this increases the cost, and these conditions are not easy to treat.

When I started in Psychiatry, Psychiatrists usually saw themselves organic medical model doctors or alternatively psychotherapists. The best reason for admission to hospital was seen as being major mental illness.

Mental Health can be widely or narrowly defined, the wider definition including distress, substance abuse and acting out behaviour. The narrower definition includes major mental illnesses, serious depression, and serious organic conditions. We should attempt to treat both groups, but treatment of those with major disorders should not be sacrificed to serve those with the more widely problems.

FORENSIC DEFINITIONS

Definitions of Insanity in the Criminal law are often narrower again. Many of these were written in the past to decide whether a person should suffer the death penalty.

In some jurisdictions Mc Naughten Rules have been used in which a person with a mental disorder may be excused conviction on the grounds that they did not know what they were doing or did not know that it was wrong. (Cognitive Defence)

In Queensland under the Criminal Code (1900), the above things also apply but in addition the accused can also be acquitted on the grounds that they cannot control their actions. (Volitional defence) (s27). Voluntary intoxication cannot be the cause. (s28)

Because the rules are somewhat narrow, some people who might be regarded as mentally abnormal, might not be seen as being insane in the criminal law. They might want treatment but might not fit well into a ward with people with major mental illnesses.

They might be seen under wider definitions to be mentally ill but the person might be convicted under the criminal law.

The law must be tempered with mercy, but the use of psychiatric detention cannot necessarily always substitute for punishment. In passing I think that the future of psychiatric defences might be the recognition that insanity and criminality are not entirely separate and the greater use of partial defences. I think that the RANZCP proposed complex disorders unit might fit in with this.

Some complexities

50 years ago, there was a dispute as to the nature of depression, with the Roth (Newcastle UK) view being that it consisted of two types endogenous, which was seen as being more serious and more organic and the other reactive or neurotic. (Narrow view)

The Lewis (Maudsley) view did not think the two types were fundamentally different but were on a spectrum. (Wider view)

The Roth view was very influential in Australia in previous eras despite Lewis being Australian, but in recent decades the Lewis view has gained in acceptance but taking a wider view of the meaning of mental health, and it requires the treatment of a wider group of people, many of whom are difficult people who are hard to treat.

While this was originally about depression, now we are largely talking about the wider and narrower ways of looking at mental health problems.

Suicide and self-harm

Suicide is sometimes the result of serious treatable depression and this needs to be treated thoroughly.

All self-harm attempts need to be taken seriously, but some-times it is difficult to tell whether the individual really attempted to cause their own death, but seemingly less serious attempts can be followed by a fatal one.

Suicide is sometimes related to substance abuse and the more severe forms of addiction including to stimulant drugs appear to be more dangerous.

Suicide appears to be more common in some indigenous communities.

Suicide is sometimes 'epidemic' as one suicide may trigger off others in relatives, friends and other community members.

Therefore, after a suicide it is good practice to give extra attention to vulnerable close associates of the victim, but this can be difficult in practice.

I think that in two cases suicides (in one case a murder suicide) occurred in a seriously mentally ill person following an interaction with a less seriously ill person both interactions occurring in an acute mental health unit.

I propose increasing the number of mental health staff to see distressed people in Emergency Departments without pressure of time and also providing case management to those remaining in the community. These teams would be placed in secondary level general hospitals which had acute mental health units.

Disease and Disability

Disease and disability are two sides of the same coin. Both the DSM and the ICD use the term "Disorder" preferentially, perhaps to avoid making the distinction. There is a belief that diseases are a matter for health services and disabilities are a problem for someone else such as the NDIS or Social Services. This misunderstands the issue. Intellectual disability can be seen as a Psychiatric issue. There has been a tendency to try to say that disabilities are not part of psychiatry, but this is wrong.

While I support increased funding for disability, as someone who is now in the older age group, I do not feel that the aged should be left behind. The NDIS has taken money away from mental health

I support the RANZCP proposal to establish a state-wide intellectual and developmental disability service (including Autism) within the Queensland Health.

Positive and Negative Features

Neurological Diseases and Major Psychiatric Diseases have Positive and Negative features. According to J Hughlings Jackson, the Negative features are the core features resulting from a deficiency, while the Positive features are merely the result of compensatory overactivity of parallel systems.

Often what we call a disease is a positive feature and disability is a negative feature.

It is generally easier to treat the positive rather than the negative. In Schizophrenia the positive features include hallucinations, delusions and disordered thinking while the negative features include poverty of thinking and social withdrawal.

Rehabilitation and Recovery

John Wing described Rehabilitation as having two aspects caring and enabling. In the past caring was seen as more important but the focus has turned to enabling or empowering.

The recovery movement encourages a positive attitude. I support the RANZCP position on this but note that there is a risk in the recovery model of downplaying the seriousness of serious mental disorders.

Indigenous issues

Growing up in Ipswich, I saw very few aboriginal people, as they had been removed to the reserves. Now many live in larger towns although many still live in the communities. In the last few decades many were sent to our hospital. Not all came from our own catchment areas, and many were a long way from home. I remember one Torres Straits islander 20 years ago 2,000 km from home who arrived on a cold foggy Toowoomba day wearing shorts and a tee-shirt who asked staff members “Will the sun come today?”

It is inappropriate to send people such long distances and while not all Hospital and Health Services can provide all services adequate Tertiary service need to be provided more widely

Transferred indigenous people were often sent with a diagnosis of Schizophrenia but it became clear that many arrived with a mixed picture. Substance abuse is often involved.

It is unclear what proportion have Foetal Alcohol Syndrome. It is a difficult issue because while community leaders see it a curse given by the settler population; it carries the implication that the mother may carry some of the responsibility. It is of course present in the wider population It is difficult to treat.

It is probably a good use of resources to expand the number of mental health workers in the indigenous communities and those living in the general community.

Community versus Inpatient

Community treatment for most mental disorders is generally better than inpatient treatment but is usually more expensive if done well. There are still some who need longer term in-patient care.

Clinical Model versus Sociological Model

Social work is important. Some social workers become good therapists. But it is ultimately different to the health professions. Their aims are valid, but somewhat expensive, and I feel should come from a social welfare budget, not a health one. These agendas need to be seen as separate.

However, as Marmot has pointed out the social determinants of health are important, as seen in the gap between the general Australian population and aborigines and the problems facing minority populations with respect to Covid.

Aggression

The MacArthur Violence Risk Assessment study (2008) purported to show that that mentally ill people are not more violent than others. This has been disputed by Fuller Torrey and Paul Mullen. Certainly, substance abuse, especially with stimulant drugs, can lead to violence.

Health and Emergency workers are sometimes targeted, but so are families. In 1989 following concerns raised by nurses I advocated for the building of a Secure Unit at Baillie Henderson Hospital. This gained political support and the Unit opened in 1992. It is still needed in my view.

There is a plan to close it and transfer resources to build a unit at the Gold Coast, but both are needed.

Previously, more dangerous patients had been sent to Wolston Park, but it became harder to transfer patients there.

Forty or fifty years ago many psychiatric wards were unlocked. But people then said, “Do these people really need to be in Hospital?” So many open wards were closed worldwide but it was felt that secure beds were needed.

About a decade ago there was a ‘riot’ which was an attempted breakout from the BHH secure unit, partly because of attempts to obtain illicit drugs.

There is a great deal of pressure to push personality disordered people and drug abusers into general psychiatric wards. These people do not mix well with the seriously mentally ill.

I had attempted to warn administrators of the worsening security situation and in the event six nurses suffered physical or psychological damage, often career ending.

Secure units play an important role in taking dangerous people out of the acute wards.

I support the RANZCP proposal that a 25-bed unit be built for complex patients including mental disorders and substance abuse.

I support the RANZCP proposal for more medium secure beds and for high security beds in North Queensland.

Some general medical issues

Rural and Remote

Queensland is really Australia’s most decentralised state, the only one with large populations a long way from a capital city. This causes major problems in the provision of health services. And it is generally more expensive to provide health services at a distance.

Many of the more vulnerable people, including the indigenous are in these areas. It is inevitably more expensive to provide equivalent treatment at a distance.

However, planning in terms of Primary, Secondary and Tertiary Services can help.

Catchment area arrangements

In my experience Districts of 250,000 to 300,000 are the best for providing secondary level services including a District General hospital. The reason for this is that a district of this size can provide all the secondary services, but smaller districts cannot provide a full range of secondary services and will then look to other districts for assistance.

Tertiary services are also needed. Their purpose is to provide services to the populations of secondary districts

Management

When I started, the Tripartite model was in place and from my perspective this worked better. This was replaced by single point accountability. This reduced the power of the clinicians and may have been intended to do so.

I have worked with some good managers, and the best had extensive experience in hospital systems. I am firmly opposed to the generic management model in which a person with a couple of years of management training can manage anything from a general hospital to General Motors.

Hopper and Hopper in *The Puritan Gift* have been very critical of this kind of management. Such managers are often most motivated by the bottom line and in health the credit side of the ledger is improved health.

We are seeing the failure of this in the Covid pandemic whereby 'just in time' supply chains models have failed in many fields and having just enough beds has been shown to only work in the good times.

I do agree with the 85% rule for hospital bed occupancy. I note that the 85% idea appears to have relevance to a number of areas of human activity, in which attempts to constrain costs might lead to difficulties in harder times. Of course, if we modify Parkinson's law, we might find out that if we make extra beds they will rapidly fill, so there need to be mechanisms to reduce unnecessary admissions.

Acute versus Chronic

Our hospital system is set up to deal mainly with mainly acute (short term) issue while most of Medicine is chronic (long term) or acute on chronic. The inpatient hospital system must prioritise the acute and the acute-on-chronic, but the chronic population still needs to be provided for.

Primary care

Much of the work in mental health has always been done in primary care and always will be. I support the RANZCP proposals or a consultation liaison model with respect to this

SUMMARY

The needs of those with wider forms of mental disorder should be addressed but not by taking away from the seriously mentally ill.

We need an increased number of staff seeing people in distress including in Emergency departments trying to provide non-admission alternatives and case managing them in

the communities. Selected and trained young nurses might be ideal. Such teams should generally be attached to hospitals with acute mental health units.

I support the RANZCP proposals generally, particularly —

- **25 bed unit for complex disorders**
- **State-wide developmental disability service**
- **Mother and baby unit**
- **More secure beds**

Dr J D Thompson

MB BS (Qld) M H Pol (Syd) FRCPsych FRSM (UK) Int FAPA (US) FRANZCP

Medical degree from the University of Queensland 1973.

Master's degree in health policy from the Public Health School of the Faculty of Medicine and Health of the University of Sydney (2015)

Fellow of the Royal College of Psychiatrists (London) 2001 (Member since 1981, exams in 1980)

Fellow of the Royal Society of Medicine (London) 1992

International Fellow of the American Psychiatric Association 2015 (Member since 2002)

Fellow of the Royal Australian and New Zealand College of Psychiatrists 1998 (accredited in Forensic Psychiatry, Addiction and Adult Psychiatry.)

Other Affiliations

Australian Medical Association

Toowoomba and Darling Downs Local Medical Association (Board member for many years and I have been Secretary and President)

Together Union

Rotary Club of Toowoomba

Brief C V

Worked at Royal Brisbane Hospital 1973 – 1976

1977 – 19 82 Some GP locums but mostly worked in psychiatry in the UK, mainly at St Bernard's Hospital, Southall

Since 1982 in Toowoomba mainly at Baillie Henderson Hospital.

3 February 2022

[redacted]

[redacted]

[redacted]
TEL [redacted]
MOB [redacted]
[redacted]