

news

 the Australian College
of Mental Health Nurses Inc.

Year in Review

We reflect on the year that pushed human kind beyond what we thought possible, physically and mentally, and take a deep-dive into the strengths and challenges facing the Mental Health Nursing profession as we head into 2021.

WWW.ACMHN.ORG | INTEGRATED MENTAL HEALTH CARE

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://www.flipsnack.com/acmhn/acmhn-yearinreview.html>

Sisyphus and the struggle for recognition of Mental Health Nursing

DR RICHARD LAKEMAN

This time in 2019 when large swathes of Australia was burning, I for one could not imagine that things could get much worse.

Just as the rains arrived, green shoots were sprouting and many people were attempting to rebuild their lives or mourn their losses, we found ourselves in a global pandemic on a scale no one has experienced in living memory.

For all the suffering we have endured thus far in 2020, I am grateful to be in a relatively sparsely populated island nation which can and did rapidly close its borders, have a public health system that has been responsive, and be part of a largely compliant population who does as they are told (or at least doesn't trash the place when their civil liberties are infringed upon).

So, at the time of writing this, we in our Island bubble are enjoying freedoms which are well beyond the reach of those in many countries. It is also clear that there are winners and losers in COVID with a massive redistribution of wealth (enjoy your personal trip to Mars, Jeff Bezos) and good on you if you are now on the cusp of retirement by investing in some otherwise dodgy pharmaceutical companies when the price was right.

Sadly, I only have my craft which is mental health nursing and psychotherapy, so this is what I want to comment on (and likely reinforce my reputation as a curmudgeon). In my appraisal mental health nursing (unlike almost all other health professions or specialties) is a net loser since the COVID-19 pandemic and faces significant challenges if it is to survive at all.

These challenges are entwined and are primarily around recognition of the psychotherapeutic capabilities of MHNs, the instrumental relationship of nursing to medicine and the



The story of Sisyphus

Albert Camus used the myth of Sisyphus to illustrate his philosophy of the absurd. Having scorned the Gods, Sisyphus was destined to roll or carry a rock up-hill each day, and then watch it roll back down, repeating this struggle each day for eternity.

The original 'ground hog day' (the movie) but with the absurdity of being unable to alter his destiny. This myth captures the ongoing struggle that mental health nurses have in realising any meaningful recognition of the skills they possess or even that they exist at all.

As someone who has invested quite a lot of energy with colleagues, researching, writing and presenting about the skills and potential of Mental Health Nurses (MHNs), whilst also calling out our collective failures to make a difference, I feel considerable empathy for this absurd hero.

challenges of working in a hierarchical and highly coercive care system, and lastly how entrenched managerialism and the trend towards centralised and protocol driven practices has impacted on professional autonomy.

The opportunity of a pandemic to mobilise mental health nursing

With the apparent and anticipated increased and ongoing need for access to mental health care in primary care settings, the time was right to have mental health nurses recognised as being able to provide the lowest clinical tier of stepped care, that is, to provide focused psychological strategies via the Medicare Benefit Scheme (MBS), 'Better Access'.

This is important because eligibility to access these item numbers confers eligibility for other item numbers such as those to provide psychotherapy for people with eating disorders. Eligibility is the proxy accreditation to provide subsidised psychotherapeutic services under the MBS. Indeed, when it comes to existential issues facing MHNs this is the big one.

Like Sisyphus, my colleagues and I had been pushing this agenda uphill for a long time. Prior to COVID-19, 'Better Access' had become inaccessible to large groups of people primarily because of the fees charged by eligible providers.

Psychologist, Dr Carr-Gregg was reported as commenting in 2019 when rebates for clinical psychologists were \$124.50 (1) that "It is not a matter that psychologists are charging too much, the rebates are too low. They're pathetic."

The average charge being quoted was \$260 per hour (Sapwell, 2019). It is really not surprising that psychologists in the last five years have come to far out-number other professions who work in mental health (enrolled as well as registered, credentialed, eligible or ineligible) by over 4000.

The good news in some ways is that allied health who can make far more lucrative a living in subsidised quasi-private practice may abandon community mental health where they have usurped roles previously held by MHNs, just leaving the coercive and ethically problematic work to nurses in the community and inpatient units.

My advice from the Honourable Greg Hunt's Office when I raised the matter of affordability and lack of access to 'Better Access' by MHNs was that MBS item numbers were under review by a committee of clinicians (no surprise what kinds of clinicians) and no changes would be made until the review handed down its report and besides, MHNs could access other item numbers like chronic disease item numbers should they wish (although what these have got to do with providing psychotherapy is anyone's guess).

With the pandemic and associated panic about mental health escalating, my colleagues and I sought to take the issue to a much wider audience and readership (Hurley et al., 2020a; Lakeman et al., 2020) as well as to our own journal (Hurley et al., 2020b) and through editorials (Lakeman, 2020). The survey of 153 MHNs interested in psychotherapy we conducted in 1999 found that 95% had practiced for over 10 years (M=24 years), 29% practiced in regional areas and 14% remote; 91% had formal post-graduate qualifications specific to psychotherapy; 96% reported competency working with suicidal people and 50% with other at risk groups;

There was a broad range of expertise across a range of psychotherapy with an estimated average of 663 hours of training in people's chosen area of interest. Just as regulatory bodies were considering how to accelerate training of psychologists and allied health to meet anticipated demand for service we concluded that in MHNs we had a highly experienced group of professionals who could rapidly be mobilised to improve consumer outcomes across the continuum of stepped care and in response to increasing need during COVID-19. Indeed we even sent a change.org petition with over 3100 signatures (<http://chnng.it/HrXDhcmQXB>) to the Federal Health Minister which to date remains un-answered. The Federal Government then announced a doubling of 'Better Access' sessions across the country as well as extending the 'Better Access' telehealth provisions. Here is an excerpt from my response to being ignored and to this issue:

.... Doubling the number of sessions for psychologists or even increasing their subsidy does not address the problem that highly competent psychotherapists with no history of avarice (unlike some guilds) are entirely excluded from providing a subsidised service at a time when apparently there are huge waiting lists for services and massive gap fees being demanded for the provision of psychological strategies of low sophistication. I further wish to inform the Minister that mental health nurses are the oldest regulated health profession next to medicine in Australia and the potential demise of this honourable specialty has been well documented and will likely be linked to the poor treatment delivered to it by the current Australian Government...Please address this inequitable, anticompetitive and discriminatory policy at the earliest opportunity and enable mental health nurses to access 'Better Access'.

It is probably not lost on anyone (except perhaps politicians) that this very expensive virtue signalling of doubling 'Better Access' has not increased capacity, has not and will not improve accessibility and can only increase waiting times for subsidised services by months.

Inquiry after inquiry and the instrumental nature of nursing

Pre-pandemic I think it was fairly widely recognised that Australia's mental health system was a mess (2). Rosenberg and Hickie (2018) noted there were 36 statutory inquiries within 6 years and pretty much none of the recommendations were ever implemented. So, 2020 has brought more inquiries with the latest massive tome by the Productivity Commission being handed down. It was fitting that this was launched by the prime minister at Orygen where an additional \$100 million of expenditure was announced which will likely appease the recipients and public as like most inquiries related to the mental health field any recommendations are unlikely to be implemented. Certainly, none that will have a positive impact on mental health nurses. This report is fairly voluminous (see <https://www.pc.gov.au/inquiries/completed/mental-health/report>) mentioning nurses some 187 times and MHNs 64 times. However, no academic papers on their capabilities were cited and the primary recommendations to make more mental health nurses to address a shortage in community mental health was to me quite ill-informed by the report itself. Now I haven't had time (or the inclination) to read all 1617 pages (so don't want to pass judgment on the whole package). However, most people only go to the recommendations and executive summary anyway (and I just looked to every time nurse was mentioned). The report refers to the "missing middle" a massively large missing middle who can't get what they need from State services or Better Access. Child health nurses get more credit for potentially being able to make a difference than MHNs (and it is not an unreasonable argument).

However, what gaps is training direct entry mental health nurses going to fill (recommended) and why? That the report recommended that all undergraduate nursing training programmes have at least one standalone mental health unit speaks volumes regarding the perception of nursing training and by association, mental health nursing. The projected gaps in community mental health are just as likely to be due to allied health clinicians going to more rewarding pastures as they are to the struggle to keep importing mental health nurses. Many such nurses e.g. Helen Nicoll (slide used with permission) can't practice within their advanced scope of nursing practice in this country which is absurd!

Whilst the arguments for an entirely different model of mental health in primary care where mental health nurses are involved in a multidisciplinary team is promoted, the mechanisms of how to fund such a system are entirely ignored and unattainable to mental health nurses. We do not need more 'blue sky' thinking

about multidisciplinary hubs until MHNs like Helen can be free to do what they are exceptionally well trained to do and the mechanism for that is parity with others and at least being able to access Better Access.

Peplau, considered by many to be the mother of modern psychiatric nursing was unwavering in her assertion that what set psychiatric nurses apart from others was their psychotherapeutic skills, and of all their multifaceted roles, the counselling role was the most important (Peplau, 1994; Peplau, 1989). I would concur with Peplau and have argued that what characterises and distinguishes MHNs is not only the capacity to be with people experiencing extreme states, but to judiciously adapt psychotherapeutic approaches so that every moment of contact has the potential to be a therapeutic moment. Of course, not every graduate nurse is equipped with skills in specific psychotherapy such as Helen or John (see below) or the inclination to work with people in the therapeutic hour. However, all mental health nurse's ought to be able to coach people in emotional regulation, and distress tolerance skills, or engage people in basic positive psychology or cognitive behavioural therapy. That many don't know how to, that credentialing doesn't make these skills absolutely explicit, that mental health nurses are not seen to be doing this and are often presumed to have no psychotherapeutic skills at all is a perhaps the greatest impediment to our survival as a speciality.

How we have arrived at this position is in part because of the instrumental relationship with medicine. We follow "doctor's orders" and it's very difficult not to (whatever our thoughts on whether it is helpful or damaging). We work in systems that have become highly hierarchical and nurses in terms of any real authority are well down the hierarchy (and further education or qualifications makes no difference to this social positioning). One either believes in the prevailing model of treatment or one can't work as a nurse in the system without having to experience considerable moral distress (Lakeman, 2013). Very few authors have ever talked about the problem of the instrumental relationship with medicine that nurses have. You will find a rich field in medical sociology (people love studying us) but it is an issue that few nurses ever address themselves. However, when I chat to my colleagues this is almost always the issue of discussion. I speak to very talented people with an absurdly high level of education and they are so very constrained in their roles because they are playing a 'doctor nurse game' that was discussed over 50 years ago. Nurses rarely claim any credit for anything they do. No one ever gets better because of nursing it is always medicine or the medicines. This is so very different from the grand narrative of any other professional group. This was of course also fine when we were all in this together. However, now we are clearly not (Lakeman, 2020).

This problem is particularly acute in inpatient settings where nurses no longer have much say at all about what goes on in their workplace. Nurses working in mental health and MHNs are often quite profoundly disempowered and cannot even



"It is probably not lost on anyone (except perhaps politicians) that this very expensive virtue signalling of doubling 'Better Access' has not increased capacity, has not and will not improve accessibility and can only increase waiting times for subsidise services by months."

– DR RICHARD LAKEMAN

make a decision about whether or not to unlock a door in some States such as Queensland (Lakeman, 2017) and this is despite near universal condemnation from all disciplines as well as legislative changes such as a new Human Rights Act. Australian's State mental health system is one of the most coercive in the world with tens-of-thousands of people being brought to emergency departments every year under duress by police, and then over half of all nights in hospital are under coercion via a Mental Health Act. In this context, nurses primarily are supposed to facilitate personal recovery, enact trauma informed care or whatever phrase captures the zeitgeist of the time (which is usually diametrically opposed to whatever current coercive practice is). However, they by and large have no control over coercive pathways into care, or indeed people's treatment trajectory. A compliant nursing workforce is needed to coercively deliver medical treatments, contain people against their expressed will, and as a body be convenient scapegoats for failings in the system.

Managerialism, surveillance and what your job is really about

A further constraint on the agency of MHNs, but also of most

professional groups in State Mental Health Services, is the pervasive reach of managerialism (Germov, 2005). Whilst, in the 1990s this may have been quite benign, and we rapidly got used to talking about 'unit managers' and then an escalating number of non-clinically involved managers in local hierarchies. It even meant career advancement for nurses who would rapidly hit a glass ceiling as consultants or specialists, or sometimes just weren't that good at patient care. Today managerialism is taken for granted, it is after all self-justifying and self-sustaining. Clinicians need to gather vast quantities of data and report to management, because of course how can people manage without big data, and every problem needs to be managed. However, a dominant trend in our monolithic State Health Systems is the centralisation of decision making and quite overtly trying to shape the behaviour of clinicians through adherence to protocols and computer systems which dictate what clinicians need to do as well as document at every step in a 'care episode'.

Before the pandemic I suggested that mental health professionals are getting too much screen time and these protocol systems of care was at best stifling creativity, innovation and helpful responses to people (Lakeman, 2019). Giving the computer / organisation what it wants has in many



Helen is a mental nurse with 20 years' experience, working in drug and alcohol units, case management and first episode psychosis, where she developed a new service, policies and structures as well as being the team manager of the Manchester Early Intervention in Psychosis team for 4 years. As well as a MH nursing qualification, Helen has a degree in Cognitive Behavioural Therapy (CBT) and psychosis and post graduate qualification in CBT, where she was accredited to the BABCP in the UK and she was a high intensity CBT therapist delivering trauma focus therapy in the specialist military service.

She offers trauma focused supervision and has developed a range of resources in trauma interventions and can't deliver exposure therapy as **Helen's clients cannot access a subsidy through 'Better Access'.**



John is a Professor of mental health, a credentialed mental health nurse and has worked in the field of mental health for nearly forty years. He trained and qualified as an experiential psychotherapist in the 1980s and then in problem solving counselling in the 1990s. He took these psychological therapy skills and knowledge and used them in daily clinical practice for 16 years, first as a senior clinician and then to lead crisis and home treatment services in Australia and overseas. He worked with those with the most complex mental health needs, integrating experiential psychology and psychiatric nursing capability to best meet the high level needs of consumers.

However, John's clients cannot access a subsidy through 'Better Access'.

settings become the work, measuring outcomes has become more important than the outcomes, and completing the required paperwork the most substantial part of many people's working day. This combined with risk averse and risk obsessed bureaucracies might account for why nurses don't even have the discretion to open a door in some places, are effectively gagged from talking about what they do, cannot be remotely critical of their services, let alone implement genuinely recovery focused nursing models which might at least ease the patients journey through an otherwise pathogenic system.

So where to from here?

Like Sisyphus, many of us will keep struggling and some might even make it to the top of the hill at some time and not inevitably have to start the struggle again the next day.

There are many quite remarkable MHNs out there who are doing fantastic work against all odds. MHNs and nurses who work in mental health in Australia have also risen to the challenge of maintaining an already stretched acute mental health system at a time of unprecedented challenge brought by COVID and advocated for the continuation of treatment to those most in need (Lakeman & Crighton, 2020).

That there have not been catastrophic system failures is largely due to compassionate and committed MHNs who practice their craft in often psycho-noxious environments which they have little power to change. They know they can and do make a difference to the people whom they meet and that every moment is a therapeutic moment.

Our collective challenge, is to have this kind of skilful activity recognised for what it is, attenuate the necessary instrumental relationship with medicine by respectful dialogue with our medical colleagues about issues that impact on both nurses and patients, and collectively work towards returning to person centred care rather than palliating a paranoid and anxious system by producing endless paperwork.

References

References for this article can be found on page 29. The following footnotes are also specified by Dr Lakeman when reading this article:

(1) *These have since been raised but different subsidies are paid depending on one's professional group for exactly the same interventions with no demonstrated difference in outcomes. This is after 50 years of "equal pay for equal work" was celebrated in 2019.*

(2) *World Health Organisation's Mental Health Atlas. Amongst other things you can compare countries on a range of indices. You will likely find that we are resource rich but our prevalence of mental health problems are some of the highest in the world. https://www.who.int/mental_health/evidence/atlas/profiles-2017/en/*



Richard Lakeman

Dr Richard Lakeman is a credentialed mental health nurse, psychotherapist and a member of the college.

He presently works for Southern Cross University as a Senior Lecturer and coordinates the SCU-Online post graduate mental health programmes. He completed his doctorate with James Cook University (Australia) whilst working at Dublin City University (Ireland) from 2007-2011 and his recent post has been as a clinical nurse consultant working in an Emergency Department and as an Adolescent Mental Health Nurse Navigator.

He has previously worked as a team leader for a homelessness outreach team, clinical nurse consultant on a community team and a mobile intensive treatment team, and for a year was a researcher/project officer.

Whilst living in Townsville, Richard completed a post graduate diploma in psychotherapy with the University of Queensland and has subsequently completed a masters in psychotherapy and done further training in EMDR.

Prior to this, he worked as a senior lecturer at the Eastern Institute of Technology in Hawke's Bay, New Zealand and completed undergraduate and an honors degrees at Massey University.

REFERENCES

The resources below are references for the article by Dr Richard Lakeman titled 'Sisyphus and the struggle for recognition of Mental Health Nursing'

REFERENCES

- Germov, J. (2005). Managerialism in the Australian public health sector: towards the hyper-rationalisation of professional bureaucracies. *Sociology of Health & Illness*, 27(6), 738-758. <https://doi.org/https://doi.org/10.1111/j.1467-9566.2005.00472.x>
- Hurley, J., Lakeman, R., Cashin, A., & Ryan, T. (2020a). 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>
- Hurley, J., Lakeman, R., Cashin, A., & Ryan, T. (2020b). The remarkable (Disappearing Act of the) mental health nurse psychotherapist. *International Journal of Mental Health Nursing*, Early View. <https://doi.org/10.1111/inm.12698>
- Lakeman, R. (2013). Talking science and wishing for miracles: understanding cultures of mental health practice. *International Journal of Mental Health Nursing*, 22(2), 106-115.
- Lakeman, R. (2017). Mandated locked wards and mental health nursing. *ACMHN News*, Summer, 18-19. https://testandcalc.com/Richard/resources/ACMHN_Summer_News_2017_Mandated_Locked_Wards.pdf
- Lakeman, R. (2019, Nov 29). Are health professionals getting too much screen time? Computer-driven care and its impacts on mental health practice. *J Psychiatr Ment Health Nurs*. <https://doi.org/10.1111/jpm.12579>
- Lakeman, R. (2020). Mental health nurses locked out while Australia locks down. *Journal of Psychiatric and Mental Health Nursing*, n/a(n/a). <https://doi.org/10.1111/jpm.12638>
- Lakeman, R., Cashin, A., Hurley, J., & Ryan, T. (2020). The psychotherapeutic practice and potential of mental health nurses: an Australian survey. *Australian Health Review*, -. <https://doi.org/https://doi.org/10.1071/AH19208>
- Lakeman, R., & Crighton, J. (2020). The Impact of Social Distancing on People with Borderline Personality Disorder: The Views of Dialectical Behavioural Therapists. *Issues in Mental Health Nursing*, 1-7. <https://doi.org/10.1080/01612840.2020.1817208>
- Peplau, H. (1994). Psychiatric mental health nursing: challenge and change. *Journal of Psychiatric and Mental Health Nursing*, 1(1), 3-7.
- Peplau, H. E. (1989). Psychiatric Nursing: Role of Nurses and Psychiatric Nurses. In A. W. O'Toole & S. R. Welt (Eds.), *Interpersonal Theory in Nursing Practice* (pp. 80-133). Springer.
- Rosenberg, S., & Hickie, I. (2018). If we're to have another inquiry into mental health, it should look at why the others have been ignored. *The Conversation*, Oct 30. <https://theconversation.com/if-were-to-have-another-inquiry-into-mental-health-it-should-look-at-why-the-others-have-been-ignored-105728>
- Sapwell, G. (2019, 29 July). Need a therapist but can't afford one? This Byron teen is hoping to change that. *ABC North Coast*. <https://www.abc.net.au/news/2019-07-29/teen-pushes-for-free-therapy-for-people-under-25/11348074>

Visit: <https://working4recovery.com/MHN/>