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AMA TASMANIA
ABN 11 009 484 931

AMA Submission to the Legislative Council Government Administration Committee 'A' Sub Committee Inquiry into Health Services in Tasmania
Psychiatric Services/Mental Health
15th August 2017

Preamble

The Australian Medical Association, Tasmania, hereafter referred to as the AMA, provides this submission to the inquiry with respect primarily to Psychiatric Services delivered at the Royal Hobart Hospital (RHH) in Hobart, as service provision at that hospital has significantly decreased over recent years, particularly in the context of the RHH Redevelopment. Losses have included 10 acute psychiatric beds, and substantial amounts of floor space and associated amenity, especially with respect to access to outdoor areas, so critical for the care of those struggling with severe mental illness. An on-site, dedicated-to-acute-inpatients-only Clinical Director, a full-time Consultant Psychiatrist and full-time training Psychiatric Registrar for the Psychiatric Intensive Care Unit, and a second Consultation-Liaison Consultant Psychiatrist, are all positions that have been abolished. As a result, the ability of Psychiatric Services to respond to demand across the RHH has been substantially reduced, which has directly impacted upon patient care and patient outcomes. This submission will focus on the reduction of acute psychiatric beds at the RHH.

Brief history

Until the late 1990's, at the RHH, there were two acute mental health wards, 5A and 6A, with 35 beds between them. This enabled the management of acutely mentally ill patients who were not at high risk. Patients who were at higher risk could be treated in a number of wards at the Royal Derwent Hospital (RDH) in New Norfolk, notably Ward 7. It is understood that at least 12 beds at the RDH were acute in function, making a total of 47 acute psychiatric beds for Southern Tasmania.

Around the turn of the century, both 5A and 6A were decommissioned as acute psychiatric wards, and two new wards were opened at the RHH. The Department of Psychological Medicine, later to be re-named the Department of Psychiatry (DoP), was a 34 bed open ward. This ward was initially to be on the third floor, but it was eventually moved to the ground floor (Liverpool St ground floor level), both for safety reasons, and for easier integration with internal green spaces. The Psychiatric Intensive Care Unit (PICU) was a 10 bed secure unit, also on the ground floor (Campbell St level). It was a relatively spacious unit with several dining, socialising and recreational areas, and an outdoor courtyard. Only eight of the 10 beds were ever commissioned (except under exceptional circumstances). It was approximately 750 square metres in size. When PICU was being designed, however, many senior psychiatric staff wrote a letter of complaint to the then Minister of Health, the Honourable Judy Jackson, regarding the proposed situation of the unit, believing that it would be very claustrophobic, as the unit faced Campbell St, and, for privacy, a high courtyard wall was necessary. Both wards were in B Block.

The RDH shut in 2001, and acute at risk patients could no longer be managed there. The RDH – at its peak with over 900 beds – was replaced by the new Millbrook Rise Centre. It houses 27 beds, none of which are acute. It is used to manage patients with treatment-resistant severe mental illness requiring medium to long-term hospital admissions. It is not medically staffed outside of

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business hours. All acutely ill patients at risk from 2000 were required to be managed in the new PICU, except for a very small number of highly aggressive patients who were transferred to the Secure Mental Health Unit at Risdon Vale, after it was completed in 2006.

For many years, psychiatric services at the RHH were managed internally, and funding for those services was preserved. Approximately six years ago, the management of both the DoP and PICU was taken over by Mental Health Services (MHS), based at St Johns Park in New Town. It is only since management of psychiatric services at the RHH has been outsourced that resources – particularly the acute beds and the medical staff - have been lost to the RHH.

RHH Redevelopment and the need to remove B Block

With the RHH Redevelopment came the need to demolish B Block, which meant that alternative arrangements had to be found for acutely mentally ill patients requiring acute psychiatric beds; these patients would need to be "decanted" elsewhere. MHS management, working in relative isolation from senior clinical staff, devised a number of solutions. The centrepiece solution involved a six-bed "PAPU", or psychiatric assessment and planning unit, at the RHH, with the majority of patients to be transferred to and treated in an acute mental health unit in Lenah Valley. The PAPU was to have admitted and assessed all new patients, of all ages and with all conditions, as well as functioned as a high dependency unit for the most acutely unwell and agitated psychotic patients. The proposed suburban acute mental health unit involved taking over the current Older Persons Mental Health Unit, the Roy Fagan Centre, and moving those patients elsewhere. The AMA deemed that both the PAPU and the plan to move acutely mentally ill patients to a suburban facility were unsafe and seriously deficient, and, with the local branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP), lobbied the State Government to abandon the proposal. This lobbying was successful, primarily because acutely mentally ill patients need to be managed – for multiple clinical and safety reasons – on the grounds of a general public hospital.

MHS then began looking at options for accommodation on the site of the RHH. At one point an "overbuild" was considered, so that the acute psychiatric beds in B Block would remain, while other removal and building work carried on, but this was deemed to be physically unsafe. MHS and the RHH Redevelopment team then decided to decant acutely mentally ill patients into a temporary demountable unit in the forecourt of the RHH, ultimately to be called "J Block", whilst other wards for acute mental health care were built in the new tower, to be known as "K Block".

MHS management staff reviewed three years of bed occupancy data, and determined that only 30 beds would be required in both the more temporary demountable unit, and in K Block, only 71% of the previous number of beds. The AMA believes that MHS management utilised data from a period of time that was not reflective of the needs of the population. The AMA – again with the RANZCP - lobbied the government for more beds, over a lengthy period of time. The argument used was that the bed number arrived at by MHS was manifestly too low, and that – using national datasets and local population numbers - a bare minimum 39 beds were required. The number 39 does not take into account Tasmania's low socioeconomic status and mental health-related difficulties, the increasing numbers of patients presenting with crystal amphetamine ("ice") related problems, or any future-proofing of any kind. The advice given to government by MHS management regarding necessary bed numbers the AMA believes was incorrect, but lobbying for more beds by the AMA and the RANZCP was generally dismissed as unnecessary by management. The number of acute psychiatric beds in J Block was only increased by two, to 32, and the number of acute psychiatric beds in K Block by three, to 33.

The new wards had been designed by architects in conjunction with MHS and a user group. The designs when seen by the AMA were noted to be seriously inadequate, and were of wards that the AMA believed were not fit for purpose.

Acute mental health units are optimally situated on the ground floor. This is for the obvious safety reason, but also importantly a ground floor location lends itself to easier and more cost-effective access to outdoor space. The units in J Block and K Block were to be on the second and third floors.

Contemporary design principles for acute mental health units also mandate that wards should be carefully designed, such that they are predominantly patient or client-centric, not staff centric, however all wards in the J and K Block designs are more old-fashioned in that respect. The most obvious example of this is the continuation of the use of large sheets of glass to separate staff from patients at nursing stations. In contemporary units, in all but the most acute areas, these areas are carefully designed so that this sort of patriarchal separation is minimised or eliminated. Research shows that these kinds of change improve patient outcomes (see Appendix C).

The shape and design of the socialising, dining and recreational areas in contemporary units is also very important. The design should be as domestic in feel as possible, and these areas are organised so that they are contiguous, maximising both the space, and the sense of space. The units as currently designed do not follow these principles, and have a claustrophobic feel to them. The J Block wards are particularly small, covering approximately 2200 square metres only. K Block will only be modestly larger. The recently demolished DoP and PICU was thought to have extended over about 4400 square metres, however, when the plans were sought via Freedom of Information policies, whilst the units were still in use, management stated that the plans had been lost (see Appendix A).

Contemporary units elsewhere in Australia also have outdoor areas. In the original plans, neither J Block nor K Block had any outdoor areas of any kind. After AMA, RANZCP and ANMF lobbying, however, small areas in these units were redesigned so that patients could have some sort of outdoor experience. The outdoor areas are however very modest in size, and, for safety reasons, are secured with a metal mesh. The effect is similar to a prison exercise yard.

A recommendation to the RHH Redevelopment Project Team to utilise mainland expertise in acute mental health unit design was ignored.

Bed block

When acute beds were available at the RDH in the 1990's, bed block at the RHH rarely occurred. In the early years of the 21st century, with 42 beds, bed block occurred occasionally. In August 2013, the first of the bed cuts – four - to psychiatry began, to make way for the Redevelopment. Internal green spaces became inaccessible. More beds were cut over the ensuing three years, so that by late 2016, with the move to the demountable unit in J Block, the original 42 beds had already been cut to 32. By this time, bed block had begun to occur repeatedly.

By December 31, 2015, the acute psychiatric bed number at the RHH was 33. A middle-aged man presented to the RHH that day, and was diagnosed with a first episode of clinical depression; a decision was made that he needed to be admitted to an acute psychiatric bed. No beds were

available, and he waited overnight in the Emergency Department (ED). The next morning he was re-assessed by the on-call Consultant Psychiatrist, and both the diagnosis and the need to admit were confirmed. However, the acute mental health unit was full, and the Consultant estimated that it might be up to 72 hours before a bed became available. As the ED is known to be a counter-therapeutic environment for patients struggling with severe mental illness, it was agreed that the patient could go home with his wife, to have a break from the environment of the ED, to have a shower, and to get some fresh clothes. He was due to return later the same day, to continue his wait in the ED until a bed became available. While his wife was in the shower, the man left the house, and hung himself. In a finding made late in 2016, referring to the deceased as "Mr. S", Coroner Cooper remarked that the death would most likely have been avoided had beds been available at the RHH (see Appendix B).

In July 2016, another male patient, younger, in his late twenties, presented to the ED for assistance. He was seen to have mental health-related issues and suicidal ideation. He was given a triage rating of three, meaning that he needed to be seen within 30 minutes by a medical officer. It is understood that all of the ED cubicles were full at the time, and an active decision was made for him to wait in the waiting room, as this was the safest space available at the time. The patient hung himself in the ED waiting room toilet. The Coroner is yet to make findings in this case, but it is understood that bed block may be implicated.

Bed block has been particularly severe throughout 2017. The 32 acute psychiatric beds are not only almost full, but there are almost always psychiatric patients requiring acute beds waiting in the Emergency Department (ED); these are designated, "admitted psychiatric patients". Official figures regarding these patients are not published, and are not available to the AMA, however, it is widely recognised that there are often four to six such patients waiting in the ED, and, on occasion, more, sometimes eight, and these patients might wait for up to 48 or 72 hours, or occasionally more, for a bed.

It should be noted that the ED is a particularly unhelpful environment for those suffering with mental illness (counter-therapeutic). It is small, noisy, and bed-based. Patients suffering with mental illness, however, are, most frequently, ambulant. They need early access to specialist treatment in both a safe and appropriate environment, with therapeutic space and spaces, including outdoor spaces, and with professional therapeutic input, and time.

Problems associated with bed block

1). Patients of all craft groups requiring admission to an acute hospital who are subject to bed block suffer with increased mortality rates – patients with severe mental illnesses are no exception, and at least one death has been directly related to bed block involving acute psychiatric beds. However, the situation is more complex, as bed block involving acute psychiatric beds affects the ED more broadly, with mentally ill patients occupying beds that are also required by medical and surgical patients.

2). Patients with mental illnesses also suffer increased morbidity when subject to bed block. They may avoid presenting themselves to hospital, they may become worse during extended waiting periods, they may not be appropriately assessed in the ED, they may not be admitted to hospital when admission is necessary, they may become unnecessarily subject to the Mental Health Act, or to episodes of seclusion, they may receive unnecessary sedative medication, they may not receive the appropriate medication, and they may have such adverse experiences that they avoid future necessary assessment and treatment. A number of patients have also left the waiting

room whilst mentally unwell, and some of these have been arrested, for crimes committed as a result of mental illness.

The Mental Health Act 2013 deserves particular mention. The Act states that patients treated in hospital under the Act must be in a hospital with the appropriate staff and facilities for the treatment and care of the patient, and the hospital should be the most appropriate place available to accommodate the patient. With patients under Mental Health Act orders being forced to stay in the ED for extended periods, the AMA contends that the facilities provided for care are not appropriate.

Verbal reports from inpatient staff clearly indicate that as workloads have increased, the inpatient unit has also become increasingly disorganised, and patients who are admitted to that unit are no longer always subject to a reasonable standard of care.

Finally, patients who are admitted to the inpatient unit are frequently discharged prematurely because of the need to admit more acutely unwell patients.

3). The workload for medical staff in the acute mental health unit has increased significantly, as medical staff are increasingly requested to provide assistance to admitted psychiatric patients in the ED, and because of the higher turnover of patients. Both junior and senior medical staff have found themselves under substantial pressure.

4). As a result of 3), the local body responsible for training psychiatric registrars, the Branch Training Committee of the RANZCP, wrote to their Federal counterparts, asking for an urgent accreditation review. Accreditation for trainees in the acute psychiatric unit was withdrawn on August 7, 2017, pending a site visit in September, 2017.

5). As a result of 3) and 4), there are also likely to be significant recruitment and retention issues for medical staff. These potential losses occur in the context of what is otherwise a very well-regarded and highly successful psychiatry training program.

6). The effects of bed block are also significant in community mental health. Public adult mental health services in the south of Tasmania are supported by three regional community teams, all with in-house crisis staff. Since beds have been cut at the RHH, no extra resources have been supplied to the adult community mental health teams.

It is the work of these community teams to prevent admission whenever appropriate and safe, however, acute admissions are sometimes required. Community mental health staff are now frequently advised by ED staff that, as there are "no beds" for psychiatric patients, to avoid bringing patients to the ED. This is both unsafe and clinically inappropriate.

However, patients do not find lengthy waits to be helpful for their conditions, and community teams often find themselves attempting to manage patients who should otherwise be in hospital. This is resource-intensive, stressful, and it affects the care given to others in need, as the focus of care moves increasingly to those who are acutely unwell, and away from more preventative work.

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Community teams also find themselves increasingly working without adequate clinical and risk information, as inpatient medical staff now have insufficient time available to them to complete critical discharge summaries and to attend liaison meetings.

It is difficult to accurately convey how distressing and unsafe bed block is for patients, and it is just as difficult to convey how distressing this is for staff, who are simply no longer able to secure timely, safe and reasonable mental health care for their patients, care that has been generally available in Hobart for decades.

J Block concerns

The AMA has always held concerns about the J Block temporary acute mental health wards. These wards are not on the ground floor, and they do not have access to meaningful outdoor spaces. The wards are also very small, and this is particularly relevant with respect to both the High Dependency Unit (HDU) and the Open ward. The wards are also not designed along contemporary lines, they are not patient-centric, and they do not maximise the space or the sense of space by co-locating dining, socialising, recreational and outdoor spaces. Almost all windows in J Block are also permanently obscured by internal window coverings. The outdoors and the sky are therefore also permanently obscured, which gives the unit a particularly claustrophobic and industrial feel. Since the new unit opened, it has also been discovered that the HDU is particularly noisy, which is difficult for patient and staff alike.

K Block concerns

The AMA has also held concerns about the K Block mental health wards, and these are much the same as the concerns for J Block. The unit is slightly bigger, at approximately 2800 square metres, but is it is still not on the ground floor, still has insufficient beds, with only one more bed than the temporary J Block, is too small in footprint, and is not of contemporary design. A new unit in Caboolture, south-east Queensland, is worthy of comparison. It is on the ground floor. It houses 43 beds. It is spread over 9000 square metres.

Governmental responses

The AMA has held such significant concerns about the numbers of beds, the footprint sizes, and the designs of both the J and K Block units, that it liaised repeatedly with other relevant bodies regarding these concerns. This culminated in the development of the Tasmanian Mental Health Stakeholders Consortium, which comprised the following members – AMA, RANZCP, ANMF, Registrar Training Representatives, GP/RACGP Representative, Mental Health Council of Tasmania, Mental Health Carers Tasmania, UTAS Representative, Flourish, National Mental Health Consumer and Carer Forum, Australian Psychological Society, Australian Association of Social Workers, and the Australian College of Mental Health Nurses. Because of the seriousness of the concerns, a meeting was requested with Mr Michael Pervan, Acting Secretary of the DHHS, so that these concerns could be voiced at the highest level. This meeting was held on 14 May 2015. Approximately 30 people, representing a large body of organisations, attended the meeting, for 90 minutes. Mr Pervan was not able to attend the meeting. Mr Pervan wrote to the Consortium via the AMA on 3 July 2015 (see Appendix A). The conclusion to that letter included the following, "Any future modelling based on activity data will need to be presented to the THO-South for approval and considered within the budget process. However, it is clear that further consideration of inpatient bed numbers should occur within the context of the entire mental health service system, specifically in relation to an increasing focus on service provision within the community...On this basis, I am of the view that mental health redesign is entirely appropriate within the scope and resources available for this phase of the development." Earlier

in the letter, Mr Pervan also wrote, "There is agreement that the preferred location for mental health inpatients would be in a ground floor location. This is provided for in the second stage of the RHH Master plan..."

In early 2016, Dr David Alcorn was appointed as the new CEO of the Tasmanian Health Service. Dr Alcorn is a psychiatrist and a health administrator. The AMA wrote to Dr Alcorn on 15 July 2016, requesting an expert external review of the J and K Block designs, for an independent opinion to be given (see Appendix A). Dr Alcorn refused the review, in a letter dated 29 July, stating that, "The issues you have outlined have been addressed previously" (see Appendix A).

J Block opened in November, 2016. The Health Minister, Mr Michael Ferguson, toured the facility and stated to an ABC television news crew that there had been, "No corners cut, no compromise", made in relation to the development of the unit.

In June 2017, the ABC television news ran a story on bed block for patients suffering with mental illness at the RHH, and raised the issue of the Coroner's findings into the death of Mr. S with Minister Ferguson. The Minister asserted that the current number of acute psychiatric beds was, "The appropriate number to meet the needs of the community." Minister Ferguson also pointed out that community beds and supported accommodation needed to be factored in, "which numbers in the hundreds". It has never been clear to the AMA what advice Minister Ferguson had at his disposal to support the number of acute psychiatric beds currently at the RHH, and the cuts to bed numbers.

MHS management have generally described the ongoing problems with bed block as, "unpredictable surges", rather than predictable demand, and as such have looked at factors that might assist, "patient flow"; they have provided the AMA with two documents that have been written to attempt to address the difficulties. The first of these is neither dated nor signed, but has one timeframe of end May 2017, so was completed before this date. It has 13 strategies (see Appendix B). None of these strategies refer to increasing the number of acute psychiatric beds, rather they generally refer to more efficient use of current resources, excluding strategy 12, which refers to drafting a business case to fund an additional five to eight mental health beds in the south. The "outcome" column states that these beds, "Will provide increased flexibility for clients and will improve patient flow through DoP". No further detail is given.

The second document, also referring to solutions to assist with patient flow, is similarly neither dated nor signed, however, this document was circulated in June 2017. It lists 18 strategies (see Appendix B). It outlines several changes to local service structure. First, it suggests that the current non-acute 10 bed unit, Mistral Place, located very near the RHH, be changed from both a step-up (from the community) and a step-down (from the acute wards) facility, to a purely step-down facility, to service the RHH, and to no longer serve the needs of community patients. This change may create some efficiencies, as both the DoP and Mistral Place under this model of care would be staffed by the RHH, in comparison to the current situation which predominantly utilises community psychiatrists for Mistral Place care. This strategy however does not significantly change the total numbers of beds available, as although the document outlines that the six current respite beds will be replaced by "two to four" respite beds in the Community Sector, the AMA understands that the plan only includes funding for two extra beds.

It should, however, be noted that by changing the model of care for beds at the current Tolosa St centre, from respite to step-up, that this model may also modestly assist the overall needs of the

population. However, it is likely that the patient mix at Tolosa St step-up will be of lower acuity than the current step-up beds at Mistral Place, because the Tolosa St unit is more suburban in location, and may have lower levels of available support. (Mistral Place is situated within 100 metres of both a police station and a teaching hospital).

Importantly, it should be noted that closure of acute beds at the RHH cannot be compensated for by the opening of non-acute beds, for risk and resource reasons (see Appendix C). The number of acute beds needed for a particular catchment size can be readily calculated, and provision of a lesser number of beds is associated with an unreasonable safety risk.

The second patient flow document also refers to the creation of a four bed observation unit within the ED. Such a unit would essentially ensure that some of those suffering with severe mental illness or acute psychiatric crises would be required stay in very small spaces, not fit for purpose, underground, with no natural light, and no access of any kind to therapeutic or outdoor spaces, potentially for extended periods. This proposal has been modified, and now involves a "Multi-purpose Short Stay Unit", on the site of the current RHH transit lounge. This area will be configured according to the clinical need at the time, as either a five bed unit for those struggling with mental illness, or seven beds and two recliners for general (non-psychiatric) patients. This space is not suitable for those with mental illness, particularly those acute patients who are new to the service and carry unknown risks. The concept has however come about in the context of bed block, and because no other short-term solutions have been put forward.

The second document also refers to the development of a "Mental Health Hospital in the Home" team. However, in the current system, three crisis teams already operate. The creation of a standalone fourth team would be inefficient, but the addition of resources to the current crisis teams would be advantageous.

In the context of an upcoming state election, the AMA wrote to Minister Ferguson, asking him whether the State Government would acknowledge that bed block had arisen as a consequence of beds being closed, and whether the State Government would make a commitment to re-opening acute mental health beds in the short term, to allocating more beds to K Block, and to the creation of a second stage, more "state of the art" acute mental health unit, in the medium term. That letter was sent 28 June 2017, calling for a response by 14 July 2017. At the time this submission was tendered, no response had been received.

Management culture – lack of meaningful consultation

Although the AMA, the RANZCP, the ANMF, and other stakeholders have been involved in RHH Redevelopment meetings, and their lobbying has brought some modest change to the J and K Block units, it is the belief of the AMA that the State Government has been generally reluctant to incorporate senior clinical advice. This has been particularly the case with respect to the number of acute psychiatric beds needed, and with respect to the need for all units to have appropriate therapeutic and outdoor spaces. More recently, the responses to severe problems with bed block have been slow, and show an insufficient understanding of contemporary public mental health principles, with the State Government planning to replace acute psychiatric with non-acute beds, a solution that carries too many risks to the patient population and to the community.

In late July and early August 2017, however, a series of meetings regarding bed block were called by the new RHH CEO, and the new RHH management team. The team acknowledged the degree

of difficulty associated with the protracted bed block, and began working productively with a range of stakeholders to address the issues.

AMA Recommendations

1. **Urgent response required – 10 acute psychiatric beds to be re-opened**

The AMA contends that the current prolonged acute psychiatric bed block crisis was repeatedly predicted by the AMA and the RANZCP, and is a direct result of MHS management closing 10 of their own acute psychiatric beds. MHS management responses have never included increasing the number of acute psychiatric beds. The AMA contends that, for the safe and reasonable care of the acutely mentally ill cohort in Southern Tasmania, all acute patients must be first admitted to J Block for safety and for assessment reasons. **The AMA also contends that the 10 acute beds that were shut should urgently be re-opened, somewhere within the current RHH campus; patient flow would involve some patients leaving J Block for care in this additional ward.** Patients struggling with severe mental illnesses or acute psychiatric crises should not be expected to be accommodated in a small, underground observation or emergency unit.
It is also vitally important to repeatedly note that non-acute beds can never be used to replicate acute beds.

2. **Changes required in K Block – 9 extra acute psychiatric beds required in K Block**

The AMA further contends that the acute mental health unit in K Block is insufficient with respect to bed stock, and the number of beds in that unit be urgently increased to 42. This will require substantial remodelling and redesign on an urgent basis.

3. **Long-term commitment required to build "stage two of the master-plan"**

Although the units in J and K Block do meet some contemporary design principles, for example with respect to abolishing wherever possible ligature points, in the majority of areas, they are deficient. They are not on the ground floor. They have insufficient beds. They have very limited outdoor areas, or no outdoor areas at all. They are of inferior design, neither involving "palm and finger" design, or more contemporary patient-centric design principles. Also they have no mother-baby bed, and no youth specific beds. Also, they have little or no amenity for medical staff with respect to offices and training space.

As such, the units are substandard. This finding has always been acknowledged at high levels, and a Master Plan has long existed for a more "state of the art" acute mental health unit. This "second stage" unit has been referred to many times (it has been called a second stage, as K Block was seen to be the first stage, but with the demountable J Block, it is perhaps more accurately labelled a third stage). For example, it is referred to in the RHH Redevelopment Project Key Findings and Recommendations, 28 November 2014 (see Appendix B). To quote, "The Taskforce agreed that the preferred location for mental health inpatients would be in a ground floor design but this could only incorporated in a subsequent stage of the Master plan. On this basis, the Taskforce noted that the opportunities to progress the Master plan should be explored so as to provide the most appropriate level of contemporary care to mental health inpatients". Mr Pervan referred to this Master plan in the July 2015 letter (above), and in a letter dated 23 March 2015, "The Rescue Taskforce agreed that the preferred location for mental health inpatients would be in a ground floor design but this can only be incorporated into future, currently unfunded, stages of the Master plan" (see Appendix A). Craig Watson, Chief Operating Officer of the RHH in 2016, also stated that, "The Master plan for a stage three, much better

designed, mental health facility on the corner of Campbell and Collins St was still very much desired and something we will continue to pursue funding for" (see Appendix A).

The AMA believes that to adequately cater for the future needs of the acutely mentally ill patient in Southern Tasmania that an urgent commitment needs to be made to this final stage of development for a state of the art acute mental health unit.

4. **Medical staffing at the RHH**

The current level of staffing within the DoP is clearly insufficient, and this issue warrants urgent attention. If the DoP is to subsume the care of Mistral Place, whilst still required to manage care of the mentally ill patient in the DoP, and currently in the ED, and the new beds that should replace the beds closed, at least two more full-time psychiatrists and two more psychiatric registrars will be required. These additions would not only make for a reasonable standard of care, and a safe standard of care, such additions would create an environment in which the RANZCP are likely to accredit junior training positions.

5. **Acute mental health units in Launceston and Burnie**

The AMA has very few members from the craft group of psychiatry working in the north or north-west of the state, and receives little information about service provision in those areas. This occurs because of low levels of both senior and junior medical staff in those regions, and because of the extensive use of locum psychiatrists. It is, however, generally understood that the two acute mental health inpatient units at Launceston and Burnie are also frequently under pressure with respect to bed block. In addition, there are no other public mental health beds of any kind in the north of the state, no non-acute, no medium term rehabilitation, no older persons, and no detoxification beds. As such, it is likely that those units also require expansion. The north and north-west regions also need intensive work with respect to workforce recruitment and retention.

6. **Need for on-site clinical directors**

Acute mental health units manage many patients at high risk, and are inherently highly stressful environments, with many and varied needs. The acute mental health unit at the RHH has gradually lost resources, and the loss of the on-site dedicated-to acute-inpatients Clinical Director has been particularly important in this context. As such, it is the firm view of the AMA that all three acute mental health inpatient units in Tasmania should have their own on-site, dedicated Clinical Directors. These Clinical Directors should play oversight, governance, leadership, resource allocation, strategic, and advocacy roles. They should also provide leave backfill, therefore assisting with the provision of a critical mass for staffing.

7. **Medical staffing at the Roy Fagan Centre**

It is understood by the AMA that admissions to the state's only dedicated Older Persons Mental Health unit, the Roy Fagan Centre, in Lenah Valley, have approximately quadrupled over recent years, with no change to the levels of medical staffing. It is further understood that if medical staffing levels could be improved there that admissions and discharges could proceed more quickly, which would not only benefit those Older Persons suffering with mental illness, it would also relieve bed pressure at the RHH.

8. **Child psychiatry inpatient teams**

It is understood by the AMA that there are significant gaps in the care of young people in Tasmania suffering with mental illness, particularly as there are no dedicated inpatient beds

anywhere in the state. As such, it is not possible to provide developmentally appropriate care to this cohort. There are however plans to develop adolescent units at both the RHH and the Launceston General Hospital (LGH). The RHH currently has a small multidisciplinary child psychiatry team, but the other regions do not, and all regions need functional teams; the most pressing current need is for the development of teams to service the LGH and the North-West Regional Hospital. These teams must also cater for those many young patients who suffer with complex medical conditions. As the adolescent inpatient units are developed, careful attention will also need to be given to appropriate multidisciplinary staffing models.

9. Employment/contractual issues

Because of delays in the enterprise bargaining process, and because the majority of staff specialists working in psychiatry are not employed directly by the RHH, and are not granted access into the Private Patients Scheme, and therefore have been forced to negotiate their own market allowances with government, it has been extremely difficult to employ specialists into psychiatry for the last two years. Several local trainees, who wanted to stay in Hobart and work in the public system, have left the public service because of the difficulties. It should also be noted that, at the time this submission was prepared, that the majority of staff specialists working in psychiatry are out of contract. The announcement, on August 10, 2017, that a new Salaried Medical Practitioners Agreement has been made will put an end to many long-held uncertainties, and is likely to be of significant benefit with respect to morale, recruitment and retention.

End-notes

Please note that this submission is the result of an internal AMA consultation process. Please also note that the AMA does not always have access to all relevant documents, and this submission is written in good faith, but may be subject to error.

Finally, please note that AMA members are prepared to give evidence before the Sub Committee Inquiry, and can be contacted through the offices of the AMA.

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Please see relevant attached correspondence:

Appendix A – Correspondence in chronological order
Appendix B – Related documents in chronological order, parts 1 to 4
Appendix C – Relevant Academic Literature

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