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[redacted]

30 August 2017

Ms Jennifer Manering
C/o The Legislative Council
Parliament House
HOBART 7000

Dear Ms Manering

Re: Acute Health Services in Tasmania Committee

Please find my enclosed submission. Unfortunately I did not receive the title above till this morning - too late to arrange to change it to meet a courier to deliver it to you.

Yours sincerely

Dr CR Wareing.

P.S. I have not included it in the submission, but I had considerable experience with the Centre for Mental Health Development in the 1990's, and the solutions for Mental Health Service Development I have used before in the UK.

Submission to the Current Tasmanian Government enquiry into Health Care

Dr C.R. Wareing

29th August 2017

Contents

1. Introduction

Tasmania is a population of 600,000 in several centres. Only half the population live in Hobart, the other half is in the Northern and North West Regions, Launceston and the cities of Devonport and Burnie respectively. All regions have outlying areas with access difficulties. Outside any large centre of population this is a worldwide problem. In the South there is the area south of Hobart, in the North Scottsdale and the settlements on the East Coast. In the North West outlying areas are the West Coast, Smithton and Sheffield.

2. The North West

Specifically regarding the North West the indices of social disadvantage are the worst in Tasmania.

- Decline of the industrial base in Burnie which accentuates the problem of limited employment opportunities.
- An aging population with the highest demands on health care services as a group.
- The incidence of teenage abuse and pregnancy is very high.
- Limitation of higher educational opportunities which results in:
  - A population with limited aspirations
  - Any young person seeking career opportunities with any "get up and go" has to do just that, to mainland Australia.
  - Devonport has the state's highest crime rate.
  - Absence of any critical mass of professional culture which has an adverse effect on professional recruitment including medical. In medicine it is a beginning or end of career option.
- A culture of alcohol and drug abuse especially amphetamines and their derivatives, which cause behavioural problems which present to Casualty/DEM for acute containment and treatment, and in Mental Health Services (MHS), by causing psychotic episodes as well, this increases the load on both services. There appears to be little legal or social consequence for this behaviour. A whole of government approach is needed to contain this. As the result, a big weekend party can completely crash the health service.
- There is difficulty providing services outside the main centres.
- Funding is by head of population not by indices of social disadvantage. The North West and also the North are proportionately underfunded and this imbalance needs to be addressed.
- Community Services are particularly vulnerable with a shortage of skilled staff (this workforce is also ageing rapidly). When there is a need to maintain rosters of staff, when there is a shortage in inpatient units, pressure comes on to use the community staff. This undermines the community staff structures, and contributes to increased admission rates and pressure on casualty department staff. Attention to this process, expanding community staff, accretive follow up and early identification of relapse symptoms to permit rapid community treatment is the solution of casualty overloads. The solution is NOT a direct admission policy.

- There has been little involvement of the community in health planning. Expectations become raised because no one has told the truth that not everything expected of state funded health services can be afforded or provided. The population must be involved in deciding what and how services should be provided. It is their service. Just as war is too important to be left to the generals, health care is too important to be left to the managers.
- Recruitment of key staff in key positions is impaired by many processes.
  - Tasmania has not paid competitive rates with other parts of Australia and refuses to accept it is in competition with other states. This and a recruitment package from the council with a photo of Cradle Mountain just does not cut it.
  - The attempt to get it on the cheap results in getting it on the expensive with locum costs.
  - The toxic management culture is known, I hear it all the time in discussions with locum agency staff. That this is so well known is a serious disincentive.
  - When I first came here in 2012 we could then appoint a number of foreign Doctors who the Royal Australian and New Zealand College of Psychiatrists rated as Substantially Comparable International Medical Graduates (SIMG's). They had learning targets and experiences to achieve and a specified supervision process and an examination. Thanks to the assistance of the then Chief Psychiatrist and his staff we at one point had only one Locum Psychiatrist in the service. The College has now made recruitment to an area of need almost impossible due to tighter regulations. Asking potentially employable Doctors to fly from England for an interview with no guarantee of employment is a big expensive ask.
- AHPRA is another problem as a time to make decisions about registration matters is getting longer and longer.
- As a consequence it used to routinely take a year to hire someone. Now hiring at all is near impossible. Medical personnel are key individuals and a rate limiting step in process. The metaphor is in bio-chemistry when there are several chemical processes in the body and one enzyme can determine the rate of the whole process. Hiring key people is the equivalent to getting the one enzyme. This was clearly identified by the Business Round Table in New Zealand in the late 1980's.
- I have considerable admiration for the members of North West Medical Staffing who manage to contend with this intensely frustrating and bewildering process without banging their heads on the wall.

3. Experiences as Clinical Director Mental Health North West and of Management Toxicity

I began work here as Clinical Director Mental Health Services (MHS) on 23rd July 2012. Previously I had been doing locums in England for an extended period and due to changes in locum payments and conditions this had become less than economically viable.

In order to maintain clinical skills and credibility I acted as a second consultant to the CATT Team.

At this time the manager of MHS in the North Region was also managing the NW. In late 2012 she began to try to move the MHS offices in Parkside in Burnie from Level 1 to the ground floor, this was clinically inappropriate, would have impaired confidentiality and would have disadvantaged staff and clients. There was not enough space to fit everyone in, and there were areas in which people could be assaulted without being able to attract attention.

Earlier in the year the then CEO Mr Gavin Austin was alleged to have toured the building stating he wanted the Level 1 offices for his management staff. A pretext for this intended move was an alleged assault on a staff member by a client in the lift. I have no reason to believe that this had actually occurred and I worked at Parkside for the next five years and no such incident has taken place. A member of the Crisis Assessment and Treatment Team (CATT) proposed a swipe card to prevent floors other than level 1 being accessed by MHS clients entering the building. This cheap and non-disruptive solution was rejected by the manager. In the event after about six months the solution was finally accepted, the proposed move sensibly abandoned, and there have been no problems over the following years.

The intended floor move was opposed by HACSU as it disadvantaged staff and clients and I agreed with HACSU. Significant HACSU members there were two union delegates. In meetings with me the manager made a continuous series of allegations that they were "running the place like a closed shop" and were opposed to the management for the sake of it. This was persistent and in response to their carrying out their legitimate duties supporting their union members.

Eventually the manager decided to use a "code of conduct" matter over something they had said to someone at Queenstown Hospital about management. The manager had appointed a team leader, who was unable to accurately relate what I had said to her in meetings to other people. Even the manager in speaking to me referred to her as a "pathological liar" which was a frequent staff observation. There was several staff grievances against this person which seemed to receive little attention from the manager to whom she was responsible.

The manager appointed this person to investigate the complaint from a locum staff member in Queenstown about what had been said. In no wise could this person be seen to be an independent or disinterested party.

Not wanting this minor event to grow into something out of proportion and organisationally damaging I asked the manager what needed to be done to settle the matter. She told me "they have to apologise to (this person)". Accordingly I saw them and an apology was written by both of them. Expecting that she would actually mean what she said, I thought the matter was at an end.

In a subsequent meeting with me she indicated that it was not over, producing a situation of double jeopardy. On the 12th April 2013 I wrote a letter to her intending to get this matter settled to save everyone including her from setting a hare running which could have adverse consequences for everyone involved.

She met with me and I went through the letter with her, but she would not change her behaviour to the two union delegates. And that in spite of her instructions to me as in two paragraphs above.

I then discovered through a then recently appointed quality and safety officer that the manager had divided up the issue into two parts in order to give pseudo-legitimacy to continue her actions.

CATT (of which they were very experienced members and on whose judgement I could consistently rely), has been central in holding the NW Mental Health Service together. Five years on it is to be noted:

- CATT has had no suicides amongst persons in their care.
- The NW Mental Health Service has achieved the highest ratings of all three regions in achieving KPI's.

The manager attempted to claim that CATT was an unnecessary hot bed of anti-management activity. As Clinical Director MHS I could not stand by and do nothing about an attempt to discriminate against two significant and experienced members of the team putting both it and co-ordination of NW Mental Health Services at risk. Ethically there comes a point when silence becomes collusion with a destructive process, and I therefore gave my 12th April letter to the Union Representatives which they could use for their own protection. They successfully made a complaint to the then Antidiscrimination Commission. To stop short of a full commission hearing, the manager had to make an apology to them personally and allow them some extra leave.

The manager then attempted to summon me to a disciplinary hearing claiming this was a breach of confidentiality. I took legal advice and made a complaint to the Health Ombudsman which prevented that attempt. Due to the stress of this, I suffered an acute episode of arthritis for which I had to take steroids and then I got a chest infection. Due to immunosuppression, this was potentially dangerous and I had to have some time off for a week to recover.

The manager was then replaced by a General Manager for the MHS North West. He was in post eight weeks only before going to a more senior management post in Hobart. I witnessed that he was extensively being briefed by the previous manager and was very slow to meet with me.

In meeting with me he became very intimidating very quickly, made statements about serious consequences should I breach confidentiality and then "if we can't work together then one of us has to go" Despite his subsequent denial about this statement, I was diarising these kinds of events and I gave these to my lawyer immediately.

He then wanted a meeting with me with Human Resources. He refused to give a reason why, so I declined to attend. The 12th April letter was not made available to anyone other than those who absolutely needed to know. However the former manager was overheard by an

administration officer on the telephone telling her that she had made the comment about being a pathological liar. I understand that "that person" went off and is now on full pay until retirement age. The administration officer made a witness statement. I believe that the intent that the new manager had of taking me to HR was to engineer making me responsible for this outcome regarding "that person" which I was not.

I then took two weeks stress leave, the only time in my then 32 years as a Consultant. I seriously considered resigning and getting out of this toxic environment but then realised the intimidation was witness intimidation in respect of the antidiscrimination commission complaint of the two union members. As it breached Section 18 subsection 2 of the relevant act, I therefore made my own complaint to the Antidiscrimination Commission.

The matter was then passed to the now discredited Mr Gavin Austin, CEO of Tasmanian Health Organisation (THO) NW which the MHS would be joining. In April 2013 he held a meeting with the senior staff of the THO, medical included, I was sitting next to the CD of the DEM when he made the statement that he was sure the first manager had taken money and positions from MHS NW for her Northern region. There must have been at least 40 witnesses to this statement. He also said "this service has been kneecapped before we get it". One would assume he would have some form of evidence to support his public statement. Certainly when I came the first manager tried to get me to agree to lose one Consultant Psychiatrist position. I disagreed. "That person" was always trying to find ways to pay CATT less and some positions had been lost before I came.

After the first manager and "that person" had left, a Team Leader came up as Team Leader from the South. He found that funding of positions had been confused all over the Mental Health teams, so you could not trace which staff member had come from which budget. It took him six months to unscramble it. In the commercial world such fiscal tactics in my experience can be used to conceal asset stripping.

That money had been taken from the NW in other clinical service areas, apart from Mental Health was told me in early 2017 by the Director of Medical Services.

In October 2013 Mr Austin summoned me to a meeting in which he demoted me from my Clinical Director position. I took my lawyer as a witness. The meeting was victim blaming in that he claimed his managers had to be protected against me. This was a cognitive distortion and this document should demonstrate it was the other way around.

The only alleged offences he could dredge up came from during the time of the first manager, before my employment by the THO.

1. That I had spoken to the CEO of Richmond Fellowship. The aim was to produce a discussion proposal about a respite unit (which we still don't have) co-located with CATT. Talk of partnerships with CSO's is now the order of the day.

2. That I had incurred extra costs without permission by sending Dr Russell McGregor (a long term locum at Oldaker in Devonport) to Drug and Alcohol Services in Ulverstone on Mondays. This was to scope out the number of dual diagnosis Mental Health/Drug Services clients to inform the eventual development of dual diagnosis clinics.

Integration of substance abuse and mental health services has been flavour of the month since then. The costs of paying the locum to have some spare time at Devonport or to spend it in this way were exactly the same. There was no extra financial cost incurred.

Locum DMS's since have told me I was demoted for no legitimate reason. I had little doubt Mr Gavin Austin's actions were inspired by the second manager. After demoting me the second manager and Mr Austin conspired to appoint Dr McGregor as Clinical Director.

He lasted two weeks, he felt they had promised him one package of salary and conditions and then gave him a different one and so he resigned. He pursued the organisation through the legal system. I also suffered the Clinical Director of the North region who had a close relationship with the first manager frequently repeating to me on the telephone what the first manager had said. At one time he told me to get rid of CATT. I told him to stop giving me inappropriate advice outside of his jurisdiction.

When demoted I objected and sought legal advice and industrial advocacy. Eventually it was likely I would have to go to the Supreme Court or the full Antidiscrimination Commission. As a result the system was eventually pushed to reinstate me as Clinical Director. The Tasmanian Industrial Commission (TIC) ruled that I was an officer as opposed to having no right to go to the TIC. The total costs to me of such legal advice and advocacy added up to $60,000.

When demoted I continued as CATT consultant.

In February 2014 another female manager became the NW General Manager MHS. She was from New Zealand and was the person described as Mrs T in the report of the Integrity Commission which resulted in the dismissal of Mr Austin and Ms Holden, the South CEO for nepotism amongst other matters. In this process Dr X was hired by Mrs T it being intended that she replace me.

At a meeting with Dr X, the management of the NW hospital and someone from HR, Dr X tried to bully me hoping that I would leave. She then tried to bully me on the phone which was observed and intercepted by my industrial advocate, Dr Damien Durkin.

I went off on a Workers Compensation claim for a few weeks. Mr Durkin arranged an independent return to work consultant. I had no trust of internal THO systems or personnel. This resulted in the specification in the return to work plan that I was not to be administratively responsible to Dr X.

As a consequence the service were now paying two clinical directors at the same time. The extra cost would be in the order of $700,000. In fairness to Dr X she did get the DMR installed in the NW.

I continued to press my complaint with the Antidiscrimination Commission. This was dragged out as long as possible by the employers in defiance of the expectation that they were supposed to be model litigants. When it eventually appeared likely to go to full commission or the Supreme Court a settlement was made, which I cannot disclose but was very significantly lower than my $60,000 legal costs and I was taxed on it. The settlement tried to force me to agree to a number of things which it could not legally order and it had to go before my lawyer again incurring further costs.

Having been accepted back into the position by Mrs T (this was reluctantly) she then attempted to exceed her authority by trying to interfere with clinical matters. This has frequently occurred with managers in Mental Health Services and is a consequence of putting clinicians under managers in the organisational structure. To my knowledge this only occurs in Mental Health.

There were areas of dispute between CATT and the DEM in which she on a number of occasions attempted to interfere to the detriment of CATT.

- The DEM's constant pressure to try to get persons intoxicated with alcohol with suicidal thinking or behaviour assessed immediately to clear the DEM. We insisted we would not assess people over the blood alcohol level of 0.05%. She attempted to insist that we were the only service in Australia to do this. We know that this is not the case. When seen at an appropriate blood level:
- Suicidality disappears in over 95% of people and the client was then safe to leave the DEM. If this policy is not followed there is an associated suicide rate. Again it is to be noted that CATT has had no suicides in the last five years. This would appear to be consistent with suicide prevention policy.
- The client is able to negotiate and remember a safety plan. The intoxicated cannot.

DEM has tried to complain that this forces some people into alcohol withdrawal.
The safest place to go into alcohol withdrawal is the DEM. If they do they need medical treatment anyway.

False complaints were written against CATT. The report of the Integrity Commission commented that false complaint making was in the culture. The DEM breathalyser was often alleged to be absent or broken. When this was challenged it would miraculously appear. Because of this and an incident where a CATT member was aggressively poked by a DEM staff member, HACSU became involved and it was ruled that two members of CATT would attend the DEM at any one time.

There was also constant pressure to get people admitted to Spencer out of business hours when the ward has no RMO without a proper medical review in casualty/DEM. It should be noted that the only two deaths in Spencer over the last five years were of people admitted with end stage COPD.

They both came through the same DEM consultant who tried to overturn established policy. If direct admissions like this were permitted, in this unsafe manner, this would ratify diagnostic overshadowing.

Mrs T tried to set up stacked meetings, where I would have been alone and opposed by DEM and their supporters. As I had no witness or support person present I could be misreported to have agreed to what I had not agreed I declined to attend.

A further attempt to undermine Mental Health Services policy in relation to DEM clients was made, when a new CEO came with a locum Director of Medical Services (DMS). This again had to be repulsed by myself in partnership with HACSU.

While I was away from the Clinical Director position I was the CATT consultant. The former consultant position had been downgraded to a CMO. It was impossible to do both CD and CATT consultant jobs and through Mrs T I had the assistance of a locum who did not need a finder's fee, but he could only be a visiting consultant about one to two weeks in every four. His wife also worked as locum on similar terms. Both were very flexible regarding the service needs, would move from service unit to service unit as clinically required and were excellent.

After having to give the apology to the two union members, the first manager became manager of Primary Health in the North, she then had nothing to do with the North West. Somehow she was allowed to return to her former Mental Health General Manager role in the in middle of winter 2016.

This return coincided with a number of disturbances in the medical hierarchy in which two locum and two substantive consultants, had difficulties with interpersonal behaviour with other consultants and became particularly challenging to me without legitimate cause. They were observed by one of the locum consultants to make a statement of intent to try and get rid of me.

Subsequent emails have originated from the first and now current manager which attempted to insist on the appointment and support of these individuals. That she may have been behind these interpersonal problems is a distinct possibility.

In March 2017 I received a letter from Ms Adie Gibbons stating that my contract was due to end on 21st July 2017 of which I was already aware. The letter suggested I could apply for other jobs I might consider suitable relevant to my seniority and expertise.

In the event no jobs were so advertised, I wrote to her again by email asking when these adverts would occur. As there was no response, in the end I got my lawyer Mr Tony Mihal to write to her. At least this was going to get a response.

Her resultant letter stated that the priority was for employing locums with whom they already had contractual obligations. Effectively she told me there was no availability for me to extend my employment.

1. I was unaware of such contractual obligations. As staffing was such a problem I was having weekly meetings with the Medical Staffing Unit. In these meetings I was unaware of any implied contracts with locums. There was even a gross shortage of consultant locums across the country.
2. There was nothing legally to prevent the extension of my contract, there were no professional failings claimed or demonstrated. Failing to extend my contract and consequent locum employment is of legitimate public interest as it increases locum costs.
3. I had indicated my interest in the statewide position as Statewide Clinical Director, even though I disagreed with it as it would have no local sensitivity and it would continue to undermine clinical input with regard to the disproportionate input of management. The clinical position would get even weaker.

I had asked Ms Gibbons when the advert was likely to come out. She claimed she had no idea of this or control of it.

In the event on the 24th June 2017, I was leaving to go to the Royal College of Psychiatrists conference and to check on my house in England. The advertisement appeared by email half way through the afternoon of 22nd June 2017. It specified an on line response (it was known I was not the best at this) and the closing date was in the middle of the time I was away on 2nd July.

The impression was therefore created that the statement about not knowing when the advertisement was going to be out was disingenuous and that it was released in a manner intended to exclude me from making an application.

Immediately before I left for England I suffered persistent attempts by the returned first manager to force me out of my office at the end of the CATT room (essential for me to work with and support the team).

I advised the manager that attempts to do this were personal harassment. As she would not desist I issued a grievance before I left.

On my return I did attend an interview for the position. The matter of the non-extension of my job led to enquiries with Ms Ruth Forrest, and the issue of preference of locum contracts was raised in Parliament. I am told the minister gave an assurance that there was no precedence given to locum contracts, and that it was recommend that I meet with Dr Alcorn.

Attempting to arrange this meeting I was told it would be on the 27th of July 2017 which was after my contract ended. This was brought to Dr Alcorn's attention and as to whether he was going to extend my contact until that meeting.

In the event he asked for the meeting to be in his office in Launceston at 9.00 am on 20th July 2017. There was no indication that I was going to meet with anyone other than Dr Alcorn. In the event the meeting took place one hour late, present were a lady from HR and Ms Adie Gibbons.

In spite of the ministers assurance I was given the same message again as in the previous March that I could apply for jobs that were available. Given recent experience, and that the employment process would inevitably be managed by the first manager with whom I had a grievance, and Ms Gibbons it was pretty clear that any such application would be pointless. Accordingly I have now made representation to others.

I think my personal experience of toxic management is abundantly clear.

This culture must be changed in the interest of clients and staff.

4. Toxic Management: How did we get to this?

Deviant socialisation processes, target culture and groupthink

This process which evolved into the disempowerment of clinicians and management usurping of clinical decisions has a recognisable process which began in Britain and has crept in elsewhere.

In the 1970's, the legal profession began increasingly to see medicine and health care as a job creation scheme which led to the ambulance chasing industry. There began a large rise of complaints and threatened legal actions. The idea grew of needing management to contain these. Management jobs were increasingly taken by ex-nurses. Investigations of complaints and recommendations of actions to be taken developed, often said to be without a culture of blame. This was the exception rather than the rule. Thus began the separation of authority and responsibility, with managers assuming authority and clinicians ending up with the responsibility.

Management began to be increasingly well paid. This was contemporaneous in nursing with the move to University rather than hospital based training and promotion into management began to be seen as their career path.

Nursing at the coal face began to be replaced by nurse aides and assistants, in this process some allied health professions lost out very badly, noticeably social work.

As management got stronger and was paid very well (not infrequently paid more than senior medical clinicians) they began to impose target culture. As a senior clinician you used to go to work firstly to do your best for the client. Now firstly comes "how do I fulfil the target and

defend myself against the management?". Allocation of funding has increasingly begun dependant on achievement of targets often KPI's. These are not proxies for clinical outcomes. In this process care and compassion are diminished and clients/patients begin to be regarded as quantities, numbers to be moved around, which contributes to their dehumanisation and the dehumanisation spreads to the coal face staff as well.

A typical example is the four hours in Casualty/DEM rule. This was imported from Britain. Targets like this are actually unachievable. But now the box has to be ticked.

Three hours fifty eight minutes comes. The client is tipped onto a gurney, pushed out of the DEM into the corridor or a ramped ambulance. Then the four hour box can be ticked. A while passes before, "admission to DEM" can be seen as a new episode. The client becomes a commodity, and the slippery slope to loss of kindness and compassion begins. This actively undermines standards of care, and because of this the management response is to impose more and more targets which accelerates the process.

It reaches two absurdities.

1. The imposition of regulations on clinicians, where there is no evidence base to show they improve patient care. CPD after Chelmsford Hospital in 1983 and Revalidation of doctors in England are examples. These waste time and energy that could and should be going into clinical time for client care. Any responsible clinician keeps themselves up to standards without these regulations and if they don't and get this wrong negligently then there are legal consequences anyway.
2. Kindness and compassion failure can erode health care to the extent of whole health organisation failure. The best example is in Mid-Staffordshire in the UK, well documented by the "Francis Report". Significantly and to its shame the report did not hold anyone responsible. There is no regulatory body for health care managers. Power without responsibility or accountability. In the ultimate of NHS manager cynicism, and complete denial of what had happened this has been responded to by one day courses on kindness. Tick the box on your CPD.

Deviant socialisation and groupthink

Quite a number of managers move between organisations. A process begins of selection of people to appoint by the initial management. Gradually more people are appointed, and they like people who behave similarly to them. Eventually this ends up in a process where people who may have innovative or different ideas are simply not appointed, and as the culture becomes known, such people recognise the futility of applying, and then you no longer have the capacity to appoint anyone with a different view anyway.

This leads to a personal power and its maintenance agenda of people who think and behave similarly and are not open to other ideas. This is Stage One of groupthink. Stage Two is when group ethics and moral values degenerate till it becomes organisationally acceptable to do anything to anyone who is perceived not to be part of the group.

In Tasmania this leads to

1. Impairment of recruitment as the culture becomes known (the word is out) an example is wilful refusal to pay competitively for key clinical positions.
2. Failure to retain because of unacceptable management behaviour (bullying, harassment and personal targeting of individuals becomes the norm. As a result key individuals are lost. Staff turnover increases, efficiency and productively go down and costs increase.

There also develops a culture of endless meetings which lead to nothing, talk without decision making, (for to make a decision and be known to have you may be held responsible for the consequences). This must be avoided and obfuscated at all costs. Consequently there is organisational inertia and appointment of more and more non clinical positions at the expense of budgets available for the direct provision of clinical services. For evidence of this all you have to do is to look at the positions advertised in the paper. It also leads to bullying of staff to achieve short term political ends.

The most recent example is the insistence of a direct admission policy to resolve the extension of time patients spend in the Casualty Department. The real solution is to attend to the factors that cause increased casualty presentations.

In the initial draft those who would not comply with the directive were overtly threatened with performance management, it was there in so many words.

This is trying to force on people the four hour KPI target. Furthermore this has been reported in the media as a strategic aim no less. This cannot be met. In Mental Health Services total bed occupancy in Spencer is becoming very frequent, and so are occasions when there is no acute psychiatric bed available in the state. Persons known to Mental Health Services who are in case management and known to have no serious comorbidities are directly admitted to Spencer by arrangement anyway.

A contributory factor to the casualty stay problem has been the loss of ten psychiatric beds with the redevelopment of the Royal Hobart Hospital, absurd in the CBD and in which should have been on a brown field site on the edge of the city, where it could expand if needed and people could actually get to. This has been a tipping point for mental health bed capacity, and casualty bed capacity. This is not solely a problem for mental health either, there are frequent occasions at the NWRH where all impatient beds have been full and there has been nowhere to admit anyone.

The supposed guardians of the budget appear to be the greatest risk to it. I suspect that 50% of the Tasmanian Health budget is spent in this way.

Direct admission to where, to what?

Another problem collusive with the unaccountable power of management is senior clinicians who act in support of management groupthink, and so are given positions with some financial advantage and a title. Their usual reputation is that of "going where the power is". They often regard this as an approaching end of career reward for work previously done. It seems such persons are eager to sell their souls and live happily off the proceeds. The consequence is they become just as unable to make decisions and are seen as unsupportive of the staff in their hierarchy, and actually have minimal influence and aid and abet toxic management. Until recently as Clinical Director of MHS North West, I believe I have been targeted for failing to behave in this way. I saw my role as supporting the staff to care for clients. If you want loyalty from a workforce then show some.

The persistent history of constant change between regionalised and centralised statewide services is also seen as a constant waste of the health budget and irrelevant to service delivery. The grass roots staff see this as rearranging the deck chairs on the Titanic, while they are struggling to stop the ship going down and resourcing never improves. These models are never allowed to settle or to be evaluated, so continuous change operates with little or no consultation of the staff, or consultation with very short times for feedback, suggesting the "result" has already been decided. Better called "pseudo consultation". It maintains a culture of opacity not transparency, so no one knows who to approach about a decision as the goal posts keep moving and the individuals keep changing. "Change" is to be seen as the creation of an illusion of progress. Actually it often obfuscates inertia or decline.

5. Solutions

Tasmanian Health Care Statewide

A model applicable to Tasmania is that from Oregon. The second poorest state in the USA, it has a primary produce based forestry economy and a similarly decentralised population.

In the 1980's it was realised that:

- 22% of the Health budget was going in contract administration costs
- 24% of the population had no health insurance being the "wealthy poor", earning too much for the American model of Medicare (not to be confused with the Australian model) and not enough to afford private insurance.

Initially the Kaiser – Permanente Insurance Company was invited to do an actuarially based cost-benefit analysis of all diagnoses paired with treatment, such as appendicitis-surgery, anxiety disorder – CBT psychotherapy. This was across the board, from the technologically simple and low cost to the technologically complex and high cost, such as heart transplants.

It was then realised that making funding decisions like this without community involvement was simply not politically marketable to the population and community values had to be incorporated into this as well.

Consequently the Citizens Health Parliament and Oregon Health Decisions were established in locations across Oregon. Information on this and videos of the process, conducted by ethicists, are publically available.

Weighting of these decisions were then added to the actuarial cost benefit analysis by a complex mathematical model.

The result was 13 ranked bands, the diagnosis treatment pairings in the upper ones were funding priorities, which generally meant low cost, high benefit interventions. The less this was the case the lower the band rating.

The uppermost concern for Oregonians was substance abuse. Mental Health diagnosis treatment pairing came out in the top four bands.

I believe this strategy would be a bio-socioeconomic model:

- Be honest with Tasmanian citizens about what is possible and what is not, acknowledging that as everywhere, unlimited health costs are not affordable. Increasing funding does not necessarily get you a better health service, especially if funds disappear into administration.
- Create an atmosphere of transparency, and end opacity.
- Involve the community in the planning of the health service.
- Encourage an alliance of health professionals, consumers and carers and other providers how to work together against health problems, and end the climate of concentration on complaints and adverse incidents, which introduces a divisive process between professionals and consumers which prevents this alliance.
- End toxic management. Vision should be developed by a professional, consumer and carer alliance through this model. The task of management is to support this model and organise practical implementation, accountable to professionals, consumers and carers.

Mental Health Services

To my knowledge there has been no external review of services for at least the last five years. Making clinicians organisationally responsible to managers has facilitated this and obstructed needs assessment and client and carer focussed change and service development. It has also been a negative influence on recruitment. Having said that many locums in the North West have been excellent professionals that I would have been anxious to recruit if possible, but it does not get over the consequences of lack of consistency over time, and lack of ownership of the service, and attendant increased costs.

Claiming that needs assessment can be derived from existing computerised data is false. Recently a clinician in the North West was supported by management in looking at population trends but the final results were not specific, were not detailed enough to guide development and the results didn't tell me anything I didn't already know. The computerised data systems are:

- The electronic patient record (DMR) which the North West has, but is not uniform across the state.
- iPM which is really an activity record, it does not record outcome
- TRIO

These systems are not consistent, do not talk to each other and when resources are limited entering such data is the last things on clinicians minds. Entries are less than reliable.

So you cannot replace needs assessment by deductions from big data.

Everything results from needs assessment

This process can only be undertaken by mental health clinicians not by managers.

6. The needs Assessment Process

1. A one day census of all clients in contact with all the service units of a region on an agreed day.
2. A local Clinical Director should go through the case loads from the census day, case manager by case manager looking at issues specifically relating to each client and identifying gaps in services so that they can be quantified and hard data informing implementation quantified.

This cannot be done by a statewide Clinical Director. The job is then too big and there cannot be the same relationship with case management staff or knowledge of local resources or local clients. In addition this actually facilitates the influence of toxic management.

What should be recorded:

- Demographic data
- Referral source
- Working diagnosis
- Physical illness, substance abuse and learning disability comorbidities to identify shared care needs with other services, to establish need for dual diagnostic services.
- Relapse signature symptoms and speed of their evolution to facilitate early intervention and encourage community tenure and reduce demands on admissions, and to quantify persons who should be in co-located care of case management and CSO's.
- Medication in use which determines monitoring strategies, clozapine, lithium, anti-psychotics and lamotragine.
- Dangerousness alerts, and where the client is best seen and by whom, for everyone's safety including the client.
- What types of accommodation are required:
  - Respite (co-located with CATT)
  - 8-16-24 hour staffed hostels
  - Long term slow stream rehabilitation
  - Group home
  - Group home for vulnerable women.
  - Challenging behaviour unit (Mental Health), a separate one needs to be provided for learning disability services. Failing to provide this will lead to occupation of HDU's in acute wards blocking their availability for Mental Health clients.
  - Specialist accommodation for the care of the elderly.
  - Specialist accommodation for brain injured adults and sufferers from Huntington's disease.
  - Adolescent Unit
- What services are needed in addition to inpatient acute services.
  - CATT
  - Assertive Outreach
  - Co-located Case Management and CSO's
  - Different specified periods for case management, three months, six months, one year and for some people with significant treatment resistant illness and/or dangerousness for life.
  - Eating Disorder Service
- What therapy skills are needed
  - CAT, CBT, DBT

- EMDR
- Schema Therapy
- Family Therapy

In Individual and Group settings

- Then go through the data with the relevant Mental Health Team and digitally map the clients.
- That will specify what is needed and where it should be sited.
- Assign project officers to different development components, look at implementation lead times and identify negotiations needed across interfaces, with housing departments and CSO's as examples.
- Close the large discontinuity between statutory services and CSO's, to acquire accommodation and funding by redesign of CSO's contracts.

This again needs direct consumer and carer participation and evaluation. This should be determined directly with the consumers of the service, not any external person claiming to "represent" them which easily becomes tokenism for a management agenda.

Further process

1. Invite every service consumer on the census to lunch at convenient venues. Provide the lunch!
2. Local Clinical Director to get out the flip charts, ask what works, what doesn't, what people think would be helpful, and what other services they could usefully use. Present the needs assessment data in the spirit of openness and transparency for response.
3. Repeat the exercise for carers, their needs are different.
4. Encourage the setting up of a consumer and carer advisory group to participate in.
   - A service steering committee
   - Deciding how representation in various tasks and meetings should be achieved
   - Achieving a selection process by which lived in experience workers can be hired by the service.
   - Decide how representation in appointment processes should be achieved.
   - Decide with which other departments, organisations with interfaces with Mental Health Services should be included in liaison meetings and how to incorporate their views and advice.

7. Conclusion

In summary the solutions appear to be

1. Undertake suitable research to consider the application of the Oregon Health Care Plan to Tasmania.

2. Undertake a regionalised needs assessment for all services, initial trials in Mental Health Services.
3. Abandon centralisation.
4. Standardising forms, policies and procedures and information systems across the state are one thing, but centralisation of clinical direction and management does not work and denies the existence of constituencies of political interest.
5. Limits to management growth and a regulatory body for managers.
6. Streamline recruitment, sideline college interests and consider withdrawal from AHPRA, pay key people competitively, provide car and also accommodation as incentives.
7. Commence discussion with the unions who are not some form of enemy but legitimate stakeholders. Care of the staff is very important. In my experience the unions have been useful and constructive, and representation should as legitimately be built into health services as it is in membership of the company board in the Germany car industry. Looking after the staff and enhancing skills are essential to recruitment and retention.

I trust this is of assistance.

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