

REFORM OF MENTAL HEALTH CARE IN AOTEAROA-NEW ZEALAND: DISCUSSION DOCUMENT

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[1] Introduction:

The immediate context for presenting this discussion paper is the current Inquiry, set up by Minister of Health, Dr David Clark, into the country's Mental Health and Addiction services. However, I have been thinking about these issues for many months, and in mid-2017 – when Dr Clark was shadow minister - I had sent him a document, a forerunner of this essay. Now is the time to up-date the document, and make it public for discussion.

Mental health is a complex topic. One can safely say that no-one individual has wide enough experience and expertise to comment knowledgeably about all facets of this difficult area. Thus it is necessary for people with different perspectives to share their insights, in the hope of producing a more complete prescription for the way forwards. It is for this reason that the essay is set up as discussion document: It is an 'opinion piece', not fully-referenced as a scholarly analysis or policy proposal. To achieve that would require a substantial book. That is on my agenda, but not now. The few references I cite here are usually semi-political ones, or media reports.

A question which underlies much of this essay is *How profound should be the reconstruction?* . . . and therefore *How deep should the Inquiry dig?* The Inquiry panel is expected to report back by October 2018. The short time over which it has to operate is no doubt guided by a perception that our mental health and addiction services are failing badly, and action is needed urgently. However, it is my view that the roots of the problem go very deep; and thus some of my recommendations are far-reaching. In the few months of their operation, the panel may not be able to dig deep enough to get to the roots of the dysfunction of which many are aware. However, my comments should not be seen as in opposition to activities of the panel, but rather to supplement them – as an attempt to promote the in-depth discussion, not limited by such tight time constraints - which in the fullness of time may lead to the fundamental restructuring that I believe is needed.

Since my perspective is but one amongst many valid viewpoints bearing upon the issue of reform of our mental health and addiction services, I start by summarising my own experiences in relation to mental health, psychiatry, and related areas of health provision. At one time, I was a medical student in Britain, before emigrating to New Zealand in 1977. I never completed the degree, because I was overwhelmed by my own psychiatric problems. Thus, I *have* been a patient, and have first-hand experience of psychiatric practice from that side. However, before I abandoned the attempt to get a medical degree, I *did* see hospital medicine from the other side - the inside - as a medical student. Eventually I reinvented myself as a neuroscientist, exploring the theory of normal brain function, and, later, the relationship of this to understanding major mental disorders. This work has meant that I know about actions of some medicines used in psychiatry both as one who has been prescribed them, and as a scientist concerned to understand their mode of action, and how they should *best* be prescribed. Later, my work focused on the nature of 'psychosis'¹, and the disorder called 'schizophrenia'. My largest

¹ The term psychosis has had a checkered history. However, for much of the twentieth it had a relatively narrow definition, referring to a state of mental turmoil, in which characteristic delusions, hallucinations, and turbulent emotions are present. In the above sentence, I refer to this usage. In the last twenty years, the definition has been expanding to include immediate responses to very traumatic events (a concept which had currency 100 years ago, but then fell into neglect).

work, published in 2008, was on the theory of the disorder called ‘schizophrenia’². Ten years later I no longer use the term. That does not mean that I reject the evidence or the reasoning in my large work; but I now see it in a bigger framework, within which the ‘schizophrenia’ concept – whose historic scientific foundations were always shaky – can be recast. The bigger framework, a work still in progress, is to devise a way to describe - and perhaps to classify - mental disorders, quite generally, on a sounder scientific footing, and one true to the proper ethical commitment of all health professions. This is an endeavour which the psychiatrists have hardly ever attempted, let alone accomplished. Some of my support in these developments comes from a very fruitful collaboration, which has grown over the last 20 years, with a fine group of psychiatrists and mental health professionals in the University of Hong Kong.

Over this period, I was also much involved with the community side of mental health, specifically with the organization formed shortly after I arrived in New Zealand, the Schizophrenia Fellowship of New Zealand – renamed ten years ago, as ‘Supporting Families in Mental Illness, New Zealand’ (SFNZ). This involved me in a good deal of work in a ‘public education’ context; and I wrote an educational book for the general reader, entitled ‘Straight talking about mental illness’.

With regard to the professions actually involved in psychiatry and mental health care and the administrative arrangements for delivery of such care, I am informed by two lines of recent experience. *First*, for five years (2009-2014) I was invited as a Community Representative on Committees of the Royal Australian and New Zealand College of Psychiatrists. This led me to ask many basic questions about the profession of psychiatry. *Then*, from mid-2013, I became involved with supporting a person with a serious mental disorder – who eventually took his own life, while in care of our mental health services. Sadly, this story is far from unique: I know of similar tragedies in many other parts of the country, leaving major questions unanswered, despite determined and energetic efforts by aggrieved relatives to call those responsible to account. By being close to the front-line of mental health care in this way, and from my interaction with many agencies supposed to respond to complaints and criticism in our systems for health- and mental health-care, I have learned much about bureaucratic control in our health systems. I too am left with unanswered questions. These recent experiences have given me an immediate basis on which to analyse the current dysfunction in our mental health services; but I hope that my earlier experiences, as a one-time medical student, as a patient, as a scientist and in other contexts, provide depth to my critique, and to my proposals for reform.

The objective of this essay *is* to foster public discussion. Thus, it is presented in a public forum in which comments are invited for continued discussion. When necessary, I will endeavour to respond to comments provided, as fairly and as quickly as possible. However, there are some ground rules in this discussion:- ***I will not respond unless commentators give me their name and leave contact details. Criticism should not be against named individuals, nor should it indulge in abusive comments. Any such comments will be either redacted, or the commentary will be deleted from the public record.*** It is anticipated that some topics for discussion will be very complex, such that

² Miller R. (2008) *A neurodynamic theory of schizophrenia and related disorders*. Lulu Enterprises, Morrinsville, North Carolina

full comment cannot be made quickly. My document is structured into numbered sections. For ease of responding, I ask commentators to identify sections in this target article on which they make their comments.

[2] Outward Manifestations: A Mental Health System in Disarray:

[2.1] *Individual or Systemic failure?*

In recent years I have witnessed troubling incidents within our mental health services. With few exceptions I avoid blaming individuals, especially those near the front line of service delivery. Shortcomings of front-line staff follow almost automatically from circumstances in which they are forced to work. However, individual culpability increases, at higher levels of management, and for persons wielding power yet shielded from the realities of what their decisions lead to, and from direct criticism. Thus, the most troubling exceptions are mainly at higher levels of management, involving persons in positions of public trust and high responsibility. In such cases, if there has been criminal or civil wrong-doing, the law should take its course. If professional guidelines have been flouted, professional disciplinary action would be appropriate.

Beyond this, I see abundant evidence of a *mental health system* in profound disarray. It is hard to strike the right balance between the ‘big picture’, and the detail; and in the same way, it is hard to get the right balance between individual culpability, and systemic failure. If individuals are to be blamed, these failings pale into insignificance compared to systemic problems. Indeed it is the latter which often provide an environment which enable personal failings to proliferate. In any case, systemic failings apply more widely in our public health systems than just in mental health; yet mental health tends to be a bell-wether for wider dysfunction in health systems and other social services.

[2.2] *Organizational Culture Within DHBs*

A difficulty in the following subsections is that, to identify dysfunction in mental health systems, I need to write about what I have witnessed, but I necessarily have to do this in general terms, precise enough to show that I know what I am talking about, but without detail which might lead to legal action. Thus, I give no detail which would involve naming names, or which would allow identification of persons. Since this essay is a document for discussion, I invite those who wish to comment on this part to state whether they have or have not witnessed behaviour which matches my descriptions; but again, I advise this to be done without naming names or revealing other details which would enable persons to be identified. An exception is when there has already been public comment about relevant incidents (for instance in newspapers). In this case, it may be useful for writers to cite their sources. Of course, I am happy to receive comments which contradict my experiences, as well as those in support.

(2.2.1.) *Defensive Responses, Cover-up and Denial:* Many times in my recent interactions with mental health-care systems, I have seen defensive reactions and cover-ups when faced with criticism: It was a face-to-face meeting with a DHB CEO which first drew my attention to deep systemic problems. This was obvious at that meeting; but, as the story unfolded, it took many other forms: Sometimes it was an attempt to transfer blame to a blameless person caught up in events, who tried, ever more persistently, to

draw attention to the system shortcomings. On one occasion, it took the form of a senior clinician using specialist psychiatric terminology as invective against that person in a defensive confrontation. On another occasion, I felt that an attempt was made by a top manager to cast me in the position of ‘mediator’ (when I would be pulled to the ‘middle ground’ and therefore less able to defend my own perspective), or to recruit me as a collaborator; but I was neither of these, and I stuck to my role as advocate and protagonist in an intensifying confrontation. I have seen top management take extreme actions to avoid press coverage, or to defer or forestall press criticism. There have been occasions when complex defensive strategies appear to have been based on fabricated evidence; and there are suspicions that personnel likely to be ‘in the know’ have been ‘moved sideways’ to other positions (or in other ways) to escape their being identified and questioned. Often, after a tragedy, DHB management avoids face-to-face meetings, between those with immediate or ultimate responsibility and aggrieved parties, in a wholesome attempt to heal wounds, or in a spirit of restorative justice (when there is no escaping a victim’s raw emotions). I have seen evidence strongly suggesting collusion between top management in different DHBs in some of their unacceptable behaviour. Generally I find profound fear by DHB management of anything approaching an appropriately transparent mental health service.

Of course, in complex administrative systems, mistakes occur all the time: They are completely normal. The right way to deal with them is: (a) acknowledge that a mistake has happened; (b) find out as much as possible about what happened; (c) put right the damage, as far as possible, including making amends to victims if necessary; (d) put in place procedures to make sure the same mistake cannot happen again; (e) Move on. *If however there is any evidence of cover-up, or of hiding or distorting evidence, this is not normal, and persons responsible should be identified and held to account.*

(2.2.2) ‘Blame Culture’ and ‘Bullying Culture’: For complex organizations such as the healthcare industry, effective team-work is essential. All employees need to be able to trust that their colleagues will perform their part effectively in a team effort. When this goes awry it is often due to team failure (breakdown of morale or collaboration) rather than individual failure. This has been well understood in the civilian airline industry³, and (I believe) in military organizations: Investigators of airline crashes or ‘near misses’ see as their top priority to establish *what actually happened*. It is important, in the first instance, to avoid search for individuals to blame, and so to avoid defensive ‘cover-ups’ by those closest to the action. If there have been breaches of the law, or if there are signs of cover-up or deception, the law should take its course. Often however, if individuals *are* found to be culpable, there are deeper causes at a systemic level to be identified.

Health industries have been slow to adopt the style of the airline industry. Without this, too much stress is placed on individual responsibility, and therefore on the ‘culture of blame’, and not enough on team responsibility. As a result, when things go wrong, everyone is likely to say ‘not my fault’; and, as a defensive strategy, may then hide what they know. It reflects a prevailing *blame culture*, which I have seen in DHBs. (There is an alternative defensive strategy, discussed below: Systems may actually be *structured* in

³ ‘Safety: The Blame Game’ (June, 2012) *Airlines: IATA*. (<http://airlines.iata.org/analysis/safety-the-blame-game>)

such a way that responsibility, whether at individual or team level can never be pinned on *anyone*, and so can be totally denied.)

Growth of a *bullying culture* is more serious, but a likely sequel to a long-established blame culture. Anecdotes I hear from staff in some DHBs speak of bullying, sometimes from superiors to juniors ('vertical bullying'), sometimes between those at the same level ('horizontal bullying'). Most seriously, I have seen bullying directed at patients and their families, or support persons. There is some evidence of it being directed by top management (or with their connivance). Public comment has been made about 'bullying culture' in the Ministry of Health⁴, or between that ministry and DHB board personnel or chief executives⁵; and a few years ago, it was well known that there had been political (or personality) struggles between CEOs of two DHBs in the Greater Wellington region⁶. Given these signs of malfunction at high levels of health administration, one should seek deeper reasons why persons bearing high responsibility should behave in ways which starkly belie their supposed mission. This topic is discussed in a later section.

(2.2.3) Unidentifiable Chain of Responsibility: Health services deal with matters of life and death; and, as in the armed forces, it is essential that there be a clearly-defined chain of responsibility. Notably, in any clinical team there is a Clinical Manager, and for every patient, an identified Responsible Clinician. However there are signs in some DHB mental health services that the hierarchy has, to a large extent, broken down. Persons are appointed to positions for which they are not qualified. Examples I know include an occupational therapist in charge of a clinical team, with more highly-qualified registered nurses working under her; at a higher level, a social worker in charge of a DHB hospital mental health service; and I include CEOs of DHBs, with no medical training, and, from their behaviour to individuals, no grasp of medical ethics.

There are signs of unease in existing professional relationships, as though no-one quite knows what the chain of command *is*. I hear of a case where an order of an RC that a patient's status under the Mental Health Act be shifted from Community Treatment Order to Compulsory In-Patient status, was not implemented by nurses under the RC. I hear of attempts in more than one DHB by staff low in the hierarchy to set up a more collaborative set of relationships between agencies; but when higher levels heard about it, further development was prevented.

If service users or their families try to get serious complaints addressed and resolved, an alarming feature is revealed: Complainants are referred to one of several state agencies, supposedly set up to deal with such complaints; but then, all too often, the story is one of the tardy and unhelpful responses which singularly *fail* to bring closure to the issues around which complaints were made. There may be endless delays, failure to take responsibility or to make clear decisions. There may be a show of glossy brochures, and impressive flow-charts of what *should* happen; but generally nothing substantial *does* happen. Much concern is conveyed about having good regulations and processes in place,

⁴ Stacy Kirk (2015) Allegations of bullying in Ministry of Health (*Stuff; Politics*; 25th June, 2015). <https://www.stuff.co.nz/national/politics/69692520/allegations-of-bullying-in-the-ministry-of-health>

⁵ Canterbury DHB clinician says Ministry of Health official misled clinicians (from *New Zealand Doctor*): <http://www.nzdoctor.co.nz/news/2015/september-2015/09/canterbury-dhb-clinician-says-ministry-of-health-official-misled-clinicians.aspx>

⁶ <http://www.stuff.co.nz/national/health/64187035/DHB-bosses-rift-requires-mediation> (Dominion Post 16.12 2014. 'DHB bosses' rift requires mediation')

but there is scant regard for whether they are – or ever could be - implemented. There is a frustrating tendency for responsibility to be passed from one person or agency to another, always with further delays. With the near-universal tendency to ‘pass the buck’, no-one knows where the buck stops.

These shortcomings suggest that a clearly-defined chain of responsibility is sometimes replaced by an amorphous (i.e, ‘without form’) set of professional relationships. One is led to ask ‘why?’ - and again one is drawn to seek deeper, structural reasons for this manifest failure to fulfil the stated objectives of the various agencies.

(2.2.4) Problems in Staffing; Rapid Staff Turnover, Difficulty Retaining Good Staff. In mental health services, it is a perennial world-wide problem to ensure adequate numbers of staff (psychiatrists, mental health nurses, psychotherapists, psychologists, social workers, etc) with appropriate training, attitudes and skills. At present, this appears to be a critical problem in New Zealand. However, those with long memories assure us that this was also the case forty years ago. So perhaps this is the norm for New Zealand; and we should all accept it as ‘par for the course’. However, there are signs that the problem is, at least in part, a bi-product of underlying systemic issues, and need not be a permanent fixture.

I start with a recent anecdote: A friend, who had been an excellent mental health field worker in a community organization, had been away from the field for some years. She asked me to write a character reference for her, for a position as manager of a rural hotel/tavern. I knew she would have preferred to return mental health work. In truth, the skills required might not be so different. . . but what a waste! Across the country, there will certainly be many similar people whose talents are similarly wasted.

A comment is often made that our mental health services are too reliant on overseas-trained staff (especially psychiatrists), or recent immigrants. In one DHB I know, all psychiatrists are overseas-trained, excepting a single permanent staff member, plus registrars (inevitably ‘in transit’). One need not question the training or skills of overseas-trained staff; but, inevitably it takes many months for recent arrivals in New Zealand to adapt to cultural norms and expectations. Overseas staff come from various countries with different mental health laws, and criteria for compulsory treatment. Often they are recruited at short notice, and on short-term contracts, when the staffing situation in a ward becomes desperate; and they are then thrown in ‘at the deep end’, that is, in an acute ward (the most challenging part of any mental health system). For this, they are ill-prepared, with little support or education, for instance on complexities of New Zealand’s Mental Health Act or on cultural issues. They are unfamiliar with the need for a patient to go before a family court judge, with their own legal representation, and with the doctor having to justify his decision, prior to making a compulsory treatment order. They are left to sink or swim. Although overseas-trained doctors may have competency in English, more than that is required to work effectively in mental health, to cope with the nuances of patients’ communications, and the multiple ‘technical’ languages needed in an acute ward. One American psychiatrist I met went to great lengths to become fluent in *Te Reo*, but returned to USA, dismayed at the setting in which he had to practice.

An important statistic to assess the staffing situation is the rate of staff turnover. Rapid turnover is often a sign of poor workforce morale and defective organizational culture. In the mental health area, building of therapeutic relationships is of vital importance, and therefore so is *continuity of care* by a single clinician/therapist. Rapid turnover of staff is

one of the factors which undermines continuity of care, but it is not the only one (see section 4.3.2[xiii], below). I am not sure whether statistics on staff turnover are compiled by DHBs, or Ministry of Health, but if they are, results seem not to have been released. I have never seen such statistics. Anecdotally, in one DHB, between 2011 and 2016, I hear that there was a succession of six overseas-trained psychiatrists on one- or two-year contracts; and some broke 2-year contracts at the 1-year mark. Some left because they felt that their reputation would be irreparably damaged if they stayed. I have been told that, in one of the smaller European countries, a turnover rate of more than 10% per annum would be regarded as a crisis. In those terms, this DHB seems to have been in permanent crisis for a number of years.

Such evidence, admittedly anecdotal in places, suggests that the crisis in staffing in our mental health service is *not* an irrevocable norm, but is a bi-product of some aspect of the administrative framework within which mental health care is delivered.

(2.2.5) Top-down 'Control and Command' Administrative Style vs Distributed Leadership: A survey conducted in mid-2013 by the Association of Salaried Medical Staff (ASMS), released in June 2014⁷, examined the extent to which 'distributive clinical leadership' characterised each of the country's 20 DHBs. The term 'Distributive clinical leadership' defines a collaborative, somewhat democratic style of policy formation and decision making. It is the direct antithesis of a 'top-down, command-and-control' style of management⁸. The key statistic from the survey was the percentage of staff surveyed who thought their Board was genuinely committed to distributive clinical leadership. Across the country, only 30% of respondents felt that their DHB was genuinely committed. In only 2 of 20 DHBs (Canterbury and Lakes) was the figure above 50%; and in the worst case, it was as low as 6%. Although this survey was conducted a few years ago, the results indicate the pervasive nature of 'top-down' managerial culture in DHBs. The executive director of ASMS, Dr Ian Powell, identified the problems as stemming from behaviour and culture of the District Health Boards themselves. If so, difficulties might be resolved by replacing Board chairs, and/or Chief Executives in the more problematic DHBs. However, as I argue below, the evidence suggests wider dysfunction, rooted in the legislative framework for *all* DHBs, and therefore unlikely to be eradicated simply by change of leadership.

(2.2.6) Unhealthy Tension Between Financial Controllers and Clinical Staff: Early in my recent encounters with DHB management, I was led to suspect that their questionable behaviour was driven mainly by financial concerns, and the need to create a good impression at higher levels. Above all, adverse press coverage had to be suppressed. I am no expert on financial matters; yet others, who *are* experts, point out the difficulty in delivering health services as budgets are constrained: A recent article in *New Zealand*

⁷ Ian Powell (2014) DHBs fail clinical leadership test. *ASMS Newsletter*, 2nd April, 2014. (<https://www.asms.org.nz/news/asms-news/2014/04/02/dhbs-fail-clinical-leadership-tests/>)

⁸ In the theory of bureaucracy, according to Max Weber, writing in the 1890s (see: 'Bureaucratic Theory by Max Weber': <https://www.toolshero.com/management/bureaucratic-theory-weber/>) an effective bureaucracy was both hierarchical, and characterised by 'top-down control'; but it was not designed so that responsibility could be avoided by those higher in the hierarchy

*Medical Journal*⁹ argues that expenditure on our health system is low by international comparisons, has been falling, and that there are compelling reasons to spend more on health. I have no wish to enter this debate, but wish to make one point: Healthcare is a complex operation involving many different sorts of expert working together; effective teamwork is of utmost importance. Whatever funds are available from the public purse, delivery of good quality services depends on good workforce morale and organizational culture. Even if there are severe financial constraints, amazingly good outcomes can be delivered if organizational culture and morale remain strong. As an example, I mention Middlemore hospital, about whose physical infrastructure we have heard bad news in recent months; yet, recently, I heard nothing but glowing praise about its mental health service from a friend whose relative was treated there for a psychotic breakdown: there was excellent treatment, minimal medication side effects, exemplary communication with relatives; the relative soon recovered to resume her life. Pleasant physical surroundings can certainly confer therapeutic benefits; but the main predictor of good care is good interpersonal relationships and staff who work together as a trusting team. Of course good morale is hard to sustain if a ‘blame and bullying culture’ prevails more widely.

(2.2.7) Comparable shortcomings in other agencies: Experiences on which I draw in the preceding subsections point to inadequacies not only within DHBs and their mental health services, but in other state agencies, whose role should be to resolve grievances, or have a ‘watchdog’ role over state health-care agencies. Long delay seems to be common, and takes many forms. In dealings with various public bodies, I have discerned what can be called ‘overload and delay’ tactics, intentional or otherwise, used to avoid serious complaints against services being acknowledged, addressed, or ever brought to public notice. In one instance a police officer cited the statute of limitations to avoid an assault case in a public hospital being followed up (although I hesitate to direct criticism at the police, knowing how hard-pressed they are). Another strategy is that, by subtle shifts of wording, the strength of an original complaint is progressively ‘diluted’. To restore the potency of the original complaint adds to delays. In terms of legal liability, a complex story may be rendered meaningless, by carving it into small items, whereby each agency rules on minor matters, rather than building up a comprehensive account of a connected story which make sense to the ‘reasonable man’ of Common Law tradition. I have detected a style where agencies apparently colluding in wrong-doing may split their responsibility to avoid collusion being detected.

Given the limited resources of the individual complainant compared to the large supra-structure of the organisation against which they bring complaints, or who are supposed to handle their complaints, the individual stands little chance of bringing serious issues to a satisfactory conclusion. Overall, in defining the dysfunctions in our mental health system, my impression is that administrative failings are more important than clinical mismanagement. If the former can be rectified, so probably will be the latter. Clearly, to get to the root of the dysfunction described in this section, it is required to unearth a complex mass of problems at many levels. There are likely to be structural flaws which allow the numerous travesties and tragedies to happen.

⁹ Lyndon Keene, Philip Bagshaw, M Gary Nicholls, Bill Rosenberg, Christopher M Frampton and Ian Powell (NZMJ; 27th May 2016; pp. 10-20) ‘*Funding New Zealand’s public healthcare system: time for an honest appraisal and public debate*’.

[3] Managerialism and the Legislative Roots of Dysfunction; How Their Consequences Unfolded:

(3.1) History: The roots of the dysfunction in our mental health services can be traced back many years, but the focus here is mainly on the last generation. A radical transformation of public administration, which affected most areas of the Public Service, took place in New Zealand in the late 1980s. It was part of a global trend, which can be termed 'managerialism'. I trace this back to the Second World War, and writings of James Burnham. His most influential work '*The Managerial Revolution*' (1941) was a great influence on George Orwell (in '*Animal Farm*' and '*1984*'). As a socio-political 'theory' of history, similar to Marx's '*Das Capital*', he suggested that neither capitalism nor socialism would prevail. Rather a society would emerge dominated by 'managerial classes', who would control - and increasingly, come to own - the means of production. In the 1970s, this perspective started to take root in the theory of nation-state governance in Western countries. In many countries it is now dominant. Often the rhetoric used to support this has been that the managerial approach 'improves efficiency'. Of course, this begs the question: Efficiency to what end? The concept of 'efficiency' surely implies 'a means to an end' and not an 'end in itself'. However, one never hears clear answers to that question.

In New Zealand managerialism became a reality with precipitate legislation introduced by Roger Douglas. The impact of this legislation is very important, but now little understood because it occurred a generation ago. In particular, I specify the State Sector Act of 1988, and the Public Finance Act 1989, although other legislation of the time reinforced the management style it imposed. The State Sector Act defined new power relationships between government ministers and chief executives of state agencies. The Public Finance Act 1989, its inseparable 'twin', defined financial aspects of this new relationship. In effect they were in the nature of constitutional laws, expressed in abstract and general terms, applying to all state agencies. Taken together, they were immensely powerful, and hard to change. Since then, provisions of this and related legislation have become steadily more deeply entrenched: A generation later, only those with a long memory know anything different, making them even harder to change. What has this legislation meant?

The State Sector Act 1988 separated policy formation (the minister's task) from policy 'implementation' (the task for what were henceforth called Chief Executive Officers - CEOs). In my view it is a mistake to make such a sharp distinction:- Policy formation cannot be attuned to on-the-ground realities, unless there is continual, back-and-forth debate between those who design policies and those who know from first-hand experience, what is possible. The rationale for the change was said to be to 'depoliticise' implementation of policy; but this is sophistry, since policy formation and implementation can hardly be separated, and, taken together are both *essentially* political. In the new framework, CEOs were given great power to use whatever means they thought necessary to implement the minister's policies, but little chance of come-back to the Minister, based on what was possible. CEOs were fixed-term appointments (usually for 5 years, their tenure determined by 'performance') rather than 'Permanent Heads of Department'. Thus, the relation between minister and CEO became very asymmetrical in power, one of 'command and control' from minister to CEO, not the 'free, frank and fearless' advice given from civil service permanent

heads to ministers, as in former days¹⁰. The sharpest sign of this asymmetrical relationship has been the decline of public health services in the last decade, with board chairpersons or CEOs unable to state in public what they must have known. CEOs were responsible not to the minister, but to their legal employer, the State Services Commissioner, making it near impossible to hold ministers to account for policy failures. With policy formation separated sharply from implementation, a minister facing obvious problems in his or her area, could easily ‘wash his hands’ of the consequences, with the line ‘Oh – that’s just an operational matter’. Under Helen Clark’s administration there was some shift from the legacy of the 1980s, but Roger Douglas’s revolution was not fundamentally changed. John Key’s administration, focused on finance, not social policy, and the ‘command and control’ dynamic became ever more powerful.

The State Sector Act 1988, also redefined the relation between public and private sectors. In the previous Act – the State Services Act 1962 - the two were strictly separate: State servants could not take on other employment. In the mid-1980 the need for a ‘triangular hierarchy’ with the minister at the apex was questioned, and it was suggested that there was a need for more diverse inputs into government policy development, notably from the commercial world. This thinking influenced the State Sector Act 1988; and although many clauses were inserted supposedly to avoid conflicts of interest for external consultants, it was almost inevitable that they would proliferate.

The Public Finance Act 1989 was legislation which formally separated ‘outcomes’ from ‘outputs’. It specified financial aspects of top-down control. Under this Act, ‘providers’ contracted to provide services required by the ‘purchaser’, according to standards set by the latter. Since the purchaser was in a monopoly position, it was a one-sided contract. An ‘outcome’ was ‘a state or condition of society, the economy, or the environment, and includes a change in that state or condition’. Government was the ‘purchaser’ and ‘owner’ of the outcomes. ‘Outputs’ were defined as ‘goods or services that are supplied by a department, Crown Entity, Office of parliament, or other person or body’, including ones supplied under contract or intended to be so supplied, with CEOs as the agents responsible.

Both these Acts were passed with scant regard for democratic scrutiny: The State Sector Act 1988, was passed under urgency; the Public Finance Act 1989, became law without its authors ever responding to criticism from the Legislative Advisory Committee, as is supposed to happen. Considering their importance, they should have been given more careful examination in parliament.

In fact there was stark incoherence in the legislation. The relation between Ministers and CEOs became similar to that between shareholders (owners) and managers in a limited liability company, as emerged after the ‘South Sea Bubble’ fiasco of 1720: Ministers had limited responsibility (in strict sense of the word) for what emerged from their demands for outcomes. The Legislative Advisory Committee argued that the idea of the Crown ‘owning’ a department’s net assets in the manner of an investment, and making capital contributions to departments, misrepresents the relationship. ‘Departments *are* part of the

¹⁰ This principle was supposed to be retained in the new Act; but because of the highly unequal power relationship which was defined between minister and CEO, this was largely fictional.

Crown. The public legal relationship between them is not one of investment¹¹. A consequence was that government is both owner of a department, and purchaser of its outputs. Purchasers want to pay as little as possible; yet lower prices reduce the rate of return. Newbury¹² comments that the ambiguity was resolved by 'requiring departments to set their prices to cover but not exceed full costs, including the cost of capital, and paying departments no more than a fair market price for outputs'. This is not the way purchasing between independent agencies are supposed to operate. Later, a report of the Productivity Commission, 2015¹³ comments 'This system has strengths and weaknesses. It is strong on accountability and delivering services specified in terms of outputs, yet weaker on delivering outcomes.' . . 'This weakness is due both to fragmentation of expenditure and to a lack of focus on, and information about, actual clients. . .' This typifies the managerial emphasis on 'efficiency' without ever defining the end in view.

It was not until the 1990s that managerialism started to pervade health and social policies. The impact of the State Sector Act 1988 in the health and mental health sectors is described shortly. Under the Public Finance Act 1989, performance is monitored in terms of outputs, financed in specified categories. Thus, in health systems, it was hard for creative and conscientious practitioners to depart from these categories to deliver what they saw as quality care in health systems: Top-down control was thereby reinforced.

In the mental health area, after passage of these two Acts, area, there were other developments: In 1992, a new Act of Parliament was passed (the Mental Health [Compulsory Assessment and Treatment] Act 1992). This followed much consultation with families involved (probably less with the actual service users of the time). It was framed in awareness of the arbitrariness of committal to state asylums in former years. It is discussed in section 4.3.2[ix].

In the mid-1990s, a Royal Commission, under leadership of Judge Ken Mason produced its report (1996)¹⁴, and led to considerable progress in the next decade. This included the formation of the Mental Health Commission, massive growth of the NGO mental health care sector, increasing involvement of past users of mental health services as employees in DHBs, and by the mid-2000s, the setting up of a confidential listening forum to document the serious abuses which had occurred in asylums (now closed), in former decades. It should be noted however that the changes approved by parliament were far less than what Ken Mason and his panel had wished, both financially and structurally. Warwick Brunton writes:

The government established the Mental Health Commission as a 'tightly-focused' body with a 'watch-dog role', not as the quasi-department envisaged by the Inquiry. The most likely explanation is that the recommended body would have cut across the prevailing management ideology of the policy-purchaser-provider

¹¹ Legislative Advisory Committee, submission on Public Finance Bill, 1989, Parliamentary Library. http://www.ir.canterbury.ac.nz/bitstream/handle/10092/862/thesis_fulltext.pdf?sequence=1&isAllowed=y

¹² Newbury SM (2002, p. 94) *New Zealand's Public Sector Financial Management System: Financial Resource Erosion in Government Departments*. PhD Thesis, University of Canterbury, New Zealand, p. 95. http://www.ir.canterbury.ac.nz/bitstream/handle/10092/862/thesis_fulltext.pdf?sequence=1&isAllowed=y

¹³ Productivity Commission (2015) *More Effective Social Services*, p.119-120.

¹⁴ Mason, K. (1996) *Inquiry Under Section 47 of the Health and Disability Service Act 1993 in respect of Certain Mental Health Services*. Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley, Christchurch.

split. Just as important, it would have reduced the Ministry's own claim to national leadership.¹⁵

Dilution of the effectiveness of the Mason report, even of those recommendations which *were* implemented, started in the later years of the Clark administration and continued under the administration of John Key. When, in 2012, the Key government wound up the Mental Health Commission, this can be seen as a foreseeable consequence of the fact that it had not been established as firmly as the Mason panel would have liked, a further impact of the entrenched philosophy of managerialism. A somewhat independent body such as the Mental Health Commission did not fit the managerial model.

There have been other insidious but far-reaching consequences of the 1980s legislation, some applying generally, others particularly in the health area, detailed next:-

(3.2) *Flow-on Effects of State Sector Act 1988: Concept of Ministerial Responsibility:* In Westminster style of government, the principle of 'Ministerial Responsibility' plays a crucial role: In the end, the buck stops on the minister's desk. In the past, if dysfunction of sufficiently serious nature was evident to parliament, it was honourable for a minister to resign, whether or not he/she had personal responsibility. This principle is an important guarantee that responsibility for each government decision is assigned to an elected official. It motivates ministers to scrutinise operations of departments in their charge. In recent years, resignation has been rare, except for serious personal misconduct, but not for administrative failure. Nonetheless, in the latter cases, at parliamentary question time, it is still usual for ministers to accept responsibility before parliament and to apologise.

In New Zealand, the principle of ministerial responsibility has been weaker than in other Westminster systems¹⁶. In the late 1980s legislative changes just discussed, made it harder to hold ministers to account, even in most blatant cases. After introduction of the MMP electoral system, cabinet ministers no longer needed to be members of the majority party in parliament. An increasing number of ministers were not members of cabinet. It was more complex to implement principles of Ministerial Responsibility¹⁷, but these are still upheld in latest versions of the Cabinet Manual. Despite this, in case of serious departmental failure, it is nowadays rare to hear so much as an apology at parliamentary question time. As already mentioned, complaints are often brushed aside with the line that 'that is just an operational matter', or 'I was not informed', or there may be a sudden attack of 'amnesia; and any idea of a formal apology degenerates into parliamentary banter ('I'll apologise for this if you apologise for what you did in the last government'). It was the legislation passed in the late 1980s, which gave ministers strong motivation to evade the rigours of Ministerial Responsibility. Indirectly this contributed to shortcomings identified in section 2.

(3.3) *Flow-on effects from State Sector Act 1988: Top-down administrative style in DHBs:* Changes in the 1980s meant that CEOs were given great power (some say too much). In addition, later, for health, delivery of most services was devolved to 20 DHBs,

¹⁵ from: Brunton W. [2005] The place of public inquiries in shaping New Zealand's national mental health policy 1858-1996 *Australian & New Zealand Health Policy* 2, 24.

¹⁶ https://readtiger.com/wkp/en/Individual_ministerial_responsibility#New_Zealand

¹⁷ https://www.parliament.nz/en/pb/hansard-debates/rhr/document/47HansS_20030521_00001053/power-simon-budget-debate

each of them having a large degree of autonomy. If something went seriously wrong, the minister was no longer responsible: CEOs *were* responsible, and were thus in a very exposed position, with no public mandate, yet asked to deliver on objectives which might be near-impossible. What did this mean for the relation between CEOs and ‘lower levels’ in each DHB (including top-class clinical experts in many fields)? It depended on the style of each DHB. This varied widely, as a result of the high degree of autonomy permitted for DHBs. The style *might* be excellent, but it need not be so. One can characterise the spread in terms of two extremes, as strategies by which CEOs and boards found ways to cope with their exposed position. Some DHBs developed a very democratic style (although this was not required). The CEO might then see it as part of his/her job to front up to the public, answer their questions and respond to their criticisms. In this case, there was likely to be relatively free flow of information within the DHB, and the dynamics of interaction within the DHB might mitigate the controlling style from the ministry. At the other extreme was a ‘top-down’ style, in which flow of information was tightly constrained to ensure that control remained unchallenged. CEOs were likely to build defences to protect their vulnerable position, so that close scrutiny of top management became near impossible. They, like the minister, could scarcely ever be held to account for failure. It seemed to be assumed that, if top-management (and they alone) knew everything that was going on, control, and therefore efficiency, would be optimised. In this case, the top-down control from the ministry was continued as top-down control of lower levels, unresponsive to realities at front lines. Any upward flow of information was to ensure that those at lower levels followed instructions, rather than to adjust the plan to realities at ground level. Of course, because the personnel (if not the CEOs) tended to stay the same year after year, over many years the respective styles became entrenched, for better or worse. Change of CEOs, while important, was unlikely to solve enduring problems of organizational culture.

(3.4) Flow-on effects: Erosion of a Clear Chain of Responsibility within DHBs: In section 2.2.3, examples were given suggesting erosion, and at times collapse of the discipline and hierarchy, in the chain of responsibility. One is led to ask: How does the chain of responsibility disintegrate to become such an ‘amorphous’ and dysfunctional set of professional relationships? This does not seem to be a *direct* or explicit consequence of anything in the State Sector Act 1988 or the Public Finance Act 1989. The effects were indirect, unintended, and evolved slowly over a whole generation under the new regime. The effects can be summed up as the slow impact of staff attempting to deliver a good service under legislation which in significant ways was itself unwise, and in places incoherent, and therefore put staff in difficult, sometimes near-impossible situations.

The previous subsection described how the power relationships defined by the State Sector Act 1988, starting at ministerial level, and spreading downwards, led persons to evade their proper responsibilities. This tendency derives from implicit incoherence of the power relationships, notably that policy formation be separated sharply from working out the details of policy implementation. Incoherence of the Public Finance Act 1989, was also described in section 3.1. In general, the quest for ‘efficiency’ without defining the end in view is also incoherent. Erosion of the chain of responsibility was encouraged further by the blurring of the boundary between public and private sectors: There has been a steady increase in the numbers of highly-paid consultants recruited from outside

the public sector to advise on state sector agendas¹⁸. Despite many clauses in the State Sector Act 1988 to prevent it, conflicts of interest were inevitable – notably, external consultants recruited to implement a political agenda about which the electorate was never informed, let alone had a chance to vote on.

These changes played out slowly over a whole generation, so slowly, that few understood the insidious changes. Sometimes there was recognition that professional relationships could be better organized; and there were power struggles, which should not have been permitted under this (or any other) legislation. In recent years, when things went wrong, all-too-often, no-one could identify ‘where the buck stops’, probably because, literally, it did not stop *anywhere*; but this was due to the imprudence and incoherence of the legislation, not to any of its deliberate intentions.

(3.5) Flow-on effects of State Sector Act 1988: Emergence of blame culture and bullying culture: Consider the gradual impact of the State Sector Act 1988 on the health workforce, especially if financial pressure – to ‘deliver more with less’ – intensified, or as a general edict ‘to work smarter’. If there was a democratic style in the DHB, and organizational culture favoured free flow of information, good team-work and mutual support, there may have been little fall in standards, although staff worked under increased stress. With a more controlling style, a decline in morale set in, flow of information to top management lost its accuracy, because ground level employees adopted a defensive strategy. Bullying may start to break out, at first vertical bullying, then horizontal. In due course, and over the years, the ‘command and control’ style in the relationship between minister and CEO, spread outwards and downwards to every part of the CEOs fiefdom. In the end it often led to a ‘blaming and bullying culture’. At its worst (especially in mental health services), it has led to bullying by staff of patients and their families, leading to unnecessary deaths. I have seen this: an apparent suicide by a staff member – never documented as such; and the well-documented suicide of a patient in an acute mental health ward. I *do* know about this! However, most of the blame should not be directed at front-line staff. Their behaviour grows out of the administrative framework in which they have to practice. It may not grow immediately; but over a generation, new styles become embedded in workforce culture, and are progressively entrenched. Staff may be little aware, let alone understand the gradual erosion of standards. Certainly they are in no place to challenge what comes to be taken as the norm.

(3.6) Flow-on effects of State Sector Act 1988: Effects on staffing: Inevitably, as financial pressure increases, front-line staff find it increasingly hard to deliver good services. They cannot work well when they are not valued. In the end, they may be asked to deliver beyond their capacity; morale declines more steeply, especially in the more controlling environments. As this happens, good staff start to leave, seeking employment elsewhere, and it becomes difficult to recruit competent staff to replace them. Recruitment starts to draw on personnel with little training, poor attitudes, or from overseas (who may be good, yet need a few years to adjust to special features of practice in New Zealand); and by this stage, the situation starts to accelerate as a vicious spiral:

¹⁸ see for instance: Sam Sachdeva (2017) ‘Government super-ministry under fire for spending on external consultants’ *Stuff*, 15th February, 2017. (<https://www.stuff.co.nz/national/politics/89390521/government-superministry-under-fire-for-spending-on-external-consultants>).

The only staff who can be recruited, and retained are those with poor attitudes and training, or overseas staff, without local knowledge, either on short-term contracts, or retained only for short periods. Predictably this leads to total breakdown of the service, as I believe is now the case in the mental health service in some DHBs. At this point, woe betide any member of the public who tries to make a complaint. He or she will meet endless defensiveness, can never find where the buck stops, and may themselves become targets of the DHBs controlling style.

(3.7) Flow-on Effects of Managerialism: Pseudo-quantification: The mantra of administrators in the last generation has been ‘*if you can’t measure it, you can’t manage it*’. Obsessive worship of what social planners thought to be ‘quantitative reasoning’ goes back three centuries. After Isaac Newton’s astonishing quantitative reasoning, in which he gave accurate descriptions of planetary orbits, prototypical social scientists/managers thought that they too must base their decisions on measured *quantities*. There were serious flaws in this, which prevailed, largely unchallenged, to the present day:- *First*, a ‘number’ is not necessarily the same as a ‘quantity’. For it to become a quantity, it should obey rules permitting arithmetic operations (as did variables in Newton’s system). Money (in dollars and cents) *is* a quantity, but many other numerical measures devised by social administrators (especially in the last generation) are not. *Second*, precise reasoning, whether or not quantitative, depends on precise concepts. Newton’s system worked so well not just because it was quantitative, but because concepts used were securely validated, to enable precise reasoning.

To illustrate the obsession with - and flawed application of - quantitative measures in our mental health service, documents from Ministry of Health list 63 ‘Key Performance Indicators’ (KPIs) for adult mental health services, 28 for child/youth mental health (with no detail given on the age-range included), and 13 for the ‘forensic stream’¹⁹. These are ‘a set of nationally comparable indicators of service performance reported by the District Health Boards (DHBs) *and non-government organisation (NGOs)* [emphasis added] to bring about quality and performance improvement across the sector.’

How precise is the measurement achieved by this cloud of KPIs? Are the derived numbers even quantities? Talk to front-line psychiatrists: Many will tell you that they are so busy completing the necessary paperwork from which these KPIs are compiled, taking time from their real mission, namely interaction with patients, that they do it in a perfunctory fashion. Moreover, many clinicians, nurses and middle management know well what will look good; so, at various levels in the hierarchy, it is likely that statistics are ‘massaged’ before they reach top management. These distortions severely undermine any conclusions which might be drawn from the aggregate figures.

Many of the indicators *are* simple quantities, however inaccurate (such as ‘Average length of acute patient stay’; ‘Average duration of contact’ [of staff with patients, in minutes]). Some are ratios (‘Community treatment days per service user per quarter’; ‘Acute inpatient cost per acute in-patient bed night’). Strangely, only two KPIs attempt to document *effectiveness* of treatment. These use the ‘HoNoS’ (‘Health of the Nation Outcome’ scale), averaged across patients, at time of admission and at time of discharge.

¹⁹ ‘Key Performance Indicators for the New Zealand Mental Health & Addictions Sector [<https://www.mhakpi.health.nz/>].

Doubts exists about whether this is reliable or valid as a routine measure of outcome²⁰, and one might ask if numbers derived from the HoNoS are really quantities. Moreover, as a KPI for effectiveness of a mental health service, there are serious shortcomings, in its being an *aggregate* measure, giving no information on *how many individuals* actually recover - and to what extent - as a result of hospital care. To this writer, it is also absurd, to condense the complexities of recovery from mental disorders into a single number. As explained later the definition of mental health is clearly a *quality*, different in each individual, not a quantity; and likewise recovery from a mental disorder is uniquely different in each person. In logic, qualities cannot be reduced to quantities.

This leads to the question: Why was there no more thorough attempt to assess the effectiveness of DHB mental health services? The neglect of assessment of true outcome is a prime example of a managerial style, where ‘efficiency’ is emphasized, without ever addressing the related question: ‘To what end?’ Above all, the dearth of measures of outcomes was most likely a consequence of the fact that it cannot easily be quantified.

A *major* area where the real objectives of a good service cannot be quantified is in services where different people, with different skill-sets, and perhaps in different agencies need to collaborate. The Productivity Commission, commenting on the public Finance Act 1989, notes that ‘narrowly specified budget appropriations are in tension with efficient cross-service allocation and service integration.’²¹ Difficulties with the Public Finance Act are especially pronounced for non-governmental organizations working in the community and voluntary sector, to deliver social support, as detailed in a recent report²². Prior to this Act, government grants usually aimed to fund *organisations* in the community and voluntary sector. They did not focus on specific *outputs*. After the Act, support was to be provided by contract for delivery of specific services, shifting from a ‘community development’ to a ‘service development’ model. In the latter style, government decides what outputs are required, and specifies that success is to be measured only with respect to those separate, categorized outputs; and it seems to be beyond comprehension of government officials that good community services consist of many interweaving components, separation of which would destroy the whole tapestry.

The World Health Organization defines health as a ‘State of complete physical, mental, and social well being, and not merely the absence of disease or infirmity.’ This does not fit the managerial style, since *there is an infinite variety of states of health: They are all qualities, not quantities.*

When all this is pointed out, the mantra that management decisions in our mental health services must be based on quantitative measurements appears to be flawed beyond repair, if, by that token, managers lay claim to being ‘rational’ or ‘scientific’. Managers may be fooling themselves, but they do not fool me!

(3.8) Flow-on Effects of the Public Finance Act 1989: Tension Between Clinical and Financial Mandates: Undue emphasis on quantification has been reinforced by the

²⁰ Brook R (2000) The reliability and validity of the Health of the Nation Outcome Scales: validation in relation to patient derived measures. *Australian & New Zealand Journal of Psychiatry*, 34, 504-11.

²¹ Productivity Commission (2015) *More Effective Social Services*, p. 119-120.

²² Grey,S, Sedgwick,C. (2013) *Fears, constraints and contracts. The democratic reality for New Zealand’s community and voluntary sector.* (Report presented at the Community and Voluntary Sector Forum, Victoria University of Wellington, 26, March 2013).

<http://www.victoria.ac.nz/sacs/pdf-files/Fears-constraints-and-contracts-Grey-and-Sedgwick-2014.pdf>

Public Finance Act 1989, because outputs had to be fully-costed. Finance-driven styles of administration came to prevail in healthcare. Examples I cite are what I infer rather than what I know directly: Direct knowledge of motives for decisions would be intrinsically hard for an outsider such as myself to access. However, as a generality, all procedures should be costed, to permit 'rational' budgeting decisions. This creates problems:

- Even for high-tech procedures, such as joint replacement surgery, accurate costing may be difficult, given uncertainties of the procedure, discovered only during the operation.

- In mental health treatments, whose essence is often the building of a therapeutic relationship, full cost accounting becomes problematic, because it cannot be quantified.

- Psychotherapy, if available, is often limited to a small number (usually six) sessions under the health service budget, which makes therapeutic relationship-building difficult.

- There is a severe lack of psychological therapists and psychological treatments across the country, in either hospital- or community-based statutory mental health services. I ask: Is it too expensive, compared to supposedly effective psycho-pharmaceutical treatment? . . . or is the real reason that it is intrinsically non-quantifiable, compared to medication?

- I have evidence of covert (and therefore unethical, and probably illegal) moves to have a difficult patient moved to care in a rehab/forensic facility, when he was not a forensic patient, perhaps because it was deemed to be cheaper.

- I also know of a patient in a manic state in a ward who ran up \$20,000 debt by transactions on a computer, to which he should not have had access; later, the ward appeared to try to hold him financially accountable for what were really the ward's failings.

Granted, there *is* intrinsic tension between financial and clinical imperatives; but there should be structures in place to resolve this in a systematic, disciplined, and ethical manner. Otherwise we move towards the rationale prevailing in health care during the Third Reich, where decisions over euthanasia were justified in financial terms. The only part of our health service where anything like such a structured approach exists, is, I believe, in PHARMAC. Elsewhere, it usually seems to be a straight power struggle, with financial controllers in a dominant position. This feeds into the bullying culture; and in turn it means that, added to financial stringency, staff no longer give of their best, had collective morale been better, in the prevailing straitened circumstances.

(3.9) Flow-on Effects of Managerialism: Misplaced Emphasis on 'Evidence'; Demise of History-Taking as a Clinical Skill: I suspect that it is managerialism which, in part, has led to a related flaw, the perennial demand that any proposal be 'evidence based'. In health-care systems, this arose *at first* from realisation that decision-making by clinicians was often based on personal 'intuition' and authority, which could not be challenged, yet might lead to serious mistakes. However, consider for a moment how a conscientious practitioner actually operates – or used to operate: Much bed-side decision-making was based on three processes: *pattern-recognition*, *hypothesis-testing*, and *deduction*.

Pattern-recognition is known in another context as 'inductive inference'. It *is* subjective, error-prone and hard to render as definite rules. Nonetheless, aside from clinical medicine, we all use the process many times each day, without a moment's thought. Every time we recognise someone by their face or tone of voice, it is pattern recognition. We cannot say how we do it, but we know more than we can say. If the pattern is indistinct (such as when a face is seen from afar, or when a voice is obscured by other sounds), we *do* make mistakes. In clinical practice, errors due to faulty pattern recognition are of course less frequent for practitioners with long experience than for relative novices.

Hypothesis testing may be used deliberately to disambiguate patterns which are too indistinct to resolve clearly. In bedside clinical medicine, it may amount to a physician asking

careful questions about tiny details of a patient's experiences, answers to which may refute one possibility or support another. This is a form of deduction, and could be explained in explicit and verbal terms.

However, *deduction* is often neither explicit, nor verbal. Again, this is an everyday, process for most of us: When parking a vehicle, 'reverse parking' can be described as a variety of non-verbal, implicit deductive inference; and for most of us, we cannot explain how we do it: Again, we know more than we can say! In other terms this is called 'intuition'. Another example of the same non-verbal deduction, more relevant to clinical situations and mental health care, is that, when we know another person quite well, we can predict fairly accurately how they will behave in a novel situation. This is exactly the situation faced by an experienced astute clinician, faced with a difficult, perhaps urgent decision, yet lacking full evidence. Often, clinicians *do* make correct decisions, yet can give no better account of this than to refer to 'intuition'.

In former days, as I know, ambitious young doctors might try to mimic the intuition of their more experienced seniors. I remember one such young high-flyer assert pontifically: 'I think this lady has a large ovarian tumour'. Later her problem turned out to be more benign – diverticulitis. As part of the strategy to constrain the vagaries of such unaccountable intuitive decisions, clinicians are now generally required to explain in their records, the rationale for their decisions; but in reality this usually falls far short of a fully explicit and rational account of their decisions. The crux of many decisions is still 'intuition'. In addition, it is now routine for doctors to work with their peers and submit hard decisions to peer review; but this hardly amounts to truly independent review, going back to all raw evidence (unless a patient calls for a second opinion).

This is all part of the background leading health administrators to emphasise 'evidence based medicine'. Of course, evidence, if available, *is* important; but what about situations, including many from past medical practice, where evidence is scanty, or where reliance on 'evidence' led to a veritable *cul de sac*? In any case, lack of any plausible KPIs concerning effectiveness of treatment (see above), suggests that the motive behind the collection of evidence was *not* to improve outcomes, but, arguably, to exert control, or even 'to *show* who was in control' – but perhaps, by now, just as a mindless routine.

There is some concern that these trends have led to a decline in physician's clinical skills. The most fundamental clinical skill for doctors – at least in the past – was taking a detailed history. This provided valuable information on a patient's disorder: It might be all that was needed to reach a diagnosis and decide on an effective treatment; but it also provides nuanced information about how a disorder affects a person, and thus amplifies the diagnosis with important individual detail. Beyond this, it allows an astute clinician to learn about his/her patient, and, most important, to establish rapport and a relationship based on trust. Nowadays, I suspect this is often not given so much emphasis in medical training. Instead, there is increased emphasis on results of technical investigations, and on documenting '*risk factors*' besetting a patient (but rarely on '*protective factors*').

The concept of a 'risk factor' was not part of medical practice until recently: It is actuarial in origin, arising from the insurance industry. Only since the early 1990s has this become prominent in medical discourse with an increase in 'check-list medicine'²³. I suggest that this is a sign of the 'managerial take-over' of clinical medicine. Another

²³ see: <http://alertandoriented.com/risk-factor-medicine/>

example of the trend is the style of recent editions of American Psychiatric Association's *Diagnostic and Statistical Manual*, where diagnoses are reduced to a checklist of supposed objective symptom classes. These then are significant parts of the 'evidence' which clinicians might cite to justify their decisions.

There are many concerns with such trends: Risk factors are transformed unnecessarily into disease entities. There may be over-eagerness to treat on this basis, under the catch-all banner of 'preventive medicine'. There is a serious but largely unrecognised statistical flaw: Logically there is no reason to expect risk factors (including molecular genetic risk factors) to summate arithmetically: There is no necessary reason why a patient who has three defined risk factors for a condition, or three supposed genetic markers conferring slightly increased risk, is at greater risk overall than one who has just a single one. Indeed, it is logically possible for one risk factor to cancel out another. Compiling constellations of risk factors should not replace detailed history-taking and clinical reasoning based on the history.

In addition clinicians may come to trust results of expensive scanning procedures more than their own intelligence. Practice then becomes a defined process of 'following the book' rather than reckoning with each patient's idiosyncrasies. In psychiatry, this may amount to over-reliance on measures on poorly-collected, poorly-validated rating scales. The neglect of detailed history taking – which may be enforced by the sheer number of patients to be seen – is more serious than in other specialties, because there is little more to go on other than a detailed history, which may be very complex, encompassing the whole of a patient's life. I have heard clinicians from more than one country bemoan the fact that, with the emphasis on 'checklist medicine', a clinical interview involves the psychiatrist staring at his computer screen, filling in boxes he sees, and therefore missing vital cues from his patient's facial expression or body language.

Introduction of 'Care Plans': The supposed theory behind this development is pure managerialism – to define a problem; identify procedures to fix it; and then sign off when done. It might work to some extent in routine surgery but not elsewhere, especially when you are dealing with long-term care in the community, or for older people whose home is a room in a residential care facility. It also assumes a mechanistic or 'engineering' model of humanity, which I describe and criticise in section 3.11 (below). This is but part of modern managerial style - of putting in place numerous 'regulations', with little done to ensure they are or ever could be followed; and staff may not even have time to read them. I am told that they are put in place merely to comply with higher-order 'regulations' and the need to get accreditation.

Altogether, the substitution of detailed history-taking by documentation of risk factors, high-tech investigations, 'Big-Data' statistical analysis, and endless sets of regulations seems to replace the subtleties of the 'Art of Medicine' by a semi-automated algorithm-driven process. This is captured succinctly in a startlingly impersonal line I have been told, when a community mental health practitioner had his last session with one of his clients: '*We're closing you now!*' It seems that in the brave new world of contemporary medicine everything should be entirely predictable, and therefore grist to the mill of controlling administrators, with low tolerance for uncertainty; who like to issue edicts, expecting them to be carried out as given; and who can then take pseudo-rational financial decisions. It makes bedside medicine *seem* more scientific; but there is a flaw: Science, strictly defined, is not just based on evidence, but on 'evidence combined with reasoning'; and reasoning cannot be secure if the concepts it uses are also shaky. The truth, though scarcely admitted, is that the

managers who insist on ‘evidence’ and ‘quantitative measures’ are often using such methods (and their positions of power) to enforce their way, because it is they who define the ‘pseudo-concepts’ around which ‘evidence’ is collected and quantified. Demands for ‘quantification’ and ‘evidence’ is thus an exercise of administrative power dressed up as ‘rigorous social science’. To put it another way, the style purports to be ‘rational’, but in reality is an edifice, erected to make decisions ‘defensible’ within current managerial frameworks. Thus the call for evidence-based medicine merely replaces one unaccountable authority, with another.

(3.10) Conflict over Professional Ethics: Concepts of medical ethics can be traced back to the ancient Hippocratic Oath, and in modern times to the Nuremberg Trial of Doctors (1946-7). Generally these concepts define the responsibility of a doctor as an *individual practitioner* to an *individual* patient. Examples of questionable professional behaviour in mental health and health services, referred to in Section [2], above, might be characterised as ‘unethical’ in these terms. However, today, there may be sleight of hand in use of the term ‘ethics’: There is an underlying clash between *different concepts* of professional ethics: The word ‘ethics’ has a different meaning in the medical world – its proper field - from the commercial world. In the latter, ethics may refer to confidentiality between completing tenders, or similar conventions for business deals. In that scenario, the individual patient counts for nothing, although the purchaser or seller of services might be an individual. Clash of different ethical frameworks has become more obvious in the last generation, when health administrators often have no medical education. So, we frequently see a business/administrative mind-set encroaching on health- and mental health-care: A patient or her family member realises that there may have been serious shortcomings and possible malpractice, and registers a complaint. After long delays, involving other agencies – Privacy Commission, Health & Disability Commission, or (in mental health), a District Inspector – the complaint may (in a sense) be upheld; but the last thing any complainant will hear is a wholehearted apology, or disciplinary action (or at least, not one which is publicly acknowledged). There may be vague mealy-mouthed impersonal expressions of ‘regret’ (using passive rather than active forms of verbs), falling far short of an admission that anyone, or any service, or the system as a whole, was culpable; and there may be assurances that procedures (with added paperwork) have been put in place to make sure that such an unfortunate event cannot recur – but this is a response at an aggregate, not a personal level. Another way in which mental healthcare may be depersonalised is by placing undue reliance on diagnoses, assigning each person to a definite administrative category. For *clinical* purposes, diagnoses in psychiatry is quite problematic, and far from a sure guide to the best treatment (see section 4.3.2[i]) In *summary*, the administrator’s mind-set is coming to prevail over clinical medicine, thereby undermining time-honoured traditions of medicine, including ethical traditions.

(3.11) Service Coordination: Failure of Necessary Synergies: Here I cite a few instances, without much detail, because they have features in common, and my focus is on the commonalities. Consider the following examples (and other similar ones):-

- Building Correct synergies between acute mental health wards, community mental health teams, and CAT teams;
- Defining the proper roles of - and synergy between - Crisis and Assessment teams, Emergency Departments in hospitals, ambulance services, and police;
- Fostering collaboration between different services required for various dual-diagnosis combinations.

- Truly collaborative relationships between hospital or community services and families in which a member has serious mental health or addiction problem.

What I hear suggests that, often, necessary synergies fail to operate. Communication between acute wards and community teams may be minimal, especially at time of discharge; petty bureaucracy hinders fast response by CAT teams ('Is this patient really our responsibility?'); and there may be endless buck-passing between EDs and CAT teams, with inevitably, police (one of the few agencies to operate round the clock) as the last resort for desperate patients and their families. For dual-diagnosis combinations (especially when drug and alcohol problems combine with mental disorders), services for the different parts of a patient's problems seem to operate from different, even antithetical philosophies, and no-one knows how to weld the different professional services. While central government recognizes that family (or other) caregivers are vital members of treatment teams, in practice, in community mental health services, family caregivers not always welcome, and their role may become minimal, and perfunctory.

Much of the failure here can be viewed as a consequence of the Public Finance Act, 1989, which insisted on separable sources of funding for different components of collaborators in teamwork. One sees exactly the same pseudo-rational siloed approach in the principles of the State Sector Act 1988, in its separation of policy formation from policy implementation.

(3.12) Synopsis: *The Underlying Fallacy about Human Nature:* There is a fundamental implicit assumption jointly underlying the philosophy of Managerialism, and its legislative offshoots in New Zealand, the State Sector Act 1988, and the Public Finance Act 1989. It is about the model of human nature which they employ. When the scientific revolution of the sixteenth and seventeenth century started to transform human societies, its focus was 'natural philosophy', what we now call physics. In subsequent centuries the style, and many of the assumptions of this 'philosophy of nature' came to define many other disciplines, notably chemistry and engineering. However, at its inception, biology was not included, and – notably – '*human nature*' – was never considered under the heading 'philosophy of nature'.

It is impossible to define any model of human nature without also considering the nature of a society built around such a model: The two prescriptions are inseparable. Inevitably all human societies have needed a model of 'human nature' as a guiding norm. In the absence of a model grounded in the natural sciences of the time, two alternatives - or a combination of the two - have been proposed since the seventeenth century. One of these was a reversion to classical notions that the 'power of reason' was somehow 'natural', a defining feature of the essence of 'human nature'. This and the related concept of the 'reasonable man' became founding assumptions for jurisprudence, and legal processes; and, after the French revolution, departure from this supposed natural state of rationality became a founding assumption to define 'mental illness', in the nascent discipline of psychiatry - a supposedly scientific branch of medical expertise. Unfortunately, however, the assumption that reason was a natural and essential feature of humankind was far from completely correct; and nowhere did this assumption about the natural power of reason amongst humankind make contact with the 'common language' of the expanding field of the natural sciences.

The other model of human nature, mainly a twentieth century development, can be called 'the engineering model' of human nature. It is based on the assumption that human behaviour can be understood by analogy with the deterministic cause-and-effect relationships, guiding the design of all engineering and technology devices devised at the time. It flourished in the aftermath of research on basic principles of conditioning – Pavlovian conditioning in Russia; instrumental conditioning in the USA. Both were important scientific advances, but it is quite

incorrect to regard them as complete accounts of the mentality of either animals or humans; yet this was widely assumed in middle years of last century. Add to these the activities of Edward Bernays (American nephew of Sigmund Freud), a ‘public relations’ version of Freudian psychology, based on manipulating behaviour of the masses by appeal to their hidden emotional drives. Add further the mechanistic ideas for industrial production called ‘Taylorism’ (precursor of James Burnham’s ‘managerialism’). Together such trends led to an assumption that human behaviour, was deterministic, not only in principle, but in practice; and therefore it was the responsibility of ‘wise social managers’ (themselves somehow freed from the limits of this determinism) to exert control over the rest of the populace, ‘for their own good’. In this, it was assumed that humans were infinitely malleable by processes of conditioning or emotional manipulation.

Managerialism is infused with some of the deterministic credo, along with the supposed infinite malleability of the general public; but beyond that, later offshoots, including the New Zealand State Sector and Public Finance Acts, and economic thinking with which they have been associated, combined the ‘rationalist’ and ‘engineering’ models of human nature. Thus by offering a judicious combination of incentives, rewards, and sometimes threats and punishments, human beings, guided by their own unerring sense of rationality, could be led in a direction favoured by the social planners. In principle this was also seen to be near-deterministic. The conditioning might take a generation to be built into a ‘reformed’ version of human nature; but in the long run it would certainly become the accepted norm; and a happy and stable society would then arise. The model of ‘rational self-interest’, beloved of economists in the last generation, has a similar underlying assumption: that persons are defined by little more than their economic roles, as consumers, investors, shareholders, earners, and taxpayers, and can therefore be predicted and manipulated.

There are several fundamental flaws in this prescription. I draw attention to one which is well analysed by some of the brightest scientific and mathematical minds of the last century. Principles of causation may or may not be strictly deterministic *in principle* – no-one can tell; but even if they are so, in complex systems such as many in biology, and most social systems, *in practice* they are indeterminate, and unpredictable. The engineering devices, to which a twentieth century model of human nature was likened, *were* predictable, and would not have been successful had they not been predictable; but this was achieved by avoiding the complexity typical of biological and social systems. In biological (and therefore social) systems, there is no reason to suggest that basic principles of causation are in any way different from those in the physical world; but the complexity of these systems means that they are largely unpredictable. Just as social planners of the eighteenth century misapplied the rigorous scientific reasoning of Newton, likewise those of the last generation have misunderstood and misapplied scientific advance from the twentieth century. Nonetheless, to preserve their positions of power, there has been a degree of ‘make-believe’ so that what in reality is a subtle exercise in compulsion, is given a supposedly rational, philosophical or ‘scientific’ justification.

Why do I dwell on this? If we want to reform our failing, dysfunctional mental health system, reconstruction needs to be built on firm foundations. That is, it should be based on a more realistic, and practically-useful model of human nature; and - I insist - one based on the best of what modern science (including brain science) has to offer. In the next section, an important subsection gives details of exactly this:- my conception, grounded in theory of modern brain function, of how our brain constructs for us, each in our own way, our sense of being a person. To bring into play such a pragmatically-sound model of human nature (in all its diversity), will help not only our understanding of ‘mental disorders’; it will also be a

good guide to setting up the complex social systems by which health and mental health care can be delivered as a public service. If this is to come about, revision or repeal of those two Acts of parliament, based on more viable notions of human nature, may be needed. Of course, those two Acts have had their impact not only on mental health care, but quite widely across the whole of the Public Service, especially the 'human services'. The conclusions I draw from consideration of failure in our mental health system could probably be reached by considering dysfunction in many other areas of public service. Therefore, to get to the roots of the current crisis in mental health care, such that an enduring remedy can be found, may have an impact far beyond the immediate focus of the Inquiry: It has the potential to bring healing to a deeply-fractured, over-individualistic and troubled society. The context of the current Inquiry into mental health and addiction services is unlikely to be enough to set in motion this legislative reform. However, others in high places have been saying the same²⁴; so, 'with a little help from our friends', change may occur.

[4] Detailed Proposals for Reform of a Dysfunctional System:

(4.1) Introduction: Intensifying Public Pressure for Reform: My own experiences in recent years, which provided much of the basis for this essay is by no means unique in New Zealand today. In recent months, my attention has been drawn to similar stories across the country, where unnecessary deaths have occurred of persons in care of state mental health services. I am in touch with aggrieved relatives of persons who died in such circumstances in various parts of the country. Common themes include: inadequate clinical management, which is unresponsive and inhumane; defensiveness; and at times obstructive behaviour when complaints are made. In the year before the 2017 General Election there were many calls for comprehensive review of the Country's Mental Health Services (my voice being one). A private psychotherapist in Auckland, Kyle MacDonald, with support of Mike King (comedian turned mental health activist) conducted a 'People's Review of the Mental Health System'. Kyle and his colleagues collected over 500 submissions about care individuals received in the country's mental health system. The report on these submissions was released on 19 April, 2017, and added substantially to the chorus of voices pressing for a large-scale public enquiry. In the following section, I summarise my ideas on the way forwards, to rebuild a broken system. Many issues crowd together demanding resolution, some urgent, others long-term and fundamental. It is hard to know where to start; yet, in what follows, I try to prioritise.

The formation of the new administration last September provides a chance to unwind the sad legacy of managerialism. I rather think - and hope - that the combined leadership emerging from the election may be capable of the fundamental reforms for which I call. The Prime Minister is from a new generation, not tainted by the 1980's brush; and the Deputy Prime Minister has a longer memory than anyone currently serving in our parliament. He knows what happened in the 1980s, and, I believe, never accepted the legislation brought in by Roger Douglas. However, reform will require determination, skill, courage and idealism. It might not occur in the present parliamentary term, but - I hope - perhaps in the next.

²⁴ Alastair Thompson 'The Role Of A Free Press In Defending & Fostering Democracy'. Scoop NZ website, 12th March 2017.

A difficulty here, as explained in my introduction section, is that some issues require to be addressed with urgency; yet underlying structural problems must be addressed, more thoughtfully, deliberately and inevitably more slowly. I start with the most urgent issues (section 4.2), and work towards the most fundamental and long-term reforms. Section 4.3 deals with overarching matters of Leadership and Administrative Style. The longest part, section 4.4, deals with a large number of ‘Special issues’. Section 5 looks to the further future, which also means addressing outstanding issues from the past.

(4.2.) *Urgent issues:*

(4.2.1.) *Assistance for Individuals and Families in Crisis Now.* The sharpest edge of the mental health crisis is happening *now*: It cuts deep into the lives of individuals and families, destroying lives and livelihoods. Urgent action is needed *now*. This aspect of the crisis includes unprecedented levels of suicide, especially youth suicide and suicide in rural communities; the scourge of addiction to amphetamines in their various forms; and, most obvious in our city streets, homelessness, with many sleeping rough – often the result of unaddressed crises in mental health and addiction.

To marshal a response to this dire situation a coordinated response is needed from many agencies: As a start, I list:- Ambulance services, Police, Emergency Department staff in hospitals, Crisis Assessment and Treatment teams of DHBs, other staff with mental health expertise in public and the private sectors, Drug and Alcohol Counsellors, Social workers, School Principals and Guidance Counsellors. The non-governmental organizations concerned with mental health issues should also be part of the response to the crisis, as described in the next section. Coordination of their several activities requires leaders of such agencies to come together urgently, in each region. As genuine whole-of-community responses to the crisis, many other agencies might be involved – church groups, service clubs, and - not least - local branches of banks and other financial institutions. Such bodies *should* be involved, because local finance would be needed to support local initiatives.

Some participants would come from DHBs, but if this is to be a whole-of-society response, the coordination should not be under the auspices of DHBs. I advise this for two reasons: *First*, many agencies which need to be involved have nothing to do with DHBs. *Second*, DHBs do not have a great track record in setting up the sort of coordinated approach I envisage. Indeed, I hear accounts from more than one DHB where lower levels in the hierarchy within a DHB attempt to coordinate activities of different groups in democratic collaborative fashion, to improve the delivery of services; but when higher levels of the administration get to know of this, measures are taken to undermine these grass-roots efforts, because it cuts across the established power structure.

The incoming Labour government has already initiated some aspects of a response to the crisis in mental health, for instance, in the proposal to fund positions for practice nurses with mental health expertise in all secondary schools. Other similar initiatives may require funding from central government. However coordination of the many agencies who need to work together is best done at regional or local levels.

In addition, there may be a need for leaders of such local initiatives to come together nation-wide, to share experiences, and to learn from each other’s successes and mistakes; but the process should start with local leadership, rather than being coordinated from a start at a national level. A model of the whole-of-society approach is mentioned in section (4.3.2[v]) – a program developed in Kentucky, USA, to reduce youth suicide.

(4.2.2) *Emergency Assistance for Viable Community Organizations:*

Response to mental health crises of individual persons requires local knowledge. Most communities in New Zealand have non-governmental organizations with mental health as their concern; and these organizations are often the best repository of local knowledge of individuals and families where crises are developing, might develop, or have occurred. In recent years, funding of NGOs from public sources has become tighter. Some NGOs have been forced to close, and many others have had their independence constrained by government conditions, including funding limited to specific ‘outputs’ (which is then hard to direct towards unpredictable, but common crises of mental health). Others may now be on the point of collapse. As part of a coordinated ‘whole-of-society’ response to mental health crises for individuals, and as a matter of urgency, it is necessary to support NGOs with a capacity to respond to crises and emergencies. This includes supporting those organizations which might otherwise close their doors, and to restore those which have recently closed, but are still viable. Reinstating the vibrancy of the NGO mental health sector must be part of the community response to crisis, outlined in section 4.2.1.

(4.2.3) *‘First Aid’ for Severely Dysfunctional DHB Mental Health*

Services: In a few DHBs, mental health services appear to be in melt-down. In these DHBs, the task may be not so much to *re-build* a dysfunctional system, but to start afresh and build something new. Change of top management (board chairperson; CEO), though important, is not enough to shift an entrenched culture. Initially, there may be a need to recruit a small team of mental health professionals from outside the region to assess the whole service, provide whatever immediate support they can, and gain an impression of which local staff can be trusted. I write here first as a logician, then more pragmatically.

Logically, a way forward is as follows: A small committee is selected, to interview all other mental health staff. That committee might include some of the visiting experts; or such experts might help to select committee members. Committee members might then include two psychiatrists (one strong on in-patient care, the other on community care); two mental health nurses (one experienced in in-patient care, the other in community care); members of other supporting professions, including a pharmacist, social worker or occupational therapist; a person with medico-legal/forensic psychiatry expertise; and an administrator. All of these should be selected on the basis of *their having the trust of the communities they serve*. The committee should then operate on a triage principle, sorting interviewees (former staff members) into three groups who are: (a) Competent in almost any condition; (b) Unsuitable in almost any conditions; (c) Competent, if they ‘shape up’ after considerable retraining, and under good supervision. The focus of interviews (apart from qualifications and prior experience) should include: attitudes to mental disorders and to patients with such disorders; attitudes to precepts of health ethics; their special application in mental health care; full appreciation of how mental disorders undermine an individual’s sense of personal agency; the commitment of each staff member to restoration of full health to their patients; and their integrity in reporting malpractice.

Some years ago, the proposal I have just made was no more than my own ‘thought experiment’. *Pragmatically* it would indeed be a tough policy to implement, because it may lead to redundancies, and may well lead to strong resistance from vested interests (unions and professional colleges); yet, pragmatically, one way or another, redundancies would be inevitable, once it is accepted that fundamental change is needed and cannot be achieved while existing staff hold positions of influence. They say ‘You cannot make an

omelette without breaking eggs’; and certainly the revolutionary legislation from the 1980s (which I criticise in section 3) led to many thousands of redundancies across the country. More recently, when I had access to clinical records for a patient (now deceased) going back 15 years, and saw, to my shock, that the rotten administrative practices which I knew of in years 2013-4 were a near-exact replica of what occurred in the same service in 2001, my proposal gained a sense of reality, no longer just a thought experiment.

No doubt some existing staff *would* protest about the financial and administrative pressures and organizational culture under which they had been working, and were powerless to change. The committee would need skill and wisdom in assessing the validity of these claims. In any case, the very process of interviewing would indicate that a new regime had begun. Of course, what I suggest may not be possible except in the context of fundamental re-shaping of the whole mental health sector. Such a strong measure would also require recruitment of many new staff, a point I address below.

(4.3) Long-term Measures for Fundamental Reform:

(4.3.1) Leadership and Administrative Style:

(4.3.1[i]) The First Step: Getting the ‘Right Persons’ at the Top: The most fundamental place to start the process of change may be to get the right leadership, although, by itself, that is not sufficient. By the ‘*right leadership*’, I refer to three perspectives which leaders should embody: (a) having an appropriate concept of human nature; (b) being fully committed to ethical principles for modern healthcare; (c) recognizing that, in resolving tension between clinical and financial imperatives, the two have equal status, and must develop a collaborative approach rather than the latter dominating the former. By ‘*the top*’ I refer certainly to CEOs of DHBs and Board chairpersons, and above that to the Minister of Health. In sections 4.3.1(ii), 4.3.1(iii), and 4.4.1, I expand on each of these attributes of potential future leaders.

The problems currently faced by the mental health service require both urgent action and deliberate long-term strategic development. These *might* require different styles of leadership, the former playing a more dominating role, the latter more collaborative in style. In either case, leaders need to acknowledge past faults and be able to explain the strategy adopted to lower levels in the system; and by showing willingness to listen, new schemes might be given a hearing, as a start to developing a culture of innovation (see section 4.3.1[iv], below, on Toyota management principles).

(4.3.1[ii]): Defining a Realistic Concept of Human Nature; Defining a Healthy Society: Fundamental reform requires re-examination of fundamental assumptions. The model of human nature employed is fundamental to mental health, not only in getting a solid grasp of what is meant by ‘mental health’ and ‘mental disorder’ but also in devising the complex social structures by which mental health care is delivered. In Section 3.11, I criticized the concept of human nature which seemed to underlie legislative changes of the late 1980s. The changes, introduced in undemocratic fashion, were often unrealistic, and at times incoherent; yet, over the generation since then, had consequences quite destructive of the best aspects of New Zealand society, and its social cohesion. Is there a better model of human nature?

What is human nature? If posed as a scientific question, many people will assert that it is unanswerable. That is not my view: I have been thinking about this for most of my professional life. Indeed, my first book, published 1981, was entitled ‘*Meaning and Purpose in the Intact Brain*’. That was juvenilia. Nearly 40 years later, I am closer to

providing a useful answer. In a lecture entitled '*A Voyage of Healing*', given at a conference in Hong Kong in November 2017, I summarized my ideas on how the brain we have constructs for each of us – and then continually reconstructs throughout our life – *our sense of being a person*²⁵. It is significant that this lecture was delivered outside New Zealand; at present the climate here does not favour the sort of ideas I presented.

A central idea in this lecture is that our brain constructs, or 'invents' *contexts* within which our day-to-day experiences acquire meaning. This simple statement can be supported by a well-developed and detailed theory of the brain mechanisms by which those 'contexts' are constructed²⁶. It is not necessary to go into those details in what follows. However, one of the major functions of such context is to enable us to recollect past episodes in our personal life story: We can retrieve these memories to a large extent by re-activating the context in which they were first acquired. Our sense of 'being a person' depends absolutely on our ability to have continuity of these memories of our life story. The most fundamental context is then what I call 'a context for living'. This is more-or-less synonymous with our sense of being a person. Thus, the human brain and the mind it embodies is designed to construct for each of us (and then, throughout our lives, to continually reconstruct) an image of our 'self' and our personal story, which attains the greatest possible sense of coherence and consistency of purpose. Other cultures have similar concepts, though not to my knowledge ever derived from brain science. Notably the Maori concept *Turangawaewae* – the 'place' (literal or figurative), where you feel at home, your 'spiritual home', or, in Paul Tillich's phrase, the 'ground of our being' - has many of the same implications as my concept. My lecture also referred to Victor Frankl's short but profound book '*Man's Search for Meaning*.' Whoever we are, *that search* is our voyage; it is what we are here for. Many types of mental disorder can be conceived as arising when life's traumas combine with each person's intrinsic vulnerability to completely undermine and overwhelm the context for living, which he/she has so carefully constructed; and recovery can then be seen as the period, perhaps many months, when those contexts must be reconstructed, often on a deeper foundation.

Human beings are members of a *social* species of mammal. Others might dispute this; but if it is accepted, the question '*What is human nature?*' cannot be separated from another question: '*What is a healthy society?*' Many philosophers have attempted to describe such a society, with diverse prescriptions. In particular a 20 year old will have a very different view from a 70 year old. Nonetheless, I want get to the heart of the question, and build on the notion of human nature just referred to (which *does* encompass the whole of a person's life). I make a general suggestion, which should cross generations: That society should be constructed to allow all its members freedom to discover their own 'context for living', their own *Turangawaewae*. Information from each person's daily experience can then be placed in their own personal 'context for living' within which information is transformed into personal meaning. It is the freedom to pursue that search for meaning, which defines a healthy society. Given that humans *are* members of a social species, the quest can never be just an individual quest: As John Donne wrote: 'No man is but an island': Each person, as they develop their personal

²⁵ see:- http://robertmiller-octspan.co.nz/octspan/?page_id=581

²⁶ Miller R (1991) *Cortico-hippocampal interplay and the representation of contexts in the brain*. Springer Verlag, Heidelberg ('Studies in brain function' series).

‘world view’ inevitably adapts his/her own viewpoint continually, in response to what he or she hears from others. If this is accepted, interactions between people – though at times stressful – should, as far as possible be respectful, fully aware of the diversity of human personality and of life experience.

Looking to the future, we are told that automation will advance to such an extent that, before long, few people will be in the position of actually ‘earning their living’ in the traditional sense. New Zealand’s policy for higher education in the last generation held that higher education is primarily about training for gainful employment. This is now exposed as fallacy: Higher education is not primarily about making persons ‘employable’ (though that may be a secondary ‘spin-off’); it is, *primarily* about giving people the mental versatility to help them find fulfillment within that society - sometimes inside, sometimes outside traditional means of employment (including the voluntary sector); to become active participants in the democratic processes of their society; and thus to find their own meaning in that society.

Consider the macro-economic implications of my arguments: GDP as a quantitative measure of national economic success is now questioned, in part because many things of value (notably ‘meaning’ in its most general sense) cannot be quantified. Some countries are experimenting with the notion of a ‘national basic income’, implying that people may be valuable in ways other than through their earning capacity. Follow through the logic of this, and look further to the future: Money, as a way to quantify, and thus to exchange things of value, may lose some of its hold. So... is there another currency, which could be encouraged, and could, in part, come to replace monetary currency? What about the currencies of *trust*, of *human relatedness*, the ‘*milk of human kindness*’? In Aotearoa/New Zealand this currency already has considerable validity; and it did since earliest days of settlement: The country would probably be near to collapse, were it not for the large, vibrant, unpaid voluntary sector, focused on important issues - local, national, or international - often pursued with great dedication and expertise.

Trust is the essential glue that holds together any society. It is also the glue that binds together an effective public health service: It makes for good organizational culture and good morale. Of *prime* importance, the *general public* should trust the service; but as a close second, trust should exist between the different streams and levels in the *health workforce* itself. Erosion of trust can occur insidiously over many years before it becomes obvious. When this has occurred, and especially where it has developed into a bullying culture, it may be hard for staff to speak out, since what they say could lead to their being harmed or targeted. To restore public trust, and trusting relations within the service, strong leadership is needed, and wise concerted action, sustained over an extended period. Only slowly will staff regain the confidence to feel safe when they speak out. Essential starting points have just been mentioned: Getting the right persons at the top, able to infuse a healthy concept of human nature into the organizational culture. A guiding principle in restoring trust has to be *transparency of information flow*.

(4.3.1[iii]) Ethical Principles for Modern Healthcare: In section 3.10, I referred to precepts of Medical Ethics, and their history. Proposals coming from the Nuremberg trial of Doctors dealt with ethics of medical *research*. For this the concept of ‘informed consent’ was central. More recently, this principle has been extended to many therapeutic interventions which are *not* research. Nowhere does this extension of the concept apply more powerfully (yet still subject to much debate) than in mental health care, given that,

in this discipline, legislation permits compulsory treatment in some circumstances. The priority given to the informed consent principle is actually relatively recent. In older medical traditions, four basic principles of medical ethics were recognized: *beneficence*, *non-maleficence*, *justice* and *autonomy*. (I am inclined to add a fifth principle – transparency – to the list; but the application of this is far wider than in medicine, and may not always apply there.) ‘Informed consent’ fell under the ‘autonomy’ heading. In early days, solid evidence for efficacy and safety of medical interventions, let alone scientific understanding, was very limited. As a result, physicians assumed a mantle of unassailable, quasi-religious authority (and legal immunity), which patients were not expected to challenge. So, for most of history, the beneficence principle outweighed the autonomy principle by far, often as ‘benevolent deception’; there was no expectation that patients should give ‘informed consent’.

In parallel with this history, over the decades since the Nuremberg trials, managerial styles have changed, and many top health administrators have been appointed, who have no medical background, and who may have little grasp of, or commitment to basic precepts of medical ethics. In this context, I point out that at the Nuremberg Trial of Doctors, the majority of defendants were not practitioners who carried out the atrocities, but administrators at higher levels, who, by the stroke of a pen, authorized them.

Today, I believe, ethical commitment has to be a basic requirement for future health administrators appointed to leadership roles. Their ethical sensitivity, and commitment to ethical principles, must be deep and instinctive, despite the fact that policy decisions often require delicate balance between competing interests and ethical principles. In my recent lecture in Hong Kong, I made the suggestion that, it is important for health administrators (whether or not they have medical training) to give public assent to a document similar to the Hippocratic Oath, adjusted to the context, to define their ethical commitment. Such a requirement would have flow-on effects, in that it would influence the manner of training and induction of health administrators.

An aphorism of William Osler, renowned Canadian physician of a past generation, defines a patient-centred approach:- ‘*It is much more important to know what sort of patient has a disease than what sort of disease a patient has*’. Given the imprecision of psychiatric diagnosis as a guide to treatment, this maxim should perhaps be applied in psychiatry more than any other specialty. Beyond this, commitment of administrators needs somehow to retain a focus on individuals as much as on diagnostic or other categories, despite the fact that these persons deal with issues in generic terms, rather than with individual patients. Certainly, the ‘*non-maleficence*’ principle forbids an administrator to publicly target an individual patient or family member, if their criticism of services gets too ‘near the bone’.

(4.3.1[iv]): *Administrative Style and Workforce Culture: Lessons to Learn from Toyota*: It may seem unusual to refer to management style in a major motor industry, in advocating reform in mental health services, but I am serious: On workforce culture, there is much to learn from comparing the management styles of a uniform mass-market motor company, such as Ford (as it was at the time) and Toyota, as it broke into the market from near zero sales in the 1950s and 1960s. This *was* itself very unusual - and noteworthy. For Ford, production plans were specified in last detail from the outset. Production lines forced workers into endless, meaningless, dehumanising routines, as portrayed in Chaplin’s silent movie ‘*Modern Times*’; the concept of workforce morale if

it ever existed, did so on a different planet. Models produced were of a limited variety, and within each model, all were the same: 'You could have any colour you liked, so long as it was black'. Toyota's production style was more flexible, and more adjustable to the ever-shifting realities of demand. Initially, at each stage of production, workers fed back their needs not to top management, but to the immediately preceding stage. Eventually the management style evolved to include individual customers in the process, so that production was quick to respond to demand of real consumers. In the end, every aspect of production was 'pulled' by consumer demand, not 'pushed' by top management. This meant that Toyota vehicles were produced in a greater range of models, to suit the range of actual demand rather than some hypothetical 'average' in the mass market. This in turn meant that each member of the workforce needed more diverse skills than in at Ford. Then, as demand shifted, workers could move from one part of the production process to another. This led to better workforce morale: Workers had greater job satisfaction when they made an intelligent contribution to a high-quality product. As far as management style goes, the top priority was *first* the customer, *then* workforce morale; the actual management plan was lower down the list. In the Ford system, top management (supposedly) knew everything that was going on; the worker on the shop floor knew little of the overall plan. In Toyota, no-one (probably) could claim to know all that was going on (because it was much more complex than at Ford); but far more people knew a great deal of what was going on, and could contribute their insight to improving relevant parts of the production process. This gave the workforce a genuine sense of contributing to a large and successful collective enterprise. As at Ford, there *was* a hierarchy in Toyota, as there had to be, but it was one which allowed much mutual deliberation between levels – captured in a Toyota slogan: '*pick a friendly fight with your superior*'. Encouragement of freedom of debate on the shop floor was part of a culture of continual innovation and improvement built into the management style.

Human beings, as members of a social species, usually grow stronger in collaborative ventures; and this should not be forgotten, despite the fact that human individuals and groups often devote much time and effort to competition and rivalry. The Toyota style was based on a more realistic concept of human nature than that at Ford, one where work was a way to find meaning in a collective venture. Possibly it was also based on an Eastern philosophy, rather than the dogmatic rationalism of Western industries of the day.

In applying this comparison to a workforce for mental health care, the reader can no doubt fill in details on the basis of his/her experience. As hints, in complex healthcare systems, it is necessary to give support to the social, collaborative side of human nature. Consider also the advantage to clients if there were numerous routes to mental health care or to recovery from mental disorders. Consider advantages for service delivery and staff morale if staff could switch from in-patient to community care, or from either of these to forensic psychiatry, as needed. Consider how the 'plant' (the actual layout and location of buildings) should be arranged to allow rapid shift from community to in-patient care, or *vice versa* (for instance as demand for intensive in-patient care changes according to how the scourge of amphetamine addiction waxes and wanes). The notion of services 'pulled by demand' figured prominently in a recent report of the New Zealand Productivity Commission (*More Effective Social Services* [2015]). However, adoption of Toyota principles could go much further. Nonetheless, it must be admitted that some parts of

effective mental health services (for instance, effective early intervention programs) must necessarily have advance planning, as well as responding to actual demand.

(4.3.1[v]) *Flow of information:* In the top-down systems of managerial control which were criticized in sections 2.2.5 and 3.3, information flow is mainly downwards. Information *may be* collected from the shop-floor, and fed back to highest levels, to check that directives are followed as intended; but even if the feedback is used to adjust those directives, the response is likely to be subject to long delay, by which time, the situation on the shop-floor may have changed. Such information flow is thus inherently an inefficient form of management. In Toyota management style, information flow is mainly upwards, step-by-step, or horizontal, rather than downwards. This enables decisions to be taken nearest to the level where they are to be implemented, allowing quick response to realities, and use of the intelligence and initiative of staff nearest the action, without tactical decisions needing to go to top management. However, at Toyota, it was also important for staff at high levels in the hierarchy to visit production teams and salesrooms at regular intervals (and thus to be fluent in relevant languages). Likewise in a good mental health service it should be important not only for the leader of that service to visit periodically every part of the services in his or her charge, but on occasion for the CEO of the entire DHB also to make such visits. If that means that service leaders or the CEO accompany community teams to find out who is ‘sleeping rough’ on city streets, that would, in due course, lead to improved service delivery.

Staff located at ‘junction points’ in the branching hierarchy (from top level to the front line) play an important role. They would have two closely-related functions: From close acquaintance with activities in their oversight, they might be able to suggest specific ways to improve services by collaboration between different ‘streams’ under their eye; and, as far as funding goes, decisions on how resources for the collective enterprise should be divided between the alternative parts below them could be made at that level, rather than higher up. At this level, decisions might also be made about initiating a new practice, to resolve an unforeseen problem; and if the initiative proves successful, their success story could be shared more widely. This would embed a culture of innovation and continual improvement to the collective endeavour.

In section 3.8, the question was raised how experienced physicians can retain freedom to base their decisions on intuition, without the vagaries and flaws coming from unaccountable authority. We are now in a position to suggest an answer to this: Direct feedback from end-users to front-line clinicians should be encouraged, along with a culture which empowers end-users in this respect to engage with clinicians in a collaborative spirit. Sometimes this certainly does occur; but at other times it is far from the reality of clinical interactions. In this it is also vital that complaints are evaluated and responded to quickly, near the front line, as far as possible informally and effectively, without involvement of bureaucracy.

(4.3.1[vi]) *Creating Necessary Synergies Between Different Parts of the Mental Health System:* Transparency of information flow is a vital ingredient for building or rebuilding trust. The Toyota management philosophy, with transparent flow of information – not only upwards or downward, but also horizontally - leads naturally to emergence of the synergies needed between different sections of the workforce, and it prevents inter-service rivalry or disjunctions from forming. Synergies between adjacent parts of the management structure could come about easily; those between more distant parts might require oversight. On a larger-scale, fostering inter-professionalism, and inter-professional training (see section 4.3.2(xii) below), would, over time, encourage synergies to develop between large sections

of the workforce, so that the complementary nature of their respective contributions becomes embedded as the natural *modus operandi*.

(4.3.2) Special issues:

(4.3.2[i]) Critique of the Psychiatric Profession; Balance Between Dynamic and Biomedical Approaches: In the profession of psychiatry, for more than a century, there has been a deep philosophical rift: On the one hand are those who conceive mental disorders in biomedical terms, referring especially to supposed brain processes, and favouring treatment with physical or pharmacological means. On the other, are those who seldom if ever refer to brain processes for their understanding, but use entirely psychological concepts. This is the ‘psychodynamic tradition’, in which psychoanalysis, psychotherapy, or other forms of ‘talking cure’ are favoured. In the 1890s, this split did not exist in centres for psychiatric thought (Germany, Vienna, parts of France): The different approaches were all parts of a single developing discipline in which there was no radical split of mind from brain. The *split* owes its origin almost entirely to Sigmund Freud, originally trained as a neurologist, but who, in the late 1890s, turned his back on attempts to understand mental disorders in terms of brain processes. Instead he invented his own language of rather idiosyncratic psychological terms. Arguably he was the best mental health politician of the time, to judge from his legacy, but not the best intellect.

For myself, after many years dedicated to study of the theory of brain function, I see no necessary tension between the two approaches: In principle, their fundamental assumptions are compatible, although to bring them together in detail and in practice is a huge challenge. My attempts to bring the two together has given me a way to understand the mind/brain entity which is far from mainstream neuroscience (which *may* not be compatible with psychodynamic ways of thinking). Here I write as a neuroscientist, but, since I am not clinically-trained, I concentrate on ways to *understand* mental disorders rather than on effective therapies. In recent years I have been profoundly influenced by involvement in translating into English and editing the lectures of Carl Wernicke (1847-1905). He is best known as a pioneer of neurology, a reputation gained as a newly-trained physician, but the last twenty years of his life were spent working in a psychiatric institution. By the time he gave these lectures, his thinking was more diverse, an intimate blend of what he inferred about brain processes and the dynamic fluctuations in the mind in his patients. My objective here is not to dwell on detail, but to show that there may be an informed, coherent approach to understanding mental disorders, quite different from that offered by the either side of the Big Divide in psychiatric professions which has existed since Freud’s day. This approach which need not force practitioners to jump to one or other side. I give a few examples:-

First I mention the ‘over-pathologising’ of experiences which do not depart from a ‘normal range’ (looking broadly across human cultures):-

In many culture the experience of ‘hearing voices’ is fully accepted, and the capacity to do so is sometimes even seen as a ‘gift’, but is pathologised in western psychiatry as as ‘hallucinations’. Beliefs vary widely between people. In psychiatry there is the concept of an ‘over-valued idea’ which merges gradually into a definite delusion; but the processes involved are often well within the normal range of experiences. One can make similar comments about strong expression of emotions when a person is under stress; or the *lack* of expression of feelings when a person is under threat. What might be is called

‘manipulative’ or deceptive behavior, is quite understandable as a normal reaction by people who have few ways to avoid the demands a coercive environment.

Next, I identify some of the many problems arising from use of current diagnostic systems. The fundamental flaw in systems for psychiatric diagnosis, is that concepts of mental disorder are defined without a secure notion of ‘the normal case’ (that is ‘human nature, in all its diversity’). In every other branch of medicine, this was an implicit, unavoidable necessity, but not in psychiatry, where diagnosis serves administrative ends, rather than those of clinician-scientists. Multiple flaws in such systems then becomes inevitable:-

‘Depression’ or ‘Depressive Disorder’ are imprecise, over-inclusive terms. Symptom lists can be contradictory (including both over sleeping *and* early waking; or over-eating *and* loss of appetite, for instance). Treatments are many and varied, including many types of medicine (all of which are *sometimes* effective, but in different patients), and various approaches to psychotherapy. The diagnosis provides little help in deciding whether it should be psychotherapy or medication, and if the latter, which.

The diagnoses ‘Schizophrenia’, ‘Schizoaffective disorder’ and ‘Bipolar Affective Disorder’ (formerly called ‘Manic-depressive disorder’) gives rise to many puzzles. The first- and last-mentioned were originally conceived as supposedly separate categories. Wernicke acknowledged both depression (‘affective melancholia’ in his terms) and mania, but did not accept the existence of a definite bipolar category, nor the forerunner of the schizophrenia concept. ‘Schizoaffective disorder’ came later, a compromise to label disorders with features of both schizophrenia and manic-depressive disorder. More recently many have argued that rather than separate categories, these disorder are different points on a ‘spectrum’; and in the last decade, in some countries, the term ‘schizophrenia’ has been abandoned. If the category of ‘bipolar disorder’ *is* valid, it is problematic, because there seem to be subtypes with different responses to medications.

The topic of ‘Personality Disorders’ is especially puzzling: These different disorders are defined without referring to either a model of ‘normal’ personality, or to the large body of research from the discipline of psychology on ‘personality theory’, which defines many dimensions of normal personality variation. By defining certain personality features as ‘disorders’, it follows that the psychiatric profession should offer ‘treatment’; but it is remarkable how little success there has been in providing effective treatment. I prefer to call them ‘extremes of personality variables’, and what follows then, as the best approach to helping clients, would be to guide them to understand their own personality, in comparison with other personality types, and thus to find a *modus vivendi* in relation to the surrounding society; but this is hardly ‘treatment’ as usually understood.

Some significant psychiatric problems are scarcely recognized in official diagnostic systems. I think here of a variety of problems which might be called ‘sensory’ (such as ‘noise sensitivity’), but which are best described as modality-specific hypersensitivity of selective attention. These can be a cause of severe social disability, almost certainly have a physical basis in the brain, and are largely unrecognized by general public, and health professions alike (including both neurologists and psychiatrists).

Should treatment be by medication or by talking therapy? I see no incompatibility in principle; but my impression is that few psychiatrists (to the cost of their patients) understand the underlying theory of how their medicines work, even when that is known; nor do they have a rational way to decide between pharmacotherapy and psychotherapy.

Antipsychotic drugs have been in use around the world for 60 years, but I fear they are still widely misused. My understanding is that, once the dose is above threshold, dissipation of a psychotic state is a function more of time (taking the order of a few weeks, sometimes longer) than of dose. There is little gain by further increase in dose. We hear little of what happens in the mind of patients during those few weeks, but it is a rich area for intervention by dynamic approaches of some psychiatrists. However, instead, it seems to be common practice to use antipsychotic drugs as tranquilizers. Since these medicines often also have sedative properties, this *does* achieve stabilization in the short term, if not real resolution of the psychotic state. It also means that doses far larger than the threshold, and far larger than needed are often prescribed, at cost of unpleasant side effects, and likelihood, later, of non-compliance with medicine regimes.

Antipsychotic drugs can be administered by depot injection (given every two to four weeks), and some patients *do* prefer this to the discipline of daily pill-taking. However, adjustment of dose is problematic, and if the dose has been too large, it is difficult to reverse quickly and may have most unpleasant consequences. I question whether enough care is given to explaining to patients how the medicines work, so that patients might be more amenable to the daily tablet-taking regime.

It has generally been thought that when a person is prescribed antipsychotic drugs, they need to be taken for years afterwards, and perhaps on a permanent basis. The evidence for this view is hard to find; and research studies are needed (and are in progress in a few places) to discover the detail of how patients on these medication manage, in safety, to wean themselves off them (as many do now).

Some patients do not respond well to standard antipsychotic drugs, but the reasons are not always the same. Some patients have acquired fixed habits of thought or perception (fixed ‘delusions’ or ‘hallucinations’) regardless of medication. For them, CBT or other talking therapies may be needed. Others have on-going *active* psychotic states different from those responsive to standard medications; and for them, other medicines (such as clozapine) are often the best way forward. I raise this issue because I suspect that many practitioners do not grasp the difference between these reasons for apparent treatment resistance – nor the difference between *expression* of psychotic habits of thought and perception, acquired earlier, and an *active* psychotic process.

It is clear that Lithium is beneficial to control pure manic states. These states sometimes have psychotic features, which has led to prescription of antipsychotic drugs as first-line treatment. This may be a mistake: Psychoses of pure mania have subtle differences from those of schizophrenia-like disorders, which require astute clinical skill if they are to be recognized, and *are* responsive to lithium in a more fundamental way than they are to antipsychotic drugs.

Electroconvulsive therapy (e.g. for severe depression) is a topic which arouses strong emotions (especially amongst service user groups). In many jurisdictions, it is strictly controlled. My point is that ECT *does* work, sometimes quite dramatically; but it is not understood *why* it works, and so one cannot predict *when* it will work. I believe that adverse effects of ECT (if properly administered) are exaggerated. However, when ECT equipment is available, it is easily misused or abused. In New Zealand use of unmodified ECT, or electric shocks delivered as punishments is well-documented in the past, and contributes to fear in this country about ECT. In my view, such fear is related to the history of abuse in each jurisdiction, not to its ineffectiveness, or lasting adverse effects.

On psychotherapies, there are many varieties to choose from. My understanding is that psychotherapies can be very effective interventions, but not usually for persons for whom medication is first line treatment. The specific ingredients of each method are not the main reason why psychotherapy is effective: Rather it is the nature of the relationship built with a therapist, the therapeutic power of human understanding, and the ‘therapeutic alliance’. Nonetheless, whichever method a therapist uses, he or she should be well-trained and accredited in that method. I would add that a really good grounding in neuroscience can help practitioners in psychotherapy (but this might reflect my own, somewhat unusual approach to neuroscience). Psychotherapies are of course time consuming, and therefore expensive. This has led to attempts to automate psychotherapy, or produce computerized versions; however, this seems counterproductive, given that it eliminates the central reason why psychotherapies are effective.

The workforce of well-trained psychotherapists needs to be greatly enlarged. In Scotland, there is a growing network of well-trained psychotherapists, some medically training, others coming from a clinical psychology background. However, I hear of unhelpful rivalry there between these two sources of psychotherapy training. If therapist numbers are to be increased in New Zealand (a proposal I support), it would be important to find ways to avoid this unnecessary problem. Personnel needed for psychological treatment or psychotherapy could be considerably increased if other professional groups could be accredited for work in DHBs. I think particularly of ‘counseling psychologists’, who, in private practice, often provide valuable service to clients. Their non-inclusion at present may be due to professional rivalries, but also to administrative barriers.

Other technical topics related to psychiatry perhaps attract too much attention from the general public: MRI scanning is almost entirely a research tool in psychiatry, not for routine diagnosis (apart from its use to exclude clear physical processes, such as growth of a brain tumour). Molecular genetics in psychiatry has been a prodigious waste of time and money. I have more time for the old-fashioned studies of inheritance: asking about family history is relevant in practice, especially in relation to bipolar disorder.

(4.3.2[ii]) *Ward Management; Balancing Hospital- and Community-Based Services:* Hospital-based treatment of serious mental disorders will continue to be needed, to deal with the most difficult cases. The extent to which in-patient treatment *is* needed is *partly* related in inverse proportion to the effectiveness of community-based and early intervention services. I say ‘partly related’: There are also challenging conditions, hardly manageable in the community, including severe amphetamine addiction, whose prevalence is influenced not so much by community outreach, but by extraneous factors such as the success of off-shore suppliers of street drugs in evading our border controls. Whatever the balance between in-patient and community treatment or care, the notion of full recovery should be paid more than lip service: It should pervade every aspect of services.

Should acute mental health units be locked wards? In my view, what matters is the quality of care *within* the ward. If it is good, it matters little if it is a locked ward; if it is poor, it is not going to be improved by an ‘open door’ policy. If it is an open ward, suicidal patients may abscond, and complete suicide outside the ward; and harmful and illegal drugs may be brought into the ward from outside. This speaks in favour of locked wards. By this, I do not mean that visitors should be excluded. Indeed it is vital that they be made welcome; but there should be security checks as visitors come into the ward.

For voluntary patients, it would still be necessary to have a locked door, with patients needing to ask staff for permission to leave the ward, who would explain necessary conditions. Clear direction from the Ministry of Health is needed for such a policy, specifying that the directive has priority over others, and explaining the rationale.

Use of seclusion? At present, in some acute units, seclusion is massively overused and misused; but I do not support a total ban on seclusion: It should be used rarely, as an emergency measure, carried out safely, briefly, and with full reporting; and if it is used, there should be examination afterwards of what led up to its use, how the procedure was carried out, and how to avoid repetition. If an acute unit seems to use seclusion excessively, this could be seen as a 'warning signal' that the atmosphere in the ward is deteriorating, and remedial measures should be considered.

Smoking policy in acute wards? Cigarette smoking is of course bad for health in many ways. In 2011, the government, through the Ministry of Health, announced its goal that New Zealand should become (cigarette) smoke free by the year 2025. However, nicotine is *highly* addictive, with severe withdrawal symptoms on cessation. Many in-patients in mental health wards are severely addicted to tobacco. Smoking in acute mental health wards of hospitals is thus at present a front-line for implementing government policy. Should each such ward set up special areas for smokers? What about those who wake early, and who then want to smoke when such areas are inaccessible? It is documented that potentially suicidal in-patients get so desperate for a smoke, that they use any means to get outside the ward, and then go on to kill themselves. Cigarette smoking *is* legal, while use of cannabis is not; but smoking policy causes more problems in acute wards (including behavioural disturbance, wrongly diagnosed as a sign of mental illness) than does cannabis. Anti-smoking policy in mental health wards should be implemented with a 'softer touch', bearing in mind that the *real* objective of in-patient care is to restore patients to as complete mental health as possible.

Discharge planning: This should be well-organized in advance, with attention given before discharge to building trust between community staff and family care-givers (or others). To avoid a split between in-patient staff and community teams, it would be good if there was some interchange of staff between the two roles, with staff perhaps meeting clients and their families first in one situation, and then in the other. This is preferable to sharp separation of roles, or the situation which sometimes prevails of having a staff member dedicated to the transition from hospital care to community care, with others dedicated just to in-patient care, or just to community care. In addition administration should be flexible, not set in stone, so that, in response to shifting needs, and shifting emphasis on in-patient versus community care, staff can move from one to the other.

Community Mental Health Teams: While management of acute wards is usually the most challenging aspect of mental health care, staff in community mental health teams also have difficult situations to manage. This includes care of patients on Community Treatment orders, and supervision of depot injections for persons on CTOs. CTOs may make for a greater freedom for many patients compared to any feasible alternative, but there is bound to be tension, for which CMH staff bear the brunt.

Home visits: I cannot find clear guidelines regarding home visits by mental health staff, although there are such guidelines for social workers. I know a few psychiatrists who occasionally feel it necessary to make a home visit; and this is more common in community teams by CPNs or Occupational Therapists. It is clear that home visits *are*

needed, especially if patients live in outlying areas, or are not allowed to, not able to, or are not safe to drive. If relations are relatively cordial between CMH staff and clients, this should be no problem; but sometimes it seems not to be the case. Perhaps home visits should be encouraged, and statistics collected about home visits.

Information management systems: Case histories of some patients of mental health care systems are long and complex; yet a patient may be admitted to hospital with urgent decisions requiring detailed knowledge of the case history. Under-standably, mistakes occur because there is no time to study the case history, although detail *is* available there upon which better decisions might have been made. This problem is little recognized, and merits serious discussion. There may be a variety of solutions. Here is one such:-

A person with suitable skills is entrusted with compiling the clinical records in a more systematic fashion, classified according to type (eg: nursing reports, consultant's reports, community mental health reports, crisis team reports, dispensary forms, and other evidence of what medications were actually given, medico-legal documents, patient's own documents, etc), with each type filed in chronological order, omitting repetitious or redundant documentation. When a patient's files become complex and voluminous, another person with different expertise should be brought in, whose task it was to explore the files, perhaps indexing them according to subjects, and examining them for treatment options which proved effective in the past, or other relevant details in the history, which might be overlooked by clinicians focused on the 'here-and-now' and the need to take quick decisions. This person should also be able to search out relevant research papers to corroborate or clarify unusual or puzzling details in a patient's history. He or she should also have a voice in meetings when clinical decisions are taken. In the end such 'medical intelligence' specialists might avoid unnecessary, time-consuming, costly and sometimes dangerous mistakes – and prove to be cost-effective in service delivery.

(4.3.2[iii]) *Specialist Services for Adolescents and Young Adults:* Adolescents and young adults are an age-group which is specially vulnerable to mental health issues:

- Generally this is the peak age of onset of many identifiable disorders.
- In addition, in New Zealand at present there is an alarmingly high rate of youth suicide, and within these statistics there are pockets of seeming copycat teenage suicides (eg recently at a school in the Wairarapa).
- Increasing availability of very dangerous, highly addictive street drugs (such as amphetamines) is currently a scourge across the country.
- To this can be added stresses of financial hardship (especially for students paying high tuition fees) and family or relationship breakdown.

Overall, the adolescent/young adult cohort represents a 'transitional group' which has been poorly served in the past. They do not fit well into child psychiatric or pediatric services, nor into services designed for adult patients. At worst this may mean that disturbed and extremely vulnerable young people are placed in wards populated by severely disturbed long-stay adult patients. The need to develop specialist services catering to needs of this sensitive and vulnerable age-group is now recognized, not least by Professor Pat McGorry of Melbourne University. Amongst other things, he is world famous for pioneering work on early intervention services for psychotic disorders. Such services should be components of specialist services for adolescents and young adults.

Another area of risk for young people is the impact and distortions of personal relationships imposed by internet culture. Many young people appear to be so bewitched

by this, that they think that exchange of text messages is a real relationship – although it lacks all nuances of face-to-face conversation – facial expression, vocal tone, body language etc – which make communication real and trustworthy. ‘Conversation’ by text messaging also opens the door to easy, yet severe deception. Since it fosters the incorrect belief that it is real communication, it may prevent some young people from doing what is normal at their age – *learning* how to make good relationships with other people. Indeed I suspect that many young people resort to texting simply because of their growing *fear* of face-to-face meeting, when their own vulnerable self would be exposed.

Beyond this, I mention the severe distortion of sexuality in much on-line culture to which young people are continually exposed. Few professionals or professional groups (including RANZCP) seem willing or able to take the lead on this, within our ‘anything goes’ culture; so perhaps it falls on me, aging walrus that I am, to express these concerns. Specifically, there seems, in many on-line dating websites, to be more concern about the numerous physical techniques of sex promoted there – as if participants were ticking off boxes on a list of Heinz 57 varieties (!) – than with the central psychological fact that sex is actually part of the building of relationships between two people; that it develops in a context of mutual trust; and then can be one of the ways to build lasting love. So, I ask, who will take the lead, publicly to promote a more wholesome approach to sex and relationship building?

(4.3.2[iv]) *Role of Family/Whanau Caregivers:* In mental health care, especially in the case of chronic disorder or disability, family/whanau care-givers (or others in similar supporting roles) have a vital role to play, since in-patient care can only be a temporary measure. When a patient’s mental state fluctuates, the first persons to notice warning signs are likely to be these care-givers. They may not speak expert’s language, but they are experts on the situation in their own family. Prompt response by clinical staff to alerts from caregivers pays real dividends, in that it can dramatically reduce the need for hospitalization. Thus such caregivers should be recognized as essential parts of a treatment team. This is recognized by the New Zealand government, and also by RANZCP. However, to make use of this vital, but usually non-professional resource requires clinical and nursing staff to develop a trusting relationship with care givers. Unfortunately, in some services, this is by I means the case. There may be room for much improvement in this area.

(4.3.2 [v]). *Aged Care and Mental Disorder:* The age-structure of the New Zealand populace is changing, such that the proportion of the elderly is increasing. It is easy to predict that this will lead to increasing difficulty in aged care. At present many elderly people live on their own. They may be relatively healthy, but often experience loneliness and lack of social connection. This is hardly on the agenda of our health service, but certainly fits into the broader remit of the Ministry of Health’s Inquiry in Mental Health & Addiction. The best services to address this aspect of aged care, by building links between elderly people and their community are in the NGO sector. Funding streams should support such organizations – the organizations themselves that is, not ‘payment per service, according to contract’. There should however be some sort of formal links between such community-based support and both health services, and residential care facilities, because community-based support staff are likely to be the first to identify developing health problems of many varieties, including onset of dementia. If these links

are well organized, they can help elderly persons to maintain good enough health to remain at home, rather than moving to residential care facilities.

At present, most residential aged care occurs in private facilities, and these are now expanding in scale. Clientele may be isolated from families but otherwise not severely impaired. However, some clients are subject to growing dementia. From several sources I hear of services offered by local branches of international consortiums. When such consortiums take over from pre-existing services, registered nurses may be replaced by less qualified staff, cost of care increases, and quality declines. Problems arise with staffing, and with pressure ‘to perform more with less’; staff find themselves missing out on meal breaks, being asked to work double (or even treble shifts) in a row, or to work when they should be off sick. Under such circumstances, ‘care’ becomes rushed and mechanical, and loses the human touch. This may be compounded by the fact that for increasing proportions of staff, English is not their first language. They are not very fluent in English, let alone *Te Reo*.

Some aged care facilities specialize in dementia care, but, I hear, the big aged care providers often prefer not to provide beds for those with dementia (because it is more labour intensive, and so more expensive). People under age 65 who develop dementia may be in a particularly difficult position, because their care may not qualify for a government subsidy for residential care. Dementia care in mental health facilities often offers little beyond custodial care, and sometimes not on the ground floor, making it hard for residents to spend time outside, even if they are mobile. The much-needed recent pay rise for aged care staff, has meant that some staff previously working in mental health units for dementia have transferred to aged care residential facilities. This may be a short-term problem which can be solved, but it puts additional pressure on staffing in mental health dementia facilities.

With the predictable increase in this problem in coming years, I fear that we will be overwhelmed by demand, and ‘care’ offered in many establishments will fall to the lowest level. I already hear accounts of bullying by staff in an aged care facility of a frail, vulnerable person there. I also fear that the trend to outsource such care to international consortiums will extend beyond aged care, to include central aspects of mental health care for the more severely disabled adults. I suggest that methods should be found to resist this trend. New Zealand can do better than this, using local talent, expertise and management, and our own best traditions of care.

(4.3.2[vi]) A role for ‘Public Mental Health Specialists’? For general health, the specialty of ‘Public Health’ is well recognized, dealing, for instance with immunization, and other measures to combat epidemics of infectious disease. The format for making submissions to the Inquiry into Mental Health & Addictions (its section 4) raised the issue of whole-of-society mental health. Mental health *is* a whole-of-society issue, and needs addressing at this level, as well as at the individual level. The logical follow-on from this is to consider whether we need advocates for ‘Public *Mental Health*’, specialists for society-wide mental health. Four topics already mentioned are ones needing a whole-of-society approach, more than an individual one – youth suicide, the impact of internet culture, distorted messages regarding sexuality purveyed on-line, and efforts to combat stigma and discrimination (including, but not limited to discrimination related to mental disorders). To these specific issues can be added the fact that many of those with mental disorders are socially isolated and unable to find or maintain

permanent employment (or are debarred from employment by drug-screening requirements, as part of the recruitment process). This leads to problems of poverty and social isolation which can exacerbate mental illness. Regarding so-called 'mental health problems' developing in the context of poverty, unemployment and isolation, these should not be dealt with in a medicalised context. The social work profession, and related political activity is needed to address these issues. One might add that these issues require a whole-of-government approach. Indeed, one might define the primary role of government being to create a 'healthy society', with economic policy as a means to this end, not an end in itself.

On youth suicide prevention, there is a good overseas precedent for what I suggest: Prior to 2000, Kentucky was amongst ten states in the USA with the highest rates of attempted and completed youth suicide, the second leading cause of death in that age group. In October of that year, under leadership of Dr Omar Hatim, a pioneering campaign was launched ('*Stop Youth Suicide campaign*'). It was a 'grass-roots' community-based program, involving more than 30 local agencies. It worked via public education, education of school teachers, school guidance counselors, youth centre staff, and health professionals, as well as websites, videos and other educational media. The program used positive messages from young people who had themselves survived suicide attempts, and went on to lead rich and fulfilled lives. Some formerly suicidal young people were recruited as volunteers in the program. Positive messages were conveyed via texting and e-mails, responding to phone calls from teens and/or their parents asking for help. It ran several conferences and many lectures and workshops for local communities. During its years of operation, many young people who sought assistance received it in a way that helped them stay alive, change their lives, and later to help others. The outcome after ten years was that youth suicide rates had fallen considerably. In areas of Kentucky where a direct service was provided, suicides and attempts fell by 25-40% sustained for 10 consecutive years. Publicity did *not* lead to a spate of copy-cat suicides; rather the number of copy-cat suicides fell as awareness of the program spread. Kentucky state legislature was persuaded to pass laws requiring suicide-prevention education for high-school teachers, and to permit suicide prevention training for some classes of employee. The style of this program has some similarity to the *Like Minds Like Mine* anti-stigma program in New Zealand. Both might be regarded, as prototypes for what might become a wider concept - a 'Public Mental Health' program.

(4.3.2[vii]) *Role of GPs/PHOs in Mental Health Care:* The history of General Practice in New Zealand, which is very different from that in the United Kingdom, is one of GPs originally practicing as private physicians; of government then trying to bring them into the public health system; and of GPs resisting, to retain as much independence as possible, especially financial independence. During the fourth Labour government of the 1980s, Minister of Health, Dr. Michael Bassett tried to cap patient fees and increase the subsidy to GPs, with the intention of reducing some of the pressure (and expense) on the hospital system, and making primary health care more accessible. There was opposition to this by GPs, and the proposal was dropped. During the Bolger administration there were moves to set up Primary Health Organizations (PHOs), community-based consortiums of GPs and other health professionals, tasked with managing primary health care. Today, the funding structure for GPs largely preserves their status as independent businesses, albeit often within a PHO consortium framework.

Even with part charges, the treadmill of 15-20 min appointments means that a proper case history is often not taken. For this reason, and (in some regions) because of frequent use of locums, GPs often cannot get to appreciate longitudinal aspects of a person's problems. As a result, they often fail progressively to improve their practice. And yet, paradoxically, despite their near-independent status, GPs, as always, are the gateway to specialist care. With part charges of \$40-50 per 15 min session, people who are seriously impoverished (including many with mental health problems) cannot afford regular GP visits. When user charges increase, patients may opt to use free hospital Emergency Departments. My own experience is that the receptionist in a PHO may try to encourage a patient to see their GP (and pay their fee), although all he has to do is write out a script or refer to a specialist. GPs then often become little more than administrators in the bureaucratic health machine; and, as argued long ago by Michael Joseph Savage's (for specialists), GPs have a motive *not* to cure, but to over-treat and under-prevent. It is not clear whether GPs are public or private health providers.

This account may be too severe, influenced in part by my own experiences. I have no doubt that many GPs and PHOs deliver good quality primary health care, and do get to know a full history of their patients. In any case, this is not the place to explore solutions to this knotty political problem. However, this history forms a context to suggestions on how GPs and PHOs *could* contribute to improving our mental health service.

In recent years, a suggestion from central government has been that much mental health care should move from secondary services to PHOs and GPs. At first sight, this seems somewhat problematical: While some GPs are well versed in psychological medicine and psychiatry, many (perhaps most) are not. If they are to be increasingly involved in mental health care, they often lack the training and experience to carry out their new role. They are ill-prepared to deal with subtleties of either psychotherapy or psychopharmacology. However at best, amongst many GPs there are strong traditions in community medicine, in engaging with communities, and gaining their trust and respect. The psychiatric profession, on the other hand, aspires in a specialist area to a role similar to that already well-established in General Practice – to be trusted and respected by the communities they serve; yet, whatever their expertise, they often have little idea how to engage in the sort of relationship which this entails.

A key element of the process of reform should thus be to forge links between general practice and psychiatry, so that strengths of each group compensates for weakness of the other, a collaboration working equally in both directions. So, in the future, one might foresee a typical PHO including a specialist psychiatrist, who, on the one hand acquires from his/her GP colleagues the ethos of community-based health care; and on the other hand, helps his/her GP colleagues develop skills in mental health care, whether it be psychopharmacology, psychotherapy, or the two combined. Many large practices already include practitioners with specialist knowledge of mental health matters; but, I gather, demand for their services outstrips what they can provide. This service thus needs to be expanded. In principle, if political issues around funding of PHOs and GPs can be resolved, GPs and PHOs could be key players, perhaps even the glue to make a wider system of reform weld together.

(4.3.2[viii]) Role of NGO's, and Their Relation to State Mental Health Services:
In the decade after the Royal Commission on mental health services reported in 1996, there was massive growth of the non-governmental sector for mental health care,

substantially supported by government funding; but in the last decade, funding has become tighter. Some NGOs have been forced to close, and many others have had their independence constrained by government conditions placed on funding. Nonetheless, NGOs still play an important part in the country's mental health services, albeit with a role different from that of mainstream mental health services, provided by DHBs or direct from government. Often these NGOs have different attitudes and philosophies from mainstream services, and sometimes operate to a degree in opposition to those services. NGOs have much to learn from, but also much to teach mainstream services; yet there is little dialogue between the two. (This varies widely in different parts of the country.) If the mental health system were to undergo fundamental change, the reformed sector could be set up such that NGOs and mainstream services work in true partnership based on different but complementary roles, sharing information, and learning from and teaching each other. This may be the reality in some regions. The caveat here is that sharing information about the actual clients is fraught with problems: the Privacy Commissioner recently voiced his opposition to this recent policy proposal, a view I support until there is much greater mutual trust between the two.

Another role for NGOs which should be expanded and receive government support to do so (as mentioned above – section 4.3.2[vii]) is to support elderly individuals, especially those living alone, and so to help them preserve their health (including mental health) and vitality. Overall one of the major role of NGOs is in community support, much of which is part of the community outreach of mental health services. In view of this, funding of the corresponding NGOs should revert to support of organizations, not support for specific services delivered according to contract.

Quite apart from community support, NGOs given mental health support could also become a venue for initial stages of training psychiatrists and other mental health professionals). This arrangement has many advantages, not least in that it would allow trainee psychiatrists to meet people in relatively good health (on 'their own turf'), who can talk with insight about times when they have been seriously unwell. This is a more wholesome training scenario than trainees being thrown in 'at the deep end', in acute wards where they see only the un-wellness, not the underlying strengths of those same people. At present this possibility is held back by government regulations about accreditation of venues for specialist training (almost always in a hospital setting).

Whether or not funding of NGOs comes from government sources, it is important that the NGO sector retains (or regains) its independence, as a source from which government and DHBs can obtain advice based on front-line experience. The special role of NGOs in the whole sector should be defined so that fruitful collaboration can occur, based on true partnership, without assuming that the NGOs are necessarily subservient to mainstream services, as is implied by their inclusion in the DHBs KPI system (see: section 3.6).

(4.3.2[ix]) *Deployment of Past Service Users within DHB Mental Health Systems:* Past users of mental health services are now employed at various levels within DHBs – as buddies, peer support workers, or policy advisers. When this arrangement arose in the late-1990s it was certainly a welcome development. However, it has not been without problems. By pointing these out, it is hoped that solutions can be found, so that service-user deployment within mental health services continues on a sounder footing.

The problems I identify are as follows:-

Service users seldom have thorough training in their role. In particular, ethical aspects of their role may not have been given sufficient consideration. When a crisis arises (often over professional relationships, boundary issues and ethics), they may have little in the way of professional support. Seen from a distance, one might comment that past service users have been recruited by DHBs because they are emotionally closer to current service users than are the DHB's own staff, and then find themselves in front-line situations which regular DHB staff might prefer to avoid. This is problematic, and implicitly a confession of failure of training for DHB staff.

Some pioneering developments from the 1990s – I think here of the *Like Minds Like Mine*, anti-stigma campaign and its groups – may have been set up unwittingly more-or-less in opposition to orthodox mental health care systems. This may have been inevitable given the prevailing feelings at the time LMLM was set up; but today, we can do better. My proposal – also to be applied generally to NGOs and community-based mental-health activist groups - is that they should not receive government funding until they have selected, as a 'professional affiliate', a person from within orthodox mental health professional groups, *who they trusted*. The rationale is not simply that this professional affiliate could be an adviser when things get difficult – although that is one role. Added to this however, is learning in the opposite direction, so that this professional affiliate can feed back to his or her professional groups, what they learn during close interaction with the community groups. This seldom occurs in consulting room meetings. It is enabled when the balance of power is reversed. In other words, with this arrangement, there would necessarily be two-way learning and teaching, so that the divide between community mental health groups and orthodox professions is narrowed. Art and parcel of this recommendation is that there should be a move back to support of organizations rather than specific projects.

There is also difficulty in service-user roles in DHBs, when past service users are witness to practices which they might want to question. This difficulty arises when they are employed by the very organization they might want to criticize or question. For the general safety of mental health services, those services certainly need to be open to disciplined but independent scrutiny, such as provided by District Inspectors for Mental Health. Somehow a means should be devised to protect the whistle-blower role of service users, working in DHBs. Whether this requires adjustment of their employment situation to give them greater independence, or that there is a truly independent intermediary through whom they could register their concerns, is a topic for discussion.

(4.3.2[x]) Operation of the Mental Health (Compulsory Assessment and Treatment) Act, 1992: This Act usually operates through the Family Court, regarding issues of compulsory assessment and treatment, whether in hospital, or in the community. Such a court hearing provides independent oversight of decisions made regarding compulsion under the Act. When I have witnessed proceedings of the Family Court in this context, I felt that it had a lightness of touch which was not particularly onerous for the vulnerable person about whose care decisions were being made, less so than for many clinical interviews, or group meetings within an acute ward. (This might not always be the case.)

The problems I have noticed with operation of the Act are generally decisions made by clinical or nursing staff related to the Act, but which need never go before the Family Court. Here are three examples:-

- a difficult patient, whose status under the Act appears to have been for compulsory in-patient treatment for a six-month period; but when his behaviour on the ward proved too difficult for the ward, he was taken off the Act completely, and discharged at short notice, to be cared for by a relative. Such a decision, I understand does not require a Family Court hearing. (This example is more than ten years ago)
- an Order form is completed by a Responsible Clinician (psychiatrist) that a patient's status under the Act should change from CTO to Compulsory in-patient status (a decision also not involving the Family Court). The RC's order was not implemented by the nursing staff member; the patient then went on to get himself into more serious trouble, which would have been forestalled, had he been in secure in-patient care, as intended by the RC.
- A decision about a patient's transfer to a residential facility for an extended period is discussed a number of times by ward staff, without the matter ever being raised with the patient's family or advocates. The decision appeared to have been finalized without due process.

I have no views about remedies for such problems; but they may come to be considered when mental health legislation is next revised.

(4.3.2[xi]) *Proper Role for Compulsory Residential Care and Treatment:* This is a difficult topic for me, which I try to address in a sense of logic despite emotional qualms. I conclude that there *is* a place for compulsory residential care and treatment, secure if necessary, in a mental health care system; but it needs to be defined carefully, and tightly circumscribed. The circumstances where I can understand its necessity are as follows:-

- Patients whose mental health problems have become so difficult and deeply embedded (perhaps due to previous inappropriate care or abuse) that they are no longer able to connect the present with the past, and therefore can have no intelligent appraisal of what is in their own best interest.

- The same may be true for persons who have fallen victim to the most severe issues arising from street drugs (notably amphetamines) and alcohol.

There are no doubt other categories of patient requiring secure residential care. These may include patients in a 'forensic' category; but I will say no more about this, because I have no experience on which to base any reasoned opinion.

The objective in such cases would be to provide a safe and stable environment – perhaps in a secure ward – where, over a period of many months (perhaps up to two years), persons can rebuild their whole sense of being a person. If this can be achieved, the hoped-for outcome would be to restore to that person the ability to join past and present into a sensible life story, which in turn gives them the ability to make sensible plans for their future. It must be admitted however, that some of the persons just referred to will never be able to live with full independence in the community; and, if they leave the rehabilitation facility, provision should be made for careful monitoring and support, perhaps over many years. Although this period of rehabilitation might be in a secure facility, the objective would definitely be rehabilitation, not custody ('keeping a person away from the community'). The focus of Judge Ken Mason, in his report of 1988 was also on rehabilitation, which he wished to be separated from issues of those going through the criminal court system.

When I refer to my 'emotional qualms', I am well aware of the reputation that grows around facilities which jointly deal with rehabilitation and forensic aspects of mental

health care. I can appreciate that for persons facing the possibility of extended care in such a facility, thoughts of suicide may loom large. Thus in making this proposal, my conditions are:- (i) that care should be of first-rate standard in terms of humanity and skill of staff; and (ii) that rehabilitation and forensic functions of mental health care should be separate, and not combined on the same site. (iii) Standards of care should be subject to rigorous independent scrutiny. Given these provisos, it is my hope that the facilities which are developed would *not* become surrounded by the aura or fear and suspicion, which too often has prevailed for institutions providing extended secure residential care of psychiatric patients.

(4.3.2[xii]) *Mental Disorders in Prisons: Large-Scale Crisis, Unaddressed:* Despite denial or inaction, it is well known that there is a massive cohort of people in our prison population with serious mental disorders, often related to drug use, and often essentially untreated. This is compounded by the fact that persons in prisons have lost some of their civil rights, including (I understand) the right to treatment. I am told by someone in touch with this area of mental health care, that if acute hospital beds were made available for all those in prison in need of such acute care, the number of such hospital beds around the country would need to be more than doubled. This being so, it is clearly impossible to address this huge crisis in the short term; but it *should* be addressed. Realistically it cannot be so, until the mental health system *outside* the prison gates is in a better state of health. This is clearly some years away. This problem should not however be forgotten. There may be better remedies than I suggest in this bleak paragraph.

(4.3.2[xiii]) *Professional Colleges and Inter-Professionalism:* Colleges for medical specialties have the aura of perpetuity, but major changes *do* sometimes occur. In the antipodes, many (but not all) such colleges are bi-national – Australia plus New Zealand; but some colleges are specific to New Zealand. The recently-formed New Zealand College of Public Health Medicine is one such specialty college, which, I understand, originated as a break-away group from the bi-national college of medicine.

The bi-national Royal Australian and New Zealand College of Psychiatry (RANZCP) has in recent years developed a policy of greater involvement with communities it aims to serve; and I sat on their committees for five years, as a community representative. In my opinion, their policy of community involvement was not thought through in coherent fashion, and is unlikely to achieve what the college wants – to be respected and trusted by those communities. I reach this conclusion for several reasons: The culture and ethnic mix in Australia and New Zealand are quite different; funding mechanisms for health (including mental health) are different, as is the balance between public and private healthcare. Over 90% of RANZCP members work in Australia, only 6% in New Zealand. Although current college leaders in both countries back the policy of community involvement, it is likely that if all college members voted on the issue, community representation on college committees might not be supported. Lastly, the contradictions involved in shift from mainly asylum-based psychiatry to a profession hoping to be respected and trusted by the communities it serves, may be too great; and it may be better, in either country, to blaze a fresh path.

These reasons might not be enough to lead to major change without a viable alternative. The alternative for New Zealand, in my view, might a professional college for a field broader than psychiatry – a '*New Zealand College of Mental Health Care*'. This would necessarily bring together a number of professions involved in mental health care,

within a single professional body; it could foster collaboration between professions, and the development of preventative measures; and it could draw on special strengths of New Zealand, not least the holistic philosophy of the *Tangata whenua*. Leaders of that new entity need not all have a medical background. There is a precedent for this in the New Zealand College of Public Health Medicine, whose membership is not limited to medical professionals. Those who, in my view, should take on leadership roles, would be ones with strongest democratic instincts, not necessarily medically-trained. This would be in line with developments in several specialty colleges – the Palliative Care Council, New Zealand College of Mental Health Nursing, and possibly also the New Zealand College of Public Health Medicine – for which bodies, I understand, moves to greater democratic accountability are part of their agenda.

Since RANZCP is supposedly independent of government on either side of the Tasman, the Inquiry into Mental Health & Addiction services is in no position to make recommendations along the lines I suggest. However, panel members are likely to have discussions with a wide range of mental health professionals. Simply by raising this issue in appropriate contexts may in itself be quite influential, if – as I believe – there are many professionals in New Zealand, including psychiatrists, who would favour the change I propose. The alternative college could emerge gradually without posing an immediate threat to the bi-national college; or there might be a long period of *inter-regnum*.

If any such changes were to come about, a corollary would be to give greater emphasis to Inter-Professionalism. Several initiatives in this direction have developed in recent years in New Zealand; but it is difficult to develop full inter-professional integration between professional bodies, when they already each have their established structures, traditions, and distinctive ways of thinking. The most effective way to develop inter-professionalism is to arrange for training, especially in early stages, to involve students from several professional schools learning together in the same classes. Some initiatives in New Zealand have gone as far as inter-professional residential courses. An important part of the learning in such courses would be about expertise of other complementary professions. This would help each group to know what its special strengths are; and then, on the principle that ‘good fences make for good neighbours’ it would prevent rivalry or demarcation disputes arising once students are qualified (as for instance often prevails between psychiatry and clinical psychology). The aim would be for inter-professional practice to become the natural style of professional work, rather than a special ‘add-on’.

(4.3.2[xiv]) Staffing: Recruitment, and Training/Retraining: My own past and recent experience throws light on this. It is my experience that there are, and always were, many excellent medical students or medical graduates who wanted to become psychiatrists, and so to develop their skills in face-to-face clinical encounters, rather than in technological medicine. However, they were put off psychiatry, when they saw what it was actually like. (I refer here to its administrative framework, not the necessity of patient contact.) In addition, within New Zealand, in my recent experience, I know of non-medical, highly talented mental health workers, who would like to contribute their skills; and yet, because of the framework in which they would have to work, they abandon this ambition. In section 2.2.4, I mentioned one such person, who wished to return to mental health work, but was put off for this reason; and so became manager of a rural hotel/tavern. Over the country, there will certainly be many similar people whose talents are being wasted.

In the past few years, I have also worked with a fine mental health team in Hong Kong. If psychiatrists in our part of the world think that they are embattled and neglected, they should work in Hong Kong (or even more dramatically, in mainland China!). Early in 2014 this psychiatrist wrote to me expressing his serious concern about difficulty in recruiting trainees into the profession. He asked me to write something to encourage medical students, or recent graduates, to consider this specialty for further training. The document I sent him *was* used for this purpose, and I received a gratifying letter from one medical school entrant, thanking me for what I wrote.

In section 4.2.3 above, I referred to potential difficulties from unions and professional bodies, if major change were to be implemented, because of fear of redundancies. What I *actually* hear, from a contact in the Public Service Association (main union for mental health nurses) is exactly the opposite – that, if the administrative framework could make for a better workplace, there would be many trained staff wishing to re-enter the mental health workforce. Likewise, if a reformed mental health sector could come into being, and was presented well to medical school intake, recent medical graduates, and others with skills or aspirations in the mental health area, the crisis in staffing for mental health care might be averted or minimised. The best advocates for this career choice might be those who, like myself as a former patient, had relatively good experiences in mental health services. Such persons are now used in a number of roles within DHBs. Why not enlist their help to encourage more trainees in health professions to specialise in mental health? With these moves, it is envisaged that it would be easier to ensure staffing ratios were adequate in both acute hospital care, and in community mental health services.

A major problem arising from the staffing situation is to ensure continuity of care of each patient, as far as possible by a single clinician (so that a therapeutic relationship can develop). However, this problem arises not just from staff shortages and rapid staff turnover. In many major hospitals it arises from the requirement to train medical practitioners (young doctors) in our public system. The latter need to gain experience in a wide variety of specialties, and medical conditions, and so there is an inevitable transience to any relationship with patients, and in psychiatry, it is difficult to maintain therapeutic relationships. is also probably inadequate supervision by senior trained staff. How this situation can be addressed is uncertain; but any policy which addresses the overall staffing issue in mental health services will make this a more tractable problem.

My impression is that staff currently working in mental health have a great spread of attitudes and skills, some modern and forward-looking, some having not really distanced themselves from the asylums, although now deployed in different settings. Large-scale re-education and retraining of many DHB-based mental health staff may be required, more in some DHBs than others. If a version of the Toyota model is to be applied, staff would need a wider diversity of skills to come within their capability. For staff working in NGOs, further education may be needed, but very different from that for staff working in DHBs, because attitudes, skills they bring to bear on their jobs, as well as gaps in their training, are likely to be very different. At its heart, much of the retraining may require extensive discussion of how personal agency and responsibility are compromised in mentally-disordered people; and how caring staff can build on those capacities of their clients which remain intact. Close attention to ethical principles, how to handle conflicts of interest, and boundary issues should also be included.

At present, DHBs employ few clinical psychologists, especially in hospital-based services. Our universities produce many well-trained graduates in clinical psychology. DHBs should employ more such graduates. *This* is where they should be finding their jobs, rather than moving off-shore (as many do).

(4.4) Governance:

(4.4.1) *Ways to Resolve Tension Between Financial and Clinical Imperatives:* Here, I write in metaphorical vein: I take the liberty of suggesting how I would proceed, in the unlikely event of my ever being able to influence the deliberation. *First*, participants for negotiation would be carefully selected, to represent an equal balance of forces – an equal split between senior clinical staff of various sorts, and financial, administrative and legal persons; and if there are those in either camp who already have had experience of reconciling the two (rather than forcing a solution by fiat), so much the better. Once participants are assembled in the conference room, I, as the hypothetical convenor, would take a large key out of my pocket, brandish it prominently for all to see, and securely lock the door. Then, I would explain the different sides to the questions at issue; and I would end up by saying, with a broad smile, on my face, that ‘I have the key to this room, and no-one is leaving until a rational reconciliation of these issues has been reached’. Then I would order the menu, lavish, but without alcohol, *for the next week*, and assembled persons could order the next meal; but they would also be in no doubt that they are in for the long haul. I would try to encourage a style of discourse which was open, respectful, and free; and I would model this by my own behaviour; expressing my own uncertainty, even confusion, with honesty, and the areas where I lack expertise, in the hope that others would be equally open.

After the discussion had been in progress for a while, and at a strategic moment, with a canny smile, I would invite health professionals to accept the proposition that the budget *is* limited; and that some form of rationing *is* essential, however difficult the ensuing choices might be; but that the need for this can be lessened if efficiency of service delivery can be improved. I would invite such staff to join budgeting seminars, so that they can see for themselves the essence of the financial situation. Then, with an even more canny smile on my face, I would address the financial, administrative and legal people, and invite them to accept the proposition that the best way to ensure optimum effectiveness in service delivery, is not by putting health care staff under ever-increasing pressure, but rather by doing the utmost to optimise organizational culture and morale of the work-force. This would include strengthening lines of communication (up, as well as down the hierarchy, and horizontally); encouraging everyone to see themselves as team-workers; promotions occurring in low key fashion for the best team-players (as at Toyota); and inviting everyone to come together at regular ‘coordination meetings’ to contribute their best ideas for improving the service as a whole, not just their own contribution. I would encourage all participants to cross boundaries. For clinical staff, that would mean socialising, formally or informally, with administrative, legal, and financial staff; and for the latter to visit and talk with people on the wards, patients, nurses, specialists and allied health workers; and in the case of mental health care, to visit acute wards, including locked sections and forensic facilities, talk with people there, likewise with regard to rehabilitation centres, and sections for community outreach. Most of this is the essence of democratic representation and deliberation.

If there was little movement to an agreed position, I would invite persons with strong views on either side of the debate to prepare a short talk on what they would advise, were they themselves on the *other* side of the debate. The essence of the process is that, while clinical and financial/legal perspectives are utterly different, nonetheless, the two sides have common cause, namely to deliver high quality, affordable healthcare; and therefore a collaborative, deliberative approach, however difficult, is the *only* way forwards.

(4.4.2) *Towards Democratic Governance of Health and Mental Health Care Systems:* Government departments in the Westminster tradition are part of the structure of democratic governance; and so policies they develop and implement *are* responsive to public sentiment, albeit usually in an indirect way, and often slowly. Until recently, Ministries of Health have not been notable for the speed of their response to community views. This tardiness arises in part because medical professions, historically have hardly been bastions of democracy. Subdivisions of health ministries responsible for psychiatry or mental health care have often been the very antithesis of a transparent, open and responsive part of national life. Again this reflects the historic fact that psychiatry, more than most specialties, has often tended to be secretive with more-or-less brutal authoritarianism. However, this is changing. The public is now increasingly willing to challenge medical authority; and this extends to psychiatry and mental health care. The mental health workforce, at many levels, now includes persons with their own experience of mental disorders. The catch-phrase, often quoted by the current Health and Disabilities Commissioner, is '*nothing about us without us*'. This may oversimplify the issues in mental health care, but pressure for democratization of health care, including mental health care, has been growing in recent years, and is likely to intensify. The only way to reduce the pressure is to find ways to respond to legitimate demands. In the end this means not only that delivery of health care in the clinic or hospital should be more transparent, open and responsive, but also that, at national levels, health policy formation should be more responsive and open, and more fleet of foot in its response to community pressure. Some form of greater democratization of health care has to be considered, and this includes mental health care. Lip-service is paid to this in that seven out of eleven members on District Health Boards are elected by the local populace; but this gesture to democratic style is undermined by the fact that, once elected, they are responsible to the Minister, not to their electorate, and cannot speak freely to their electorate. Predictably, the participation rate in such local elections is low. The exact nature of the democratic processes by which a better democratic style is to be achieved is an exceptionally difficult question, and this is not the place to explore the options – but the question must be on the agenda for future public debate.

(4.4.3) *Mental Health Care at 'Double-Arms-Length' from Government of the Day:* Alongside recent developments, there are many reasons why psychiatry is (and always has been) ill at ease in the company of other medical specialties. This is even more obvious if psychiatry is extended to the broad field of 'mental health care', whose boundaries extend ever more widely. Historically, psychiatry and mental health care have often been under more direct control of central government than other parts of the health services; and yet, under such control, it has hardly been a resounding success story. Over historical time- scales, there has been a repeated cycle of public neglect, scandals, public enquiries, progress for a while, and then again gradual neglect. The public may at times be concerned, but for an area so poorly understood by – and hidden from - the public,

there is still fear and denial of realities. In quiet times, the public may be happy to leave the difficult topic to government experts, who in turn keep realities of mental health care in varying degrees of secrecy; and then periodically there is alarm about how the mental health system is actually working. Looked at over 150 years of history, administration of the mental health sector by the elected government of the day scarcely seems capable of creating, let alone sustaining a humane service.

With this perspective in mind, I suggest that mental health care should no longer be defined, for administrative purposes, as one of the medical specialities, but should have its own distinctive administrative structure. This is already true to some extent: There is nothing like the Mental Health Acts for most other medical specialties.

The specific proposal I make is that administration of mental health care should be separated from the government of the day, because political ideology, and political pressures often lead government to cut funding to the least attractive part of the health system, which is usually mental health care. I therefore suggest that the mental health system be re-configured as independent of the Ministry of Health and probably therefore responsible directly to Parliament. The original concept of Judge Ken Mason, for what became the Mental Health Commission was somewhat along these lines: As a Commission, it was envisaged that it be independent of the government of the day, a more permanent body, not likely to be swayed by immediate pressures which governments face. However, its establishment was not robust enough to give it such permanence; and it was such pressures which led to its being disbanded in 2012.

There are many precedents for state agencies being independent from the government of the day, while nonetheless built into our democratic structures in a more permanent manner. Several vital state institutions report to parliament rather than to any government ministry. Most important is independence of the judiciary. Others include an independent police force, the Electoral Commission, and the Serious Fraud Office. An interesting case is the Guardians of New Zealand Superannuation – a Crown entity described in the Productivity Commission report of August 2015 as at ‘double arm’s length’ from government. All these can be regarded as examples of the constitutional principle of separation of powers; and independence of most of these institutions has arisen because of the significant dangers of giving government direct authority over their business. In just the same way, a significant advantage of such independence for mental health care is that it would no longer be influenced by political ideology, no longer subject to pressures on government to survive.

Of course, dangers of malpractice and abuse in mental health care are ever present, because of the vulnerability of many with mental disorders; these dangers would still exist. Therefore rigorous independent judicial oversight of mental health care is needed, with an independent inspectorate well versed in realities of mental disorders and mental health care (as was decidedly *not* the case in the asylum era, when it required no more than the word of a non-specialist JP to authorise a person’s being ‘put away’ in an asylum). The role of judicial specialists would be to scrutinise the activities and probity of mental health services, to protect whistleblowers who expose malpractice, but also to protect the public when patients are thought to pose public danger. The system of District Inspectors operating at present serves this role, and in my limited experience, serves it well. There may however be reasons for this system to be strengthened further.

[5] Aware of the Past; Preparing the Future:

Section 4 offered many suggestions on reform of a system of mental health care which is currently in a state of disarray. Some of these proposals addressed systems requiring urgent attention. Others addressed issues which were less urgent, yet still pressing. The present section looks further to the future, attempting to envisage a rosier scene which *might* become possible. At present serious barriers hinder moves to radical improvement. Unless these can be surmounted, we are destined to have ‘more of the same’ (with the words of the nineteenth century French wit ringing in our ears: ‘*Plus ça change, plus ces le même chose*’. [‘The more it changes, the more it stays the same’]). Any ‘divination’ I can offer about a possible better future must be based on awareness both of the history of psychiatry and mental health care in many countries, and of factors now playing out internationally. This allows me to focus on two areas, which, I believe must be addressed before there is any hope of moving to that rosier future. Both are areas on which I am currently working. My contribution may be part of an evolving scene.

(5.1) *Unfinished Business:*

The history of psychiatry and mental health care over the past 150 years has hardly been one of steady, confident advance in understanding and treatment of mental disorders. There *has* been some progress overall, but it has been interrupted by truly barbaric chapters. More typical is a succession of false promises, unhelpful fashions fading into obscurity, cyclic return of old debates in new garb, interspersed periodically with both profound insights from gifted psychiatrists, and shocking scandals revealed from dark corners. Today, the increasing role of the end-users of mental health services in the design and operation of such services appears to be a major step forwards. One can but hope that the momentum is maintained; but this is uncertain, given that such moves occurred in the past and are now forgotten. In any case, the considered experience of end-users of services needs to be combined with other areas of expertise. The hope is that psychiatry and related professions are accepted as branches of the caring professions, with a sound basis in clinical science, and a solid ethical foundation. This might enable these professions to be true to the calling of all health care professionals, in this case concerned with personal *mental* health care.

Apart from this area of uncertainty - over the last century (and before) - ‘mental health care’ sometimes meant something quite different: In the asylum era, psychiatry was often seen more as an administrative specialty rather than as a caring profession. The emphasis was on ‘managing a social problem’, with scant regard for health of individuals. The dominance of the administrative mindset, with focus on aggregate rather than individual solutions was undoubtedly exacerbated by the biggest events in twentieth century history – two world wars and the Cold war. The need to screen vast armies of young men as recruits, and to deal with mental health needs of huge numbers of soldiers, traumatised while on active service, undoubtedly reduced the focus on individual mental health care. Other aspects of these wars, especially the Cold War, led to atrocious violations of basic principles of health care by highly trained members of the psychiatric and related caring professions. Given these unfortunate aspects of the history of these disciplines, I identify two areas where there is ‘unfinished business’ hanging over from the twentieth century - the lack of a robust intellectual or scientific framework for this area of health care; and

the sad legacy of abuse during the last century, carried out in the name of psychiatry, or in which psychiatry and related professions and state agencies was complicit.

(5.2) Digging Deeper Conceptual Foundations:

In the history of psychiatry, there have been times when emergence of a profession genuinely focused on personal mental health care, based on robust clinical science and sound ethics seemed possible. The most obvious example is psychiatry in the 1890s, in the German-speaking world and in Paris; and another possible contender was the USA, in the years prior to World War II. These brief epochs of enlightenment were overwhelmed by world events and social trends, which meant that they never fulfilled their promise. In the 1890s, in the writings on psychiatry of Carl Wernicke, there was a serious attempt to found psychiatry on the neuroscience of the day, and its clinical spin-offs. As a sign of the fertility of debate at the time, Wernicke was in correspondence with many other leading clinicians, including Sigmund Freud. In particular Wernicke formulated ideas of how the brain we have allows us to construct - and then to continually reconstruct - our sense of being an integrated person. These ideas, astonishing for their day, are still well worth reading, and formed the scientific background upon which he described a wide variety of mental disorders. Sadly, Wernicke's writings on psychiatry were neglected even in the German-speaking world, partly because of his premature death, to be eclipsed by his contemporaries, notably the arch-administrator – Emil Kraepelin. As a result, to this day, systems of psychiatric diagnosis used around the world have tended to serve mainly the interests of psychiatric administrators rather than the needs of true clinicians or clinician-scientists. Mainly these were administrators of asylums; today, more often, they are administrators of mental health finance.

In the last few years, it has been my privilege, working with John Dennison of Otago, to produce the first available edited English translation of Wernicke's lectures on psychiatry²⁷. I am now able to combine his ideas with some of my own on brain theory. As a result, I am emboldened to think that a truly scientific account of human personhood can be provided²⁸. From this, the door opens to complete revision of the way mental disorders are described, classified, and diagnosed²⁹. How far I can get with this task in the time I have left is uncertain. I will give it my best shot.

(5.3) Addressing Past Misdeeds: Prelude to a More Wholesome Future:

The history of serious abuse of psychiatry in state institutions in many countries is well documented. It is rare for state authorities or professional bodies to apologise, or redress grievances of those subjected to abuse. In New Zealand, some abuses in state care occurred in the recent past. Many victims call for full acknowledgement, apology (and

²⁷ Miller R, Dennison KJ (2015) *An Outline of Psychiatry in Clinical Lectures: The Lectures of Carl Wernicke* (transl: KJ Dennison and R Miller, from Carl Wernicke's 'Grundriss der Psychiatrie in klinische Vorlesung' (1906); edit: R Miller and KJ Dennison. Springer Verlag, Heidelberg and New York

²⁸ 'A Voyage of Healing': Keynote lecture to be delivered to conference of *Mind UK*, and inauguration of *Mind Hong Kong*, Hong Kong. November, 2017.

²⁹ 'Prototype for a **Scientific** Classification of Mental Disorders': Public Lecture given by Robert Miller at Department of Psychiatry, Li Ka Shing Faculty of Medicine, University of Hong Kong, April 12th 2016.

some call for recompense). So far, government authorities have dragged their feet, yet the pressure does not abate.

There is even less acknowledgment of the harm done by state agencies in the context of military psychiatry, or the role of psychiatrists or psychologists in a nation's military intelligence agencies. During the world wars, and also in some more recent wars, the role of psychiatrists has been deeply problematic, in a way which does not apply to other medical specialties: Their role appeared to undermine any commitment they might have had as members of a caring profession. Information on the role of psychiatrists and psychologists in military intelligence agencies is slowly seeing the light of day. I mention this disturbing topic, after careful consideration, for three reasons: It is in itself important; it is amongst a nation's darkest secrets, and is therefore too easily 'forgotten'; and in the USA and Britain, there is evidence enough to show that grossly unethical behaviour in aid of military intelligence occurred in state psychiatric institutions, with complicity of psychiatrists or psychologists. The same may have been true in New Zealand.

In the year 2010, the German Psychiatric Association gave a public apology for the profession's role in atrocities during the Third Reich. In the USA, in the 1990s, President Clinton apologised on behalf of previous administrations, for abuses of psychiatry and psychology by US intelligence agencies; yet similar abuses continued in more recent wars. In Britain, authorities have been slow to acknowledge the culpability of its military and intelligence agencies; the full extent of past misdeeds has not reached public consciousness. It is clear that dark secrets remain hidden. Some British documents may not be made public until the second half of the present century. In New Zealand dark secrets may also lie hidden. My own researches have not yet obtained decisive evidence of collaboration between psychiatry and military intelligence in a New Zealand context; but they leave strong suspicions, and little doubt that there *are* secrets which few now know about, and which those few in positions of authority who *do* know, are keen should be kept secret.

These issues are not just history: They live on in peoples' subconscious minds, in their instinctive fears, and in 'folk memory'. As such, they feed public animosity towards psychiatry and related professions, even when no-one remembers the origin of their fears. The reason why I study this topic is that only when these areas of state-sponsored trauma have been brought to the light of day and adequately dealt with, can that rosier future for the mental health professions become a realistic goal. The issues I raise here have also been raised with the Royal Commission on Abuse in State Care. That Commission will operate for the full length of the present parliamentary term. It is possible that it can access documents which are beyond my reach.

Robert Miller
5th June, 2018
