



Submission of the PSA to the Government Inquiry into Mental Health and Addiction

The PSA is the largest trade union in New Zealand and the largest trade union for mental health workers. We have a long and proud history of being actively involved in advocating for better mental health and addiction services.

Mental health and addiction services are in crisis. This has occurred with the confluence of three elements: an increased demand for mental health and addiction services; a significant shift in the delivery of mental health treatment away from institutionalization without resources following; and a funding shortfall in health generally and mental health specifically.

The PSA has canvassed members who work in mental health and addiction services, led by the Mental Health Committee, about what they think would make a difference to those services. We also asked for examples of what is working well.

Summary of Recommendations

This submission addresses 10 key areas for action and encompasses 26 recommendations, listed here. We have used the term *Tangata whai ora* to refer to people experiencing mental illness. A translation of this is a person on the journey to wellness.

WORKFORCE PRIORITIES

Address workforce shortages

- Introduce an overarching workforce strategy across the Mental Health and addiction sector, including the issue of staff retention.
- Properly value work and pay accordingly.
- Develop an integrated workforce who could have career paths seamlessly across the DHB and community sector.
- Integrate education and training across and between sectors, which enables the flow of mental health and addiction workers between services.
- Ensure pay and employment equity across the sector.

Ensure safe staffing

- Agree to safe staffing levels for all services across the sector and implemented.
- Address workforce shortages so that safe staffing levels are achieved without compromising decent working conditions and access to professional development.
- Ensure safe staffing includes staff to client ratios both in the acute inpatient/forensic units and community services – across both DHBs and NGOs.
- Ensure work cell phones and laptops are provided for ease of communication.

Engage with staff

- Investigate barriers to implementing a High Performance High Engagement approach throughout the sector in order to create a culture shift that values the insights of people working closely with Tangata whai ora.

MENTAL HEALTH AND ADDICTION SERVICES

Integrate services into one cross sector mental health strategy

- Develop and implement a national mental health strategy that encompasses the DHB and community sector.
- Integrate services across the DHB and community sector.
- Ring fence funding for mental health.
- Fully fund and resource mental health services for tangata whai ora experiencing high, enduring and complex needs. This includes: Community mental health centres, acute inpatient units, longer term residential facilities, respite facilities, community support work services.

Provide a continuum of care

- Standardise contracts with providers in the community sector without restricting flexibility to reflect individual client needs and local service innovation.
- Ensure the transition between different services is smooth, seamless and based on the needs of Tangata whai ora.

Review Compulsory treatment orders

- Review the operation of compulsory treatment orders to ensure they are fit for purpose.
- Resource the Substance Addiction Compulsory Assessment and Treatment Act by making the necessary facilities and staffing available.

Mental health in prisons

- Increase resources for forensic mental health services.

Addiction services

- Frame alcohol and other drug addiction as a health first issue, while also holding people to account for criminal behaviour.
- Resource Alcohol and Other Drug (AOD) services so that waiting times are eliminated.
- Ensure that decisions about appropriate services for Tangata whai ora with co-existing problems/dual diagnosis are driven by the needs of Tangata whai ora rather than cost shifting and/or availability of services.

ASSOCIATED PRIORITIES

Intervene early

- Fully fund and resource mental health in the primary health sector, before Tangata whai ora become acutely unwell.
- Implement prevention strategies.
- Raise awareness in communities and schools.

Meet basic human needs

- Ensure everyone has access to an adequate standard of living including warm dry housing. The basic social determinants of wellbeing should be available to every person.

About the PSA

The New Zealand Public Service Association: Te Pūkenga Here Tikanga Mahi (the PSA) is the largest trade union in New Zealand, representing 63,000 members who are taxpayers and users of the health system. We are a democratic organisation with members in the public service, the wider state sector, spanning the district health boards, crown research institutes and other crown entities, state owned enterprises, local government, tertiary education institutions and non-governmental organisations working in the health, social services and community sectors.

Of these members, around 17,000 work for DHBs as allied health, mental health nurses and support workers and public health professionals, and as administration and clerical support. We also have around 9,000 members who work in community-based health services; they provide home support to elderly and disabled people, mental health and addiction services, drug and alcohol services, social services and residential disability support services. Of those approximately 1800 work in mental health services. They are employed by not-for-profit and private providers who are funded by Vote Health through contracts with DHBS.

PSA members who are mental health workers are also employed in other parts of the state sector providing social services, notably in Corrections, Oranga Tamariki and the Ministry of Social Development.

We are the largest union in mental health, with members working as mental health nurses, alcohol and drug clinicians and counsellors, psychiatric assistants, occupational therapists, social workers, psychologists, kaihaumanu, whanau ora kaimahi, Pukenga Atawhai community-based support workers and clerical and administration workers (*see further list below*). This provides us with a unique whole-of-service perspective, rather than a specifically occupational perspective.

Mental health services and the PSA

The PSA has an historic connection to mental health services. Our membership in the sector goes back to the days when mental health services were delivered directly by the Department of Health and the range of our membership has expanded since those days. We have been actively involved in advocating for better mental health and addiction services for many years, and in the 1990s were part of a movement that led to the Mason Report and the publication of the original *Blueprint for Mental Health Services in New Zealand*.

This submission has been developed by the Mental Health Committee of the PSA which comprises members working in mental health services in DHBs, in the community, and in core public service agencies. In preparing this submission we sought feedback from PSA members working in mental health. The submission reflects their collective views. Membership details of the members of our mental health committee are attached as Appendix A.

Feedback to inform this submission was received from members working in mental health in a wide range of settings: in DHBs, in the community sector and in the public service (MSD, Corrections, Ministry of Health and Oranga Tamariki). Roles represented include: Nurses, social workers, navigators, case managers, consumer evaluators, support workers, therapists, taiohi ora wellness leaders, psychiatric assistants, kaihaumanu, peer support specialists, addiction practitioners, probation officers, AOD clinician, nurse educators, amokaiora matua, family therapists, diversional therapists, dual diagnosis clinicians, youth substance abuse counselors, recovery facilitators, clinical psychologists, corrections officers, programme facilitators, intervention coordinators, residential managers, administrators, health and safety advisors. The depth of experience is reflected in the range of time PSA members have worked in mental health: from four months to 47 years.

Mental Health services in context

The 1970s and 1980s saw a big move in New Zealand to care for mentally ill people outside of large institutions. By the 1990s, almost all psychiatric hospitals had closed and patients moved into community care. *Rising to the Challenge*, which provides the government's vision to guide the mental health and addiction sector for 2012-2017, further expanded the focus of the mental health system from providing services for the 3 percent of the population requiring most high level care, to meeting the needs of the 20 percent experiencing mental illness at any given time.

In the PSA's view, this expansion in scope has not been accompanied by sufficient resource and funding. Budget 2016 provided an extra \$3 million per year for the next four years to increase support for primary care and social services to enable people to access mental health help earlier. The New Zealand Council of Trade Unions (NZCTU) estimated that there was a shortfall in funding for mental health services of nearly \$5.6 million in Budget 2016. Overall, the NZCTU estimates the funding shortfall in total government health spending for 2016/17 compared to 2009/10 is between \$1.2 and \$1.5 billion, and this is a conservative estimate.

The insufficient funding for the widened scope of our mental health system is compounded by the estimated doubling in demand for mental health services by 2020. In 2015, the Ministry of Health estimated that demand for mental health services would double by 2020, in its draft Mental Health and Addiction Workforce Action Plan 2016-2020 ¹ which was circulated for public consultation. In late 2016, the Ministry of Health confirmed that demand on youth and adult mental health services had grown by 70 percent in the last 10 years. ²

¹ <http://anzasw.nz/wp-content/uploads/Mental-Health-and-Addiction-Workforce-Action-Plan-2016-2020.pdf>, see page 8

² http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11724258

Our approach

The Mental Health Committee of the PSA submit that the problems in service delivery of mental health and addiction services (and the consequences of these failings) are well traversed. We have focused on solutions – what would improve services, and, where possible, examples of these approaches.

“If we continue to focus on what’s not working, that’s all we will see. Recognise the gaps and fill them.

The sense of frustration and anger from members working in mental health is palpable. The PSA seeks action on delivering better services for Tangata whai ora.

We ask that the panel has the courage to make recommendations on integrating services; ensuring truly safe and effective staffing and clearly articulating the contributions of the psycho/social environment such as sufficient income and adequate housing to wellbeing. We will also be calling on Government to implement much needed improvements to services that are stretched to breaking point. A number of members observed that setting zero target for deaths by suicide may be useful to focus national efforts to improve mental well-being across the population. Another wondered this:

“We have money put aside for national emergencies – isn’t this a national emergency?

“If you tasked all government agencies to commit to resourcing aspects of mental health that collide with their agency then we would be able to get a lot more done -approach it like the road toll -many agencies -traffic management, ACC , Plunket, police, councils, NZTA all have a commitment to the outcome- 0 deaths on the road and all commit to aspects of work in a coordinated systemic way that contribute to this. Mental health is no different eg if MSD/ WINZ, police, ambulance, EDs, hospitals , dental depts, outpatient departments, Plunket, education/schools, councils, regional councils , justice all have Mental health targets this will contribute to lowering the death rate. It is not just the remit of MHS to be responsible eg ED could have the target of training their nurses in MH triaging reducing stigma (noticing their own values how this influences their engagement) and taking ownership of helping not just triaging and as soon as get rid of the patient to MH etc etc

“Adopting the zero suicide as a target and all the actions that go with the model eg including workforce support , family involvement, government agencies all committing to play a part and then resourcing staffing and bed numbers to what’s needed

NOTE: Quotes from members are *italicised* and in **bold** throughout this document.

WORKFORCE PRIORITIES

Addressing current and future shortages

PSA members urge a comprehensive effort be put into ensuring there are sufficient skilled staff working in mental health now and into the future. Our observation is that there is a shortfall now and given an ageing workforce and a growing population shortages are likely to get worse without retaining, training and attracting staff. Workforce planning for mental health is urgent.

PSA members want to see a nationally consistent workforce strategy across the sector.

One group said their ideal future was:

“Enough staffing, with an ideal mix of skills, experience and training, to create a therapeutic relationship with patients, with a recovery focus.

That mix of skills and experience includes the need for the workforce and mental health services to reflect Tangata whai ora.

Valuing the workforce by addressing the following issues would be a useful start:

- Address poor pay and conditions
- Ensure pay parity between DHBs and between DHBs and the community sector
- Recognise increased skills in pay rates
- Ensure a safe working environment
- Provide part time work arrangements where these are sought by staff
- Doing more to address the aging population in the workforce so that experienced staff who are not able to manage the intense physical input needed at the face-to-face clinical input level to respond to the increasing levels of aggression – are used in more of a supporting/educative role (where they have appropriate skills).
- Address workload issues that are ‘burning out’ staff. *(See more below)*
- Ensuring barriers to professional development are removed. *(See more below)*

“Team building, team training and team work planning activities seem to be things of the past nowadays. We're all 'head down bum up' no time for anything else.

“If rehabilitation is desired then staff need space/time/funding to do quality work. If setting minimum requirements, we need to upgrade the workload tools we're using because people can't work at maximum efficiency all the time.

The workforce must include people with the ability to provide kaupapa Māori services.

“Presently there is a paucity of Māori staff to treat with Māori Service Users ie. Nurses, Psychiatrist, Doctors which demonstrates inequities re service delivery. Obviously more Māori staff would make a big difference for Whanau where there have been some serious casualties eg. self-harm, domestic fatalities

“What does work best is where Māori have Tikanga Māori valued as much as clinical practices and there is an exchange of ideas.

“At Auckland DHB the result of this was to set up a MDT of Clinicians and Kaiatawhai . The project was scoped but failed because resourcing and funding was not forthcoming.

Consequently the project was not fully realised and the learning was negligible.

Many of the members responding to the PSA questionnaire talked about lack of access to professional development. A number of respondents struggled to access sufficient professional development to comply with professional registration requirements. They also identified a lack of access to professional development that would support better practice, such as inter-disciplinary approaches, Treaty workshops and new ideas and approaches in general. Budgets for professional development and continuing education were being reduced.

When professional development and continuing education was available there was no cover or backfill, so staff could not be freed up to attend. Opportunities were lost.

“Reduce barriers to accessing training for existing staff - including implementing safe workloads that allow time away from caseloads for training days.

“Training and retraining is critical. Again, I am unsure as to what staff receive, but we need the right staff in the right place, ALL the time, and they should be compensated accordingly.

RECOMMENDATIONS

- Introduce an overarching workforce strategy across the Mental Health and addiction sector, including the issue of staff retention.
- Properly value work and pay accordingly.
- Develop an integrated workforce who could have career paths seamlessly across the DHB and community sector.
- Integrate education and training across and between sectors, which enables the flow of mental health and addiction workers between services.
- Ensure pay and employment equity across the sector.

Safe working environments

Staffing ratios in mental health need to reflect the optimal mix of skills, gender and cultural background to meet the needs of Tangata whai ora they are responsible for. For example safe staffing in the inpatient setting requires dedicated allied health staff on the wards, such as social workers, Pukenga Atatwhai, occupational therapists, psychologists with talking therapy capability and a full number of support staff including admin-clerical, cleaners and gardeners. Where bureau staff are employed, they need to be fully integrated.

Calculating safe staffing levels needs to recognise the acuity of Tangata whai ora. Ratios need to reflect fluctuating demand including acuity. Acuity tools must be robust and internationally validated to (1) accurately reflect current requirements for observation and care (2) accurately predict staff numbers needed – not only nursing staff, but also social work, cultural support, occupational therapy, psychology and community support input needed by Tangata whai ora.

“The Safe Staffing Healthy Workplaces (SSHW) Unit established a Mental Health Addiction & Disability Advisory Group (MHADAG) in 2012. We need to ensure that appropriate resource is available to guarantee that any patient acuity driven staffing methodology including MH Work Analysis & Care Rationing tools within the Care Capacity Demand Management (CCDM) programme is suitable and accessible for DHB Mental Health services in New Zealand.

There needs to be sufficient staff so that safe staffing is maintained without resorting to the following ‘work arounds’ and unintended consequences:

- Short changes.
- Double shifts.
- Compromising continuing education and professional development.
- Staff working without meal and rest breaks.
- Staff not taking rostered days off.
- Counting new graduates working under supervision who should be supernumerary in their first year.
- Spending insufficient time inducting and supervising new staff.
- Compromising therapeutic interactions with Tangata whai ora.

***“The staffing where I worked was unacceptable as I'm sure it is the same now and all around the country. Constantly understaffed and asked to do double shift and short changes. Such poor working conditions and low morale that they could not hire staff as word travelled ultimately putting strain on the staff that worked there. Mental health nursing is not general nursing and there needs to be a safe amount of numbers and skill base on the ward otherwise clients will not receive the care they need.*”**

***“Extra shifts on the floor, longer shifts, work done in own time, using own car as not allocated to have one even though role covers 3 large towns -areas and often not enough pool cars to go around ,using own money to give to clients for medications/travel as there is no slush fund for staff to access -no money for this from DHB .not having an office -sharing computers -no quiet place to think and work - all staff generally going the extra mile for each other and clients -volunteering to do extra shifts - not being valued by the organisation - having clients and their families abuse you because you can not provide what they need because the resource required is not available, doesn't exist or not available to them at the time its needed.*”**

Safe staffing levels can only be achieved by addressing workforce shortages. The work-arounds listed above are not sustainable and compromise the health and safety of staff and those they are supporting. The result is burn out, staff leaving and compromised care. Safe staffing needs to be implemented safely.

The other side of the safe working environment is that Tangata whai ora who pose a greater risk need to be identified and appropriately managed. If a person attacks a staff member or significantly damages property there needs to be an assessment for their current and ongoing level of danger. This ideally should involve consultation or assessment with a forensic psychiatrist at the earliest opportunity. People who are assessed as not being able to be safely managed in their current clinical setting should be transferred to a more appropriate clinical setting.

***“Staff are committed and dedicated to the cause. Without them there would be no care. - Staff are worn out, mentally and physically exhausted of the current situation. Workers consistently strive to achieve positive outcomes for their clients often at the detriment of their own wellbeing.*”**

And this impacts on Tangata whai ora.

***“Programs such as Safewards www.safewards.net need to be adopted at the national-level and a national and regional train-the-trainer process established. Precedent for Safewards*”**

success can be found with our cousins in Australia. The Victorian state government has invested heavily in Safewards and has had positive results... see <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards>

“Staffing numbers and appropriate skill mix needs to be urgently addressed. Low staffing levels/inappropriate skill mixes is unsafe for staff (staff feel pressured to work overtime, leading to burnout/poor decision making and new grad nurses/inexperienced nurses are required to manage patients with complex presentations well beyond their capacity) and patients (unable to receive appropriate care due to time constraints/ less 1:1 time).

“With all the good will in the world, staff in a dysfunctional system will never make the inroads that a well provisioned and staffed programme will.

“This is a no brainer -- at the moment like most other areas of the helping profession staff shortages are impacting on the quality and quantity of service professionals are able to deliver -- front line people are hit hardest by this and suffer pressure from management but also from clients themselves; they are caught in the middle and often end up burnt out and/or suffering some mental health issues themselves.

“Services are frequently short staffed, which leads to service users missing out on the care they should be receiving It also results in the safety of both service users and staff being compromised. I have personally witnessed multiple incidents that may not have occurred or been less severe had there been adequate staffing.

This is especially important because of recent moves to reduce (and ultimately eliminate) seclusion in mental health settings. There needs to be appropriate clinical and safety strategies available for use when Tangata whai ora are so unwell that they are not able to maintain safe behaviour and are a threat to the safety and wellbeing of others.

“No worker should be put at risk. Also, more staff and resources would mean that Tangata whaiora could be supported to move forward in their recovery rather than being maintained at their current level of functioning and crisis managed. Many of those in the forensic service have fallen through the cracks due to a lack of staffing.

Members are reporting considerable breaches of health and safety standards. Violence against staff appears to be a frequent occurrence which is being under reported. There is concern about how these harms are being eliminated. Safe staffing must include detailed thinking about how staff and Tangata whai ora can be kept safe from violent behaviour.

“Staff who experience workplace violence are not supported, e.g.GP costs are not met, no direction from managers about how to deal with workplace violence.

“PSA during the 2017 bargaining meetings raised issues around assaults on staff by mental health patients. The parties engaged in a small working group set up to consider a range of resources and information already available. The group agreed that the approach set out in the National Bipartite Action Group Protecting Staff from Violence Draft Guidelines was sensible, well considered and recommended adoption. However the issue of safe levels of staffing needs to be resolved. An Escalation Pathway has been added as part of the Healthy Workplace Agreement in the MECA and this will be implemented as part of any agreed MECA outcome.

Safe staffing levels also need to be developed for community and addiction services.

“I know some areas in the community have recommended caseloads such as Navigators (Mental health support workers) under the CCDHB are recommended to have 12-15 folk to support but areas such as mine, Social Housing. .. there is no cap and the caseloads can get far too high and stressful.

Staffing in home based services should also factor in potential risks to safety. Thorough assessment of the safety of home environments for both Tangata whai ora and those who care for them is needed. Double staffing may also be required to ensure staff are safe when providing home based services.

RECOMMENDATIONS

- Agree to safe staffing levels for all services across the sector and implemented.
- Address workforce shortages so that safe staffing levels are achieved without compromising decent working conditions and access to professional development.
- Ensure safe staffing includes staff to client ratios both in the acute inpatient/forensic units and community services – across both DHBs and NGOs.
- Ensure work cell phones and laptops are provided for ease of communication.

Staff engagement

Reference was often made for the need to listen to staff, to consult (genuinely) with people in the front line.

“More workplace democracy would allow more effective approaches The present 'top down' system of management throughout our DHB squashes initiative, suppresses contribution & the sense of involvement. We feel like cyphers only important for our ability to make up the numbers & subject to negative cost-cutting policies & without any of the support we are expected to supply to patients.

“Consultations processes are empty, decisions are made by management alone, but staff are expected to implement decisions.

“Organisation is too hierarchical which means that management/leadership are not hearing from the frontline staff, who are not recognised for their ideas.

“It is often difficult for worker voice to be heard at the top of an organisation. Union representation provides that opportunity. An organisation is better able to formulate responses and solutions if they are aware of the issues on the floor.

The PSA's High Performance High Engagement strategy has been piloted in some parts of the DHB sector and is a methodology of staff working together to identify better working systems

High Performance High Engagement methodology underpins the way that DHB leaders, staff and Unions should continually engage in creating and maintaining sustainable healthcare delivery that will

ensure that everyone can genuinely contribute to improving the day-to-day operations of their DHB by sharing decision making throughout the organisation and creating a high trust environment.

The objectives are to provide quality patient experiences and outcomes and a safe and healthy workplace that supports the wellbeing of the workforce and where everyone feels valued and wants to get involved. It is important that all staff are fully connected to the DHB so that they share a commitment to and ownership of high performance.

Staff engagement has the potential to identify the resources required to implement policy such as the recovery focus of *Rising to the Challenge*. Implementation of *Rising to the Challenge* was insufficiently resourced, members report. As a consequence the policy was not as effective as it could have been.

“System improvement is an ongoing process which should involve listening to the workers delivering the services and the clients receiving the services.”

Another example PSA members raised is the lack of evaluation of new policies once implemented. They observed that changes are not consolidated, which compromises continual improvement and increased effectiveness. There is a need to resource ongoing research, education and upskilling across the system.

“The pattern of services in NZ has tended to follow overseas models fairly blindly, and also lag behind best practice as there is no significant investment in researching and developing unique and diverse ways of operating here in Aotearoa as well as ensuring we are continuing to learn, reflect and develop the ways we engage with mental health.”

RECOMMENDATION

- Investigate barriers to implementing a High Performance High Engagement approach throughout the sector in order to create a culture shift that values the insights of people working closely with Tangata whai ora.

MENTAL HEALTH AND ADDICTION SERVICES

Integrated services / working together

Members support the idea of an overarching organisation of services which is client centred. A client centred provision of service mean that services work in an integrated way to provide a wrap-around seamless service. A holistic approach is envisaged.

The PSA recommend a national Mental Health strategy that encompasses DHBs and the community sector. No matter where Tangata whai ora live they would have access to appropriate support. No-one would fall between the cracks because of dual diagnosis or co-morbidity or geographic location.

A coherent across the sector approach should include:

- A nationally consistent identification of service needs.
- Seamless transition for Tangata whai ora across and between services.
- Provision of a continuum of care across the country.
- A nationally consistent workforce strategy.

Funding for mental health needs to be ring-fenced as it was in the Blueprint for Mental Health strategy. It has been too easy for mental health services to be eroded to fund other parts of health.

Addressing the current fragmentation of services would ensure clients, their families and the people providing mental services are not wasting time trying to locate the support services Tangata whai ora need. This includes travel time.

“Systems are complex, often following various legal requirements. The systems across services are hard enough to understand and navigate for the typical New Zealander, or (mental health and addiction worker) so you can imagine what it is like for those who are unwell or the elderly in society.

“One big issue is the multitude of funding contracts and PUCs i.e. purchase unit codes that exist within each DHB and across the DHBs. There are hundreds of different funding contracts with their own PUCs. There needs to be national consistent funding for services for community delivered services across the different DHBs. There is no rhyme or reason for the current coding and contracting system. It is very ad hoc and hard to decipher and get a good picture of the services being delivered within the community sector.

PSA recommends a greater degree of standardisation of contracts without restricting flexibility to reflect individual client needs and local service innovation.

Fragmentation of services is particularly challenging in provincial settings because services are thinner on the ground and there is a lot of distance between services, which impacts on travel time.

“A "One Stop Shop" set up particularly in small communities where some resources can be shared eg: building rental, utilities, and over heads. From a health perspective it would be beneficial to have professionals working together rather than in silos, and be client centre focussed.

That said, time spent travelling to, and between services is also an issue in metropolitan areas.

Integrated services also support better working together by breaking down siloed provision of services.

Tangata whai ora, their whanau and support workers assisting the transition between acute services and community and home based services experience difficulty gaining timely and clinically appropriate movement between services. And there is also a difficulty in switching between service streams.

“If I am diagnosed with an intellectual disability and using services in ID and I later on develop mental health issues and they become more prominent than the disability I cannot switch services and get mental health support. And vice versa.

“Collaboration between all networks working with an individual is key to that person’s success. Ensuring all agencies are also on the same page with an approach.

“Different services need to communicate and work together to achieve shared outcomes. Right now, most services work on more independent levels, only communicating occasionally. This can lead to service users working on different goals and outcomes with different services. It would be more beneficial to the client to have all services working to achieve the same goals.

Co-location of services whether physical and/or virtual could facilitate that.

“Co-location is useful and important, but multi-disciplinary staff, information sharing arrangements, and access to services in the first place are all extremely important.

There are differences of opinion amongst members in the breadth of services to be networked. Tangata whai ora also need services to address their basic human needs such as warm dry housing, access to basic health services and income sufficient to meet daily needs. Co-location could facilitate meeting those needs to support wellness. Mental health and addiction services could also be better integrated, although comment varied on how this would work, given the different approach taken to recovery.

“At present substance abuse is one of the major contributors to crime and health issues in NZ but the services available to address these issues are few and far between. The services are severely underfunded and more aimed at the high risk users. The people that recognise they have an issue are not getting the assistance they require until their addiction issues are extreme.

“In my opinion addictions are often the result of other issues which could/should have been prevented by earlier intervention, for example anxiety and depression, family violence, undiagnosed physical problems such as dental, hearing, sight etc., sexual abuse.

Certainly the interrelationship between addiction and mental health needs attention. The presence of addiction is often a barrier to accessing mental health services and accessing addiction services usually requires Tangata whai ora to be willing to engage.

“Significant issues around co-morbidity of mental health and addiction. trying to find help for a client in mental health crisis is almost impossible as mental health say "it's an alcohol and drug issue" like it's not possible for an addict to also be mentally unwell???? Accessing support is a nightmare, this increases risk to them, and to the community.

Member's feedback on the usefulness of virtual hubs (integrated networks online) is mixed. This strategy may be useful to some users of services but certainly not to all.

“Many people suffering from mental health issues can get 'lost' online; becoming frustrated and anxious if they fail to locate the site etc. This can lead to fixation and rumination on their 'failure' and be unhelpful. For this reason I would strongly advocate and support a physical multi-disciplined, well-resourced central location.

Physical co-location would also facilitate better working together. Some members have suggested that physical co-location be attached to the local DHB, others are of the view that a mental health hub in the community would be more responsive to community needs. A community services hub needs to be adequately funded and staff must have manageable workloads, otherwise it could become a run-down ghetto. It also needs to be appropriate for the various communities it serves.

Services must also be responsive to / reflective of the communities they serve. Māori should be able to access Kaupapa Māori services, and this includes culturally appropriate spaces, approaches and staff. Younger Tangata whai ora need access to an age differentiated appropriate workforce. Effective services need to be built around Tangata whai ora needs – what will work for them.

“Having these hubs situated in an environment that is uplifting and represents Te Whare Tapa Wha, strengthening the positive links of mental, physical, social and spiritual wellbeing.

“What would make a difference - “For the DHB structures to have a stronger commitment to the Bicultural Approach insofar as having robust systems to measure and monitor cultural competencies with Maori and non-Maori staff.

“Multiculturalism is held up to infer what our workplace is about. However this detracts from the commitment to have culturally fluidity as per Te Tiriti o Waitangi. This prevents a personalised investment to recovery for Maori with Mental Health issues.

Better integrated services include providing support to police who are frequently first responders in the event of an acute presentation. Members advocate for better training for the police to manage these situations but also that acute mental health specialists need to be available to support them.

Integration between services and between people working to support wellness may well be more easily integrated with virtual networks. Suggestions for using integrated information technology to better integrate services include:

“A national database to identify who is on a compulsory treatment order, so that itinerant people can get treatment restarted if they have left one area and relocated elsewhere.

“Better sharing of information between services – for example a common set of documents all used nationwide (i) triage form, (ii) comprehensive assessment, (iii) risk assessment and risk management plan, (iv) individual treatment plan – variation for acute inpatient, long term supported accommodation, and community treatment. Needs to be agreed timeframe for review/update of each document.

“Agreed minimum information requirements for transfer or care from one service to another.

“Upgraded IT Infrastructure – almost every DHB has different proprietary software systems, so that someone who works in one DHB cannot easily (i) get onto a different DHB system easily if they transfer to work elsewhere, and (ii) as software may be different, it may take some time to understand the local systems. New Zealand is relatively small in size and population. There doesn’t need to be the proliferation of different programs – a common suite of agreed and supported systems can be implemented nationally so that sharing of patient information can be easily undertaken, and staff moving from one place to another are already familiar with how to use the systems.

Spending time on complex and time consuming documentation was mentioned by many members as a barrier to better care for tangata whai ora.

“Within the DHB service in West Auckland we appear to have a good number of well trained staff. Unfortunately the systems we have to work within are old fashioned outdated and extremely inefficient. Many hours are spent typing information about clients rather than actually being able to spend time with them.

RECOMMENDATIONS

- Develop and implement a national mental health strategy that encompasses the DHB and community sector.
- Integrate services across the DHB and community sector.
- Ring fence funding for mental health.
- Fully fund and resource mental health services for tangata whai ora experiencing high, enduring and complex needs. This includes: Community mental health centres, acute inpatient units, longer term residential facilities, respite facilities, community support work services.

Community and home-based service: ensuring a continuum of support

Respite

Almost all the members responding to the PSA questionnaire agreed that more respite provision was required. But, they were clear that quality respite services were required – it was not a matter of just providing beds.

The following elements of quality respite support were identified:

- Staffed by skilled workers who have access to funded and ongoing professional development.
- Providing planned and appropriate respite support, whether or not respite is being provided for acute admissions or planned respite.
- Providing respite care in local communities, close to whanau.
- Providing culturally safe respite services.
- Including respite services that are age and gender appropriate (for example women only respite services where experiences of sexual and other gendered violence has contributed to unwellness).

Members also commented that too often Tangata whai ora are placed inappropriately in respite facilities in response to a shortfall in inpatient beds. For example, the least unwell person in an inpatient unit (IPU) is moved to a respite facility against clinical advice to accommodate an acutely

unwell person. This is also played out in the criminal justice system. Offenders with mental health issues are sentenced to community based care, and probation officers are tasked with finding the services needed to support the person. This movement of Tangata whai ora to community sector placements to free up beds, rather than where their needs are best met appears to be a problem across the system.

An increase in respite facilities should not be seen as a trade off. Tangata whai ora who are acutely unwell need to be where they can be cared for - that should be the primary determination of where they are placed.

Clearer entry criteria for moving between levels of support would be useful.

“Also give a thought what type of respite facilities are being offered: - 1) For the service user - 2) For the carer - 3) Short term - less than 3 days - 4) Up to 2 weeks - 5) Respite for addiction related services

“There should be a short stay mental health assessment and planning unit with 6 to 10 beds next to ED Wellington, which would be functioning similar to MAPU to allow mental patients to be triaged either to home base treatment team or in patient admission.

“This could be modelled on the “GB” which I worked at in the mid 00’s at the Royal Brisbane & Women’s Hospital which was a 6 bed unit specifically for overnight mental health watch and assessment and was staffed by 3 mental health nurses. It is now called the Psychiatric Emergency Centre. Their web page states “We provide advice and a comprehensive mental health assessment 24 hours a day for people who present to the Emergency Department” <https://metronorth.health.qld.gov.au/rbwh/healthcare-services/psychiatric-emergency>

“Released prisoners with mental health should have a sub- acute unit that they can transition to from prison. This would allow time to establish medication regimes, community support and short and long term accommodation options.

Members in provincial areas also talked about Emergency Departments which did not have after hours services available, so that Tangata whai ora were sent home when acute admission was needed. A home based crisis service is working well in one locality. The team responds within an hour of request. This initiative is an example of timely response.

Our members also comment that the lack of accommodation for people generally is a complicating factor. Tangata whai ora are unable to be discharged without a place to go, and so acute beds and respite beds are being used to plug the shortfall of appropriate accommodation. It must be remembered that respite facilities are intended as part of a continuum of supported housing environments.

“Community housing support, supportive landlord services and supported accommodation. When people have a home to call their own the incentive to recover a “life worth living” is greatly enhanced.

Part of that continuum is intense home based treatment (HBT) options.

“I currently work in a mobile CATT/HBT team and thoroughly recommend it to be replicated in other centres.

“It's more labour intensive than putting the "clients" together, but has better chance of better outcomes by keeping people connected with their communities. Also breaks down community perception of difference/otherness.

Members also said that availability of properly resourced home based treatment shows promise.

“I'm not sure how effective or resourced this is, I do believe however that this operating well and safely is an excellent resource for clients and in all likelihood continues to be an effective strategy for helping people stay in the community for longer without the need for repeat hospital admissions

“This is something that I see as an important part of a person's recovery journey. As a mobile community support worker, I spend my time visiting people in the community in their homes. This is where a person is able to work towards their independence and wellbeing the best.

“HBT is an awesome service that has had great press and outcomes in Europe for many years now. Once again, the education of the people at an early opportunity will increase the effectiveness of these teams. Also the correct, effective and robust training of HBT teams is essential. Pro-activity is far better than reactive responses.

“So many of the stresses that result in relapse can be headed off with the right support in-home. Adequate nutrition, warm safe housing, help with medication compliance/education, goal directed plans and support in achieving them, supported employment services, supported education all can lead to better outcomes for clients.

“Continuity of care so that ongoing community support is kept engaged and informed as part of the care package. Especially with CYMHS being able to stay involved when specialist mental health services engage and it's not seen as double dipping.

In some areas this option has been successful but discontinued for lack of funding, or amalgamated into a home based acute crisis response. Members expressed frustration when successful initiatives were abandoned.

“WDHB did have a home based treatment service as part of each MH Crisis team. These were disassembled a few years ago to save money. Crisis staff are now expected to provide home based treatment and intensive follow up support

If Mental Health and addiction services are enhanced and stabilised in the community, this will lead to savings in hospital services provisions and the wider Health Budget. Ultimately there will be flow-on effects on other Budgets as Tangata whai ora might find it easier to find and sustain work, study and other aspects of their life.

RECOMMENDATIONS

- Standardise contracts with providers in the community sector without restricting flexibility to reflect individual client needs and local service innovation.
- Ensure the transition between different services is smooth, seamless and based on the needs of Tangata whai ora.

Compulsory treatment orders

PSA members have identified problems with the initiation of treatment orders under the Mental Health Act.

Perverse incentives to be sectioned need to be reviewed. Tangata whai ora remain under a compulsory treatment order unnecessarily in order to access services and/or free medication. People should be able to access free medication and have access to mental health services without a compulsory treatment order. The PSA also thinks that, if in place, a compulsory treatment order should not lapse when a client is imprisoned.

On the issue of having to appear before a judge rather than by video conference members were divided. Members who favoured having video conferencing as an option emphasised minimising the stress of traveling long distance, the stress of appearing in court and the absence of whanau support. These members also advocated for Tangata whai ora to determine video conferencing as an option.

Members who advocated for face to face (kanohi ki te kanohi) hearings suggested that a way to make the experience less stressful was to have the hearing, outside a courtroom in another setting (such as the mental health facility) and for the judge to travel to where Tangata whai ora are. The main objection to video conferencing for these members was concern about abuse of process. These respondents also wanted to acknowledge respect for the significance of the situation and saw the process of appearing before a judge as part of the healing process.

RECOMMENDATION

- Review the operation of compulsory treatment orders to ensure they are fit for purpose.

Recent legislation enabling compulsory treatment orders for addiction (the Substance Addiction Compulsory Assessment and Treatment Act 2017) has not been matched by resources and facilities. This approach could be helpful, but needs resourcing.

“Addiction services have recently had a change to the SACAT. This piece of legislation has been implemented without any additional resources to make it even possible to implement it properly. The legislation talks about detaining the person for compulsory treatment and yet there is no-where to do that or a workforce who is equipped to provide that level of care and intervention. (The skills for the treatment are there but the facility and policy framework are not) - Current AOD services are not equipped to compulsorily detain. There is no secure facility available. The current system relies upon consent.

“The new SACAT Act has no teeth and there are few compulsory beds for rehab.

RECOMMENDATION

- Resource the Substance Addiction Compulsory Assessment and Treatment Act by making the necessary facilities and staffing available.

Mental health in prisons

One member estimated that 60% of offenders in the criminal justice system have mental health issues. Another said “jails bulge with addicts” and a third observed that the “at risk” unit in the prison they worked at was essentially a mental health unit.

“There has been a huge increase in the number of offenders who are attending Community Corrections Probation Services who have severe mental health needs, pose a risk to themselves and the public, have either no accommodation or unstable accommodation, that would benefit from a facility to support them to live in the community and deal with their health issues. Probation is not the place for their health issues.

“Prison staff are not mental health workers but often have to act as such. At risk units are often just a pseudo psych ward. Forensic staff try their best but are limited by bed space. Services for intervention and prevention of deterioration in mental health and the promotion of wellbeing to facilitate positive empowerment and wellbeing would benefit all within prisons.

RECOMMENDATION

- Increase resources for forensic mental health services.

Addiction services

PSA members generally would like to see addiction seen as a public health rather than a criminal issue. They said addiction is most usefully treated within a health first approach but people also need to be accountable for criminal behaviour.

“Addiction is a public health issue, however at times it also becomes a criminal justice issue , I do not believe that substance use should be a reason for not being accountable for criminal activity. However I do believe that offering help and assisting people to address their issues while being accountable for their behaviours should be a large part of their sentence and treatment

“Working in the CAMHS setting has given me the perspective to see the vast majority of mental health and addiction issues as within a systemic developmental context that usually evolves over years of dysfunction and trauma. If there was the possibility of choice, I believe most people suffering with addictions would not choose to be, but that successive poor life circumstances and trauma have contributed to addiction manifestation. Provision and manufacture of drugs is a criminal issue that manipulates those with addiction – a health issue.

“Not putting people into jail for addiction issues, putting in processes that stop the police and the Department of Corrections being the front line of mental health services. Judges should not be putting people suffering mental health issues on orders just to get a Probation Officer to ensure they are treated. That should be up to mental health providers. When judges do so they are simply criminalizing mental health.

“The Hanmer taha Māori service worked very successfully for Māori

A PSA member suggests the panel look at the Mental Health initiative at Whanganui Prison.

PSA also recommends the elimination of waiting times for addiction rehabilitation services, which will require an increase in services. More AOD clinicians are required.

There is a need for a Co-existing Problem (CEP)/Dual-diagnosis education module that should be provided to all addictions and mental health clinical staff.

***“Currently there are long wait times and few clients are able to be admitted to rehab facilities directly after completing detox. There is an increased burden on acute mental health services to manage substance abuse.*”**

A number of respondents to our questionnaire suggested the panel look to Portugal as a model where the use of all drugs was decriminalised in 2001. Possession and use of small quantities is treated as a public health issue, not a criminal matter. Drugs are still illegal but the response to being caught in possession is not jail time and a criminal record but a small fine and possibly a referral to a treatment programme.

RECOMMENDATIONS

- Alcohol and other drug (AOD) addiction must be seen as a health first issue, while also holding people to account for criminal behaviour.
- Resource AOD services so that waiting times are eliminated
- Ensure that decisions about appropriate services for Tangata whai ora with co-existing problems/dual diagnosis are driven by the needs of Tangata whai ora rather than cost shifting and/or availability of services.

ASSOCIATED PRIORITIES

Address mental health and addiction issues early

Members often commented on the need for access to support earlier, by providing mental health services in the community for Tangata whai ora experiencing early indications of being unwell and by providing services for young people in schools and youth oriented community hubs.

“Invest in primary mental health services for mild-moderate patients, with enough sessions to treat them and prevent recurrence.

“Early access and support, prior to escalating levels of need. Better publicity and resourcing for telehealth services, and free counselling sessions from GP referrals. Continued work to de-stigmatise mental health.

“There needs to be a boost to primary mental health services, so people with mild depression and anxiety etc. can get quick and easy access to counselling services at minimal cost.

“Paying for behavioural therapy while on a low wage is pretty much cost prohibitive

“(What would make a difference?) – That funding models and staffing levels actually reflect the NEED of the community not the amount of funding actually in hand. IE the notion of only providing services for the top 3% of mental health cases based on needs is critically flawed and appropriate analysis of required investment and funding in the sector needs to be undertaken to actually address the need not just deliver the services that are so minimally funded at present.

Community awareness of mental health and addiction also needs to be raised, so that people can seek (and access) help early without stigma. However as one worker commented encouraging people to ask for help when services are stretched or not available is not helpful.

“Investment in mental health and addiction education at primary and secondary school, earlier family education on the impact of trauma and poor attachment and the subsequent influence this has on poor mental health outcomes. This should start in ante-natal classes and continue into health curriculum throughout schooling - we need to teach young people how to express their emotions and develop adequate coping skills to self-manage and also seek help, rather than allowing acute mental health addiction issues to develop before help is sought.

“I am a crisis nurse, we see more people who are stressed out due to social stressors than we do people with a diagnosed or diagnosable psychiatric illness. We need more supports at a primary level so we can care for and manage people with a true psychiatric illness.

Timeliness was an issue identified which frustrated mental health workers, who observed that Tangata whai ora had to be acutely unwell before they could access services..

“It's currently too hard to find the right service and when you do clients have to be critical before any actions, if any, are taken

“It appears there is such a shortage of support that suicide ideation with a plan and intent is not enough to require an intervention.

RECOMMENDATIONS

- Invest in providing Mental Health services early, before Tangata whai ora become acutely unwell.
- Invest in prevention strategies, raising awareness in communities and in schools.

Meet basic living needs

Initiatives to assist Tangata whai ora to meet their basic healthy living needs is reported to work well in some locations, but has risks. It would be unhelpful to limit this kind of assistance to Tangata whai ora only. Access to decent housing and access to primary health care (including no cost dental health care and free medication) was often mentioned as making a noticeable difference to people’s well-being.

Social stressors like poverty, inadequate housing and access to basic health needs were described by many of our members as a contributory factor in people becoming unwell. Addressing these deficits were seen as necessary in enabling recovery. There was concern expressed that access to an adequate standard of living, access to primary health care, and decent housing were living conditions everyone should expect.

“Mental/physical health, addiction, crime, poverty, education, social injustice ... they're all linked, and divisions of policy/funding into health, justice, social development, education etc are arbitrary boundaries designed to try to make the mess look tidier. Humans like to clump things together and make divisions so decisions seem more reasonable. Then, creatures of habit that we are, we enshrine the divisions, look only at confirmatory information and try not to see the arbitrary, chaotic connectedness because we're human.

“The more support and resources that is offered to people when they need it can only enhance their wellbeing – Include dieticians, podiatrists, diabetes support, smoking cessation support and opticians. We all know of the physical implications that occur from years of medication, unbalanced diets, smoking, diabetes and COPD (Chronic Obstructive Pulmonary Disease) for our people.

RECOMMENDATION

- Ensure everyone has access to an adequate standard of living including warm dry housing. The basic social determinants of wellbeing should be available to every person.

Appendix A

Mental Health Committee PSA

The Mental Health Committee of the PSA includes mental health workers from the community, from District Health Boards and from other government departments who have mental health workers in their workforce. Between them the committee has over 200 years' experience working in the field. A number of committee members also have lived experience of mental health and addiction challenges, either personally or within their whanau.

Andy Colwell – co-convener

Andy has worked in the mental health sector for 18 years as a qualified and registered social worker. He has extensive experience and knowledge working in the community as an allied health clinician. His roles have included continuing care, residential support, and assertive outreach. He currently works in a crisis team.

Pollyanna Alo – co-convener

Pollyanna is Samoan and has a social work postgraduate paper. She has worked as a health worker in the Mental Health Sector. Pollyanna has been in the health sector for 10 years, and prior to that was in the education sector for five years. She is passionate about Social Justice and Animal welfare, and continually strives to advocate for equality and fairness in the workplace.

Brent Doncliff - RN, MN (Hons), FCNA (NZ)

Brent has been a registered nurse since 1988. He holds a Master of Nursing degree, specialising in mental health. He is a Fellow of the College of Nurses Aotearoa (NZ). He has worked in clinical practice, nursing education and mental health service management. He has published several articles in professional nursing journals.

Tarn Evans

Professionally, Tarn has been a Mental Health Support Worker for 13 years in a variety of areas: youth respite; residential supported living; crisis respite; and community support. She is currently employed as a Housing Case Worker. Personally, Tarn has spent many years supporting family and friends at various times to navigate Mental Health services.

Richard Hemingway

Richard works as a Rehabilitation Assistant at Stanford House, a 15 bed inpatient medium secure forensic unit on the Whanganui District Health Board campus. He has been working in this area of mental health since 1996 when he commenced work at the National Secure Unit (maximum security) at Lake Alice. He currently holds a National Certificate in Mental Health (Mental Health Support Work) Level 4 and recently commenced the Diploma of Health and Wellbeing (Applied Practice) Forensic Inpatient Level 5 and has completed training in Social and Therapeutic Horticulture.

Yvette Faass

He tamaiti o Te Ati Haunui a Paparangi, he whangai ahau, me he tamaiti o Kāi Tahu whanau tuturu.

Yvette works at Purapura Whetu Trust Ltd. She has worked in the specialised Kaupapa Māori Mental health field for the past 10 years after working in the Domestic Violence field. She has a BA double major in Psychology and Education, and is a qualified Registered Social Worker. Her other qualifications include a Dip MH Support Worker and Heke Rongoa (Diploma in Natural Māori medicine) from Te Wananga o Raukawa. She has participated in numerous Kaupapa Māori modalities of practice trainings and courses to assist her provide effective best practice.

Personally, Yvette was born into a whanau as the child of parents with MH issues, domestic violence and alcoholism, with a pattern of intergenerational comorbidity. She has experienced clinical depression and through counselling and personal development of strategies and skills has learnt to manage her depression. Involved in Te Ao Maori and practices to nourish mana ahua ake have enabled Yvette to support others to also reach their goals and dreams

Billy West

Billy started working in the 1980s in Disability support at the time people were beginning to be moved from Hospitals into the Community. He returned to the Mental Health and Disability field in 2005. He has worked for several organisations, including “Youth Horizons”, P.A.R.S (Mt Eden Prison special unit). Richmond-Wellink (Emerge Aotearoa), Day Services in Henderson and Onehunga, ACC, Rehabilitation unit (Auckland Wide). Youth Justice (Pakuranga), Odyssey House (Drug and alcohol) Recovery Facility and School, Spectrum Health Care, and Pathways Health Limited. He is currently a Support Worker (Navigator) in the Mobile Team at Pathways.

Billy completed Pre- Degree course in Youth work at B.M.E.T.S Then a Degree at Auckland University in Social Services with a Major in Youth Work and a minor in Disability and Mental Health. He has a level 4 National Certificate in Mental Health and Addictions.

Amanda Martin

Amanda is a Senior Recovery Facilitator in the Crisis Assessment Team (CATT) and Home Based Treatment (HBT) Team with Mental Health NZ and Healthcare NZ. She has a National Certificate Mental Health Support Worker, Diploma in Pastoral Care and a Diploma in Counselling. Amanda has worked in the mental health and addictions field for the last 25 years. Her experience includes: Supportive Accommodation; Alcohol & Drug Services; Prison/Forensic; Court Support; Acute/Crisis Respite; Planned Respite; Facilitator - Psycho-Social Counselling, Rwanda & Burundi Genocide Survivors; Community Support; and Counselling.

Nancy Dally

Nancy has been nursing since 1969. She has been working in the mental health sector since 1974. Nancy worked in the Māori unit and the acute ward at Kingseat Hospital until it closed and then went to Tiaho Mai at Counties Manakau DHB, where she is now. Nancy is an enrolled nurse.

Allan Franks

Tena Koutou, tena Koutou,
He mihi, he mihi
Ko Allan Franks tenei. Ko Ngaapuhi, Ngaati Maniapoto Ngaa Iwi

Allan has worked in Māori Mental Health Services at Te Korowai Atawhai (CDHB) as He Pukenga Atawhai; and Manawanui (ADHB) as Kaiatawhai. He is presently employed at Te Whetu Tawera Adult Inpatient Services. Allan trained as a Psychiatric nurse in the '70s. He has been He Kaimahi for Hauora Māori for 20 years.

Allan's whanau has had links with Te Rau Matatini, Māori Mental Services at Tokonui Hospital, and Carrington Hospital.