PSA Submission

Mental Health (Compulsory Assessment and Treatment) Amendment Bill

May 2021

PSA
For a better working life
New Zealand Public Service Association
Te Pūkenga Here Tikanga Mahi

About the PSA

The New Zealand Public Service Association Te Pūkenga Here Tikanga Mahi (the PSA) is the largest trade union in New Zealand with over 78,000 members. We are a democratic organisation representing members in the public service, the wider state sector (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.

The PSA has been advocating for strong, innovative and effective public and community services since our establishment in 1913. People join the PSA to negotiate their terms of employment collectively, to have a voice within their workplace and to have an independent public voice on the quality of public and community services and how they are delivered.

The PSA has a 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*. More recently we have made a submission on *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. We have also submitted on subsequent pieces of legislation and strategic policy documents related to implementing the recommendations of He Ara Oranga.

The PSA is affiliated to Te Kauae Kaimahi the New Zealand Council of Trade Unions, Public Services International and UniGlobal.

This submission

This submission has been developed by the Mental Health and Addictions Committee (MHAC) 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. Their views informed and are an integral part of this submission.

Our values

Solidarity - Kotahitanga

We champion members' interests with a strong effective voice. We stand together, supporting and empowering members, individually and collectively.

Social justice - Pāpori Ture Tika

We take a stand for decent treatment and justice. We embrace diversity and challenge inequality.

Integrity and respect - Te Pono me te Whakaute

Our actions are characterised by professionalism, integrity and respect.

Solution focused - Otinga Arotahi

We are a progressive and constructive union, constantly seeking solutions that improve members' working lives.

Democratic - Tā te Nuinga e Whakatau ai

We encourage participation from members. We aim to be transparent, accessible and inclusive in the way we work.

Summary

The PSA strongly supports the purpose of the bill but believes that some adjustments are needed to ensure a reformed Mental Health Act is comprehensive, fit-for-purpose and relevant moving forward. These include:

- Acknowledging through cross-referencing,or including provisions to ensure health and safety of the workforce.
- Broadening the definition of Mental Health Practitioner to include 'registered health professionals working in specialist mental health services'.
- Requiring the inclusion of a kaumatua and/ or cultural team in assessment processes.
- Ending indefinite orders and promoting regular reviews.
- Inclusion of support for the transportation provisions of patients; and additional recommendations to mitigate associated risks.

The PSA's position

The PSA **supports the intention of this bill** which is to improve the protection of individual rights and the safety of patients and the public, and to enable a more effective application of the Mental Health (Compulsory Assessment and Treatment) Act 1992 by eliminating indefinite treatment orders and minimising the risk of harm to the patient or the public when transporting forensic special, patients.

He Ara Oranga highlighted the importance of repealing and replacing the Mental Health Act 'to reflect a human rights approach, promote supported decision-making and align with a recovery and wellbeing model, and minimise compulsory or coercive treatment.' The PSA welcomes the updating of the Act to make it consistent with international treaty obligations and to reduce trauma and harm to compulsorily treated patients. However, the **PSA is concerned that the amendments are mere improvements** of the existing Act and are not based on a re-imagined mental health service that recognises the human rights of all involved. It falls short of repealing and replacing the existing Act.

The Mental Health and Addictions Committee (MHAC) of the PSA submit that the problems in service delivery of mental health and addiction services are improving but prevail in many areas. Especially the issue of **safe staffing** while offering the most effective and meaningful services continues to be an issue and fails to keep staff, patients and the public safe.

Recommendations

Recommendation 1: The Mental Health workforce

The PSA is concerned that there is no mention in the bill of workers' safety and protection in mental health and addictions services. Although the PSA is aware that Health and Safety in the workplace is guaranteed elsewhere in legislation, an acknowledgement or cross-referencing to the Health and Safety Act would be useful to underline the complementary nature of safe and protected staff and safe and protected patients and the public. In addition, safe staffing levels are curcial to ensure the health and safety of staff, patients and the public. This is an issue the PSA has raised on numerous occasisions over our decades of being involved in mental health and addiction services, and which remains unresolved. Also more investment in training, such as building health workers' skills in deescalation and therapeutic responses to people's distress, would enhance everyone's safety.

The MHAC recommends that the Bill includes the need to ensure in appropriate ways that the importance of safety of mental health workers is acknowledged and enabled and that the human rights of workers and patients are complementary. We note that the substantive Act does not include a purpose statement. This would be a positive addition to the Act and could include reference to workers' health and safety. Such reference could acknowledge the intention to repect, protect and fulfill human rights of both patients and workers.

Comments and examples supporting the need for and inclusion of the workforce to be safe and protected:

> *I work in the front line of MH as an administrator. Dealing with verbal abuse, threats of complaints if Client / PTs don't get their way. Everyone from Administration to Doctors need to know that they are protected out there (…).*
>
> *I agree that the safety of mental health workers is not guaranteed as there are too many health workers being assaulted in their workplace.*
>
> *I have had experience in this area and in my opinion the mental health workers require more support and a structure to safeguard their mental health. They can't continue to support struggling whanau if they are struggling under the immense stress and workloads they have.*
>
> *I work in the addictions field and the clients can on occasions be difficult to manage and manipulative behaviour is not unusual. I have had complaints made which on investigation were found false but the client ends up with benefit of doubt until conclusion of investigation which unsettling. Clients' rights important but a balance to protect staff be good.*

Safety for mental health workers is definitely not taken seriously enough by the workplace. And as someone who has been assaulted on 3 different occasions by the same patient and had significant amount of time off work from concussions. I believe this is something that should be done more seriously especially as the area I am in is not an acute ward.

I believe the Act needs to specifically guarantee legislative safety of the workers who are at the front line enforcing the Act. It needs to acknowledge that in this day and age workers are often subjected to significant abuse both of a physical and verbal nature that tends to get 'brushed under the carpet because it's just ' 'mental health' when they are going about their lawful duty.

I am an occupational therapist and key worker in an early intervention psychosis service. I have had several clients become acutely unwell requiring treatment under the MHA and support colleagues with their clients in the same situation. I think it is very important to ensure safety of mental health workers is acknowledged in the Act.

I work sole charge overnight in an acute crisis respite service. I am female and feel there should be 2 workers on during the night in crisis as many of our guests are very high risk and suffer from various symptoms with no sleep and all sorts of other issues in the night from trauma related history, personality disorders, suicidal ideation, self-harm, history of violence and drug addiction the list goes on. I have had many recorded incidents relating to the high risk and need for 2 staff on during my 2 years working here the awake nightshift in crisis respite. I have expressed my concerns around this many times. It's also been brought up by other staff members. My Team coach has said firmly no! It won't happen.

I work in a building that has no centralised alarm system, no security at the entry - no way of calling for help that is efficient. Yet the building is open to whoever comes in the door including in the evening when staff and clients might be isolated within the building. Our AOD clients are a vulnerable group. So far nothing has happened.

Safety of mental health workers is totally minimised (unless you are a Dr) I am doing a return-to-work programme after a severe bashing and experiencing emotional trauma. Nothing really has changed in the work environment (though management are very supportive of me along with OCC Health).

Agree as a community nurse who quite often attends situations in the community, I believe it's pivotal to make sure that the staff are protected and that their safety comes first prior to the execution of the MHA on a client in the community. We don't have powers/tools like the police to keep ourselves safe.

Recommendation 2: The definition of a Mental Health Practioner

The Bill defines a mental health practitioner as a medical practitioner, nurse practitioner, or a registered nurse working in a mental health setting. The MHAC's recommendation is that the definition be broadened to include 'registered health professionals working in specialist mental health services'. While the PSA is aware that this can under certain circumstances dilute an already fragile process, there is a need to recognise the multi-disciplinary nature of teams working in

specialist settings and their respective competencies, especially in crisis teams. In particular, a previous Section 8B amendment enabled Registered Nurses to do assessments. We recommend that registered Social Workers and Occupational Therapists working in mental health can also do Section 8B assessments.

Comments and examples broadening the definition of Mental Health Practitioner to include registered health professionals working in specialist mental health services to:

> *I believe that anyone with at least 5+ years experience should be able to complete Section 8B assessments. This is where experience proven. Why do we have to have registered staff filling in this section when some of them don't even know the person and their family/whanau. I have worked in Mental Health for the past 17 years and have questioned some of the staff on what is their rational for putting a person under the MHA.*

> *I agree with this broader definition to include registered mental health professionals working in specialist mental health services and to extend that RSW can complete SecB assessments, but only after doing appropriate training or education.*

> *I am a registered counsellor who has worked for the DHB in both Adult Mental Health and Adolescent Mental Health. I think that it is important counsellors are also recognised more so in clinical practice through the DHB's. There is a crossover in many aspects of counselling training and social work training.*

> *The new Act needs to account for the changing nature of MH&A services with the NGO sector picking up more work and not necessarily defining themselves as 'specialist mental health services'.*

Recommendation 3: Importance of cultural considerations in the rights of patients and whānau/family, are imperative to wellbeing.

The PSA believes that the importance of cultural considerations in respecting, protecting and fulfilling the rights of patients and whānau/family is imperative to wellbeing. The MHAC recommends requiring a kaumatua and/or cultural team to be included in assessment processes (section 9). Although implementing this might be difficult especially in rural and remote areas and for already stretched organisations, this would improve outcomes and assist with better, embedded patient follow-up in the community. Enabling factors such as funding and apprpriate staff must be accessible as an integral part of mental health and addiction services. Further, we recommend that there is a significant need for more Kaupapa Māori services in mental health.

Comments and examples supporting the inclusion of kaumatua/cultural team in assessment processes:

If there is an active kaumatua on site who knows the whanau, great. However the cultural team would be more recommended as the relationship between the person and whanau would be interweaved as part of the treatment package. There is a desperate need for more kaupapa maori services. The resources that are available are not adequate with the increase of Maori entering mental health services.

I agree in the significant need for more kaupapa Maori services in mental health that are more readily available, and which can help to bridge that gap between cultural and clinical. I agree in some part to the availability and inclusion of kaumatua and cultural support during the section 9, however I think caution should be around delaying assessment and exacerbating distress, risk and client wellbeing if this is a delayed process, due to availability of cultural support (realistically given current availability) and that inclusion should be extended to ongoing sections of the Act and the process if not readily available at the time of the Sect 9. From being involved in the process previously it is very stressful on the client and their whanau and I would be cautious about any potential prolonging of this (especially if it is hours).

Cultural recognition of tangata whenua is a intrinsic part of any assessment and it should be just part of the process. When introducing tangata whaiora into a service Kaumatua play a very important part in ensuring cultural process is followed and tikanga is upheld for whaiora whanau and staff.

All tangata whaiora who identify as Maori automatically have a referral to our cultural team on entering our service. We also have a kaupapa Maori service in which tangata whaiora are able to have their community follow up through, however there are some limitations to this, including geographical limits.

I totally agree with this, most Maori Health Services are only used on a need basis and should be more visual and placed within teams not in their own services. Maori working in Teams that are not under Maori Health Services can also have more knowledge and experience than staff in MHS, so therefore need to be recognised also.

It is an important aspect to have on board as this looks at the holistic aspect of the person and not just at the illness. They are a person first and foremost and part of knowing where they sit within their culture is a good place to start recovery.

Recommendation 4: Ending indefinite orders.

The PSA supports the ending of indefinite orders as proposed by the Bill. The MHAC's promotes regular reviews. Indefinite orders are resource-driven rather than need-driven. Often systemic issues within the mental health system drive the use of indefinite orders to ensure e.g. patients have shelter and ongoing medication. Basic human rights such as access to adequate shelter and medication must be guaranteed through appropriate mechanisms outside of the mental health system.

The MHAC supports ending indefinite orders but recommends that mechanisms are considered to ensure patients do not end up in inadequate housing (or hospital) situations without medication or support. Dedicating resource should be considered to enable regular reviews of patients' situations.

Comments and examples supporting the ending of indefinite orders and promoting regular reviews:

> *Any change in this will require commitment from DHB to adequately fund the extra duties involved. Most mental health services are already stretched to their limits to complete already identified tasks.*
>
> *As a secretary I know from my doctors' experiences that a lot of people will stay (probably unnecessarily) under the MHA because of the free prescription, and I believe that this needs to be addressed. Regular reviewing can be difficult as I always run out of space in the three psychiatrists' clinics that I work for. Perhaps some patients that have a lot of admissions could receive free prescriptions and the need for Indefinite Orders could be abolished completely. I reiterate that it is difficult to have more than regular reviews as clinic space and time may not always be available.*

Recommendation 5: Transportation.

The PSA supports the proposed amendments for transporting special patients. The MHAC recommends that the scope should be widened to also include acutely unwell patients, and that guidelines for transportation of acutely unwell patients are established through active participation of the health workforce who hold the expertise to make suitable decisions. Additionally, the assessments should be carried out in a facility fit for purpose – e.g. in a dedicated mental health area with dedicated staffing in Emergency Department (EDs). At present ED configuarations don't provide for this to happen. Assessments at a person's home could be an opition but might not fully guarantee the safety of the health worker and might

disturb the person in need. The MHAC also recommends that mental health professionals are best placed to assess safety and risk issues.

Comments and examples supporting the transportation provisions of patients and additional recommendations to mitigate associated risks.

Transporting an acutely unwell person has normally been carried out with police assistance due to the nature of safety and risk. For a health worker who is assessing on a home visit there has been police presence. Health & Safety is always at the forefront of any assessment undertaking.

A dedicated area at any medical facility would be of preference, for easier more efficient assessment and to facilitate the process of any need of hospitalisation.

There should definitely be a dedicated section in ED with dedicated staff especially qualified in mental health, with their own security guards as EDs and ED staff are not trained or set up for this, and mental health puts a further burden on already strained ED resources. This special division would also need to serve those taken to ED with drug overdose, addictions and alcohol overdose addictions.

Having sat multiple times in ED listening to Mental Health workers querying patients next to me behind a curtain having to discuss suicide attempts and their terrible suffering, I feel a dedicated area is vital.

I have witnessed patients being taken from ED in a Police paddy wagon, stainless steel seating, no cushions, no blanket, cold. No support person with them. Needs to be a designated space in ED that is safe for Tangata whaiora and Staff.

Agree. Not my experience, but a close colleague was pulled from one ward to ED to watch a mental health patient who was agitated. There were many other patients around, and the space was open. My colleague was worried for other people and was not trained to manage this patient. It took a while for a mental health assessment and caused stress for the patient and the staff member during the wait. The patient was getting more agitated by all the people around and the noise. The staff member noted at the time, that mental health patients needed a dedicated space while they wait - for their safety, and for other members of the public's safety.

Having to sit in ED waiting to be seen is not appropriate for all concerned. It stigmatises our clients further and makes them feel awful and like people are talking about them which makes things worse.

The PSA would like to end our submission with a final comment from one of our members supporting the importance of mental health services and adequate resourcing for the wellbeing of all New Zealanders.

> *I both work in the mental health field and have family members who are clients of the service. Staff do their best with the resources they have. Severe mental illness impacts many NZ families and both clients and staff need appropriate resources to help everyone involved.*

We appreciate the opportunity to speak with the Select Committee about our recommendations.

Thank you for considering our submission.

For further information, please contact:

Andrea Fromm
Senior Advisor
Policy and Strategy
New Zealand Public Service Association
PO Box 3817
Wellington 6140

Phone: 027 5816170
Email: andrea.fromm@psa.org.nz