



**PSA Submission**

**Mental Health Bill**

**December 2024**

## 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 96,000 members. We are a democratic organisation representing members in the public service, the wider state sector (Te Whatu Ora, 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. 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 including the Mental Health Amendment Act 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 (PSI) and UniGlobal.

## This submission

This submission has been developed by the PSA Mental Health and Addictions Committee (MHAC) which comprises members working in mental health services across the Health Sector in specialist inpatient and community services, also in the funded community services (Non-Government Organisations), and in core public service agencies. Their views informed and are an integral part of this submission.

In preparing this submission, in addition to input from committee members, we also used feedback from PSA members working in mental health who completed a survey in 2021 which was used in preparation of a submission to an earlier Mental Health Amendment Bill. In reviewing the survey responses, we have determined that the concerns remain similar and are - if anything - more pronounced, so we chose to include some of the comments to illustrate our recommendations with our members' voice.

## 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 MHAC supports the purpose of the Bill namely to provide for compulsory mental health assessment and care in a manner that promotes a person's decision-making capacity; making significant improvements in equitable mental health outcomes; the protection of people's rights, safety and wellbeing. However, the PSA MHAC believes that some adjustments are needed to ensure a reformed Mental Health Act is fit-for-purpose and relevant moving forward. These include:

- Adding that the purpose of the Bill is to provide compulsory mental health assessment and care in a manner that *respects, protects and supports pae ora*.
- Acknowledging the importance of ensuring *health and safety of the workforce* through e.g. including reference to workers' health and safety, to workers' participation and to Te Mauri o Rongo | the NZ Health Charter.
- The Bill being explicit about *minimising psychosocial harm and creating a culturally safe environment* through e.g. the inclusion of a kaumatua/kui and/ or cultural support in the decision and assessment processes.
- Ensuring that regular reviews as outlined in the Bill should go hand in hand with a *strategy and implementation plan for additional resourcing of the workforce*.
- Additionally, systemic issues need to be dealt with such as ensuring patients' have access to basic free medication and adequate housing and other aspects of recovery capital.
- To consider the proposal of transportation provisions to include acutely unwell patients in addition to forensic patients; and additional recommendations to ensure safety of all involved and to mitigate associated risks.
- Changing the definition of Mental Health Practitioner to include 'registered health professionals *working in specialist mental health services*'.
- Clarifying how police powers will take effect when they announced a reduction in service to mental health callouts.

## The PSA MHAC's position

The PSA MHAC **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 Act by eliminating indefinite treatment orders and minimising the risk of harm to the patient or the public when transporting forensic special, patients. The PSA MHAC highlights the importance of drafting additional guidelines should the Bill be adopted to provide additional clarity for instance by further defining concepts and processes. We welcome an opportunity to provide feedback into this process.

However, the **PSA MHAC is concerned that the Bill** is not accompanied by a **concerted strategy which includes resources and an implementation plan** - especially with regards to Aotearoa New Zealand's workforce- will remain a mere aspiration. An implementation plan also needs to be carefully considered to prevent flow on effects to mental health community services. These workers provide support before or after someone has been under compulsory mental health care. They carry considerable responsibility often without having the appropriate resources in safe staffing levels and required capability due to a lack of training

Our members largely agree with the Bill but are worried that the implementation falls short in supporting workers to fully implement the Bill. For instance, we welcome care plans and regular status reviews and examination of patients undergoing second assessment by a judge. Yet they need additional resource to implement. The PSA MHAC submit that the problems in service delivery of mental health and addiction services 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

### Part 1 Preliminary Provisions

#### Recommendation 1: Pae Ora of Clients

The PSA MHAC supports the purpose and the principles outlined in the Bill. However, we recommend adding that the purpose of the Act is to provide compulsory mental health assessment and care in a manner that **respects, protects and support pae ora**.

#### Recommendation 2: The Mental Health Workforce

The PSA MHAC is concerned that there is no mention in the Bill of **workers' safety and protection** in mental health and addictions services. Although the PSA MHAC 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 crucial to ensure the health and safety of staff, patients and the public. This is an issue the PSA MHAC has raised on numerous occasions over our decades of being involved in mental health and addiction services, and which remains unresolved. Particularly in the current environment of serious staffing cuts in Health this is an immanent risk which can't be taken lightly. Also, more investment in training, such as building mental health workers' skills in de-escalation and therapeutic responses to people's distress, would enhance everyone's safety.

In addition the importance of **worker participation** in ensuring safe services and protection of clients is not mentioned. Workers are the ones who know best what works and what doesn't. They are the ones who know what is needed and where to invest effectively to improve services, care and protection of clients.

The MHAC recommends that the Bill includes the need to ensure in appropriate ways that the importance of safety of mental health workers and their participation in how services are delivered and improved is acknowledged. The principles of health and safety of workers, safe staffing and worker participation are covered by Te Mauri o Rongo | the NZ Health Charter. Human rights of workers and patients are complementary. The purpose statement of the Bill could include reference

to workers' health and safety and participation or to Te Mauri o Rongo. Such reference could acknowledge the intention to respect, 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 is unsettling. Clients' rights important but a balance to protect staff would 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.*

*We are stretched for staff throughout the country it appears in both inpatient and community services, and we lack a national or local vision for what it means to provide quality client centered care.*

## Part 2 Tangata Whaiora Rights and Support

### Recommendation 3: Cultural Rights of Patients and Whānau

The PSA MHAC believes that the importance of psychosocial safety including cultural safety is foundational for respecting, protecting and fulfilling the rights of patients and whānau in realising their wellbeing. The PSA MHAC supports supported decision-making including whanau involvement. We support **hui whaiora** (wellbeing meetings) to support tangata whaiora to make decisions about their care, to resolve issues and prevent escalation to a more formal process. In particular, we support hui whaiora using restorative practices which uphold the mana of all parties. The PSA MHAC supports the explicit mentioning of a **patient's right to respect for culture and identity**.

The PSA MHAC recommends adding explicit reference in the Bill to the importance of **minimising psychosocial harm** and of creating a **culturally safe environment** for Māori within which they have the support to make decisions and be assessed. For instance, a person should be enabled to request a kaumatua/kuia and/or cultural support be included in the processes. 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 appropriate staff must be accessible as an integral part of mental health and addiction services.

Further, we recommend considering as part of the resourcing strategy and implementation plan that there is a significant need for more **Kaupapa Māori services** in mental health. We would also like to highlight the negative message that has been sent by the disestablishment of **Te Aka Whaiora**. Impacts will be felt widely in the future by tangata whaiora.



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 Māori services. The resources that are available are not adequate with the increase of Māori entering mental health services.*

*I agree in the significant need for more kaupapa Māori 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 Māori automatically have a referral to our cultural team on entering our service. We also have a kaupapa Māori 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 Māori Health Services are only used on a need basis and should be more visible and placed within teams not in their own services. Māori working in Teams that are not under Māori 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.*

## Part 3 Compulsory Care

### Recommendation 4: Promoting Regular Reviews with a Resourcing Strategy

The PSA MHAC's promotes **regular reviews**. Often Indefinite orders of the past were resource-driven rather than need-driven. Often systemic issues within the mental health system have driven 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. To avoid the workforce having to struggle to comply with the Bill's requirement to conduct regular reviews, this needs to go hand in hand with a **strategy to resource the workforce**. A resourcing strategy and implementation plan must be considered when defining the requirements under a Bill.

The PSA MHAC recommends that mechanisms are considered to ensure patients do not end up in inadequate housing (or hospital) situations without necessary medication or support to ensure successful discharge and community reintegration.

### Comments and examples promoting regular reviews:

*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.*

*Regular reviews are good, but we must have the resources, both clinical and administrative, to do this.*

*I support the change but note the importance of dedicating resource to enable regular reviews. We do note, however, that many patients accept being under the Act because they don't have to pay for medications.*

*I support the recommendation proposed, as this would free up stretched resources across the mental health system. However, the government needs to ensure that practitioners can perform regular reviews and enable accessibility and equity to clients who need their medications (...).*

*Some of our community clinicians are carrying case loads of up to 60 people – this is not likely to allow staff the luxury of time to really participate meaningfully in the multiple meetings envisaged in this legislation.*

*People are discharged to transitional housing – or remain in hospital under the act purely because they are homeless - clogging beds for months when no housing can be found, as we*

*are no longer allowed to discharge to the street. Transitional housing has been reduced, so people find it harder to get transitional housing and are likely to become homeless much more quickly as the entitlement has been tightened up. In the transitional housing areas meth use is rife and the temptation to use is ever present for many clients who have histories of childhood sexual abuse, neglect, and trauma. This increases the likelihood of transient psychotic episodes or longer-term chronic psychosis.*

## Part 4 Forensic Patients and Restricted Patients

### Recommendation 5: Transport of Forensic Patients

The PSA MHAC supports the proposed process for safe transport of forensic patients. The PSA MHAC has considered it would be beneficial to include acutely unwell patients under this part of the Bill, and that guidelines for transportation of acutely unwell patients should be established. Ideally this would be done through active participation of the health workforce who hold the expertise to make informed decisions.

Additionally, any assessments prior to transport 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 configurations continue to not provide for this to happen. We suggest that long-term infrastructure planning is required to manage this long-standing problem.

Assessments at a person's home could be an option but might not fully guarantee the safety of the health worker and might disturb the person in need. The PSA 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.*

*Often inpatient units are run at over 100% capacity, patients wait to be assessed at ED for hours. Sometimes people have to be put under a MHA order to be admitted to an inpatient facility due to the constant bed pressure, when this is counter therapeutic to client centred care.*

## **Part 6 Administration and public assistance**

### **Recommendation 6: Broadening of the Definition of a Mental Health Practitioner**

The Bill defines a mental health practitioner as a health practitioner, who is either a medical practitioner, a nurse practitioner, a registered nurse practising in mental health, or any other person or class of person appointed under section 149. It also acknowledges clinical psychologists.

The PSA MHAC's recommendation is that the definition be adjusted so that a mental health professional is a 'registered health professional working in specialist mental health services and/or has undergone training in, and is competent in, the assessment and care of persons requiring compulsory care.' We suggest that registered social workers and occupational therapists working in mental health and who meet the training requirements as indicated above are explicitly recognised by the Bill and enabled through authorisation to do assessments as well. While the PSA MHAC is aware that this can under certain circumstances dilute the 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. The Bill refers to them as Rōpū whaiora, a collaborative care team.

## Comments and examples broadening the definition of Mental Health Practitioner:

*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'.*

## Part 7 Powers and offences

### Recommendation 7: Support for Police Powers in a Challenging Environment.

The PSA MHAC supports the powers conferred to police to take the required action if they find a person appearing to meet compulsory care criteria in public places. However, we have serious concerns about how this will be implemented given the **recent announcement of police to reduce service to mental health demands**. The intention to introduce a higher threshold for attending to mental health callouts, namely acting when there is an immediate risk to life and safety, will put considerable strain on workers and puts patients at risk. Mental health services rely on police for numerous reasons and the phased changes create significant risks to whaiora, workers, patients and the public. As mentioned earlier this needs to be seriously considered and appropriately resourced. We recommend clarifying how this will work and -if the situation remains as it is- that this includes a strategic approach into the implementation plan to maintain everyone's health and safety.

The PSA MHAC 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.

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