NEW ZEALAND COUNCIL OF TRADE UNIONS
Te Kauae Kaimahi

Submission

of the

New Zealand Council of Trade Unions

Te Kauae Kaimahi

to the

Mental Health and Addiction Inquiry

P O Box 6645

Wellington

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1. Introduction

1.1. This submission is made on behalf of the 30 unions affiliated to the New Zealand Council of Trade Unions Te Kauae Kaimahi (CTU). With 320,000 members, the CTU is one of the largest democratic organisations in New Zealand.

1.2. The CTU acknowledges Te Tiriti o Waitangi as the founding document of Aotearoa New Zealand and formally acknowledges this through Te Rūnanga o Ngā Kaimahi Māori o Aotearoa (Te Rūnanga) the Māori arm of Te Kauae Kaimahi (CTU) which represents approximately 60,000 Māori workers.

2. The CTU and the Mental Health and Addiction Inquiry

2.1. This inquiry is of major importance to the CTU and the CTU affiliated health unions who represent mental health professionals and mental health workers. The mental health workforce is large, highly unionized and has well-established union organization in all DHBs. There is also a growing mental health professional and mental health support workforce employed in NGOs and community organizations.

2.2. The CTU represents the interests and needs of its greater membership – all of our affiliate unions and their members. Union members need access to high quality mental health services for themselves as well as for their whānau and people in their communities.

2.3. The CTU is concerned with the social and economic interests and needs of all working people. A well-functioning, responsive and effective public mental health and addiction service is necessary and a prerequisite for a decent and good society and strong economy.

2.4. The CTU is a values-based organization. We stand by the principles of Fairness, Security, Improved Living Standards, Sustainability and Sovereignty (CTU, 2010) in all our work/mahi. These principles, that stand the test of time, provide the basis for our responses, positions and our recommendations.

2.5. Four CTU affiliates have made submissions to the Inquiry: The Public Service Association (PSA), The New Zealand Nurses Organisation (NZNO), the Association of Salaried Medical Specialists (ASMS) and the New Zealand Educational Institute Te Riu Roa (NZEI). Other CTU affiliates who have union members in mental health are E tū and First Union.

2.6. There are recurring common elements in our affiliates' submissions. These resonate with the calls and concerns from civil society about our mental health services and the expression of these concerns in the landmark report, "The People's Mental Health Report "(Elliott, M, 2017): inadequate funding, rising level of demand, inability to access services and treatment, very high suicide rates, the unequal experiences and outcomes for Māori in the mental health services and the inadequate state of many mental health facilities.

2.7. The CTU affiliates and this CTU submission endorse all of these issues and concerns. These issues will be fully traversed in the submissions to the Inquiry. In our submission, as in the CTU affiliates' submissions, our focus is towards workforce issues: inadequate staffing levels, high occupancy rates in acute mental health units, staff burn-out and unacceptable health and safety management and risks.

2.8. Funding for mental health services is central to this Inquiry and the implementation of recommendations. This submission draws on work that the CTU has done in previous years on overall health funding, health underfunding and comments on the levels of funding that may be required to address the challenges and make necessary and overdue improvements to New Zealand's mental health system.

2.9. This Inquiry is ambitious in its aspirations to hear and listen to the voices of service users and in its consultation with community. We want to stress the need for the Inquiry panel to look at mental health services through a workforce lens. Without full consideration and understanding of these challenges the Inquiry's work/mahi will be incomplete.

2.10. The interest and strong hope of the CTU is that in the responses to this Inquiry there is recognition of the role that unions can play in improving dramatically the state of

our mental health services in New Zealand/Aotearoa. Unions provide a form of organized representation and structure with which the mental health management in all its forms can and must engage.

2.11. This Inquiry into mental health is a rare opportunity to make needed changes and re-set the direction of the mental health services. This can be done and it must be done. We have no doubt that the Inquiry Panel will make recommendations that could improve mental health services. But everything will depend on implementation of the recommendations. Mental health services are characterised – almost beset – with inquiries – at a national level and at local level.

2.12. We wish the Inquiry Panel courage and offer our support in their deliberations and recommendations. This CTU submission is structured on the questions that the Inquiry Panel has posed:

- What is working well (in our mental health services)?
- What is not working well (in our mental health services)?
- What could be done better recommendations)?
- What sort of society would be best for the mental health of all our people?

3. What is working well (in our mental health services)?

3.1. It is encouraging, and quite amazing, given the current pressure on services that people using mental health services show and record high levels of satisfaction when asked about the services they have received. So despite the multitude of problems in the mental health services, the evidence is that people who are getting access to mental health services are satisfied. A 2015 national survey of users showed an 82 percent satisfaction rate (Ministry of Health, 2016).

3.2. That high level of satisfaction rate can be attributed to the delivery of mental health services at the front line and the commitment of the mental health workforce to the people they serve and their needs. Mental health workers want to do more and worry that they are not doing enough. A survey of 6000 mental health workers conducted by the Yes We Care campaign found that 90 per cent of staff felt they did

not have the resources or staffing to give New Zealanders the health care they need, when they need it ("Nine in 10 healthcare workers feel understaffed and under-resourced," 2017).

3.3. Other good developments and things that are working are that there are projects and new models in which the workforce is highly engaged. The PSA submission to the Inquiry was supportive of more kaupapa Māori services. Te Rūnanga o Aotearoa (NZNO) has also been advocating for increased funding and investment in kaupapa Māori services. The PSA are encouraging of the effectiveness of home-based treatment services and call for more of these. The ASMS's Time for Quality agreement promotes enhanced clinical engagement and leadership. There are union engagement forums too – at a high level the Health Sector Relationship Agreement, and at the DHB level, the ASMS Joint Consultation Committees. The Bipartite Committees are well-established in DHBs.

3.4. The third response to this question of "What is working?" is that there is a far greater level of speaking up and out about mental health service expectations and needs. It was people willing to speak out that has led to this Inquiry. One of the precursors to the Inquiry was a campaign called Yes We Care. This coalition of community groups and people working in the health sector collected the stories of peoples' experiences in the health system, the mental health system and with families bereaved by suicide.

3.5. This was also evident in the People's Mental Health Report that started a wider national conversation recording people's mental health and illness stories and giving power to the call for an Inquiry into mental health and addiction services. The Wellbeing Manifesto developed by Peerzone is another example of groups – in this case, people with lived mental health experience – responding in an organised way about what needs to change from their perspectives to improve mental health and addiction services.

3.6. And there is agreement:

- That funding must increase to meet real and unmet need

- That access to services including primary health and early intervention is a priority
- That there must be action taken to reduce suicide rates
- That the mental health system must do better for Māori
- That poverty and inequality are drivers of mental distress and mental illness.

4. What is not working?

4.1. Regrettably and sadly, it is not hard to find evidence and reporting of things that are not working well in our mental health and addiction services. The submissions to this Inquiry will show that.

4.2. There have been many reports and inquiries in recent time that have identified failures and quality of care issues and distressing problems. The reports have investigated some catastrophic events and distressing outcomes. There have been major reviews of care and treatment at a number of DHBs including: the Inquiry into care and treatment at the Mental Health, Addictions and Intellectual Disability Service (MHAIDs) of the three DHBs in the Lower North Island; a 2015 review into Waikato DHB mental health services after serious incidents in mental health services; and a 2009 review of three deaths in Christchurch, thought to be suicides, while people were in mental health services. There will have been more.

4.3. An investigation by the Auditor General's office (Ministry of Health, 2016) shows the depth of the problems in acute mental health services. This investigation found that mental health services were struggling, that many people left acute care with no plan of care, without suitable accommodation, or a support plan. And that there were not good processes for handover. There was also confusion about whether plans were to be shared.

4.4. The Auditor General's Report found a revolving-door effect where follow-up support after discharge from hospital was often inadequate due in part to 'high caseloads of community mental health teams', which in some DHBs led to high

numbers of mental health clients being re-admitted to DHBs within 28 days of being discharged.

4.5. The 2018 report from the Office of the Health and Disability Commissioner (New Zealand's mental health and addiction services: the monitoring and advocacy report of the Mental Health Commissioner, 2018) identified concerns including:

- A lack of early interventions
- Low commitment by services to shared planning with consumers, and their family and whānau
- Coordination challenges within and between services
- High uses of compulsory treatment especially for Māori
- Stagnation in seclusion reduction
- Poorer physical health outcomes for people with serious mental health and /or addiction issues
- Disparity in outcomes for Māori and other population groups.

4.6. A glaring inequity is that Māori face a disproportionally higher likelihood of mental ill-health of any ethnic group. They are also over represented among people detained under compulsory treatment orders.

4.7. A now well-known fact is that New Zealand has the highest rate of youth suicide in the OECD. As well as for Māori, suicide rates have also increased for Pasifika youth and those with lower socio-economic status. New Zealand's high youth suicide rates are very distressing. NZNO submitted in 2017 on high rates of youth suicide in Aotearoa New Zealand, alarming rates of suicide in pregnant women and an increasingly high rate of suicides in people over 65 years of age .

4.8. The question therefore is why are we doing so poorly?

5. Critical Issues

5.1. Increasing Demand

5.1.1. Ministry of Health figures show the growing need for mental health services is far exceeding the growth in resources. There is widespread agreement that there is increasing demand in mental health and addiction services and unmet health need.

5.1.2. Between the June years 2009 and 2016 (latest available) the number of unique 'clients seen' by Mental Health and Addiction services teams grew by 50.2 percent from 111,734 to 167,840,[1] much faster than the 9.1 percent growth in New Zealand's resident population (from 4,302,610 to 4,693,210).[2]

5.1.3. There is an increase in mental health needs internationally, and in New Zealand it has been encouraged by growing social awareness and increasingly open discussion of mental health issues, including public education programmes encouraging people to seek help.

5.1.4. The growth in mental health needs in the vulnerable prison population also must be responded to and addressed. A recent report (Gluckman, 2018) indicated that nearly all (91 percent) of people in prison in New Zealand have a diagnosable mental illness or substance-use disorder, with 62 percent diagnosed in the past 12 months.

5.1.5. There are a growing numbers of New Zealanders wanting to accessing addiction treatment services. Public health approaches and treatment

[1] Mental Health, Alcohol and Drug Addiction Sector Performance Monitoring and Improvement, Performance Measure PP6: Improving the health status of people with severe mental illness through improved access, available at https://nsfl.health.govt.nz/accountability/performance-and-monitoring/baseline-data-quarterly-reports-and-reporting/mental

[2] From Estimated Resident Population by Age and Sex (1991+) (Annual-Jun), Statistics New Zealand, Infoshare series DPE056AA.

services need to increase to meet this need and reduce the social and economic burden and cost of alcohol and drug addiction.

5.2. **Funding in Pace with Demand**

5.2.1. According to the former Minister of Health, Jonathan Coleman, Mental Health funding grew from $1.1 billion in 2008/09 to $1.4 billion in 2015/16 (Coleman, 2017). This is an increase of 16.5 percent in real terms (that is, after adjusting for CPI inflation), less than one-third of the 50.2 percent increase in clients.

5.2.2. An analysis of mental health funding in the 2017 Budget (Rosenberg & Keene, 2017) showed that the announced funding 'boost' of $224 million over four years announced by Ministers was largely illusory. In 2017/18, mental health services funded by the Vote: Health budget were likely to receive just $18 million extra funding – an increase of approximately 1.2 percent and a cut in real terms. The analysis estimated a 7.3 percent funding increase was needed in 2017/18 to maintain current service levels, taking into account the average annual increase in need over recent years and rising prices and wages. The present Government, confirming the findings of that analysis, has found that the largest part of the purported increased funding ($25 million per year over four years for "social investment trials" which were not identified) was unspent, and has reallocated it.

5.2.3. There is therefore a very large gap between available resources and needs facing the present Government.

5.3. **Better Workforce Planning and Strategy**

5.3.1. Workforce is a critical component of mental health and addiction services. The three CTU health affiliates' submissions all expressed serious concerns about the effectiveness of workforce planning to

meet the current and growing needs of people with mental health and addiction care and treatment needs.

5.3.2. The aims of the Mental Health and Addiction Workforce Action Plan 2017-2021 (Ministry of Health, 2018) to empower patients and their families, develop coordinated and integrated approaches to care, more support for primary and community based services and better and more equitable access to services are all supported. The challenge is how to achieve this.

5.3.3. The ASMS wisely makes the point that without sufficient training, time and staff, the aspirational goals of this strategy will not happen. The PSA urge a comprehensive effort into ensuring sufficient skilled staff working in mental health now and into the future and observe that the current shortfall with an ageing workforce and growing labour and skills shortages are likely to get worse without retaining, training and attracting staff.

5.3.4. The mix of workforce skills and experience includes the need for the workforce and mental health services to reflect that more Māori are using mental health and addiction services and that the workforce must reflect this in its staffing and professional skill mix.

5.3.5. We also want to reiterate that the mental health workforce encompasses support workers, clerical and administrative staff who take a professional approach to their work and the people they support. They also have training and support needs.

5.3.6. Workforce planning and strategy issues identified by our affiliates and that the CTU strongly endorses are:

- Ensuring fair remuneration as well as good and safe working conditions

- Pay and employment equity between DHBs and between DHBs and community workers
- Address staff burnt-out as a workforce and health and safety issue
- Ensuring the provision of professional development opportunities, including at the advanced level
- Mental health training for the primary health care workforce.

5.3.7. The wellbeing of the mental health system is dependent on the wellbeing and health and safety of the people who deliver the care and treatment services.

5.4. Ensuring Safe Staffing

5.4.1. Staffing levels are a health and safety matter for the staff involved. There needs to be sufficient staff so that safe staffing is maintained without resorting to the following work practices that compromise patient safety and health workforce wellbeing, health and safety:

- Short changes and double shifts
- Cancellation of continuing education and professional development
- Staff working without meal and rest breaks
- Staff not taking rostered days off
- New graduates working under supervision being counted in the shift count rather than being supernumerary in their first year.
- Spending insufficient time inducting and supervising new staff.

5.4.2. Staff turnover is a critical issue. The PSA estimate that it is as high as 30 percent in the Community Mental Health and Addiction sector.

5.4.3. Significant progress has been made working to apply a Care Capacity Demand Management (CCDM) programme's staffing methodology to be appropriate for New Zealand DHB mental health wards/units. The CCDM is now starting to provide the baseline data needed to inform

appropriate staffing levels and enable safe responses to variations in demand. This needs to continue.

5.4.4. DHBs must engage with their workforce and their representatives when making decisions about staffing practices.

5.5. Workforce Health and Safety

5.5.1. Health professionals and workers in mental health services face increased risk of physical violence and assaults. The high level of assaults and injuries suffered by healthcare workers affects both staff and patients. The consequences of high injury and assault rates are increased service costs and lower standards of care and losses of staff from the profession and workforce.

5.5.2. The risk of violence for mental health workers and other health professionals comes from a multitude of different factors. Some acute mental illnesses escalate the propensity to violence. Added to these factors are high occupancy rates in acute wards, poorly designed units, high patient to nurse ratios, high client to mental health worker ratios and unsafe skills mixes. Additional factors may be the role of drugs and alcohol. There are specific concerns about the impacts of methamphetamine. Adding these factors to a coercive and highly controlled environment, including the use of seclusion, leads to a much greater risk of assaults and injuries in mental health services.

5.5.3. The crisis in our mental health services has costs and consequences for health professional and health workers and the future health workforce. Mental health nurses are the most frequent victims of assault among health professionals. Other occupational groups are also exposed to high rates of physical and verbal abuse: support workers, clerical, administrative staff, allied health and medical staff. There are difficulties obtaining up to date figures of the national

picture because each DHB captures the incident separately but recent reports show the seriousness of this issue.

5.5.4. Acute mental health nurses at an acute mental health unit in Christchurch report being assaulted at least twice a week, and as often as once a day ("Chch Hillmorton nurses assaulted at least twice a week," 2018). It must be in desperation that mental health nurses and their union have got to the point of calling for security guards in their workplace. This is a sign of a service that is in crisis and fear.

5.5.5. Any recommendations to improve mental health services that are made by the Inquiry should explicitly consider the health and safety impacts on the staff whose work and tasks will ultimately be affected by it.

6. What could be done better?

6.1. Recommendations

- That funding levels are increased to meet unmet mental health and addiction needs
- That workforce planning addresses the need for more Māori and Pasifika health professionals and workers
- That workforce capacity and capability is strengthened to meet increasing demand and workforce skills and experience valued
- That there is a national health and safety in mental health workforce plan developed in response to serious health and safety management issue and risks
- That, in consultation with the workforce and their representatives, safe staffing models are implemented in all mental health services
- That models of workforce engagement are embedded in mental health services
- That mental health and addiction issues are based on principles of early intervention models, integration of government services and NGOs and DHBs working together collaboratively
- That there is increased support for community and home-based services

- That raising incomes of people on low wages and benefits and reducing poverty are essential components of improving mental health outcomes.

7. What sort of society would be best for the mental health of all our people?

7.1. A society that positively supports people with mental health needs, mental illness and mental distress

7.2. A society that provides quality, accessible, affordable mental health and addiction services that are based on a recovery model.

7.3. A society that ensures and recognises the importance of the social determinants of health: decent incomes; jobs, adequate housing, access to education. Meeting all the social determinants of health are fundamental to improving the mental health of all of our people.

7.4. A society that recognises that poor housing circumstances, inadequate primary health care access, youth unemployment and underachievement in education will be detrimental to mental health.

7.5. A society that recognises the strong relationship between child and family poverty and adverse mental health outcomes. Any approach to improving mental health outcomes need a strong focus on reducing poverty and on fair incomes, wages and decent employment.

7.6. A society that is good for mental health would address the social factors leading to ill health and health inequities. We refer to the three overarching recommendations of the Commission on the Social Determinants of Health (Marmot, Friel, Bell, Houweling, & Taylor, 2008):

- Improving daily living conditions
- Address the inequitable distribution of power, money and resources
- Measure, understand and assess the impacts of action.

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