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for Emergency Medicine

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Submission to the New Zealand Government Ministry of Health on the Discussion document: Transforming our Mental Health Law

Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to provide this submission to the Ministry of Health with our feedback on the *Discussion document: Transforming our Mental Health Law*.

1. About ACEM

ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand. As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring the highest standards of medical care are provided for all patients presenting to emergency departments (EDs).

2. Overview of the submission

This submission is primarily informed by our members' experiences working in EDs across Aotearoa New Zealand, combined with experiences by our members working in EDs across Australia.

ACEM acknowledges the body of work being undertaken by the New Zealand Government to shift the mental health and addiction system towards a recovery and wellbeing approach. The College commends the decision to repeal and replace the current mental health legislation, noting the significance of this action as a strong foundation upon which to build a reformed mental health and addiction system in Aotearoa New Zealand.

ACEM supports changes to the Mental Health Act that promote human rights, that are aligned with the principles of Te Tiriti o Waitangi and incorporate trauma oriented person-centred care for those experiencing mental health difficulties and their whānau in Aotearoa New Zealand.

We note that there is a clearly signposted process for the development and implementation of new mental health legislation and welcome the New Zealand Government taking a strategic approach. ACEM considers that this is a critically important process and calls for the New Zealand Government to engage in broad consultation across the sector with the appropriate experts at regular intervals. This will ensure that the resulting piece of legislation is comprehensive and clearly articulates the rights of people subject to treatment under the Act and the responsibilities of clinicians.

Our submission emphasises that not all system reform can be achieved by changes to legislation. The issues that are highlighted in the discussion document cannot be addressed solely through legislation and will be best met by developing models of care that include appropriate infrastructure and resources to allow early and effective interventions, and avoid long delays before reaching definitive points of ongoing mental health care. The new legislation should provide an overarching framework that facilitates these models to recognise and respond to physical and mental health, the abuse of alcohol and other

substances, and the complex psychosocial needs of many persons presenting to EDs with mental health conditions.

EDs will continue to play a vital role within a reformed mental health and addiction system, and ACEM welcomes the opportunities to consult with the New Zealand Government and to participate in the reform process.

3. Recommendations

ACEM makes the following recommendations, with reference the College's recent submission made on the Pae Ora (Healthy Futures) Bill (the Bill) in 2021:

1. The legislation should reflect the significant reform process being undertaken through the Pae Ora (Healthy Futures) Bill.
2. That Te Tiriti o Waitangi is central to this process and that Māori communities have clear, legally enforceable representation and authority to make decisions. New legislation created to reflect te ao Māori needs to be written by and with Māori. The new legislation must contain provisions to achieve equity by reducing disparities in outcomes among Aotearoa New Zealand's population groups, in particular for Māori.
3. That the New Zealand Government puts the full draft legislation through a robust process of consultation with representatives of all health providers involved in the care of people with mental health conditions.
4. That the Act is written to provide an overarching framework that supports models of care which recognise and respond to the full range of health comorbidities that people living with mental health conditions experience.
5. That the Act acknowledges that there are circumstances where clinical judgment should be prioritised over the patient's rights i.e., when there is imminent risk of harm to the clinician, patient, and/or others.
6. That the new legislation should enable better community-based responses so that there are alternatives to the ED.

ACEM provides the following series of broader recommendations to enhance the implementation of the new mental health legislation:

7. That the New Zealand Government implements ACEM's Hospital Access Targets, supported by appropriate funding and reporting, in order to reduce the time spent in EDs and help move patients to definitive mental health care more efficiently.
8. That all 24 hour waits in an ED should be reported to the Health Minister routinely, alongside any CEO interventions and mechanisms for incident review.
9. That the New Zealand Government develops clear clinical governance frameworks for all service providers, standardised documentation tools and reporting pathway that allow for system improvement.

4. Mental health in the ED

EDs have been acknowledged by the New Zealand Government as having a vital and ongoing role in the provision of mental health care and support. In the *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (2018), the Government's vision for a reformed mental health and addiction system included that "… all EDs will have access to skilled mental health workers who can provide immediate support and advice … in appropriate physical spaces."[1]

Demand for mental health care is outpacing the availability of acute mental health services, particularly after-hours, which has created a situation where EDs have become a major and often default entry point

[1] Government Inquiry into Mental Health and Addiction 2018, He Ara Oranga, https://www.mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

for people seeking access to mental health care, often when in crisis – put simply, there is nowhere else to go.

Our members report, and our data confirms, that patients presenting to EDs for mental health care routinely experience excessively long wait times to receive mental health care, often in inappropriate, and at times, unsafe environments.

Through the Ministry of Health's Office of the Director of Mental Health and Addiction Services, reporting of mental health and addiction service use is undertaken annually, providing a detailed picture of service use. Anecdotally, ACEM's emergency physicians in Aotearoa New Zealand report noticeably and significantly increasing numbers of persons attending EDs for mental health related reasons. However, reporting and data availability on acute mental health care for people attending EDs in Aotearoa New Zealand is lacking. There will be an increased availability of data on the total number of mental health presentations once SNOMED is rolled out across the District Health Boards.

The ACEM report *Mental Health Service Use: A New Zealand Context* (2019) presented an analysis of data from the Programme for the Integration of Mental Health Data database from the Ministry of Health, and from ACEM's multi-year Prevalence of Mental Health Access Block Study in EDs across Aotearoa New Zealand.[2] The report highlighted a steady annual increase in the number of people accessing mental health and addiction specialist services, an increase in the number of mental health related to presentations, and a startling increase in wait times for an inpatient bed. The full report can be accessed here.

In September 2020, ACEM published the *Nowhere Else to Go Report*, which considers the complex issues that were discussed at the national Mental Health in the Emergency Care Summit convened by the College in 2018. The report contains a series of recommendations to drive reform and improvement of the Australian mental health system and has been used to inform our work in Aotearoa New Zealand. The *Nowhere Else to Go Report* can be accessed here.

ACEM has commissioned a new report in a similar vein to the *Nowhere Else to Go Report* that will focus solely on Aotearoa New Zealand, in recognition of the socio-political differences to Australia. This is expected to be published by the end of 2022 and will build from our 2019 Mental Health in the ED Summit in Aotearoa New Zealand.

5. ACEM response to the discussion document

Part 3: Embedding Te Tiriti o Waitangi and addressing Māori cultural needs

The initial report for the WAI 2575 kaupapa inquiry found that the Crown has breached Te Tiriti o Waitangi by failing to address persistent health inequities for Māori and failing to give effect to tino rangatiratanga[2]. ACEM acknowledges the complexity of the task that the New Zealand Government is currently undertaking, and that major reforms to the governance of the mental health and addiction system have the potential to generate both significant improvements and create unforeseen risks.

In May 2019, ACEM launched *Te Rautaki Manaaki Mana: Excellence in Emergency care for Māori*. Te e Rōpū Manaaki Mana is a Māori-majority group of Fellows of ACEM (FACEMs), nurses, Māori health leaders and ACEM support staff overseeing the Manaaki Mana strategy. ACEM is honoured to be gifted the name Manaaki Mana by Dame R. Naida Glavish, Ngāti Whātua me ngā Ngāti Hine. The name reflects the College's aim to provide care in ways that uphold the mana of those seeking our services and for that care to be culturally safe and equitable.

The College would like to highlight *He Ara Tiatia ki te Taumata o Pae Ora Manaaki Mana: Pathways to achieving excellence in emergency care for Māori*, which was developed by the Manaaki Mana Rōpū in 2020-2021 is currently available in draft format on the ACEM website. The first goal of the Manaaki Mana strategy was to develop a set of ACEM standards on Pae Ora for EDs in Aotearoa New Zealand. The

[2] ACEM 2019, Mental Health Service Use: A New Zealand Context, https://acem.org.au/getmedia/dc683d35-116a-4a4d-8481-733e9f49aad7/ACEM-Report-2019-Mental-Health-Service-Use-A-New-Zealand-Contextv2

document outlines the steps that need to be taken, with clear indicators of change to demonstrate that the following four overarching goals have been actualised:

1. Uphold Te Tiriti o Waitangi in authentic partnerships

We note that the reforms to the mental health and addiction system are occurring within the broader reforms to the healthcare system with the establishment of Health New Zealand (HNZ) and the Māori Health Authority (MHA). It is essential that Te Tiriti o Waitangi is central to this process and that Māori communities have clear, legally enforceable representation and authority to make decisions as a result of these changes. Te Tiriti o Waitangi includes the principles that must be used to guide rights for Māori in all legislation, therefore any new legislation created to reflect te Ao Māori needs to be written by and with Māori.

2. Seek to provide and demonstrate equitable care

Service use data collected in PRIMHD demonstrates that there are persistent inequities and disadvantage Māori experience when assessing mental health services. The new legislation must contain provisions to achieve equity by reducing disparities in outcomes among New Zealand's population groups, in particular for Māori. This will require service providers to actively address and eliminate institutional racism, including by ensuring that all policies and practices at all levels are reviewed to ensure outcome will not advantage non-Māori over Māori, or not advantage ethnically European New Zealanders and immigrants over those of colour.

3. Be anti-racist in action and policy

As stated above, there should be provisions that require service providers to actively address and eliminate institutional racism, including by ensuring that all policies and practices at all levels are reviewed to ensure outcome will not advantage non-Māori over Māori.

Additionally, services must provide a 'by Māori for Māori' service that not only respects te Ao Māori but is populated by practitioners that fully understand, respect and/or live te Ao Māori. This requires the recruitment and most importantly, retention of Māori staff.

4. Provide culturally safe care

To achieve the best outcomes for individuals and whānau, family / whānau / aiga[3] should be involved as much as possible in all stages of care, regardless of the age of individuals (this is currently only a requirement for those under 18 years). Clinicians should use this approach to support whānau to work as a collective, or across services without losing sight of the individual health needs of tāngata whaiora. We note that a broad view of whānau should be taken in new legislation to ensure that care is culturally appropriate, particularly for Māori and Pacific populations. Legislation should allow tāngata whaiora to determine who their whānau are, with the acknowledgement that they may not always be kin.

ACEM endorses moving to an expanded view of consent to treatment that gives prominence to a participatory engagement process where people including whānau, friends, carers, and key supporters of tāngata whaiora can contribute to and help navigate the process. Supported decision making is especially important where the informed consent is complicated by disability, disordered functioning and / or impaired decision-making capacity of tāngata whaiora

[3] Aiga is a Samoan word meaning 'family', which includes the whole union of families of a clan, whether related through blood, marriage, or adoption.

Part 4: Defining the purpose of mental health legislation

ACEM welcomes the intent signalled by the New Zealand government to shift the mental health and addiction system to reflect a wellbeing and recovery approach, however the College considers it is critically important that new legislation balances the human rights of a person, with a duty of care for their safety and wellbeing, as well as balancing the rights of those around them including whanau, members of the public and healthcare staff. Therefore, ACEM cautions against the abolishment of any form of compulsory treatment provided under mental health legislation that offers therapeutic benefit to the patient.

ACEM considers that the new mental health legislation should set out the rights of the patient/tāngata whaiora and responsibilities of the clinician. In shifting to being a patient-centred piece of legislation, it is crucial that there is sufficient details on the legal responsibilities of treating clinicians, rather than leaving the legislation open to interpretation and creating significant confusion across the sector.

It is ACEM's position that the legislation should acknowledge the varied environments and circumstances in which the legislation is being applied, in particular the difference between acute care delivered in an ED and longer-term care in a mental health ward or in the community. It is important that this distinction is included, and that expectations of the kinds of care available in varied environments and circumstances are realistic and achievable, and developed in consultation with the experts relative to the appropriate field.

Part 5 & 6: Capacity and decision making & Supporting people to make decisions

The College recognises the complexity of developing mental health legislation that decreases the risk of coercion. However, ACEM would like to caution that instances of coercion under the new Act may not be able to be eliminated entirely because of the grey area of *compliance*, in comparison to *consent*. While consent is active and clear, patients may comply with treatment without giving informed consent.

The College is broadly supportive of tools that enable supported decision-making such as statements of rights, advance statements, nominated persons and second psychiatric opinions.

At a consultation session ran by the Mental Health Act Review project team in December 2021, it was indicated that persons subject to compulsory treatment under the Act have limited access to advocacy services. ACEM would like to draw upon the Victoria, Australia context by highlighting the services provided by agencies such as the Independent Mental Health Advocacy (IMHA) and the Office of the Public Advocate (OPA) as leading organisations that provide short, medium and long-term advocacy for persons subject to compulsory treatment orders, or who lack the capacity to give informed consent to treatment.

Part 7: Restrictive practices

ACEM acknowledges the broad range of initiatives under way to reduce the use of seclusion and restraint under the Act. Whilst ACEM supports the development of new models of patient-centred care that measurably improve the experience and outcomes of people who need acute mental health care, extensive consideration must be given to the context in which restrictive practices are used.

The use of restrictive practices in EDs and the drivers of their use are complex and sometimes necessary to protect an individual patient/tāngata whaiora, and/or the people around them (staff, carers and other patients). Changes to mental health legislation regarding restrictive practices and their use must be balanced by the need to protect patients/tāngata whaiora and others in response to short term risk. Clinical judgement must be acknowledged and respected in assessing complex presentations and managing harmful behaviour.

EDs provide a compelling window into the strengths and weaknesses of the health system and hospitals. The use of restrictive practices in many circumstances is a symptom of system failure.

The sections below highlight the common challenges that can result in the use of restrictive practices in EDs:

Delays to mental health treatment

Demand for mental health care is outpacing the availability of acute mental health services, particularly after-hours, which has created a situation where EDs have become a major and often default entry point for people seeking access to mental health care, often when in crisis.

Our members report, and our data confirms, that patients/tāngata whaiora presenting to EDs for mental health care routinely experience excessively long wait times to receive mental health care, often in inappropriate, and at times, unsafe environments.

Despite mental health accounting for a relatively small percentage of all presentations, persons presenting for mental health related reasons are overrepresented in the data on Access Block, defined as the situation where ED patients who have been admitted and need a hospital bed are delayed from leaving the ED for more than eight hours due to a lack of inpatient bed capacity. They are also overrepresented for patients with a length of stays of 24 hours or more in the ED. In Aotearoa New Zealand our members report that ED lengths of stay exceeding 24 hours are increasingly common.

An ACEM analysis of mental health related ED presentation data comparing December 2017 and October 2020 showed that there was a slight increase in the number of patients needing admission for mental health care, from 8.2% in 2017 to 9.4% in 2020. However, there was a staggering increase in the number of mental health patients experiencing access block from 4.5% in 2017 to 47% in 2020.

Access block compromises both the patient experience and the delivery of safe, high-quality emergency medical care. Recent research[4] shows that, in Aotearoa New Zealand, when more than 10 per cent of patients in an ED are experiencing access block, subsequent patients arriving have a 10 per cent greater chance of dying within seven days of their admission.

The College is concerned by the increasing frequency of cases where mental health patients/tāngata whaiora who have been assessed in the community and referred to an inpatient mental health service are being directed to the ED, where they are subjected to lengthy delays to access definitive care, due to a lack of mental health beds

The sheer volume of demand for mental health care results in an overreliance on EDs to fill gaps in the system and highlights ever increasing issues pertaining to the accessibility of specialist mental health services who are equipped to respond appropriately to the needs of the population.

The conditions created by systematic underfunding of specialist mental health services has caused a growing discontent among ACEM's members at the variety of tactics used to delay accepting referrals into in-patient wards because of a lack of inpatient capacity. EDs are designed to provide efficient management of emergencies and potentially life-threatening presentations. They are staffed and resourced to provide appropriate initial management and stabilisation, not supervision over prolonged periods of time. Our members regard the indefinite detention of mental health patients/tāngata whaiora in EDs as 'anti-therapeutic'.

The College would like to highlight the importance of implementing a set of time-based-targets that is both realistic and achievable. ACEM believes that a more carefully constructed set of targets, supported by appropriate funding and reporting, will reduce the time spent in EDs and help move patients to definitive care more efficiently. ACEM's Hospital Access Targets are a nuanced measure that consider the complexity of possible patient pathways from the ED.[5] The HAT very deliberately refers to hospital access rather than

[4] Jones, PG and van der Werf, B. Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand. Emerg. Med. Australas. 2020 Dec 10. Doi: 10.1111/1742-6723.13699. Online ahead of print

[5] ACEM 2021, *A new approach to time-based targets and why we need one, https://acem.org.au/getattachment/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block-(1)/Hospital-Access-Targets/It-s-About-Time_Abridged.pdf?lang=en-AU*

emergency access, reflecting our desire for our shared patients once assessed, to be seen in the appropriate environment and by the right people for their health needs.

To ensure there is accountability for patient flow across different aspects of the hospital, it is recommended that ED length of stay targets are set for different patient streams:

- A primary measure for the admitted/transferred patient stream; and
- Secondary measures for the discharged and short stay units (SSUs) patient stream

Having multiple streams can ensure the ED, inpatient teams and hospital management have targets that encourage accountability for the length of time patients spend in the ED. The maximum length of ED stay recommended by the HAT for any one stream is 12 hours. All 24 hour waits in an ED should be reported to the Health Minister routinely, alongside any CEO interventions and mechanisms for incident review.

Co-occurring intoxication

There is substantial overlap between mental health and alcohol and other drugs, yet this is scarcely included in the discussion document. How the Act will be applied in these complex situations, such as a person in the ED experiencing an acute episodic mental health condition resulting from alcohol or drug use (e.g., drug induced psychosis), is not reflected in the discussion paper.

The management of agitated or violent patients in the ED can be challenging and poses a safety risk to the individual, the people accompanying them, other patients in the department and the ED staff. A research article[6] in 2016 found that alcohol-related verbal aggression from patients had been experienced in the past 12 months by 97.9% of respondents, and physical aggression by 92.2%. ED nurses were the group most likely to have felt unsafe because of the behaviour of these patients (92% reported such feelings). Alcohol related presentations were perceived to 'negatively' or 'very negatively' affect waiting times (noted by 85.5% of respondents), other patients in the waiting room (88.3%). Alcohol-affected patients were perceived to have 'negative' or 'very negative' impact on staff workload (94.2%), wellbeing (74.1%) and job satisfaction (80.9%).

Evidence demonstrates that patients who are intoxicated with alcohol or other drugs are less likely to respond to verbal forms of de-escalation and are more likely to require acute sedation compared to patients with a principal diagnosis of mental illness[7,8]. A metropolitan ED in Australia found that of 229 instances where a code grey (unarmed threat) had been called, illicit drug use accounted for 40% of behavioural disturbance, with the majority due to amphetamine and methamphetamine[9]. Other research has also confirmed that methamphetamine use is frequently associated with aggression towards staff and other patients, and the need for restrictive practices[10].

Pre-hospital environment

The use of restrictive practices in the ED may also be influenced by the context in which in the decision is being made and this may include their use in the pre-hospital environment. People with mental health conditions arrive at the ED by ambulance or police escort at higher rates compared with other people

[6] Egerton-Warburton et al., 2016, *Perceptions of Australasian emergency department staff on the impact of alcohol-related presentations, Med J Aust,* 204(4): 155

[7] Yap et al., 2019, *Management of behavioural emergencies: a prospective observational study in Australian emergency department*, *J Pharm & Prac,*49 (4): 341-348

[8] Braitberg et al., 2018, *Behavioural assessment unit improves outcomes for patients with complex psychosocial needs, Emergency Medicine Australasia*

[9] Gerdtz et al., 2020, *Prevalence of illicit substance use among patients presenting to the emergency department with acute behavioural disturbance: Rapid point-of-care saliva screening*, *Emergency Medicine Australasia*

[10] Unadkat A, Subsasinghe S, Harve RJ, Castle DJ 2019, *Methamphetamine use in patients presenting to emergency departments and psychiatric facilities: what are the service implications? Australasian Psychiatry*, 27 (1): 7-14

seeking care in the ED in Australia, and anecdotally we know this to be the case in Aotearoa New Zealand also.

Mental health related behavioural disturbance is primarily a health issue. Therefore, it is ACEM's position that transport should ideally be via a health service/ambulance, with police used in a support role where required for safety of emergency service providers. However, we are seeing an increase in the involvement of police completing transfers to the ED. The apprehension of a person experiencing behavioural disturbance in the community can be a traumatic experience, therefore, the use of restrictive practices in the pre-hospital environment may impact the behaviour of the patient on arrival in the ED.

Additionally, there is a significant risk to the patient/tāngata whaiora, staff and other patients posed by behaviourally disturbed mental health patients that could be managed elsewhere, but are brought into the ED by police/ambulance or directed specifically to the ED for care. It is ACEM's recommendation that the new legislation should enable better community-based responses so that there are alternatives to the ED for assessment.

Part 9: Protecting and monitoring people's rights

In past submissions, ACEM has been supportive of the idea that restrictive practices in the ED have clear clinical governance frameworks, standardised documentation tools and reporting pathways that allow for system improvement. The engagement paper lacks detail on regulation and accountability, however, the College suggests that hospital services should be resourced, and required to report on the use of restrictive practices in the ED. The level of access block and overcrowding in EDs at the time restrictive practices were used should also be included in any reporting requirements to examine the correlation between ED capacity and restrictive practices.

The mental health system is inextricably linked with a range of other formal systems including criminal justice, housing, family violence, child protection, income support, and education and training as well as with multiple informal caring networks including families, communities, faith groups and non-government organisations. The enormous complexity of this web of relationships presents challenges to service coordination and information sharing.

Too often, inconsistency in treatment occurs due to delays in information sharing. For instance, there is limited integration of information systems and doctors in EDs currently do not have access to the necessary information systems and therefore are unable to access mental health care plans and provide tailored care from the time of presentation. Information sharing between community mental health, EDs, psychiatric wards, emergency services and criminal justice facilitates improved outcomes for patients, particularly in emergency situations

Conclusion

It is ACEM's position that all people living in Aotearoa New Zealand have the right to access mental healthcare. EDs in public hospitals are free, open 24 hours a day, and provide physical or mental health emergency care. Emergency physicians are honoured to provide this service to the community.

The College believes that legislation may be necessary but must be viewed as just one component within a broader reform agenda. It is essential that the New Zealand Government engages in further consultation with the appropriate experts at regular intervals in the development process to ensure that the new legislation it is fit for purpose.

EDs should be resourced and supported to offer a safe and supportive environment for people seeking help for mental health problems. ED clinicians should be engaged in the implementation of reform to ensure barriers to, unintended consequences of and further improvements can be made in mental health reform.

Changes to mental health legislation regarding restrictive practices and their use must respect and acknowledge the complex risk analysis, clinician judgement, context and time frames in assessing and managing behaviour.

Thank you again for the opportunity to provide this submission. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact Jesse Dean, General Manager, Policy and Regional Engagement (jesse.dean@acem.org.au; +61 423 251 383).

Yours sincerely,

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