ASMS
ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
TOI MATA HAUORA

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Committee Secretariat
Health Committee
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Tēnā koutou

Toi Mata Hauora Association of Salaried Medical Specialists submission on the Mental Health Bill

Thank you for the opportunity to provide feedback on the Mental Health Bill. As the union for salaried senior doctors and dentists, this submission focuses on several workforce implications of the Bill. We are aware that education and standards setting bodies will provide more specific feedback on clinical aspects of the Bill.

About Toi Mata Hauora Association of Salaried Medical Specialists

Toi Mata Hauora is the union for salaried senior doctors and dentists in Aotearoa New Zealand and represents over 6,000 members. Toi Mata Hauora promotes and protects the interests of members in all aspects of their employment. Also, under our constitution, we advocate for high standards of publicly funded healthcare services for all New Zealanders, including the right to access those services. Toi Mata Hauora has an interest in the Mental Health Bill from the impact it will have on our members, and on patients accessing services.

Overall feedback on the Bill

Toi Mata Hauora considers the principles behind many of the changes to the legislation are laudable and reflect strengthening of a patient-centred and human rights-based approach. However, Toi Mata Hauora is concerned that a number of structural and resourcing issues within the health sector will prevent the proposed legislation from achieving its purpose and principles, and in turn better care for tāngata whaiora. We note that the Ministry of Health raised this issue in regards to the Bill in its Briefing to the Incoming Minister, stating “achieving the transformation sought through new mental health legislation will be dependent on the future mental health and addiction system and service configuration, workforce capacity and capability…” (Ministry of Health, 2023). Adequate resourcing for workforce and facilities will need to accompany the legislation, to ensure human rights are upheld. This will require funding for urgent recruitment and retention measures to address current workforce shortages, as well as funding for training and long-term planning.

Regarding the Bill, Toi Mata Hauora strongly urges the Health Committee to consider the following issues:

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1. Severe workforce shortages, inadequate facilities, and lack of resource will prevent the purpose and principles of the Bill from being realised and may create perverse incentives towards compulsory care.
2. The training, skills, qualifications and experience of mental health practitioners is a critical safeguard for tāngata whaiora who are subject to compulsory treatment. This must be considered carefully within the Bill.
3. Accountability under the Bill should only be allocated to those with commensurate agency. The Bill must not ascribe accountability to mental health practitioners in areas where they do not have agency, such as wider resource allocation within the service they work in. The accountability for resource allocation must sit with the organisational leaders who make decisions on resource allocation.

Further detail and examples of these three issues are provided below.

1. Severe workforce shortages, inadequate facilities, and lack of resource will prevent the purpose and principles of the Bill from being realised.

Specialist mental health and addiction services rely on Psychiatrists as pivotal members of the mental health workforce. Psychiatrists have significant training and experience in complex and nuanced elements of care for tāngata whaiora and hold accountability for the outcomes of that care. However, Aotearoa New Zealand has a critical shortage of Psychiatrists (with 13.6 Psychiatrists per 100,000 people compared to an OECD average of 18 per 100,000 people). Sixty per cent of New Zealand's Psychiatry workforce is overseas trained, and within the next decade, half of the current workforce will be aged over 65. An ageing psychiatric workforce has implications for after-hours capacity, as on-call burden is a common driver for doctors considering retirement. (British Medical Association, 2019)

Workforce shortages have also fuelled burnout among the profession, sparking a trend for Psychiatrists to resign from permanent employment and pick up locum work to enable themselves to choose safer working hours. Further detail on workforce pressures is provided in A**ppendix 1**. The workforce crisis risks impacting the capacity to train the future Psychiatry workforce if there are too few Psychiatrists to supervise trainees. (Royal Australian and New Zealand College of Psychiatrists, 2024).

In addition to shortages, senior Psychiatrists face significant workforce pressures due to interpretation of current legislation. Currently, although experienced nurse practitioners and psychiatric registrars are able to complete first assessments, the legislation is interpreted in many regions to require a Senior Medical Officer to provide a second assessment soon after. This creates a significant level of overnight on-call burden among a chronically short-staffed senior medical workforce, exacerbating burnout, and the trend of mid-career psychiatrists leaving the public sector to instead work as a locum or work in private practice. Also, Psychiatry registrars in New Zealand are not authorised as responsible clinicians who can complete the mental health legal assessment process, including writing court reports and representing whaiora in court. This means when trainees become consultants, they will have had limited training and skill acquisition in the legal assessment process. This is different to Australia, where psychiatry trainees are able to complete legal

assessments. There must be balance between professional oversight, pragmatics and skills acquisition which is safe and sustainable.

Many of Aotearoa's mental health facilities are also inadequate and under-resourced, with too few beds for tāngata whaiora who need care (Ellingham, 2024), and facilities that are not fit for purpose, with poor maintenance and inadequate space to meet the needs of tāngata whaiora (Ombudsman, 2021).

Inadequate resourcing already creates compliance issues with existing legislation for compulsory treatment orders. For example, patients receiving compulsory mental health treatment are legally required to have a Responsible Clinician assigned to their care, but data from Te Whatu Ora has identified workforce shortages have meant this requirement is not met, putting patients at risk (Hill, 2024).

It is critical that the Health Committee reviews the Mental Health Bill in this context. Elements of the Bill are likely to increase the workload of Psychiatrists and the wider mental health workforce further. To meet the expectations of the Bill and enable successful implementation, significant steps must be taken to increase New Zealand's Psychiatry and wider mental health workforce, and access to the tools, facilities and resources mental health practitioners need to meet the needs of tāngata whaiora.

One example of increased workload arising from the Bill is the requirement for hui whaiora (well-being meetings) under section 17 to assist tāngata whaiora with making decisions about care, resolving issues, disputes or complaints, and supporting restorative practice. Although similar meetings already happen under different names, consistent implementation of this requirement across the sector will require protected time for mental health practitioners to prepare for, facilitate and document these meetings. Responsibility for resourcing the additional clinical and administrative workload to support hui whaiora must sit at a management level, where decisions about resource allocation are made. Without adequate resourcing to support compulsory care processes, it is possible resource will be diverted from tāngata whaiora presenting for voluntary treatment. This could create a perverse incentive towards compulsory treatment orders, just to enable tāngata whaiora to access the care required.

Toi Mata Hauora urges the Health Committee to consider all aspects of the Bill that are likely to increase workload for the mental health workforce, and to examine what levers are available to ensure adequate resourcing is available before the legislation is implemented.

2. The training, skills, qualifications and experience of mental health practitioners is a critical safeguard for tāngata whaiora who are subject to compulsory treatment.

Assessments for compulsory treatment must be done by those with a high level of training and experience working in mental health to ensure that tāngata whaiora are not unnecessarily subjected to compulsory treatment, and human rights are protected. These assessments are complex, requiring the skill and experience to differentiate between medical causes of symptoms and mental health causes of symptoms, especially in older patients. Mental health practitioners require the ability to advocate for the patient with other senior clinicians who may hold differing views (for example, practitioners referring patients to mental health services when medical issues have not yet been

adequately ruled out). The Bill also introduces requirements to assess the decision-making capacity of tāngata whaiora, which is a complex task, and will require additional training even for those experienced in first assessments.

Toi Mata Hauora is concerned that section 149 of the Bill enables the Director of Mental Health to appoint a person or a class of person to be a mental health practitioner if the Director is satisfied with the level of training and competence that person or class of persons has in the assessment and care of persons requiring compulsory care. This represents a widening of the workforces who can potentially undertake first assessments, without needing a legislative change.

If other classes of practitioners are enabled to do first assessments under section 58, there must be clear minimum standards for registration, scope of practice, qualifications, ongoing professional development, training, experience working in mental health, and supervision requirements. These requirements should be specified in the legislation (in the same way medical practitioner, nurse practitioner, and registered nurse practising in mental health are all defined in section 4 of the Bill).

Any extensions must be carefully assessed, and a risk analysis undertaken, as a critical safeguard for tāngata whaiora. A clear and transparent assessment process would be required to demonstrate how the Director of Mental Health would robustly assess the training, experience, and skill of additional classes of practitioners. Toi Mata Hauora urges the Health Committee to carefully consider what safeguards are needed when it comes to assessing who can provide assessments for compulsory treatment.

Toi Mata Hauora also encourages the Health Committee to think carefully about the scope of new roles included within the Bill, and to provide clarity on the requirements for undertaking such roles. For example, the Bill includes a 'Hui Whaiora Co-ordinator." It is not clear if this is a stand-alone role, or if it is a role that can be held by multiple people. It is also not clear if it is an administrative role, or a role requiring clinical skill. Some of the role reads as though clinical skill is required, for example the ability to assess and decide upon who can attend hui whaiora in the best interests of the patient. The parameters of the role and skill and qualifications required need to be clarified.

3. Accountability under the Bill should only be allocated to those with commensurate agency.

Toi Mata Hauora has significant concerns that the Bill ascribes accountability and responsibility to mental health practitioners in areas they do not have control or decision-making authority over, creating a disconnect between accountability and authority. In particular, section 42 of the Bill specifies that the responsible practitioner "must ensure that an appropriately qualified and experienced rōpū whaiora (collaborative care team) is provided to a patient."

Toi Mata Hauora members have provided consistent feedback that they have little to no influence on the resources allocated to employ appropriately qualified and experienced collaborative care teams, and so are unable to ensure such teams are available to tāngata whaiora.

We urge the Health Committee to amend this aspect of the Bill, so that accountability for ensuring access to appropriately qualified and experienced collaborative care teams sits with service

managers or Te Whatu Ora senior leadership, where decisions on staffing and resource allocation are made and controlled.

Nāku noa, nā

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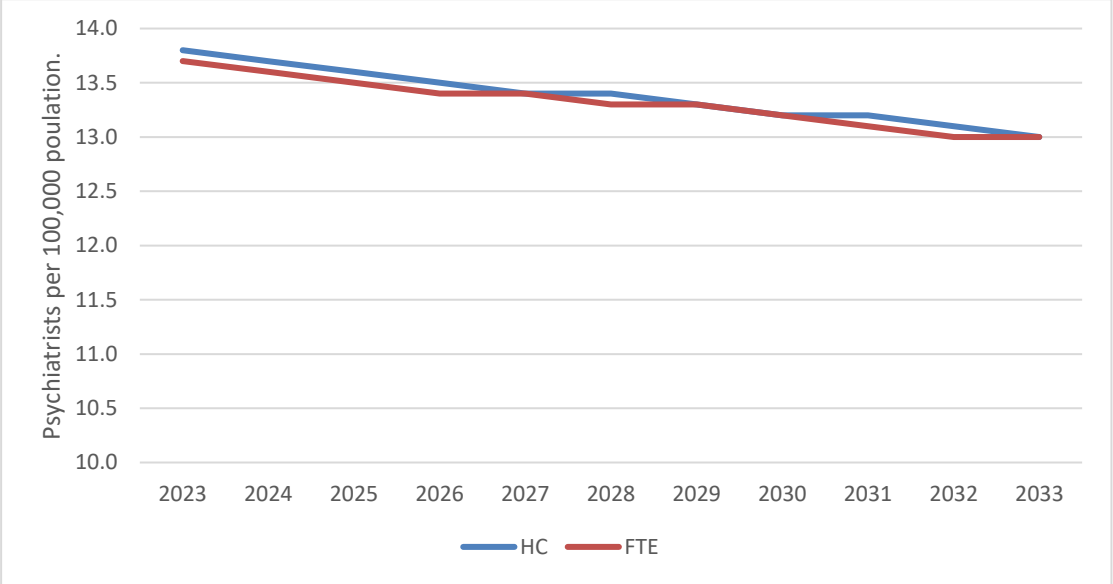
Appendix 1: Psychiatrist Workforce: By the numbers

Employed by Te Whatu Ora in adult MHA services (understated due to incomplete data):

- Estimated number (2023): 359 full-time equivalent (FTE)
- Vacancy rate: 18% (Northern 14%, Te Manawa Taki 14%, Central 30% Te Waipounamu n/a)
- Resignation rates: 18.0%
- Recruitment rates: 11.8%
- Age: 60% aged over 50; nearly 20% are aged 65 or over
- Ethnicity: (3% Māori, 1% Pasifika)

The psychiatrist workforce forecasts in Figure 1 are projected from workforce entry and exit trends over the five years to 2023 for public and private sectors combined.[1] The forecast trends are reflected in Te Whatu Ora's incomplete data on its psychiatrist workforce, outlined above, showing an ageing workforce and resignation rates significantly outstripping recruitment rates.[2]

Figure 1: Forecast psychiatrist workforce (public and private) by headcounts and full-time-equivalent numbers, 2023-2033



Source: Te Whatu Ora 2023

This decline in the workforce is occurring at the same time as public sector psychiatrists are shifting to the private sector. Unpublished Medical Council figures show a 77 per cent increase in the number of FTE psychiatrists working privately from 2019 to 2023 (from 53 FTE to 94 FTE). On average, nearly 30 per cent of psychiatrists' time is now spent in the private sector or in other non-public health service employment.[3]

[1] Ministry of Health, 2023.

[2] Te Pou. *Te Whatu Ora adult mental health & addiction workforce estimates, 2023*, 26 September 2024. (Note resignation rates were updated from the original publication.)

[3] MCNZ. Unpublished medical workforce data, 2024.

This trend towards more private work in psychiatry is reinforced by the results of a national survey of ASMS members on the reasons behind decisions to work part-time outside of the public system. A third (34 per cent) of psychiatrist respondents said they were thinking about working part-time in other employment. Combined with the 41 per cent already working privately in addition to their public roles, three out of every four psychiatrists employed by Te Whatu Ora either work privately or are thinking about doing so.[4]

Recently announced plans to increase training positions from around 33 in 2024 to 50 in 2025 onwards is a positive step but the trends indicated above highlight a critical need for more immediate measures to significantly improve retention and recruitment.[5]

[4] [4] ASMS. *A less public place: A survey of ASMS members on reasons for working part time outside the public health system.* August 2023. https://asms.org.nz/wp-content/uploads/2023/08/A-Less-Public-Place-FINAL-1.0.pdf

[5] Te Whatu Ora. Mental *Health and Addiction Workforce Plan 2024-2027*, September 2024.