

PUTTING THE PIECES TOGETHER.... JIGSAW PUZZLE OR MOSAIC?

**Training mental health services' staff
in managing the interface between
privacy legislation;
other legislation; and
other relevant concerns and considerations**

**Peter Hines
Corporate Privacy Officer, Canterbury DHB**

Some useful acronyms:

AHPs = Allied Health Professionals (eg. physiotherapists, occupational therapists, social workers, speech language therapists, dietitians, etc)

CDHB = Canterbury District Health Board

DHB = District Health Board

HIPC = Health Information Privacy Code 1994 (a Code of Practice under the Privacy Act)

MHC = Mental Health Commission

MHD = Mental Health Division (of Canterbury DHB)

MOH = Ministry of Health.

My co-panellist from the Ministry of Health, with whom I worked in 2002 on the Ministry's 'National Statement', has noted the series of events leading to the Director-General of Health's request that DHBs (a) revisit (and where appropriate revise) their policies on privacy and information-sharing in the mental health services and (b) provide training in that topic for staff in those services.

I will not repeat those events, except to look back, briefly, to the event which kick-started my involvement in CDHB's response to the MHC's critical Report.

The MHC's Report was released in February 2002.

As it happened, the Commission's Acting Chair, Mr Bob Henare, had scheduled a visit to Canterbury DHB's Mental Health Division (MHD) just two days later.

On arrival, Mr Henare asked to meet the Privacy Officer. First, we discussed my experience with the MHC Review Team during its 2001 visit to Hillmorton Hospital (formerly Sunnyside Hospital), when I had been quizzed for some 40 minutes or so about our privacy and information-sharing practices, policies and problems.

Mr Henare suddenly asked me, point-blank, what I was going to do about the MHC's Report (which, incidentally, I was only two-thirds of the way through reading – and was still annotating furiously!)

A little rashly perhaps, because I had not by then had any opportunity to brief CDHB and MHD management, I committed us to ensuring that every member of MHD's staff

(and that means 900+ people) received two hours' targeted training in "Privacy and Information-sharing in the mental health services", within 18 months or so.

MHD's management team has been a great support in helping me to keep my undertaking. The training has been up and running for four months. It has been well-received and invitations, apparently generated as much by favourable word-of-mouth as by management directive, keep coming in from the 40+ teams, units, specialist services, villas and wards which make up our Mental Health Division.

SOME EXPERIENCES AND SOME OBSERVATIONS

- Having just one presenter avoids confusion and ensures consistency. MHD's Training Co-ordinator, a professional trainer and educator, sees this as fundamental and has insisted upon it.
- The training is delivered in two separate one-hour sessions.
- The logo for the training is that of the pieces of a jigsaw puzzle (not the perfect analogy longer my preferred analogy, but it is the only halfway relevant image I could find in my computer.) The training has the theme of 'putting the various pieces together'.
- The first session includes a quick run-down of relevant events; a presentation and explanation of the various 'pieces' (ie HIPC; the different pieces of legislation; good, safe clinical practice; professional ethics and obligations) and advice as to how they relate one to the other.
- A hand-out on the various 'pieces' is provided for staff to use in preparation for the second session and to keep for reference.
- The second session is of a more interactive, workshop style, with workplace scenarios and the staff encouraged to present real-life problems. The aim is to learn to work one's own way through problems.
- The goal is to have mental health services' staff who are
 - confident in their ability to give proper consideration to privacy / information-sharing problems and to make well-informed decisions; and
 - confident in their ability to communicate those decisions (and their reasons, as appropriate) to both the client and his or her support network (eg family / whanau / carer / supporter / advocate.)
- The underlying aim (and I am sure it is one which the Commissioner would welcome) is to make wholly redundant any thought of using that much discredited "explanation" *"I can't because of the Privacy Act."*

- MHD was unable to accommodate large-scale, formal training because of budgetary constraints on the quantum of staff ‘down time’ with which services could cope. There were also other competing training priorities which the Consumer Advisors argued would bring more immediate benefit to clients / service user (eg staff training and reinforcement in “Calming techniques”).
- The decision was therefore made to deliver this training *via* the inservice training / education sessions which are already built in to the budget of every unit / team.
- I am now convinced that that decision has been a major key to the successful implementation and uptake of this training, to date. It has proved to be the most effective way of delivering this training (although it is of course much more demanding of the presenter’s time...)
- Unit Managers and the presenter have to work co-operatively, especially in units which provide a round-the-clock service. Some creative rostering on the part of Unit Managers is helpful, coupled with the presenter’s preparedness to return to a unit again and again, as required. (In one small inpatient unit, I delivered this training to just three people around the tea-room table, while the only other staff member on the shift remained with the patients - and the process is there to ensure that I catch up with him next time.)
- Advantages of inservice-based training *versus* a more set-piece style include
 - attendance as a team enables everyone to be alert to any problems or responsibilities which fall only upon certain people (eg s.7A of the Mental Health (Compulsory Assessment and Treatment) Act 1992, which requires a “medical practitioner” (only) to consult with family / whanau in certain circumstances relating to assessment for and continuation of compulsory treatment.)
 - smaller groups mean that everyone is visible and stays engaged;
 - the opportunities to contribute are maximised;
 - units’ client groups (and therefore many of their clinical and other practices) vary considerably. A well-informed presenter can tailor the training to the unit’s real-life problems (which has the incidental spin-off of persuading staff that management does understand what happens in the front line services); and
 - the profile of the Privacy Officer is enhanced and his or her availability to assist becomes better known.
- One important lesson, (for the presenter as much as for anyone else) is to be alert to the truth that privacy does not live in a separate box. Privacy issues can pop up anywhere - unexpectedly and in any guise - and a sort of continuous ‘privacy issues alert’ is needed. For example-
 - When MHD was implementing National Mental Health Standards 9 and 10 (*“Promoting the greater involvement of clients and their family / whanau / carers in the planning, delivery and evaluation of mental health services”*), we rolled-out comprehensive Information Kits (tailored either to clients or to their support people) which staff are to use as a starting point for their relationships with clients and their supporters.
The Family, Whanau and Consumer Advisors delivering the training were taken aback at the first session by a staff member who raised any number of ‘privacy

concerns'. In fact, the staff member was resistant to the shift in culture which NMHS 9 & 10 and the Kits represented, but was cloaking that resistance in the rather more virtuous disguise of concerns for privacy.

I was co-opted into the training group and we were able to respond promptly (and hopefully authoritatively) to all subsequent privacy issues.

- Alerted by one person's comments overhead in a lift where ethnicity data training was advertised, a similar set of 'cloaked responses' was anticipated by another Division training admitting staff in the accurate collection of such data. In that case, a pre-emptive "*word from the Privacy Officer*" (who just happened to sit-in on the sessions) was built into the introduction, so that the privacy position was clear from the outset and potential red herrings were avoided.
- The training needs to be as professional and organised as possible. MHD's Training Co-ordinator has been of great assistance in offering thoughtful and professional critiques of the training content, presentation and supporting material. He also produced and analysed evaluation forms, which have provided informative feedback, and we are now working to develop a post-training audit to try and measure both the uptake and retention of knowledge and, if possible, identify changes to practice.
- On that same tack, with the assistance of the Consumer, Family and Whanau Advisors we will also audit a sample of the experiences of consumers and their families / whanau / carers to ascertain their views on current practice.
- In an innovative move by the DHB, in recognition of its new and wider role in the health community, I now have a mandate to talk / train on privacy issues for any health organisation (with, perhaps, some emphasis on those of which CDHB is the funder.) There is no charge for this service nor, indeed, for any other training I deliver.
- The rationale is that CDHB has an in-house resource which it is happy to share in order to assist its contracted service-deliverers avoid duplication and the diversion of scarce funding from service-delivery (paid for by CDHB) to infrastructure.
- The uptake of these offers (plus the uptake of an allocation to NGOs and other non-DHB providers of a proportion of places on every CDHB training course) has been excellent. Feedback to CDHB has been positive and appreciative.
- MHD's NGO Liaison Officer, with whom I have worked closely for some time, organises two or three privacy seminars / workshops a year for staff of NGOs and other non-DHB providers. An interesting breakthrough recently, was the enrolment and attendance of two people from the City Council's Housing Department, which is landlord to a number of our community-based mental health clients / consumers and with which information-sharing issues (in both directions) arise from time-to-time.
- Other training I do is for students of the Certificate of Social Service at Christchurch Polytechnic and students of the Certificate of Mental Health Support Work at the Southern Institute of Technology (which is Southland-based, but has a local campus at Wigram).

- In each of the above cases, I invariably find that a number of the students are already working part-time for CDHB whilst studying to improve their qualifications, so the training effort has immediate payoff for us.
- This year, I accepted an invitation to present sessions on privacy to students of a new University of Otago post-graduate course for allied health professionals (AHPs). This will complement my existing involvement in a 6-month long, structured orientation programme for MHD's newly appointed AHPs.
- Some weeks ago, I spent half a day on privacy and information-sharing issues with the Schizophrenia Fellowship's (SF) South Island Network of Family Advisors and I am also working with SF's CEO and Consumer Advisor on pamphlets on privacy and information-sharing.
- Every opportunity is taken to talk with the family / whanau support groups, which a number of our services support and foster. It is almost like 'information-sharing' training in reverse – from the perspective of those who want information but who may, in some circumstances, be unable to get it and do not always understand why (and, in truth, are not always given a proper explanation of why it is unavailable.). In my experience, once they have an appreciation of the context of the staff's concern to maintain the client's / consumer's relationship with the service, family members will put their own limits on what information they expect and ask for.

POSTSCRIPT - "JIGSAW PUZZLE OR MOSAIC?"

As mentioned earlier, our logo for training in "Privacy and information-sharing in the mental health services" is a colourful image of interlocking jigsaw pieces. The same theme is also used during the training, as in "..... how the pieces fit together."

However, I'm not quite so sure now of that analogy. At best, it's an over-simplified approximation.

Consider –

- **a jigsaw puzzle's finished form is pre-ordained;**
- **it fits together in only one way; and**
- **it fits together the same way every time.**

That does not sound to me like the sort of privacy and information-sharing issues which arise in our mental health services.

Typically, the elements there need to be brought together in ever-shifting ways, sometimes creatively, often with fine judgement and always with the recognition that the weighting of the various elements is not fixed, but can vary with circumstances.

It's a great deal more subtle than doing a jigsaw puzzle.

Next time I choose a logo, I'll be going for the mosaic.