

Minister of Health

Cabinet material and briefings: Transforming Mental Health Law: Second Tranche of Policy Decisions

29 August 2023

These documents have been proactively released by the Ministry of Health on behalf of the Minister of Health, Hon Dr Ayesha Verrall.

Titles of Cabinet papers:

- Transforming mental health law: Second tranche of policy decisions (including RIS: Transforming Mental Health Law - Second Tranche of Policy Decisions)
- Transforming mental health law: Foundations for new mental health legislation (including RIS: Transforming Mental Health Law)

Titles of minutes:

- Report of the Cabinet Social Wellbeing Committee: Period Ended 28 July 2023 (CAB-23-MIN-0338)
- Transforming Mental Health Law: Second Tranche of Policy Decisions (SWC-23-MIN-0096)
- Report of the Cabinet Social Wellbeing Committee: Period Ended 9 December 2022 (CAB-22-MIN-0581)
- Transforming Mental Health Law: Foundations for New Mental Health Legislation (SWC-22-MIN-0234)

Some parts of this information release would not be appropriate to release and, if requested, would be withheld under the Official Information Act 1982 (the Act). Where this is the case, the relevant

sections of the Act that would apply have been identified. Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

Key to redaction codes:

s9(2)(f)(iv): to protect constitutional conventions protecting for the time being the confidentiality of advice tendered by Ministers and officials

Out of scope of the subject of this proactive release.



Cabinet

Minute of Decision

This document contains information for the New Zealand Cabinet. It must be treated in confidence and handled in accordance with any security classification, or other endorsement. The information can only be released, including under the Official Information Act 1982, by persons with the appropriate authority.

Report of the Cabinet Social Wellbeing Committee: Period Ended 28 July 2023

On 31 July 2023, Cabinet made the following decisions on the work of the Cabinet Social Wellbeing Committee for the period ended 28 July 2023:

Out of scope



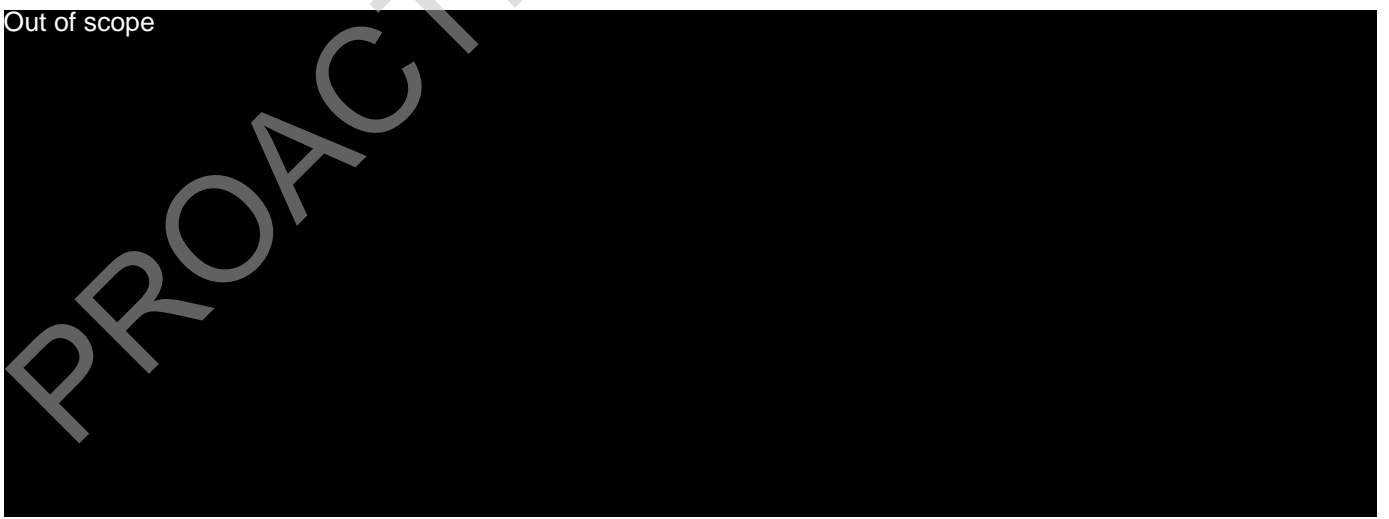
SWC-23-MIN-0096

Transforming Mental Health Law: Second Tranche of Policy Decisions

Portfolio: Health

CONFIRMED

Out of scope



Rachel Hayward
Secretary of the Cabinet



Cabinet Social Wellbeing Committee

Minute of Decision

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Transforming Mental Health Law: Second Tranche of Policy Decisions

Portfolio Health

On 26 July 2023, the Cabinet Social Wellbeing Committee (SWC):

Background

- 1 **noted** that in May 2019, Cabinet agreed to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) as part of the response to *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* [CAB-19-MIN-0182];
 - 2 **noted** that:
 - 2.1 in October 2021, SWC approved release of the document, *Transforming our Mental Health Law* for public consultation [SWC-21-MIN-0147];
 - 2.2 policy proposals for new legislation have been guided by feedback received through this public consultation;
 - 3 **noted** that in December 2022, SWC agreed to a suite of policy proposals to set the foundational settings for new mental health legislation, including:
 - 3.1 new purposes and principles, and the inclusion of specific provisions to clarify how the legislation will give effect to the Crown's obligations under Te Tiriti o Waitangi;
 - 3.2 updated entry criteria for compulsory care, and clear statutory processes when a person is subject to the legislation;
 - 3.3 placing a person's ability to make decisions about their own care at the centre of decision-making, through supported decision-making approaches;
 - 3.4 greater recognition and involvement of whānau, hapū and iwi in a person's care;
 - 3.5 more holistic and comprehensive approaches to mental health care provided under legislation; and
 - 3.6 more balanced provisions for the use of seclusion, restraint, and other restrictive practices;
- [SWC-22-MIN-0234]

- 4 **noted** that SWC also agreed that the general administrative machinery contained in the current Mental Health Act be retained in new legislation with updates required to reflect more modern understandings and give effect to other agreed policy proposals, subject to final Cabinet approval [SWC-22-MIN-0234];
- 5 **noted** that:
- 5.1 SWC also invited the Minister of Health to issue drafting instructions to the Parliamentary Counsel Office (PCO) to give effect to the above decisions [SWC-22-MIN-0234];
- 5.2 the authority to issue drafting instructions to PCO in relation to decisions being sought below fits within the above authority;
- 6 **noted** that the new mental health legislation holds a category 5 priority on the 2023 Legislation Programme (instructions to be provided to PCO before the 2023 general election);

Statutory roles and responsibilities

District inspectors

- 7 **noted** that the Mental Health Act lacks clarity regarding the role and functions of district inspectors, including their independence from health services and their role in upholding the rights of tāngata whaiora;
- 8 **agreed** that new legislation will clarify the role, functions, and duties of district inspectors, including impartiality and independence requirements, warrant powers, and duties relating to upholding rights of tāngata whaiora set out in the legislation;

Minister of Health decisions in relation to leave and release of special patients

- 9 **noted** that the 2010 Law Commission report *Mental Impairment Decision-Making and the Insanity Defence* (Report 120) recommended that Ministers no longer have a decision-making role in relation to special patients;
- 10 **agreed** that new legislation will enable decisions about leave or discharge of special patients to be confirmed through an appropriately independent body such as a court or the Mental Health Review Tribunal;
- 11 **authorised** the Minister of Health and Minister of Justice to finalise policy decisions in relation to the appropriately independent body referred to in paragraph 10 above;

Rights of people subject to legislation

- 12 **agreed** that the rights and protections for tāngata whaiora under new legislation be strengthened, including through new rights and obligations for tāngata whaiora to be supported to make decisions and express their views;
- 13 **agreed** to extend rights and protections under the new legislation to those receiving voluntary treatment in mental health inpatient services as appropriate and relevant for voluntary patients;

Complaint resolution

- 14 **noted** that the Mental Health Act provides processes for making a complaint in relation to a breach or omission of rights;
- 15 **agreed** that to improve accessibility, inclusivity, timeliness, and transparency of complaints processes, new legislation include:
- 15.1 a set of principles to guide district inspectors and the Mental Health Review Tribunal in undertaking their functions, emphasising accessibility, timeliness, proportionality, and restorative practices;
 - 15.2 requirements for public reporting of complaints made under the legislation;
 - 15.3 a power for district inspectors to obtain and rely on advice from Māori experts to assist them in upholding the rights of tāngata whaiora Māori;
 - 15.4 a power for the Director of Mental Health to direct health service providers to publicly set out how they will address recommendations of a complaint investigation where an investigation finds that a breach or omission of rights has occurred and the resulting recommendations have not been addressed;

Mental Health Review Tribunal

- 16 **agreed** that a Mental Health Review Tribunal must include a lawyer, an appropriately qualified health practitioner, a Māori member appropriately knowledgeable in tikanga and mātauranga Māori, and a tangata whaiora with lived experience of being subject to mental health legislation;
- 17 **agreed** that disabled tāngata whaiora may request that a disabled member be co-opted to the Mental Health Review Tribunal where they are not represented on a review panel;

Monitoring and reporting

- 18 **agreed** that new legislation increase transparency and accountability through clarified and strengthened monitoring and reporting requirements, including by:
- 18.1 requiring the Director of Mental Health to publish a public report annually on specified matters;
 - 18.2 clarifying that statutory officers and health providers must report on matters as requested by the Director of Mental Health;
- 19 **noted** that the Minister of Health expects that the specified matters to be reported on will include the use and duration of compulsory care, seclusion and restraint, and monitoring of equity, particularly for Māori;

Implementation costs

- 20 **noted** that Vote Health will move to a three-year funding cycle from Budget 2024 onward [SWC-21-MIN-0157];
- 21 **noted** that implementation of changes made through new mental health legislation are estimated to cost up to an additional \$12.3 million per year;

22 **noted** that costs for implementing new mental health legislation will be managed within agreed multi-year health budgets alongside other health priorities.

Rachel Clarke
Committee Secretary

Present:

Rt Hon Chris Hipkins
Hon Carmel Sepuloni
Hon Grant Robertson
Hon Dr Megan Woods
Hon Jan Tinetti
Hon Dr Ayesha Verrall
Hon Priyanca Radhakrishnan
Hon Ginny Andersen
Hon Barbara Edmonds
Hon Willow-Jean Prime
Hon Dr Deborah Russell

Officials present from:

Office of the Prime Minister
Officials Committee for SWC

PROACTIVELY RELEASED

In Confidence

Office of the Minister of Health

Cabinet Social Wellbeing Committee

Transforming mental health law: Second tranche of policy decisions

Proposal

- 1 This paper seeks agreement to a second tranche of proposals for new legislation to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 and provides an overview of the approach for implementation.

Relation to government priorities

- 2 The Government committed to repeal and replace the Mental Health Act as part of the response to *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga)* [CAB-19-MIN-0182].

Executive Summary

- 3 Cabinet has agreed to the foundational settings for new mental health legislation, emphasising human rights, recovery, and enabling te ao Māori approaches within a legislative framework for compulsory mental health care [SWC-22-MIN-0234].
- 4 I now seek further decisions required to continue drafting new mental health legislation (the Mental Health Bill), focused on new and enhanced oversight, monitoring, and accountability mechanisms. I propose improvements to:
 - 4.1 statutory roles and responsibilities for administering and overseeing the legislation;
 - 4.2 the rights of tāngata whaiora¹ under legislation and associated complaint resolution procedures;
 - 4.3 means of reviewing and challenging statutory decisions; and
 - 4.4 strengthened monitoring and reporting requirements.
- 5 The Mental Health Bill is on the 2023 Legislation Programme. I expect instructions to be provided to Parliamentary Counsel Office (PCO) before the 2023 general election. § 9(2)(f)(iv)

¹ 'Tāngata whaiora' refers to the population group who use mental health services, and tangata whaiora to an individual. These terms are used in this paper to refer to people to whom mental health legislation would apply. It is preferred over terms such as 'patient', 'service user' and 'consumer'.

Background

- 6 The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) sets out the specific circumstances under which people may be subject to compulsory mental health assessment and treatment.
- 7 In December 2022, Cabinet agreed to the first suite of policy proposals for new mental health legislation [SWC-22-MIN-0234]. These proposals focused on shifting the legislation governing compulsory mental health care towards an approach centred on human rights and recovery, and enabling care in line with a te ao Māori world view. The policy proposals have been guided by public consultation undertaken from October 2021 to January 2022 [SWC-21-MIN-0147]. Following consultation, an Expert Advisory Group was established to test and refine policy proposals.
- 8 The foundations for new legislation include [SWC-22-MIN-0234]:
 - 8.1 new purposes and principles, and the inclusion of specific provisions to clarify how the legislation will give effect to the Crown's obligations under Te Tiriti o Waitangi (Te Tiriti);
 - 8.2 updated entry criteria for compulsory care, and clear statutory processes when a person is subject to the legislation;
 - 8.3 placing a person's ability to make decisions about their own care at the centre of decision-making, through supported decision-making approaches;
 - 8.4 greater recognition and involvement of whānau, hapū and iwi in a person's care;
 - 8.5 a more holistic and comprehensive approach to mental health care provided under legislation; and
 - 8.6 more balanced provisions for the use of seclusion, restraint, and other restrictive practices.
- 9 Cabinet also agreed that the general administrative settings contained in the current Mental Health Act be retained, with updates required in line with the policy direction of new legislation. Cabinet invited the Minister of Health to report back with any further changes needed to continue the drafting of a Bill [SWC-22-MIN-0234]. This paper delivers on that report-back commitment.

Additional policy decisions are required to ensure appropriate oversight and monitoring mechanisms

- 10 New mental health legislation will require general administrative settings to ensure the legislation functions as intended. This includes mechanisms for monitoring and review, responding to complaints, challenging decisions, and statutory roles required to discharge functions and powers relating to compulsory mental health care. These mechanisms are reliant on understanding the overall direction and foundations for the proposed legislation.
- 11 Now that Cabinet has agreed to the foundational proposals, I consider that improvements to these existing mechanisms are needed to align with the direction of the new mental health legislation. These proposals will provide more effective means to monitor mental health services, respect and protect human rights, and help ensure equitable outcomes for tāngata whaiora Māori and other priority population groups under legislation.
- 12 Details of these proposals are set out below.

Statutory roles and responsibilities

- 13 The Mental Health Act contains a number of statutory roles with corresponding responsibilities to cover the range of functions needed for administering and overseeing the legislation. These include:
 - 13.1 independent monitoring of quality and safety at a service and individual level through the roles of district inspectors;
 - 13.2 the general administration and oversight roles of the Director of Mental Health and Directors of Area Mental Health Services; and
 - 13.3 the decision-making role of the Minister of Health.

District Inspectors

- 14 Under the Mental Health Act district inspectors ensure that tāngata whaiora subject to compulsory assessment and treatment are advised of their rights, complaints of breaches of their rights are investigated, and services are improved if required for their rights to be upheld.
- 15 The district inspector role will continue to be a critical function in the overall support tāngata whaiora will be entitled to under new legislation. This role, alongside the introduction of new nominated persons and independent support roles that Cabinet has agreed to [SWC-22-MIN-0234], will ensure comprehensive support for tāngata whaiora where issues relating to care, treatment, and support arise.

- 16 However, submitters to the public consultation had a perception that district inspectors are not independent from the health services. Some were not aware of what tāngata whaiora rights are in relation to seeing a district inspector and having a complaint investigated by them.
- 17 In response to those issues, I propose that new legislation should clarify the role, and related functions and duties of district inspectors, including impartiality and independence requirements, warrant powers, and their role in undertaking duties relating to upholding rights set out in the legislation.

Minister of Health decisions in relation to special patient leave and release

- 18 Under the Mental Health Act, the Minister of Health has a decision-making role in relation to tāngata whaiora who are detained in a hospital following an order under the Criminal Procedure (Mentally Impaired Persons) Act 2003 (the CP(MIP) Act) or transferred from a prison to receive mental health care.
- 19 These tāngata whaiora are referred to under legislation as 'special patients'. The Minister of Health makes decisions about special patient leave from hospital for periods longer than seven days (long leave) under the Mental Health Act and eventual change of status or discharge under the CP(MIP) Act.
- 20 The 2010 Law Commission report *Mental Impairment Decision-Making and the Insanity Defence* (Report 120) recommended that Ministers no longer have a decision-making role in relation to special patients and that a new tribunal be established to fulfil this function. The Law Commission sought to avoid politicisation of the decisions, and to improve procedural fairness for tāngata whaiora who do not have an opportunity to be heard in the existing process. The Government agreed with the Law Commission's outline of the problem, however, the tribunal was not established due to cost.
- 21 Changes made by the Rights for Victims of Insane Offenders Act 2021 provide rights for victims to receive notifications and make submissions to inform decisions about people who have offended against them, including decisions about leave and change of legal status. I am not proposing to make any changes to these settings.
- 22 To go some way toward giving effect to the Law Commission recommendation, I propose that new mental health legislation should shift responsibility for these decisions from the Minister of Health to an appropriate independent body, such as a court or Mental Health Review Tribunal. I estimate that shifting these decisions to the Mental Health Review Tribunal would cost an additional \$515,000 per year. I will determine the appropriate body in discussion with the Minister of Justice, as this would require related amendments to the CP(MIP) Act.

Rights of people subject to mental health legislation

- 23 The Mental Health Act sets out the rights of people subject to compulsory assessment and treatment. They cover a range of matters including general rights to information, respect for cultural and ethnic identity and personal beliefs, and the right to legal advice.
- 24 To further embed supported decision-making in new legislation, I propose that new legislation should include additional rights and obligations for tāngata whaiora to be supported to make decisions and express their views, including any communication assistance required. This would include the provision of appropriate accommodations for people with physical, sensory, learning and other impairments.

Extending rights and protections to voluntary patients in inpatient services

- 25 The rights and protection mechanisms in the Mental Health Act do not apply to tāngata whaiora receiving voluntary mental health care and treatment. Voluntary patients retain the rights set out in the Code of Health and Disability Consumers' Rights and other instruments. Submitters said there have been situations where voluntary patients had been placed in locked wards, or secluded. Where such incidents have occurred, voluntary patients do not have access to the complaints process set out in the Mental Health Act, and their circumstances cannot be reviewed by district inspectors.
- 26 To address these issues, I propose that new legislation should extend the rights and protection mechanisms to those receiving voluntary mental health care and treatment in inpatient services. This will ensure voluntary patients, in addition to retaining their rights under the Code of Rights, will also be under the oversight of district inspectors and have access to the complaints and investigation process provided under the legislation.

Complaint resolution

- 27 The Mental Health Act provides a process for making a complaint in relation to a breach or omission of rights. Tāngata whaiora or a person acting on their behalf are entitled to make a complaint to a district inspector or an official visitor for investigation, who may in turn make recommendations to the Director of Area Mental Health Services for remedy.
- 28 If tāngata whaiora are not satisfied with the outcome of a complaint investigation, they may have the matter reviewed by the Mental Health Review Tribunal. This process is in addition to complaints processes available through other bodies such as the Health and Disability Commissioner and the Ombudsman.

- 29 Submitters raised concerns around the accessibility, inclusivity, and timeliness of the complaints process under the Mental Health Act. In response to these concerns, I propose that new legislation should:
- 29.1 provide principles to guide district inspectors in investigating complaints, and the Mental Health Review Tribunal in reviewing applications and complaints, including principles such as:
 - 29.1.1 fairness and accessibility of processes, with particular regard to tikanga Māori;
 - 29.1.2 resolution in a timely and efficient manner, and resolution at a level appropriate to the nature and seriousness of the matter; and
 - 29.1.3 upholding the mana of the parties involved and promoting restorative practices
 - 29.2 require regular anonymised reporting publicly of complaints made under the legislation.
- 30 I also propose that new legislation should provide that district inspectors can rely on advice from Māori experts to assist them in upholding the rights of tāngata whaiora Māori. This will support consideration of Māori needs in complaints resolution processes. I anticipate this would be implemented through establishing a committee of Māori experts to provide assistance and advice on an ad-hoc basis, at an estimated cost of \$160,000 to \$200,000 per year.
- 31 I further propose that, where an investigation finds that a breach or omission of rights has occurred and the resulting recommendations have not been implemented, that new legislation empowers the Director of Mental Health to direct health service providers to publicly set out how they will address recommendations. This would address a gap in the current legislation by providing the Director of Mental Health with an intervention power to help ensure recommendations of investigated complaints are addressed.

Mental Health Review Tribunal

- 32 The Mental Health Review Tribunal (the Review Tribunal) is an independent statutory body that, among other functions, can review a person's condition upon application, or of its own motion. Under the Mental Health Act, the Review Tribunal consists of three members: a lawyer, a psychiatrist, and a community member who generally brings lived experience of the legislation or is a whānau member or supporter of tāngata whaiora.
- 33 Although the Review Tribunal usually sits as a panel of three, a fourth member is occasionally co-opted where specialised knowledge or expertise is needed. Co-opting an additional member is mandatory where the panel does not include a member of the same ethnic identity or gender as the tangata whaiora and they request that the Review Tribunal ensures representation.

- 34 Submitters to the public consultation saw the inclusion of Māori in key decision-making roles as an opportunity for new legislation to reflect Te Tiriti. There is also opportunity to strengthen the voice of tāngata whaiora and their whānau and include a broader range of health professionals.
- 35 I therefore propose that new legislation requires membership of the Review Tribunal to include the following members:
- 35.1 an appropriately qualified health practitioner;
 - 35.2 a Māori member appropriately knowledgeable in tikanga and mātauranga Māori;
 - 35.3 a tangata whaiora who has lived experience of being subject to compulsory mental health assessment and treatment; and
 - 35.4 a lawyer.
- 36 In order to ensure representation for disabled people, I further propose that mandatory co-opting requirements should also apply on request of disabled tāngata whaiora. Health services will have a duty to advise tāngata whaiora of this right and ensure it is understood.

Monitoring and reporting

- 37 The Director of Mental Health publishes an annual report on matters relating to the administration of the Mental Health Act, however, this is not a legislative requirement. Further, there is variable compliance with requests by the Director of Mental Health for information from health providers and statutory officials. The current legislation lacks clarity with respect to the Director of Mental Health's power to request information outside of the minimal reporting obligations contained within it, and there are limited enforcement powers available to address non-compliance.
- 38 In order to increase transparency regarding the administration of the legislation, I propose that new legislation should strengthen and clarify reporting obligations by:
- 38.1 requiring the Director of Mental Health to publish a public report annually on specified matters; and
 - 38.2 clarifying that statutory officers and health providers must report on matters as requested by the Director of Mental Health.

Iwi and hapū involvement

- 39 In December 2022, Cabinet Social Wellbeing Committee requested further information on how new legislation will provide for recognition and involvement of iwi and hapū [SWC-22-MIN-0234]. This will be enabled through:
- 39.1 the inclusion of supported decision-making approaches, which, in accordance with the wishes of tāngata whaiora, would allow for whānau, hapū, and iwi of tāngata whaiora to act as a nominated person or take part in supported decision-making hui; and
 - 39.2 more collective approaches to key processes under the legislation, for example, requirements for whānau, hapū, and iwi to be kept informed and have opportunities to express their views and those views be considered in statutory assessment and care planning processes, in line with the wishes of tāngata whaiora.
- 40 Iwi and hapū input will also be enabled through the involvement of Iwi-Māori partnership boards (IMPBs) established under the Pae Ora (Healthy Futures) Act 2022. Under that legislation, IMPBs have a role in monitoring hauora Māori and determining priorities for their local areas, which could include supporting tāngata whaiora Māori who are or have been subject to mental health legislation.
- 41 IMPBs are currently in a foundational phase, determining how they will fulfil their statutory functions and engage in their priority areas across the health system, as well as the nature of their relationships with government agencies.
- 42 It will be important, and in line with the purpose of their establishment, that IMPBs be afforded the independence to determine for themselves what their role could be and how they want to undertake it. The Ministry of Health and Te Aka Whai Ora plan to engage with IMPBs on this as planning for the implementation of new legislation progresses.

Implementation

- 43 Successfully implementing new legislation will involve communication and collaboration between the health and disability sectors, key government agencies and communities, as well as availability of a broader range of mental health services and care options, workforce expansion and training for practice change, and improved technology. Supporting regulations and updated guidelines will be developed. I anticipate a lead-in time of at least two years from the date new legislation is enacted to allow health services and the wider government, particularly the courts, to prepare for change.
- 44 Implementing new legislation will form part of the overall changes to transform New Zealand's approach to mental wellbeing and the mental health and addiction system in line with *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*. Implementation will be supported by the significant investment and system transformation activity already underway.

- 45 Officials are working to identify where new activity will be required, and where early progress could be made to start shifting services and practice to support the direction of the new legislation. For example, there is an opportunity to pilot new workforce arrangements for supported decision-making approaches and continue workforce training to improve practice prior to the commencement of new legislation.
- 46 A high-level overview of the approach for implementing new legislation is attached at **Appendix A**.
- 47 I estimate that implementing the new legislation will cost up to \$12.3 million per year. The largest component is the cost of new system roles, in particular independent support and whānau support roles (\$7.9 million).
- 48 There are also costs associated with training in new requirements and techniques to reduce the use of seclusion and restraint (around \$2.5 million), to support the goal of reducing the use of restraint and eventually eliminating seclusion. There are further potential costs for the Mental Health Review Tribunal to consider matters relating to special patients (\$515,000).
- 49 Cost estimates are set out more fully in the regulatory impact statements attached to this paper and the December 2022 paper authorising drafting instructions for the Mental Health Bill [SWC-22-SUB-0234].
- 50 These are conservative estimates, and it is likely that the figures are over-estimates of the actual additional cost. I note the estimated cost is not significant. The Ministry of Health is working to refine cost estimates and funding implications will be managed within agreed multi-year health budgets.

Legislative Implications

- 51 Legislation is required to implement the proposals in this paper. The proposals will be given effect through the Mental Health Bill which is on the 2023 Legislation Programme. The Bill was submitted as a category 4 priority (to be referred to a select committee before the 2023 general election), however, it is now suggested that it hold a category 5 priority (instructions to be provided to PCO before the 2023 general election). The Act will bind the Crown.

Impact Analysis

Regulatory Impact Statement

- 52 The regulatory impact analysis requirements apply to this paper. A Regulatory Impact Statement is attached. The Ministry of Health quality assurance panel has reviewed the Impact Statement and considers that it meets the quality assurance criteria.

Population Implications

- 53 The proposals in this paper are anticipated to benefit specific population groups, as set out in the below table:

Population group	How the proposal may affect this group
Māori	<p>Māori are disproportionately subject to compulsory mental health treatment. In 2020/21, Māori represented around 35% of those subject to compulsory assessment, and around 38% of those subject to a compulsory treatment order.</p> <p>Proposals in this paper identify areas where new legislation can respond to the Crown's obligations under Te Tiriti by enabling Māori expertise and representation, for example, through a new requirement for Māori representation on the Mental Health Review Tribunal and enabling Māori expertise to guide the decisions of district inspectors.</p> <p>Proposals also aim to incorporate te ao Māori approaches, for example, through principles to underpin complaints processes, including that processes should uphold the mana of parties and promote restorative practices.</p>
Pacific peoples	<p>In 2020/21, Pacific peoples represented around 7% of those subject to compulsory assessment, and around 9% of those subject to a compulsory treatment order. Proposals relating to monitoring and reporting of equity outcomes will improve visibility of the experiences of Pacific peoples under the new legislation.</p>
Disabled people	<p>Tāngata whaiora under compulsory mental health assessment and treatment may have other disabilities such as physical, sensory, and learning impairments.</p> <p>The proposals in this paper will better enable these tāngata whaiora to exercise their rights, including through the addition of legislated rights and obligations for tāngata whaiora to be supported to make decisions and express their views, as well as principles to underpin complaints processes emphasising accessibility.</p> <p>Representation will be enabled through specifying that disabled tāngata whaiora may request that a disabled member be co-opted to the Mental Health Review Tribunal where they are not represented on a review panel.</p>
Children and young people	<p>In 2020/21, there were 311 children and young people aged 16 years or younger under the Mental Health Act. Improvements to rights and protections, including new rights and obligations relating to supported decision-making, will support this group to better exercise their rights.</p>
Older people	<p>Enhanced rights and protections for tāngata whaiora under legislation and strengthened complaints resolution mechanisms will better protect the needs of older people under the legislation.</p>

Human Rights

- 54 The proposals in this paper are consistent with, and advance the purposes of, the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Consultation

- 55 This paper was prepared by the Ministry of Health in consultation with: the Department of the Prime Minister and Cabinet, Ministry of Social Development, Ministry of Business, Innovation and Employment, Social Wellbeing Agency, Treasury, Te Arawhiti, Oranga Tamariki–Ministry for Children, Department of Corrections, Ministry of Housing and Urban Development, Ministry of Education, Ministry for Women, Te Aka Whai Ora, Te Whatu Ora, Te Puni Kōkiri, Ministry of Justice, New Zealand Police, New Zealand Defence Force, Te Kawa Mataaho, Accident Compensation Corporation, Whaikaha – Ministry of Disabled People, Ministry for Ethnic Communities, Ministry for Primary Industries, Office for Seniors, Ministry for Pacific Peoples, and Ministry of Youth Development.

Communications

- 56 Any specific public announcements will be coordinated by the Office of the Minister of Health.

Proactive Release

- 57 I intend to proactively release the set of papers that outline the full suite of proposals for new mental health legislation, which includes this paper and the paper approved by Cabinet in December 2022 [SWC-22-MIN-0234]. They will be released within 30 days of final decisions being taken by Cabinet, with any redactions as appropriate under the Official Information Act.

Recommendations

The Minister of Health recommends that the Committee:

- 1 **note** that on 6 May 2019, Cabinet agreed to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) as part of the response to *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* [CAB-19-MIN-0182 refers]
- 2 **note** that policy proposals for new legislation have been guided by feedback received through public consultation on the document, *Transforming our Mental Health Law*, approved for release by Cabinet on 4 October 2021 [SWC-21-MIN-0147]
- 3 **note** that on 12 December 2022, Cabinet agreed to a suite of policy proposals to set the foundational settings for new mental health legislation [SWC-22-MIN-0234], including:
 - 3.1 new purposes and principles, and the inclusion of specific provisions to clarify how the legislation will give effect to the Crown's obligations under Te Tiriti o Waitangi;
 - 3.2 updated entry criteria for compulsory care, and clear statutory processes when a person is subject to the legislation;

- 3.3 placing a person's ability to make decisions about their own care at the centre of decision-making, through supported decision-making approaches;
 - 3.4 greater recognition and involvement of whānau, hapū and iwi in a person's care;
 - 3.5 more holistic and comprehensive approaches to mental health care provided under legislation; and
 - 3.6 more balanced provisions for the use of seclusion, restraint, and other restrictive practices
- 4 **note** that Cabinet has agreed that the general administrative machinery contained in the current Mental Health Act be retained in new legislation with updates required to reflect more modern understandings and give effect to other agreed policy proposals, subject to final Cabinet approval [SWC-22-MIN-0234]
 - 5 **note** that Cabinet authorised the Minister of Health to issue drafting instructions to the Parliamentary Counsel Office (PCO) in line with recommendations 3 and 4 above [SWC-22-MIN-0234]
 - 6 **note** that the authority to issue drafting instructions to PCO in relation to decisions being sought in this paper fits within the authority obtained in SWC-22-MIN-0234

Statutory roles and responsibilities

District inspectors

- 7 **note** the Mental Health Act lacks clarity regarding the role and functions of district inspectors, including their independence from health services and their role in upholding the rights of tāngata whaiora
- 8 **agree** new legislation will clarify the role, functions, and duties of district inspectors, including impartiality and independence requirements, warrant powers, and duties relating to upholding rights of tāngata whaiora set out in the legislation

Minister of Health decisions in relation to leave and release of special patients

- 9 **note** that the 2010 Law Commission report *Mental Impairment Decision-Making and the Insanity Defence* (Report 120) recommended that Ministers no longer have a decision-making role in relation to special patients
- 10 **agree** that new legislation will enable decisions about leave or discharge of special patients to be confirmed through an appropriately independent body such as a court or the Mental Health Review Tribunal

- 11 **authorise** the Minister of Health and Minister of Justice to finalise policy decisions in relation to the appropriate body referred to in recommendation 10 above

Rights of people subject to legislation

- 12 **agree** that the rights and protections for tāngata whaiora under new legislation be strengthened, including through new rights and obligations for tāngata whaiora to be supported to make decisions and express their views
- 13 **agree** to extend rights and protections under the proposed legislation to those receiving voluntary treatment in mental health inpatient services as appropriate and relevant for voluntary patients

Complaint resolution

- 14 **note** that the Mental Health Act provides processes for making a complaint in relation to a breach or omission of rights
- 15 **agree** that to improve accessibility, inclusivity, timeliness, and transparency of complaints processes, new legislation include:
- 15.1 a set of principles to guide district inspectors and the Mental Health Review Tribunal in undertaking their functions, emphasising accessibility, timeliness, proportionality, and restorative practices;
 - 15.2 requirements for public reporting of complaints made under the legislation;
 - 15.3 a power for district inspectors to obtain and rely on advice from Māori experts to assist them in upholding the rights of tāngata whaiora Māori; and
 - 15.4 a power for the Director of Mental Health to direct health service providers to publicly set out how they will address recommendations of a complaint investigation where an investigation finds that a breach or omission of rights has occurred and the resulting recommendations have not been addressed

Mental Health Review Tribunal

- 16 **agree** a Mental Health Review Tribunal must include a lawyer, an appropriately qualified health practitioner, a Māori member appropriately knowledgeable in tikanga and mātauranga Māori, and a tangata whaiora with lived experience of being subject to mental health legislation
- 17 **agree** that disabled tāngata whaiora may request that a disabled member be co-opted to the Mental Health Review Tribunal where they are not represented on a review panel

Monitoring and reporting

- 18 **agree** that new legislation increase transparency and accountability through clarified and strengthened monitoring and reporting requirements, including by:
- 18.1 requiring the Director of Mental Health to publish a public report annually on specified matters; and
 - 18.2 clarifying that statutory officers and health providers must report on matters as requested by the Director of Mental Health
- 19 **note** that I expect the matters to be reported on, referred to in recommendation 18.1 above, will include the use and duration of compulsory care, seclusion and restraint, and monitoring of equity, particularly for Māori

Implementation costs

- 20 **note** that Vote Health will move to a three-year funding cycle from Budget 2024 onward [SWC-21-MIN-0157]
- 21 **note** that implementation of changes made through new mental health legislation are estimated to cost up to an additional \$12.3 million per year
- 22 **note** that costs for implementing new mental health legislation will be managed within agreed multi-year health budgets alongside other health priorities.

Authorised for lodgement

Hon Dr Ayesha Verrall

Minister of Health

Appendix A: High-level overview of approach for implementing new mental health legislation

This page provides a high-level overview of the broad implementation approach for new mental health legislation. Detailed work to support implementation will take place concurrently with the development of the legislation to ensure government and relevant stakeholders are prepared for when the new legislation commences.

KEY ENABLERS

New mental health legislation is intended to emphasise human rights, equity, recovery, and enable te ao Māori approaches within a legislative framework for compulsory mental health care. Implementing new legislation will build on the significant work and investment already underway to expand services and workforce as part of the wider transformation of Aotearoa New Zealand's approach to mental wellbeing as outlined in Kia Manawanui. The key enablers describe what needs to be achieved to ensure the successful implementation of new mental health legislation.

COLLABORATION

Description: Relevant agencies, including the voices of Māori and lived experience, work together to plan, design and deliver changes required to implement the new legislation.

Example of activity: Establishment of cross-agency working groups to lead implementation work.

COMMUNICATION

Description: The intent and requirements of new legislation are understood by those who will be implementing the legislation as well as tāngata whaiora, whānau and the general public.

Example of activity: Development of accessible information and materials to explain the requirements in new legislation.

WORKFORCE

Description: Growing and establishing the range of roles needed to ensure there is sufficient workforce in place to administer and implement the requirements of the legislation.

Example of activity: Defining new workforce requirements needed to implement the new legislation in particular to embed te ao Māori approaches, including identifying the skills, competencies and attributes needed across mental health and kaiāwhina workforces.

PRACTICE CHANGE

Description: Practice shifts in line with the direction of new legislation, supporting a human rights, whānau-centred, culturally appropriate and recovery approach.

Example of activity: Developing or updating guidance/practice guidelines and training. Further investigation of critical factors needed to support the aim of eliminating seclusion and reducing restraint.

INVESTMENT

Description: There is sufficient investment to support implementation of the legislation.

Example of activity: Detailed estimates of funding required to implement new and additional activities, and continue to broaden the range of support and services available including to enable te ao Māori approaches to compulsory mental health care, to be allocated through agreed multi-year Budgets.

MONITORING & REPORTING

Description: The implementation of the legislation is monitored and reported on to ensure that it is functioning in line with the policy intent.

Example of activity: Developing new regulations that prescribe the information that must be reported on.

TECHNOLOGY

Description: Digital tools support the effective operation of the legislation.

Example of activity: Developing the improvements or system updates needed to existing technology (eg, PRIMHD, National Health Information Platform) to enable the new requirements.

s 9(2)(f)(iv)

PROACTIVE

Regulatory Impact Statement: Transforming Mental Health Law – Second Tranche of Policy Decisions

Coversheet

Purpose of Document	
Decision sought:	The analysis in this paper has been undertaken to support the second tranche of Cabinet decisions on new mental health compulsory assessment and treatment legislation.
Advising agencies:	Ministry of Health
Proposing Ministers:	Minister of Health
Date finalised:	27 February 2023
Problem Definition	
<p>Legislative authority is required for the State to intervene for people with mental health conditions that, if left untreated, will have significant adverse effects on those people or others, but who do not have (at the time of intervention) the capacity to make informed decisions about their treatment. Reform is needed as current legislation does not reflect human rights obligations, provide for supported decision-making, or align well with the recovery approach to mental health treatment. The current legislation has not been designed to meet Māori beliefs, needs and aspirations. While the legislation has a significant impact on the wellbeing of all people subject to compulsory treatment, there are substantial differences in the way the current legislation is working for different population groups, in particular Māori face more discrimination and inequitable outcomes than non-Māori.</p>	
Executive Summary	
<p>This is the second of two regulatory impact statements relating to the proposed Mental Health Bill.</p>	
Limitations and Constraints on Analysis	
<p>Cabinet agreed scope and principles</p> <p>The Government has accepted the recommendation of the Inquiry into Mental Health and Addiction that it:</p> <p>Repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 so that it reflects a human rights-based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment.</p> <p>Previous Cabinet decisions narrow the scope of considerations from the Inquiry recommendations to the minimised use of compulsory care but within a more human rights-based approach. This means that wider scope options such as general mental health legislation or no legislation have been ruled out of scope. Cabinet has agreed to the</p>	

following high-level policy principles to guide development of new legislation and the overall transformation of the mental health system:

1. human rights approach
2. maximum independence; inclusion in society; and safety of individuals, their whānau and the community
3. upholds Crown obligations under Te Tiriti o Waitangi
4. improved equity of care and treatment
5. recovery approach to care and treatment
6. timely service, access and choice
7. provision of least restrictive mental health care
8. respect for family and whānau.

(SWC-19-MIN-0070 refers).

Evidence and insights from consultation

There is limited evidence both domestically and internationally on the effectiveness of compulsory mental health treatment. Qualitative and quantitative studies both report mixed findings. There is also a lack of research on negative effects of compulsory detention and treatment. The issues around compulsory care – both inpatient and in the community – continue to be debated. However, there is a general consensus that coercion, which can be defined as any measure applied against the patient's will or in spite of their opposition, is overused in mental health care.

Feedback gathered from public consultation resulted in diverse views on what should be included in legislation making it difficult to rely on the feedback alone to help narrow options – including across key areas such as compulsory care and restrictive practices.

Cost-benefit analysis

We have not undertaken a comprehensive cost-benefit analysis. We have analysed selected benefits and costs, using conservative assumptions, to identify whether there is a plausible benefit from the proposed law changes. This analysis should not be treated as a precise valuation of the benefits or costs of the proposals, and we do not consider the figures are applicable to other contexts.

Responsible Manager(s)

Kiri Richards
Acting Associate Deputy Director-General
Mental Health and Addiction
Ministry of Health
27 February 2023

Quality Assurance

Reviewing Agency: Ministry of Health and Ministry of Justice

Panel Assessment & Comment:

The Ministry QA panel has reviewed the Impact Statement titled “Transforming Mental Health Law – Second Tranche of Policy Decisions”, produced by the Ministry of Health and dated February 2023

The panel considers that the Impact Statement **meets** the quality assurance criteria.

The Impact Statement is clear, complete, considered, consulted and concise. The analysis is balanced in its presentation of the information, reflects consultation on the proposals and the major impacts are identified and assessed.

PROACTIVELY RELEASED

Section 1: Diagnosing the policy problem

What is the context behind the policy problem and how is the status quo expected to develop?

Current state

1. The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act / Mental Health Act) sets out the specific circumstances under which people may be subject to compulsory mental health treatment. The intended purpose of the Act is to provide for people experiencing a serious mental disorder to receive treatment, even if they do not want to receive treatment, and to define and protect their rights.
2. The Act only applies to a narrowly defined group of people and was intended to be quite restrictive in the number of people it covers. The Act applies only to people who meet the Act's definition of 'mental disorder': an 'abnormal state of mind' which results in the person posing a serious danger to the health and safety of themselves or someone else, or seriously diminishes their capacity to care for themselves.
3. The Act sets out processes for people acquitted by the Court on account of insanity¹ or unfit to stand trial to receive mental health treatment in a secure environment. It also applies to people in prison in regard to their transfer to and from prison into a mental health service and youth offenders in Oranga Tamariki care or custody who meet the criteria to receive compulsory care.
4. In the financial year 2020/21, there were 11,149 people subject to some form of compulsory mental health assessment or treatment. Māori were assessed and treated under the Act at about 3 times the rate of non-Māori.

Background information on current law

5. The current Act replaced the prior Mental Health Act 1969. The current Act introduced reforms necessary to embed respect for human rights and enable a new model of mental health service delivery following the closure of older psychiatric hospitals and the deinstitutionalisation of mental health care.
6. At the time, the Act was seen as transformative and represented a step forward with its requirement for care to be provided in the least restrictive manner, encouraging community care where possible, and recognition and protection of tāngata whaiora rights.
7. The Act is now seen as no longer achieving its intended purpose and does not align with the wider Aotearoa New Zealand health system transformation. Since the Act was passed, Aotearoa New Zealand ratified the United Nations Convention on the Rights of Persons with Disabilities in 2008. The Act does not align with these rights.

Inquiry report and agreement to repeal and replace

8. In 2018 *He Ara Oranga – Report of the Government Inquiry into Mental Health and Addiction* (He Ara Oranga) was released. It set out a future vision of mental health and wellbeing for all. One of the recommendations was to repeal and replace the Act, noting that Aotearoa New Zealand has faced strong criticism about the Act. Criticism particularly related to non-compliance with international obligations and that the Mental

¹ The Rights for Victims of Insane Offenders Act 2021 came into effect on 13 December 2022. It replaced the finding of "not guilty on account of insanity" with "act proven but not criminally responsible on account of insanity".

Health Act had a significant negative impact on people in terms of compulsory treatment and care, detention, seclusion and restraint.

9. In 2019, Cabinet agreed to repeal and replace the Act, and agreed on a set of high-level principles and objectives to guide the policy development:

- human rights approach
- maximum independence; inclusion in society; and safety of individuals, their whānau and the community
- upholds Crown obligations under Te Tiriti o Waitangi
- improved equity of care and treatment
- recovery approach to care and treatment
- timely service, access and choice
- provision of least restrictive mental health care
- respect for family and whānau.

(SWC-19-MIN-0070)

10. In 2021, Cabinet approved a discussion document, *Transforming our Mental Health Law*, for public consultation. The discussion document set out the key topics that must be considered in the development of new mental health legislation. Public consultation opened on 22 October 2021 and closed on 28 January 2022. Submissions were received from over 300 people and feedback gathered from over 500 people across 60 online hui.

Key features of the current law

11. The Act is intended to only apply to those people with a 'mental disorder' as defined in the Act. The Act presents a two-step test:

- the first step requires the presence of an 'abnormal' state of mind, whether of a continuous or intermittent nature, which is characterised by delusions, or by disorders of mood, volition, cognition or perception, and
- the second step requires that the presence of that state of mind causes consequences of a certain severity – either resulting in the person posing a serious danger to themselves or others, or seriously diminishing the capacity of the person to take care of themselves.

12. The presence of both an abnormal state of mind, and the risk of danger to self or others is needed before a person can be required to undergo assessment and treatment. The two-step process and definition are intended to stop someone being subject to the Act based on having an abnormal state of mind alone. The Act does not require those meeting the two-step test to accept treatment – as anyone assessing a tangata whaiora must also consider whether treatment is desirable.

13. The Act provides for compulsory examination where a person is believed to have a mental disorder. In general, this requires an application that is accompanied by a certificate issued by a mental health practitioner (medical practitioner, nurse practitioner or nurse practicing in mental health), stating that there are reasonable grounds for believing that the person may be suffering from a mental disorder. The application once completed is made to the Director of Area Mental Health Services (a statutory role appointed by the Director-General of Health for a particular area) or Duly Authorised Officer (a health professional designated by the Director of Area Mental Health Services to perform certain functions). The Director of Area Mental Health Services or Duly Authorised Officer may then require the person to attend an examination or arrange for one to be conducted where the person is. The outcome of that examination may be a further period of compulsory assessment. The responsible

clinician may apply to a court for a compulsory treatment order. The person who is the subject of the application is entitled to be present and represented .

14. The Act includes checks and balances to provide safeguards against any inappropriate use of coercive powers allowed under the Act. It provides for a Director of Mental Health, with powers to enter and inspect any facilities, people or records. It also provides for district inspectors and official visitors, with similar powers of entry and inspection for their districts. Review Tribunals may be appointed to consider complaints and review treatment or detention decisions. A person subject to compulsory treatment or assessment may appeal to the Court against ongoing compulsion.
15. There are also rules for restricted and special patients, special provisions relating to children and young people, people with intellectual or physical disabilities and the protection of rights of tāngata whaiora and proposed tāngata whaiora. The rights enumerated in the New Zealand Bill of Rights Act 1990 and Human Rights Act 1993, and the Code of Health and Disability Consumers' Rights also protect recipients of compulsory assessment and treatment.

How is the situation expected to develop if no further action is taken

16. Changes to practice to align with human rights can only go so far within the parameters of the current Act. This means people will continue to be subject to legislation that is not in line with international or domestic human rights obligations. Māori are particularly disadvantaged by the Act, and if no further action is taken, they will continue to experience significant inequities and discrimination.
17. *He Ara Oranga* found the legislation does not align with domestic and international human rights obligations. The report highlighted potential inconsistency with the rights and freedoms contained in the New Zealand Bill of Rights Act 1990. In particular the rights relating to cruel treatment and arbitrary detention may be engaged due to the lack of statutory controls on the use of seclusion and restraint, and the lack of consideration of a person's decision-making capacity in the current definition of mental disorder.
18. Similarly, the monitoring bodies for international human rights instruments, particularly the United Nations Convention on the Rights of People with Disabilities have highlighted inconsistencies. The rights to equal recognition before the law and the liberty and security of the person are especially relevant. The Convention provides that people with disabilities (which includes mental health conditions) should enjoy legal capacity on the same basis as others, and that they should not be deprived of liberty merely because they have a disability. Other rights, such as reasonable access to mobility devices, may be engaged by some restraint practices, that are not adequately controlled by current legislation.
19. New Zealand has responsibilities under treaties, a number of which were ratified after the commencement of the Act. A change to the legislation would better uphold the rights protected by those treaties.

Ongoing government work programmes that are relevant

20. Aotearoa New Zealand's health and disability system is undergoing significant reform. The management of health services on a national, rather than district basis can be expected to improve care and support by internal monitoring and reduction of undesirable variation. The Pae Ora (Healthy Futures) Act 2022 outlines principles to guide the health sector, which will bind mental health services. The Minister of Health, the Ministry of Health, and other government agencies to whom these principles apply must be guided by these principles. These will have positive implications on the Crown's Treaty obligations under new mental health legislation, as the Health Sector

Principles specify the need for an equitable health system and engagement with Māori, amongst others.

21. *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing* (Kia Manawanui) also sets out the direction to transform Aotearoa New Zealand's approach to mental wellbeing, with short, medium and long-term actions to achieve the overall vision of pae ora. The repeal and replacement of the Mental Health Act is just one of the actions to improve the health system and is part of the wider framework of change to reform New Zealand's mental health and addiction system.
22. These ongoing government work programmes and commitments need to be considered and new legislation will need to align with the transformation of the health and disability sector.
23. In December 2022, Cabinet agreed to the first tranche of policy proposals which set the foundations for new legislation, including:
 - a. new purposes and principles, and the inclusion of specific provisions to clarify how the legislation will give effect to the Crown's obligations under Te Tiriti o Waitangi
 - b. significantly limited entry criteria for compulsory care
 - c. supported decision-making approaches
 - d. improvements to mental health care provided under legislation; and
 - e. limitations on the use of seclusion, restraint, and other restrictive practices.
24. Cabinet also agreed that the general administrative machinery contained in the current Mental Health Act be retained, with updates required in line with the policy direction of new legislation [SWC-22-MIN-0234]. Cabinet agreed that a Mental Health Bill be drafted to give effect to the above proposals.

What is the policy problem or opportunity?

25. The current Mental Health Act is out of date and does not align with Aotearoa New Zealand's international and domestic human rights obligations, as well as being out of step with a rights-based and recovery approach to mental health care. Aotearoa New Zealand's Health and Disability system is being reformed, as well as the transformation of the mental health and addiction system and the current Act does not align with this new shift.
26. There are significant inequities in compulsory mental health assessment and treatment. Māori are particularly disadvantaged by the Act, as they are disproportionately represented in the number of people treated under the Act. In 2020/21, Māori were more likely to be assessed or treated under the Mental Health Act than other ethnicities. Māori represented around 35% of those subject to compulsory assessment, and around 38% of those subject to a compulsory treatment order.
27. Submitters to the public consultation said services are sometimes discriminatory towards disabled people. They said there is often no accommodation for the needs of disabled people, and there is a lack of understanding of their needs, as well as adequate resourcing and training which we were told has resulted in their means of communication and mobility being removed or restricted.
28. Reform is needed as current legislation does not reflect human rights' obligations, provide for supported decision-making, or align well with the recovery approach to mental health treatment. The current legislation has not been designed to meet Māori beliefs, needs and aspirations. While the legislation has a significant impact on the wellbeing of all people subject to compulsory treatment, there are substantial

differences in the way the current legislation is working for different population groups, in particular Māori face more discrimination and inequitable outcomes than non-Māori.

29. Additional policy decisions are required to inform the drafting of the legislation. They cover several issues that were not examined in the regulatory impact statement: Transforming Mental Health Law (the RIS) that accompanied the first tranche of proposals. These issues relate to:
 - a) Issue 1: roles, responsibilities, and related powers
 - b) Issue 2: upholding rights and protections
 - c) Issue 3: reviewing and challenging decisions
 - d) Issue 4: monitoring and reporting.
30. There is an opportunity to ensure that the proposed improvements to these existing mechanisms will provide more effective means to monitor mental health services, ensure that human rights are respected and protected, and support equitable outcomes for tāngata whaiora² under legislation.

What objectives are sought in relation to the policy problem?

31. The policy objectives for this work have been informed by principles and directions indicated in previous Cabinet decisions for this work, as well as from *He Ara Oranga, Kia Manawanui*, and feedback we received during public consultation.
32. The policy objectives for this work are to achieve a modern mental health legislative framework that:
 - a) upholds the Crown's obligations under Te Tiriti o Waitangi
 - b) supports modern approaches for mental health care that are grounded in te ao Māori, a recovery approach, and supports the safety of tāngata whaiora and others
 - c) encourages maximum independence and social inclusion
 - d) ensures that human rights are respected and protected
 - e) supports people to make decisions about their mental health care and ensures those who have decision-making capacity are not compelled to receive mental health care
 - f) achieves equitable outcomes for those receiving support under the legislation, with particular attention to achieving equitable outcomes for Māori
 - g) minimises the use and duration of compulsory care, including by preventing the need for a person to enter or re-enter compulsory care, rather than just managing crises
 - h) minimises the use of seclusion and restraint, with the intention to eliminate seclusion

² Tāngata whaiora refers to the population group who use mental health services, and tangata whaiora to an individual. These terms are used in this paper to refer to people to whom mental health legislation would apply. It is preferred over terms such as 'patient', 'service user' and 'consumer'

- i) includes effective mechanisms to monitor services, ensuring human rights are respected, and the purposes of the legislation are achieved.

Te Tiriti o Waitangi

33. An expanded set of Te Tiriti o Waitangi policy objectives have helped to shape the policy work and identify and assess detailed options. The Te Tiriti o Waitangi policy objectives are:

Te Tiriti o Waitangi policy objectives for new mental health legislation	Relevant Te Tiriti o Waitangi principle/s
A. Tikanga and te ao Māori conceptions of holistic wellbeing and traditional approaches to healing are promoted and protected	Active protection, equity, options
B. Tāngata whaiora Māori are entitled to choose support that meets their needs and supports their recovery	Equity, options
C. Tāngata whaiora Māori are recognised in the context of their whānau, hapū, iwi, and hāpori (communities)	Equity, tino rangatiratanga
D. Equitable mental wellbeing outcomes for tāngata whaiora Māori and their whānau, hapū, iwi, and hāpori are prioritised	Equity
E. Tāngata whaiora Māori, their whānau, hapū, iwi, hāpori, and other Māori experts are empowered to collaborate and partner with agents of the Crown	Partnership, tino rangatiratanga

34. The Treaty consideration is within the context that all health services, including mental health services, will be guided by the health sector principles in the Pae Ora (Heathy Futures) Act 2022. Those principles incorporate the concepts of the Treaty principles identified by the Waitangi Tribunal in its Hauora inquiry. For example, the health sector principles provide that the health sector should provide a choice of high-quality services to Māori, including by resourcing services to meet the needs and aspirations of iwi, hapū, and whānau, and Māori.

Section 2: Deciding upon an option to address the policy problem

What criteria will be used to compare options to the status quo?

35. The criteria below are the same criteria outlined in the previous RIS. They have been identified to ensure options align with the policy objectives and will support transformational change. The criteria are:
- **Te Tiriti o Waitangi** – options will be assessed on the extent to which they align with our Te Tiriti o Waitangi obligations better than the status quo. This includes how well options work for Māori and encompass te ao Māori world views, as well as how they align with the Tiriti framework
 - **Effectiveness** – options will be assessed on how effective they are at achieving the policy objectives better than the status quo. This includes the extent to which options are effective in implementation, effective in positively transforming the mental health system, and effective in solving our problem definition
 - **Human rights** – options will be assessed on the extent to which they align with our domestic and international human rights obligations better than the status quo
 - **Sustainability and durability** – options will be assessed on how well they will last, how feasible it is to have the option as a long-term solution, and how it will stand up to other changes in the system over time compared to the status quo
 - **Fiscal, practicality, and implementation** – options will be assessed on how well they balance value for money as well as ease and feasibility of implementation – especially around workforce and resourcing considerations.
36. These criteria have not been explicitly weighted; however, a failure to achieve a positive score in relation Tiriti o Waitangi and Human rights would significantly reduce an option's chances of being the preferred approach.

What scope will options be considered within?

37. The RIS for the first tranche of Cabinet decisions outlines the scope within which the options for a new legislative framework for the compulsory mental health system were considered.
38. In particular, in 2019, Cabinet agreed to repeal and replace the current Mental Health Act [SWC-19-MIN-070 refers]. The Minister of Health outlined to Cabinet that the overall objectives of new legislation must be to ensure individual and whānau human rights are protected and respected, and that equity is improved. The Minister also stated that the use of compulsory treatment under new legislation must also be limited, with mechanisms in place to closely monitor its use. This presumes that new mental health legislation will be developed. This means we have not undertaken a first principles review of the nature and scope of new legislation.
39. Options have been considered in the context of the significant transformation being undertaken of the approach to mental health and addiction in Aotearoa New Zealand. There are non-regulatory options that will contribute to our overall goal, for example, through the continued expansion of mental health and addiction services and workforces through recent Budget investments and the development and implementation of the Oranga Hinengaro System and Service Framework, which sets

the intended direction for and availability of mental health and addiction services with a 10-year horizon.

40. In addition to these factors, this second tranche of options has been considered within the parameters of Cabinet's decision to retain the general administrative machinery provided for in the current Mental Health Act. The machinery includes mechanisms for monitoring and review, and roles required to discharge functions and powers related to compulsory care, subject to some updating [SWC-22-MIN-0234 refers].

What options are being considered?

41. Options for addressing the problem have been considered in relation to the following four key policy issues:
- Issue 1: roles, responsibilities, and related powers
 - Issue 2: upholding rights and protections
 - Issue 3: reviewing and challenging decisions
 - Issue 4: monitoring and reporting.

Roles, responsibilities and related powers

Option One – Status Quo

42. There are a number of issues with the current Mental Health Act that affect the ability of the Director of Mental Health (the Director), district inspectors, and Police to carry out their roles and responsibilities effectively.
43. Further clarity is also required in relation to the responsibilities and powers of the new independent support roles that Cabinet approved for inclusion in the legislation, in the first tranche of decisions. Independent support is a key aspect of the supported decision-making approach provided for in the Tranche 1 decisions.

The Director of Mental Health

44. The Director has various statutory functions and powers under the current Act, including:
- responsibility for the general administration of the Act under the direction of the Minister and the Director-General of Health
 - all the powers of the Director-General of Health to arrange for the inspection of any hospital, ward or unit where compulsory assessment and treatment occurs
 - the ability to instigate an inquiry by a district inspector into systemic matters related to the use of compulsory assessment and treatment
 - the ability to require regular reporting from statutory officers on the exercise of their functions and powers, including district inspectors and Directors of Area Mental Health Services.
45. The Director's ability to require statutory officers to act in certain circumstances is limited under the current legislation. For example, changes may need to be implemented following an investigation or inquiry by a district inspector, or in response to known issues with practice. The Director can, and does, informally ask for action to be taken by statutory officers. However, compliance can be variable, and this has resulted in known issues not being addressed. Some examples are how recommendations for an apology has been made that have not been complied with, as well as recommendations relating to staffing and facilities that have not been undertaken

District inspectors

46. District inspectors are statutory officers that operate independently of health services under the oversight of the Director. They are appointed by the Minister of Health on the advice of the Director. They can hold office for up to three years and can be reappointed. The Mental Health Act provides that only barristers and solicitors can be appointed as district inspectors. The *Guidelines for the Role and Function of District Inspectors Appointed under the Mental Health Compulsory Assessment and Treatment Act* requires them to maintain their law practice and to limit their district inspector duties to a maximum of 30 percent of their normal workload (including pro bono work).
47. Additional eligibility criteria, and the processes for selecting, appointing, and reappointing district inspectors are set out in the District Inspector Guidelines, which are issued under section 130 of the Mental Health Act and have the status of secondary legislation.
48. The Mental Health Act provides that the role of district inspectors is to ensure that people subject to compulsory assessment and treatment are advised of their rights, complaints of breaches of their rights are investigated, and services are improved if required for their rights to be upheld.
49. They can provide tāngata whaiora with information about the Mental Health Act, but they cannot act as the person's legal adviser or legal representative in any related proceedings. Nor can they act as the person's non-legal advocate.
50. On occasion, a district inspector is brought in from another district to help resolve a formal complaint where necessary to preserve the relationship the local district inspector has with the health service. The legislation does not make express provision for this and while it can be done consistently with the legislation, this is not a straightforward exercise and requires seeking Ministerial approval.
51. Some submitters to the consultation in 2021/22 had a perception that district inspectors are not independent from the health services they oversee. Others said they were not aware of what district inspectors do and do not do, and what tāngata whaiora rights are in relation to seeing a district inspector and having a complaint investigated by them. There was also a view that district inspectors may not be best placed to ensure tāngata whaiora Māori have their rights upheld, including the right to have their culture respected. Some stakeholders have also queried whether the requirement for district inspectors to be lawyers should be retained.

Special patients

52. Currently under the Mental Health Act, the Minister of Health has a decision-making role in relation to some tāngata whaiora who are detained in a hospital following an order under the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP Act) or transferred from a prison to receive mental health care. These tāngata whaiora are referred to under the Mental Health Act as 'special patients'.
53. The Minister of Health makes decisions (under the Mental Health Act) about special patient leave from hospital for periods longer than seven days (long leave) and (under the CPMIP Act) on eventual change of status or discharge.

Independent support

54. On 12 December 2022 Cabinet agreed, in relation to the supported decision-making proposals, that the legislation provide for independent support to assist and support a person to, for example, exercise their rights and participate in decisions being made about them and that this support be independent of other decision-makers set out in legislation [SWC-22-MIN-0234 confirmed by CAB-22-MIN-0581].

Option Two – New statutory powers

55. The Bill would provide for new statutory powers that are necessary to enable the Director, district inspectors and independent advocates to carry out their role and perform related functions and duties. For the Director and district inspectors, the proposed powers are additional to their existing powers under the Mental Health Act.
56. The proposed new statutory powers are:
- Director of Mental Health:
 - a) to issue directions to service providers to rectify issues
 - b) to authorise district inspectors to act outside their usual areas
 - District inspectors able to rely on advice from Māori experts
 - An independent body making decisions of special patient leave and change of status, rather than the Minister.

The Director of Mental Health

57. Under the current Mental Health Act, a district inspector or Review Tribunal can make recommendations following an inquiry or investigation into a complaint of a breach of rights under the legislation (section 75). The Director of Area Mental Health Services is then responsible for taking “all such steps as may be necessary to rectify the matter”. We propose the Bill would, where these recommendations have not been adequately addressed, enable the Director to issue directions to health service providers³ to require them to set out publicly how they will address recommendations. This is similar to powers in other legislation, which allow the regulated party to determine the specific action to be taken to address an issue.
58. This proposal is intended to address a gap in the current legislation by providing the Director with a more graduated set of intervention powers to ensure recommendations of investigated complaints are addressed. This approach would ensure there are appropriate and proportionate mechanisms and escalation pathways built into new legislation. All compulsory treatment is provided by publicly owned health entities or under contract to them, meaning further action can be taken using the provisions of the Crown Entities Act or Health and Disability Services (Safety) Act.
59. The Bill would also give the Director the ability to authorise the use of a warrant in another district in situations where a district inspector has been asked to take over a section 75 complaint investigation in order to preserve the relationship between the health service and the district inspector from whom the investigation has been transferred. Currently this has to be approved by the Minister of Health. As this practice supports the district inspectors’ independence, it should be made more efficient and expedient. The alternative option would be to warrant all district inspectors nationally. This option would have unacceptable impacts on their role, for example the requirement that they visit all services in their area regularly.

District inspectors

60. The Bill would give district inspectors the ability to obtain and rely on advice from Māori experts to assist them in upholding the rights of tāngata whaiora Māori, and to obtain advice from other experts, for example, those with expertise in other cultures or disability issues, to assist them with upholding rights in relation to those groups. This will help to address competency gaps for district inspectors in these areas. We propose

³ Any health service responsible for delivering compulsory assessment and care to tāngata whaiora under the Mental Health Act.

to establish a committee of Māori experts, appointed by the Director of Mental Health, who will be able to provide assistance and advice on an ad-hoc basis.

61. Allowing additional powers for district inspectors will resolve many of the issues that were raised by submitters during consultation, such as district inspectors lacking independence, confusion of tāngata whaiora about the role, and issues with the complaints process. The Bill will specify that district inspectors must act independently and impartially, which will help to address the perception that district inspectors are not independent from health services and that the complaints process is biased.
62. Legislation will also be amended to omit 'locality' from s94A(2), to align with current practice and make it clear that district inspectors are independent of all health services, not just the ones in their district. The Bill will clarify the roles and responsibilities of district inspectors, especially the monitoring role, as well as being clear that a district inspector is not an advocate, as this is a common misunderstanding that needs to be addressed. These changes will make it easier for people to know and understand what a district inspector can and cannot do to help them so that they can make more informed decisions about whether and when they need to seek legal advice or representation, or advice and support from an independent support person (discussed below).

Special patients

63. The legislation would shift responsibility for any decisions relating to special patients' leave and change of status from the Minister of Health to an independent body. The two options considered are:
 - the Court
 - a Special Patient Review Tribunal.
64. A Special Patient Review Tribunal would be established as a Review Tribunal under the Mental Health Act, having carried over the existing provision in section 101 of the Mental Health Act, which allows the Minister to establish Review Tribunals for the purposes of the Act.
65. In its 2010 report, *Mental impairment Decision-Making and the Insanity Defence*, the Law Commission recommended that the Minister of Health not be involved in decisions relating to special patient leave or change of status. This was on the grounds of:
 - avoiding politicisation
 - ensuring the duration of detention was based on clinical need, rather than being punitive
 - procedural limitations meaning patients did not receive a hearing.
66. The Commission recommended a new tribunal be established under the Criminal Procedure (Mentally Impaired Persons) Act to consider cases under the:
 - Mental Health Act
 - Intellectual Disability (Compulsory Care and Rehabilitation) Act.
67. Our consideration has been limited to special patients under the Mental Health Act. Shifting responsibility for decisions relating to special patients' change of status from the Minister of Health will require amendments to the CPMIP Act, which is administered by the Ministry of Justice. Discussions are ongoing between the Ministries of Health and Justice on whether these decisions should in fact be made by a new tribunal and if so, on the tribunal's composition, structure, and procedures. The Ministries of Health and Justice will provide advice to their Ministers on this later in 2023. For the purposes of the analysis in this RIS, we have assumed a tribunal and estimated costs accordingly. This is because a tribunal would impose financial costs, while the Courts

would be felt in additional workload, and impact on scheduling for other work, rather than a direct financial cost.

PROACTIVELY RELEASED

How do the options compare to the status quo/counterfactual?

	Option One – Status Quo	Option Two – New statutory powers
	District inspectors not entitled to rely on advice; Director has no intervention power where a service does not respond to a complaint; District inspectors must have ministerial authorisation to act outside their districts	Statutory powers for a district Inspector to rely on advice from a Māori expert; the Director of Mental Health to require a service provider to publish a statement outlining how they will address an identified issue; and the Director of Mental Health to authorise a district inspector to act outside their district.
Te Tiriti o Waitangi	0	<p>+</p> <p>Improvement on the status quo due to:</p> <ul style="list-style-type: none"> Ability for district inspectors to obtain and rely on advice from a Māori expert when investigating complaints in relation to tāngata whaiora Māori supports the principles of equity, options and active protection. Potential for more equitable outcomes for Māori as the new powers proposed for the Director will provide a stronger incentive for providers to meet Te Tiriti obligations, particular related to equity, options and active protection and their duties regarding the rights of tāngata whaiora Māori under the Act. In situations where the incentive is not effective, the Director will be able to intervene.
Effectiveness	0	<p>+</p> <p>Provides the Director with additional tools to incentivise and enforce compliance that enables a more proportionate response in situations where the prosecution threshold is not met or where prosecution would be a disproportionate response to the nature and severity of the breach.</p>
Human rights	0	<p>+</p> <p>The Director's new power will provide a stronger incentive for providers to carry out their duties to give effect to people's human rights.</p> <p>The district inspector's power to obtain advice from experts in relation to matters such as disability rights will strengthen the upholding of human rights.</p>
Sustainability and durability	0	<p>+</p> <p>Will ensure the Director can require health service providers to give public notice of how the service intends to address issues raised in complaints where the service has not adequately responded to a District Inspector's recommendations.</p>
Fiscal, practicality and implementation	0	<p>-</p> <p>Administration of the new powers for the Director will require some additional costs compared to the status quo, but these are not expected to be significant and will be met through baseline. Implementation of changes in response to directions are expected to be met by the relevant health service provider or statutory official.</p> <p>It may also be difficult to find Māori experts to advise district inspectors given the widespread demand across government for people to fill these types of roles.</p>
Overall assessment	0	3

Key:

- ++ much better than the status quo
- + better than the status quo
- 0 about the same as the status quo
- worse than the status quo
- much worse than the status quo

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

68. Option two is the best option, as while there will be a slight increase in costs, it is significantly better than the status quo in nearly all assessments. The new statutory powers will benefit tāngata whaiora by promoting independence and support, as well as ensuring service providers are operating to the best model of care.

PROACTIVELY RELEASED

Upholding Rights

Option One – Status Quo

69. Part 6 of the Mental Health Act sets out the rights of people subject to compulsory assessment and treatment under the Act. These rights supplement the rights affirmed by the New Zealand Bill of Rights Act 1990 and those set out in the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (the Code). The rights set out in the Mental Health Act are:
- general rights to information
 - respect for cultural identity and personal beliefs
 - right to treatment
 - right to be informed about treatment
 - further rights in case of visual or audio recording
 - right to independent psychiatric advice
 - right to legal advice
 - right to company, and seclusion
 - right to receive visitors and make telephone calls
 - right to receive and right to send letters and postal articles.
70. In addition to the rights in Part 6, section 44 of the Mental Health Act sets out the right of special patients to be given the same care, treatment, training and occupation that they would be given if they were subject to a compulsory treatment order.
71. The Mental Health Act limits the right confirmed by the Bill of Rights Act to refuse to undergo medical treatment. While the rights in Part 6 protect people against the improper application of these limitations, under current settings, electro-convulsive treatment (ECT) can lawfully be given to a competent patient who does not consent to it when a psychiatrist appointed to assess the person's interests by the Review Tribunal considers it is in the interests of the person to receive it. This has been criticised by stakeholders as something that should not be permitted. For example, a petition was presented in March 2022 seeking a prohibition on ECT.⁴ We note that in 2020/21, four competent patients received ECT against their will, out of 259 total patients given ECT.
72. The rights in the Mental Health Act do not apply to tāngata whaiora receiving voluntary care and treatment. While voluntary tāngata whaiora retain their rights contained in the Code and other instruments, submitters noted that sometimes voluntary tāngata whaiora have been locked in wards, or secluded. In addition, voluntary tāngata whaiora do not have access to the complaints process set out in the Act, and their circumstances cannot be reviewed by district inspectors.
73. The Mental Health Act provides a process for making a complaint in relation to a breach or omission of rights. Tāngata whaiora, or other complainants, are entitled to

⁴ Petition 2020/232 of Michael Richards https://www.parliament.nz/mi/pb/petitions/document/PET_97992/petition-of-malcolm-richards-end-electroconvulsive-therapy

make a complaint to a district inspector or an official visitor for investigation. The Act provides that:

- if satisfied after investigation that the complaint has substance, the district inspector must make recommendations to the Director of Area Mental Health Services, who must do whatever is necessary to remedy the matter
- the complainant can refer the matter to a Review Tribunal if they are not satisfied with the outcome of the district inspector's investigation.

74. Some submitters raised concerns around accessibility and inclusivity of the complaints process, as well as timeliness. They were also concerned that district inspectors did not have the ability to enforce the recommendations they made to resolve complaints, in the event that the health service did not follow the recommendation.
75. In addition to the complaints process set out in the Act, tāngata whaiora can use several different complaints processes including other external bodies such as the Health and Disability Commissioner, the Privacy Commissioner, and the Ombudsman. However, the Mental Health Act does not provide for complaints received by district inspectors to be transferred to the Health and Disability Commissioner or other complaints bodies where there is overlapping jurisdiction.
76. Submitters considered that tāngata whaiora should be given better information about how these different processes work, how they relate to one another, and how to access them.

Option Two – Strengthen rights and related complaints process

Strengthen rights

77. Under this option, the legislation will include:
- duties on specified persons to uphold rights
 - adding the right for tāngata whaiora to be supported to make decisions and express their views, including any communication assistance required
 - updates and enhancements to some existing rights, for example:
 - a) clarifying that the right to seek legal advice is additional to the right to see a district inspector
 - b) the right to send and receive mail should include electronic communication, as currently provided for in guidelines, and be subject to the same limitations that currently apply when sending and receiving mail
 - c) a duty to take reasonable steps to ensure that information provided is understood.
78. In relation to restricted treatments, the legislation will:
- only allow the use of ECT where a person:
 - a) has capacity to consent and gives their informed consent in writing to the treatment (in which case they would not be subject to compulsory treatment), or
 - b) does not have a valid advance directive in place refusing the use of ECT, or
 - c) lacks capacity to consent and a second opinion provider agrees to the use of ECT.

79. We appreciate there are strong views about ECT among stakeholders, especially among tāngata whaiora. We intend legislative provision allowing people to refuse consent, including via an advance directive, and to have that refusal respected. However, there remains a place for ECT as an effective treatment for severe neuropsychiatric conditions where other interventions have failed.
80. Where a tangata whaiora does not have capacity to consent, we propose a change so that a second opinion must be obtained, which is not presently the case. The requirements to consult whānau and involve them and the tangata whaiora in care planning will also support the use of effective treatment, in line with the will and preferences of the tangata whaiora. For the avoidance of doubt, the use of ECT would be prohibited, with no exception for urgent treatment, where a person:
- a) has capacity to consent and refuses to accept the treatment, or
 - b) has a valid advance directive in place noting their refusal to ECT, or
 - c) lacks capacity to consent and a second opinion provider disagrees that ECT should be used.
81. There are likely to emerge forms of treatment in the future which may warrant similar restriction in the context of compulsory treatment. We propose that new legislation include regulation-making powers to enable regulations to be made to restrict the use of other forms of treatment where necessary.

Extend rights to voluntary patients

82. The legislation would extend the Part 6 rights, with the exception of rights that are only relevant to compulsory tāngata whaiora, such as review and appeal rights, and the rights proposed in relation to supported decision-making, to tāngata whaiora receiving voluntary care and treatment in inpatient and community long-term residential care services. These tāngata whaiora would also be under the oversight of district inspectors and have access to the complaints process provided under the legislation.
83. This would address concerns that voluntary tāngata whaiora in these settings could be at risk of coercion for example, to consent to treatment for fear of being placed under compulsory treatment orders, or that they might wrongly be placed under a compulsory treatment order.

Improve the complaints process

84. The legislation would:
- place a duty on the responsible clinician⁵ to ensure tāngata whaiora are informed of the internal complaints processes required under the Code and external complaints processes and advocacy bodies
 - provide for complaints to be transferred to other complaint bodies where there is overlapping jurisdiction
 - include principles to guide district inspectors in investigating complaints, and the Review Tribunal in reviewing complaints, including principles such as:
 - a) fairness, accessibility (with particular regard to tikanga Māori), timeliness, efficiency, and resolution at a level appropriate to the nature and seriousness of the matter
 - b) upholding the mana of the parties involved and promoting restorative practices

⁵ The responsible clinician is the person with overall responsibility for the patient.

- c) ensuring that all tāngata whaiora, including those with physical, sensory, learning and other disabilities, can fully access and participate in the process
 - enable timeliness requirements to be set in secondary legislation in relation to complaints made under the legislation
 - require regular anonymised public reporting of complaints made under the legislation.
85. Submitters' concern about district inspectors not being able to enforce complaint resolution recommendations is addressed by the proposal for the Director to have powers to issue directions to publish notices setting out how a service will address recommendations. This power can be used by the Director to encourage a service to implement changes. Compulsory services are delivered by, or under contract to publicly funded health entities, so there is a range of intervention options available via the Crown Entities Act and Health and Disability Services (Safety) Act.
86. We considered a power for the Director to direct particular action in response to identified issues but discounted it. This was because of the need to:
- ensure accountability sat in the correct place. If the Director was effectively making operational decisions, they would become accountable for them
 - ensure separation between monitoring and operational activity. Under this option, the Director would be making operational decisions, and would not be in a position to effectively monitor them.

How do the options compare to the status quo/counterfactual?

	Option One – Status Quo	Option Two – strengthen rights and improve complaints process		
		Expand, enhance and clarify compulsory tāngata whaiora rights	Extend rights to voluntary tāngata whaiora	Improve the complaints process
Te Tiriti o Waitangi	0	<p>+</p> <p>Specification of duties and duty holders is likely to incentivise duty holders to perform the duties necessary for tāngata whaiora Māori to exercise their rights and have them upheld. In particular, the right to be treated with respect for their culture.</p>	<p>++</p> <p>Significant improvement on the status quo because it extends all Te Tiriti-related benefits of other workstream proposals to tāngata whaiora Māori voluntary patients, who would otherwise not be covered by the rights and related protection mechanisms under the legislation.</p>	<p>++</p> <p>Significant improvement on the status quo as processes will be more accessible to and inclusive of Māori, and there will be requirements to improve timeliness, and principles to uphold the mana of the parties involved, which could result in more equitable outcomes for Māori.</p>
Effectiveness	0	<p>+</p> <p>Some improvement on the status quo. This option will make the duties explicit and make it easier to see where accountability lies when rights are breached.</p>	<p>++</p> <p>Significant improvement on the status quo in relation to achieving the objective of ensuring that voluntary tāngata whaiora at risk of coercion are protected by the rights framework under the legislation. It also reinforces the care, treatment and support proposals by providing rights protections for those transitioning out of compulsory care and treatment.</p>	<p>++</p> <p>These changes will make these processes much more accessible to tāngata whaiora which could result in increased uptake. Timeliness requirements could improve outcomes for tāngata whaiora where quick decisions are required to avoid rights breaches occurring or continuing. Public reporting will improve transparency and accountability and support feedback loops for continuous improvement of the process.</p>
Human rights	0	<p>++</p> <p>Some improvement on the status quo by further restricting the use of ECT without consent and enabling further restrictions to other restricted practices through regulations.</p> <p>Specifying duties incentivises duty holders to perform the duties necessary for tāngata whaiora to exercise their rights and have them upheld.</p> <p>Requirement to support tāngata whaiora to make decisions and to take reasonable steps to make sure information is understood is likely to make it easier for tāngata whaiora to know and understand what their rights are, what has to happen for them to exercise those rights, and who is responsible for making that happen.</p>	<p>++</p> <p>Significant improvement on the status quo because it brings people receiving voluntary care and treatment in inpatient settings under the legislation's rights framework which is broader than the range of rights that they enjoy under the Bill of Rights Act. It also brings them under the oversight of the district inspectors and Director who can use their enforcement powers to uphold those rights.</p>	<p>+</p> <p>Some improvement on the status quo as people will be better able to have their human rights upheld through this scheme and the Director's ability to refer complaints to other schemes will make it easier for them to, for example, use the Health and Disability Commission scheme in situations where the complaint is more appropriately dealt with by that scheme.</p>
Sustainability and durability	0	<p>+</p> <p>Including rights to embed supported decision-making and recognising the use of supported decision-making approaches for ECT supports the direction we are seeking to achieve in a new Mental Health system, and in particular, one of the key intents that <i>He Ara Oranga</i> set out in its recommendation for the new legislation.</p>	<p>++</p> <p>Significant improvement on the status quo because it supports sustained change in the direction sought for mental health and addiction system transformation by providing human rights protections that will support people and should limit the number of people who come under the legislation.</p> <p>It also reduces inequities between those at risk of coercion in the voluntary system and those who enjoy the protection of the Mental Health Act rights framework in the compulsory system.</p>	<p>+</p> <p>Some improvement on the status quo as this option is more consistent with the policy and legislative instruments referred to in this criterion and improves transparency and accountability through anonymised public reporting.</p>
Fiscal, practicality and implementation	0	<p>-</p> <p>Likely to be some additional costs associated with supported decision-making rights complaints. There will also be marginal costs in relation to staff training as they would be expected to assist now in upholding rights (ie, specific boards, changes to information and education material). Relatively straightforward to implement but there may be some aversion to having the duty holders specified in legislation.</p>	<p>-</p> <p>Likely more expensive than the status quo, but this cost has been very difficult to determine, as it is hard to estimate how many voluntary tāngata whaiora would need or want to use the resources of a district inspector. However, in many cases the rights set out reflect best practice and should be actions that practitioners/services should be doing anyway.</p> <p>Will have flow on effects for resourcing for district inspectors and the Director's office to carry out their duties to uphold rights.</p>	<p>-</p> <p>Likely to be more expensive and administratively complex than the status quo. However, because this option leverages existing institutional arrangements, related costs and complexity will likely be less than those that would apply if a new complaints scheme was established.</p> <p>Reliance on guiding principles rather than prescription trades off certainty for the flexibility to tailor processes to the specific needs and circumstances of complainants.</p>

	Option One – Status Quo	Option Two – strengthen rights and improve complaints process		
		Expand, enhance and clarify compulsory tāngata whaiora rights	Extend rights to voluntary tāngata whaiora	Improve the complaints process
	0	4	7	5

Key:

- ++** much better than the status quo
- +** better than the status quo
- 0** about the same as the status quo
- worse than the status quo
- much worse than the status quo

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

87. Embedding a supported decision-making process to better enable people to make their own decisions is a key pillar of the proposed new legislation. Proposals to strengthen rights and improve the complaints process is a key part of achieving the direction of new legislation. Submitters to the public consultation have raised issues with the current complaints process including accessibility and inclusivity of the process, as well as timeliness issues. It is also often hard for tāngata whaiora to navigate this process and they are often not sure how the different processes work, how they relate to one another, and how to access them. Additionally, under the status quo, rights are not extended to voluntary tāngata whaiora.
88. Therefore, option two is the preferred option. While the option has an increase in costs, this is outweighed by the rest of the criteria and the benefits. This option meets all the objectives, and ensures that all people using mental health services, whether voluntary or under a Compulsory Treatment Order receive the same improved rights and are supported through the complaints process.

PROACTIVELY RELEASED

Reviewing and challenging decisions

Option One – Status Quo

Second opinion assessments

89. Under the Mental Health Act, if a person does not consent to treatment, treatment can only continue after the first month if a psychiatrist appointed by the Review Tribunal determines that the treatment is in the interests of the tangata whaiora. Only psychiatrists can provide second opinions about the interests of tangata whaiora under the current legislation.
90. The Mental Health Act is silent as to the independence of the psychiatrist providing the second opinion, although guidelines to the Act provide that they should not work in the same team as the responsible clinician. Some submitters raised concerns that psychiatrists providing second opinions are not always perceived to be independent from the responsible clinician.
91. The current legislation is silent as to how long a second opinion remains in effect, and it does not prescribe a process for situations where the second opinion assessor does not agree that the proposed treatment is in the interests of the tangata whaiora. Further, the Act does not allow for tangata whaiora to challenge a second opinion assessment.
92. Greater specificity in legislation is needed to clarify, strengthen, and increase transparency and quality with respect to the second opinion process.

Review Tribunal membership and procedures

93. Under the current Mental Health Act, the Review Tribunal consists of three members: a lawyer, a psychiatrist, and a third member who is referred to in practice as a 'community member'. There are also 19 deputy members, who act for the equivalent member where that member is unable to perform the duties of the office. Community members are generally people with significant experience of the Act, including through lived experience or as a friend or whānau member of a person with lived experience. The Review Tribunal elects one of its members as a convenor. Review Tribunal members are appointed by the Minister of Health for a term of three years.
94. Although the Review Tribunal usually sits as a panel of three, a fourth member is occasionally co-opted to the panel where specialised knowledge or expertise is needed. Co-opting an additional member is mandatory where the panel does not include a member of the same ethnic identity or gender as the applicant, and they request that the Review Tribunal ensures representation.
95. Submitters to the public consultation saw the inclusion of Māori in key decision-making roles as an opportunity for new legislation to reflect Te Tiriti o Waitangi. There is also opportunity to strengthen the voice of tangata whaiora and their whānau and include a broader range of health professionals.

Option Two – Improve processes for reviewing and challenging decisions

Second opinion assessments

96. In order to clarify, strengthen, and increase transparency with respect to the second opinion process, under this option, the new legislation will:
 - allow a wider range of health practitioners to give the second opinion, rather than requiring a psychiatrist, with the Review Tribunal determining suitability
 - require second opinion givers to be independent from the original decision-maker and have expertise in the proposed treatment

- provide for second opinion assessments to be undertaken by audio visual link to ensure an adequate national pool of assessors and timely assessments
 - provide that a second opinion assessment lasts only while a person's condition and treatment remain consistent within the scope of the opinion, and, in any event, for a period no longer than the duration of the compulsory treatment order
 - allows the responsible clinician to appeal to the Director of Area Mental Health Services (DAMHS) for a final decision. If the DAMHS is not an approved assessor with appropriate expertise, they must refer the matter to the appropriate expert. Those provisions reflect current guidelines. The tangata whaiora would also be able to appeal to the DAMHS.
97. While the guidelines to the current Act do require that the second opinion provider not work in the same team as the responsible clinician, we consider that there is benefit in strengthening and clarifying the independence requirement in the principal legislation. This option responds to stakeholder feedback that the second opinion provider was not perceived to be independent from the responsible clinician.
98. Expanding the categories of persons who can undertake second opinions will support a move away from the psychiatrist/medical practitioner-dominated model/approach, which was also a concern raised in submissions.

Review Tribunal membership and procedures

99. The proposal would expand membership of the Review Tribunal to include the following members.
- A lawyer.
 - An appropriately qualified mental health practitioner.
 - A Māori member appropriately knowledgeable in tikanga and mātauranga Māori.
 - A tangata whaiora who has lived experience of being subject to compulsory mental health assessment and treatment.
100. The new legislation would also provide for the mandatory co-opting of a person with a disability when a tangata whaiora with a disability requests that the Review Tribunal do so (co-opting an additional member is already mandatory under the same terms with respect to ethnic identity and gender).
101. To ensure the Review Tribunal can be convened and decisions made in a timely way, and where there are exceptional circumstances, we recommend that new legislation should provide:
- for a minimum quorum of three, with at least one lawyer member and one appropriately qualified mental health practitioner member (as stated above, co-opting an additional member will continue to be mandatory if the panel does not include a member of the same ethnic identity or gender as the tangata whaiora and they request that the Review Tribunal do so)
 - that where a decision is split and members are unable to reach consensus, the convenor of the Review Tribunal will make the final decision.

102. As discussed above in relation to improving rights provisions, it will be expected that tāngata whaiora are made aware of their ability to request co-opted representation on the Review Tribunal where relevant.
103. We further recommend that the principles referred to in paragraph 83 above guide the Review Tribunal in all its procedures.

PROACTIVELY RELEASED

How do the options compare to the status quo/counterfactual?

	Option One – Status quo	Option two – improve processes for reviewing and challenging decisions	
		Changes to second opinion assessment requirements and processes	Changes to Mental Health Tribunal membership and processes
Te Tiriti o Waitangi	0	<p>+</p> <p>Broadening the range of second opinion assessors and requiring they have appropriate expertise will support the ability to use assessors with Māori cultural expertise/competency.</p>	<p>+</p> <p>Including a Māori member on the Review Tribunal and introducing guiding principles for the Review Tribunal will assist in ensuring new legislation has a te ao Māori focus, and ensures that Te Tiriti principles, especially around equity are met.</p>
Effectiveness	0	<p>++</p> <p>Strengthens and clarifies the second opinion process, provides more independence and provides additional transparency at appropriate stages while the person is subject to compulsory treatment.</p> <p>Provides greater clarity in situations where clinicians do not agree about proposed treatment, or where tāngata whaiora do not agree with the second opinion assessment.</p>	<p>+</p> <p>Expanding the Review Tribunal's membership will ensure a more balanced approach to the Review Tribunal's consideration of applications. Similarly, changing the clinical membership from a psychiatrist to a broader range of health practitioners will move away from a psychiatry-centric approach (raised as a concern in submissions), and assist with workforce constraints (a known issue).</p> <p>Review Tribunal decisions are generally made by way of consensus, but some are more contentious and can require a vote to be taken. Having an even number of members has the potential to result in a situation where members are divided 2:2. To mitigate this risk, the proposal includes the ability for the convenor of the Review Tribunal to make the final decision. Whilst not ideal, having the convenor make the final decision will only be possible in exceptional circumstances and following a process whereby members seek to reach consensus.</p>
Human rights	0	<p>+</p> <p>Compulsory mental health treatment has significant human rights implications, in particular on the right to refuse medical treatment. The proposal will ensure an appropriate second opinion process is in place to ensure any unconsented compulsory treatment is in the interests of the tāngata whaiora and that the opinion is provided by an independent person.</p> <p>It will also clarify that a second opinion is valid only as long as the treatment and condition of the tāngata whaiora remains the same, and in any case, for no longer than the duration of the order.</p>	<p>+</p> <p>The proposal provides for the mandatory co-opting of a person with a disability where the tāngata whaiora has a disability and there is no person on the Review Tribunal with a disability, and the tāngata whaiora requests that the Review Tribunal do so (co-opting an additional member is already mandatory under the same terms with respect to ethnic identity and gender). This ensures that people have the representation available that they need, and legislation is being more inclusive of all ethnicities and abilities.</p>
Sustainability and durability	0	<p>+</p> <p>Broadening the categories of people who can undertake second opinions will support a move away from a psychiatry-centric approach (raised as a concern in submissions) and broaden the workforce of people who can undertake assessments (a known issue).</p>	<p>+</p> <p>Allowing a broader range of people to serve on the Review Tribunal will assist with workforce issues while still ensuring there is an appropriate range of expertise.</p>
Fiscal, practicality and implementation	0	<p>-</p> <p>More frequent second opinions are likely to have cost and resource implications for health practitioners and for Directors of Area Mental Health Services in providing a final opinion at the request of tāngata whaiora (under the existing guidelines this is currently only available</p>	<p>-</p> <p>There will be additional costs to the increase the Review Tribunal's membership from three to four, although some</p>

	Option One – Status quo	Option two – improve processes for reviewing and challenging decisions	
		Changes to second opinion assessment requirements and processes	Changes to Mental Health Tribunal membership and processes
		<p>to the responsible clinician), as we are anticipating these changes will lead to an increase in the use of second opinions.</p> <p>There is no data available on the number of second opinions currently undertaken under existing legislation as this is managed at service level. We do anticipate that there will be an average net increase of second opinions undertaken as their maximum applicability will now be limited to the duration of the order. However, other proposals such as the amended criteria for compulsory treatment and the introduction of supported decision-making are expected to reduce the frequency of unconsented treatment, and expected to limit the overall impact of the proposal to some extent.</p> <p>Second opinion providers are expected to have a high level of expertise in the treatment being proposed. As such, potential resource implications will likely only have a material impact on a relatively small group of health practitioners with known workforce shortages. This is something that will need to be considered as part of implementation planning to ensure an adequate workforce is available to support the new process.</p>	<p>of these costs may be offset due to the reduced need for co-opted members.</p> <p>There could be difficulties in hiring Māori members, which is something that has been challenging in the past. This risk could be compounded by the establishment of other roles in the new legislation that require a similar skill set as the Māori member on the Review Tribunal. To ensure the Review Tribunal is able to be convened in a timely manner, a minimum quorum of three will be introduced. In addition, recruitment challenges will be carefully considered during implementation planning to ensure there is an adequate workforce available, potentially supported by training opportunities and using different ways of attracting applicants to the position.</p>
Overall assessment	0	4	3

Key:

- ++ much better than the status quo
- + better than the status quo
- 0 about the same as the status quo
- worse than the status quo
- much worse than the status quo

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

104. There are significant human rights implications associated with compulsory mental health assessment and treatment, and new legislation must provide people with appropriate protections, including fair and transparent legal processes and the ability for individuals to effectively challenge decisions about their care. The current Act has administrative machinery that will be required in the new legislation, but the proposed amendments will clarify and strengthen these processes and provide additional transparency at appropriate points while the person is subject to compulsory assessment and treatment. Option two is therefore our preferred option.

Monitoring and reporting

Option One – Status Quo

105. The Director of Mental Health publishes an annual report on matters relating to the administration of the current legislation. This is not a mandatory requirement in the current Mental Health Act.
106. There is variable compliance with requests by the Director for information from health providers and statutory officials. The Act lacks clarity with respect to the Director's power to request information outside of the minimal reporting obligations contained in the current Act, and there are limited enforcement powers available to address non-compliance.

Option Two – Strengthen monitoring and reporting

107. To ensure more transparency, and to strengthen and clarify reporting obligations, this proposal will:
 - require the Director of Mental Health to report annually on specified matters
 - prescribe in regulations the matters that must be reported on (we anticipate this will include, for example, minimising the use and duration of compulsory care, seclusion and restraint, and the monitoring of equity outcomes, particularly for Māori)
 - clarify that statutory officers and health providers must report on matters as requested by the Director.

How do the options compare to the status quo/counterfactual?

	Option One – Status quo	Option Two – Strengthen monitoring and reporting
		<ul style="list-style-type: none"> - Director to report annually on matters prescribed in regulations - Clarify reporting obligations for statutory officers and health services
Te Tiriti o Waitangi	0	+ Strengthened reporting requirements will increase transparency with respect to compliance with Te Tiriti obligations and ensure transparent monitoring of outcomes for Māori under the new legislation. Public reporting will support Māori decision-making, and allow them to respond to trends, including through iwi-Māori Partnership Board input into service planning.
Effectiveness	0	+ Strengthening reporting obligations and requiring that the Director's annual report be public will increase transparency regarding how the new legislation is administered and the extent to which it is achieving its policy intent.
Human rights	0	+ The use of compulsory care has significant human rights implications, for example with respect to the rights to liberty, to refuse medical treatment, and freedom from discrimination. Monitoring and oversight are a critical part of the regulatory system, and the proposal will support increased transparency and monitoring of human rights implications in the new legislation.
Sustainability and durability	0	+ The ability to prescribe the matters that must be reported on in regulations will ensure areas of future focus can be adequately monitored with the flexibility to amend/add matters as required to reflect how the Act is operating over time.
Fiscal, practicality and implementation	0	- There may be some increased costs and resources required to ensure consistent national reporting for the regulator/s (i.e. the Ministry of Health and Te Whatu Ora) and at service level. Costs and implementation requirements will depend on the matters that need to be reported on and any technical needs and system changes. These matters will be considered in the development of regulatory instruments.
Overall assessment	0	3

Key:

- ++** much better than the status quo
- +** better than the status quo
- 0** about the same as the status quo
- worse than the status quo
- much worse than the status quo

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

108. Option two is the preferred option, as it will allow for increased transparency in reporting and also clarify and strengthen reporting obligations. While there will be some increased costs and resources, this option performs strongly against the rest of the objectives, and is significantly better than the status quo.

What are the marginal costs and benefits of the option?

Affected groups <i>(identify)</i>	Comment <i>Nature of cost or benefit (eg, ongoing, one-off), evidence and assumption (eg, compliance rates), risks.</i>	Impact <i>\$m present value where appropriate, for monetised impacts; high, medium or low for non-monetised impacts.</i>	Evidence Certainty <i>High, medium, or low, and explain reasoning in comment column.</i>
Additional costs of the preferred option compared to taking no action			
<i>Regulated groups</i> Mental health services, especially inpatient services operated by Health New Zealand	Likely to be additional resources in initial period to assist with rollout of new guidance.	Low	Low
<i>Regulators</i> The Ministry of Health and appointed statutory officers.	Yearly cost of having district inspectors extend rights to voluntary tāngata whaiora. It is estimated as an increase of 22% on current district inspector spend, plus additional people requiring this service. There will also be yearly costs for a committee of Māori experts to assist district inspectors, which include all overhead, training and administrative costs.	\$1.1 million in additional FTEs and additional staffing costs, including training sessions, plus a one-off \$220,000 in an additional FTE for enhanced monitoring and reporting, and oversight/administration of having more district inspectors.	Medium
Mental Health Review Tribunals: statutory appointments by Minister of Health.	Costs of an additional tribunal member, co-opting an extra person and a Special Patients Review Tribunal. Overestimation regarding travel costs (there are only a small number of special patients so these tribunal meetings may not be very frequent).	\$680,000 additional tribunal costs, including administration costs.	
Others (eg, wider govt, tāngata whaiora, etc.)	N/A	Low	Low
Total monetised costs		\$1.8 million per year, plus a \$220,000 one off cost.	Medium
Non-monetised costs		Low	Medium

Additional benefits of the preferred option compared to taking no action			
Regulated groups	Potential increase in job satisfaction for district inspectors as they have better tools to help them in the new roles.	Low	Low
Regulators	N/A		
Others (eg, wider govt, tāngata whaiora, etc.)	Benefit for tāngata whaiora as they are being provided with additional support which will better uphold and protect their human rights. This cost is based on the conservative estimate of costs and the wellbeing improvements.	\$4.1 million–\$7 million	Medium
Total monetised benefits		\$4.1 million–\$7 million	Medium
Non-monetised benefits		Medium	Low

Further information about preferred options

109. The figures calculated for costs and benefits are not intended to be precise estimates of the actual real-world costs and benefits of the proposals as we have made deliberately high assumptions about costs to ensure we are subjecting the proposals to a robust test. For example, the estimate for the Special Patients Review Tribunal has been calculated on every special patient being considered for a status change or long leave. Even with this assumption, the costs are low compared to the improvement the proposals will bring to tāngata whaiora.
110. These costs are also limited to the specific proposals related to four areas explored in this analysis. They are in addition to the cost estimates in the RIS completed for Tranche 1 policy proposals. The total cost including the Tranche 1 proposals is estimated at \$12.3 million, plus a one-off cost of \$200,000.
111. The costs of the preferred options are largely workforce related, primarily the cost of expanding the district inspectors role to cover voluntary tāngata whaiora. We are able to make reasonable estimates for the costs of this and the other workforce costs by basing our assumptions on current workforce costs and workloads.
112. The benefits of the preferred options will be seen in improved experiences for tāngata whaiora and for the workforce, especially district inspectors, as they will be given tools to enhance their practice that will, in turn, benefit tāngata whaiora. We have not, however, calculated these benefits on the basis of taking a conservative approach.
113. It is important to note that we have not attempted a comprehensive cost-benefit analysis. We have analysed selected benefits and costs, using conservative assumptions, to identify whether there is a plausible benefit from the proposed law changes. This analysis should not be treated as a precise valuation of the benefits or costs of the proposals, and we do not consider the figures are applicable to other contexts. Where specific figures are used, these have generally been taken from the

Treasury CBAX database⁶, and some figures around the Māori expert committee were taken from the DPMC fees framework.

Costs

FTE increases

114. The majority of the costs arise from the proposal to increase district inspector support to voluntary tāngata whaiora in mental health inpatient and long-term residential care settings. We have calculated that the addition of voluntary tāngata whaiora (assuming half will seek access to district inspectors) is a 22% increase on services, to a total of \$800,000 per annum. Additionally, if a quarter of voluntary patients in long-term residential care would require access to District inspector support, this is roughly an additional 17% increase on the new estimate, meaning there could be an additional spend of \$135,000, which brings the total for an increase to FTEs for district inspectors to \$935,000 a year.

New roles

115. We anticipate the establishment of eight new Māori expert roles to assist district inspectors on a yearly ad-hoc basis. To ensure a conservative approach we assumed that of the 814 people under inpatient orders who identified as Māori, approximately half would want district inspectors to work with a Māori expert, which equals to roughly 407 people requiring this resource. To implement this proposal, we suggest having a similar set up to the Suicide Media Expert Panel where the members of that panel provide on-call support to the Chief Coroner on their request. For this proposal, there would be a committee of people appointed by the Director to provide on-call advice when needed. Based on the DPMC fees framework, we established which band they would fall under, which is how the fees for the suicide Media Expert Panel are worked out, and therefore were able to work out a rough range of their fees. These costs also include overheads and administration costs associated with establishing the committee. The range for this role could be between \$152,000–\$188,000 annually for an eight-person committee.

116. There would also be a benefit to holding an in-person meeting in Wellington once a year for training and face-to-face opportunities. The cost estimate for this is overestimated as travel costs are fluctuating and we are assuming that six of the members would need to travel. The annual cost for a meeting of this nature, based on average flight and taxi costs and catering in line with Ministry of Health guidelines, comes to roughly \$6000 per year. This brings the total cost for these additional roles to roughly between \$158,000–\$194,000 per year.

117. There are also costs for a four-person tribunal (up from the current three), the ability to co-opt an additional member with a disability and people to make up a special patient's tribunal. The cost for an additional tribunal member roughly comes out to be \$150,000 per year. The additional member costs are an estimate based on current costs for tribunal members and are based on deliberately high assumptions about costs to ensure we are subjecting the proposals to a robust test. The figure is based on the Tribunal member costings for 2018/19, which we reviewed and slightly increased, based on the following factors.

- Increased travel expenses post-pandemic.
- Inflationary increases for Tribunal member expenses.

⁶ [CBAX Spreadsheet Model](https://www.treasury.govt.nz/publications/guide/cbax-spreadsheet-model) available from: <https://www.treasury.govt.nz/publications/guide/cbax-spreadsheet-model>

- The potential for increased costs following the upcoming review of Tribunal fees, which we anticipate will occur prior to introduction of the new legislation.⁷
 - An increased number of Mental Health Review Tribunal applications following the introduction of the new legislation while case law is being settled. This assumption is based on anecdotal feedback that there was a marked increase in cases for around ten years following the introduction of the 1992 Act.
 - Minor increased secretariat costs to support an additional member.
118. There will be ways in the long run to potentially minimise these costs by having more hearings via audio visual links, which would reduce travel fees. However, this may not always be possible or desirable for the client. Other proposals, such as the amended criteria for compulsory treatment and the introduction of supported decision-making, are expected to reduce the frequency of unconsented treatment. This may reduce the number of applications to some extent, particularly in the medium to long term, once case law is settled.
119. Mandatory co-opting is already required under the current legislation where the Review Tribunal membership does not include a person of the same gender or ethnicity as the applicant, and they request that the Review Tribunal do so. In 2021/22, about 17 percent of applicants requested the co-opting of a tribunal member⁸.
120. We have estimated the annual cost of this proposal at around \$15,000, which is 10 percent of the cost of an additional permanent tribunal member, as set out above. Again, we have used deliberately high assumptions about costs to ensure we are subjecting the proposals to a robust test. For example, the figure of \$15,000 is on the assumption that 10 percent of applicants will have a disability and ask for the Review Tribunal to co-opt someone but full take-up is not expected, based on the low take-up of existing opt-in provisions relating to gender and ethnicity.
121. There are costs for a Special Patients Review Tribunal to be established and confirmed following the provisions in the current Act, which allow for the establishment of review tribunals. Although the mechanism for making these decisions is still under consideration, we have estimated the costs of an additional tribunal as that is the option with additional financial costs. The impact on the Court of making decisions about special patient leave and change of status would be in additional workload, with impact on other work, rather than increased costs.
122. For the 2018/19 financial year (the last full reported financial year prior to the pandemic, which had a significant impact on tribunal costs (mainly due to remote hearings)), there were 147 applications and, of those, 54 percent of applications were withdrawn, so a total of 67 tāngata whaiora had their application reviewed by the tribunal, for a total cost of **\$367,000** (consisting of around \$270,000 in member fees/expenses and \$96,000 in travel costs, with some miscellaneous costs making up the difference). This is for the current tribunal make up of three tribunal members. If we add in the cost for a fourth member, it is a total of \$517,000.
123. There are on average 50 special patients a year for whom an application for long leave or request a review of their legal status is submitted. Based on the regular Mental Health Review Tribunal costs, this additional cost will be a potential \$388,000 per annum for a Special Patients Review Tribunal. There will also be additional costs for secretarial duties, as well as administration costs that will occur during the

⁷ Using an increased fee is not intended to predetermine the outcome of the fees review as this decision is made by Cabinet's Appointment and Honours Committee. Tribunal fees were last reviewed in 2004, and the Office of the Director of Mental Health has confirmed they intend to undertake such a review.

⁸ Mental Health Review Tribunal Annual Report (1 July 2021-30 June 2022), p7.

appointments of the panel, as these positions will be appointed by the Director. Combining secretariat costs and administrative overhead costs, the costing for this proposal comes to \$515,000 per annum.

Benefits

124. The main benefits from the preferred options are improved experiences for tāngata whaiora, and improvements in their subjective and mental wellbeing. There are also likely to be benefits for people in the workforce, although we have not attempted to quantify these.
125. We have quantified benefits in two categories; improved mental health status, and improvement in subjective wellbeing. The analysis is not intended to be a comprehensive assessment of the value of interventions and should not be used as such. Rather we have quantified plausible benefits, on conservative assumptions, as a means of checking whether the likely benefits from the proposals outweigh the more precisely determinable costs.
126. **Improvement in subjective wellbeing:** the majority of the preferred options are expected to have an impact on a person's subjective wellbeing, through more transparency and independence from providers, as well as expanding members of the tribunal to ensure a fair spread of expertise. The changes to second opinion assessments promote independent reviews and allow a tāngata whaiora to have confidence that they have been assessed correctly. We have estimated this as a 5% increase in life satisfaction from more transparency and independence from providers, as well as the benefits of the additional tribunal members.
127. On average, there are 5685 people subject to compulsory treatment or assessment. We have used the subjective wellbeing figures from the UK Treasury⁹. Taking the midpoint of \$15,511 per year, for a five-percentage-point improvement in a person's subjective wellbeing, we arrive at a figure of \$4,405,875. Using the low estimate we arrive at \$1,574,460.
128. **Improvement in mental health status** is modelled with respect to the changes in the use of ECT and the rights being extended to voluntary tāngata whaiora patients. The changes would reduce the coercion that some voluntary tāngata whaiora face, as well as improve their mental health by being offered the same rights as other patients. Including those in long-term residential care, there are 3272 voluntary tāngata whaiora. We have made a conservative assumption that half of the voluntary tāngata whaiora will benefit from an improved rights process, so roughly 1636 tāngata whaiora will benefit. We have then assumed that an improved rights process will improve someone's mental health by one percentage point, as a one-off improvement. An improvement in one percentage point is \$1490, so if it affects 1636 tāngata whaiora, we reach a figure of \$2,437,640.
129. The proposals also include a change in the use of ECT. In 2020/2021, four people received ECT who had capacity but refused to consent, under the new legislation, these people would not be subject to ECT. We can make a conservative assumption that a person not being subject to ECT against their preference will improve someone's mental health by 10 percentage points. Therefore, the cost benefit for this proposal comes in at \$59,600 annually.

⁹ Figure taken from CBAX, based on Wellbeing Guidance for Appraisal: Supplementary Green Book Guidance: HM Treasury: retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005388/Wellbeing_guidance_for_appraisal_-_supplementary_Green_Book_guidance.pdf

Section 3: Delivering an option

How will the new arrangements be implemented?

130. This work is part of a major reform of the mental health and addiction system in Aotearoa New Zealand. Implementing this new legislation will form part of the overall changes to transform New Zealand's approach to mental wellbeing and the mental health and addiction system in line with *Kia Manawanui*. Implementation of these proposals will be supported by the significant investment and system transformation that is already under way.
131. Implementation of these proposals will also be supported by communicating and collaborating with the health sector, key government agencies, and communities, as well as the ongoing efforts to expand the availability of a broader range of mental health services and care options, workforce expansion, and training for practice change under way as part of the transformation programme noted above.

Ongoing operation and enforcement of the options

132. New guidelines will be developed in order to assist family, whānau, clinicians, and other interested parties in the operation, implementation, and enforcement of the new options. It is intended that new legislation will provide for directive, rather than advisory guidelines. Training programmes will be commissioned and adjusted to reflect new requirements.

Implementation

133. There will be a period of adjustment and bedding in of changes once new legislation is enacted. The Director and the office of the Director will have more responsibility and so there will be a period of adjustment for this office.
134. Successfully implementing new legislation will involve communication and collaboration between the health sector, key government agencies, and communities, as well as availability of a broader range of mental health services and care options, workforce expansion and training for practice change, and improved technology. Supporting regulations and updated guidelines will also need to be developed.
135. There is also an opportunity to pilot new workforce arrangements for supported decision-making approaches and continue workforce training to improve practice prior to the commencement of new legislation.
136. There will also be an appointment process for the Māori experts and additional tribunal members which will take some time.
137. There is already an independent national mental health monitor – the Mental Health and Wellbeing Commission. The Commission's objective is to contribute to better and equitable mental health and wellbeing outcomes for people in Aotearoa New Zealand. They have functions, such as:
 - assessing and reporting publicly on the mental health and wellbeing of people in Aotearoa New Zealand
 - assessing and reporting publicly on the effectiveness, efficiency, and adequacy of approaches to mental health and wellbeing
 - advocating for the collective interests of people who experience mental distress or addiction (or both), and the people (including family and whānau) who support them.

138. The Commission will continue in its monitoring and reporting role and is expected to continue to bring focus to areas where long-term transformation can take place.
139. Manatū Hauora will also play a role in the monitoring and review of the new arrangements, through Director of Mental Health reports and through the Director issuing directions to health service providers and statutory officials.
140. It is expected that legislation will provide for a five-yearly review.

PROACTIVELY RELEASED



Cabinet

Minute of Decision

This document contains information for the New Zealand Cabinet. It must be treated in confidence and handled in accordance with any security classification, or other endorsement. The information can only be released, including under the Official Information Act 1982, by persons with the appropriate authority.

Report of the Cabinet Social Wellbeing Committee: Period Ended 9 December 2022

On 12 December 2022, Cabinet made the following decisions on the work of the Cabinet Social Wellbeing Committee for the period ended 9 December 2022:

Out of scope

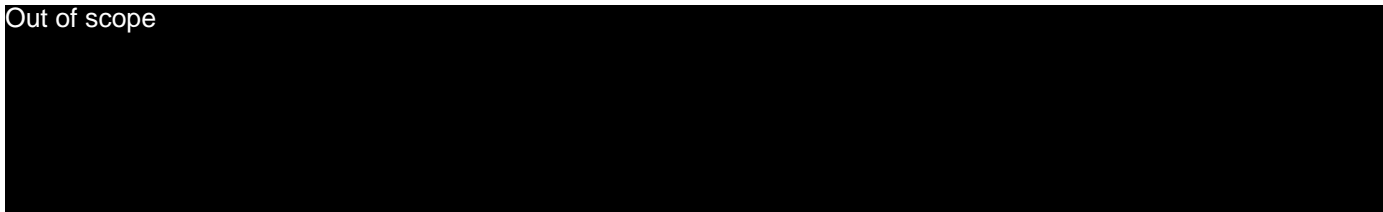


SWC-22-MIN-0234

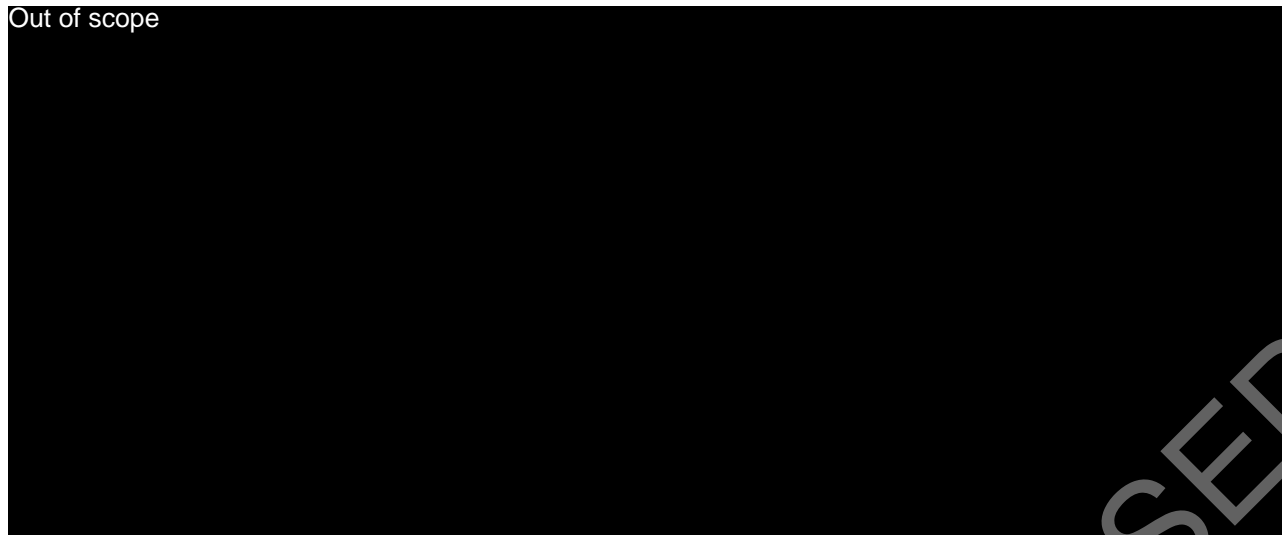
**Transforming Mental Health Law:
Foundations for New Mental Health
Legislation**
Portfolio: Health

CONFIRMED

Out of scope



Out of scope



Rachel Hayward
Secretary of the Cabinet

PROACTIVELY RELEASED



Cabinet Social Wellbeing Committee

Minute of Decision

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Transforming Mental Health Law: Foundations for New Mental Health Legislation

Portfolio Health

On 7 December 2022, the Cabinet Social Wellbeing Committee:

Background

- 1 **noted** that in May 2019, Cabinet agreed to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) as part of the response to *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (He Ara Oranga) [CAB-19-MIN-0182];
- 2 **noted** that the repeal and replacement of the Mental Health Act forms part of the wider transformation of the mental health and addiction system and is an action in *Kia Manawanui: Long-term pathway to mental wellbeing* and the *2019-2023 Disability Action Plan*;
- 3 **noted** that in October 2021, Cabinet approved the release of the public consultation document, *Transforming our Mental Health Law* [SWC-21-MIN-0147] and public consultation occurred from October 2021 to January 2022;
- 4 **noted** that public consultation submitters supported the recommendation of He Ara Oranga that the current Act be repealed and replaced so that it reflects a human rights-based approach, promotes supported decision making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment;
- 5 **noted** that the aim of the reform is to achieve a modern mental health legislative framework that:
 - 5.1 upholds the Crown's obligations under Te Tiriti o Waitangi;
 - 5.2 supports mental health care that is grounded in te ao Māori, a recovery approach, and supports the safety of tāngata whaiora and others;
 - 5.3 encourages maximum independence and social inclusion;
 - 5.4 ensures that human rights are respected and protected;
 - 5.5 supports people to make decisions about their mental health care and ensures those who have decision-making capacity are not compelled to receive mental health care;

- 5.6 achieves equitable outcomes for those receiving care under the legislation, with particular attention to achieving equitable outcomes for Māori;
- 5.7 minimises the use and duration of compulsory care, including by preventing the need for tāngata whaiora to enter or re-enter compulsory care, rather than just managing crises;
- 5.8 minimises the use of seclusion and restraint, with the intention to eliminate seclusion;
- 5.9 includes effective mechanisms to monitor services, ensuring human rights are respected, and the purposes of the legislation are achieved;

Scope, purposes and principles

- 6 **noted** that the nature of compulsory care places significant limits on human rights, and new legislation will need to define the specific circumstances when compulsory mental health care is needed, clarify the requirements for assessment and compulsory care as well as set out the appropriate protections, safeguards and oversight;
- 7 **agreed** that the purpose of mental health legislation should be to provide compulsory mental health assessment and care that respects human rights, and supports te ao Māori and recovery approaches, in order to:
 - 7.1 restore a person's capacity to make informed decisions about their mental health care and to live well in the community;
 - 7.2 protect the safety of the person and others;
 - 7.3 support equitable outcomes;
- 8 **agreed** that the health sector principles in section 7 of the Pae Ora (Healthy Futures) Act 2022 (the Pae Ora Act), will apply to any person carrying out a function under new mental health legislation;
- 9 **agreed** that a set of principles guide decision-making under the new legislation, which will build on the health sector principles set out in the Pae Ora Act, and will aim to:
 - 9.1 affirm the rights of people subject to compulsory mental health care as well as the person's whānau;
 - 9.2 express the expectations on services and support under legislation;
 - 9.3 address the needs of specific population groups;

Obligations under Te Tiriti o Waitangi

- 10 **agreed** that new legislation include specific provisions which will clarify how the legislation will give effect to the Crown's obligations under Te Tiriti o Waitangi;
- 11 **noted** that a specific Te Tiriti o Waitangi clause may be appropriate, and will be considered in light of the specific provisions, in line with guidance from the Treaty Provisions Oversight Group;

Criteria for compulsory mental health care

- 12 **noted** that the current criteria for compulsory assessment and treatment are based on there being ‘serious danger’ to the health or safety of the person or others and that over time this has been broadly interpreted, enabling compulsory mental health treatment in some cases that is not proportionate to the limits placed on human rights;
- 13 **agreed** that compulsory care should only happen when:
- 13.1 a person has a serious need for mental health care, support or treatment, and there is a benefit from it being provided through statutory intervention;
 - 13.2 if mental health care, support, or treatment were not accessed serious adverse effects are likely to occur in the near future;
 - 13.3 a person does not have the capacity to make informed decisions about their own mental health care, support and/or treatment;
- 14 **noted** that the requirements for meeting the decision in paragraph 13.3 above will consider the person’s individual circumstances, including their cultural context;

Empowering people to make decisions about their own mental health care

- 15 **noted** that supported decision-making will be central to new mental health legislation and flows from the proposed requirement of including a test of decision-making capacity;
- 16 **agreed** that the new legislation include a range of approaches that enable a person to make decisions about their own mental health care to the best of their ability even where they do not have capacity, or in advance, including through:
- 16.1 advance directives that include provision for binding directions on certain aspects of care, for example, in relation to particular treatments when they come under legislation as well as provision to record personal preferences;
 - 16.2 provisions to enable a person to appoint a nominated person to represent their interests;
 - 16.3 independent support to assist and support a person to, for example, exercise their rights and participate in decisions being made about them and that this support be independent of other decision-makers set out in legislation;
 - 16.4 supported decision-making hui to identify options for care, treatment and support where a person does not have other decision-making processes and directions in place Greater recognition and involvement of whānau, hapū and iwi;
- 17 **noted** that new legislation will strengthen the involvement of whānau, hapū and iwi in mental health care, in accordance with the wishes of the person;
- 18 **agreed** that the new legislation:
- 18.1 strengthen involvement of whānau, hapū, and iwi in care at key points in statutory processes and care planning;
 - 18.2 support whānau and tāngata whaiora to maintain their connections and role in their whānau, hapū, and iwi, including where they have childcare or other caregiving responsibilities;

- 18.3 provide that a person's wishes on their self-identified whānau, hapū and iwi and how they wish those persons to be involved in decisions and processes under legislation are paramount;

Statutory process requirements when people come under legislation

- 19 **agreed** that statutory processes for compulsory mental health assessment and treatment:
- 19.1 include a broader range of people to support a more holistic approach in support of tāngata whaiora (including for example, their culture and beliefs and to meet disability needs), which would include clinical, cultural and lived experience perspectives, as well as whānau, hapū, and iwi;
- 19.2 include more frequent reviews of the status of tāngata whaiora under legislation and opportunities for exit from the legislation;

Mental health care, support, and treatment

- 20 **noted** that the current Act does not specify the range of support that should be provided;
- 21 **agreed** that compulsory mental health care, support, and treatment will:
- 21.1 involve a broader range of support including for example, counselling, cultural supports, kaupapa Māori approaches, support to access social services, and any other interventions that aim to address the symptoms and underlying causes of the need for compulsory care;
- 21.2 include a holistic and comprehensive assessment of needs and a care plan that identifies the support required to respond to those needs;
- 21.3 use a collective approach to assessment and care planning, that would include consideration of the views of the person and other professionals and people of significance, such as whānau, hapū, and iwi;
- 21.4 ensure transitional support is made available to the person when they are preparing to transition out of compulsory care, including care planning and arrangements for ongoing mental health care on a voluntary basis;
- 22 **agreed** that the new legislation should set out the high-level requirements to achieve the decisions in paragraph 21 above, with guidelines providing more detail on how these requirements will be carried out;

Seclusion, restraint, and other restrictive practices

- 23 **noted** that the government has a policy of reducing seclusion and restraint in mental health services and progress for meeting this goal needs to be prioritised;
- 24 **noted** that significant practice improvements are needed to eliminate seclusion and reduce restraint;
- 25 **agreed** that legislation significantly limit the use of seclusion and restraint by:
- 25.1 placing a duty on people exercising functions under legislation to use their best efforts to reduce seclusion and restraint, including eliminating seclusion;
- 25.2 requiring the Director of Mental Health to issue guidelines to reduce seclusion and restraint, with the aim of eliminating seclusion;

- 25.3 requiring every use of seclusion or restraint to be reported to the Director of Mental Health, and the Director to report publicly on the use of seclusion and restraint at least annually;

Other matters

- 26 **noted** that the existing Act contains general administrative machinery of the kind required for any legislation allowing compulsion: for example, mechanisms for monitoring and review, and roles required to discharge functions and powers related to compulsory care;
- 27 **agreed** that the general administrative machinery contained in the current Act be retained in new legislation with updates required to reflect more modern understandings and give effect to other agreed policy proposals, subject to final approval by Cabinet in early 2023;

Authorisations and next steps

- 28 **invited** the Minister of Health to report back to the Cabinet Social Wellbeing Committee with any further changes needed to finalise the drafting of a Bill by March 2023;
- 29 **authorised** the Minister of Health to issue drafting instructions to the Parliamentary Counsel Office to draft a Bill to give effect to the above decisions;
- 30 **authorised** the Minister of Health to make any minor or technical policy changes that are not inconsistent with the policies agreed in the paper under SWC-22-SUB-0234;
- 31 **agreed** that the Mental Health Bill should include a provision stating that the Act will bind the Crown.

Rachel Clarke
Committee Secretary

Present:

Rt Hon Jacinda Ardern
Hon Grant Robertson
Hon Kelvin Davis
Hon Chris Hipkins
Hon Carmel Sepuloni (Chair)
Hon Andrew Little
Hon Poto Williams
Hon Damien O'Connor
Hon Peeni Henare
Hon Willie Jackson
Hon Jan Tinetti
Hon Michael Wood
Hon Kiri Allan
Hon Dr David Clark
Hon Dr Ayesha Verrall
Hon Priyanca Radhakrishnan
Hon Meka Whaitiri

Officials present from:

Office of the Prime Minister
Office of the Chair
Officials Committee for SWC

In Confidence

Office of the Minister of Health

Cabinet Social Wellbeing Committee

Transforming mental health law: Foundations for new mental health legislation

Proposal

- 1 This paper seeks policy decisions required to begin the drafting of a Bill to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act).

Relation to government priorities

- 2 The Government's manifesto committed to deliver on *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga)*.
- 3 The repeal and replacement of the Mental Health Act was one of the recommendations, to which the Government agreed.

Executive Summary

- 4 New legislation is needed to minimise the use of compulsion and shift mental health care towards a human-rights based and recovery approach where tāngata whaiora¹ are central to decisions that affect them, their rights are respected and protected, and they are able to live self-directed lives.
- 5 Minimising the need for compulsory care will be dependent on wider system transformation which will support earlier access to services people require when they need them. However, legislation will be a critical safety net for tāngata whaiora and their whānau when urgent intervention as a last resort is required.
- 6 The scope of the new mental health legislation will focus on reducing inequities and enabling stronger rights-based approach to compulsory care. The proposed legislation is intended to cover the statutory requirements where compulsory assessment and care are justified, rather than legislation governing the entire mental health system. The proposals in this paper set out a changed statutory environment that will transform the way in which tāngata whaiora and whānau receive compulsory mental health care. Legislation will require services to focus on how care can be provided in a way that protects and respects the rights of tāngata whaiora and their whānau.
- 7 I consider that new legislation must enable people to regain their independence, have autonomy over their mental health care, and to preserve

¹ Tāngata whaiora refers to the population group who use mental health services, and tangata whaiora to an individual. These terms are used in this paper to refer to people to whom mental health legislation would apply. It is preferred over terms such as 'patient', 'service user' and 'consumer'.

critical and trusted relationships that enable them to participate in their communities. I also intend new legislation to support a broader range of treatment and support for tāngata whaiora, and to minimise the use of seclusion and restraint, with the goal of eliminating seclusion over time.

- 8 The proposed legislation is on the Legislation Programme with a category 5 priority (instructions to be provided to Parliamentary Counsel Office in the year). I intend to return to Cabinet in March 2023 to seek approval for any final policy decisions required. s 9(2)(f)(iv) [REDACTED] s 9(2)(f)(iv) [REDACTED].

Background

- 9 The Mental Health Act sets out the specific circumstances under which people may be subject to compulsory mental health assessment and treatment. In 2020/21, 11,149 people (5.8% of specialist mental health and addiction service users) were subject to compulsory assessment or treatment. Tāngata whaiora Māori experience inequitable outcomes under the Mental Health Act; Māori represented around 35% of those subject to compulsory assessment, and around 38% of those subject to a compulsory treatment order.
- 10 In 2018, *He Ara Oranga* set out a future vision of mental health and wellbeing for all. In 2019, Cabinet agreed to repeal and replace the Mental Health Act, as part of the response to *He Ara Oranga* [CAB-19-MIN-0182]. It also agreed to a set of high-level principles to guide the policy development for repealing and replacing the Mental Health Act [SWC-19-MIN-0070].
- 11 A phased approach has been taken to reforming our mental health legislation [SWC-20-MIN-0123]. The first phase addressed immediate issues with the application of the current Mental Health Act. This included publishing revised guidelines to improve practice under the current legislation and the passing of the Mental Health (Compulsory Assessment and Treatment) Amendment Act 2021, which eliminated indefinite compulsory treatment orders.
- 12 The second phase is focused on the full repeal and replacement of the Mental Health Act. To guide this work, the Ministry of Health undertook public consultation from October 2021 to January 2022 [SWC-21-MIN-0147]. Views were sought on what new mental health legislation should look like in Aotearoa New Zealand.
- 13 Feedback was sought widely to ensure it was representative of key groups, including dedicated consultation streams with Māori and people with lived experience and their whānau. There were also dedicated consultation hui for Pacific, Asian and ethnic communities, young people, tāngata whaiora with coexisting disabilities, the mental health sector including non-government organisations, clinicians, as well as the general public. Over 300 written submissions were received, and feedback was gathered from over 500 people across 60 online consultation hui.
- 14 Following public consultation an Expert Advisory Group (EAG) was established. Members come from different backgrounds and bring a range of

expertise including Māori and tāngata whaiora with personal or whānau lived experience of the current Mental Health Act, service providers and clinicians, as well as legal and academic expertise. Members with different perspectives were sought to assist officials to consider all sides of key issues that need to be addressed in the development of policy proposals.

- 15 Cabinet invited me to report back to the Cabinet Social Wellbeing Committee (SWC) by 31 December 2022, seeking approval to policy proposals [SWC-21-MIN-0147].
- 16 Given the importance of this work, the drafting of new legislation should start without delay. I seek agreement to the proposals that will lay the foundation for transformation as well as areas needed to set the overall structure for new legislation.
- 17 Authorisation is also sought to begin drafting the remaining content currently under development relating to monitoring and oversight mechanisms as well as any additional requirements needed to support particular groups, for example, people transferred from the justice system.

New legislation forms part of the transformation of our health system

- 18 The repeal and replacement of the Mental Health Act forms part of the Government's response to the recommendations of *He Ara Oranga* and is an action in *Kia Manawanui: Long-term pathway to mental wellbeing (Kia Manawanui)* and the 2019-2023 Disability Action Plan. It will contribute to the overall vision of pae ora, healthy futures, for Māori and all New Zealanders.
- 19 It is important to recognise that the development of new legislation is only one element of the broad programme of work underway (as set out in *Kia Manawanui*) to implement the Government's strategy to transform Aotearoa New Zealand's approach to mental wellbeing. The proposals I am recommending will require significant shifts in practice and services for those being supported under the proposed legislation, who represent a subset of people engaging with the health and disability system.

New legislation will shift mental health care towards a human rights and recovery approach

- 20 I expect that wider transformation of the mental health and addiction system will have improved outcomes for tāngata whaiora and their whānau with increased access to effective interventions and support earlier, which will help to minimise the need for compulsory care. However, I recognise that legislation is an important safety net for tāngata whaiora and their whānau when urgent intervention is required as a last resort.
- 21 When I reported to Cabinet in 2019 on the approach for repealing and replacing the Mental Health Act [SWC-19-MIN-0070 refers], I was clear that the use of compulsory care under new legislation must be limited and there must be mechanisms in place to closely monitor its use. Across stakeholders, the majority of submitters to the public consultation considered that

compulsory care is needed but that it should only be used as a last resort and be limited to extreme and serious circumstances.

- 22 My expectation is that when compulsory mental health care is needed, new mental health legislation will significantly shift the experience of tāngata whaiora and place them and their whānau at the centre of decision-making processes. Drawing on the principles agreed by Cabinet to guide the development of new legislation [SWC-19-MIN-0070 refers], the proposals presented in this paper seek to balance the complex ethical, legal and policy issues within mental health legislation and aim to achieve a modern legislative framework that:
- 22.1 upholds the Crown's obligations under Te Tiriti o Waitangi
 - 22.2 supports mental health care that is grounded in te ao Māori, a recovery approach, and supports the safety of tāngata whaiora and others
 - 22.3 encourages maximum independence and social inclusion
 - 22.4 ensures that human rights are respected and protected
 - 22.5 supports people to make decisions about their mental health care and ensures those who have decision-making capacity are not compelled to receive mental health care
 - 22.6 achieves equitable outcomes for those receiving care under the legislation, with particular attention to achieving equitable outcomes for Māori
 - 22.7 minimises the use and duration of compulsory care, including by preventing the need for tāngata whaiora to enter or re-enter compulsory care, rather than just managing crises
 - 22.8 minimises the use of seclusion and restraint, with the intention to eliminate seclusion
 - 22.9 includes effective mechanisms to monitor services, ensuring human rights are respected, and the purposes of the legislation are achieved.

Proposals for new mental health legislation

- 23 The nature of compulsory care means that it places significant limits on human rights, such as the rights to liberty, to refuse medical treatment, and to freedom from discrimination. Compulsion can also significantly affect the autonomy, personal dignity, and mana of tāngata whaiora and their whānau. It can also have long-term effects on the participation of tāngata whaiora in their communities including in employment.
- 24 The circumstances in which compulsory care can be used are not well defined in the current legislation. The proposed new mental health legislation will be designed to ensure the circumstances when compulsory mental health care is justified are clearly defined. Legislation will also need to explicitly set out the

key requirements around assessment and the provision of compulsory care as well as appropriate protections, safeguards and oversight.

- 25 Details of initial proposals are set out below. As noted, I have sequenced the decisions I seek from Cabinet, and will bring additional policy decisions in March 2023. These will further support meeting the objectives outlined at paragraph 22 above.

Scope, purposes and principles

- 26 The scope of the proposed legislation is intended to only cover circumstances where compulsory assessment and care are justified, rather than governing the entire mental health system (refer paragraph 38 below). The system as a whole will be managed through existing mechanisms including recent reform through the Pae Ora (Healthy Futures) Act 2022.
- 27 The current Mental Health Act does not include explicit purposes or guiding principles, which I consider would help shift the application of new legislation towards a rights-based and recovery approach and better support te ao Māori concepts of wellbeing in the context of compulsory care.
- 28 A purpose statement would set out the scope and policy aims of the legislation, which should be to provide compulsory mental health assessment and care that respects human rights, and is inclusive of te ao Māori worldviews and recovery approaches to the greatest extent possible, in order to:
- 28.1 restore a person's capacity to make informed decisions about their mental health care and to live well in the community
 - 28.2 protect the safety of the person and others
 - 28.3 support equitable outcomes.
- 29 A set of principles to guide decision-making will support meeting the purposes of new legislation. The health sector principles in the Pae Ora Act already apply to compulsory care provided in inpatient settings, which is delivered by the public health system. I propose a provision to apply them to those outside the public health system delivering compulsory care, for example general practitioners conducting examinations or treating someone subject to compulsory assessment or care.
- 30 While the health sector principles apply at a system and services level, the principles proposed in this paper would apply at an individual level. They will guide decision-makers when making decisions about a person's care and provide more detail on how some of the health sector principles will be supported within the specific context of providing compulsory mental health care. The intent of the principles will be to:
- 30.1 *affirm the rights of people subject to compulsory mental health care, as well as the person's whānau* – these principles would focus on

ensuring people are assisted to make decisions and express views, place the wellbeing of tāngata whaiora and their whānau at the centre of decision-making, and ensure that decisions made consider a range of views

- 30.2 *express the expectations for services and support provided under legislation* – these principles will clarify what compulsory care should be aiming to achieve and how services should be provided
 - 30.3 *address the needs of specific population groups* – these principles would clarify any specific considerations to ensure the needs of different groups are met, for example, children and young people.
- 31 A set of considerations to inform principles are set out at **Appendix A**. These will continue to be refined in line with the intent outlined above through the drafting process.

Crown obligations under Te Tiriti o Waitangi

- 32 Upholding the Crown's obligations under Te Tiriti o Waitangi is a priority for new legislation. Submitters to the public consultation want to see Te Tiriti o Waitangi as the foundation for new legislation; they also wanted clarity on what this means in practice. Ensuring that new legislation adequately supports the delivery of culturally appropriate care will be an important part of improving the way legislation promotes the Tiriti principles and the Māori-Crown relationship.
- 33 As the guiding principles outlined in this paper build on the health sector principles from the Pae Ora Act, they already incorporate the concepts of Te Tiriti principles identified by the Waitangi Tribunal in the Hauora Inquiry (WAI 2575). In addition to the principles I am proposing, I recommend that new legislation contains specific provisions which will clarify how the legislation will give effect to the Crown's Te Tiriti obligations in the context of providing compulsory mental health care.
- 34 This would include, for example, that compulsory assessment and care planning must be holistic and see the tangata whaiora as a whole person (including cultural assessment) and be undertaken using a collective approach (tāngata whaiora, their whānau, hapū and iwi, cultural experts and clinicians).
- 35 I expect Iwi-Māori partnership boards are likely to have a strong interest in the proposed legislation and in monitoring. However, they are not expected to be operational until early 2023. In the interim, the Ministry of Health has undertaken to work with Te Aka Whai Ora on key areas of the legislation to explore how they might be grounded in te ao Māori approaches to mental health care, particularly in relation to proposals relating to restrictive practices, decision-making capacity and supported decision-making. This will provide a strong foundation for any future involvement of Iwi-Māori partnership boards in ensuring services respond to the needs of Māori. I will report back to

Cabinet on the ongoing work by the Ministry of Health and Te Aka Whai Ora as appropriate.

Criteria for compulsory mental health care

- 36 Under the current Mental Health Act, a person must meet the definition of 'mental disorder' before they can be subject to compulsory assessment or treatment. This means a person must have an 'abnormal state of mind' that results in them:
- 36.1 posing a serious danger to the health or safety of themselves or others, or
 - 36.2 having seriously diminished capacity to take care of themselves.
- 37 This definition has been criticised for being too broad and enabling compulsory mental health treatment that is not proportionate to the significant limits on human rights and other impacts of compulsion. The use of 'serious danger' as a criterion is considered by experts to have contributed to an over-emphasis on conceptions of risk in practice.
- 38 To minimise the use of compulsory care to circumstances where it is justified, I propose that compulsory mental health care should only happen when:
- 38.1 a person has a serious need for mental health care, and there is a clear expected benefit from it being provided through statutory intervention; and
 - 38.2 if mental health care, support or treatment were not accessed then serious adverse effects are likely to occur in the near future; and
 - 38.3 a person does not have capacity to make informed decisions about their own mental health care, support and/or treatment.
- 39 The new element of decision-making capacity ensures that people who retain decision-making capacity are not compelled to receive mental health care. This change would bring the approach to compulsory care in line with other legislation where people are presumed to have capacity, such as the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.
- 40 I expect the proposed legislation to set clear thresholds and expectations about how the elements at paragraph 38 will be assessed to help ensure the policy intent is achieved. This will include how capacity needs to be assessed, with regard to a person's individual circumstances, including their cultural context, as well as detail on 'serious adverse effects'.

Empowering people to make decisions about their own mental health care

- 41 Supported decision-making will be a key pillar of new legislation and will be critical for ensuring people can make their own decisions based on their will and preferences to enable greater self-determination and autonomy in their lives. If new legislation is to include a test of decision-making capacity, there will need to be requirements to ensure people are supported to make decisions about their own mental health care to the best of their ability even if they do not have capacity, or in advance of becoming unwell.
- 42 Under the proposed principles, tāngata whaiora would be assisted to make decisions and to express their views. I therefore propose a range of supported decision-making approaches to underpin tāngata whaiora and whānau centred decision-making:
- 42.1 *Advance directives* – these enable people to make statements about their future care. While these are already used in mental health settings outside of legislation, they are inconsistently promoted and used, and are advisory rather than conclusive. I recommend the legislation enable tāngata whaiora to give binding directions on specific areas, such as particular treatments when they come under legislation. There should also be a provision to record a person’s preferences, such as in relation to their personal affairs.
- 42.2 *Nominated person* – this would enable tāngata whaiora to nominate a person to represent their interests. In practice, this is likely to be a member of their whānau, hapū or iwi, or another significant trusted person who has more detailed understanding of the journey and experiences of the tangata whaiora. This would not be a formal attorney as provided for in the Protection of Personal and Property Rights Act 1988. The nominated person could be nominated via an advance directive.
- 42.3 *Independent support* – this would be a person independent of other decision-makers. They are intended to assist and support the person, including to support the person to exercise their rights, and participate in decisions being made about them. The person fulfilling this role could be, for example, a peer support worker or social worker.
- 42.4 *Supported decision-making hui* – these would take place to identify options for care, treatment and support when a person does not have other decision-making processes in place, such as an advance directive. This process would be inclusive of tāngata whaiora and other people of significance identified by tāngata whaiora such as their whānau.
- 43 While I am proposing that certain directions will be binding rather than optional considerations, there will need to be robust processes in place to manage situations where any binding directions may need to be overridden, for example, to ensure the safety of the tangata whaiora. This could include

the hui I am proposing at paragraph 42.4 before escalation to more formal process such as the mental health review tribunal.

Greater recognition and involvement of whānau, hapū and iwi

- 44 Building on the proposed principles which will reflect the importance of whānau, I propose new legislation:
- 44.1 strengthen involvement of whānau, hapū and iwi at key points in statutory processes and care planning
 - 44.2 support whānau and tāngata whaiora to maintain their connections and role in their whānau, hapū and iwi, including where they have childcare or other caregiving responsibilities.
- 45 Across any provisions involving whānau, hapū and iwi, the wishes of tāngata whaiora will be paramount with respect to who they identify as their whānau, hapū or iwi, and how they want them to be involved.

Statutory process requirements when people come under legislation

- 46 The current process in the Mental Health Act consists of an initial assessment, a first period of assessment (up to 5 days), a second period of assessment (up to 14 days) and then compulsory treatment orders (up to six months). There are also mechanisms to ensure there are pathways out of the legislation.
- 47 I propose that improvements are made to the current processes so that:
- 47.1 decision-making processes include a broader range of people to support a more holistic approach in support of tāngata whaiora (including for example, their culture and beliefs and to meet disability needs). This could include for example clinical, cultural, lived experience and whānau, hapū and iwi
 - 47.2 there is more frequent review of the status of tāngata whaiora under legislation and opportunities for exit from the legislation.

Mental health care, support and treatment

- 48 Minimising the need for compulsory treatment is also about providing care, treatment and support that better meets the needs of tāngata whaiora on their recovery journey. It is critical that tāngata whaiora are supported to transition out of compulsory care where appropriate. This is consistent with the health sector principle in the Pae Ora Act that services be tailored to the person's needs and circumstances.
- 49 While legislation will set out high-level requirements, I expect guidelines to provide more detail on how these requirements will be carried out. I propose that compulsory assessment and care involve:

- 49.1 *A broad range of support* – legislation would clarify that a broad range of support is intended, as appropriate to a person’s needs and preferences. In practice this could include counselling, kaupapa Māori approaches and other cultural support, disability support, support to access social services, and any other interventions that address the underlying reasons for compulsory care.
- 49.2 *Needs assessment* – a holistic and comprehensive assessment of the needs of tāngata whaiora must be undertaken (including cultural assessment), and a care plan developed that identifies what supports will be provided to tāngata whaiora in response to the needs assessment.
- 49.3 *Collective approach to assessment and care planning* – this would include consideration of the views of tāngata whaiora, their whānau, hapū and iwi, as well as clinicians, cultural advisors, peer supporters, and any other professionals as necessary for example to meet disability needs.
- 49.4 *Transition care planning* – when preparing to transition out of compulsory care, transitional support is made available to tāngata whaiora, including care planning and arrangements for ongoing mental health care on a voluntary basis. As agreed by tāngata whaiora this process may include the people outlined in paragraph 49.3 above.

Seclusion, restraint and other restrictive practices

- 50 I am committed to eliminating seclusion and reducing restraint. This will require strengthened legislative and non-legislative measures to achieve. This includes consideration of the trade-offs between the human rights implications and lack of therapeutic benefits, with the need to ensure safety, the readiness of the system and workforce to implement the position taken in legislation and potential unintended consequences (eg, an increase in other inappropriate forms of restrictive practices).
- 51 Firstly, significant practice improvements will be needed to achieve this goal. While there is work underway, progress would be further advanced by revised regulatory guidelines. These would include, for example, greater use of person-centred and culturally appropriate approaches to prevent the use of seclusion and restraint. This will be further supported by improved training and clinical practice, and closer monitoring by the Director of Mental Health.
- 52 Secondly, the proposed legislation must take a stronger position than the current Mental Health Act by:
- 52.1 placing a duty on all people working in mental health services to use their best efforts to reduce the use of seclusion and restraint, with the goal of eliminating seclusion
- 52.2 requiring the Director of Mental Health to issue regulatory guidelines to reduce seclusion and restraint, with the aim of eliminating seclusion

52.3 requiring that any use of seclusion or any form of force be reported to the Director of Mental Health, and that the Director report publicly at least annually on the use of seclusion and restraint.

53 This position would be supported by other elements of proposed new legislation, such as supported decision-making approaches and regulation-making powers to further limit the use of restrictive measures when possible. While this means I am unable to commit to a timeframe for prohibiting the use of seclusion in legislation, I have asked the Ministry of Health and Te Aka Whai Ora to progress this work and may be in a position to make an appropriate amendment in committee, depending on progress. There would also be an opportunity as part of the standard five-year review of new legislation to consider whether the Act could be amended at that point to prohibit certain practices.

Other matters

54 The current Mental Health Act contains reasonably standard administrative machinery which I propose should, in principle, be retained. For example, any legislation authorising the use of compulsive powers needs mechanisms for monitoring and reviewing the use of such powers. The current Mental Health Act has a system of district inspectors, and tribunals, and the oversight role of the Director of Mental Health.

55 While the provisions will need to be amended to ensure they reflect a more modern understanding, and to ensure they work as intended with other areas of the new legislation, any legislation permitting compulsory care will need similar provisions. I anticipate for example, that there will still need to be a compliance-focused role such as those of district inspectors, but the scope of that role may require changes to ensure cohesion with the proposal relating to independent support set out at paragraph 42.3 as well as other proposals which will necessitate there being appropriate cultural and lived experience support.

56 Any final changes to these mechanisms will be sought when I return to Cabinet in March 2023. Building on the foundations set out in this paper, I have directed officials to explore what additional changes may be required to strengthen or modernise provisions relating to review, monitoring and oversight as well as the overarching rights of people in the legislation. How the legislation will work for different population groups requires special attention, and officials will be looking specifically at whether additional changes may be required for people referred from the justice system, children and young people, and disabled people.

57 Ministry of Health officials will continue to work closely with affected agencies, including those that will have a role in implementing the proposed legislation. This includes the Department of Corrections, New Zealand Police, Ministry of Justice and Oranga Tamariki–Ministry for Children.

Financial Implications

- 58 There are costs associated with some proposals but they will be met within the agreed multi-year health Budgets.

Legislative Implications

- 59 Legislation is required to implement the proposals in this paper. The proposals will be given effect through the Mental Health Bill which holds a category 5 priority on the 2022 Legislation Programme (instructions to the Parliamentary Counsel Office in the year). The Act will bind the Crown.

Impact Analysis

Regulatory Impact Statement

- 60 The regulatory impact analysis requirements apply to this paper. A Regulatory Impact Statement (RIS) is attached. The RIS was reviewed by a panel with representatives of the Ministry of Health and Ministry of Justice. The panel considers that the information and analysis summarised in the RIS meets the quality assurance criteria.

Population Implications

- 61 The proposals in this paper are expected to have significant benefits for population groups who experience inequities under the current Act:

Population group	How the proposal may affect this group
Māori	Māori are disproportionately subject to compulsory mental health treatment and are also more likely to be subject to seclusion events. The proposals in this paper would enable the provision of culturally appropriate care to tāngata whaiora Māori. For example, through a broader range of people and perspectives involved in decision-making including supported decision-making processes (eg, whānau and cultural perspectives) and te ao Māori approaches to care, support and treatment.
Pacific peoples	In 2020/21, Pacific peoples represented around 7% of those subject to compulsory assessment, and around 9% of those subject to a compulsory treatment order. The proposals are expected to improve outcomes for Pacific peoples. For example, through proposals that enable a broader range of care, support and treatment that recognises wider world views and a broader range of people involved in decision-making.
Disabled people	Tāngata whaiora under the legislation may have other disabilities such as physical, sensory, and learning disabilities. The proposals in this paper will better enable these tāngata whaiora to exercise their rights. Supported decision-making is central to the proposals in this paper and will better assist disabled people to make and participate in decisions as well as provide independent support to ensure their rights are upheld.
Children and young people	In 2020/21, there were 311 children and young people aged 16 years or younger under the Mental Health Act, and of these, 41% were Māori. 41 children and young people were under an inpatient compulsory treatment order. Thirty-two young people, aged 16 years or younger, experienced seclusion. Of those, 50% were Māori. The intended principles will affirm the rights of children and young people under legislation, for example, ensuring they are assisted to make decisions or express their views, and that a

	holistic approach is taken with regard to age and developmental stage and te ao Māori approaches to care, support and treatment.
Older people	Greater involvement of whānau, hapū and iwi, recognition of wishes of tāngata whaiora and enabling greater autonomy, as well as limiting the use of seclusion and restraint, will better protect the needs of older people under the legislation.

Human Rights

- 62 The proposals in this paper are consistent with, or will improve consistency with, the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993. The proposals will also help improve consistency with international human rights obligations/conventions and declarations, including the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Declaration on the Rights of Indigenous Peoples.
- 63 Compulsory mental health care and treatment places significant limits on human rights, such as the rights to liberty, to refuse medical treatment, and to freedom from discrimination. I consider the proposals better ensure that these limits are reasonable and proportionate, and the minimum necessary to support tāngata whaiora to access care when they are experiencing serious mental distress to support their safety and the safety of others.
- 64 In particular, rights are supported by proposals to narrow who can be subject to compulsory mental health care to only include those who do not have decision-making capacity, and to include supported decision-making mechanisms.

Consultation

- 65 This paper was prepared by the Ministry of Health in consultation with: Te Aka Whai Ora; Te Whatu Ora; the Ministries of Education, Justice, Social Development, Housing and Urban Development, Women, Primary Industries; Pacific Peoples, Youth Development; and Business, Innovation and Employment; Whaikaha – Ministry of Disabled People; the Department of Corrections, the New Zealand Defence Force, the New Zealand Police, Oranga Tamariki–Ministry for Children, Te Puni Kōkiri, Te Arawhiti, the Accident Compensation Corporation, Office for Seniors, the Social Wellbeing Agency, Te Kawa Mataaho, the Department of the Prime Minister and Cabinet (Policy Advisory Group and the Child Wellbeing Unit), and the Treasury.
- 66 The approach to give effect to the Crown’s Te Tiriti obligations (as set out in paragraph 33 above) was discussed with the Treaty Provisions Oversight Group. Officials will continue to work with this group as part of the policy development, as well as other relevant agencies including Te Aka Whai Ora.

Communications

- 67 Any specific public announcements will be coordinated by the Office of the Minister of Health.

Proactive Release

68 I intend to proactively release this paper when legislation is introduced into the House s 9(2)(f)(iv), following final approval by Cabinet.

Recommendations

The Minister of Health recommends that the Committee:

- 1 **note** that on 6 May 2019, Cabinet agreed to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) as part of the response to *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga)* [CAB-19-MIN-0182 refers]
- 2 **note** that the repeal and replacement of the Mental Health Act forms part of the wider transformation of the mental health and addiction system and is an action in *Kia Manawanui: Long-term pathway to mental wellbeing* and the 2019-2023 Disability Action Plan
- 3 **note** that on 4 October 2021, Cabinet approved the public consultation document, *Transforming our Mental Health Law*, for release [SWC-21-MIN-0147; CAB-21-MIN-0395] and public consultation opened in October 2021 and closed in January 2022
- 4 **note** that submitters to the public consultation supported the recommendation of *He Ara Oranga* that the current Act be repealed and replaced so that it reflects a human rights-based approach, promotes supported decision making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment
- 5 **note** that the aim of the reform is to achieve a modern mental health legislative framework that:
 - 5.1 upholds the Crown's obligations under Te Tiriti o Waitangi
 - 5.2 supports mental health care that is grounded in te ao Māori, a recovery approach, and supports the safety of tāngata whaiora and others
 - 5.3 encourages maximum independence and social inclusion
 - 5.4 ensures that human rights are respected and protected
 - 5.5 supports people to make decisions about their mental health care and ensures those who have decision-making capacity are not compelled to receive mental health care
 - 5.6 achieves equitable outcomes for those receiving care under the legislation, with particular attention to achieving equitable outcomes for Māori

- 5.7 minimises the use and duration of compulsory care, including by preventing the need for tāngata whaiora to enter or re-enter compulsory care, rather than just managing crises
- 5.8 minimises the use of seclusion and restraint, with the intention to eliminate seclusion
- 5.9 includes effective mechanisms to monitor services, ensuring human rights are respected, and the purposes of the legislation are achieved

Scope, purposes and principles

- 6 **note** that the nature of compulsory care places significant limits on human rights, and new legislation will need to define the specific circumstances when compulsory mental health care is needed, clarify the requirements for assessment and compulsory care as well as set out the appropriate protections, safeguards and oversight
- 7 **agree** that the purpose of mental health legislation should be to provide compulsory mental health assessment and care that respects human rights, and supports te ao Māori and recovery approaches, in order to:
 - 7.1 restore a person's capacity to make informed decisions about their mental health care and to live well in the community
 - 7.2 protect the safety of the person and others
 - 7.3 support equitable outcomes
- 8 **agree** that the health sector principles in section 7 of the Pae Ora (Healthy Futures) Act 2022 (the Pae Ora Act), will apply to any person carrying out a function under new mental health legislation
- 9 **agree** that a set of principles guide decision-making under the legislation, which will build on the health sector principles set out in the Pae Ora Act, and will aim to:
 - 9.1 affirm the rights of people subject to compulsory mental health care as well as the person's whānau
 - 9.2 express the expectations on services and support under legislation
 - 9.3 address the needs of specific population groups

Obligations under Te Tiriti o Waitangi

- 10 **agree** that legislation include specific provisions which will clarify how the legislation will give effect to the Crown's obligations under Te Tiriti o Waitangi

- 11 **note** that a specific Te Tiriti o Waitangi clause may be appropriate, and will be considered in light of the specific provisions, in line with guidance from the Treaty Provisions Oversight Group

Criteria for compulsory mental health care

- 12 **note** that the current criteria for compulsory assessment and treatment are based on there being 'serious danger' to the health or safety of the person or others and that over time this has been broadly interpreted, enabling compulsory mental health treatment in some cases that is not proportionate to the limits placed on human rights
- 13 **agree** that compulsory care should only happen when:
- 13.1 a person has a serious need for mental health care, support or treatment, and there is a benefit from it being provided through statutory intervention
 - 13.2 if mental health care, support or treatment were not accessed serious adverse effects are likely to occur in the near future
 - 13.3 a person does not have capacity to make informed decisions about their own mental health care, support and/or treatment
- 14 **note** that the requirements for meeting recommendation 13.3 above will consider the person's individual circumstances, including their cultural context

Empowering people to make decisions about their own mental health care

- 15 **note** that supported decision-making will be central to new mental health legislation and flows from the proposed requirement of including a test of decision-making capacity
- 16 **agree** that the legislation include a range of approaches that enable a person to make decisions about their own mental health care to the best of their ability even where they do not have capacity, or in advance, including through:
- 16.1 advance directives that include provision for binding directions on certain aspects of care, for example, in relation to particular treatments when they come under legislation as well as provision to record personal preferences
 - 16.2 provisions to enable a person to appoint a nominated person to represent their interests
 - 16.3 independent support to assist and support a person to, for example, exercise their rights and participate in decisions being made about them and that this support be independent of other decision-makers set out in legislation

- 16.4 supported decision-making hui to identify options for care, treatment and support where a person does not have other decision-making processes and directions in place

Greater recognition and involvement of whānau, hapū and iwi

- 17 **note** that new legislation will strengthen the involvement of whānau, hapū and iwi in mental health care, in accordance with the wishes of the person
- 18 **agree** that the legislation:
- 18.1 strengthen involvement of whānau, hapū and iwi in care at key points in statutory processes and care planning
- 18.2 support whānau and tāngata whaiora to maintain their connections and role in their whānau, hapū and iwi, including where they have childcare or other caregiving responsibilities
- 18.3 provide that a person's wishes on their self-identified whānau, hapū and iwi and how they wish those persons to be involved in decisions and processes under legislation are paramount

Statutory process requirements when people come under legislation

- 19 **agree** that statutory processes for compulsory mental health assessment and treatment:
- 19.1 include a broader range of people to support a more holistic approach in support of tāngata whaiora (including for example, their culture and beliefs and to meet disability needs). This would include for example clinical, cultural and lived experience perspectives as well as whānau, hapū and iwi
- 19.2 include more frequent reviews of the status of tāngata whaiora under legislation and opportunities for exit from the legislation

Mental health care, support and treatment

- 20 **note** that the current Act does not specify the range of support that should be provided
- 21 **agree** that compulsory mental health care, support and treatment will:
- 21.1 involve a broader range of support including for example, counselling, cultural supports, kaupapa Māori approaches, support to access social services, and any other interventions that aim to address the symptoms and underlying causes of the need for compulsory care
- 21.2 include a holistic and comprehensive assessment of needs and a care plan that identifies the support required to respond to those needs

- 21.3 use a collective approach to assessment and care planning, that would include consideration of the views of the person and other professionals and people of significance, such as whānau, hapū and iwi
 - 21.4 ensure transitional support is made available to the person when they are preparing to transition out of compulsory care, including care planning and arrangements for ongoing mental health care on a voluntary basis
- 22 **note** that the legislation should set out the high-level requirements to achieve the recommendations in 21 above, with guidelines providing more detail on how these requirements will be carried out

Seclusion, restraint and other restrictive practices

- 23 **note** that the government has a policy of reducing seclusion and restraint in mental health services and progress for meeting this goal needs to be prioritised
- 24 **note** that significant practice improvements are needed to eliminate seclusion and reduce restraint
- 25 **agree** that legislation significantly limit the use of seclusion and restraint by:
- 25.1 placing a duty on people exercising functions under legislation to use their best efforts to reduce seclusion and restraint, including eliminating seclusion
 - 25.2 requiring the Director of Mental Health to issue guidelines to reduce seclusion and restraint, with the aim of eliminating seclusion
 - 25.3 requiring every use of seclusion or restraint to be reported to the Director of Mental Health, and the Director to report publicly on the use of seclusion and restraint at least annually

Other matters

- 26 **note** that the existing Mental Health Act contains general administrative machinery of the kind required for any legislation allowing compulsion: for example, mechanisms for monitoring and review, and roles required to discharge functions and powers related to compulsory care
- 27 **agree** that the general administrative machinery contained in the current Act be retained in new legislation with updates required to reflect more modern understandings and give effect to other agreed policy proposals, subject to final approval by Cabinet in early 2023

Authorisations and next steps

- 28 **invite** the Minister of Health to report back to the Cabinet Social Wellbeing Committee with any further changes needed to finalise the drafting of a Bill by March 2023
- 29 **authorise** the Minister of Health to issue drafting instructions to the Parliamentary Counsel Office to draft a Bill to give effect to Cabinet decisions on the recommendations in this paper
- 30 **authorise** the Minister of Health to make any minor or technical policy changes that are not inconsistent with the policies agreed in this paper
- 31 **agree** that the Mental Health Bill should include a provision stating that the Act will bind the Crown.

Authorised for lodgement

Hon Andrew Little

Minister of Health

Appendix A: Considerations for principles to guide decision-making

Considerations to inform principles for new mental health legislation are set out below. These principles will continue to be refined through the drafting process in line with policy intent.

Principles to affirm the rights of the person and their whānau, and how they should be dealt with

1. Any person being compulsorily assessed or receiving compulsory care should be assisted to make decisions and express their views in relation to any decision or process affecting them to the best of their ability even where they do not have capacity, including views set out in an advance directive. The person's views should be a paramount consideration.
2. The wellbeing of the person and their whānau should be at the centre of the decision-making that affects the person and their whānau, and, in particular:
 - a. The person's rights, including those set out in the Convention on the Rights of Persons with Disabilities, the Declaration on the Rights of Indigenous Peoples, and the Convention on the Rights of the Child, should be respected and upheld to the extent possible.
 - b. Compulsory mental health care should only be used as a last resort, where other less-restrictive options are not effective, and the benefits of compulsion outweigh any potential trauma and harm that compulsion may cause.
 - c. The duration of compulsory mental health care should only be for as long as it is necessary to protect the health and safety of the person and others or when capacity is restored.
 - d. The importance of the person's connections with their whānau, hapū, iwi, and other support people should be recognised and respected.
 - e. A comprehensive and holistic approach should be taken that looks at the whole person and not just their mental health needs and gives proper consideration and respect to the wider determinants of health and wellbeing which includes, but is not limited to, the person's cultural and ethnic identity; language; disability; religious, spiritual, or ethical beliefs; gender identity; sexual orientation; age; and developmental stage.
 - f. Every effort should be made to ensure that decisions made in respect of a person consider a range of views, including the views of the person, the person's whānau and other support people, clinical expertise, Māori and other cultural expertise, and lived experience expertise.

Principles that express expectations for services and support provided under legislation

3. Compulsory mental health care should:
 - a. aim to restore the person's capacity to make decisions about their health care
 - b. be culturally responsive and promote te ao Māori and recovery approaches to responding to mental health needs
 - c. be responsive to any trauma the person has experienced
 - d. be provided in the least-restrictive environment and using the least-coercive methods appropriate in the circumstances
 - e. enable the optimal conditions for whanaungatanga relationships between the person, their whānau, and those providing compulsory care
 - f. bring about the best therapeutic and restorative outcomes for the person and their whānau.
4. The reasons for a person's need for compulsory mental health care should be addressed.
5. A choice of quality mental health care services should be made available, including Māori expertise and approaches to healing.

Principles relating to specific population groups will be continued to be worked on, this will include for example:

6. Children and young people subject to compulsory care should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, as practicable and appropriate.

Regulatory Impact Statement: Transforming Mental Health Law

Coversheet

Purpose of Document	
Decision sought:	The analysis in this paper has been undertaken to support Cabinet decisions on new mental health compulsory assessment and treatment legislation.
Advising agencies:	Ministry of Health
Proposing Ministers:	Minister of Health
Date finalised:	29 November 2022
Problem Definition	
<p>Legislative authority is required for the State to intervene for people with mental health conditions that, if left untreated, will have significant adverse effects on those people or others, but who do not have (at the time of intervention) the capacity to make informed decisions about their treatment. Reform is needed as current legislation does not reflect human rights' obligations, provide for supported decision-making, or align well with the recovery approach to mental health treatment. The current legislation has not been designed to meet Māori beliefs, needs and aspirations. While the legislation has a significant impact on the wellbeing of all people subject to compulsory treatment, there are substantial differences in the way the current legislation is working for different population groups, in particular Māori face more discrimination and inequitable outcomes than non-Māori.</p>	
Limitations and Constraints on Analysis	
<p><i>Cabinet agreed scope and principles</i></p> <p>The Government has accepted the recommendation of the Inquiry into Mental Health and Addiction that it:</p> <p><i>Repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 so that it reflects a human rights-based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment.</i></p> <p>Previous Cabinet decisions narrow the scope of considerations from the Inquiry recommendations to the minimised use of compulsory care but within a more human rights-based approach. This means that wider scope options such as general mental health legislation or no legislation have been ruled out of scope. Cabinet has agreed to the following high-level policy principles to guide development of new legislation and the overall transformation of the mental health system:</p> <ol style="list-style-type: none"> 1. human rights approach 2. maximum independence; inclusion in society; and safety of individuals, their whānau and the community 3. upholds Crown obligations under Te Tiriti o Waitangi 	

4. improved equity of care and treatment
5. recovery approach to care and treatment
6. timely service, access and choice
7. provision of least restrictive mental health care
8. respect for family and whānau.

(SWC-19-MIN-0070 refers).

Evidence and insights from consultation

There is limited evidence both domestically and internationally on the effectiveness of compulsory mental health treatment. Qualitative and quantitative studies both report mixed findings. There is also a lack of research on negative effects of compulsory detention and treatment. The issues around compulsory care – both inpatient and in the community – continue to be debated. However, there is a general consensus that coercion, which can be defined as any measure applied against the patient's will or in spite of his or her opposition, is overused in mental health care.

Feedback gathered from public consultation resulted in diverse views on what should be included in legislation making it difficult to rely on the feedback alone to help narrow options – including across key areas such as compulsory care and restrictive practices.

Cost-benefit analysis

We have not undertaken a comprehensive cost-benefit analysis. We have analysed selected benefits and costs, using conservative assumptions, to identify whether there is a plausible benefit from the proposed law changes. This analysis should not be treated as a precise valuation of the benefits or costs of the proposals, and we do not consider the figures are applicable to other contexts.

Responsible Manager (completed by relevant manager)

Kiri Richards
Group Manager
Mental Health and Addiction Strategy and Policy
Ministry of Health
30 November 2022

Quality Assurance (completed by QA panel)

Reviewing Agency:	Ministry of Health and Ministry of Justice
Panel Assessment & Comment:	The Regulatory Impact Statement was reviewed by a panel with representatives of the Ministry of Health and Ministry of Justice. The panel considers that the information and analysis summarised in the RIS meets the quality assurance criteria.

Section 1: Diagnosing the policy problem

What is the context behind the policy problem and how is the status quo expected to develop?

Current state

1. The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act / Mental Health Act) sets out the specific circumstances under which people may be subject to compulsory mental health treatment. The intended purpose of the Act is to provide for people experiencing a serious mental disorder to receive treatment, even if they do not agree to receive treatment, and to define and protect their rights.
2. The Act only applies to a narrowly defined group of people and was intended to be quite restrictive in the number of people it covers. The Act applies only to people who meet the Act's definition of "mental disorder": an "abnormal state of mind" which results in the person posing a serious danger to themselves or someone else.
3. The Act also sets out processes for people found by the courts to be not guilty by reason of insanity¹ or unfit to stand trial to receive mental health treatment in a secure environment. It also applies to people in prison and youth offenders in Oranga Tamariki care or custody who meet the criteria to receive compulsory care.
4. In the financial year 2020/21, 11,149 people were subject to some form of compulsory assessment or treatment. Māori were assessed and treated under the Act at about 3 times the rate of non-Māori.

Background information on current law

5. The current Act replaced the prior Mental Health Act 1969. The Act introduced reforms necessary to embed respect for human rights and enable a new structure for the delivery of mental health services following the closure of older psychiatric hospitals and the deinstitutionalisation of mental health care.
6. At the time, the Act was seen as transformative and represented a step forward with its requirement for care to be provided in the least restrictive manner, encouraging community care where possible, and recognition and protection of patients' rights.
7. The Act is now seen as no longer achieving its intended purpose and does not align with the wider Aotearoa New Zealand health system transformation. Since the Act was passed, Aotearoa New Zealand ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2008. The monitoring committee for the Convention considers that the Act does not align with the rights enumerated in the Convention.

Inquiry report and agreement to repeal and replace

8. In 2018 *He Ara Oranga – Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga)* was released. It set out a future vision of mental health and wellbeing for all. One of the recommendations was to repeal and replace the Act, noting that Aotearoa New Zealand has faced strong criticism about the Act. Criticism particularly related to non-compliance with international obligations and that the Mental

¹ The Rights for Victims of Insane Offenders Act 2021 comes into effect on 13 December 2023, and will change this to "act proven but not criminally responsible on account of insanity"

Health Act had a significant negative impact on people in terms of compulsory treatment and care, detention, seclusion and restraint.

9. In 2019, Cabinet agreed to repeal and replace the Act, and agreed on a set of high-level principles and objectives to guide the policy development:
 - a. human rights approach
 - b. maximum independence; inclusion in society; and safety of individuals, their whānau and the community
 - c. upholds Crown obligations under Te Tiriti o Waitangi
 - d. improved equity of care and treatment
 - e. recovery approach to care and treatment
 - f. timely service, access and choice
 - g. provision of least restrictive mental health care
 - h. respect for family and whānau.

(SWC-19-MIN-0070 refers)

10. In 2021, Cabinet approved a discussion document, *Transforming our Mental Health Law*, for public consultation. The discussion document set out the key topics that must be considered in the development of new mental health legislation. Public consultation opened on 22 October 2021 and closed on 28 January 2022. Submissions were received from over 300 people and feedback gathered from over 500 people across 60 online hui.

Key features of the current law

11. The Act is intended to only apply to those people with a mental disorder as defined in the Act. The Act presents a two-step test:
 - a. the first step requires the presence of an abnormal state of mind, either continuously or intermittently, characterised by delusions, or by disorders of mood, perception, volition or cognition
 - b. the second step requires that the presence of that state of mind causes consequences of a certain severity – either resulting in the person posing a serious danger to themselves or others, or being seriously diminished in the capacity to take care of themselves.
12. The presence of both an abnormal state of mind, and the risk of danger to self or others is needed before a person can be required to undergo assessment and treatment. The two-step process and definition are intended to stop someone being subject to the Act based on having an abnormal state of mind alone. The Act does not require those meeting the two-step test to accept treatment – anyone assessing a patient must also consider whether treatment is desirable.
13. The Act provides for compulsory examination where a person is believed to have a mental disorder. In general, this requires an application endorsed by a mental health practitioner (medical practitioner, nurse practitioner or nurse practicing in mental health) to be made to the Director of Area Mental Health Services (a statutory role appointed by the Director-General of Health for a particular area). The Director of Area Mental Health Services may then require the person to attend an examination or arrange for one to be conducted where the person is. The outcome of that examination may be a further period of compulsory assessment. The responsible clinician may apply to a court for a compulsory treatment order. The person who is the subject of the application is entitled to be present and represented.
14. The Act includes checks and balances to provide safeguards against any inappropriate use of coercive powers allowed under the Act. It provides for a Director of Mental Health, with powers to enter and inspect any facilities, people or records. It also

provides for district inspectors and official visitors, with similar powers of entry and inspection for their districts. Review Tribunals may be appointed to consider complaints and review treatment or detention decisions. A person subject to compulsory treatment or assessment may appeal to the Court against ongoing compulsion.

15. There are also rules for restricted and special patients, special provisions relating to children and young people, people with intellectual or physical disabilities and the protection of rights of patients and proposed patients. The rights enumerated in the New Zealand Bill of Rights Act 1990 and Human Rights Act 1993, and the Code of Health and Disability Consumers' Rights also protect recipients of compulsory assessment and treatment.

How is the situation expected to develop if no further action is taken

16. People will continue to be subject to legislation that is not in line with international or domestic human rights obligations. Māori are particularly disadvantaged by the Act, and if no further action is taken, they will continue to experience significant inequities and discrimination.
17. *He Ara Oranga* found the legislation does not align with domestic and international human rights obligations. The report highlighted potential inconsistency with the rights and freedoms contained in the New Zealand Bill of Rights Act 1990. In particular the rights relating to cruel treatment and arbitrary detention may be engaged due to the lack of statutory controls on the use of seclusion and restraint, and the lack of consideration of a person's decision-making capacity in the current definition of mental disorder.
18. Similarly, the monitoring bodies for international human rights instruments, particularly the United Nations Convention on the Rights of People with Disabilities have highlighted inconsistencies. The rights to equal recognition before the law and the liberty and security of the person are especially relevant. The Convention provides that people with disabilities (which includes mental health conditions) should enjoy legal capacity on the same basis as others, and that they should not be deprived of liberty merely because they have a disability. Other rights, such as reasonable access to mobility devices, may be engaged by some restraint practices, that are not adequately controlled by current legislation.

Ongoing government work programmes that are relevant

19. Aotearoa New Zealand's health and disability system is undergoing significant reform. The management of health services on a national, rather than district basis can be expected to improve care and support by internal monitoring and reduction of undesirable variation. The Pae Ora (Healthy Futures) Act 2022 outlines principles to guide the health sector, which will bind mental health services (as part of the health sector). The Minister of Health, the Ministry of Health, and other government agencies to whom these principles apply must be guided by these principles. These will have positive implications on the Crown's treaty obligations under new mental health legislation, as the health sector principles specify the need for an equitable health system and engagement with Māori.
20. *Kia Manawanui: Long-term pathway to mental wellbeing (Kia Manawanui)* also sets out the direction to transform Aotearoa New Zealand's approach to mental wellbeing, with short, medium and long-term actions to achieve the overall vision of pae ora. The repeal and replacement of the Mental Health Act is just one of the recommendations to

improve the health system and is part of the wider framework of change to overhaul the New Zealand mental health system.

21. These ongoing government work programmes and commitments need to be considered. New legislation will need to align with the transformation of the health and disability sector.

What is the policy problem or opportunity?

Nature, scope and scale of the problem

22. The current Mental Health Act is out of date and does not align with Aotearoa New Zealand's international and domestic human rights obligations, as well as being out of step with a rights-based and recovery approach to mental health care. Aotearoa New Zealand's health system is being reformed, with specific transformation of the mental health and addiction system underway. The current Act does not align with these shifts.
23. There are significant inequities in compulsory mental health assessment and treatment. Māori are disproportionately affected by the Act. In 2020/21, Māori were more likely to be assessed or treated under the Mental Health Act than other ethnicities. Māori represented around 35% of those subject to compulsory assessment, and around 38% of those subject to a compulsory treatment order, while making up about 17% of the population.
24. Submitters to the public consultation said services are sometimes discriminatory towards disabled people. They said there is often no accommodation for the needs of disabled people, and there is a lack of understanding of their needs, as well as adequate resourcing and training which we were told has resulted in their means of communication and mobility being removed or restricted.

Specific equity data related to compulsory treatment

- a. Of all population groups, Māori men were the group most likely to be subject to community and inpatient treatment orders
- b. Māori were 3 times more likely to be subject to indefinite community treatment orders than non-Māori, and 2.9 times more likely to be subject to indefinite inpatient treatment orders than non-Māori
- c. Pacific peoples were about twice as likely as the general population to be subject to compulsory treatment.
- d. for those subject to compulsory treatment, 38% of Māori, 27.7% of Pacific peoples and 28.1% of other ethnicities were under 20 years of age. This suggests compulsory treatment may be being overused for young Māori.

Specific data relating to the use of seclusion and restraint

- e. In 2020/2021, 8,596 people were accommodated in inpatient mental health services for a total of 238,948 bed nights; of these, 815 individuals (9.5%) aged 20 and over were secluded (excluding forensic patients, and those with an intellectual disability); this is a rate of 27.0 people per 100,000
- f. Māori were secluded at a rate of 79.5 people per 100,000 population, Pacific peoples at 27.0 people per 100,000 population and other ethnicities at a rate of 16.6 people per 100,000 population
- g. Restraint data in 2020/2021 is incomplete, as data was unavailable from four of the former district health boards and there are inconsistencies in the data. The

incomplete 2021 data that we do have shows 1,934 individuals were restrained for a total of 6,769 restraint events².

Stakeholder views

25. Through the recent public consultation³, we engaged widely to ensure feedback was representative of key groups, including people with lived experience and their family and whānau, Māori, Pacific, Asian and ethnic communities, members of the disabled community, the mental health sector including non-government organisations and clinicians as well as the general public. There were diverse views and very few areas of consensus across the topics and areas up for discussion.
26. Across stakeholders there was a desire to see major changes to mental health law in Aotearoa New Zealand, including that it be more tāngata whaiora⁴ and whānau-focused. Some stakeholders consider that the current Act is misused, especially as a punitive and coercive measure. Māori stakeholders have raised that the current Act does not adequately reflect the special relationship between Māori and the Crown, and principles under Te Tiriti o Waitangi (tino rangatiratanga, equity, options, partnerships and active protection)⁵.
27. Some stakeholders in the mental health sector see the current Act as no longer relevant and not tāngata whaiora focused. They also said the Act is ambiguous which makes it harder for clinicians and people in the mental health sector to apply it consistently, as well as being disadvantageous to users.
28. These points were also raised by stakeholders in the Māori mental health sector, along with the lack of focus on whānau and the disproportionate effect of the Act. Submitters also have concerns about the inherent bias of mental health professionals and that the Act is disadvantageous to Māori.
29. Some stakeholders with lived experience criticise the Act for being dis-empowering and not protecting individuals' human rights. They said the Act causes trauma to those who are placed under it, and it is hostile, culturally unsafe and coercive.

What objectives are sought in relation to the policy problem?

30. The policy objectives for this work have been informed by principles and directions indicated in previous Cabinet decisions for this work, as well as from *He Ara Oranga, Kia Manawanui*, and feedback we received during public consultation.
31. The policy objectives are to achieve a modern mental health legislative framework that:
 - a. upholds the Crown's obligations under Te Tiriti o Waitangi
 - b. supports modern approaches for mental health care that are grounded in te ao Māori, a recovery approach, and supports the safety of tāngata whaiora and others

² Data taken from PRIMHD – the Ministry of Health mental health database – extracted 3 June 2022. All data is for 2020/21. Restraint data is from manual reporting from the former DHBs.

³ Repealing and Replacing the Mental Health Act: Analysis of Public Consultation Submissions https://www.health.govt.nz/system/files/documents/publications/repealing-replacing-mha-consultation-submissions_analysis-august-2022.pdf

⁴ Tāngata whaiora refers to the population group who use mental health services, and tangata whaiora to an individual. These terms are used in this paper to refer to people to whom mental health legislation would apply. It is preferred over terms such as 'patient', 'service user' and 'consumer'

⁵ [Te Tiriti o Waitangi | Ministry of Health NZ](https://www.health.govt.nz/our-work/te-tiriti-o-waitangi)

- c. encourages maximum independence and social inclusion
- d. ensures that human rights are respected and protected.
- e. supports people to make decisions about their mental health care and ensures those who have decision-making capacity are not compelled to receive mental health care
- f. achieves equitable outcomes for those receiving support under the legislation, with particular attention to achieving equitable outcomes for Māori
- g. minimises the use and duration of compulsory care, including by preventing the need for a person to enter or re-enter compulsory care, rather than just managing crises
- h. minimises the use of seclusion and restraint, with the intention to eliminate seclusion
- i. includes effective mechanisms to monitor services, ensuring human rights are respected, and the purposes of the legislation are achieved.

Te Tiriti o Waitangi

32. An additional set of Te Tiriti o Waitangi policy objectives have helped to shape the policy work and identify and assess detailed options. The Tiriti o Waitangi policy objectives are:

Te Tiriti o Waitangi policy objective for new mental health legislation	Relevant Te Tiriti o Waitangi principle/s
A. tikanga and te ao Māori conceptions of holistic wellbeing and traditional approaches to healing are promoted and protected	Active protection, equity, options
B. tāngata whaiora Māori are entitled to choose support that meets their needs and supports their recovery	Equity, options
C. tāngata whaiora Māori are recognised in the context of their whānau, hapū, iwi, and hāpori	Equity, tino rangatiratanga
D. equitable mental wellbeing outcomes for tāngata whaiora Māori and their whānau, hapū, iwi, and hāpori are prioritised	Equity
E. tāngata whaiora Māori, their whānau, hapū, iwi, hāpori, and other Māori experts are empowered to collaborate and partner with agents of the Crown	Partnership, tino rangatiratanga

33. The Treaty consideration is within the context that services will be guided by the health sector principles enumerated in the Pae Ora (Healthy Futures) Act 2022. Those principles incorporate the concepts of the treaty principles identified by the Waitangi Tribunal in its *Hauora* inquiry. For example, the health sector principles provide that the health sector should provide a choice of high-quality services to Māori, including by

resourcing services to meet the needs and aspirations of iwi, hapū, and whānau, and Māori.

Section 2: Deciding upon an option to address the policy problem

What criteria will be used to compare options to the status quo?

34. The criteria below have been identified to ensure options align with the policy objectives and will support transformational change. The criteria are:
- a. **Te Tiriti o Waitangi** – options will be assessed on the extent to which they align with our Te Tiriti o Waitangi obligations better than the status quo. This includes how well options work for Māori and encompass te ao Māori world views, as well as how they align with the Tiriti framework.
 - b. **Effectiveness** – options will be assessed on how effective they are at achieving the policy objectives better than the status quo. This includes the extent to which options are effective in implementation, effective in positively transforming the mental health system and effective in solving our problem definition.
 - c. **Human rights** – options will be assessed on the extent to which they align with our domestic and international human rights obligations better than the status quo.
 - d. **Sustainability and durability** – options will be assessed on how well they will last, how feasible it is to have the option as a long-term solution, and how it will stand up to other changes in the system over time compared to the status quo.
 - e. **Fiscal, practicality, and implementation** – options will be assessed on how well they balance value for money as well as ease and feasibility of implementation – especially around workforce and resourcing considerations.
35. These criteria have not been explicitly weighted, however a failure to achieve a positive score in relation to criterion a (Te Tiriti o Waitangi) and criterion c (Human rights) would significantly reduce an option's chances of being the preferred approach.

What scope will options be considered within?

36. Previous Cabinet decisions provide direction and parameters on the overall scope of this work. In particular, in 2019, Cabinet agreed to repeal and replace the current Mental Health Act. The Minister of Health outlined to Cabinet that the overall objectives of new legislation must be to ensure individual and whānau human rights are protected and respected, and that equity is improved. The Minister also stated that the use of compulsory treatment under new legislation must be limited, with mechanisms in place to closely monitor its use. This presumes that new mental health legislation will be developed, including some degree of compulsion. This means we have not undertaken a first principles review of the nature and scope of new legislation. This also means that having no specific mental health legislation has not been considered as an option. The options considered are within this scope of some compulsion based on the presence of mental health needs.
37. Options have been considered in the context of the significant overhaul being undertaken of mental health and addiction services in Aotearoa New Zealand. There are non-regulatory options that will contribute to our overall goal, for example, through the development and implementation of Te Oranga Hinengaro - Māori Mental Wellbeing, the System and Service Framework which will set expectations for what services should be to different groups of people, as well as the significant investment in

service expansion and workforce developments in recent budgets. This analysis does not explicitly consider those non-regulatory options but does refer to them as appropriate.

What options are being considered?

38. This analysis considers options in three areas in detail, generally because they have potential financial implications. These three areas are:
 - Criteria for compulsory mental health care
 - Person and whānau led approaches and supporting people to make decisions
 - Restrictive practices, such as seclusion and restraint.
39. This includes considering in detail the question of legal criteria for compulsory treatment, as it is fundamental to the proposed legislation. The options have been considered from a safety/harm lens as well as from a decision-making lens focusing on broader welfare/wellbeing and more narrowly on treatment.

Legal test for compulsory treatment

40. The key decisions related to the legal criteria for compulsory treatment are the threshold for intervention and the consideration of a person's capacity to make decisions. The present criteria do not include an assessment of a person's competence as part of the decision to require them to accept assessment or treatment.

Capacity

41. A consideration of capacity is key to meeting the objectives of reform. Compulsory treatment is a significant limitation on a person's rights, and it is not clear that the limitation can be justified where a person has the capacity to decide for themselves. Limited decision-making capacity is a good place to draw the line between the state's duty to respect individual autonomy, and its duty to safeguard its citizens' wellbeing.
42. Capacity assessments are complex, and capacity can fluctuate. Any option including capacity is likely to be more resource intensive. The impact on overall service use is unclear. There is no New Zealand literature suggesting that a large number of people with capacity are made subject to compulsory treatment. International data is ambiguous, with some jurisdictions increasing their use of compulsory treatment after introducing capacity tests and others remaining roughly constant. These largely appear to reflect existing trends and careful monitoring will be required.
43. Capacity should be assessed in the context of a person's life and culture. The introduction of a capacity test is an opportunity for the health system to be more responsive to Māori by incorporating Māori concepts and social structures into capacity assessments. For example, if a person has capacity when supported by whānau and such support is in place, they should be assessed as having capacity.
44. Capacity may be assessed in the general context of a person's management of their life or more narrowly in the context of particular decisions. The general capacity assessment opens the possibility of people being assessed on the basis of the outcome of decisions, rather than their capacity to make them. For example, it would be easier to find a lack of capacity related to personal care that did not necessarily relate to a person's mental condition. The narrow scope, related to decisions about mental health treatment would ensure decisions related to a person's mental condition and contribute to reducing the inappropriate use of compulsion.
45. Submitters were concerned that the introduction of a capacity element to the criteria for treatment might delay treatment. Their concern was that people would be left without treatment until their condition had deteriorated and caused adverse effects. It is unlikely that a significant number of people meet the other criteria for compulsory treatment and retain decision-making capacity. It is also important to remember that people can and

do seek and receive treatment voluntarily. These concerns reflect a view that compulsory treatment is a way to secure treatment where services are stretched.

Option One: Status Quo

46. Under the status quo, a person cannot be subject to compulsory treatment unless they have a 'mental disorder' as defined in the Act:
 - a. abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition
 - b. to such a degree that it
 - i. poses serious danger to the health or safety of that person or of others, or
 - ii. seriously diminishes the capacity of the person to take of himself or herself.
47. Both elements have to be met before a person can be subject to compulsory treatment. A person may not be required to accept treatment on the ground of an abnormal state of mind alone.
48. It is unclear where the thresholds for serious danger, or seriously diminished capacity are. The broadness and lack of clarity of the definition has led to inconsistent use and overuse of the Act. The definitions are vulnerable to threshold creep in a risk-averse environment. The status quo has been also criticised by numerous groups, mainly for the use of the term 'mental disorder' and the 'serious danger' element. These are seen as stigmatising.

Option two: Safety/harm criteria but with higher threshold

49. Under this option, the legal test would be based on a safety/harm approach, as follows:
 - a. The person must **need** mental health care or treatment, and
 - b. The person must be **able to benefit** from mental health care or treatment, and
 - c. If the person does not get mental health care or treatment, there will be serious **adverse effects**, which are both likely and imminent.
50. This option aligns with stakeholders who saw a place for very limited compulsory treatment, and as the criteria is narrower than the status quo it would be expected to reduce unnecessary coercion. Stakeholders may not see this option as transformative enough, and too similar to the status quo. However, it would certainly still be an improvement on the status quo by requiring the adverse effects to be both likely and imminent, which is far more narrow than the status quo
51. This option would need to be supported by changes in practice and wider elements of the legislation. For example, Māori are currently overrepresented in compulsory treatment, and this option could continue a narrow assessment of risk, which is likely to continue to disproportionately affect Māori. This would be mitigated through other elements of the legislation; for example, the health sector principles in the Pae Ora (Healthy Futures) Act will apply, including the requirement that services are culturally responsive and find opportunities for Māori to exercise decision-making authority.

Option three: Improved test with capacity element relating to welfare

52. New entry criteria would be based on a broadly defined capacity approach, as follows:
 - a. The person must **need** mental health care or treatment, and

- b. The person must be **able to benefit** from mental health care or treatment, and
 - c. If the person does not get mental health care or treatment, there will be serious **adverse effects**, and
 - d. The person does not have **capacity to make decisions about their own wellbeing/welfare**.
53. This option would have greater alignment with the views of some stakeholders that wanted to see some form of capacity element introduced in new legislation, however this option could be seen as too broad and subjective.

Option four: Improved test with capacity element relating to decision making

54. New entry criteria would be based on a narrowly defined capacity approach, as follows:
- a. The person must **need** mental health care or treatment, and
 - b. The person must be able to **benefit** from mental health care or treatment, and
 - c. If the person does not get mental health care or treatment, there will be **serious adverse effects**
 - d. The person does not have **capacity to make decisions about their care or treatment**.
55. The capacity threshold in this option relates only to decision-making capacity about care and/or treatment. Because the scope of this option is quite narrow it does not face some of the criticisms of the other options.
56. In particular, this option best reflects international legal precedents and frameworks for decision making capacity in relation to health interventions.
57. There is a large difference in the nature of the capacity consideration in options three and option four. Option three has a much wider scope as it relates to any decision regarding their own wellbeing or welfare, not just mental health care and treatment. Option three would allow for someone to find a lack of capacity related to a person's personal care that did not necessarily relate to a person's mental illness

How do the options compare to the status quo/counterfactual?

	Option One – Status Quo	Option Two – Safety/harm, higher threshold	Option Three – Decision-making capacity re welfare/ wellbeing as required element	Option Four – Decision-making capacity re treatment as required element
Te Tiriti o Waitangi	0	0 <ul style="list-style-type: none"> This option is only marginally better through having a higher threshold. This option still represents state intervention without incorporation of matters important to Māori. 	+ <ul style="list-style-type: none"> A deeper understanding of te ao Māori would need to inform the practice of capacity assessment, particularly the nature of support available from whānau, which may in practice mean a person has functional capacity 	+ <ul style="list-style-type: none"> Similar to option 3, but with a tighter focus to the capacity assessment (focus on particular care/treatment decision at hand). A deeper understanding of te ao Māori would need to inform the practice of capacity assessment, particularly the nature of support available from whānau, which may in practice mean a person has functional capacity.
Human Rights	0	+ <ul style="list-style-type: none"> Would continue to allow the decisions of competent people to be overridden through substituted decision-making. However, would permit substituted decision-making/compulsory care only as a last resort. 	+ <ul style="list-style-type: none"> Significant limits on human rights remain but may be more justifiable than the status quo, given the decisions of people who retain capacity would not be overridden. This aligns more with the UNCRPD principle that people with disabilities should enjoy legal capacity on the same basis as others. Because of the broad view of capacity, this may overly limit rights through consideration of capacity not related to mental illness. 	++ <ul style="list-style-type: none"> Significant limits on human rights remain, but likely to be more justifiable than the status quo and the other options. Supports principle of people enjoying legal capacity on an equal basis. Restriction of assessment to decisions about treatment limits risk of inappropriate assessment.
Effectiveness	0	+ <ul style="list-style-type: none"> Somewhat supports a shift from harmful risk-based approaches, with a focus on needs and benefits and narrower adverse effects. 	+ <ul style="list-style-type: none"> Supports a shift away from risk-based approaches, as capacity becomes a key element of entry criteria and not risk. 	++ <ul style="list-style-type: none"> As with option 3, supports a shift away from risk-based approach, as decision-making capacity becomes a key element of entry criteria and not risk. Capacity is considered in a narrow way, specific to a particular decision at a specific time, so will narrow the entry criteria, and more likely reduce compulsory orders if implemented as intended.
Sustainability and durability	0	0 <ul style="list-style-type: none"> Likely to be criticised by national and international human rights bodies and advocacy groups due to inconsistency with human rights obligations. Moves somewhat in the direction of the transformation of the mental health system, as long as intention to narrow criteria and reduce the use of compulsion happens in practice. 	+ <ul style="list-style-type: none"> As with option 2, moves somewhat in the direction of mental health system transformation. Would need to be considered in the context of the Law Commission's review on adult decision-making capacity law. 	++ <ul style="list-style-type: none"> More closely aligned with the direction of both domestic and international mental health system reform. Would need to be considered in the context of the Law Commission's review. Aligns best with international legal precedents and frameworks for decision making capacity in relation to health interventions, such as Gillick one and two rulings.
Fiscal, practicality and implementation	0	+ <ul style="list-style-type: none"> Tighter definitions and clear intention in legislation may make criteria less broad and ambiguous than the status quo. However, still relies on fairly broad concepts that may not give a clear indication to service users when intervention may occur. 	0 <ul style="list-style-type: none"> This option for capacity is quite broad which makes assessing capacity harder. 	+ <ul style="list-style-type: none"> As with option 3, capacity assessments can be complex, and may be time consuming and resource intensive to implement. However, decision-makers in a health context should be seeking informed consent for all treatment, so there will be some experience of functional capacity assessments.
Overall assessment	0	+3	+4	+8 Preferred option

Key:

- ++ much better than the status quo
- + better than the status quo
- 0 about the same as the status quo
- worse than the status quo
- much worse than the status quo

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

58. Due to the significant limits compulsory care places on human rights, we consider it is only reasonable and proportionate for the State to intervene when tāngata whaiora do not have decision-making capacity to make decisions about their mental health care and treatment and when this is likely to cause or has already caused serious adverse effects. Including decision-making capacity as a key element of the criteria for entry into legislation ensures that people who retain decision-making capacity are not compelled to receive mental health care. Therefore, **Option four** is our preferred option, in relation to the rationale for compulsory treatment in Aotearoa New Zealand.
59. Option four is also better than the status quo in all of the areas and is the best option out of all four with respect to sustainability and durability, human rights and effectiveness.

PROACTIVELY RELEASED

Person and whānau led approaches

60. Person and whānau led approaches are key to modern health care practice. We have considered a range of provisions, broadly falling under these headings:
- a. Advance directives – there is existing provision in the Code of Health and Disability Consumers Rights. Practice is inconsistent, and there are aspects of treatment about when a directive should be more than advisory
 - b. Nominated persons – these would be nominated persons whose role is to represent the interests of the person under legislation. They would not be attorneys able to make decisions on a person's behalf
 - c. More robust family and whānau involvement in a person's care – at present the requirement is for the family to be consulted where possible, and this may be foregone if not reasonably practicable. There is inconsistent practice nationally
 - d. Independent support/ally – to advise and assist a person subject to compulsory treatment to, for example, exercise their rights and participate in decisions being made about them
 - e. Provision for whānau/clinical meetings to support a person in care and collectively determine the right approach. This could be a family or whānau group hui or a collective group discussion.

Option One: Status Quo

61. The current Mental Health Act is criticised for its lack of person and whānau-centric care. The current Act does not have any provision for people to be supported in making decisions about their own mental health care and it relies on the use of substituted decision-making.
62. The Act also does not have any explicit guiding principles, any effective provisions for the inclusion of family and whānau and has limited guidance on the care, treatment and support of people under the Act.

Option Two: Status quo with closer monitoring

63. While there are existing comprehensive guidelines in specific documents, they are not routinely enforced. This option would maintain the guidelines as they currently are (and not put anything into primary legislation), but would require closer monitoring, and data reporting on whether person-centric options in the guidelines are being used and implemented.
64. Currently the use of supported decision-making tools such as advance directives are recommended in guidelines. There is no legal requirement to offer these tools to people. There are also extensive guidelines on how clinicians should involve families and whānau in care. However, in practice it is up to clinicians how to approach the issue, and currently it is unclear what level of family or whānau involvement occurs in practice; the lack of a specific statutory requirement means it is often neglected due to time pressure. The Act also provides limited guidance on care, treatment and support to be provided.
65. This option would still largely allow for substituted decision-making as the default option, which does not uphold Te Tiriti o Waitangi principles and results in minimal Te Tiriti o Waitangi improvements. Allowing for a substituted decision-making option, even with higher monitoring, does not align with human rights, and as such, is no different to the status quo in relation to improving human rights.

Option three: Legislate for more person and whānau led approaches

66. This area of person and whānau-led approaches has been considered as a package. We have assessed the individual elements of the package (such as the provisions mentioned above) against the status quo but this is intended to be a package of options for tāngata whaiora from which they are able to choose which provision they would like to use. For example, a person may have an advance directive and leave it at that, or they may have an advance directive but also want formal involvement of their family in decision-making. The intent is to legislate obligations on health services to support tāngata whaiora if they choose to use particular options, rather than to require people to have, say, a whānau conference if they do not wish to.
67. We have not analysed the provision for nominated persons separately as it is simply formalising an existing practice and has no particular cost associated with it.
68. This option would build person and whānau-centric care into the legislation, supported by guidelines, rather than being contained entirely in guidelines. This option would have supported decision-making tools built into legislation, as well as an improved process which would mean the Act was based on a supported decision-making model. This would be supported by a set of guiding principles (including the health sector principles in the Pae Ora (Healthy Futures) Act 2022).
69. Legislating for person and whānau led approaches will also allow for greater consistency with the principles of Te Tiriti o Waitangi.
70. These inclusions will empower people to have a voice in their own mental health care, treatment and support, which is a huge improvement on the status quo, which as stated, relies on substituted decision-making.

Human rights impact

71. This option overall has a positive human rights impact. The majority of the inclusions upholds Right 7 of the Code of Rights, and potentially engages the right to freedom of association.

Implementation logistics

72. Some of these roles that are suggested – such as the independent support/ally and the supported decision-making coordinator would require additional resourcing as this would be a new role in legislation and does currently not exist. Both roles will require additional funding in order to be established, as well as salary consideration for these roles.
73. Implementing advance directives will require a national database or repository for storing the advance directives and for easy access. There would also need to be a network administrator for safeguarding and maintaining data integrity. There may also be data sovereignty issues to work through.

Advance directives

74. This option would include provision for a person to make a formal and binding advance statement. Content would include:
 - a. options and choices for care and treatment
 - b. nominated person to contact and support person
 - c. people included in care and people not to be included.

75. It would also provide a convenient place to record information about a person's preferences about their personal affairs in the event they become unwell. For example, this could include preferences about childcare, which otherwise may not be known.
76. Advance directives can potentially help create a positive relationship between the person, family and whānau and clinicians, while promoting equal participation in mental health practice.

Nominated persons

77. This would allow a person to nominate a person/s to represent their interests, for example, receive information and be consulted and involved in decisions about their care, in the event they become unwell, and for the time they are unwell. This person/s would not be an attorney and would not replace the role of an attorney appointed under the provisions of the Protection of Personal and Property Rights Act 1988. This person/s could be nominated via an advance directive.

Family or whānau involvement

78. This option would require family and whānau to be consulted as appropriate by the responsible clinician when a person is subject to compulsory care.
79. Respect for family and whānau and taking a whānau centred approach will be a principle to guide the development of new mental health legislation. Families and whānau have a key supportive role to play in care and recovery. However, the wishes of the person in respect of the involvement of their families and whānau should be the primary consideration. Nothing proposed would require a person to have their family or whānau involved if they did not wish it, or for the family or whānau to be involved against their will.
80. The guidelines on how family and whānau should be involved in a person's care are extensive, and recently updated. Anyone assessing or treating someone under the Act must follow those guidelines. We know, however, from public consultation submissions that there is inconsistent practice at present. The major opportunities are likely to be in service improvement, rather than statutory. However, there are opportunities to strengthen and better recognise the role of family and whānau by improving legislative provisions. To protect the person's decision-making rights, guidance would also set out the transitions following a return to mental wellbeing or a reduction in the chance of serious adverse effects.
81. This option will support whānau, hapū, and Iwi to be informed and empowered to participate in the assessment process and to be part of the decision-making process, in accordance with the person's wishes.

Supported decision-making mechanisms

82. We propose two additional system roles to support people to make decisions:
 - a. independent support, and
 - b. coordinators for supported decision-making hui.
83. The independent support would be a person independent of other decision-makers. They would be intended to support the person, including to exercise their rights, and participate in decisions being made about them. The person fulfilling this role could be, for example, a peer support worker or social worker. This will place tāngata whaiora in a strong position to exercise their decision-making capacity to the greatest extent possible.
84. Supported decision-making hui would take place to identify options for care, treatment and support when a person does not have other decision-making processes in place. This process would be inclusive of tāngata whaiora and other people of significance identified by tāngata whaiora such as their whānau. A person's (self-identified) whānau

are a strong supportive factor, with existing relationships and good knowledge of the person. This option requires care that the whānau group does not substitute its own judgement for that of the person, which is an important role of the coordinator.

85. Including independent support and coordinators will have a strong emphasis on whakawhanaungatanga and the desire to have wider whānau included in decisions and care.

Other person and whānau led provisions

86. Processes for compulsory assessment and treatment under new legislation:
- a. include a broader range of people to support a more holistic understanding of tāngata whaiora, for example clinical, cultural and lived experience perspectives as well as family and whānau
 - b. include more frequent review of the status of tāngata whaiora under legislation and opportunities for exit from legislation
 - c. include a greater recognition of the culture and beliefs of tāngata whaiora, and are more strengths-based.

How do the options compare to the status quo/counterfactual

	Option One – Status Quo	Option Two – Status Quo but with higher monitoring	Option Three – Legislate for Person and whānau led approaches			
			<u>Formal advance directives</u>	<u>Family and whānau involvement required</u>	<u>Independent support/ally for tāngata whaiora</u>	<u>Supported decision-making coordinator</u>
Te Tiriti o Waitangi	0	0 <ul style="list-style-type: none"> No change in Treaty provision. Possibly a marginal improvement from closer monitoring 	++ <ul style="list-style-type: none"> Providing responsive care in a more mana-enhancing manner that enables greater self-determination over a person's own mental health and wellbeing outcomes. 	+ <ul style="list-style-type: none"> Stronger involvement of whānau will support whakawhanaungatanga by enabling whānau, the tāngata whaiora and health professions to build strong and trusted relationships at key decision points about the person's care. 	++ <ul style="list-style-type: none"> This option moves away from a purely clinical and westernised lens of mental health treatment. 	++ <ul style="list-style-type: none"> This option moves away from a purely clinical and westernised lens of mental health treatment.
Human Rights	0	0 <ul style="list-style-type: none"> Would still allow a competent person's wishes about treatment to be overridden. 	++ <ul style="list-style-type: none"> Promotes personal autonomy with greater alignment to UNCRPD. 	0 <ul style="list-style-type: none"> May be seen as imposing family structure on tāngata whaiora. This is mitigated by the principle that a person's family and whānau is self-identified, rather than solely based on affiliation or whakapapa. 	++ <ul style="list-style-type: none"> Promotes personal autonomy with greater alignment to UNCRPD provision about persons being supported to exercise decision-making capacity. 	+ <ul style="list-style-type: none"> Promotes personal autonomy with greater alignment to UNCRPD. However, there is a risk that decisions made by a hui may not reflect tāngata whaiora wishes in some cases.
Effectiveness	0	+ <ul style="list-style-type: none"> Having closer monitoring and mandatory reporting would be more effective than the status quo as there would be some form of accountability and may result in better usage of the tools and guidelines that are available. 	++ <ul style="list-style-type: none"> Inclusion of these can potentially minimise the use and duration of compulsory care, particularly if everyone is collectively able to understand and work towards meeting the individual needs of tāngata whaiora and their family and whānau, however it may cause practice issues because of complexities involved in overriding advance directive. 	+ <ul style="list-style-type: none"> Family and whānau involvement in care and support of a person has a positive effect, where the person's wishes are taken into account (as far as possible). 	++ <ul style="list-style-type: none"> Puts tāngata whaiora in best position to exercise their decision-making capacity to the greatest extent possible. The time tāngata whaiora spend under the Act can feel more collaborative and effective. 	++ <ul style="list-style-type: none"> Helps to create a positive relationship between the person, family and whānau and clinicians, meaning treatment and the time tāngata whaiora spend under the Act can feel more collaborative and effective. Family likely to be in a strong position to support tāngata whaiora through existing relationships and knowledge of person.
Sustainability and durability	0	0 <ul style="list-style-type: none"> Existing objections and adverse views by international monitoring bodies continue to create pressure for change. 	++ <ul style="list-style-type: none"> Supports people who use mental health services to exercise their capacity to make decision in advance including health professionals and family and whānau. 	0 <ul style="list-style-type: none"> There can be significant barriers to family and whānau involvement, with work and other commitments interfering, that may mean in the long run, family and whānau support fades out or is hard to get. 	++ <ul style="list-style-type: none"> Strengthens peer support roles in Aotearoa New Zealand and can ensure facilitation of other supported decision-making tools. 	++ <ul style="list-style-type: none"> Supports people who use mental health services to exercise their capacity to make decisions in advance including health professionals and family and whānau.
Fiscal, practicality and implementation	0	0 <ul style="list-style-type: none"> Marginally increased cost likely 	- <ul style="list-style-type: none"> Would require workforce training to support tāngata whaiora in developing and completing an advance directive. 	0 <ul style="list-style-type: none"> Costs largely fall on the family and whānau. Likely to be some increase in travel assistance. Practicality an issue sometimes, but an emergency exception is allowed. 	- <ul style="list-style-type: none"> Independent ally pay is comparable to a health professional who has six plus years of experience. 	- <ul style="list-style-type: none"> Supported decision-making coordinator pay is comparable to a health professional who has six plus years of experience in mental health.
Overall assessment	0	+1	+7	+2	+7	+6
			Preferred options			

Key:

- ++** much better than the status quo
- +** better than the status quo
- 0** about the same as the status quo
- worse than the status quo
- much worse than the status quo

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

87. After assessing the options, it is evident that the status quo surrounding person-centric services is not sufficient. The status quo relies on substituted decision-making, has an outdated model for care, support and treatment, does not meet the needs of Māori and gives minimal effect to the role of family and whānau. The process for compulsory care is also criticised. Therefore, option three is the preferred option. This option ensures that the person along with the family and whānau are at the centre of decisions being made. This would represent a significant shift towards a supported decision-making approach through advance directives and independent support and improving the care, treatment and support of a person. This option meets all the objectives and will have a positive impact on people under compulsory care.

PROACTIVELY RELEASED

Seclusion and restraint

88. The Government's policy is that the use of restraint in mental health services should be limited and the use of seclusion should be eliminated entirely. Seclusion is the isolation of a person in solitude, and restraint refers to the use of physical force in various forms, including holding a person down, applying wrist restraints, or locking them in a particular area. These are not therapeutic practices, but are used to control people when they may pose a danger to themselves or others.
89. Reducing seclusion and restraint in mental health services was listed as an action in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. Work is happening across the motu on this, through various projects and initiatives, but there are many criticisms that this work is not doing enough to reduce and eliminate the use of seclusion and restraint.
90. We have considered four options for legislation:
 - a. status quo
 - b. prohibiting particular forms of restraint in their entirety
 - c. prohibiting seclusion, with a statutory end-date
 - d. providing mechanisms to limit the use of seclusion and restraint.

Option One: Status Quo

91. The Mental Health Act allows the use of:
 - a. seclusion – *seclusion shall be used only where, and for as long as, it is necessary for the care or treatment of the patient, or the protection of other patients* (Section 71)
 - b. use of force – *the ability to use force (Section 122B) when exercising a power under the Act implies that in some cases restraint may reasonably be used.*
92. The current Act allows people to be detained in a hospital setting for the purpose of assessment and treatment and under compulsory treatment orders. Detention in a hospital setting is seen by many as a form of restrictive practice in and of itself. We note that this speaks to the wider question of the settings and purpose in which compulsory care is appropriate.
93. The use of restraint is permitted in various settings in addition to residential mental health and addiction settings, including aged residential care, residential disability services, and public or private overnight hospital inpatient services. Any statutory prohibition would need careful consideration to avoid unintended consequences.

Option Two: Prohibition of restrictive practices, such as seclusion and restraint

94. Under this option the use of restrictive practices would be prohibited in legislation. Some mechanism would be required to detain people to receive care if needed to meet the needs of tāngata whaiora, which is likely to include personal and/or physical restraint.
95. This would be a significant departure from the current legislation, but would align with the perspectives of lived experience, Māori health sector and family, whānau stakeholders who considered that seclusion and restraint are almost always unnecessary in inpatient settings, with many in this group calling for an outright ban of seclusion. However, clinicians and those in the mental health sector consider that

some form of restrictive practice is needed to keep tāngata whaiora, staff and other tāngata whaiora safe in certain circumstances.

Considerations

96. A full ban on particular forms of restraint could lead to a potential increase in other forms of restraint. It could also lead to higher involvement by police, by removing other options to deal with serious incidents of violence. Services have a duty to keep patients and staff safe. There are justifications in law for the use of force in defence of oneself or another, but this option could create uncertainty about when force may be used and increase risk to patients and staff.

Option Three: Prohibition of seclusion within statutory timeframe

97. Legislation would ban seclusion within a certain timeframe (eg, five or ten years) but allow restraint in limited circumstances. This would be a significant departure from current legislation. This reflects the Government's existing policy of reducing restraint in mental health services, with zero seclusion as an end goal.
98. This also aligns with stakeholders who thought some form of restrictive practices should be allowed with limits set down in legislation, and those who supported an eventual elimination of seclusion.

Considerations

99. The option of eliminating seclusion in a set timeframe will potentially have greater alignment with human rights but would be dependent on that being done effectively and not resulting in an increase in other inappropriate forms of restraint.
100. There would need to be careful consideration of implementation. Attempting to significantly reduce seclusion without appropriate practice and operational changes in place may lead to an increase in other forms of restraint or diversion to the criminal justice system. This option also risks not achieving the set timeframe.
101. We do not support a statutory end-date at this stage. We consider the timing of, in particular, increases in workforce capacity and capability, are not sufficiently predictable to set a statutory deadline.

Option four: Limiting use

102. Legislation would allow restrictive practices, but provide mechanisms to control their use. It would include a duty on all persons working within mental health services to minimise the use of restrictive practices, including that all other practicable options must be tried first. It would also require all instances of seclusion and restraint to be reported to the Director of Mental Health, and the Director to then publicly report seclusion data at least annually. This data would be used to monitor any patterns or frequency of restrictive practices, to reduce inequities and to ensure that all other measures have been tried first. This option will also work towards the end goal of eventually eliminating seclusion, but not within definite timeframes.
103. This option reflects the Government's existing policy to reduce restraint and eliminate seclusion. It also aligns with stakeholders who agreed that the use of seclusion and restraint should be tightly prescribed and only be used as a last resort when all other appropriate options have been exhausted, and that this should clearly be defined in the new mental health legislation.

Considerations

104. This option will have extremely stringent data and reporting associated with any use of restrictive practices, as they would only be allowed to be used in very limited circumstances. This will provide insights on the incident and into where interventions could have made a difference, thus reducing the use of incidents over time. However, it needs to be noted that the current reporting system will not be able to record the

suggested reporting, so a new IT system designed to capture the required data or manual reporting will need to be considered.

105. There will be similar training costs and extra pressures on staff time for reporting. In 2020/21, there were 1,802 seclusion events and an estimated 10,000 uses of restraint. Under this option, these events must all be reported in detail, which will have an impact on staff time although services are already expected to undertake this reporting, so this should not be a new cost.

PROACTIVELY RELEASED

How do the options compare to the status quo/counterfactual?

	Option One – Status Quo	Option Two – Prohibition of restrictive practices, such as seclusion and restraint	Option Three- Prohibition of seclusion in statutory timeframe	Option Four- Limiting use
Te Tiriti o Waitangi	0	++ <ul style="list-style-type: none"> Restrictive practices pose serious equity issues, with Māori about 5 times more likely to be secluded. Banning the use of restrictive practices would improve equity for Māori. 	+ <ul style="list-style-type: none"> This option still allows for some use of restraint in certain limited circumstances. Submitters regarded any form of restrictive practice as inconsistent with Te Tiriti o Waitangi, so while better than the status quo, it still is inconsistent with te ao Māori views. 	+ <ul style="list-style-type: none"> Similar to status quo, but with limited use. This is receiving a positive score, as even though restrictive practices are permitted, they will be limited by a duty of people working in the sector, and the requirement that other practicable options are tried first.
Human Rights	0	++ <ul style="list-style-type: none"> By banning restrictive practices, this option aligns with our UNCRPD obligations, and also will improve human rights, dignity and reduce trauma. 	+ <ul style="list-style-type: none"> This option will allow some forms of restraint in limited use, however any reduction in restrictive practices will benefit people's human rights and reduce the trauma people face in services. 	+ <ul style="list-style-type: none"> This option will allow some forms of restraint in limited use, however any reduction in restrictive practices will benefit people's human rights and reduce the trauma people face in services.
Effectiveness	0	+ <ul style="list-style-type: none"> This option will not be effective for those tāngata whaiora who may be at 'risk' of harming themselves or others, and could have unintended consequences, as often a need for intervention is for the protection of individuals, staff and/or the public. 	+ <ul style="list-style-type: none"> Implementation of this may not be effective or efficient given it will take an uncertain time to finally eliminate seclusion and may result in unintended consequences. 	++ <ul style="list-style-type: none"> By having legislation restrict the use of restrictive practices, this will be effective in achieving change, without binding to a particular timeframe. Limiting the use of restrictive practices will require culture and practice changes which will take time to achieve nationally.
Sustainability and durability	0	0 <ul style="list-style-type: none"> May be issues with this option over time, as there potentially is still a need to have some form of restrictive practices, especially in certain situations to keep patients, staff and other tāngata whaiora safe. This could cause sustainability problems and could lead to injuries or preventable incidents. 	+ <ul style="list-style-type: none"> Reducing and/or eliminating restrictive practices will result in improved experiences for tāngata whaiora, which could also lead to benefits such as a reduced turnover of staff and reduced lengths of stays for tāngata whaiora. These benefits make this option sustainable in the long-term. 	+ <ul style="list-style-type: none"> As with option 3, reducing and/or eliminating restrictive practices will result in improved experiences for tāngata whaiora, which could also lead to benefits such as a reduced turnover of staff and reduced lengths of stays for tāngata whaiora. These benefits make this option sustainable in the long-term.
Fiscal, practicality and implementation	0	-- <ul style="list-style-type: none"> This option will take time to implement as there will need to be significant staff training, as well as the hiring of additional front load staff to provide more personal treatment and better ratios of staff to clients. 	- <ul style="list-style-type: none"> There will be costs and workforce implications associated with running programmes to ensure mental health units are implementing the forthcoming legislation and guidelines on eliminating seclusion and reducing restrictive practices. 	0 <ul style="list-style-type: none"> As there is an end goal of eliminating seclusion, but not within a specified timeframe, this option allows time for proper consideration to be taken to effectively implement, in contrast to option 2 or option 3 where the main focus and decisions are likely to be driven by meeting a timeframe.
Overall assessment	0	+3	+3	+ 5 Preferred option

Key:

- ++ much better than the status quo
- + better than the status quo
- 0 about the same as the status quo
- worse than the status quo
- much worse than the status quo

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

106. The current legislative settings and implementation have in combination contributed to poor and inequitable health outcomes for tāngata whaiora, criticism from sector stakeholders and tāngata whaiora, and inconsistency with Te Tiriti o Waitangi and human rights conventions. After the above detailed analysis, our recommended option is **option four**.
107. This option meets the objectives and is also a significant improvement on the status quo. By taking a flexible approach to eliminating seclusion, this option is less likely to lead to an increase in restraint – as significantly reducing seclusion could lead to this. The reporting requirements provide assurance that progress will continue, even though there is no statutory deadline.
108. It is also important to note that non-legislative efforts to reduce seclusion and restraint will be enhanced and continued as a priority.

PROACTIVELY RELEASED

What are the marginal costs and benefits of the preferred options?

Affected groups <i>(identify)</i>	Comment <i>nature of cost or benefit (eg, ongoing, one-off), evidence and assumption (eg, compliance rates), risks.</i>	Impact <i>\$m present value where appropriate, for monetised impacts; high, medium or low for non-monetised impacts.</i>	Evidence Certainty <i>High, medium, or low, and explain reasoning in comment column.</i>
Additional costs of the preferred option compared to taking no action			
Regulated groups	Cost of training averaged over four years. Assumes initial development cost, and a training programme over four years, with training then becoming part of standard education. Cost of new system roles likely to be a significant overestimate, based on 100% uptake by service users.	\$2.535m training cost \$7.86m staff cost \$58,565 administration time cost	Medium
Regulators	Likely to be additional resource in initial period to standardise reporting of restraint incidents, and roll out updated guidance.	Low	Low
Others (eg, wider govt, consumers, etc.)	Increased travel and time from family and whānau members of service users.	Low	Low
Total monetised costs		\$10.5 million per year	Medium
Non-monetised costs		Low	Medium
Additional benefits of the preferred option compared to taking no action			
Regulated groups	Plausible increase in job satisfaction from reduced use of force and better services for tāngata whaiora.	Low	Low
Regulators	N/A		
Others (eg, wider govt, consumers, etc.)	Benefit to consumers and wider society. Figures are based on conservative estimates of costs of current practice, and	\$24.0 million per year	Medium

	subjective wellbeing improvements. Inherently imprecise, but we have used very conservative assumptions and are confident the figures are not overstated.		
Total monetised benefits		\$24.0 million per year	Medium
Non-monetised benefits		Low	Low

Further information about preferred options

109. The figures calculated for costs and benefits are not intended to be accurate estimates of the actual real-world costs and benefits of the proposals. We have made deliberately unrealistically high assumptions about costs, and have not accounted for existing activity, to ensure we are subjecting the proposals to a robust test. For example, the calculation for the cost of the independent support and whānau support coordinator roles assumes inpatients remain in hospital for a full twelve months, which is a significant over-estimate. The fact that the analysis gives a figure for benefits more than the estimate of costs gives a strong assurance that the proposals represent value for money.
110. The costs of the preferred options are largely workforce-related. We can make reasonable estimates for the costs of training, and additional staff roles, based on current workforce costs.
111. The benefits of the preferred options are seen largely in improved experience for tāngata whaiora, and better upholding of their human rights. There may be benefits in improved staff experience, reduced turnover, and reduced length of stay. We have not attempted to calculate these latter benefits, on the basis of taking a conservative approach.
112. It is important to note that we have not attempted a comprehensive cost-benefit analysis. We have analysed selected benefits and costs, using conservative assumptions, to identify whether there is a plausible benefit from the proposed law changes. This analysis should not be treated as a precise valuation of the benefits or costs of the proposals, and we do not consider the figures are applicable to other contexts. Where specific figures are used, these have generally been taken from the Treasury CBAX database⁶.

Costs

113. We do not account for environmental redevelopment cost, as environment is a contributing, but not decisive factor. Tiaho Mai, the Counties Manukau inpatient unit, was redeveloped in 2020 in accordance with modern mental health unit design principles, which are intended to reduce the occasion for restraint or seclusion. While seclusion has reduced at Tiaho Mai, it is still common. Te Whetu Tarawera, the Auckland equivalent, which has not been redeveloped had a seclusion rate of 1% of

⁶ [CBAX Spreadsheet Model](https://www.treasury.govt.nz/publications/guide/cbax-spreadsheet-model) available from: <https://www.treasury.govt.nz/publications/guide/cbax-spreadsheet-model>

admissions in 2021/22, compared with 12% at Tiaho Mai. Auckland concentrated on practice changes and clinical leadership rather than environment changes.

114. We therefore estimate the costs of the preferred option to minimise seclusion and restraint and eliminate seclusion over time in terms of training for staff, new roles in the system, and closer monitoring. For supported decision-making, we cost the anticipated new system roles, and advance directives.
115. **Training:** Training staff in alternatives will be key to reducing seclusion and restraint in practice. There is an existing evidence-based model for reducing seclusion and restraint called the 'Six Core Strategies'⁷. This was developed in the United States by their national committee of mental health directors and adapted for Aotearoa New Zealand by Te Pou, one of the national centres for mental health and addiction workforce development. We have used this as the basis for cost estimates, as it is the most comprehensive programme, and likely to reflect the highest feasible cost. Work is already being undertaken using the Six Core Strategies, so the cost estimates below will be higher than the actual cost.
116. We estimate a cost of \$1.5 million to develop training programmes for the six strategies. This is based on estimates of \$250,000 to develop a training module for each strategy. There are about 2000 nurses whose primary area of practice is in mental health. We assume 500 of those receiving training per year, at a cost of \$200 for the training and facilitators per workshop, plus \$520 per day to backfill nurse positions. That amounts to \$360,000 for each of the six strategies, and \$3.66 million total training cost for 500 nurses in the first year, and \$2.16 million in subsequent years, reducing over time as the full cohort is trained, and such training becomes part of standard training for new entrants to the workforce. These costs are in the nature of opportunity costs rather than new money, as regular training supporting ongoing professional development is a standard part of employment in the publicly-funded health sector.
117. **New roles in the system:** we anticipate a 'zero-seclusion champion' in each inpatient unit to support and encourage changed practice. There are currently already 'zero-seclusion champions' as part of the Health and Quality Safety Commission-led project, however they are not funded. After the model of similar positions, we would anticipate this to be no more than half-time for an existing staff member. We cost this at \$70,000 for one half time person in each inpatient unit, using a figure of \$140,000 per year for a funded clinical position.
118. The independent support and supported decision-making coordinator roles are also costed at \$140,000 annually for a full-time position. In 2021/22, there were a total of 608 available beds in in-patient units. In order to ensure a conservative approach, we assume for the sake of analysis that beds are fully occupied and each inpatient uses two hours per month with an independent support person and a supported decision-making coordinator. Assuming 3 hours of non-contact time to support an hour of contact, that amounts to 192 hours per bed, per year, requiring 52.2 FTE. The total cost is therefore \$7.86 million on conservative assumptions. It is likely that the actual cost would be lower, as not all people under the legislation would require these services.
119. **Reporting and closer monitoring:** the current Act requires a register of seclusion and restraint to be kept by each service, so reporting is unlikely to impose a significant additional cost. We estimate this cost on the basis of the current rates of seclusion. In 2020/21, there were 1,802 seclusion events. Under the preferred option, these events must all be reported in detail. A report will require the reasons for the seclusion, and other options tried and considered. At a cost of \$65 per hour, that amounts to

⁷ Available from <https://www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/the-six-core-strategies-service-review-tool>

\$29,282.50 per year if reports take at a minimum, 15 minutes. If the report takes half an hour to complete, that amounts to \$58,565. This is an existing requirement in Guidelines issued by the Director-General⁸, with which services must comply, so this should not be a new cost, and is modelled here to give assurance that the burden of reporting is not excessive.

120. We have poor data on the frequency of use of other restraint which ranges from holding a person in place (personal restraint) through the use of equipment or furniture (physical restraint) to preventing a person's normal access to their environment, by for example locking a door (environmental restraint). Each incident is required to be reported to the Director of Area Mental Health Services, but there is no required further reporting or national standard.
121. We consider it likely to require establishing standard reporting procedures and forms in order to adequately monitor the use of restraint other than seclusion. We consider this as routine business of the Ministry and have not costed it separately. We considered a data cleansing exercise to examine restraint data in retrospect. We have estimated the cost of this exercise by assuming 15 minutes on average for someone to examine a record and record it in the agreed consistent fashion. If we then assume restraint is used 10 times as often as seclusion, that amounts to just under 113 working weeks, and is unlikely to be practical. Similarly, the benefit of closer monitoring would be seen by sampling and comparison of trend data between districts rather than comprehensive review of each incident.

Benefits

122. Benefits for improved health services are inherently difficult to measure precisely. The main benefits from the preferred options are improved experiences for tāngata whaiora, and improvement in upholding human rights. There are likely to be benefits in reduced turnover of staff, and reduced length of stay, although we have not attempted to quantify these.
123. We have quantified benefits in three categories; improved mental health status, upholding human rights and improvement in subjective wellbeing. The analysis is not intended to be a comprehensive assessment of the value of interventions and should not be used as such. Rather we have quantified plausible benefits, on conservative assumptions, as a means of checking whether the likely benefits from the proposals outweigh the more precisely determinable costs.
124. **Improvement in mental health status** is modelled with respect to seclusion. Seclusion is done by force, and is an inherently harmful practice, with no therapeutic benefit, and practical alternatives. Its effect will vary from person to person, and the effects on other people in the unit will also vary. It is reasonable to assume a detrimental effect on a person's mental health from seclusion. For most, we assume it is likely to be temporary, though for some the effects will be long-lasting.
125. We make a conservative assumption that being secluded makes someone's mental health worse by 10 percentage points, and that effect lasts for a week. The benefit from not secluding someone is therefore the avoided cost. We estimate that benefit at \$1,016 per incident⁹. At 1,802 incidents per year, that amounts to \$1.832 million in avoided harm.
126. This figure does not include the benefits from reduced use of other forms of restraint, which are similarly non-therapeutic. We can have some confidence that the figures

⁸ Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992 available from <https://www.health.govt.nz/system/files/documents/publications/seclusion-guidelines-feb10.pdf>

⁹ Figure taken from CBAX, based on Kainga Ora research, and General Social Survey data

above significantly understate the benefits to mental health of reducing seclusion and restraint and eliminating seclusion.

127. **Upholding human rights** is also hard to measure. The following analysis does not purport to place a definite value on the rights. The figures used are an attempt to derive a plausible minimum proxy figure. We can model the fulfilment of human rights as avoiding the potential for penalties. While that is not the purpose of respecting human rights, it does represent a known price, which we can use as a measure of the value society places on those rights.
128. We use a 2012 case heard by the Human Rights Review Tribunal as a comparator¹⁰. The case concerned a disabled person left unattended in a van. The person was unable to move, as his wheelchair was clamped in place with him strapped into it. The care worker admitted having left the person in the van unattended for at least 45 minutes. The Tribunal awarded \$5,000 in compensatory damages.
129. Because that case was in 2012, it is worth considering adjustments to the figure. Adjusted for inflation, the figure amounts to \$6,100 in 2022 dollars. The Tribunal subsequently considered the issue of compensation in more detail, in *Hammond v Credit Union Baywide* [2015] NZHRRT 6. That decision discussed bands for compensation, and considered the less serious end warranted awards up to \$10,000, with \$10,000 to \$50,000 for more serious cases and over \$50,000 for the most serious of cases.
130. While the sums described above are not the cost of the breach of rights per se, they are the most useful proxy measure we have found. Using those figures, we derive a cost of seclusion in rights-infringing terms of between \$10,992,200 and \$18,020,000. We use the lower figure for the sake of making conservative estimates, but note the true figure is likely to be higher.
131. **Improvement in subjective wellbeing:** The preferred options are expected to have a significant effect of people's subjective wellbeing, through greater support for their autonomy and respect for their wishes. We have modelled this as a 10% increase in life satisfaction from greater autonomy and services reflecting their preferences. We think the effect is likely to be greater, as loss of autonomy was a significant reason given by submitters for dissatisfaction.
132. We have used the subjective wellbeing figures from the UK Treasury¹¹. Taking the midpoint of \$14,000 per year for a ten percentage point improvement in a person's subjective wellbeing, we arrive at a figure of \$31.5 million per year. Using the low estimate, we derive a value of \$11.2 million. We use the lower figure for the sake of conservative estimates. As a check, if we use instead a one point change in the availability of help¹², to reflect the functions of the independent roles, we arrive at a figure of \$15 million.

¹⁰ Director of Proceedings v Zhu [2012] NZHRRT 7 available from <https://www.justice.govt.nz/assets/Documents/Decisions/2012-NZHRRT-7-Director-of-Proceedings-v-Zhu.pdf>

¹¹ Figure taken from CBAX, based on Wellbeing Guidance for Appraisal: Supplementary Green Book Guidance: HM Treasury: retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005388/Wellbeing_guidance_for_appraisal_-_supplementary_Green_Book_guidance.pdf

¹² Figure from CBAX, derived from Kainga Ora wellbeing assessment of social housing provision.

Section 3: Delivering an option

How will the new arrangements be implemented?

134. This work is part of a major reform of the mental health and addiction system in Aotearoa New Zealand. Operational considerations are also underway, as part of the whole transformation of the mental health system. There is a wider system transformational change underway, and these options play a large part in that, alongside the development of the Mental Health and Addiction System and Service Framework.

Ongoing operation and enforcement of the options

135. These options will require a whole system change to enforce these options. Clinicians and people in the mental health sector will need to change the way they have previously administered services and will need to adjust to the new, less risk and harm-based approach of compulsory care.
136. New guidelines will be developed in order to assist family, whānau, clinicians and other interested parties in the operation, implementation and enforcement of the new options. It is intended that new legislation will provide for directive, rather than advisory guidelines.

Implementation

137. These new arrangements will take time to come into effect, however this will allow time to develop a competent and trained workforce which is one of the major things needed to have successful implementation of the new options. We will need to invest in workforce leadership, development and training, and will need to grow the workforce, with particular focus on the Māori mental health workforce to meet the needs of tāngata whaiora and to successfully implement some of the options. We will also need to increase the diversity of the wider medical workforce. There are disproportionately low numbers of Māori and Pacific doctors in the current workforce, so work will need to be done in this area, as more Māori and Pacific medical practitioners could support addressing the disparities in mental health outcomes.
138. Additionally, Te Whatu Ora has invested in a range of initiatives to grow and upskill the mental health and addiction workforce, as well as to grow new workforces that can support mental wellbeing. This will help ensure we have the workforce needed to support new legislation. Te Whatu Ora is also investing in improved IT systems, which will support improved data collection and reporting.
139. New inpatient environments are expected to be designed to eventually remove seclusion spaces and create spaces that are more therapeutic and meet the holistic needs of tāngata whaiora. These changes are not essential to meet the goal of eliminating seclusion, so have not been included in costings, but will be helpful in the overall transformation programme.
140. The New Zealand Law Commission is also currently undertaking work to review the law in relation to adult decision-making capacity. These options may help guide the Law Commission in their work and we will work closely with them when it comes to implementing the options around assessing capacity.

How will the new arrangements be monitored, evaluated, and reviewed?

141. There is already an independent national mental health monitor – the Mental Health and Wellbeing Commission. The Commission's objective is to contribute to better and

equitable mental health and wellbeing outcomes for people in Aotearoa New Zealand. They have functions such as:

- a. assess and report publicly on the mental health and wellbeing of people in Aotearoa New Zealand
 - b. assess and report publicly on the effectiveness, efficiency, and adequacy of approaches to mental health and wellbeing
 - c. advocate for the collective interests of people who experience mental distress or addiction (or both), and the persons (including family and whānau) who support them.
142. The Commission will continue in its monitoring and reporting role and will continue to speak up and bring focus to areas where long-term transformation can take place.
143. Manatū Hauora will also play a role in the monitoring and review of the new arrangements, through Director of Mental Health reports, and frequent review and updating of guidelines to ensure they are constantly improving as we receive new and more data.
144. There will be a need for monitoring and review systems to be set up, to embed safeguards, where the onus is placed on mental health professionals to demonstrate the need for restrictive practices, and report on other types and usage around restrictive practices.
145. It is expected that legislation will provide for a five-yearly review.