



Te Kāwanatanga o Aotearoa
New Zealand Government



Mental Health Bill

Briefing notes to support introduction & first reading of the Bill

September 2024



About this document

These briefing notes have been prepared by the Ministry of Health and are intended to support the introduction and first reading of the Mental Health Bill.

These briefing notes set out:

- the policy objectives for the Bill
- an overview of what is in the Bill
- context information on the development of the Bill
- commencement information

This document also provides an overview of the policy areas of the Bill, including:

- a summary of the key proposals under each policy area
- key messages in relation to the proposals, including the rationale for the change.

Appendix A sets out the policy areas of the Bill and relevant sections of this document and clauses in the Bill.

PROACTIVELY RELEASED

Contents

Introduction	3
Policy intent	3
Overview of Bill	3
Strategic context	4
People under the Act	4
Policy development	5
Commencement	5
Foundations for person-centred care (clauses 3, 5 & 6)	6
Embedding supported decision-making (clauses 12-24)	8
Rights & complaints (clauses 25-40, 52, 171)	11
Compulsory care criteria (clauses 7-9)	13
Providing compulsory assessment and care (clauses 41-48, 50-88)	15
Reducing & eliminating restrictive practices (clauses 38(2)(b), 49 & 200)	17
Children & young people (clause 38)	19
People in the justice system (clauses 101-131)	21
Monitoring, oversight & reporting (clauses 144-177, 206-207, 211-213)	23
Appendix A: Clause references	25

Introduction

The Mental Health Bill repeals and replaces the Mental Health (Compulsory Assessment and Treatment) Act 1992

Policy intent

The policy objectives are to create a modern legislative framework for compulsory mental health care that:

- shifts compulsory mental health care towards a rights-based and recovery approach
- enables responsive needs-based care, including culturally appropriate care, that addresses the need for compulsory care
- supports the safety of individuals and others
- 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
- minimises the use and duration of compulsory care, including minimising the need for people to re-enter compulsory care
- includes effective safeguards and mechanisms to monitor the use and operation of legislation and respect human rights.

Overview of Bill

The Mental Health Bill (the Bill) sets out the regime for when a person can be subject to compulsory mental health care without their consent.

It also sets out the processes for 'forensic patients', who are patients that enter the health system via the criminal justice system. This covers people found by the courts to be unfit to stand trial or acquitted on account of insanity (as defined in the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP(MIP) Act)), and people transferred from prison who require compulsory or voluntary care, to receive mental health treatment in a secure environment.

The purpose of the Bill is to provide for compulsory mental health care that:

- promotes the decision-making capacity of the person
- improves equity in mental health outcomes among New Zealand's population groups, including for Māori
- protects the rights of people under legislation
- protects the safety and wellbeing of people under the legislation and other New Zealanders.

Strategic context

Mental health is a priority for the Government – this is reflected through a focus on increasing timely access to mental health and addiction services, growing the mental health and addiction workforce, strengthening the system’s focus on prevention and early intervention, and improving the effectiveness of mental health and addiction support.

An effective mental health and addiction system needs the right system settings. The Mental Health Bill will contribute to improving the effectiveness of mental health and addiction support and modernise our regulatory and legislative settings for people who are experiencing the most severe mental distress and intervention is required.

The Bill responds to a recommendation in the 2018 report *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga)*. *He Ara Oranga* recognised that the current Mental Health Act has not kept pace with the shift towards a recovery and wellbeing approach to mental health care and has never been comprehensively reviewed. The Bill will update the compulsory care in line with the recommendation that new legislation:

... 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.

The Bill also forms part of the Government’s response to the final recommendations of the *Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions*. This Bill will demonstrate meaningful and significant progress by contributing towards at least 11 of the recommendations relating to care safety and monitoring.

This Bill supports a future focus on safe and effective mental health care for people that require State intervention. This includes through supported decision-making approaches, safer practice through stronger protections for people subject to legislation, care that is provided in the least coercive way, is therapeutic and responsive to a person’s needs as well as greater involvement of a person’s family in key processes.

People under the Act

People who are subject to the legislation come from all walks of life – they could be a family member, friend, neighbour, or a professional or leader in our communities. These are every day New Zealanders experiencing mental distress at a level requiring State intervention to support their recovery.

Most people in New Zealand who access specialist mental health and addiction services are not subject to the Act. In 2021/22, 11,149 people (6.4% of specialist mental health and addiction service users) were under the Act.

In 2021/22, Māori were more likely to be assessed or treated under the Mental Health Act than other ethnicities:

- Māori represented around 36% of those subject to compulsory assessment, and around 40% of those subject to a compulsory treatment order

In 2021/22, there were 466 people, under the age of 18, subject to the Mental Health Act:

- of those, 42% were Māori

- 81 were subject to an inpatient treatment order, and 110 were subject to a community treatment order. 323 underwent assessment and did not progress to a compulsory order in the period.

Policy development

The development of policy proposals involved considering and balancing a range of information sources. This has included:

- the strategic direction for new legislation, for example the findings of *He Ara Oranga*
- known issues with the current Mental Health Act and how people experience it
- feedback received through extensive public consultation
- feedback from the Mental Health Act Expert Advisory Group
- available evidence from New Zealand and from comparable overseas jurisdictions.

A phased approach has been taken to reforming mental health legislation.

Since 2019, the Ministry of Health has been working on improvements to practice and the service user experience under the current Act. This included a suite of guidelines, education, and training for mental health services and clinicians, focused on protecting the rights of people receiving compulsory mental health care, promoting practice in line with the Treaty of Waitangi and human rights principles, and reducing and eliminating the use of seclusion and restraint. In 2021 initial amendments were made to the current Act which included the elimination of indefinite treatment orders.

The full repeal and replacement of the Mental Health Act started with public consultation which took place from October 2021 to January 2022. 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 family and whānau. There were also dedicated consultation sessions for Pacific peoples, Asian and ethnic communities, young people, people with lived experience 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.

Following public consultation, an 11-member Mental Health Act Expert Advisory Group was established to help test and refine draft policy proposals, bringing a range of perspectives including Māori, people with personal or family and whānau lived experience of the current Mental Health Act, service providers and clinicians, as well as legal and academic expertise. The term of the Expert Advisory Group commenced in May 2022 and ended in March 2023.

Commencement

The Bill has a proposed commencement date of 1 July 2027. This is to ensure there is sufficient time to prepare affected services in the mental health sector as well as other impacted areas, such as the courts.

Foundations for person-centred care (clauses 3, 5 & 6)

To support the shift towards a rights-based and recovery approach to compulsory mental health care, the Bill includes new purposes and principles

Summary of what is in the Bill

The Bill includes a purpose clause which sets out the policy aims of the legislation (clause 3). It is intended to support the application of new legislation towards a rights-based and recovery approach to and better support care that meets the needs of people.

The Bill has a set of principles to guide decision-making and support meeting the purpose of the legislation (clause 6). They focus on the following:

- that compulsory care should only serve a therapeutic purpose – this includes to protect, promote, and improve a person’s mental health
- that compulsory care should be applied in the least restrictive manner – this includes a preference for voluntary care options, ensuring compulsory care is applied for no longer than necessary, and that support is available to reduce the need for compulsion
- that compulsory care should be supportive and responsive – this means seeking at all times to encourage the person to develop and exercise capacity and choice and that care should be reflect the needs of the person, be guided by their will and preference, and recognise the person’s ties to family, whānau, hapū, iwi and family group.

The principles will apply to courts, tribunals and those undertaking functions, powers and duties under the legislation.

The principles in the Bill build on the health sector principles in the Pae Ora (Healthy Futures) Act 2022. While the health sector principles apply at the system and services level, the principles in the Bill apply at an individual level.

The Bill includes a clause that describes the other requirements in the legislation that are intended to give effect to the principles of the Treaty of Waitangi in the context of providing compulsory care (clause 5). These includes requirements such as requiring that each patient has a care plan that includes a holistic assessment of the person.

Key messages

- The current Mental Health Act has been criticised for not being aligned with the dominant models of mental health care in New Zealand. The Bill is needed to ensure we have modern compulsory mental health care legislation.

- The Bill will have a clear purpose statement and principles for people working under the legislation. This is needed to shift practice towards a rights-based and recovery approach, and better support the different needs of people who are subject to the legislation.
- A recovery approach is the main model in mental health practice in New Zealand. It is about supporting a person to improve their health and wellbeing to live self-directed lives.
- A rights-based approach means a person remains at the centre of all decisions that affect them, including ones about their treatment and care.
- The Bill's purpose and principles ensure a central focus on safer and more effective care. This has become even more important with the recommendations from the *Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions*.
- More effective care is about providing care based on a person's needs and keeping them at the centre of all decisions. This will support a person's recovery, minimising the need and duration for compulsory care in the future.
- The Bill has a descriptive clause which sign-posts or summarises other areas of the Bill that would give effect to the principles of the Treaty of Waitangi. This addresses feedback from by submitters to the public consultation, particularly people working in the mental health sector, who wanted the legislation to clearly set out on the steps needed to better respond to the needs of Māori, who are overrepresented under the Mental Health Act.

Embedding supported decision-making (clauses 12-24)

People will be encouraged, assisted and 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

Summary of what is in the Bill

Preparation in advance of becoming unwell

The Bill will support people to have mechanisms in place in advance of becoming unwell:

- compulsory care directives enable people, in consultation with a mental health practitioner, to make statements about their future care. People will be able to specify the methods of care they do and do not consent to receive if they become subject to the legislation, along with other preferences, for example, who they want to be involved in their care. There will be corresponding obligations on people exercising powers or duties in the Bill to follow the directions (clauses 12-15)
- enabling the appointment of a nominated persons. A person will be able to nominate someone to represent a person's views in decision-making processes should they ever be subject to the legislation. A nominated person is likely to be a family member or other trusted person (clauses 19-22).

Independent support and assistance

The Bill strengthens independent support provided to people subject to compulsory care. Alongside the existing impartial support from district inspectors who are independent watchdogs, the Bill introduces two new roles that are independent of other decision-makers in the legislation. These roles do not need to be impartial but instead, are there to be clearly on the side of the person subject to legislation. These are:

- an independent support person who will advise people on their rights and support them to understand their rights and processes under the legislation (clause 23). They cannot speak for the person but can assist people to make decisions and participate in processes
- an advocate who in addition to the roles of an independent support person, will assist people to exercise their rights, make complaints, and are able to represent the person in processes and proceedings and report on matters to the Director of Mental Health (clause 24).

Requirements to support participation

There will also be a duty on those responsible for key processes under the legislation to ensure people are encouraged and assisted to participate in decisions being made about them, and to provide reasonable assistance to understand processes and express their views (clause 16).

More robust family and whānau involvement

The Bill defines a person's 'support network', and these are the people who can be involved in processes under the legislation and will be notified of key decisions and outcomes (clause 18). This includes family or whānau, nominated persons, any welfare guardian or attorney under the Protection of Personal and Property Rights Act 1988, principal caregiver, or independent support person.

The Bill will enable the use of hui whaiora (well-being meeting), which can be used to (clause 17):

- assist people to make decisions about their care
- consider matters relating to a person's care
- resolve issues, disputes or complaints to prevent escalation to more formal processes
- support restorative practices that uphold the mana of parties following the use of coercive practices.

The person, their support network and other professionals involved in a person's care may attend the hui whaiora.

Key messages

- A key shift in the Bill is moving away from substituted decision-making (where decisions are made for a person) towards supported decision-making (where people are supported and assisted to make their own decisions).
- The Bill puts a person's ability to make decisions about their own care at the centre of key decisions and processes. This will be done through supported decision-making approaches such as compulsory care directives, nominated persons, hui whaiora (wellbeing meetings) and independent support and advocates, along with greater involvement of family, whānau, hapū and iwi in a person's care.
- The changes to embed supported decision-making in particular will contribute to the Government's response to *the Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions* – and more specifically to the recommendations relating to care safety and the need for greater advocacy.
- Ensuring people have a say and control over their own care will support the recovery of a person and more therapeutic relationships between the person and clinicians.
- Feedback from public consultation in 2021/22 showed clear agreement for a focus on supported decision-making in new legislation. People wanted to have more say in their own mental health care and wanted legislation that embedded the use of advance directives.

- To support people to make decisions about their own mental health care, the Bill enables people to make compulsory care directives where people will be able to make statements about their future care should they ever be subject to the legislation, for example the type of medication and other treatments they do or do not consent to. They are called compulsory care directives to avoid confusion with other advance directives a person may have in place.
- A nominated person is someone that can essentially be a person's voice when they are unwell. They will help decision-makers understand more about the person's will and preferences and what they are like when they are well. A nominated person is likely to be someone who has a good understanding of the journey and experiences of the person, like a member of their family, whānau, hapū or iwi.
- An independent support person and advocate are new roles that will ensure people are supported and assisted to understand and exercise their rights under the legislation. These roles are independent of other decision-makers. The introduction of these roles ensures people will have comprehensive support alongside the existing impartial and independent support provided by district inspectors.
- Family, whānau and other trusted people have a key role in the recovery of a person who needs compulsory care. The Bill includes more opportunities and strengthens requirements for the involvement of these important people in a person's care, while respecting the wishes of the person on who they want to be involved.

PROACTIVELY RELEASED

Rights & complaints

(clauses 25-40, 52, 171)

The Bill sets out rights for people under the legislation as well as a range of mechanisms for people to make complaints and challenge decisions that have been made about them

Summary of what is in the Bill

Rights of people subject to mental health legislation, including voluntary patients

The Bill updates the existing set of rights for those subject to compulsory assessment and care to modernise the rights and clarify who must discharge duties (clause 26 – 38). The rights are:

- general rights to information
- rights to respect for culture and identity
- right to medical and other health care
- right to be informed about medical and other health care
- right to independent health advice
- right to legal advice
- right to company
- further rights in case of visual or audio recording
- right to receive visitors and to communicate with others
- right to send and receive communications
- right to communication aid
- right to mobility aid
- rights of children and young persons (note more details are set out later in this document).

Relevant rights will also be extended to those receiving voluntary care in inpatient units, which allows them access to the complaints processes under the Bill. This will include the ability to make a complaint where a voluntary patient may have been detained or may have been given treatment without their consent (clause 25).

Complaints and reviewing and challenging decisions

The Bill also updates the processes for making a complaint to a district inspector in relation to a breach or omission of rights or where compulsory care has not been provided in accordance with the legislation.

Key changes include:

- district inspectors will be guided by new principles to improve the accessibility, timeliness, and transparency of the complaints processes (clause 171)

- following the investigation of a complaint, the Director of Mental Health will be empowered to direct services to publicly set out how they will address recommendations where those recommendations have not been satisfactorily addressed, to ensure complaint resolution recommendations are enforced (clause 39)
- enabling district inspectors to rely on advice from advisors with expertise in matters involving tāngata whaiora Māori (clause 40).

The Bill has a range of appeal and review provisions that apply at different stages of the process, including the right to seek review by the review tribunal, appeal to the court, or apply for judicial inquiry (summarised in clause 52). Courts and Tribunals will be guided by the compulsory care principles and must apply the supported decision-making provisions. Tribunals must also be guided by the same principles as district inspectors when reviewing applications and complaints (clause 171).

Key messages

Rights of people subject to mental health legislation, including voluntary patients

- The Bill modernises the rights in the current Act and clarifies who must discharge duties.
- When someone is subject to compulsory care the Bill places obligations on specific people to ensure a person's rights are upheld. These obligations apply to patients, proposed patients and voluntary patients and cover, for example, rights to equitable health care, to have company and communicate with others, and to information about their entitlements.
- The rights in the Bill supplement the rights in the New Zealand Bill of Rights Act 1990 and in the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.
- A key change in the Bill is extending relevant rights to people receiving voluntary inpatient mental health care, bringing them under the oversight of district inspectors, including access to complaints and investigation processes in the legislation.
- This change addresses concerns raised by submitters to the public consultation that some patients receiving care voluntarily had been placed in locked wards or secluded, and that these patients do not have access to the complaints process set out in the current Act, and their circumstances cannot be reviewed by district inspectors.
- Extending rights to voluntary patients brings New Zealand in line with other jurisdictions, including New South Wales, ACT, Victoria, and South Australia, and England and Wales.

Reviewing and challenging decisions and the complaints process

- The Bill strengthens the current complaints and review processes to improve accessibility, timeliness, and transparency of these processes.
- As compulsory care places significant limits on a person's human rights, legislation must provide people with appropriate protections, including access to justice. The Bill includes appeal and review avenues including through the courts and tribunals remain to ensure there are appropriate independent bodies to review decisions about compulsory care.

Compulsory care criteria (clauses 7-9)

The criteria ensures that compulsory care only occurs when it is reasonable and proportionate to the circumstances

Summary of what is in the Bill

The Bill sets out the criteria that must be satisfied in order for a person to be subject to compulsory care (clause 7). The compulsory care criteria will be met if:

- the person has seriously impaired mental health
- that causes, or is likely to cause in the near future in the absence of care, serious adverse effects
- that causes the person to lack capacity to make decisions about their mental health care.

Seriously impaired mental health has the same meaning as the current 'abnormal state of mind' test. It means a serious impairment of mental functioning characterised by delusions or by disorders of mood, perception, volition or cognition (clause 8).

'Serious adverse effects' is defined narrowly to include:

- serious physical harm to self or others
- serious psychological harm to others, or
- serious deterioration in a person's mental or physical health (clause 7).

The capacity test is based on commonly recognised tests of a person's capacity. A person is presumed to have capacity to make decisions about their mental health care unless assessed otherwise (clause 9).

Key messages

- The entry criteria in the current Mental Health Act have been criticised by the public and experts for being too broad and allowing compulsory mental health care in circumstances that are not proportionate to the significant limits on human rights and other impacts of compulsion.
- The intent of the new criteria is to limit State intervention to circumstances where it is reasonable and proportionate.
- The new element of decision-making capacity ensures that people with seriously impaired mental health will not be compelled by others to receive mental health care unless they lack decision-making capacity and serious harm has occurred or is likely to occur imminently.

- The new test brings the legislation 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.
- This also aligns with submitters' views that the legislation should only be used as a last resort.
- Changes are also intended to modernise the language used to describe mental distress and be clearer, more accessible and better understood, to reduce the risk of misuse.

PROACTIVELY RELEASED

Providing compulsory assessment & care (clauses 41-48, 50-88)

Providing care that better meets people's needs on their recovery journey will help minimise the need for and duration of compulsory care

Summary of what is in the Bill

Care planning

The Bill sets out the care a person must receive when they are subject to the legislation (clause 43). All patients must have a recorded care plan that is kept under review and updated as required. The care plan will include:

- a full assessment of the person's circumstances and needs
- the care that will be provided to meet those needs
- planning for transition from inpatient to community care or from compulsory to voluntary care.

The Bill requires family and whānau involvement where possible and appropriate (clause 46). It also requires the involvement of a range of experts in care planning through a rōpū whaiora (collaborative care team), which will include cultural expertise and expertise in lived experience alongside clinical expertise depending on the person's needs (clause 42).

Regular care plan and status reviews will be required to assess progress against the care plan and whether a person continues to meet the compulsory care criteria (clause 45).

Provision of care

The Bill requires that a person receive compulsory care in the community, usually their home. If they are unable to be cared for adequately in the community, then they will be cared for in an inpatient hospital setting (clauses 63 and 77).

The Bill only allows compulsory care when it is in accordance with a patient's care plan, unless it is an emergency. The Bill also requires the responsible practitioner to seek the consent of the patient, to the extent the patient's capacity allows, before providing care (clause 44).

Certain types of care are further restricted including electroconvulsive therapy (ECT) and restricted treatments such as brain surgery. ECT may only be provided if the patient consents or if an independent mental health practitioner appointed by the Mental Health Review Tribunal considers it is in the interests of the patient or it is an emergency for patients under 18 (clause 50). Restricted treatments may only be provided if the patient consents and both the responsible practitioner and an independent mental health practitioner considers it in the interests of the patient (clause 51).

Compulsory care processes

The Bill sets out the requirements for each step of the process, which includes:

- an examination by a mental health practitioner or clinical psychologist (clause 56)
- a first assessment for a maximum of 6 hours (clause 58)
- a second assessment for a period up to 19 days (clause 62)
- mental health care orders, either inpatient or community, given by the court (clause 77).

At each step in the process, the decision-maker must have regard to the views of the person being assessed and their support network (eg family and whānau). Decisions will also be guided by the compulsory care principles and focus on supported decision-making.

The Bill includes rights to seek review of or appeal against decisions at each step in the process. If at any time a person's responsible practitioner considers they no longer meet the criteria they must be released.

Key messages

Care planning and provision

- If someone is subject to compulsory care, it is important that the legislation is clear on what care that person will receive and that their progress can be tracked to ensure their care continues to meet their needs.
- The current Act has little guidance on the care a patient should receive. Patients are entitled to medical treatment and other health care appropriate to their condition, but the Act is not specific about the types of care, nor does it require patients to have a care plan. Care decisions are primarily made by a single clinician who must consult with family and whānau unless it is not reasonably practicable or in the interests of the patient.
- Many submitters to the public consultation thought that care under the Mental Health Act focuses too much on medication and not on other forms of care to meet their needs.
- The Bill will require patients to have a recorded care plan based on their needs that covers more than just medical treatment and the development of the plan must involve the patient and their support network.
- Frequent care plan and status reviews will act as a record throughout various stages of a patient's care. This will ensure that the patient has been cared for appropriately. It will also ensure the patient's needs, and their family and whānau, are kept at the centre of their care.

Compulsory care processes

- Submitters raised that the statutory processes in the Mental Health Act are confusing and disempowering, and difficult for those subject to it and their family to understand.
- The Bill makes statutory processes simpler with less steps and clearer language, but with more frequent care plan reviews and assessments against the criteria. It also sets out more clearly a patient's right to seek review of or to appeal decisions about whether they meet the criteria.
- This is intended to ensure patients are not held under the legislation for longer than is required.

Reducing & eliminating restrictive practices (clauses 38(2)(b), 49 & 200)

The Bill has requirements to support a more limited use of seclusion and other restrictive practices, to support the reduction and elimination of these practices

Summary of what is in the Bill

The Bill has specific requirements around the reduction and elimination of seclusion (clause 49). These include:

- a duty on all people working under the legislation to use their best endeavours to eliminate the use of seclusion
- a presumption that people are not to be placed in seclusion unless:
 - it is used only for as long as necessary to ensure the safety of people accessing the service, staff or others
 - it is necessary to prevent an imminent risk to life when all other least restrictive strategies and approaches have been tried without positive effect
 - it is used in accordance with a range of requirements on when and where seclusion can be used, who can authorise its use and what must be reported.
- a regulation making power that can prohibit or further restrict the use of seclusion once the system is ready.

The Bill prohibits the placement of children and young people (18 or younger) in seclusion (clause 38(2)(b)).

The Bill allows the use of force when defined powers are being exercised under the legislation and places further limitations on its use compared to the current Act (clause 200). This includes:

- a presumption that a person authorised to use force may not use force unless it is an emergency, there are no reasonable alternatives to its use, and they are using the minimum force necessary in the circumstances
- a duty on people performing functions under the legislation to use their best endeavours to minimise the use of force
- requirements for reporting the use of force.

Other provisions in the Bill will be of particular importance for the ongoing monitoring and use of restrictive practices, including:

- principles guiding decision-makers on the least restrictive application (clause 6)
- the power for the Director-General of Health to make regulatory guidelines and standards (clause 204)
- a requirement on the Director of Mental Health to report annually on the implementation of the Act (clause 211)
- requirement on the Director-General of Health to review the legislation every five years (clause 212).

Key messages

- Evidence shows that the use of seclusion and restraint are not therapeutic and can in fact be harmful. Their continued use has received criticism for being inconsistent with international human rights conventions and with the Treaty of Waitangi.
- Successive governments have had a policy of minimising the use of restraint and eliminating seclusion, for at least the past decade.
- Targeted efforts are already underway to change practices and reduce the use of seclusion in mental health services within the limitations of the current Act. This includes through updated regulatory guidelines for the current Act and the Health Quality & Safety Commission (HQSC)'s *Zero Seclusion: Safety and Dignity for All* project.
- The Bill is intended to take a stronger but balanced approach to reducing and eventually eliminating seclusion and other restrictive practices than in the current Act.
- This approach balances the human rights implications and lack of therapeutic benefits, with the need to ensure:
 - safety of the person, other patients and staff
 - the readiness of the system
 - we have the workforce to implement the position taken in legislation
 - there are no unintended consequences (for example, an increase in other inappropriate forms of restrictive practices).
- Eliminating restrictive practices will require changes that largely sit outside of the legislation – including the model of care in inpatient units, workforce capacity and capability, practice, culture, physical environments, as well as readiness for change. This would include, for example, greater use of de-escalation techniques, with the overall policy aims also supported by staffing increases and training currently being progressed through workforce development work.

Children & young people (clause 38)

The Bill addresses the needs of specific population groups and includes specific considerations to ensure the needs of children and young people are met

Summary of what is in the Bill

The Bill includes some additional requirements and protections that apply to children and young people including (clause 38):

- ensuring wherever possible that children and young people are cared for by child and adolescent mental health services
- additional protections for patients under the age of 18 for the use of ECT
- prohibiting the use of seclusion and restricted treatments (such as brain surgery)
- clarifying the role of parental and guardian consent in the context of compulsory care
- ensuring that if a Review Tribunal considers a matter concerning a patient under the age of 18, the membership of the Tribunal includes at least 1 person with appropriate expertise in child and adolescent development.

New elements in the Bill that relate to supported decision making and family and whānau involvement will also apply to children and young people.

Key messages

- The current Act applies to all people irrespective of age, and children and young people (under the age of 17) have all the same rights and protections as adults.
- In 2021/22, there were 466 aged under the age of 18 subject to the Mental Health Act, and of these, 42% were Māori. There were 81 children and young people under an inpatient compulsory treatment order, and 110 were subject to a community treatment order. There were 42 young people aged 18 years or younger, who experienced seclusion.
- Feedback received through public consultation wanted new legislation to recognise that children and young people can make decisions about their own care, that they should be supported to participate and have a voice in decisions about them, and the need for developmentally appropriate care.
- Submissions also raised concerns with the use of seclusion and restrictive practices on children and young people.
- The Bill retains the special provisions relating to children and young people. These provisions have been updated to ensure children and young people have access to developmentally appropriate mental health supports and greater protections.

- The improvements in the Bill to rights and protections, including new rights and obligations relating to supported decision-making, and more robust whānau involvement will also help support children and young people to better exercise their rights.

PROACTIVELY RELEASED

People in the justice system (clauses 101-131)

The Bill will carry over most of the processes for forensic patients and ensure they are cared for in the same way as other patients

Summary of what is in the Bill

The Bill carries over the processes for forensic patients from the Mental Health Act, including that they are to be cared for in the same way as other compulsory care patients, and the new elements with respect to supported decision-making will also apply.

Forensic patient status is conferred on people who are detained in a hospital following an order under the CP(MIP) Act or transferred from a prison. Forensic patients will include:

- defendants found not criminally responsible on account of insanity
- defendants found unfit to stand trial
- people charged with or convicted of a criminal offence and remanded to a hospital for a psychiatric report
- people who have been convicted of a criminal offence and both sentenced to a term of imprisonment and placed under a mental health care order
- remanded or sentenced prisoners transferred from prison to a hospital for mental health care.

The Bill will establish a Forensic Patient Review Tribunal to take over the role from the Minister of Health to:

- determine applications for leave of absence for forensic patients
- review the condition of forensic patients
- determine applications for change of legal status under the CP(MIP) Act.

Key messages

- The Bill sets out processes for forensic patients. These are people transferred from the justice system to the health system, to receive mental health care in a secure environment. This includes people who have been found unfit to stand trial or people found not criminally responsible on account of insanity, as well as other sentenced prisoners.
- Submitters to the public consultation wanted to ensure that forensic patients have the same entitlements to person-centred care as other patients. They also wanted to ensure the rights of forensic patients were being protected.
- The Bill ensures forensic patients receive appropriate forensic mental health care and requires that they receive the same care as other compulsory care patients. This means

forensic patients will benefit from other elements in the legislation such as supported decision-making and rights and protections.

- Changes are also intended to modernise the language used to refer to people entering through the criminal justice system including by referring to them as forensic patients rather than special patients.
- The establishment of the Forensic Patient Review Tribunal will improve independence of decision-making and procedural fairness for forensic patients who do not have an opportunity to be heard in existing processes.
- Victims will have rights to participate in the decision-making processes of the Forensic Patient Review Tribunal.

PROACTIVELY RELEASED

Monitoring, oversight & reporting (clauses 144-177, 206-207, 211-213)

The Bill strengthens monitoring, oversight and reporting provisions to ensure that the legislation is implemented as intended and that the rights of patients are upheld

Summary of what is in the Bill

The Bill carries over existing administrative roles with updates to align with the new policy intent. The roles carried over include:

- the Director of Mental Health, who is responsible for general administration of the legislation (clause 144)
- Directors of Area Mental Health Services, who are generally responsible for the oversight of the legislation at the service or facility level (clause 145)
- authorised persons, who have a range of functions and powers to advise and provide assistance (clause 148)
- district inspectors and official visitors, who are responsible for ensuring people subject to compulsory care are advised of their rights, complaints of breaches of their rights are investigated and services are improved (clause 150)
- a Mental Health Review Tribunal, an independent body that, among other functions, can review a person's condition (clause 164).

Membership of the Mental Health Review Tribunal will be expanded to include four members, one who must be a lawyer, one who must be an appropriately qualified mental health practitioner, and overall must have knowledge in tikanga and mātauranga Māori and lived experience of being subject to compulsory mental health care. There is also a requirement to co-opt an additional member on request, such as on the request of disabled people.

The Bill will require the Director of Mental Health to publish an annual report on specified matters. It will also require statutory officers and health providers to report on matters as requested by the Director (clause 211).

The Director-General of Health will be required to review the Bill within five years of commencement and then at five-yearly intervals (clause 212). The responsible Minister will be required to establish an advisory committee within six months of commencement to advise on the operation of the Bill (clause 213).

Key messages

- The Bill sets out a range of statutory offices who have a critical role in ensuring the legislation is administered as intended and that processes and decisions are made in accordance with the requirements.
- There are some issues with the current Act that affect the ability of statutory officers to carry out their roles and responsibilities effectively. Changes are intended to ensure statutory officers have the powers necessary to effectively perform their functions and duties, and to ensure services are operating to the best model of care.
- District inspectors alongside independent support and advocacy roles will ensure comprehensive support for tāngata whaiora where issues or complaints relating to care arise.
- The Bill clarifies impartial and independent functions of district inspectors, including specific duties in relation to upholding rights and monitoring services.
- The Bill includes a broader range of professionals on review tribunals to strengthen the voice and draw on a wider range of expertise, including people with lived experience, people with knowledge of tikanga and mātauranga Māori, and disabled people.
- It is important that the operation of the legislation is monitored and that there is transparency and accountability for the administration of the legislation. The Bill introduces new reporting requirements, including a requirement that the Director of Mental Health must publish an annual report on the implementation of the legislation and that the Director-General of Health must review the legislation every 5 years.
- The review and advisory committee required to be established to support the review of legislation will help ensure any issues with the Bill are identified as it is implemented, that it is achieving its purpose and that any necessary amendments can be made to the legislation as soon as possible following identification of issues.

Appendix A: Clause references

The table below shows the clauses in the Bill in sequence and cross-references them to the relevant pages in the Bill and the briefing notes.

Contents of briefing notes	Clause reference in Bill	Page number	
		Bill	Briefing notes
Introduction	-	-	3-5
Commencement	2	9	5
Foundations for person-centred care	3, 5, 6	9, 15, 16	6-7
Embedding supported decision-making	12-24	19-26	8-10
Rights & complaints	25-40, 52, 171	26-32, 37, 98	11-12
Compulsory care criteria	7-9	17-18	13-14
Providing compulsory assessment and care	41-48, 50-88	32-35, 36-55	15-17
Reducing & eliminating restrictive practices	38(2)(b), 49, 200	30-31, 35-36, 111-112	18-19
Children & young people	38	30-31	20-21
People in the justice system	101-131	61-79	22-23
Monitoring, oversight & reporting	144-177, 206-207, 211-213	88-100, 114-115, 116	24-25