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

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.

Limitations and Constraints on Analysis

Cabinet agreed scope and principles

The Government has accepted the recommendation of the Inquiry into Mental Health and Addiction that it:

> *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.*

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:

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 insanity[1] 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

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[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 events[2].

Stakeholder views

25. Through the recent public consultation[3], 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 whaiora[4]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

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[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] [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

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 hapori	Equity, tino rangatiratanga
D. equitable mental wellbeing outcomes for tāngata whaiora Māori and their whānau, hapū, iwi, and hapori are prioritised	Equity
E. tāngata whaiora Māori, their whānau, hapū, iwi, hapori, 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 (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?

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 • This option is only marginally better through having a higher threshold. This option still represents state intervention without incorporation of matters important to Māori.	+ • 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	+ • 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	+ • 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.	+ • 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.	++ • 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	+ • Somewhat supports a shift from harmful risk-based approaches, with a focus on needs and benefits and narrower adverse effects.	+ • Supports a shift away from risk-based approaches, as capacity becomes a key element of entry criteria and not risk.	++ • 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 • 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.	+ • 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.	++ • 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	+ • 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 • This option for capacity is quite broad which makes assessing capacity harder.	+ • 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.

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			
			Formal advance directives	Family and whānau involvement required	Independent support/ally for tāngata whaiora	Supported decision-making coordinator
Te Tiriti o Waitangi	0	0 • No change in Treaty provision. Possibly a marginal improvement from closer monitoring	++ • Providing responsive care in a more mana-enhancing manner that enables greater self-determination over a person's own mental health and wellbeing outcomes.	+ • 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.	++ • This option moves away from a purely clinical and westernised lens of mental health treatment.	++ • This option moves away from a purely clinical and westernised lens of mental health treatment.
Human Rights	0	0 • Would still allow a competent person's wishes about treatment to be overridden.	++ • Promotes personal autonomy with greater alignment to UNCRPD.	0 • 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.	++ • Promotes personal autonomy with greater alignment to UNCRPD provision about persons being supported to exercise decision-making capacity.	+ • 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	+ • 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.	++ • 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.	+ • 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).	++ • 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.	++ • 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 • Existing objections and adverse views by international monitoring bodies continue to create pressure for change.	++ • Supports people who use mental health services to exercise their capacity to make decision in advance including health professionals and family and whānau.	0 • 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.	++ • Strengthens peer support roles in Aotearoa New Zealand and can ensure facilitation of other supported decision-making tools.	++ • 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 • Marginally increased cost likely	- • Would require workforce training to support tāngata whaiora in developing and completing an advance directive.	0 • 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.	- • Independent ally pay is comparable to a health professional who has six plus years of experience.	- • 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.

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 an 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.

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	+ + • 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.	+ • 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.	+ • 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	++ • By banning restrictive practices, this option aligns with our UNCRPD obligations, and also will improve human rights, dignity and reduce trauma.	+ • 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.	+ • 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	+ • 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.	+ • 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.	++ • 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 • 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.	+ • 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.	+ • 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	-- • 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.	- • 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 • 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.

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

Affected groups *(identify)*	**Comment** *nature of cost or benefit (eg, ongoing, one-off), evidence and assumption (eg, compliance rates), risks.*	**Impact** *$m present value where appropriate, for monetised impacts; high, medium or low for non-monetised impacts.*	**Evidence Certainty** *High, medium, or low, and explain reasoning in comment column.*
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 database[6].

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

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[6] 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

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[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-General[8], 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) though 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 incident[9]. 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

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[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 comparator[10]. 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 Treasury[11]. 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 help[12], to reflect the functions of the independent roles, we arrive at a figure of $15 million.

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[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 disproportionally 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.