

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

## Coversheet

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

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

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

(SWC-19-MIN-0070 refers).

### **Evidence and insights from consultation**

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

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

### **Cost-benefit analysis**

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

### **Responsible Manager(s)**

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

### **Quality Assurance**

Reviewing Agency: Ministry of Health and Ministry of Justice

Panel Assessment & Comment:

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

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

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

PROACTIVELY RELEASED

## Section 1: Diagnosing the policy problem

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

#### Current state

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

#### Background information on current law

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

#### Inquiry report and agreement to repeal and replace

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

---

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

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

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

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

(SWC-19-MIN-0070)

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

#### Key features of the current law

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

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

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

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

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

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

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

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

#### **Ongoing government work programmes that are relevant**

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

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

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

### What is the policy problem or opportunity?

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

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

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

### What objectives are sought in relation to the policy problem?

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

---

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



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

### Te Tiriti o Waitangi

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

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

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

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

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

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

### What scope will options be considered within?

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

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

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

### What options are being considered?

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

### Roles, responsibilities and related powers

#### Option One – Status Quo

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

#### *The Director of Mental Health*

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

### *District inspectors*

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

### *Special patients*

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

### *Independent support*

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

## Option Two – New statutory powers

55. The Bill would provide for new statutory powers that are necessary to enable the Director, district inspectors and independent advocates to carry out their role and perform related functions and duties. For the Director and district inspectors, the proposed powers are additional to their existing powers under the Mental Health Act.

56. The proposed new statutory powers are:

- Director of Mental Health:
  - a) to issue directions to service providers to rectify issues
  - b) to authorise district inspectors to act outside their usual areas
- District inspectors able to rely on advice from Māori experts
- An independent body making decisions of special patient leave and change of status, rather than the Minister.

### *The Director of Mental Health*

57. Under the current Mental Health Act, a district inspector or Review Tribunal can make recommendations following an inquiry or investigation into a complaint of a breach of rights under the legislation (section 75). The Director of Area Mental Health Services is then responsible for taking “all such steps as may be necessary to rectify the matter”. We propose the Bill would, where these recommendations have not been adequately addressed, enable the Director to issue directions to health service providers<sup>3</sup> to require them to set out publicly how they will address recommendations. This is similar to powers in other legislation, which allow the regulated party to determine the specific action to be taken to address an issue.

58. This proposal is intended to address a gap in the current legislation by providing the Director with a more graduated set of intervention powers to ensure recommendations of investigated complaints are addressed. This approach would ensure there are appropriate and proportionate mechanisms and escalation pathways built into new legislation. All compulsory treatment is provided by publicly owned health entities or under contract to them, meaning further action can be taken using the provisions of the Crown Entities Act or Health and Disability Services (Safety) Act.

59. The Bill would also give the Director the ability to authorise the use of a warrant in another district in situations where a district inspector has been asked to take over a section 75 complaint investigation in order to preserve the relationship between the health service and the district inspector from whom the investigation has been transferred. Currently this has to be approved by the Minister of Health. As this practice supports the district inspectors’ independence, it should be made more efficient and expedient. The alternative option would be to warrant all district inspectors nationally. This option would have unacceptable impacts on their role, for example the requirement that they visit all services in their area regularly.

### *District inspectors*

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

---

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

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

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

#### *Special patients*

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

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

PROACTIVELY RELEASED

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

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

Key:

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



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

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

PROACTIVELY RELEASED

## Upholding Rights

### Option One – Status Quo

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

---

<sup>4</sup> Petition 2020/232 of Michael Richards [https://www.parliament.nz/mi/pb/petitions/document/PET\\_97992/petition-of-malcolm-richards-end-electroconvulsive-therapy](https://www.parliament.nz/mi/pb/petitions/document/PET_97992/petition-of-malcolm-richards-end-electroconvulsive-therapy)

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

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

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

## **Option Two – Strengthen rights and related complaints process**

### *Strengthen rights*

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

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

#### *Extend rights to voluntary patients*

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

#### *Improve the complaints process*

84. The legislation would:
- place a duty on the responsible clinician<sup>5</sup> to ensure tāngata whaiora are informed of the internal complaints processes required under the Code and external complaints processes and advocacy bodies
  - provide for complaints to be transferred to other complaint bodies where there is overlapping jurisdiction
  - include principles to guide district inspectors in investigating complaints, and the Review Tribunal in reviewing complaints, including principles such as:
    - a) fairness, accessibility (with particular regard to tikanga Māori), timeliness, efficiency, and resolution at a level appropriate to the nature and seriousness of the matter
    - b) upholding the mana of the parties involved and promoting restorative practices

---

<sup>5</sup> The responsible clinician is the person with overall responsibility for the patient.

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

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

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

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

**Key:**

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

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

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

PROACTIVELY RELEASED

## Reviewing and challenging decisions

### Option One – Status Quo

#### *Second opinion assessments*

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

#### *Review Tribunal membership and procedures*

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

### Option Two – Improve processes for reviewing and challenging decisions

#### *Second opinion assessments*

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



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

*Review Tribunal membership and procedures*

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

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

PROACTIVELY RELEASED

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

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

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

**Key:**

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

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

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

## Monitoring and reporting

### Option One – Status Quo

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

### Option Two – Strengthen monitoring and reporting

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

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

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

#### Key:

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

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

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

## What are the marginal costs and benefits of the option?

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

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

### Further information about preferred options

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



Treasury CBAX database<sup>6</sup>, and some figures around the Māori expert committee were taken from the DPMC fees framework.

## Costs

### *FTE increases*

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

### *New roles*

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

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

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

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

---

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

- The potential for increased costs following the upcoming review of Tribunal fees, which we anticipate will occur prior to introduction of the new legislation.<sup>7</sup>
  - An increased number of Mental Health Review Tribunal applications following the introduction of the new legislation while case law is being settled. This assumption is based on anecdotal feedback that there was a marked increase in cases for around ten years following the introduction of the 1992 Act.
  - Minor increased secretariat costs to support an additional member.
118. There will be ways in the long run to potentially minimise these costs by having more hearings via audio visual links, which would reduce travel fees. However, this may not always be possible or desirable for the client. Other proposals, such as the amended criteria for compulsory treatment and the introduction of supported decision-making, are expected to reduce the frequency of unconsented treatment. This may reduce the number of applications to some extent, particularly in the medium to long term, once case law is settled.
119. Mandatory co-opting is already required under the current legislation where the Review Tribunal membership does not include a person of the same gender or ethnicity as the applicant, and they request that the Review Tribunal do so. In 2021/22, about 17 percent of applicants requested the co-opting of a tribunal member<sup>8</sup>.
120. We have estimated the annual cost of this proposal at around \$15,000, which is 10 percent of the cost of an additional permanent tribunal member, as set out above. Again, we have used deliberately high assumptions about costs to ensure we are subjecting the proposals to a robust test. For example, the figure of \$15,000 is on the assumption that 10 percent of applicants will have a disability and ask for the Review Tribunal to co-opt someone but full take-up is not expected, based on the low take-up of existing opt-in provisions relating to gender and ethnicity.
121. There are costs for a Special Patients Review Tribunal to be established and confirmed following the provisions in the current Act, which allow for the establishment of review tribunals. Although the mechanism for making these decisions is still under consideration, we have estimated the costs of an additional tribunal as that is the option with additional financial costs. The impact on the Court of making decisions about special patient leave and change of status would be in additional workload, with impact on other work, rather than increased costs.
122. For the 2018/19 financial year (the last full reported financial year prior to the pandemic, which had a significant impact on tribunal costs (mainly due to remote hearings)), there were 147 applications and, of those, 54 percent of applications were withdrawn, so a total of 67 tāngata whaiora had their application reviewed by the tribunal, for a total cost of **\$367,000** (consisting of around \$270,000 in member fees/expenses and \$96,000 in travel costs, with some miscellaneous costs making up the difference). This is for the current tribunal make up of three tribunal members. If we add in the cost for a fourth member, it is a total of \$517,000.
123. There are on average 50 special patients a year for whom an application for long leave or request a review of their legal status is submitted. Based on the regular Mental Health Review Tribunal costs, this additional cost will be a potential \$388,000 per annum for a Special Patients Review Tribunal. There will also be additional costs for secretarial duties, as well as administration costs that will occur during the

---

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

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

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

## Benefits

124. The main benefits from the preferred options are improved experiences for tāngata whaiora, and improvements in their subjective and mental wellbeing. There are also likely to be benefits for people in the workforce, although we have not attempted to quantify these.
125. We have quantified benefits in two categories; improved mental health status, and improvement in subjective wellbeing. The analysis is not intended to be a comprehensive assessment of the value of interventions and should not be used as such. Rather we have quantified plausible benefits, on conservative assumptions, as a means of checking whether the likely benefits from the proposals outweigh the more precisely determinable costs.
126. **Improvement in subjective wellbeing:** the majority of the preferred options are expected to have an impact on a person's subjective wellbeing, through more transparency and independence from providers, as well as expanding members of the tribunal to ensure a fair spread of expertise. The changes to second opinion assessments promote independent reviews and allow a tāngata whaiora to have confidence that they have been assessed correctly. We have estimated this as a 5% increase in life satisfaction from more transparency and independence from providers, as well as the benefits of the additional tribunal members.
127. On average, there are 5685 people subject to compulsory treatment or assessment. We have used the subjective wellbeing figures from the UK Treasury<sup>9</sup>. Taking the midpoint of \$15,511 per year, for a five-percentage-point improvement in a person's subjective wellbeing, we arrive at a figure of \$4,405,875. Using the low estimate we arrive at \$1,574,460.
128. **Improvement in mental health status** is modelled with respect to the changes in the use of ECT and the rights being extended to voluntary tāngata whaiora patients. The changes would reduce the coercion that some voluntary tāngata whaiora face, as well as improve their mental health by being offered the same rights as other patients. Including those in long-term residential care, there are 3272 voluntary tāngata whaiora. We have made a conservative assumption that half of the voluntary tāngata whaiora will benefit from an improved rights process, so roughly 1636 tāngata whaiora will benefit. We have then assumed that an improved rights process will improve someone's mental health by one percentage point, as a one-off improvement. An improvement in one percentage point is \$1490, so if it affects 1636 tāngata whaiora, we reach a figure of \$2,437,640.
129. The proposals also include a change in the use of ECT. In 2020/2021, four people received ECT who had capacity but refused to consent, under the new legislation, these people would not be subject to ECT. We can make a conservative assumption that a person not being subject to ECT against their preference will improve someone's mental health by 10 percentage points. Therefore, the cost benefit for this proposal comes in at \$59,600 annually.

---

<sup>9</sup> 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](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005388/Wellbeing_guidance_for_appraisal_-_supplementary_Green_Book_guidance.pdf)

## Section 3: Delivering an option

### How will the new arrangements be implemented?

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

### Ongoing operation and enforcement of the options

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

### Implementation

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

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

PROACTIVELY RELEASED