Departmental Disclosure Statement

Mental Health Bill

The departmental disclosure statement for a government Bill seeks to bring together in one place a range of information to support and enhance the Parliamentary and public scrutiny of that Bill.

It identifies:

- the general policy intent of the Bill and other background policy material
- some of the key quality assurance products and processes used to develop and test the content of the Bill
- the presence of certain significant powers or features in the Bill that might be of particular Parliamentary or public interest and warrant an explanation.

This disclosure statement was prepared by the Ministry of Health.

The Ministry of Health certifies that, to the best of its knowledge and understanding, the information provided is complete and accurate at the date of finalisation below.

10 September 2024

Contents

Part One: General Policy Statement

Overview

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

The policy objectives of the Bill are to create a modern legislative framework for compulsory mental health care that—

- shifts compulsory mental health care towards an approach based on people's rights and recovery:
- enables responsive, needs-based care, including culturally appropriate care, that addresses the need for compulsory care:
- supports the safety of individuals and others:
- supports people to make decisions about their mental health care and ensures that those who have decision-making capacity are not compelled to receive mental health care:
- minimises the use and duration of compulsory care, including minimising the need for people to re-enter compulsory care:
- includes effective safeguards and mechanisms to monitor the use and operation of legislation and ensure that human rights are respected.

Background

In 2018, *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* identified significant issues with the Mental Health Act, including that it is out of date, inconsistent with New Zealand's international treaty obligations, embeds risk-averse attitudes towards mental health, and can result in trauma and harm to people receiving compulsory mental health care.

He Ara Oranga recommended that the Mental Health Act be repealed and replaced in order to reflect a human rights-based approach, promote supported decision-making, align with the recovery and wellbeing model of mental health, and provide measures to minimise compulsory or coercive care.

Purposes and principles

The purpose of the Bill is to provide for compulsory mental health assessment and care in a manner that—

- promotes a person's decision-making capacity, including while the person is subject to compulsory care:
- improves equity in mental health outcomes among New Zealand's population groups by striving to eliminate mental health care disparities, in particular for Māori:
- protects people's rights under legislation:
- protects the safety and wellbeing of people under the legislation and all other New Zealanders.

A set of principles underpin the Bill to guide decision making and support the purpose of the legislation. The intent of the principles is that—

- compulsory care should serve a therapeutic purpose: this includes to protect, promote, and improve a person's mental health:

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

The principles will apply to courts, tribunals, and persons performing or exercising functions, powers and duties under the legislation.

Supported decision making, including family and whānau involvement

The Bill introduces a range of proposals to support people to make decisions about their own mental health care and to express their views, either before they become unwell or when they are subject to the legislation. The Bill also strengthens the role family, whānau and other trusted people have in a person's care.

Key changes are as follows:

- the inclusion of the ability to make compulsory care directives, which will enable a person to make statements about their future care. The Bill enables people to specify the care they consent or do not consent to receive, and express other preferences should they come under this legislation. There are corresponding obligations on decision makers to follow the directives:
- provision for the appointment of a nominated person, which will enable a person to nominate someone to represent their interests if they become subject to compulsory care. The nominated person could, for example, be a member of a person's family, whānau, hapū, or iwi, or another significant trusted person:
- the inclusion of support and advocacy roles that are independent of other decision-making roles in the legislation. Those roles are intended to assist and support the person, including enabling them to exercise their rights and participate in decisions being made about them. Requirements relating to the independence and functions of those roles can be prescribed in regulatory guidelines:
- the introduction of arrangements for the use of hui whaiora (well-being meetings). This provides an additional way to help make decisions about a person's care when the person does not have other supported decision-making processes in place, such as a compulsory care directive. Hui whaiora can also be used to consider and resolve issues, disputes, or complaints, as well as to support restorative practices following the use of coercive powers. This process is intended to be inclusive of the patient and other people of significance identified by the patient, such as their family and whānau:
- the introduction of requirements for people responsible for key processes under the legislation to ensure that patients are encouraged and assisted to participate in decisions being made about them and are given reasonable assistance to understand processes and express their views.

Rights and complaints

The Bill updates the existing set of rights for those subject to compulsory assessment and care to modernise the rights and clarify who must carry out duties.

Relevant rights are also extended to those receiving voluntary care in inpatient units, which allows them access to the complaints processes under the Bill.

The rights set out in the Bill supplement the rights affirmed by the New Zealand Bill of Rights Act 1990 and set out in the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

The Bill also updates the processes for making a complaint to a district inspector in relation to a breach or omission of rights or where compulsory care has not been provided in accordance with the legislation. Updates include guiding principles to improve the accessibility, timeliness, and transparency of the complaints processes, and enabling district inspectors to rely on advice from advisers with expertise in matters involving tāngata whaiora Māori. Following the investigation of a complaint, the Director of Mental Health will be able to direct services to publicly set out how they will address recommendations that have not been satisfactorily addressed, to ensure that complaint resolution recommendations are enforced.

Compulsory care criteria

The Bill sets out the criteria that must be satisfied in order for a person to be subject to compulsory care. The compulsory care criteria will be met if the person has seriously impaired mental health—

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

The criteria will ensure that compulsory care occurs only when it is reasonable and proportionate to the circumstances. People will not be compelled by others to receive mental health care unless they lack decision-making capacity and serious harm has occurred or is likely to occur imminently.

Compulsory assessment and care

The Bill sets out requirements for each step of the process by which an individual becomes subject to compulsory care, which involves—

- an examination:
- a first assessment:
- a second assessment for a period of up to a maximum of 19 days, with formal reviews required no later than days 5, 12, and 19:
- mental health care orders, either inpatient or community, given by the court.

At each assessment point, the decision maker (either a mental health practitioner or the person's responsible practitioner) will be required to have regard to the views of the person being assessed as well as those of their support network (eg, family and whānau). Decisions will also need to be guided by the compulsory care principles and focus on supported decision-making (see process steps above).

The Bill includes rights to seek review of or appeal against decisions at each step in the process and once an order is made. If at any time a responsible practitioner considers that a patient does not meet the compulsory care criteria, the patient must be immediately released from compulsory care.

Care planning

The Bill clarifies the care a person must receive when they are subject to the legislation. It requires that all patients have a recorded care plan, which includes—

- a full assessment of the person’s circumstances and needs, such as their mental health, physical health and social needs, cultural considerations, and strengths:
- the care that will be provided to the person to meet their needs:
- planning for transition from inpatient to community care, and from compulsory to voluntary care, to better support the patient to exit compulsory care when they are ready or no longer meet the compulsory care criteria.

The Bill also requires family and whānau involvement where possible and appropriate, as well as having regard to the views of a wide range of experts in care planning, including clinical perspectives, perspectives of those with lived experience of mental distress, and cultural perspectives. Providing care that better meets people’s needs during their recovery is intended to help minimise the need for and duration of compulsory care.

Care review requirements

Regular care plan and status reviews will be required to assess whether a person continues to meet the compulsory care criteria and their progress under their care plan. This is intended to ensure patients are not held under the legislation for longer than is required and that the needs of the patient and their family and whānau are kept at the centre of their care. Additionally, these reviews will act as a record throughout various stages of a patient’s care, providing a means of ensuring that the patient has been cared for appropriately.

Reducing and eliminating the use of restrictive practices

The Bill takes a balanced approach to reducing and eventually eliminating seclusion and other restrictive practices. This approach recognises the trade-offs between the human rights implications and lack of therapeutic benefits with the need to ensure—

- the safety of the person, staff, and others:
- the readiness of the system, including sufficient workforce to implement the legislative requirements:
- the avoidance of potential unintended consequences (for example, an increase in other inappropriate forms of restrictive practices.

In addition to setting out when seclusion and the use of force may be used, the Bill introduces a duty on services to use their best endeavours to eliminate seclusion and to minimise the use of force. To support transparency, there are reporting requirements on the use of those practices.

The Bill requires that seclusion be used in accordance with regulatory guidelines. It also enables regulations to prohibit or restrict the use of seclusion.

Children and young people

The Bill provides for additional requirements and protections that apply to children and young people, including—

- ensuring wherever possible that children and young people are cared for by child and adolescent mental health services:
- ensuring that patients under the age of 18 are not given treatments intended to destroy any part of the brain or brain function and are not placed in seclusion:
- ensuring patients under the age of 18 are not given electroconvulsive therapy (ECT) unless in the case of an emergency:
- clarifying the role of parental and guardian consent in the context of compulsory care:
- ensuring that if the Mental Health Review Tribunal or the Forensic Patient Review Tribunal considers a matter concerning a patient under the age of 18, the membership of the tribunal must include at least 1 person with appropriate expertise in child and adolescent development.

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

People in the justice system

The Bill carries over the processes for forensic patients from the Mental Health Act, including the requirement that they are to be cared for in the same way as other compulsory care patients. Forensic patient status is conferred on people subject to compulsory care who are detained in a hospital following an order under the Criminal Procedure (Mentally Impaired Persons) Act 2003 (the CPMIP Act) or transferred from prison. A person who is a forensic patient under the CPMIP Act will be subject to this Bill. The criteria before being a forensic patient are set out in the CPMIP Act and therefore the patient does not need to be assessed against separate criteria under the Bill.

The Bill establishes a Forensic Patient Review Tribunal to—

- determine applications for leave for forensic patients:
- review the condition of forensic patients:
- determine applications for change of legal status under the CPMIP Act.

The Forensic Patient Review Tribunal will consider and balance important factors, such as the best mental health outcomes, public safety, and the voice of victims. Expert members will balance the desire for victims to inform decision makers as to the relevant safety considerations with the need for timely and healthcare-oriented decision making.

Monitoring, oversight, and reporting

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

- the Director of Mental Health, who is responsible for the general administration of the legislation and may, among other things, make guidelines and standards of compulsory care:
- Directors of Area Mental Health Services, who are generally responsible for the oversight of the legislation at the service or facility level:
- authorised persons, who have a range of functions and powers to advise and provide assistance in relation to people requiring compulsory care:
- district inspectors and official visitors, who are independent watchdogs with responsibility for ensuring that people subject to compulsory care are advised of their rights, that complaints of breaches of those people’s rights are

investigated, and that services are improved if necessary for rights to be upheld:
- a Mental Health Review Tribunal, an independent statutory body that, among other functions, can review a person’s condition upon application or of its own motion.

The Bill includes strengthened reporting requirements, including requiring statutory officers to report on matters requested by the Director of Mental Health and requiring the Director of Mental Health to publish an annual report on implementation of the legislation. The Director-General of Health will be required to review the legislation within five years of commencement and then at five yearly intervals.

Part Two: Background Material and Policy Information

Published reviews or evaluations

2.1. Are there any publicly available inquiry, review or evaluation reports that have informed, or are relevant to, the policy to be given effect by this Bill?	**YES**

- *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction,* Government Inquiry into Mental Health and Addiction, November 2018 (accessible at www.mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga).
- *Mental Impairment Decision-Making and the Insanity Defence (Report 120)*, New Zealand Law Commission, December 2010 (accessible at *www*.lawcom.govt.nz/assets/Publications/Reports/NZLC-R120.pdf).
- *Repealing and Replacing the Mental Health Act: Analysis of Public Consultation Submissions*, prepared for the Ministry of Health by Dr Michael Roguski and Fleur Chauvel, May 2022 (accessible at https://www.health.govt.nz/system/files/documents/publications/repealing-replacing-mha-consultation-submissions_analysis-august-2022.pdf).

Relevant international treaties

2.2. Does this Bill seek to give effect to New Zealand action in relation to an international treaty?	**NO**

Regulatory impact analysis

2.3. Were any regulatory impact statements provided to inform the policy decisions that led to this Bill?	**YES**

- Regulatory Impact Statement: Transforming Mental Health Law, Ministry of Health, 29 November 2022.
- Regulatory Impact Statement: Transforming Mental Health Law – Second Tranche of Policy Decisions, Ministry of Health, 27 February 2023.

These are accessible at https://www.health.govt.nz/about-ministry/information-releases/release-ministerial-decision-making-documents/cabinet-material-policy-decisions-transforming-mental-health-law and at www.treasury.govt.nz/publications/informationreleases/ris.

2.3.1. If so, did the RIA Team in the Treasury provide an independent opinion on the quality of any of these regulatory impact statements?	**NO**

The RIA Team based in the Treasury considered that the regulatory impact statements could be reviewed by a panel with representatives of the Ministry of Health and Ministry of Justice. That panel considered that the information and analysis summarised in the regulatory impact statements met the quality assurance criteria.

2.3.2. Are there aspects of the policy to be given effect by this Bill that were not addressed by, or that now vary materially from, the policy options analysed in these regulatory impact statements?	**NO**

Extent of impact analysis available

2.4. Has further impact analysis become available for any aspects of the policy to be given effect by this Bill?	**NO**

2.5. For the policy to be given effect by this Bill, is there analysis available on:	
(a) the size of the potential costs and benefits?	**YES**
(b) the potential for any group of persons to suffer a substantial unavoidable loss of income or wealth?	**NO**
For analysis on the size of the potential costs and benefits, see: • pages 26 - 30 of Regulatory Impact Statement: Transforming Mental Health Law • pages 31 – 35 of Regulatory Impact Statement: Transforming Mental Health Law – Second Tranche of Policy Decisions.	

2.6. For the policy to be given effect by this Bill, are the potential costs or benefits likely to be impacted by:	
(a) the level of effective compliance or non-compliance with applicable obligations or standards?	**YES**
(b) the nature and level of regulator effort put into encouraging or securing compliance?	**YES**
See section 3 of the Regulatory Impact Statements for responses to these matters.	

Part Three: Testing of Legislative Content

Consistency with New Zealand's international obligations

3.1. What steps have been taken to determine whether the policy to be given effect by this Bill is consistent with New Zealand's international obligations?
All policy options were assessed against the status quo to determine whether they better balance, protect and respect human rights. This included consideration of New Zealand's international human rights obligations under several conventions such as the Convention on the Rights of Persons with Disabilities, the Convention against Torture, and the Convention on the Rights of the Child. All policy options chosen by Cabinet were determined to support greater consistency than the status quo.

Consistency with the government's Treaty of Waitangi obligations

3.2. What steps have been taken to determine whether the policy to be given effect by this Bill is consistent with the principles of the Treaty of Waitangi?
Extensive public consultation was undertaken at the start of the policy development and this included a dedicated Māori consultation process which included consultation with Māori who have had lived experience of being under the Mental Health Act, their family and whānau and the mental health sector workforce. Treaty of Waitangi specific policy objectives were developed to identify and assess policy options. These objectives captured the outcomes sought for Māori under new legislation and the Crown's duties as a Treaty partner in legislating for mental health. The Ministry of Health also engaged with the Cabinet-authorised Treaty Provisions Oversight Group and established an Expert Advisory Group that had significant representation of Māori and Māori with lived experience to help test and refine the policy proposals. The Bill includes a range of proposals that are intended to give effect to the principles of the Treaty in the context of compulsory mental health care. Clause 5 of the Bill is a descriptive clause that sign-posts other provisions in the legislation that will give effect to the principles of the Treaty. Additionally, the compulsory care principles set out in clause 6 of the Bill build on the health sector principles from the Pae Ora (Health Futures) Act 2022, which already incorporate the concepts of the Treaty principles identified by the Waitangi Tribunal in the Hauora Inquiry (WAI 2575) and are binding on health entities.

Consistency with the New Zealand Bill of Rights Act 1990

3.3. Has advice been provided to the Attorney-General on whether any provisions of this Bill appear to limit any of the rights and freedoms affirmed in the New Zealand Bill of Rights Act 1990?	**YES**
Advice provided to the Attorney-General by the Ministry of Justice is generally expected to be made available on the Ministry of Justice website upon introduction of a Bill, at www.justice.govt.nz/justice-sector-policy/constitutional-issues-and-human-rights/bill-of-rights-compliance-reports.	

Offences, penalties and court jurisdictions

3.4. Does this Bill create, amend, or remove:	
(a) offences or penalties (including infringement offences or penalties and civil pecuniary penalty regimes)?	**YES**
(b) the jurisdiction of a court or tribunal (including rights to judicial review or rights of appeal)?	**YES**

The Bill carries over offences from the current Mental Health Act, these are set out in Part 7 of the Bill. The offence relating to neglect or ill-treatment of proposed patients and patients (clause 190) has been updated to include voluntary patients receiving inpatient mental health care.

The Bill contains provisions relating to the court and review tribunals that have been transferred from the current Mental Health Act with updates as required to align with the new policy intent. The Bill shifts decisions about long leave and change of legal status for forensic patients from the Minister of Health to a new forensic patient review tribunal.

3.4.1. Was the Ministry of Justice consulted about these provisions?	**YES**

The Offence and Penalty Vetting team at the Ministry of Justice was consulted on the offence provisions in the Bill.

As a result of consultation with the Ministry of Justice, the penalty for the offence of neglect or ill-treatment (clause 190) has been raised from 2 years to 5 years imprisonment to align with a similar offence in the Crimes Act 1961 that has a penalty of 10 years imprisonment.

Privacy issues

3.5. Does this Bill create, amend or remove any provisions relating to the collection, storage, access to, correction of, use or disclosure of personal information?	**YES**

The Bill requires the Director of Area Mental Health Services to ensure that in every service the person in charge keeps the information prescribed by notice in respect of patients under the legislation.

The Bill also requires copies of particular records, including outcomes of assessments and care reviews, to be provided to certain persons. This includes those who have oversight of a person's care, those who have an independent monitoring role in the legislation (such as a district inspector), or those that are part of a person's support network. A person's support network is limited to key people who are closely involved in a person's care and will generally be known or appointed ahead of a person being subject to the legislation (such as a welfare guardian, nominated person or principal caregiver).

3.5.1. Was the Privacy Commissioner consulted about these provisions?	**YES**

The Office of the Privacy Commissioner was consulted on policy proposals during the policy development. It noted that the policy intention to involve whānau, hapū and iwi at key points in the statutory processes and care planning, but that the individual's wishes be paramount – appears to strike a balance between privacy rights and whānau engagement.

External consultation

3.6. Has there been any external consultation on the policy to be given effect by this Bill, or on a draft of this Bill?	**YES**
The Ministry of Health undertook public consultation at the start of the policy development (from October 2021 to January 2022). Views were sought on what new mental health legislation should look like in New Zealand. Feedback was sought widely to ensure it was representative of key groups, including dedicated consultation with Māori and people with lived experience and their family and whānau. There were also dedicated consultation sessions for Pacific, Asian and ethnic communities, young people, those with coexisting disabilities, the mental health sector including non-government organisations, clinicians, as well as the general public. Over 300 written submissions were received, and feedback was gathered from over 500 people across 60 online consultation hui. Following public consultation an Expert Advisory Group (EAG) was established. Members came from different backgrounds and brought a range of expertise including Māori and people with personal or whānau lived experience of the current Mental Health Act, service providers and clinicians, as well as legal and academic expertise. Members with different perspectives were sought to assist officials to consider all sides of key issues that need to be addressed in the development of policy proposals. The following public sector organisations and Offices of Parliament were consulted during the policy development: Health New Zealand, the Māori Health Authority, Mental Health and Wellbeing Commission, Health Quality and Safety Commission, the Ombudsman and the offices of the Health and Disability Commissioner and Privacy Commissioner. The acting Chief District Court Judge and acting Principal Family Court Judge were consulted on the draft Bill with a focus on implementation considerations for the courts.	

Other testing of proposals

3.7. Have the policy details to be given effect by this Bill been otherwise tested or assessed in any way to ensure the Bill's provisions are workable and complete?	**NO**

Part Four: Significant Legislative Features

Compulsory acquisition of private property

4.1. Does this Bill contain any provisions that could result in the compulsory acquisition of private property?	**YES**

Clause 158 allows certain authorised persons to seize any item in the possession of a patient that may reasonably be believed to be a risk to the health and safety of employees of the service, or patients, or both. This must be done in line with guidelines published under clause 204.

Clauses 35, 36 and 37 set out a person's entitlement to send and receive communications, and to use communication aids and mobility aids – these rights are only able to be restricted in defined circumstances. The impact of these provisions is mitigated by the fact that they can only be used in defined circumstances:

- clause 35 – a patient must be informed when a communication is withheld, unless the responsible practitioner reasonably believes that informing the patient may have a detrimental effect on the patient. The person in charge of a hospital must also ensure that the patient has access to the entitlements under clause 35.
- clauses 36 and 37 – a responsible practitioner must take reasonable steps to ensure that the patient has access to their mobility and/or communication aid. Mobility and/or communication aids can only be withheld where it is necessary in an emergency situation.

The Bill includes processes for making complaints where patients feel their rights have been breached, these must be referred to a district inspector who may investigate that complaint.

Additionally, any person performing a function or duty or exercising a power in the Bill, including the clauses outlined above, must be guided by the compulsory care principles (in clause 6). These principles include requirements that the least restrictive practices be applied.

Charges in the nature of a tax

4.2. Does this Bill create or amend a power to impose a fee, levy or charge in the nature of a tax?	**NO**

Retrospective effect

4.3. Does this Bill affect rights, freedoms, or impose obligations, retrospectively?	**NO**

Strict liability or reversal of the usual burden of proof for offences

4.4. Does this Bill:	
(a) create or amend a strict or absolute liability offence?	**YES**
(b) reverse or modify the usual burden of proof for an offence or a civil pecuniary penalty proceeding?	**NO**

The Bill includes a strict liability offence relating to unlawful publication of reports of proceedings before a Review Tribunal without the leave of the Tribunal (Clause 193). The person is liable on conviction to a fine not exceeding $10,000. This offence has been carried across from the Mental Health (Compulsory Assessment and Treatment) Act 1992.

This is a strict liability offence because the act of publishing the report without leave of the tribunal creates an offence regardless of the mental state of the person.

Civil or criminal immunity

4.5. Does this Bill create or amend a civil or criminal immunity for any person?	**YES**

The Bill at clause 201 grants criminal immunity under certain grounds. These are:

- when a person believes on reasonable grounds that a notice has been properly given under clause 57 or 60 or a compulsory care order has been properly made, and they act relying on that belief, and act in good faith
- when a person uses force while exercising a power or performing a function in accordance with clause 200, and where it was reasonably necessary to use such force in the circumstances, and the use of force was undertaken in accordance with any guidelines issued by the Director of Mental Health under Clause 204.

The Bill also grants civil immunity for district inspectors and official visitors (clause 159) and members of review tribunals (clause 173) unless they have acted in bad faith.

These criminal and civil immunity grounds have been carried across from the Mental Health (Compulsory Assessment and Treatment) Act 1992 and have been included to ensure the statutory purpose is met.

Significant decision-making powers

4.6. Does this Bill create or amend a decision-making power to make a determination about a person's rights, obligations, or interests protected or recognised by law, and that could have a significant impact on those rights, obligations, or interests?	**YES**

The Bill, as under the current Mental Health Act, contains decision-making powers to detain and provide a person with compulsory care if they meet the legal criteria. This limits some of the human rights guaranteed under the New Zealand Bill of Rights Act, such as the right to refuse medical care, to freedom of expression, and to freedom of movement.

The Bill includes a range of safeguards to ensure these limitations only go as far as necessary to achieve the policy objectives. Safeguards include compulsory care principles that decision-makers must follow, clearly defined compulsory care criteria, opportunities for people to make compulsory care directives, requirements for patient participation and hui whaiora, explicit rights such as rights to information, independent health advice, legal advice, company and visitors alongside complaints processes, review and appeal rights, and independent oversight and monitoring.

Powers to make delegated legislation

4.7. Does this Bill create or amend a power to make delegated legislation that could amend an Act, define the meaning of a term in an Act, or grant an exemption from an Act or delegated legislation?	**YES**
The Bill includes provisions to reduce and eliminate seclusion. The use of seclusion is allowed in certain circumstances. Practice and system changes are needed before seclusion can be further restricted or prohibited. Clause 49 allows regulations to be made to prohibit, or restrict the use of, the placement of patients in seclusion. This regulation making power is intended to enable flexibility to allow further restrictions to be applied when the system is ready. The Bill specifies that a patient must not be provided with restricted treatments unless certain conditions are met. Clause 51 allows other treatments to be deemed restricted treatments via regulations. This ensures that any treatments that are developed in the future that are intended to destroy any part of the brain or brain function can be included as restricted treatments and therefore be subject to the safeguards set out in clause 51.	

4.8. Does this Bill create or amend any other powers to make delegated legislation?	**YES**
Clause 202 provides for regulations to be made by the Governor-General by Order in Council on the recommendation of the Minister. The regulations will provide for the matters of detail necessary to support the implementation and operation of the Act. The regulations required in order to implement the Act include, for example, regulations providing for anything in the Act that may or must be provided for by regulation (eg, requirements relating to the appointment and functions of advocates, regulations to prohibit or restrict the placement of patients in seclusion, information to be included in the Director's annual report), prescribing the powers and duties of district inspectors and official visitors and regulating the exercise of those powers and performance of duties, and prescribing fees for any purpose of the Act. Clause 203 provides that the Minister may make notices providing for anything the Act says or will be provided for by notice. Clause 204 enables the Director-General of Health to make guidelines for the purposes of the Act and standards for care of patients.	

Any other unusual provisions or features

4.9. Does this Bill contain any provisions (other than those noted above) that are unusual or call for special comment?	**NO**