The Royal Australian & New Zealand College of Psychiatrists
Tu Te Akaaka Roa
New Zealand National Office

Your Health in Mind
Hauora hinengaro Manatuhia

GOVERNANCE AND ADMINISTRATION COMMITTEE

EMERGENCY MANAGEMENT BILL (NO 2) 236-1

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Excellence and equity in the provision of mental healthcare

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ABOUT THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

The RANZCP is the peak body representing psychiatrists in Australia and New Zealand. We are a binational college that trains doctors to become medical specialists in psychiatry. We support and enhance clinical practice, advocate for people affected by mental illness and addiction, and advise governments on matters related to mental health and addiction care.

We represent over 8,730 members, including more than 6,000 qualified psychiatrists and 2,500 trainees. Our training, policy, and advocacy work is led by expert committees of psychiatrists and subject-matter experts with academic, clinical, and service-delivery experience in mental health and addiction.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback on the Emergency Management Bill (No 2). We acknowledge the Bill's intent to modernise Aotearoa New Zealand's emergency management system following the Government Inquiry into the North Island severe weather events. We offer our recommendations to strengthen the bill, ensuring people experiencing mental distress or addictions are not left behind or treated as an afterthought.

INTRODUCTION

We represent psychiatrists working across the motu. As clinicians, we walk alongside people during some of their most difficult moments – supporting parents trying to keep their whānau safe in crisis while managing severe anxiety or addiction, sitting with young people whose eating disorders intensify under stress, helping older people maintain connection when dementia makes change frightening, and caring for those in acute crisis who are not always able to advocate for themselves.

During the Canterbury earthquakes, we saw whānau whai ora lose their homes, their medications, their support workers, and their hope. After Cyclone Gabrielle, people were cut off from essential mental health services for weeks – some experienced psychotic relapse without access to clozapine, others went into severe withdrawal when opioid substitution therapy services could not operate. Following the Christchurch mosque attacks, the Whakaari eruption, and the recent weather tragedies at Mauao, Te Tai Tokerau, Tairawhiti and most recently the state of emergency in Ōtorohanga and Waipa, we are witnessing trauma ripple through entire communities.

These experiences show that emergency management systems either protect our most vulnerable or abandon them. There is no middle ground.

While we support the Bill's objectives, we submit that people experiencing mental distress and addiction cannot be an afterthought in emergency planning. Their safety, dignity, and access to life-saving care must be embedded throughout this legislation, grounded in Te Tiriti partnership and genuine community co-design.

MĀUIUI WHENUA, MĀUIUI TĀNGATA

Mātauranga Māori provides a crucial insight that is reinforced by each disaster: "māuiui whenua, māuiui tāngata" – if the land is unwell, the people will be too.

Cyclone Gabrielle devastated Tairāwhiti and Hawke's Bay. The recent tragedy at Mauao in January 2026 caused deep mamae across communities. These events harm people and their whenua, damage the taiao, contaminate kai and waterways, and generate trauma that runs deeper than any clinical assessment can capture.

For someone already living with depression, losing a home is not only the loss of physical shelter – it is the loss of the one place they felt safe enough to sleep. For someone managing psychosis, evacuation centres with bright lights, noise, and many strangers can trigger an acute episode. For someone in recovery from addiction, the stress and chaos of disaster can undo years of hard-won stability in a single night.

WHO BEARS THE WEIGHT OF DISASTERS

People experiencing mental distress do not face emergencies on equal footing. Many are already navigating:

- **Social isolation** – When evacuation orders are issued, they may have no one to call and nowhere to go.
- **Housing insecurity** – Living in boarding houses, emergency accommodation, or on the streets means no safe place to shelter and no capacity to prepare.
- **Poverty** – No savings for emergency supplies, no money to replace lost medications, no transport to reach safety.
- **Communication barriers** – Cognitive impairments, psychotic symptoms, severe anxiety, or acute intoxication can make it impossible to understand warnings or follow evacuation instructions.
- **Medication dependency** – When Cyclone Gabrielle hit, mental health services lost power and road access. People on clozapine – a medication requiring regular blood monitoring to prevent potentially fatal side effects – were cut off from care. People on methadone faced acute withdrawal when pharmacies could not operate. Missing psychiatric medications does not only cause discomfort; it can trigger psychotic relapse, seizures, and suicidal crisis.
- **Service dependency** – A weekly check-in with a community mental health clinician may be the only human contact keeping someone alive. When those services collapse, people's well-being can deteriorate rapidly and silently.
- **Institutional vulnerability** – People in acute psychiatric wards may be in seclusion, under restraint, or too unwell to evacuate themselves. Those subject to compulsory treatment orders cannot simply leave. When power fails or buildings are damaged, they are entirely dependent on staff who may themselves be displaced, traumatised, or unable to reach the facility.
- **Whānau already navigating hardship** – Children and families already living with adversity and cumulative harm face compounded risk during disasters. When the one parent holding things together loses their capacity to cope, when the safe adult becomes overwhelmed by their own distress or addiction, children lose their anchor. A disaster can push entire whānau systems beyond breaking point, leaving children without the protection and stability they need.
- **Compounding identities** – Māori are over-represented in mental health services and underserved by emergency responses. Rural communities face longer wait times for help. Children cannot advocate for themselves. Older people with dementia become disoriented and frightened. Migrant communities may not receive warnings in languages they understand. Each intersecting identity multiplies risk.

Without explicit recognition in this Bill, these realities remain invisible. Invisible people are not prioritised for rescue, do not receive medications, aren't checked in on, and in the worst cases, they may not survive. We have a duty to respond to this Bill as advocates for the whai ora and whānau we care for and stand alongside.

THE MENTAL HEALTH CRISIS THAT FOLLOWS EVERY DISASTER

Disasters do not only affect people with pre-existing mental health needs. They create new trauma, grief, and despair across entire communities.

In the days and weeks following Cyclone Gabrielle and the Auckland Anniversary floods, we saw:

• Emergency departments overwhelmed with people in acute mental health crisis – self-harm, suicidality, severe panic attacks, and psychotic episodes
• Parents unable to sleep, constantly vigilant for the next weather event and unable to function
• Young people withdrawing, refusing to eat, and developing acute anxiety disorders
• Increased alcohol and drug use as people tried to cope with trauma
• People initially in survival mode who only decompensated months later when the immediate danger had passed

These effects are not always temporary. Research following the Canterbury earthquakes shows elevated rates of depression, anxiety, PTSD, and suicide risk persisting for years. Disasters damage the social determinants of mental health – housing, employment, income, and community connection – and the consequences compound over time.

Yet mental health services typically receive short-term crisis funding that expires long before communities have recovered. Clinicians themselves are traumatised, experience burnout, and leave the workforce precisely when they are needed most.

If this Bill does not recognise mental health services as essential infrastructure requiring continuity, surge capacity, and sustained resourcing, preventable suffering will continue with every disaster.

OUR OBLIGATIONS TO EACH OTHER

International human rights law is not abstract. It embodies a commitment that every person – regardless of mental health status, addiction, disability, income, or location – deserves protection, dignity, and care during emergencies.

New Zealand has made binding commitments, including:

• **UN Convention on the Rights of Persons with Disabilities (CRPD)** – to protect disabled people, including those with psychosocial disability, during emergencies; to provide accessible warnings, shelters, and recovery; and to ensure disabled people participate in planning rather than merely being planned for.
• **International Covenant on Economic, Social and Cultural Rights (ICESCR)** – to progressively realise the right to health, including mental health. This obligation does not pause during cyclones.
• **Te Tiriti o Waitangi** – to ensure partnership, not mere consultation; to uphold tino rangatiratanga, meaning Māori self-determination in planning for their communities; and to realise ōritetanga, or equitable outcomes. These commitments are life-or-death during disasters, when Māori experience deeper trauma from severed connection to whenua and when racism in emergency responses means Māori communities may wait longer for help, receive less support, and experience greater harm.
• **United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)** – to uphold Indigenous peoples' rights to participate in decisions affecting them, including emergency management.

These are not aspirational standards; they are legal obligations. This Bill must operationalise them.

WHAT THIS BILL MUST DO

To protect people experiencing mental distress and addiction, and to honour Te Tiriti and international obligations, this Bill must:
• Explicitly name people experiencing mental distress and addiction as "disproportionately affected communities" (clause 5)

• Recognise mental health and addiction services as essential services requiring continuity planning
• Ensure people with mental health and addiction expertise sit on Emergency Management Committees and Co-ordinating Executive Groups (clauses 39, 41)
• Require emergency management training to include mental health, addiction, and trauma-informed approaches (clause 28)
• Make emergency warnings and information accessible to people with psychosocial disability (clauses 28, 29)
• Embed Te Tiriti partnership throughout, including specific recognition of kaupapa Māori mental health services and marae-based responses (clauses 3, 39, 77, 86)
• Require long-term (minimum 3–5 years) psychosocial recovery planning and resourcing (clause 91)

DETAILED RECOMMENDATIONS

1. Amend the definition of "disproportionately affected communities"

Clause 5 defines "disproportionately affected community" so broadly that it becomes unclear. Emergency Management Committees across the country will interpret it inconsistently. Some will remember to consider mental health and young people at risk; others will not. What is not explicitly named becomes invisible. We must identify key groups while retaining flexibility for local nuance.

We recommend amending clause 5 to specifically include:

• People experiencing mental distress and/or problematic substance use, including those with psychosocial disability
• People in acute inpatient mental health units, secure forensic services, or residential addiction treatment
• Tāngata whai ora Māori accessing mental health and addiction services
• Tāngata whai kaha (disabled people), including those with psychosocial disability
• Children and young people
• Older people (kaumātua)
• People experiencing homelessness
• People with low incomes
• New parents
• People with recent contact with whānau safety services
• Migrants and people with limited English and/or familiarity with the local services
• Rural and remote communities

The definition should also acknowledge that people often belong to multiple groups simultaneously and face compounded risks that require specific, tailored planning.

2. Mental health services are a life-saving infrastructure

The Bill lists essential infrastructure, including electricity, water, and telecommunications. Mental health care is also a critical infrastructure, and cannot be deferred until after the crisis.
We recommend explicitly classifying mental health and addiction services as essential services, including:

• Acute inpatient mental health units and secure forensic services
• Community mental health crisis teams
• Consultation-liaison psychiatry services (mental health support in general hospitals)
• Opioid substitution therapy (methadone and buprenorphine) services
• Child and youth mental health services

• Older persons' mental health services
• Kaupapa Māori mental health and addiction services
• Pacific mental health and addiction services

In practice, this means:

• Power companies must prioritise keeping mental health facilities operational
• Mental health services must have backup power for medication storage, security systems, and patient safety equipment
• Telecommunications must be maintained so crisis lines can operate
• Road access must be cleared for mental health staff and medication deliveries
• Plans must exist for the safe evacuation of psychiatric inpatient units while maintaining legal safeguards for people under compulsory treatment

3. Protect people under the Mental Health Act

People subject to compulsory treatment under the Mental Health Act are among the most vulnerable. They may be actively suicidal, experiencing severe psychosis, or unable to make decisions about their own safety. The Bill does not clarify what happens to their legal protections during emergencies.

Mental Health Act rights and oversight must continue to apply in emergencies. Emergency powers cannot override legal safeguards that protect people from arbitrary detention and ensure humane treatment. Evacuation plans must maintain these protections while keeping people safe.

We recommend amending clause 125 (emergency powers) to explicitly require that these powers be exercised consistently with Mental Health Act obligations.

4. Include mental health and lived experience expertise in decision-making

Clause 39 requires Emergency Management Co-ordinating Executive Groups to include someone representing "health and disability services." This must explicitly include mental health, addiction, and lived experience expertise.

We recommend:

- Amending clause 39(3) to require representation with mental health and addiction service delivery and lived experience expertise on every Emergency Management Co-ordinating Executive Group
- Amending clause 39(3) to require tāngata whenua mental health and addiction service representation, honouring both Te Tiriti partnership and the deep expertise of kaupapa Māori providers
- Expanding clause 41 to ensure these representatives are properly resourced – remunerated for their time, provided with protected hours from their substantive roles, and supported with appropriate training
- Amending clause 28(2)(b) to require that all emergency management training include content on mental health, addiction, psychosocial disability, trauma-informed approaches, and recognising and responding to acute mental health crisis

5. Make warnings and information accessible

Emergency warnings often assume that everyone can quickly read complex instructions, process information under stress, and act immediately. In reality, someone experiencing acute psychosis may not comprehend that the danger is real; someone with severe anxiety may freeze; someone with

cognitive impairment may not understand directives such as “evacuate to higher ground”; and someone who does not speak English may miss the warning entirely.

We recommend:

• Amending clause 29(2)(d) to require that emergency warnings use simple, clear language
• Using multiple channels – visual, auditory, and tactile – rather than relying solely on text messages
• Providing information in te reo Māori, Pacific languages, and other languages used in local communities
• Amending clause 28(2)(b) to require that all emergency information be available in accessible formats, consistent with the CRPD

6. Honour Te Tiriti o Waitangi and support community-led response

In every emergency, marae have opened before government services arrived. Hapū and iwi have provided shelter, kai, and psychosocial support while official channels were still “assessing the situation.” Community organisations supporting people with mental health challenges have continued operating when government services closed. Peer support workers have checked on people who might otherwise have been forgotten. These are not optional extras; they are essential components of effective emergency response.

Yet the Bill treats community response as supplementary. It refers to “Māori perspectives” as if Māori were advisors rather than partners. It does not recognise that for many people, especially tāngata whai ora Māori, connection to marae, whenua, and hapū is fundamental to wellbeing and survival.

We recommend:

• Amending clause 3 (purpose) to explicitly reference Te Tiriti o Waitangi, human rights, and particular attention to disproportionately affected communities
• Inserting a new clause establishing Te Tiriti principles of partnership (shared decision-making, not consultation alone), tino rangatiratanga (Māori self-determination in planning and response), and ōritetanga (equitable outcomes)
• Ensuring the National Māori Emergency Management Advisory Group includes mental health and addiction expertise
• Explicitly recognising and resourcing marae-based emergency response, kaupapa Māori mental health services, and peer-led support organisations as essential to emergency management
• Protecting access to marae and culturally significant sites during emergencies – emergency powers must not prevent people from gathering for collective grieving, healing, and planning, except where there is an immediate and demonstrable risk to life
• Amending clause 86(2)(b) to require that reviews of emergency management plans include genuine partnership with tāngata whenua, mental health and addiction service providers, and people with lived experience of mental distress and addiction

7. Psychosocial recovery takes years

After every disaster, there is a short burst of crisis funding for mental health services that does not reflect the scale or duration of community need.

Canterbury research shows mental health impacts persisting 5–10 years after the earthquakes. Children who were traumatised are now young adults living with anxiety and PTSD. Adults who lost everything continue to experience depression and prolonged grief.

We recommend amending clause 91 (regional emergency management plans) to require planning for long-term psychosocial recovery, including:

• Funding mental health and addiction services for a minimum of 3–5 years post-disaster, rather than 3–6 months
• Building surge capacity into existing services instead of establishing temporary crisis teams that are later withdrawn
• Supporting the mental health workforce, recognising that clinicians experience vicarious trauma and require supervision, rest, and support to remain in the workforce
• Co-designing recovery services with affected communities, rather than imposing external models that do not reflect local realities and needs

MĀUIUI WHENUA, MĀUIUI TĀNGATA: CONCLUSION

When the land is unwell, the people will be too. When we support the land's healing, uphold our roles as kaitiaki, and care for each other through crisis, we create conditions for collective recovery. This Bill has the potential to either safeguard our most vulnerable or abandon them. We have seen the consequences when emergency management systems fail to consider people experiencing mental distress. We have seen evacuation centres become unsafe for them. We have prescribed medications that could not be administered. We have tried to support people without power, communication, or transport. We have held space for grief that might have been prevented.

This Bill can:

• Formalise the partnership envisaged in Te Tiriti o Waitangi
• Recognise mental health as essential infrastructure
• Ensure warnings and information are accessible
• Plan for extended recovery periods rather than only the initial weeks and months
• Resource community-led responses
• Protect people subject to compulsory treatment
• Embed mental health expertise in decision-making processes

These reforms will not only benefit people with mental health needs but also enhance the overall resilience, humanity, and effectiveness of emergency management systems for everyone. By designing systems that accommodate those most at risk, we create stronger, more compassionate, and more efficient frameworks.

We respectfully urge the Committee to strengthen this Bill. The mental health impacts of disasters are profound and enduring. The importance of getting this right cannot be overstated.

The RANZCP would welcome the opportunity to present orally to the Committee.

Nāku noa, nā

Dr Hiran Thabrew

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