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

Your Health in Mind
Hauora hinengaro Manatuhia

The Justice Committee

Crimes Amendment Bill 223-1

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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 RANZCP welcomes the opportunity to respond to the Crimes Amendment Bill 223-1 (2025). We oppose the proposed assault on first responders' provisions. In our view, the Bill treats a system failure as an individual crime, penalising people experiencing mental health crises instead of addressing the real problem: untrained responders being sent into situations that require specialist mental health expertise.

INTRODUCTION

The RANZCP opposes the proposed assault on provisions for first responders in the Crimes Amendment Bill 223-1. This submission focuses on advocacy for evidence-based solutions, not on the legal complexities of criminalising distress. We take this opportunity to warn against criminalising distress and to recommend redirecting focus from punishing those who harm first responders to protecting them and our communities in the first place.

Criminal penalties, especially when used as a primary response, do not prevent harm. Skilled crisis response does. We advocate for health system responses that protect both first responders and tāngata whai ora through evidence-based crisis intervention, rather than retrospective punishment.

The Bill misidentifies the problem:

- First-responder safety and tāngata whai ora wellbeing are not competing priorities
- It treats a system failure (inadequate crisis response capability) as an individual crime (behaviour during a mental health crisis).
- Enhanced criminal penalties will not make first responders safer—international evidence shows assault rates do not decrease when penalties increase.
- What protects people are skilled crisis teams, de-escalation training, manaakitanga, and therapeutic responses—not handcuffs and criminal records.

We caution against retrospective punishment that does not prevent harm and instead advocate for investment in evidence-based crisis response systems.

DISCUSSION

The Bill Treats System Failure as an Individual Crime

People in acute mental distress may be unable to understand or control their behaviour. A person in acute psychosis may genuinely believe paramedics are attackers. An elderly person with dementia may lash out in confusion and fear. Someone experiencing severe mania may be unable to regulate their actions. People can be acutely psychotic, do harmful things during a crisis, AND fully recover with treatment. First episode psychosis typically responds to medication within weeks. Acute mania resolves with treatment in weeks to months. This clinical reality—that people experiencing severe mental distress can and do get better—is absent from the Bill's approach. Criminal penalties applied during acute illness

episodes trap people in criminal justice systems long after they have recovered, when what they needed was skilled crisis intervention and treatment, not handcuffs.

Police mental health callouts increased 152% between 2013-2023,[1] yet the Bill creates enhanced criminal penalties precisely when health staff are becoming primary crisis responders. This timing makes the policy contradiction stark: we are criminalising crisis behaviour at the exact moment when people without mental health expertise are being asked to manage these situations.

When first responders—or more concerningly, an everyday person enacting a proposed new right to undertake a citizens' arrest—without adequate mental health training, enter these situations, everyone is at risk—the person in crisis, their whānau, and the responders themselves. This Bill focuses on how to punish people after harm occurs. The more appropriate question is how to prevent harm in the first place.

The Bill also extends enhanced penalties to assaults on corrections officers, who face similar challenges. Corrections staff manage mental distress daily in prison environments that worsen rather than treat mental illness, yet receive minimal mental health crisis training despite constant exposure to acute distress.

The Bill removes current protections that prohibit striking or causing bodily harm in the defence of property. This means a person in psychosis who appears threatening on someone's property, or an elderly person with dementia who wanders in confusion, could now be legally struck by untrained members of the public who cannot distinguish mental distress from criminal intent.

Criminal penalties are the wrong tool for the problem we face. Criminal penalties are retrospective; they do not protect first responders in the moment. They do not protect the person in crisis. They do not support whānau watching their loved one in crisis or whose capacity is deteriorating.

This Bill Will Disproportionately Harm Māori

Māori are over-represented in compulsory mental health treatment[2], in police interactions during mental health crises (with higher use of force),[3] and in the criminal justice system (over 50% of prison population, despite being 17% of the population). This Bill will compound these existing inequities by creating a pipeline from mental health crisis → police involvement → criminal charges → imprisonment for Māori tāngata whai ora experiencing treatable health emergencies. Any policy that criminalises mental health crisis behaviour will have a disparate impact on Māori communities already facing systemic barriers to accessing culturally safe, early intervention mental health care.[4]

Skilled crisis response prevents violence. What keeps people safe, whai ora, whānau, first responders alike, is skilled care. Responses grounded in de-escalation methods and relationship-building, rather than in force and power imbalances, are critical to better outcomes and safer interactions in crisis situations. Harm is reduced when responders understand mental distress and can respond flexibly to different situations, equipped with a range of tools and approaches to draw on. They can de-escalate situations and approach a crisis with manaakitanga and aroha rather than force. This is supported by evidence.

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[1] New Zealand Police. (2021). Mental health-related events data 2013-2023. Wellington: New Zealand Police.

[2] Waitangi Tribunal. (2019). *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (WAI 2575)*. Wellington: Waitangi Tribunal.

[3] Holman, T., Greaves, L., & Galletly, C. (2018). Pathways to care: Police use of force in the pathway to mental health care. *New Zealand Medical Journal, 131*(1481), 18-27.

[4] Waitangi Tribunal. (2019). *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (WAI 2575)*. Wellington: Waitangi Tribunal.

The Wellington Crisis Response Team pilot[5]demonstrated reduced use of force, improved outcomes for tāngata whai ora, more culturally safe responses for Māori communities, and fewer injuries among both responders and people in crisis.

International evidence on co-response models[6] shows that having mental health specialists work alongside first responders can: de-escalate situations that might otherwise become violent, connect people to treatment instead of the criminal justice system, reduce repeat crisis presentations, and build trust between communities and services.

De-escalation training is effective.[7] Responders trained in trauma-informed practice, cultural safety, and mental health crisis intervention are better able to prevent harm. They are less likely to escalate situations and more likely to recognise that a person experiencing dementia, psychosis, or severe distress needs care, not handcuffs.

By contrast, enhanced penalties have not been shown to work as intended.[8] [9] International evidence from NSW and Victoria indicates these laws are largely ineffective—assault rates against emergency workers do not decrease when penalties increase.

The evidence is clear; investment in skilled crisis response protects people. Additional criminal penalties do not.

First-responder safety and tāngata whai ora wellbeing are not competing priorities; both depend on a system commitment to ensure that people with the right skills respond to mental health crises.

Our focus in this submission is not on the complexities of criminalising distress, but on advocating for a system-wide commitment to ensure a safer, more effective system for all.

We recommend the following evidence-based measures:

Prevention - Stop crises before they happen:

- Urgently address mental health workforce shortages to provide timely, effective care that prevents deterioration to crisis point
- Invest in accessible community mental health services—including peer support workers, kaupapa Māori providers, crisis respite services, age-appropriate spaces for youth and older people,

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[5] University of Otago. (2021). Evaluation of the Wellington Co-Response Team pilot. Department of Psychological Medicine, University of Otago, Wellington; Kuehl, S., Cooper, L., & Every-Palmer, S. (2024). Able to stop things from escalating: Stakeholders' perspectives of police, ambulance and mental health co-response to mental health calls. *International Journal of Law and Psychiatry, 94*.

[6] Shapiro, G.K., Cusi, A., Kirst, M., et al. (2015). Co-responding police-mental health programs: A review. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(5), 606-620; Kane, E., Evans, E., & Shokraneh, F. (2018). Effectiveness of current policing-related mental health interventions: A systematic review. *Criminal Behaviour and Mental Health, 28*(2), 108-119.

[7] Richmond, J.S., Berlin, J.S., Fishkind, A.B., et al. (2012). Verbal de-escalation of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *Western Journal of Emergency Medicine, 13*(1), 17-25.

[8] NSW Government. (2022). Evaluation of Crimes Legislation Amendment (Assaults on Frontline Emergency and Health Workers) Act. Sydney: NSW Department of Justice.

[9] Victorian Government. (2023). Review of assault on emergency workers legislation. Melbourne: Department of Justice and Community Safety.

detoxification services with mental health expertise, and outreach teams that maintain connection with people at risk of disengagement

Crisis Response - Skilled intervention when crises occur:

- Establish co-response teams with mental health clinicians working alongside police and paramedics
- Mandate comprehensive training in de-escalation, trauma-informed practice, and cultural safety for all first responders and corrections officers
- Fund kaupapa Māori crisis services that draw on mātauranga Māori and understand whānau needs
- Create therapeutic environments designed to reduce distress—not chaotic emergency departments that escalate it

Workforce Protection - Support the people doing this work:

- Ensure adequate staffing so responders aren't working beyond capacity in already-stressful situations
- Provide proper mental health supervision and support for frontline workers managing crisis situations
- Resource services appropriately so quality care doesn't depend on individual burnout

These measures protect everyone: first responders, tāngata whai ora, whānau, and communities.

These recommendations apply equally to corrections environments, where staff regularly manage mental distress without adequate mental health expertise or therapeutic infrastructure. These measures protect people and help prevent violence. Applying criminal penalties after harm has occurred—especially to people whose distress or addiction is central to the crisis—does not.

Conclusion

We oppose the Crimes Amendment Bill 223-1 (2025) in its current form. We urge the Justice Committee to reject the proposed assault on first responders provisions and instead invest in evidence-based crisis responses that protect everyone—first responders, tāngata whai ora, and whānau.

We recommend that the Committee notes our strong opposition to:

- Creating enhanced criminal penalties for assaults on first responders without addressing the underlying system failure—untrained people responding to mental health crises
- Relying on retrospective punishment that does nothing to prevent harm in the moment
- Treating mental health crises as crimes instead of health emergencies requiring skilled therapeutic responses

Instead, we recommend that the Committee:

- Reject the assault on first responders' provisions
- Invest in co-response models that include mental health specialists
- Mandate comprehensive training in de-escalation, trauma-informed practice, and cultural safety for all first responders and corrections officers
- Fund kaupapa Māori crisis services and culturally safe responses
- Ensure adequate staffing and workforce funding so responders aren't working beyond capacity in already-stressful situations—this protects both first responders and tāngata whai ora by preventing burnout, rushed responses, and unsafe working conditions
- Resource community mental health services to prevent crises—this includes:

- Accessible community mental health teams that can respond before situations reach a crisis point
- Peer support specialists and the lived experience workforce are embedded throughout crisis and community services
- Kaupapa Māori providers with the capacity to support whānau early, using culturally grounded approaches
- Age-appropriate spaces: dedicated youth mental health services and appropriate psychogeriatric environments for older people experiencing behavioural and psychological symptoms of dementia
- Detoxification services with mental health expertise—recognising the intersection of addiction and mental distress
- Trauma-informed crisis supports that understand how trauma shapes crisis presentation and can respond without re-traumatisation
- Crisis respite services—safe, therapeutic alternatives to emergency departments where people can receive support without hospitalisation
- Outreach teams that maintain a connection with people at risk of disengagement from services
- Adequate resourcing so community teams aren't operating at breaking point, forcing people to deteriorate to crisis level before they can access help

We would like to present an oral submission.

Nāku noa, nā

Dr Hiran Thabrew

Chair of Tū Te Akaaka Roa, Royal Australian and New Zealand College of Psychiatrists

References

1. New Zealand Police. (2021). Mental health-related events data 2013-2023. Wellington: New Zealand Police.

2. Holman, T., Greaves, L., & Galletly, C. (2018). Pathways to care: Police use of force in the pathway to mental health care. *New Zealand Medical Journal, 131*(1481), 18-27.

3. Waitangi Tribunal. (2019). *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (WAI 2575)*. Wellington: Waitangi Tribunal.

4. University of Otago. (2021). Evaluation of the Wellington Co-Response Team pilot. Department of Psychological Medicine, University of Otago, Wellington; Kuehl, S., Cooper, L., & Every-Palmer, S.

(2024). Able to stop things from escalating: Stakeholders' perspectives of police, ambulance and mental health co-response to mental health calls. *International Journal of Law and Psychiatry, 94*.

5. Shapiro, G.K., Cusi, A., Kirst, M., et al. (2015). Co-responding police-mental health programs: A review. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(5), 606-620; Kane, E., Evans, E., & Shokraneh, F. (2018). Effectiveness of current policing-related mental health interventions: A systematic review. *Criminal Behaviour and Mental Health, 28*(2), 108-119.

6. Richmond, J.S., Berlin, J.S., Fishkind, A.B., et al. (2012). Verbal de-escalation of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *Western Journal of Emergency Medicine, 13*(1), 17-25.

7. NSW Government. (2022). Evaluation of Crimes Legislation Amendment (Assaults on Frontline Emergency and Health Workers) Act. Sydney: NSW Department of Justice.

8. Victorian Government. (2023). Review of assault on emergency workers legislation. Melbourne: Department of Justice and Community Safety.