

Submission on the Crimes Amendment Bill

**By the Mental Health Foundation of
New Zealand**



16 February 2026
Justice Committee

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Tuia te rangi e tū nei
Tuia te papa e takoto nei
Tuia i te here tangata
Tihei mauri ora.

He hōnore, he korōria ki te atua ki te runga rawa
He whakaaro maha ki a rātou kua haere ki te wāhi ngaro
Rau rangatira mā, ānei ngā whakaaro me ngā kōrero nā Te Hauora Hinengaro.

Thank you for the opportunity to comment on the Crimes Amendment Bill.

The Mental Health Foundation of New Zealand (MHF) is a charity that promotes everyday actions that lift mental wellbeing, provides tools that support people through tough times, and advocates for a better mental health system and society.

Given our remit, we are concentrating our submission on provisions that seek to increase punitive measures in response to offences against first responders and corrections officers (clauses 21 to 24). We are writing on the understanding that, under clause 21, the definition of 'first responders' would extend to health practitioners attending to mental health crisis events in the community, e.g. staff in co-response teams.ⁱ Our submission focuses primarily on this context, where the proposed measures are particularly ill-suited and carry heightened risk of unintended harm.

The MHF is concerned about the changes proposed under the Bill that seek to expand and ensure maximum penalties by:

ⁱ Teams comprised of staff from police, ambulance and mental health services (dependant on availability across localities) who jointly attend mental health crisis callouts, providing simultaneous multidisciplinary input.

- Expanding the aggravated assault offence in section 192(2) of the Crimes Act 1961 to apply to all first responders and corrections officers
- Creating a new offence of assaulting a first responder or corrections officer with intent to injure, increasing the applicable maximum penalty for this conduct from 3 years' to 5 years' imprisonment
- Creating a new offence of injuring a first responder or corrections officer with intent to injure, increasing the maximum applicable penalty for this conduct from 5 years' to 7 years' imprisonment. (This new offence being added to the Three Strikes regime to ensure that offenders serve mandatory sentences in line with said regime.)

We agree that frontline responders fulfil duties essential to our society's functioning, and we acknowledge they face risks every day in providing care and treatment to those in need, and agree their health and safety require our utmost protection. Although the risk of violence is not likely to ever be fully eliminated given the nature of the care provided, it can, and must, be minimised.

However, the proposed Bill assumes the threat of a future punitive measure will effectively prompt people experiencing serious mental distress and/or substance-induced distress to behave differently during an acute mental health crisis. It further assumes the actions of people who assault, or attempt to assault, first responders are always rational, planned, deliberate and callous. Yet those operating in an altered or impaired state, such as *tāngata whaiora*ⁱⁱ experiencing crisis, cannot be reliably held to this standard, and judgments about whether there was 'intent to injure' in such circumstances are inherently precarious and difficult to determine through a criminal lens. As such, the retributive approach of the Bill is unlikely to reduce the rate of such incidents in this context.

Research also indicates that increasing the severity of penalties, including longer terms of imprisonment, does not produce a corresponding increase in deterrence.¹ Evidence from New South Wales and Victoria indicates implementation of these laws is largely ineffective – assault rates against emergency workers do not decrease when penalties increase.²

We note that a Bill with similar intent (Protection for First Responders and Prison Officers Bill) was introduced in 2020 but was terminated at the Committee of the

ⁱⁱ Literally meaning 'a person seeking health', used to refer to those with lived experience of mental distress and/or addiction.

Whole House. The MHF [publicly opposed this Bill](#). It was then tabled again in 2021 but was voted not to proceed by Parliament.

As such, we do not recommend passing the inclusion of clauses 21-24 in this Bill.

Instead, we endorse a preventative and whole-of-system approach to reducing violence against first responders.

Criminal penalties are the wrong tool for addressing the problem at hand. They risk reframing mental health and substance-related crises as criminal acts, rather than health emergencies that require skilled, therapeutic responses. They are retroactive; they do not protect first responders in moments of risk, nor do they protect a person experiencing crisis. There is also a risk that increased criminal penalties will discourage people from seeking help and escalate distress, increasing rather than reducing risk at the point of response. Real change requires addressing the conditions that give rise to these situations, including gaps in the crisis response system, limited access to timely support, and a lack of appropriate places for care.

Mental health challenges do not automatically make a person prone to violence. Myths portraying people who live with mental illness as violent, dangerous or unpredictable persist, yet the research shows that serious harm to others by people experiencing mental illness is rare, and that people experiencing severe mental distress are less likely to be violent than the average citizen and are more likely to be victims of crime than the general population.³ The use of alcohol and other drugs can increase the risk of aggressive behaviour, whether it co-occurs with mental illness or not.⁴ This highlights the ongoing need for more appropriate, safe facilities (including detoxification units) where people can be supported and supervised.

More broadly, reducing risk to first responders requires sustained investment in timely, community-based support to prevent crises from escalating, alongside the urgent development of a nationally cohesive, networked crisis response system (as recommended by [Te Hiringa Mahara | The Mental Health and Wellbeing Commission](#)). Strengthening specialist crisis responses, including responders trained in de-escalation and supported by appropriate clinical pathways, will do far more to reduce harm to both first responders and people in crisis than reliance on punitive measures after the fact.

This Bill will contribute to disproportionate harm to vulnerable members of the community.

Rather than supporting people who are already vulnerable or marginalised, the Bill relies on criminal convictions and lengthy terms of imprisonment to deter unwanted behaviour. Evidence shows incarceration itself may reduce life expectancy,⁵ and that people in prison experience significant barriers to accessing mental health care. In 2016, fewer than half of New Zealand prisoners with a mental health diagnosis had received treatment in the previous year, despite being three times more likely than the general population to have a 12-month diagnosis of any mental disorder, with nearly all (91%) having a lifetime diagnosis of a mental health or substance use disorder.⁶ Furthermore, a criminal conviction and experience of imprisonment can undermine future employment, income, travel opportunities, and personal relationships – compounding prejudice and stigma and increasing the likelihood of poorer mental health outcomes.

The Bill also fails to reflect the reality that the small minority of people who act aggressively during a mental health or substance-related crisis can, and often do, recover with appropriate support. Crisis-related behaviours are often acute, situational, and responsive to timely therapeutic intervention. A retributive response risks disrupting pathways to recovery by replacing treatment, continuity of care, and rehabilitation with punishment, increasing the likelihood of ongoing distress, disengagement from services, and compounded harm.

This Bill will disproportionately harm tāngata whaiora Māori and is inconsistent with the Crown's equity obligations.

This Bill goes against Te Tiriti o Waitangi and the Crown's obligations to actively protect Māori health and achieve equitable outcomes. Māori are approximately 30 percent more likely than other ethnic groups to have their mental illness undiagnosed, and outcomes for Māori who do access mental health services are poorer.⁷ Even when seeking help, Māori face greater barriers to receiving timely and appropriate support.ⁱⁱⁱ Māori are also more likely to present to crisis services with higher urgency and are disproportionately represented in crisis response pathways.⁸

ⁱⁱⁱ Māori were 1.31 times more likely than non-Māori to report unmet need for mental health or substance use care in 2023/2024, as found by the [NZ Health Survey](#).

In this context, the punitive measures proposed in the Bill are likely to be disproportionately experienced by Māori, compounding existing inequities rather than addressing their underlying causes. Criminalising crisis responses also risks further eroding trust in emergency and health services, particularly among communities already overrepresented in coercive systems, undermining engagement with care and increasing the likelihood of crisis escalation.

Conclusion

For the reasons outlined, the MHF does not support the inclusion of clauses 21–24 in the Bill. If the Committee wishes to meaningfully reduce harm to first responders, it should prioritise investment in crisis infrastructure, workforce capacity and capability, and nationally consistent, health-led response pathways, rather than expanding criminal penalties. A shift towards prevention and therapeutic responses will better protect first responders and tāngata whaiora.

Mauri tū, mauri ora,

Shaun Robinson

Chief Executive

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