## Mental health and addiction sector overview in 2018

Over the last 50 years, mental health services have moved from an institutional model of care to a recovery model of care. Compulsory inpatient treatment has largely given way to voluntary engagement with services in community settings. Services are also increasingly recognising the importance of cultural identity and family and whānau support. Throughout this period, much public discussion has focused on providing high-quality mental health services and identifying the needs of the community, prompting public inquiries and new legislation and services aiming to address concerns raised.

On 23 January 2018, the Government announced details of the Government Inquiry into Mental Health and Addiction (the Inquiry). The purpose of the Inquiry was to identify unmet needs and make recommendations for a better mental health and addiction system for New Zealand. Former Health and Disability Commissioner, Professor Ron Paterson, chaired the Inquiry.

The Inquiry panel travelled throughout New Zealand to hear from people with mental health and addiction challenges, their families and whānau, service providers, advocates, organisations, institutions and experts. It received 5,500 submissions and conducted 400 meetings (including 26 public meetings, which together drew an audience of over 2,000 people).

On 4 December 2018, the Inquiry published its findings in *He Ara Oranga,* which included 40 recommendations for the Government. On 29 May 2019, the Government released its response to the Inquiry, accepting 38 out of the 40 recommendations. We look forward to providing further detail in the 2019 report on ways the Office has supported the implementation of these recommendations.

In February 2018, the Substance Addiction Act came into effect. This legislation replaced the Alcoholism and Drug Addiction Act 1966. The Substance Addiction Act deals with consumers with severe addictions who do not have the capacity to make informed decisions about their care. The Substance Addiction Act contains a high threshold for detaining service users and strives to affirm their cultural identity. For more information about the Substance Addiction Act, see page 73.

The Office recognises human rights, quality and equity of patient care, and community outreach as key issues in the mental health and addiction sector. In 2018, this commitment was mirrored in the wider Mental Health and Addiction Directorate.

- The Office started to revise the Guidelines to the Mental Health Act in response to concerns that the United Nations' Committee on the Rights of Persons with Disabilities identified in 2014.
- The Office continued to carefully monitor disparities in rates of Māori service users, as well as communicating the importance of whānau engagement with the sector.

- The Office recognised that many factors can influence mental health and addictions and so maintained relationships with other ministries and non-governmental organisations (NGOs) to understand how to improve the wellbeing of New Zealanders from different angles.

Looking forward, the Office will continue its monitoring and regulatory role to inform and improve the quality and equity of care and protection of rights of clients.

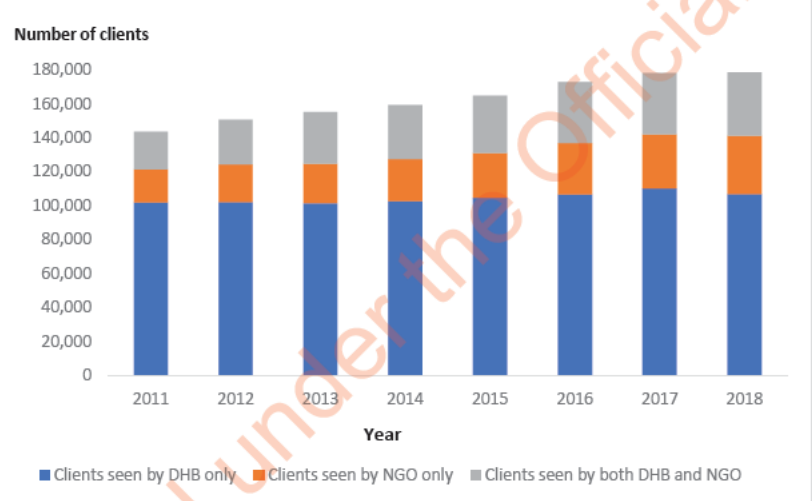
### Specialist mental health and addiction services

In 2018, specialist mental health and addiction services engaged with 182,233 people (3.7 percent of the New Zealand population).[2] Of these, 106,789 clients saw their district health board (DHB) only, 34,431 saw an NGO, and 37,394 saw both their DHB and NGO.[3]

Figure 1 shows that the number of people engaging with specialist services gradually increased from 2011 to 2018. Several changes could explain this rise; for example, data collection has become more accurate; the New Zealand population is growing;[4] services are more visible and accessible; and providers have stronger referral relationships.

**Figure 1: Number of people engaging with specialist services each year, 2011–2018**

Commented [HR1]: Recommend keeping this graph, useful to visualise how/where people access services




Note: DHB = district health board; NGO = non-governmental organisation.

Source: PRIMHD data extracted 29 July 2019.

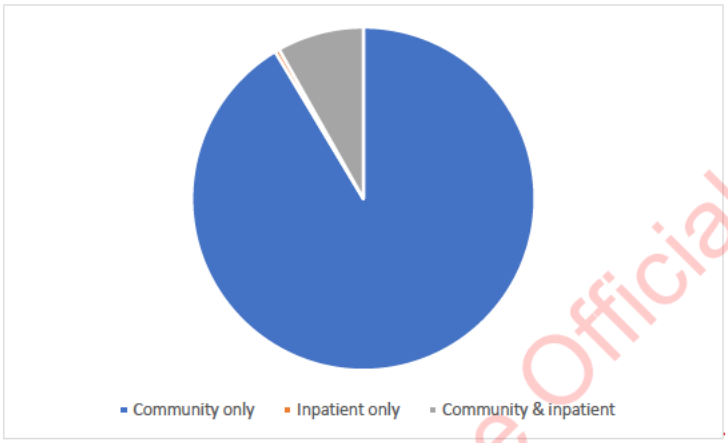
[2] Programme for the Integration of Mental Health Data (PRIMHD) as at 12 February 2020.
[3] These numbers do not include clients with no domiciled DHB on record (because they are overseas clients or their DHB of domicile is unknown).
[4] Between 2011 and 2018, the total New Zealand population increased by approximately 12 percent.

Within the total number of mental health and addiction clients, 71.9 percent saw mental health services only, 9 percent saw both mental health and addiction services, and 19.1 percent saw addiction services only.[5]

Most service users access mental health and addiction services in the community. In 2018:

- 91.4 percent of specialist service users accessed only community mental health and addiction services
- 0.4 percent accessed only inpatient services
- the remaining 8.2 percent accessed a mixture of inpatient and community services (see Figure 2).

**Figure 2: Percentage of service users accessing only community services, 1 January to 31 December 2018**




Notes: Includes non-governmental organisation services. Percentage of inpatient only services is barely visible on the graph because it is so small.

Source: PRIMHD data as at 29 July 2019.

**Commented [HR2]:** I personally understand what this data is trying to explain, but I also understand how it can be confusing to others. This data set can likely come out if we keep the data regarding the split of compulsory treatment orders between community and inpatient orders.

## Mental Health (Compulsory Assessment and Treatment) Act 1992

The Mental Health Act defines the circumstances in which people may be subject to compulsory mental health assessment and treatment. It provides a framework for balancing personal rights w th public interests when a person is a serious danger to themselves or others due to mental illness.

The long title of the Act states that its purpose is to:

[5] PRIMHD data as at 5 February 2020. These figures include clients with an unknown DHB of domicile, who are excluded from figures in the PP6 report.

redefine the circumstances in which and the conditions under which persons may be subjected to compulsory psychiatric assessment and treatment, to define the rights of such persons and to provide better protection for those rights, and generally to reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder.

See the 'Ensuring service quality' section of this report for data on the use of the Mental Health Act.

### Administering the Mental Health Act

The chief statutory officer under the Mental Health Act is the Director of Mental Health (the Director), appointed under section 91 of the Mental Health Act. The Director is responsible for the general administration of the Mental Health Act under the direction of the Minister of Health and Director-General of Health. The Director's functions and powers under the Mental Health Act allow the Ministry to provide guidance to mental health services.

In each DHB, the Director-General of Health appoints a Director of Area Mental Health Services (DAMHS) under section 92 of the Mental Health Act. The DAMHS is a senior mental health clinician responsible for administering the Mental Health Act within their DHB area. They must report to the Director quarterly on the exercise of their powers, duties and functions under the Mental Health Act (Ministry of Health 2012a).

Each DAMHS must appoint responsible clinicians and assign them to lead the treatment of every person subject to compulsory assessment or treatment (Ministry of Health 2012a). The DAMHS also appoints competent health practitioners as 'duly authorised officers' to respond to people experiencing mental illness in the community who are in need of intervention. Duly authorised officers are required to provide general advice and assistance in response to requests from members of the public and the New Zealand Police. If a duly authorised officer believes that a person may be mentally disordered, is considered a danger to themselves or other people and may benefit from a compulsory assessment, the Mental Health Act grants powers to the officer to arrange for a medical examination (Ministry of Health 2012c).

### Protecting the rights of people subject to compulsory treatment

#### *District inspectors*

Although under the Mental Health Act the Ministry expects each DAMHS to protect the rights of people in their area, the Mental Health Act also provides for independent monitor ng mechanisms. The Minister appoints qualified lawyers as district inspectors to protect people's rights under section 94 of the Mental Health Act.

District inspectors protect specific rights and investigate alleged breaches of rights under the Mental Health Act, address concerns of family and whānau and monitor services to check they are complying with the Mental Health Act process. For a list of current district inspectors, see the 'Mental health district inspectors' section of the Ministry of Health's website.[6]

Under the Mental Health Act, district inspectors must report to the DAMHS in their area within 14 days of inspecting a mental health service. They must also report monthly to the Director on the exercise of their powers, duties and functions. These reports provide the Director with an overview of mental health services and any problems that may be developing.

The Office's responsibilities in relation to district inspectors include:

- coordinating the appointment and reappointment of district inspectors
- managing district inspector remuneration
- receiving and responding to monthly reports from district inspectors
- organising twice-yearly national meetings of district inspectors
- facilitating inquiries under section 95 of the Mental Health Act
- implementing the findings of section 95 inquiries.

***Section 95 inquiries***

The Director will occasionally require a district inspector to carry out an inquiry under section 95 of the Mental Health Act (Ministry of Health 2012b . These inquiries investigate systemic issues across one or more mental health services. The district inspector will then make specific recommendations about the services.

The Director considers the recommendations, and actions any of them that are relevant to the Ministry or the mental health secto . Later, the Director will audit the DHBs for their implementation of the recommendations. The inquiry process is not completed until the Director considers that the DHBs and, if appropriate, the Ministry have successfully implemented the recommenda ions.

No section 95 inquiries were completed during 2018. Table 1 shows the number of completed section 95 inquiry reports that the Director of Mental Health received between 2003 and 2018.

[6] https://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-district-inspectors/mental-health-district-inspectors-list

**Table 1: Number of completed section 95 inquiry reports that the Director of Mental Health received each year, 2003–2018**

| 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 1 | 4 | 1 | 1 | 3 | 2 | 1 | 1 | 0 | 0 | 1 | 2 | 0 | 0 |

Source: Office of the Director of Mental Health and Addiction Services records.

**Commented [HR3]:** This data set might not be necessary, its something that can be provided on a request basis

***New Zealand Mental Health Review Tribunal***

The New Zealand Mental Health Review Tribunal (the Tribunal) is a specialist independent tribunal empowered by law to review compulsory treatment orders, special patient orders and restricted patient orders. If a person disagrees with their treatment under the Mental Health Act, they can apply to the Tribunal to examine their condition and whether it is necessary to continue compulsory treatment. Where the Tribunal considers it appropriate, it may release the person from compulsory treatment status.

The Tribunal has three members: one must be a lawyer, one a psychiatrist and one a community member. A number of deputy members are also appointed to each position, to act where a particular member is not available. The Minister of Health appoints or reappoints members and deputy members, who typically hold office for three-year terms. The Minister has to be satisfied that the members provide a well-balanced Tribunal before agreeing to their appointment. On 19 September 2018, the current Tribunal had had four new appointments and fifteen reappointments since the end of the previous term.

A selection of the Tribunal's published cases is available online.[7] The Tribunal carefully anonymises these cases to respect the privacy of the individuals and family and whānau involved. In publishing these cases, the Tribunal aims to improve public understanding of both its own work and mental health law and practices.

The main function of the Tribunal is to review the condition of people, in keeping with sections 79 and 80 of the Mental Health Act. Section 79 relates to people who are subject to ordinary compulsory treatment orders, and section 80 relates to the status of special patients. During the year ending 30 June 2018, the Tribunal heard sixty-four section 79 reviews and found five of these applicants fit to be released. In the same year, the Tribunal heard nine section 80 reviews and found one person fit to be released.

Other important functions of the Tribunal include:

- appointing psychiatrists authorised to offer second opinions (sections 59–61)
- reviewing district inspector investigations (section 75)
- recommending changes to the legal status of special patients (section 80)

[7] See www.nzlii.org/nz/cases/NZMHRT

- reviewing the condition of restricted patients (section 81).

For more information about the Tribunal's activities for the year ending 30 June 2018, see Appendix 2.

Commented [HR4]: All of this can l kely be condensed with a new summary introduction that describes the purpose the data presented and what it relates to – e.g. it's data related to the use of the Mental Health Act and provides the Director of Mental Health important information about the administration of the Act which he has a responsibility to oversee

## Substance Addiction (Compulsory Assessment and Treatment) Act 2017

The Substance Addiction Act came into force in February 2018. Its purpose is to enable people to receive compulsory treatment for severe substance addiction. Section 3 of the Act states the role of the Act is to:

- protect patients from harm
- comprehensively assess patients' needs
- treat and stabilise patients
- protect and enhance the mana and dignity of patients
- restore the capacity of patients to make informed decisions about substance use and future treatment
- help patients to transition to voluntary treatment.

See the 'Ensuring service quality' section of this report for data on uses of the Substance Addiction Act that must be published in line with section 119 of the Act.

### Administering the Substance Addiction Act

The chief statutory officer under the Substance Addict on Act is the Director of Addiction Services, appointed under section 86 of the Act. The Director of Addiction Services is responsible for the general administration of the Substance Addiction Act under the direction of the Minister and the Director-General of Health.

Directors of Area Addiction Services (A ea Directors) are appointed under section 88 of the Substance Addiction Act. Area Directors are experienced addiction treatment professionals who hold a senior role in a DHB addiction treatment service. Their primary statutory obligations are to administer and give clinical oversight of the Substance Addiction Act within their region.

### Protecting the rights of people subject to compulsory treatment

The Minister appoints district inspectors under section 90 of the Substance Addiction Act. These inspectors perform similar duties to mental health district inspectors in that they uphold the rights of patients who are subject to compulsory assessment and treatment under the Substance Addiction Act. They too hold office for a three-year term.

# Activities for 2018

## Mental health and addiction sector relationships

The Office of the Director of Mental Health and Addiction Services maintains working relationships with a range of governmental and non-governmental agencies. It does so to engage with services and consumers and to understand the key issues of the sector.

Maintaining meaningful and transparent relationships with DHBs is an important function of the Office. Each year, the Director of Mental Health and Addiction Services visits a selection of DHBs to learn more about their successes and challenges and offer Ministry support and oversight. Additionally, the Office has a team of regional advisors that coordinate the Office's response across DHBs.

The Office maintains strong relationships with central government agencies, working to support good clinical practices and person-centred services for people with mental health and addiction problems.

**Relationship with the Department of Corrections**

The Office works closely with the Department of Corrections to improve health services for people in prison. Many offenders have complex mental health needs that may need more intensive support than Corrections health services can provide and may require access to regional forensic psychiatry services. In 2018, the Office worked with Corrections in developing the Waikeria Mental Health Service Project, a proposed mental health facility next to Waikeria Prison.

**Relationship with the New Zealand Police**

Police are often in contact with people whose mental illness makes them a danger to themselves or others. For this reason, it is important for police and mental health services to maintain collaborative relationships. During 2018, the Office continued to support the New Zealand Police in responding appropriately to people with mental illness and their families and whānau.

**Relationship with the Ministry of Justice**

In 2018, the Office maintained a collaborative relationship with the Ministry of Justice, working on changes to legal aid for people who are subject to compulsory treatment under the Mental Health Act or Substance Addiction Act, and advocated for the Mental Health Review Tribunal and the Family Court to conduct a timely review of patients' legal status. The Office also works with the Ministry of Justice in connection to issues relating to special patients and the Victims' Rights Act 2002, youth justice and the 2020 cannabis referendum.

**Commented [HR5]:** Given current context and timing this whole section can potentially come out with a new overview giving more current conte t, what the data presented is for and where this w ll move in future years

## Mental Health Act Guidelines

Section 130 of the Mental Health Act empowers the Director of Mental Health to issue guidelines. Guidelines may help promote the protection of people's rights under the Mental Health Act by clarifying the responsibilities of mental health services and clinicians.

In October 2018, the Ministry of Health initiated a project to revise the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act* (the Guidelines), published in 2012 (Ministry of Health 2012d). This project began as part of the Ministry of Health's ongoing response to concerns that the United Nations' Committee on the Rights of Persons with Disabilities (the Committee) identified in 2014. Most notable among the Committee's concerns was the level of recognition given to decision-making capacity and the use of substituted rather than supported decision-making processes.

The Government has accepted a recommendation in *He Ara Oranga* to repeal and replace the Mental Health Act. Revising the Guidelines is not intended to pre-empt or take the place of repealing and replacing the Act. Instead, these revisions are intended to ensure that the current legislation is applied in a way that is as consistent as possible with New Zealand's international obligations.

Final revised Guidelines are expected to be published in 2020.

## Fixated Threat Assessment Centre

Between September 2017 and June 2019, Health and Police, with the Parliamentary Service and the 3DHB Mental Health, Addictions, and Intellectual Disability Service, ran a small trial of the Fixated Threat Assessment Centre (FTAC) concept in New Zealand.

An FTAC is a prevention-focused collaboration that brings together police and mental health professionals to share information, conduct assessments and facilitate mental health treatment, law enforcement and other interventions to manage the risks that fixated people present.

The term 'fixated' refers to a very specific type of behaviour, where someone has an obsessional preoccupation with a person, place or cause and pursue it to an irrational degree. While fixated people may harm other people and groups, often it is the fixated person who suffers most. The fixated person's family and friends may also be impacted.

The New Zealand FTAC trial focused on the threats a small number of fixated people presented to members of Parliament. The Parliamentary Service made 70 referrals to FTAC during the trial period. Consistent with overseas research, the trial found that the most of these people had unmet mental health needs and were often already known to other agencies such as Police (Every-Palmer et al 2015).

As of 1 July 2019, FTAC has been established permanently. The service enables agencies to understand a fixated person's behaviour and the type of interventions that they may need. Police and mental health professionals work together to assess people's needs and to support them to get help where necessary.

## Victims' Rights Act guidelines

The Victims' Rights Act 2002 sets out specific rights for victims of crime. It details obligations for some government agencies to notify registered victims of certain events relating to their offender.

A small subset of offenders and alleged offenders need to be assessed or treated for their mental health needs in a hospital. When this occurs, the Victims' Rights Act sets out exceptions to the Privacy Act 1993 allowing registered victims to receive certain notifications. This includes getting prior notice of the person's first unescorted leave and first unescorted overnight leave from hospital. Directors of Area Mental Health Services within DHBs make these notifications.

In 2018, the Ministry of Health published updated Victims' Rights Act guidelines for DAMHS. It also published an information sheet for registered victims of people detained in hospital for mental health assessment or treatment, giving them information about special patient processes including leave, discharge and end of sentence.

For more information about victims' rights under the law, see Appendix 3.

Commented [HR6]: Suggest deleting all of these sections and reflecting this information elsewhere on the Ministry website – can have a high-level reference to various projects that have taken place in a redrafted introductory section

## Strategies for suicide prevention in New Zealand

**Submissions on the draft suicide prevention strategy consultation**

Initial consultation for a draft suicide strategy and action plan began in 2017. Throughout 2017, 15 public consultation meetings produced 495 substantial written submissions. Themes highlighted from this work included the importance of equity and meeting the needs of Māori and different population groups; how to prevent suicide; the Government's role in preventing suicide; taking action and making changes to better prevent suicide; and what initiatives and interventions are needed to prevent suicide.

The results of this consultation, along with information gathered in *He Ara Oranga* in 2018, contributed to the development of *Every Life Matters – He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand*.

**Mental health and suicide prevention education**

The Ministry of Health continues to fund and develop mental health literacy and suicide prevention programmes such as LifeKeepers and Mental Health 101 to educate individuals, organisations and agencies working alongside vulnerable populations.

~~In 2014, the Ministry contracted Te Rau Matatini (now Te Rau Ora) and Le Va to lead Waka Hourua, the Māori and Pacific community suicide prevention programme. The aim of Waka Hourua was to build the capacity and capability of Māori and Pacific communities to prevent suicide. In 2018, the work of Waka Hourua continued, with projects aimed at supporting rangatahi, and using the marae setting to build cultural capacity and connection.~~

~~The Health Promotion Agency further promotes mental wellbeing. In particular, it continues to implement the Like Minds, Like Mine programme, the National Depression Initiative (including the Journal) and the Lowdown website.~~

~~For websites related to these initiatives, see Appendix 4.~~

**Commented [HR7]:** At this point I think this content ecomes confusing and unnecessary with the creation of the SPO and timing of the report

# Ensuring service quality

Providing timely access to high-quality mental health and addiction services is a priority goal of the wider health sector. The Ministry, DHBs and NGOs work collaboratively to achieve this goal.

The Ministry – and the wider government – set goals and targets for the health sector that are aimed at improving outcomes for people using mental health services. Reporting from the health sector is integral to this process, as it allows the Ministry to measure progress against these goals. Independent institutions, such as district inspectors and the Office of the Ombudsman, also monitor the sector's progress.

This section presents statistics on mental health and addiction services. These include mechanisms of the Mental Health Act and the Substance Addiction Act, as well as consumer satisfaction, waiting times, transition plans, special patients, serious adverse events and specialist treatment regimes.

## Specialist mental health and addiction services

~~**Consumer experience**~~

~~Since 2006, the Ministry has conducted national consumer satisfaction surveys for mental health and addiction service users as one way of measuring DHB service quality and consumer outcomes. Although these surveys started off being paper-based, in 2015 the Ministry introduced the electronic response collection system 'Mārama', and by 2018 all participating DHBs were using it. In 2018, Mārama recorded 3,238 responses from service users in 18 DHBs.~~[8]

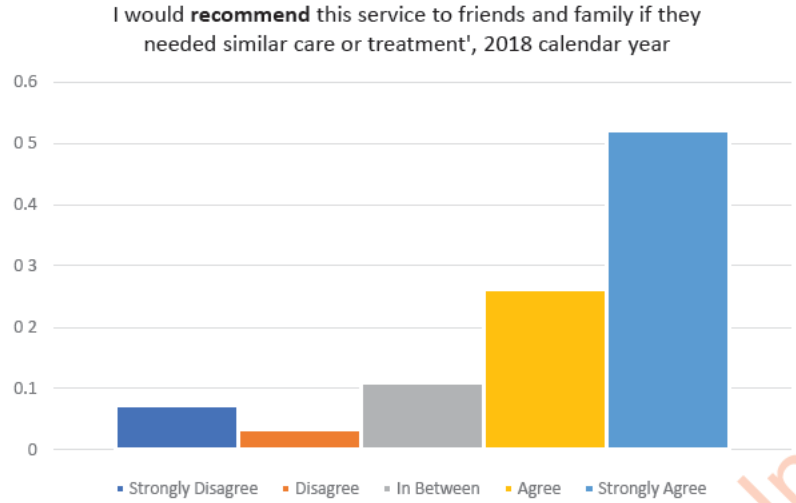
~~**Survey results**~~

~~In 2018, 80 percent of the mental health and addiction service users surveyed agreed or strongly agreed that they 'would recommend this service to friends and family if they needed similar care or treatment' (see Figure 3).~~

**Commented [HR8]:** If there is internal concern about this data it can likely come out, but we may get asked to provide on a request basis

~~[8] These responses included partially and fully completed surveys.~~

~~**Figure 3: Responses to the statement 'I would recommend this service to friends and family if they needed similar care or treatment', 1 January to 31 December 2018**~~




~~Source: Mārama real-time feedback system, 2018 calendar year.~~

### Waiting times

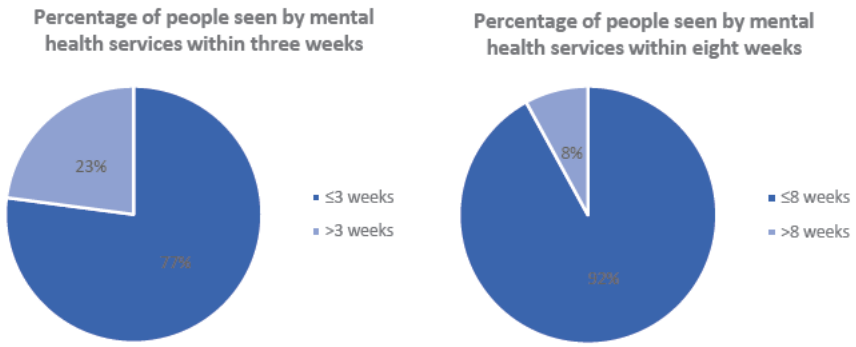
Waiting times measure how long new clients wait to be seen by mental health and addiction services. New clients are defined as people who have ot accessed mental health or addiction services in the past year. Waiting time is measured as the length of time from the day mental health and addiction services receive a referral to the day the person first receives a service.

A sector-wide target for DHBs is that mental health or addiction services should see 80 percent of people referred for serv ces within three weeks, and 95 percent within eight weeks. They must see certain types of referrals within 48 hours.

~~In 2018, DHBs saw 77 percent of new clients of mental health services within three weeks (see Figure 4). A DHB or NGO saw 81 percent of new clients of alcohol and drug services within three weeks (see Figure 5).~~

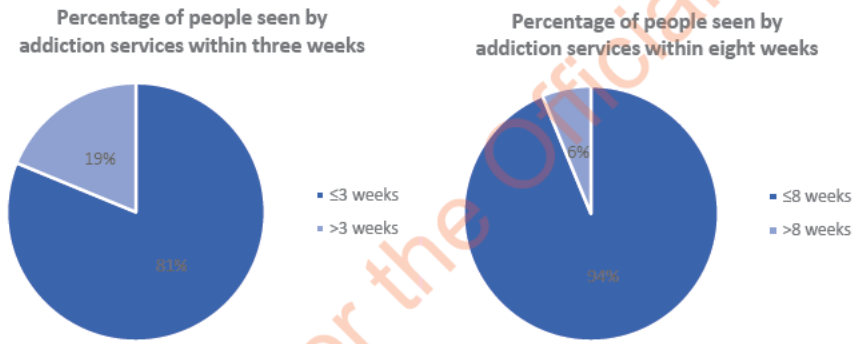
**Commented [HR9]:** Suggest removing this text in favour of keeping the visual table

**Figure 4: Percentage of people seen by mental health services within three weeks (left) and within eight weeks (right), 1 January to 31 December 2018**




Source: PRIMHD data as at 19 February 2019.

**Figure 5: Percentage of people seen by addiction services within three weeks (left) and within eight weeks (right), 1 January to 31 December 2018**




Source: PRIMHD data as at 19 February 2019.

## Transition (discharge) plans

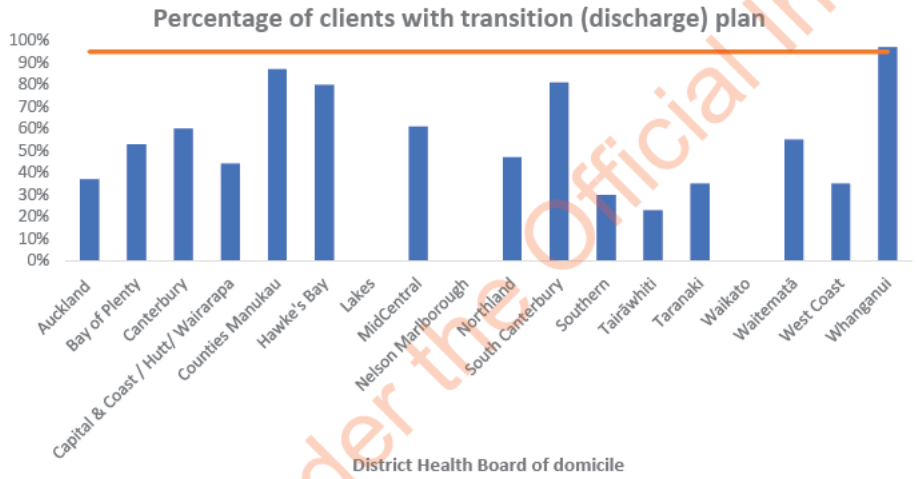
In 2014, the Ministry ntroduced a target of ensuring at least 95 percent of all people who have used menta health and addiction services have a transition (discharge) plan. Transition planning aims to:

- match the service as closely as possible to the needs of the individual, delivered by the most appropriate service provider

- make individuals and their families and whānau the key decision-makers about the services they receive
- deliver care across a dynamic continuum of specialist and primary health care services and base decisions on the needs and wishes of individuals and their families and whānau (not on service boundaries)
- have processes in place to identify and respond early if mental health or alcohol and other drugs concerns emerge again.

Figure 6 shows the percentage of all service users with a transition plan as of 31 December 2018 within each DHB. Currently, the DHBs do not use a uniform reporting system, and 0 percent indicates the DHB has not collected data rather than that it has no transition plan. Additionally, some DHBs contract with NGOs to streamline care and reintegration of the patient. This means that Figure 6 is likely to show an underestimate of how many services users have transition plans.

**Figure 6: Percentage of service users with a transition plan, by DHB, 1 January to 31 December 2018**



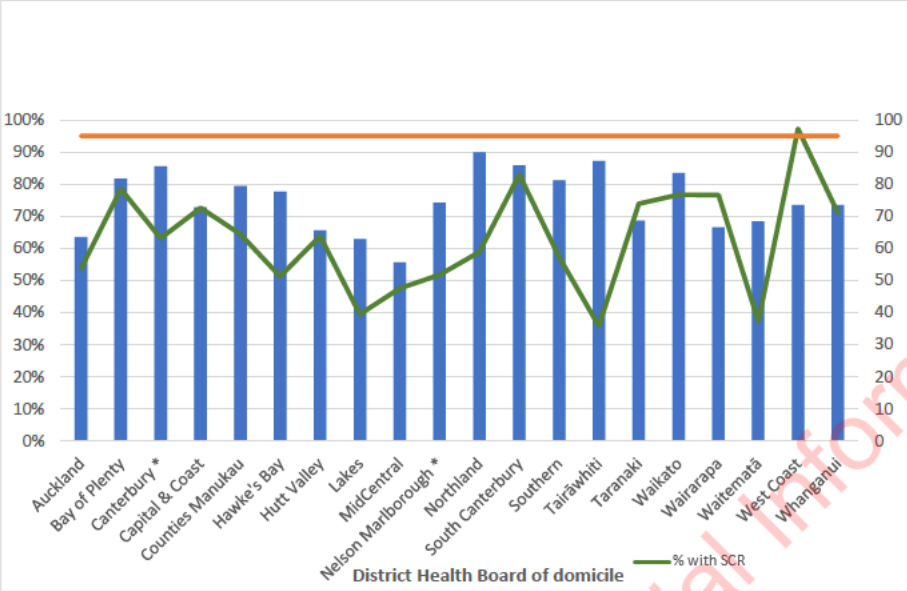

Note: 0 percent indicates the DHB does not collect this data. DHBs have been required to report this data since 1 July 2017 and are working hard to imp ove their methods of gathering it.

Source: DHB Quarterly Database (manual data), Q2 2018/19.

**Commented [HR10]:** This is trying to report data regarding a previous target, but I note all of the qualifiers regarding the accuracy of the data, I think this should have some discussion about whether or not it should be kept

~~PRIMHD also captures supplementary consumer records (SCRs) (see Figure 7). The SCRs identify and monitor the changing social and environmental factors that can affect a service user's jou ney. The variables measured include accommodation, employment, presence of a wellness plan for an individual and their education and training. Similar to a transition plan, a wellness plan is personalised to monitor and maintain a service user's wellbeing while they are receiving mental health and addiction services.~~

~~**Figure 7: Percentage of service users with a transition/wellness plan by DHB of domicile, 1 January to 31 December 2018**~~




~~Notes: DHBs vary in their ability to collect data on SCR variables such as wellness plans because the collection set is relatively new. DHBs are working to improve their methods for gathering this data. Ne Marlborough and Canterbury did not collect SCR data at all (*); the SCR volumes show data from NGOs. S x other DHBs with missing or low SCR volumes for part of 2018 are: Auckland, Capital & Coast, Hutt Valley, M C ntral, Southern and Wairarapa.~~

~~Source: PRIMHD data as at 2 October 2019.~~

**Commented [HR11]:** Suggest removing this data set per Toni's concerns about the data:

I dont think this can be included due to the data issues. I'm not sure I understand how to read the graph eg If the Canterbury SMHS is not reporting SCR at all how is it the bar graph indicates 80% of consumers have an SCR, when only half the people accessing mental health services do so via an NGO?

## Use of the Mental Health (Compulsory Assessment and Treatment) Act 1992

The Mental Health Act defines the circumstances under which an individual may be subject to compulsory mental health assessment and treatment.

In summary, in 2018:

- 10,631 people (5.8 percent of specialist mental health and addiction service users) were subject to the Mental Health Act[9] and on the last day of 2018 approximately 5,083 people were subject to either compulsory assessment or compulsory treatment under the Ment l Health Act
- DHBs varied in their use of the Mental Health Act
- males were more likely to be subject to the Mental Health Act than females

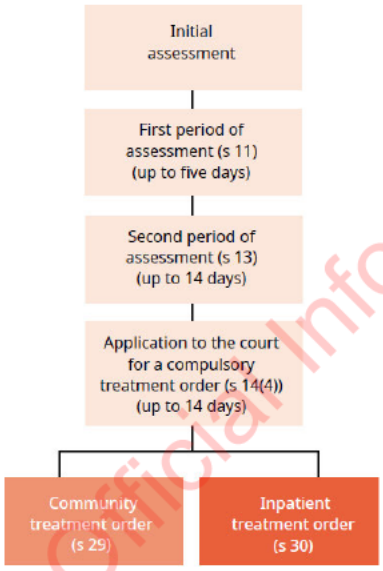
**Commented [HR12]:** This is important data and should be kept, but perhaps can be changed into a graph overtime and could present both the 2018 and 2019 data in one figure

[9] Mental Health Act sections 11, 13, 14(4), 15(1), 15(2), 29, 30 and 31.

- people aged 25–34 years were the most likely to be subject to compulsory treatment and people over 65 years of age were the least likely
- Māori were more likely to be assessed or treated under the Mental Health Act than non-Māori.

**The Mental Health Act process**

The compulsory assessment and treatment process begins when someone is referred and a psychiatrist makes an initial assessment. If the psychiatrist believes the person fits the statutory criteria, the person will become subject to the Mental Health Act and will receive further assessment accordingly.




***Compulsory assessment***

Compulsory assessment can take place in either a community or a hospital setting. There are two periods of compulsory assessment, during which a person's clinician may release them from assessment at any time.

During the assessment period, a person must receive the treatment that their responsible clinician prescribes. The first period (section 11 of the Mental Health Act) is for up to five days. The second period (section 13 of the Mental Health Act) can last up to 14 days.

Following the first two assessment periods, a person's responsible clinician can apply to the Family or District Court (section 14 4) of the Mental Health Act) to place the person under a compulsory treatment order. In 2018, clinicians made 5,646 applications for compulsory treatment or extensions under the Mental Health Act. Of these applications, the courts granted 5,002 (88.6 percent).

**Commented [HR13]:** These are useful datasets, but again could maybe turn into displays of data over time and could try to show 2018 and 2019 in one figure

At any time during the compulsory assessment process, the person (or someone acting on their behalf) can request that the District Court reviews their condition to decide whether it is appropriate for them to continue to be assessed under the Mental Health Act. A judge makes this decision based on information from clinicians.

During 2018, about 1,202 applications for compulsory treatment orders were filed for a judge's review of the patient's condition, in line with section 16 of the Mental Health Act. Of

~~this total, judges issued an order to release a person from compulsory status in 32 cases and dismissed 643. The remaining applications were withdrawn.~~

***Compulsory treatment***

There are two types of compulsory treatment orders: one for treatment in the community (section 29 of the Mental Health Act); and the other for treatment in an inpatient unit (section 30 of the Mental Health Act). An individual's responsible clinician can convert an inpatient treatment order into a community treatment order at any time. A responsible clinician may also grant an individual leave from the inpatient unit for treatment in the community for up to three months (section 31 of the Mental Health Act).

**2018 summary**

On the last day of 2018, a total of 5,083 people were subject to either compulsory assessment or compulsory treatment[10] under the Mental Health Act.

On average within each month of 2018, New Zealand service providers applied the assessment provisions of the Mental Health Act as follows.

| | | |
|---|---|---|
| Section 11 | 618<br>people were subject to an initial assessment | 13 people per 100,000 population |
| Section 13 | 621<br>people were subject to a second period of assessment | 13 people per 100,000 population |
| Section 14(4) | 443<br>people were subject to an application for a compulsory t eatment order | 9 people per 100,000 population |

Source: PRIMHD data extracted on 29 July 2019, except for Auckland, Lakes, Nelson Marlborough and Waitematā DHBs, which supplied manual data.

In New Zealand, on the average day in 2018, service providers applied the treatment provisions of the Mental Health Act as follows.

| | | |
|---|---|---|
| Section 29 | 5,349<br>people were subject to a community treatment order | 109 people per 100,000 population |
| Section 30 | 791<br>people were subject to an inpatient treatment order | 16 people per 100,000 population |

[0] PRIMHD data extracted on 29 July 2019, except for Auckland, Lakes, Nelson Marlborough and Waitematā DHBs, which supplied manual data.

**Commented [HR14]:** This is a really good overview of the process under the Act, but can likely be put somewhere else on our website hat provides a description of the Act.

**Commented [HR15]:** These are useful datasets, but again could maybe turn into displays of data over time and could try to show 2018 and 2019 in one figure

**Commented [HR16]:** This is useful high level background info to preface the data below – recommend keeping

**Commented [HR17]:** Can add a column for 2019 and display both years in the same figure

**Commented [HR18]:** Can turn into a graph over time with 2018 and 2019 data?

| | | |
|---|---|---|
| Section 31 | 201<br>people were on temporary leave from an inpatient unit | 4 people per 100,000 population |

Note: 'On a given day' is the average of the last day of each month.

Source: PRIMHD data extracted on 29 July 2019, except for Auckland, Lakes, Nelson Marlborough and Waitematā DHBs, which supplied manual data.

~~**Comparing compulsory assessment and treatment among district health boards**~~

~~Table 2 shows the average number of people per month in 2018 who were required to undergo assessment under the Mental Health Act in each DHB. Table 3 shows the average number of people subject to a compulsory treatment order on a given day in 2018 in each DHB. The following figures present the average number of people subject to a compulsory treatment order on a given day, focusing specifically on either community treatment orders (Figure 8) or inpatient treatment orders (Figure 9).~~

**Commented [HR1 ]:** It is important for us to continue to review the DHB breakdown internally, worth a discussion of whether i is useful still to report it publicly, resea cher and monitoring bodies may request the data breakdo ns but we could provide on a request basis

~~**Table 2: Average number of people each month required to undergo assessment under sections 11, 13 and 14(4) of the Mental Health Act per 100,000 population, by DHB, 1 January to 31 December 2018**~~

| DHB | s 11 | s 13 | s 14(4) |
|---|---|---|---|
| Auckland | 14 | 16 | 12 |
| Bay of Plenty | 14 | 13 | 5 |
| Canterbury | 12 | 11 | 8 |
| Capital & Coast | 13 | 14 | 10 |
| Counties Manukau | 11 | 12 | 8 |
| Hawke's Bay | 11 | 8 | 5 |
| Hutt Valley | 16 | 16 | 8 |
| Lakes | 11 | 9 | 5 |
| MidCentral | 16 | 14 | 1 |
| Nelson Marlborough | 11 | 9 | 11 |

| DHB | s 11 | s 13 | s 14(4) |
|---|---|---|---|
| Northland | 16 | 19 | 25 |
| South Canterbury | 6 | 6 | 4 |
| Southern | 12 | 11 | 7 |
| Tai Āwhiti | 14 | 12 | 8 |
| Taranaki | 14 | 11 | 6 |
| Waikato | 19 | 19 | 11 |
| Wairarapa | 11 | 2 | 9 |
| Waitematā | 10 | 11 | 8 |
| West Coast | 13 | 10 | 7 |
| Whanganui | 16 | 13 | 12 |
| **National average** | 13 | 13 | 9 |

Note: Section 14(4) data may also include PRIMHD records for section 15(1) and 15(2). The latter provisions describe similar circumstances in which a patient is waiting for a court decision on compulsory treatment.

Source: PRIMHD data extracted on 29 July 2019, except for Auckland, Lakes and Nelson Marlborough DHBs, which supplied manual data.

Volumes of section 14(4) orders in some DHBs may be higher because they apply for repeating extensions and indefinite orders under section 14(4) in addition to their original compulsory treatment order applications. Differences in local reporting explain such

variation. The Office is working to improve and standardise data collection for the next annual report.

**Table 3: Average number of people on a given day* subject to sections 29, 30 and 31 of the Mental Health Act per 100,000 population, by DHB, 1 January to 31 December 2018**

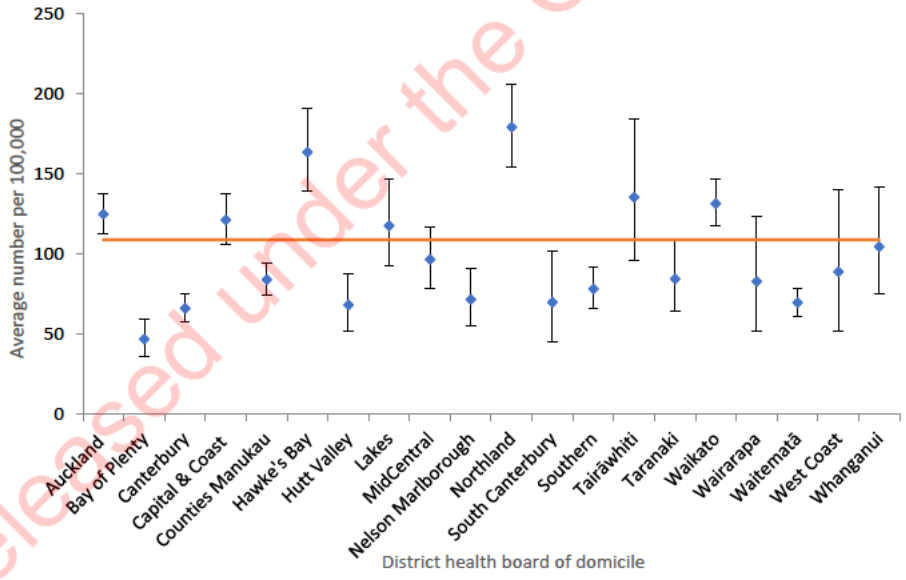
| DHB | s 29 | s 30 | s 31 |
|---|---|---|---|
| Auckland | 125 | 26 | 2 |
| Bay of Plenty | 47 | 16 | 7 |
| Canterbury | 66 | 19 | 7 |
| Capital & Coast | 121 | 27 | 3 |
| Counties Manukau | 84 | 11 | 2 |
| Hawke's Bay | 163 | 18 | 19 |
| Hutt Valley | 68 | 7 | 1 |
| Lakes | 117 | 19 | 11 |
| MidCentral | 96 | 10 | 0 |
| Nelson Marlborough | 71 | 10 | – |

| DHB | s 29 | s 30 | s 31 |
|---|---|---|---|
| Northland | 179 | 17 | 2 |
| South Canterbury | 70 | 4 | 3 |
| Southern | 78 | 13 | 3 |
| Tai ōwhiti | 135 | 5 | 2 |
| Taranaki | 84 | 4 | 2 |
| Waikato | 131 | 16 | 3 |
| Wairarapa | 83 | – | – |
| Waitematā | 69 | 12 | 2 |
| West Coast | 89 | 6 | 2 |
| Whanganui | 104 | 24 | 3 |
| **National average** | **109** | **16** | 4 |

Note: 'On a given day' is the average of the last day of each month.

Source: PRIMHD data extracted on 29 July 2019, except for Auckland, Lakes, Nelson Marlbo ough and Waitematā DHBs, which supplied manual data.

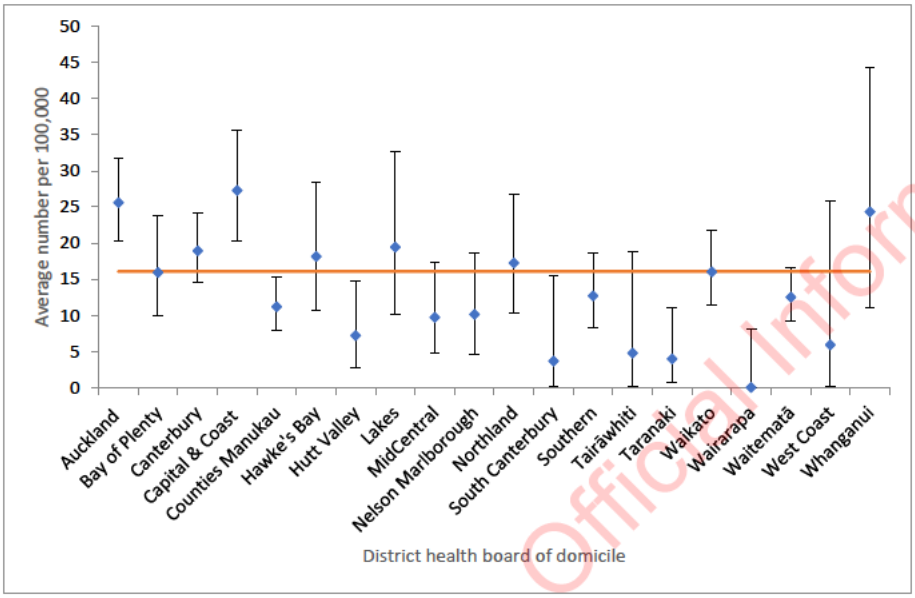
**Figure 8: Average number of people on a given day* subject to a community treatment order (section 29 of the Mental Health Act) per 100,000 population, by DHB, 1 January to 31 December 2018**



Notes: 'On a given day' is the average of the last day of each month. This graph shows confidence intervals (for 99 percent confidence) to help in interpreting the data. Where a DHB region's confidence interval crosses the national average, this means the DHB's rate was not statistically significantly different from the national average.

Source: PRIMHD data extracted on 29 July 2019, except for Auckland, Lakes, Nelson Marlborough and Waitematā DHBs, which supplied manual data.

**Figure 9: Average number of people on a given day* subject to an inpatient treatment order (section 30 of the Mental Health Act) per 100,000 population, by DHB, 1 January to 31 December 2018**




Notes: 'On a given day' is the average of the last day of each mo_th. This graph shows confidence intervals (for 99 percent confidence) to help in interpreting the data. Whe_e a DHB region's confidence interval crosses the national average, this means the DHB's rate was not statistically _ignificantly different from the national average.

Source: PRIMHD data extracted on 29 July 2019, e_cept for Auckland, Lakes and Nelson Marlborough DHBs, which supplied manual data.

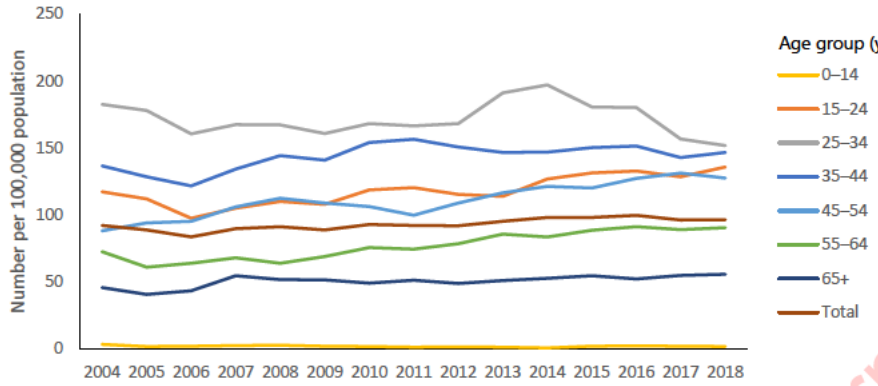
## Compulsory treatment by age and sex

**Commented [HR20]:** Add 2019 to the graphs

During 2018:

- people aged 25–34 years were the most likely to be subject to a compulsory treatment order (147 per 100,000), while people over 65 years of age were the least likely (56 per 100,000) (see Figu_e 10)
- males we_e 1.5 times more likely to be subject to a compulsory treatment order (109 per 100,000) than females (74 per 100,000) (see Figure 11).

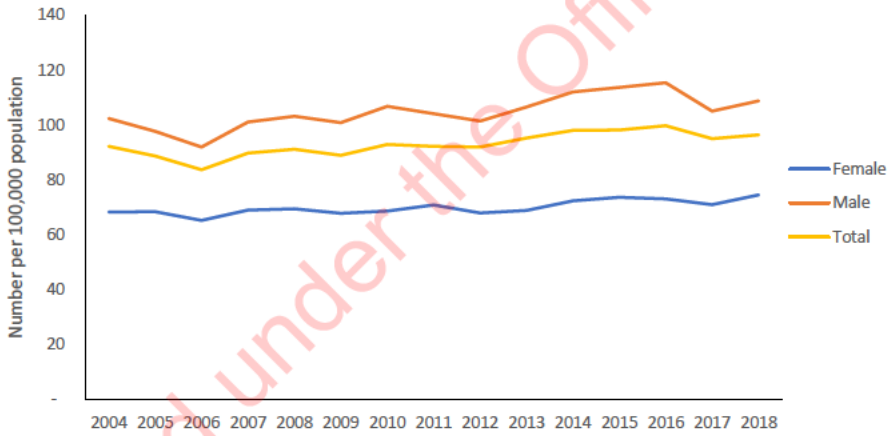
**Figure 10: Rate of people subject to compulsory treatment order applications (including extensions) per 100,000 population, by age group, 2004–2018**




Note: This system uses data entered into the case management system (CMS). The CMS is a live operational database. Figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System as at 24 June 2019.

**Figure 11: Rate of people subject to compulsory treatment order applications (including extensions) per 100,000 population, by sex, 2004–2018**

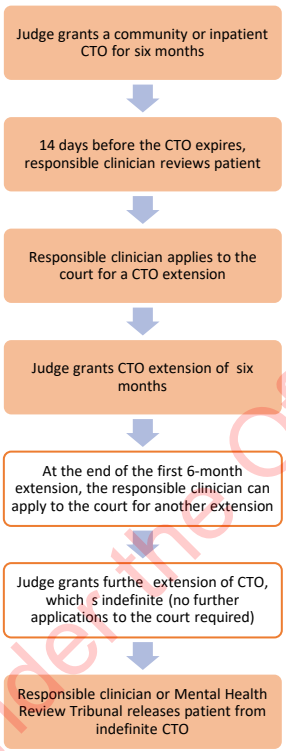



Note: This system uses data entered into the case management system (CMS). The CMS is a live operational database. Figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System as at 24 June 2019.

### Indefinite compulsory treatment orders

A compulsory treatment order lasts for a period of six months. However, a responsible clinician may review the patient's progress under section 76 of the Act and apply to the court for an extension of the compulsory treatment order for a further six months. After the second period of six months of compulsory treatment expires, the court can grant another extension. If the court grants the second extension, the compulsory treatment order continues indefinitely and is not subject to another review by a judge. Under section 35 of the Act, a patient may be released from a compulsory treatment order by their responsible clinician, or when the Mental Health Review Tribunal considers that the patient is 'fit to be released' from compulsory status (section 79).




Note: CTO = compulsory treatment order.

~~In summary, as at 31 December 2018:[11]~~

- ~~2,497 clients were subject to indefinite compulsory treatment orders~~

~~[11] PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes and Waitematā DHBs.~~

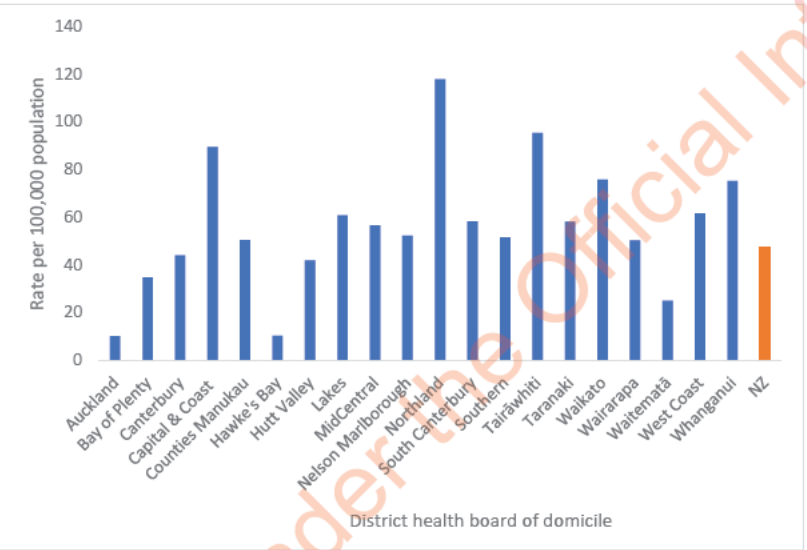
- ~~2,332 clients (53 percent of all clients on community treatment orders) were subject to indefinite community treatment orders~~
- ~~174 clients were subject to indefinite inpatient treatment orders. This represents 27 percent of all clients on inpatient treatment orders~~
- ~~the average period for which a client was subject to an indefinite community treatment order was 1,360 days and the maximum period was 10,439 days (approximately 28 years)~~
- ~~the average period for which a client was subject to an indefinite inpatient treatment order was 1,008 days and the maximum period was 7,693 days (approximately 21 years).~~

***Indefinite community treatment orders***

~~In 2018, 47.3 people per 100,000 population across New Zealand were subject to indefinite community treatment orders~~. Figure 12 shows the rates of indefinite community treatment orders in each DHB, per 100,000 of the general population.

**Commented [HR21]:** I would like to keep indefinite treatment order data because it has not been reported before and there will be more public attention on it as the ame dments progress. Would suggest for public display not breaking down by DHB, but could see if it is possible to present the sum totals over time and add 2019 data on. We would want to display indefinite community orders over time, indefinite inpatient orders over time, and break down by ethnicity (we will need to internally monitor the DHB breakdown)

**Figure 12: Rate of people subject to indefinite community treatment orders per 100,000 population, by DHB, open on 31 December 2018**




Source: PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes and Waitematā DHBs.

Nationwide, Māori were 3.5 times more likely to be subject to an indefinite community treatment order than non-Māori. Table 4 shows the rate ratio of Māori to non-Māori in each DHB, per 100,000 people subject to indefinite community treatment orders.

**Table 4: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100 000 population, open on 31 December 2018**

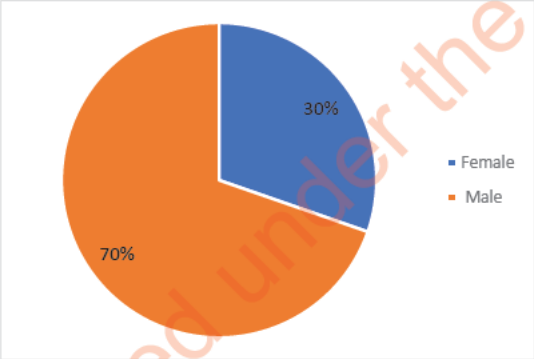
| DHB of Service | Māori | Non-Māori | Rate Ratio Māori: Non-Māori |
|---|---|---|---|
| Auckland | 51 | 7 | 7.7 |

| | | | |
|---|---|---|---|
| Bay of Plenty | 84 | 18 | 4.6 |
| Canterbury | 96 | 39 | 2.5 |
| Capital & Coast | 210 | 74 | 2.8 |
| Counties Manukau | 139 | 34 | 4.1 |
| Hawke's Bay | 16 | 8 | 2.0 |
| Hutt Valley | 77 | 35 | 2.2 |
| Lakes | 123 | 28 | 4.4 |
| Mid Central | 116 | 42 | 2.8 |
| Nelson Marlborough | 107 | 46 | 2.3 |
| Northland | 221 | 66 | 3.4 |
| South Canterbury | 133 | 51 | 2.6 |
| Southern | 138 | 42 | 3.3 |
| Tairāwhiti | 142 | 49 | 2.9 |
| Taranaki | 108 | 46 | 2.3 |
| Waikato | 185 | 43 | 4.3 |
| Wairarapa | 177 | 24 | 7.5 |
| Waitematā | 65 | 21 | 3.1 |
| West Coast | 129 | 52 | 2.4 |
| Whanganui | 98 | 67 | 1.5 |
| **NZ** | **119** | **34** | **3.5** |

Source: PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes and Waitematā DHBs.

In 2018, 70 percent of people subject to indefinite community treatment orders were male (see Figure 13). This trend is consistent with the higher rate of males subject to compulsory treatment order applications.

**Figure 13: Percentage of people subject to indefinite community treatment orders, by sex, 1 January to 31 December 2018**



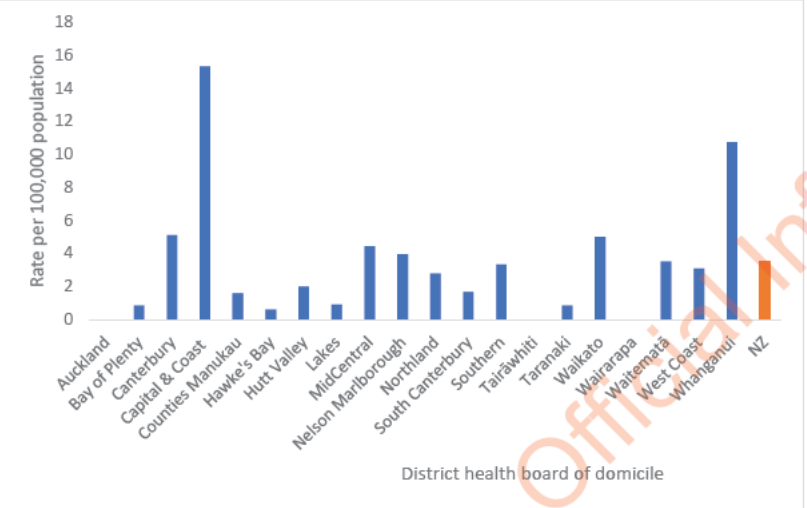

Source: PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs.

### *Indefinite inpatient treatment orders*

Commented [HR22]: Same comments a abo e, move away from DHB breakdown and display over time if possible.

In 2018, 3.5 people per 100,000 across New Zealand were subject to indefinite inpatient treatment orders. Some services may have higher rates of inpatient indefinite orders because they care for more patients with forensic and intellectual disability needs. Smaller services may be less likely to offer long-term inpatient care for people with complex needs. Figure 14 shows the rates of indefinite inpatient treatment orders in each DHB, per 100,000 of the general population.

**Figure 14: Number of people subject to indefinite inpatient treatment orders per 100,000 population, by DHB, 1 January to 31 December 2018**




Note: Wairarapa DHB does not have an inpatient service.

Source: PRIMHD data, extracted 29 July 2019, and manual data ubmitted from Auckland, Lakes and Waitematā DHBs.

Nationwide, Māori were 2.8 times more likely to be subject to an indefinite community treatment order than non-Māori. Table 5 shows the rate ratio of Māori to non-Māori in each DHB per 100,000 people subject to indefinite inpatient treatment orders.

**Table 5: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, 1 January to 31 December 2018**

| DHB of Service | Māori | Non-Māori | Rate Ratio Māori: Non-Māori |
|---|---|---|---|
| Bay of Plenty | 2 | 1 | 3.0 |
| Canterbury | 10 | 5 | 2.1 |
| Capita & Coast | 47 | 11 | 4.2 |
| Counties Manukau | 6 | 1 | 6.7 |
| Hawke's Bay | - | 1 | - |
| Hutt Valley | 4 | 2 | 2.4 |

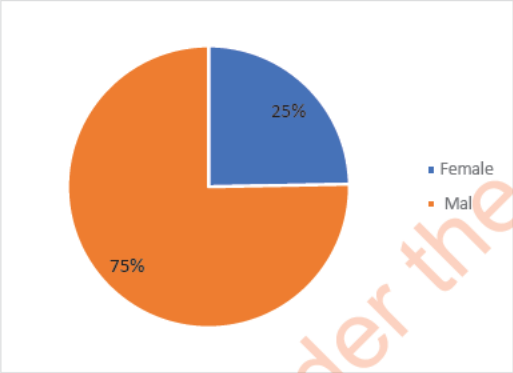
| | | | |
|---|---|---|---|
| Lakes | 3 | - | - |
| Mid Central | 14 | 2 | 6.7 |
| Nelson Marlborough | - | 4 | - |
| Northland | 7 | 1 | 7.9 |
| South Canterbury | - | 2 | - |
| Southern | 3 | 3 | 0.9 |
| Taranaki | 4 | - | - |
| Waikato | 14 | 2 | 5.5 |
| Waitematā | 11 | 3 | 4.3 |
| West Coast | - | 3 | - |
| Whanganui | 6 | 13 | 0.5 |
| **NZ** | **8** | **3** | **2.8** |

Note: Auckland, Tairāwhiti, and Wairarapa DHBs do not have indefinite inpatient treatment orders.

Source: PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes and Waitematā DHBs.

In 2018, 75 percent of people subject to indefinite inpatient treatment orders were male (see Figure 15). Similar to the findings for indefinite community treatment orders, this trend is consistent with the higher rate of males subject to compulsory treatment order applications.

**Figure 15: Percentage of people subject to indefinite inpatient treatment orders, by sex, 1 January to 31 December 2018**




Source: PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs.

## Tāngata whaiora

~~This section presents statistics on tāngata whaiora (people seeking treatment) under the Mental Health Act and the Substance Addiction Act. This information underlines the need for mental health and addiction services to take meaningful actions to address the disparity in outcomes for Māori in New Zealand.~~

~~In summary, in 2018:~~

- ~~6.6 percent of Māori accessed mental health and addiction services, compared with 3.1 percent of non-Māori~~
- ~~Māori were 4 times more likely than non-Māori to be subject to a community treatment order and 3.7 times more likely to be subject to an inpatient treatment order[12]~~
- ~~Māori males were the population group most likely to be subject to community and inpatient treatment orders (compared with non-Māori males and Māori and non-Māori females)~~
- ~~DHBs varied in their ratio of Māori to non-Māori subject to community and inpatient treatment orders~~
- ~~on average, Māori and non-Māori remained on community and inpatient treatment orders for similar lengths of time~~
- ~~Māori were 3.5 times more likely to be subject to indefinite community treatment orders than non-Māori, and 2.8 times more likely to be subject to indefinite inpatient treatment orders than non-Māori.~~

### *Māori and mental health*

Māori make up approximately 16 percent of New Zea and's population, yet they account for 28 percent of all mental health service users.[13]

The national mental health prevalence study, *Te Rau Hinengaro* (Oakley Browne et al 2006), showed that Māori experience the highest levels of mental health disorder among any ethnic group overall. They are also more likely to experience serious and concurrent disorders than non-Māori. Research suggests Māori may access services later than non-Māori and so present as more acutely unwell (Kingi et al 2018, p 177).

A 2018 survey *Te Oranga Hinengaro – Māori Mental Wellbeing*, published by the Health Promotion Agency, found that Māori were more likely than non-Māori to experience symptoms of depression, anxiety and psychological distress (Russell 2018).

**Commented [HR23]:** Condense this with less ext and use of the visual displays of the data - th s is important data to keep but the presentation ca likely be simplified

~~[12] These ratios are based on the age-standardised rates of the Māori and non-Māori populations. Source: PRIMHD data extracted on 29 July 2019. See Appendix 1 for a time-series extraction and analysis of the rate ratio between Māori and non-Māori under section 29 of the Mental Health Act.~~

[13]: PRIMHD data, extracted on 29 July 2019. This applies to both voluntary service users and those treated under the Mental Health Act.

A Māori person is 4 times more likely than a non-Māori to be subject to a community treatment order and 3.7 times more likely to be subject to an inpatient treatment order in their lifetime.

For community treatment orders that began between 2009 and 2016,[14] 70.3 percent of Māori and 74.4 percent of non-Māori under a community treatment order were subject to the order for less than a year. Another 11.2 percent of Māori and 8.9 percent of non-Māori remained under an order for between one and two years, and 18.6 percent of Māori and 16.7 percent of non-Māori remained under an order for more than two years.

For inpatient treatment orders that began between 2009 and 2016, 94.5 percent of Māori and 95.7 percent of non-Māori were subject to the order for less than a year. Another 2.8 percent of Māori and 2.2 percent of non-Māori remained under an order for between one and two years, and 2.7 percent of Māori and 2.1 percent of non-Māori remained under an order for more than two years.

***Some reasons for differences in outcomes for tāngata whaiora***

Some demographic features relevant to the high rate of Māori mental health service users are that a high proportion of the Māori population is young and Māori are over-represented in low socioeconomic groups.

In 2018, approximately half of all Māori service users were under 25 yea s of age, compared with approximately 30 percent of non-Māori service users.[15]

Māori are also over-represented in the most deprived areas as identified in the New Zealand Deprivation Index. This tool measures indicators of social and material deprivation such as unemployment, low income, unsuitable housing and lack of access to transport or the internet (Atkinson et al 2014, p 19). Among service users under a community treatment order, 52 percent of Māori live in the most deprived deciles (8–10), compared with 32 percent of non-Māori.[16]

However, these demographic factors do not completely explain why the rates for Māori with serious mental illness are higher han the rates for non-Māori (Oakley Browne et al 2006). Elder and Tapsell (2013) suggest other factors are that the:

- treatment Māori receive in the mental health system may be different from the treatment that others receive
- mental health wo kforce lacks cultural competency, leading to cultural bias

[14] This ana ysis uses 2016 as the most recent year because at least two years must have passed to ident fy how many people have remained on a treatment order for two or more years.
[15] PRIMHD data, extracted on 29 July 2019.
[16] PRIMHD data, extracted on 29 July 2019. Deprivation deciles are ranked 1 to 10, where 1 represents areas with the least deprived scores and 10 the areas with the most deprived scores.

- mental health system does not engage with tāngata whaiora and whānau.

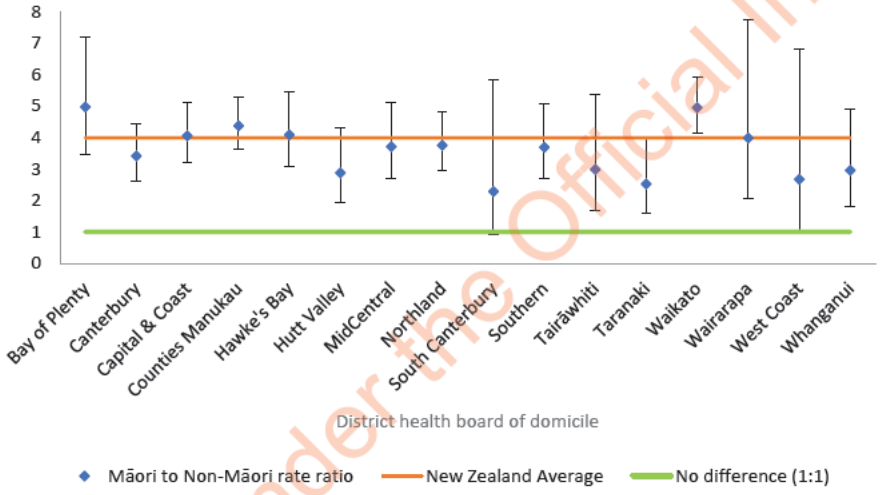
Commented [HR24]: Will need to reconsider the discussion of the equity issues I think

***Māori and compulsory treatment orders***

In 2018, Māori were more likely to be subject to community and inpatient treatment orders than non-Māori. Figures 16 and 17 show the rate ratio of Māori to non-Māori subject to these orders for each DHB. It is difficult to interpret the range of rates because the proportions of different ethnic groups within a population vary greatly across DHBs so it is hard to define an ideal rate ratio for a given population or DHB. However, to help make the comparison, each figure includes a line of 'no difference' to indicate where Māori and non-Māori would be subject to compulsory treatment orders at the same rate. The figures emphasise the need for in-depth, area-specific knowledge to understand why differences occur in each district and how to address them at a local level.

**Figure 16: Rate ratio of Māori to non-Māori subject to a community treatment order (section 29) under the Mental Health Act per 100,000 population, by DHB, 1 January to 31 December 2018**

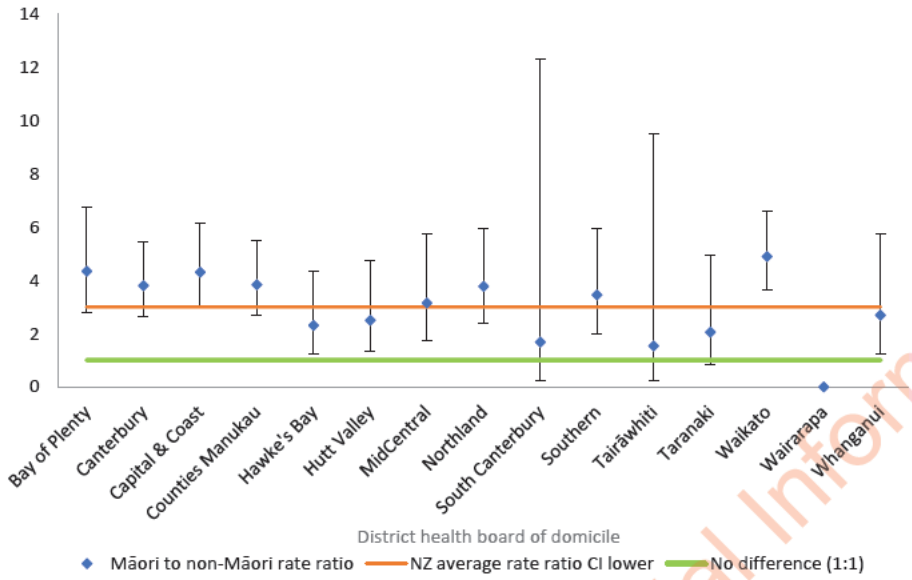
Commented [HR25]: Again, suggest considering changing to a graph over time and not displaying DHB breakdown data




Note: The graph shows confidence intervals (for 99 percent confidence) to help in interpreting the data. Where a DHB's confidence interval crosses the national average, this means the DHB's rate per 100,000 was not statistically significantly different from the national average. These are age-standardised rates.

Source: PRIMHD data extracted on 29 July 2019, except for Auckland, Lakes, Nelson Marlborough and Waitematā DHBs, which supplied manual data (and so are excluded from this graph as we do not have their age-standardised rates).

**Figure 17: Rate ratio of Māori to non-Māori subject to an inpatient treatment order (section 30) under the Mental Health Act per 100,000 population, by DHB, 1 January to 31 December 2018**




Notes: The graph uses confidence intervals (for 99 percent confidence) to help in inte preting the data. Where a DHB's confidence interval crosses the national average, this means the DHB's rate per 100,000 was not statistically significantly different from the national average. These are age-standardised rates.

Because West Coast DHB has a small population, its rates are volatile and error bars of the resulting calculations are large. For this reason, this graph does not include its data to avoid skewing the overall results.

Source: PRIMHD data extracted on 29 July 2019 except for Auckland, Lakes, Nelson Marlborough and Waitematā DHBs, which supplied manual data (and so are excluded from this graph as we do not have their age-standardised rates).

**Commented [HR26]:** Again, suggest co sidering changing to a graph over time and no disp aying DHB breakdown data

### *Sex, ethnicity and compulsory treatment*

In 2018, Māori males were the population group most likely to be subject to compulsory treatment orders. Māori males were 4.3 times more likely to be subject to a community treatment order (section 29) and to an inpatient treatment order (section 30) than non-Māori males.

Table 6 and Figure 18 present information on age-standardised rates of community and inpatient treatment orders for Māori and non-Māori males and females.

**Table 6: Age-standardised rates of Māori and non-Māori subject to community and inpatient treatment orders (sections 29 and 30 respectively) under the Mental Health Act, by sex, 1 January to 31 December 2018**

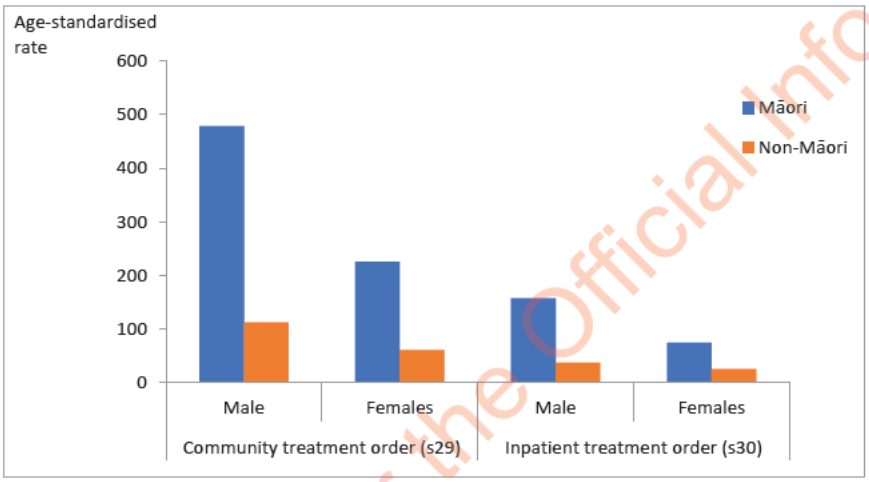
| | Community treatment orders | | Inpatient treatment orders | |
|---|---|---|---|---|
| | Male | Female | Male | Female |
| Māori | 478.6 | 225.0 | 156.8 | 73.8 |
| Non-Māori | 112.4 | 60.3 | 36.5 | 24.7 |
| Rate ratio Māori to non-Māori | 4.3:1 | 3.7:1 | 4.3:1 | 3:1 |

Note: Rates per 100,000 are age-standardised.

Source: PRIMHD data, extracted on 29 July 2019. Excludes manual data.

**Commented [HR27]:** Suggest keeping only one of these two, either the table or the graph but both seems unnecessary.

**Figure 18: Age-standardised rates of Māori and non-Māori subject to community and inpatient treatment orders (sections 29 and 30 respectively) under the Mental Health Act, by sex, 1 January to 31 December 2018**



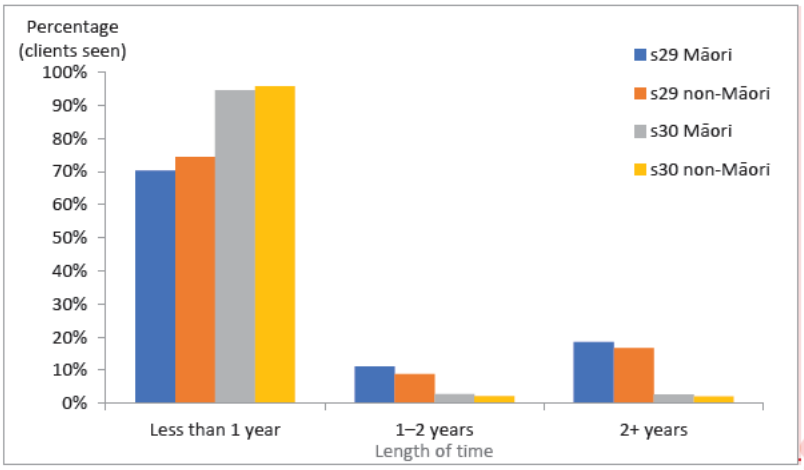

Note: Rates per 100,000 are age-standardised (A R).

Source: PRIMHD data, extracted on 29 July 20 9

***Length of time spent subject o compulsory treatment orders***

On average, Māori and non-Māori remain on compulsory treatment orders for a similar length of time (see Figure 19). For community treatment orders that began between 2009 and 2016, 70 per ent of Māori and 74 percent of non-Māori were subject to the order for less than a year. For inpatient treatment orders that began between 2009 and 2016, 94 percent o Māori and 96 percent of non-Māori were subject to the order for less than a year.

~~**Figure 19: Length of time spent subject to community and inpatient treatment orders (sections 29 and 30) under the Mental Health Act for Māori and non-Māori, 2009–2016**~~



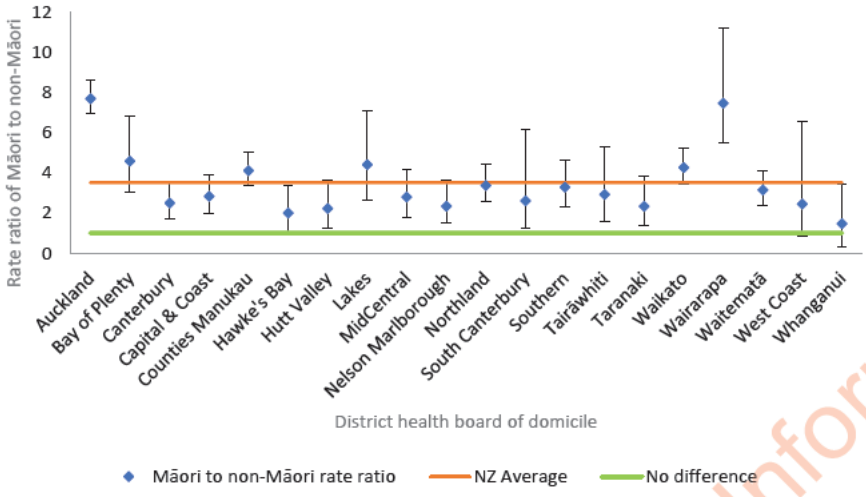

~~Notes: The data refers to treatment orders started between 2009 and 2016. This analysis uses 2016 as the most recent year because at least two years must have passed to identify how many people remained on a treatment order for two or more years. Please note this graph is not comparable with Figure 15 in the 2017 report, in which the data presented for length of community treatment orders was recorded as inaccurately high.~~

~~Source: PRIMHD data, extracted on 29 July 2019~~

**Commented [HR28]:** While interesting to see, not sure this is necessary to keep

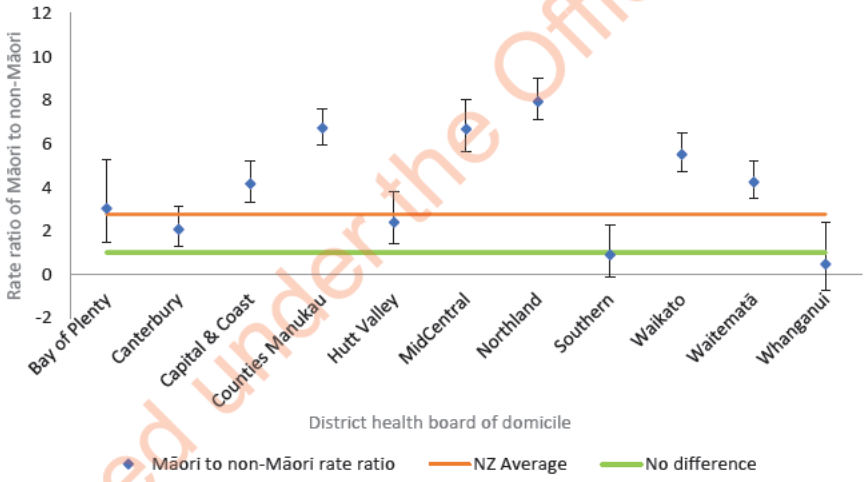
Nationwide, Māori were 3.5 times more likely to be subject to an indefinite community treatment order than non-Māori. Furthermore, Māori were 2.8 times more likely to be subject to an indefinite inpatient treatment order than non-Māori. The following figures show the rate ratio of Māori to non-Māori subject to indefinite community treatment orders (Figure 20) and indefinite inpatient treatment orders (Figure 21) for each DHB per 100,000 people.

**Figure 20: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, by DHB, 1 January to 31 December 2018**




Source: PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes and Waitematā DHBs.

**Figure 21: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, by DHB, 1 January to 31 December 2018**




Note: Auckland, Tairāwhiti and Wairarapa DHBs have no indefinite inpatient treatment orders. In Hawke's Bay, Lakes, Nelson Marlborough, South Canterbury, Taranaki and West Coast DHBs, the rate ratio is zero. These DHBs have been excluded from this graph.

Source: PRIMHD data, extracted 29 July 2019, except manual data submitted from Auckland, Lakes and Waitematā DHBs.

**Commented [HR29]:** Suggest we eliminate the by DHB breakdown for public reporting and move to a graph over time – if this is done could collapse the graphs for indefinite treatment order into one

**Commented [HR30]:** Same as above

***Future focus***

Reducing the differences between Māori and non-Māori mental health outcomes continues to be a priority for the Ministry. Publishing data on the rate of Māori subject to compulsory treatment is just one aspect of what needs to be a wider kōrero around Māori over-representation in compulsory assessment and treatment under the Mental Health Act.[17]

The Office will continue to work alongside DHBs, other ministries and other government groups to ensure we are working towards the best possible mental health outcomes for Māori in New Zealand.

**Commented [HR31]:** Per Toni's comments we need a better a d more robust discussion of the inequities and efforts to address

~~**Family and whānau consultation under the Mental Health Act**~~

~~Section 7A of the Mental Health Act requires clinicians to consult family and whānau unless it is considered not reasonably practicable, or not in the interests of the person being assessed or receiving the treatment.~~

~~Definitions and understandings of the concepts of 'family' and 'whānau' vary, with many differences based on cultural backgrounds and practices. Almost always, it is the perspective of the person subject to the Mental Health Act that is most important in defining family and whānau. For this reason, family and whānau are not limited to blood ties; instead they may include partners, friends and others in a person's wider support network (Ministry of Health 2012d).~~

~~The purpose of consulting family and whānau is to:~~

- ~~strengthen their involvement in the compulsory assessment and treatment process~~
- ~~enhance their contribution to the person's care~~
- ~~address their concerns about information sha ng and treatment options~~
- ~~help them to continue to be involved i Mental Health Act processes, such as clinical reviews of treatment or court hearings (Ministry of Health 2012d).~~

~~In summary, in 2018:~~

- ~~on average nationally, 62 pe cent of families and whānau were consulted about Mental Health Act assessment or treatment events~~
- ~~of all the steps in the Mental Health Act treatment process, families and whānau were most likely to be consulted at a person's certificate for further assessment (section 12)~~
- ~~DHBs varied in their consultation with families and whānau~~

**Commented [HR32]:** This is important for us to monitor internally as we monitor compliance with the Act, but I'm not sure its the most useful dataset for the public, could provide on an as requested basis

[17] The Ministry has been leading Action 9(d) of the Disability Action Plan 2014–18 (Office for Disability Issues 2015), to explore how the Mental Health Act relates to the New Zealand Bill of Rights Act 1990 and the Convention on the Rights of Persons with Disabilities. This work is expected to contribute in a meaningful way to this conversation.

- the most common reason why families and whānau were not consulted was that service providers considered consultation was not reasonably practicable in the particular circumstance.

***District health board reporting of consultation with families and whānau***

The Ministry requires DHBs to report on consultation with families and whānau across five different assessment and treatment events in the Mental Health Act process. These events are listed below.


***Preliminary assessment***

The clinician makes a preliminary assessment, including as to whether the person should undergo the initial five-day period of assessment under section 11.

***Further assessment***

After an initial assessment period of five days, the clinician decides whether the person should undergo a further two-week period of assessment under section 13.

***Final assessment***

After the second period of assessment, the clinician decides whether the person should be placed on either a community treatment order or an inpatient treatment order.

***Review***

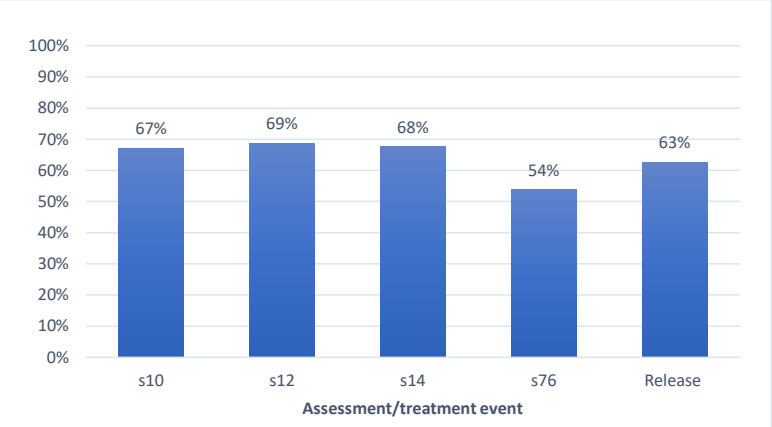
If a person has been placed on a compulsory treatment order, the clinician conducts a review no later than three months after it was put in place to see whether it should remain. After that, the clinician reviews the order at intervals no longer than six months.

***Release***

If at any time while the compulsory treatment order is in place, the clinician considers that the person no longer requires compulsory treatment, they can direct release with immediate effect.

Figure 22 shows the percentage of cases in which consultation with families and whānau occurred at each of these five points in the assessment and treatment process in 2018.

**Figure 22: Average national percentage of consultation with families and whānau for particular assessment and treatment events, 1 January to 31 December 2018**

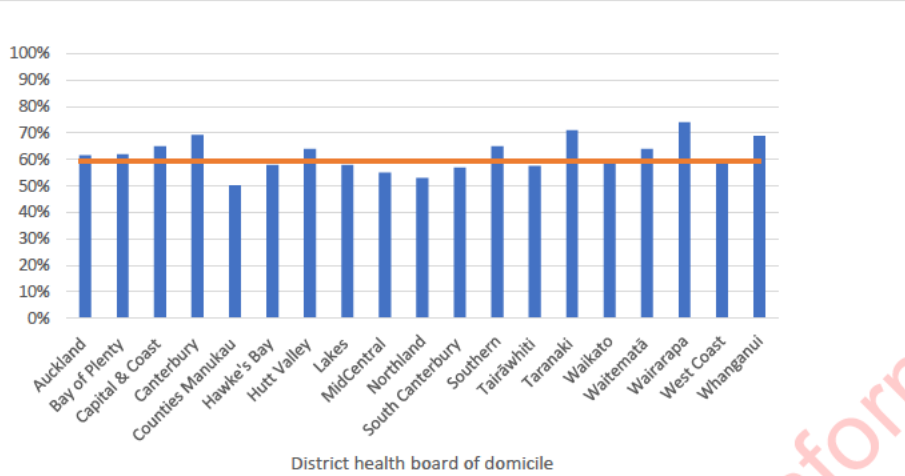



Note: Nelson Marlborough DHB submitted no data in 2018, and the data of Hawke's Bay, Waitemata and Northland DHBs is incomplete, so this graph is not comparable with equivalent graphs in previous reports.

Source: Office of the Director of Mental Health and Addiction Services records.

On average nationally, during 2018, 62 percent of cases included consultation with family or whānau across all assessment and treatment events. Among DHBs, Wairarapa DHB had the highest rate of consultation at 74 percent and Counties Manukau DHB had the lowest at 50 percent (see Figure 23).

**Figure 23: Average percentage of consultation with families and whānau across all assessment and treatment events, by DHB, 1 January to 31 December 2018**



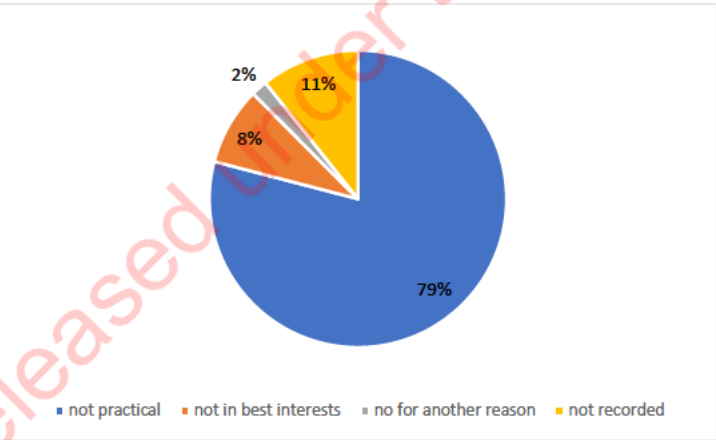

Note: Nelson Marlborough DHB submitted no data in 2018, and data for Hawke's Bay, Waitematā and Northland DHBs is incomplete, so this graph is not comparable with equivalent graphs in previous reports.

Source: Office of the Director of Mental Health and Addiction Services records.

***Reasons for not consulting families and whānau***

As Figure 24 shows, during 2018, the most common reason DHBs gave for not arranging consultation with families and whānau was that it was not reasonably practicable (79 percent). The next most common reasons were 'not recorded' (11 percent), 'not in the best interests of the person' (8 percent) and 'no for another reason' (2 percent).

**Figure 24: Reasons for not consulting families and whānau, 1 January to 31 December 2018**



~~Note: Nelson Marlborough DHB submitted no data in 2018, and data from Hawke's Bay, Waitematā and Northland DHBs is incomplete, so this graph is not comparable with equivalent graphs in previous reports.~~

~~Source: Office of the Director of Mental Health and Addiction Services records.~~

## Use of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017

### Mana-enhancing practice

In February 2018, the Substance Addiction Act came into force. One of its important purposes is to protect and enhance the mana of tāngata whaiora receiving compulsory treatment (section 3(d)).

Under the Substance Addiction Act, Area Directors must report to the Director of Addiction Services each quarter. Their report must detail how services are offering mana-enhancing and mana-protecting practices during the following stages:

- initial engagement
- assessment by authorised officers
- court hearings
- transfer of care to a designated residential facility.

As the Act is relatively new, we do not yet hold in-depth reporting on mana-enhancing practice in services. We anticipate providing more detail on mana-enhancing practices in the 2019 report.

For more information about mana-enhancing practice for implementing the Substance Addiction Act, see: Terry Huriwai and Maria Bake . 2016. *Manaaki: Mana enhancing and mana protecting practice.* Wellington: Te Rau Matatini (now Te Rau Ora).

### Consultation with families and whānau

Section 12 of the Substance Addiction Act states that a person exercising powers that they are given under the Act must prope ly ecognise the patient's whānau, hapū and iwi. The legislation requires DHBs to consu t whānau or family in the following circumstances:

- applying for assessment
- compulsory treatment certification
- court-directed compulsory treatment orders
- release from the Act.

The Director of Area Addiction Services from each DHB reports the details of family and whānau engagement to the Ministry, including reasons why a service provider did not consu t with a patient's family or whānau.

In 2018, not enough DHBs recorded meaningful consultation data to allow the Ministry to analyse whānau and family consultation across New Zealand as a whole. Some DHBs reported comprehensively involving whānau and families as a natural extension of care consistent with the consultation obligations set out in section 12 of the Substance Addiction Act. However, other DHBs emphasised consultation difficulties, such as in circumstances where the patient is estranged from their whānau or family or where DHBs had very little interaction with prospective patients. As the Substance Addiction Act is still relatively new, the addiction sector as a whole is learning the key processes and obligations related to it.

The Office anticipates publishing a more thorough analysis of family and whānau consultation in the Annual Report 2019, after more services begin providing meaningful data.

**Commented [HR33]:** Given that this is a section about why there is no data to report, this can likely be significantly condensed

## Seclusion

Commented [HR34]: Data on seclusion is mus include, however we can consider only displaying the data visually - perhaps in graphs over time. We will receive requests for full data se s from the Independent Monitoring Mechanism, we have an outstanding request from the Human Rights Commission currently I think

Standards New Zealand (2008a) defines seclusion as a situation where a service user is 'placed alone in a room or area, at any time and for any duration, from which they cannot freely exit'. Seclusion should be an uncommon event, and services should use it only when the individual or others are at an imminent risk of harm and no other safe and effective alternative is possible.

The data captured in this section focuses mainly on people under the Mental Health Act in adult inpatient wards who have been secluded. However, some patients who are secluded may be receiving treatment in another type of service, for example the Regional Intellectual Disability Secure Services (RIDSS), even though they are a patient under the Mental Health Act. While the Ministry is working to capture clearer seclusion data, this section does contain data that demonstrates such overlaps.

In this analysis, we have purposely left out data from two outliers, where a high proportion of recorded seclusion hours from Capital & Coast and Nelson Marlborough DHBs relate to a single client in each of these DHBs. For more information about this outlier data please see Appendix 2.

In summary, in adult inpatient services[18] in 2018[19]:

- the total number of people who experienced seclusion while receiving mental health treatment in an adult inpatient service has decreased by 21 ercent since 2009[20]
- the total number of hours spent in seclusion has decreased by 55 percent since 2009
- the number of adult inpatient clients secluded increa ed by 10 percent from 2017 to 2018, and the number of hours spent in seclusion also increased by 10 percent
- 72 percent of all seclusion events lasted for less than 24 hours and 14 percent lasted for longer than 48 hours
- males were more than twice as likely as females to spend time in seclusion
- people aged 20–24 years were more ikely to spend time in seclusion than those in any other age group
- Māori were more likely than non-Māori to have been secluded, have more seclusion events (as a rate per 100,000 population) and have longer periods of seclusion on average
- inpatients had an average of 6.9 seclusion events for every 1,000 bed nights they spent in adult inpatient units.

[18] Adult menta health services generally care for people aged 20–64 years. Adult inpatient services are distinct from forensic services, youth services, intellectual disability services and services for older people. Additionally, this data includes patients who have a legal status under the Mental Health Act but are t eated in RIDSS.

[19] This excludes outlier data. Source: PRIMHD data extracted 29 July 2019, except for Lakes, Nelson Marlborough, Southern, and Waitematā DHBs which provided manual data.

[20] We are comparing with 2009 because that is the year when seclusion reduction policies were introduced.

### Seclusion under the Mental Health Act

Section 71 of the Mental Health Act describes a person's rights relating to seclusion. It states that seclusion can only occur where, and for as long as, it is necessary for the care or treatment of the person, or to protect other people.

Seclusion rooms must be designated by the relevant DAMHS and can be used only with the authority of a person's responsible clinician. In an emergency, a nurse may place a person in a seclusion room; however, if they do, they must immediately notify the responsible clinician.

Clinicians must record the duration and circumstances of each episode of seclusion in a register that must be available for district inspectors to review. It is important to note that the seclusion of an individual in a non-designated room must still be recorded as a seclusion event. Seclusion should never be used for discipline, coercion or staff convenience, or as a substitute for adequate levels of staff or active treatment.

### Changes in seclusion use

The Ministry, services and relevant agencies are working together to reduce seclusion.

The Health and Disability Services (Restraint Minimisation and Safe Practices) Standards came into effect on 1 June 2009 (Standards New Zealand 2008b). Their intent is to 'reduce the use of restraint in all its forms and to encourage the use of least restrictive practices'.

In 2010, the Ministry published the revised guidelines *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. With the aim of decreasing seclusion, these guidelines identified best practice methods for clinicians using seclusion in mental health inpatient units.

In December 2012, the Government announced a five-year service development plan for mental health and addiction services, including an action to reduce and eliminate the use of seclusion and restraint. Te Pou o te Whakaaro Nui supported this action, publishing the resource *Towards Restraint-free Mental Health Practice: Supporting the reduction and prevention of personal restraint in mental health inpatient settings* (Te Pou 2015) and developing the Safe Practice Effective Communication (SPEC) training programme for services staff.[21]

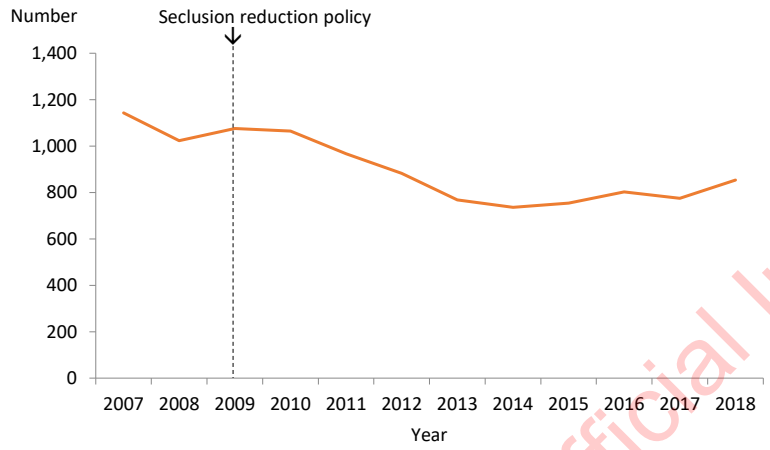
In March 2018, the Health Quality & Safety Commission (HQSC), in partnership with Te Pou, launched a national collaborative project called 'Zero Seclusion: towards the elimination of seclusion by 2020'. In collaboration with DHBs, service providers and tāngata whaiora, the Zero Seclusion project takes a recovery approach that includes a strong focus on the role of consumers, families and whānau. The project uses quality improvement methods to test and

[21] For additional information about Te Pou's work on restraint and seclusion, see www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/102

implement evidence-based strategies to reduce and eliminate the use of seclusion. For more information about Zero Seclusion, see www.hqsc.govt.nz

Since the seclusion reduction policy began in 2009, the total number of people secluded in adult inpatient services decreased by 21 percent nationally (see Figure 25). Also at a national level, the total number of hours of seclusion in adult inpatient services has decreased by 55 percent (see Figure 26).

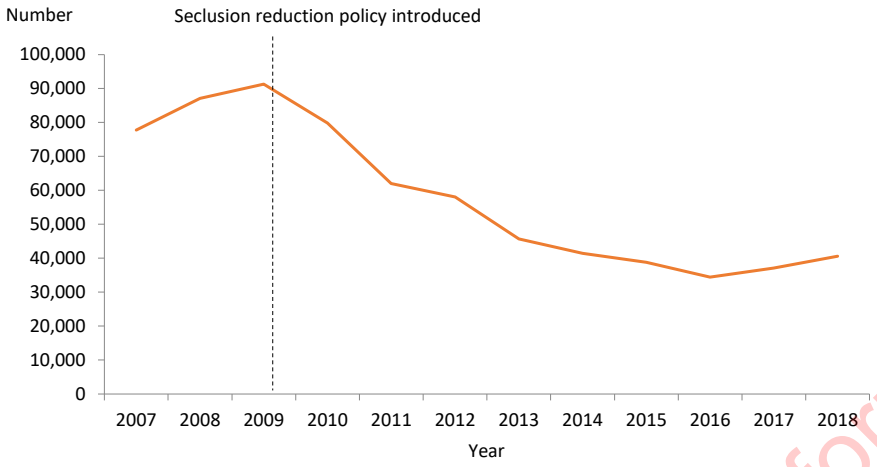
**Figure 25: Number of people secluded in adult inpatient services nationally, 2007–2018**




Note: This data excludes forensic inpatient services and two outliers. includ s patients who have a legal status under the Mental Health Act but are treated in RIDSS.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

**Figure 26: Total number of seclusion hours in adult inpatient services nationally, 2007–2018**




Note: This data excludes forensic inpatient services and two outliers. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

Against these positive trends, however, between 2017 and 2018, the total number of people who were secluded in adult inpatient services increased by 10 percent, and the number of hours spent in seclusion also increased by 10 percent.

To reduce (and eventually eliminate) seclusion, we will need strong local leadership and resourcing, evidence-based initiatives to reduce seclusion, ongoing workforce development and significant organisational commitment. In line with the findings of *He Ara Oranga*, the Office will continue to focus on service improvements that prioritise human rights and equity. We maintain close working relationships with agencies like HQSC and Te Pou and will continue to provide leadership in the project to eliminate seclusion by publishing new guidance on restrictive practices and introducing a monitoring regime for overnight seclusion events ('night safety procedures').

### Seclusion in New Zealand mental health services

Between 1 January and 31 December 2018, New Zealand adult mental health services (excluding forensic and other regional rehabilitation services) accommodated 8,768 people

for a total of 245,290 bed nights.[22] Of these people, 852[23] (9.7 percent) were secluded at some stage during the reporting period.

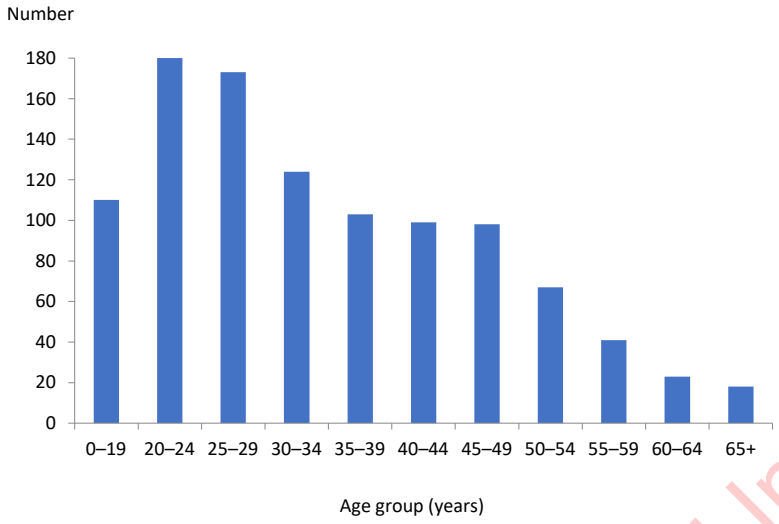
Among the adults who were secluded, many were secluded more than once (on average two times).[24] For this reason, the number of seclusion events in adult inpatient services (1,678) was higher than the number of people secluded (852).[25]

In 2018, there were 6.9 seclusion events per 1,000 bed nights in adult inpatient units. This means that – nationally and on average – for every 1,000 bed nights a person spent in an inpatient unit, the person would have 6.9 seclusion events.[26]

Across all inpatient services, including forensic, intellectual disability and youth services, 1,066 people experienced at least one seclusion event.[27] Of those secluded, 69 percent were male and 31 percent were female. The most common age group for those secluded was 20–24 years (see Figure 27). A total of 110 young people (aged 19 years and under) were secluded during the 2018 year in 290 seclusion events.[28]

[22] PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern, and Waitematā DHBs. This data excludes two outliers and forensic services. Bed nights are measured by team types that provide seclusio. This figure cannot be compared with years before 2017, when bed nights were measured by acute and sub-acute bed nights.
[23] PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs. Excludes two outliers and forensic services.
[24] PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs. Excludes two outliers and forensic services.
[25] PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs. Excludes two outliers and forensic services.
[26] PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs. Excludes two outliers and forensic services.
[27] PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs. Excludes two outliers.
[28] Of the 110 young people spending time in seclusion, 32 were in the country's specialist facilities for children and young people (in Christchurch, Auckland and Wellington). Of the 290 seclusion events, 108 occurred in those specialist facilities.

**Figure 27: Number of people secluded across all inpatient services (adult, forensic, intellectual disability, and youth), by age group, 1 January to 31 December 2018**

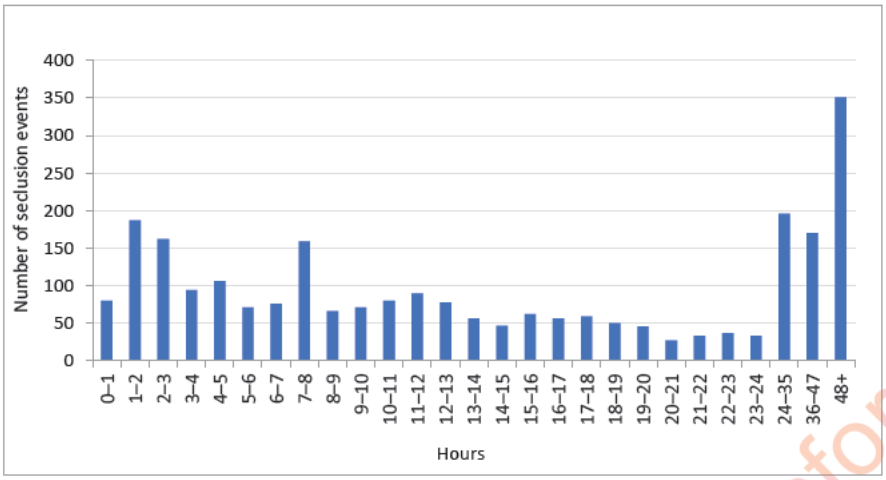



Note: This data excludes two outliers. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

The length of time spent in seclusion varied considerably. Most seclusion events (72 percent) lasted for less than 24 hours. Some (14 percent) lasted for longer than 48 hours. Figure 28 shows the number of seclusion events by the length of the event in 2018.

**Figure 28: Number of seclusion events across all inpatient services (adult, forensic, intellectual disability and youth), by duration of event, 1 January to 31 December 2018**




Note: This data excludes two outliers. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

~~**Use of seclusion by district health boards**~~

~~All DHBs except for Wairarapa DHB (which has no mental health inpatient service) use seclusion.[39] In 2018, the national average number of people secluded in adult inpatient services was 29.4 per 100,000 population, and the average number of seclusion events was 57.8 per 100,000 population.~~

~~As Figures 29 and 30 show, seclusion data varied widely across DHBs in 2018. Reasons for such variation are likely to include:~~

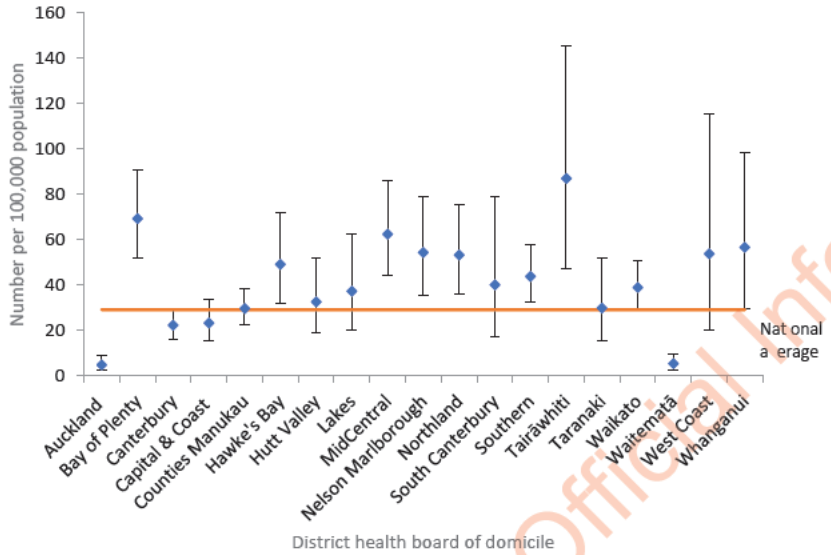
- ~~differences in service seclusion practice~~
- ~~variations in the prevalence and acuity of mental illness within a local population~~
- ~~ward design factors, such as whether intensive care and low-stimulus facilities are available~~
- ~~staff numbers, experience and training~~
- ~~use of sedating psychotropic medication~~
- ~~cases where a DHB uses frequent or prolonged seclusion of a small number of people, distorting it~~ ~~seclusion figures over the 12-month period.~~

**Commented [HR35]:** Worth a conversation about whether we want to include the by DHB breakdown

[39] ~~If a person in Wairarapa DHB requires admission to mental health inpatient services, they are transported to Hutt Valley or MidCentral DHB, and the seclusion statistics relating to these service users appear on that DHB's database.~~

Because it is difficult to measure and adjust for these factors, the Ministry recommends comparing an individual DHB's performance over time in addition to considering the adjusted comparisons between DHBs in this report.

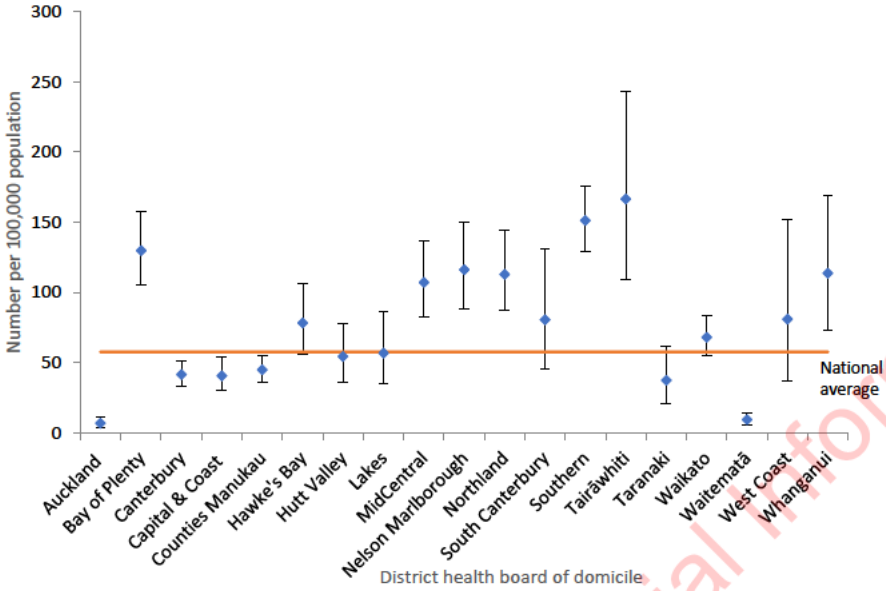
**Figure 29: Number of people secluded in adult inpatient services per 100,000 population, by DHB, 1 January to 31 December 2018**




Notes: The graph uses confidence intervals (for 99 percent confi ce) to help in interpreting the data. Where a DHB region's confidence interval crosses the national average, this means he DHB's rate was not statistically significantly different from the national average. This data excludes two ou liers. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS. As Wa arapa DHB does not have an inpatient unit, they have been removed from this graph.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

**Figure 30: Number of seclusion events in adult inpatient services per 100,000 population, by DHB, 1 January to 31 December 2018**




Notes: This graph uses confidence intervals (for 99 percent confidence) to help in int rpret ng the data. Where a DHB region's confidence interval crosses the national average, this means the DHB rat wa ot statistically significantly different from the national average. This data excludes two outliers. It includes pat ents who have a legal status under the Mental Health Act but are treated in RIDSS. As Wairarapa DHB does ha e an inpatient unit, they have been removed from this graph.

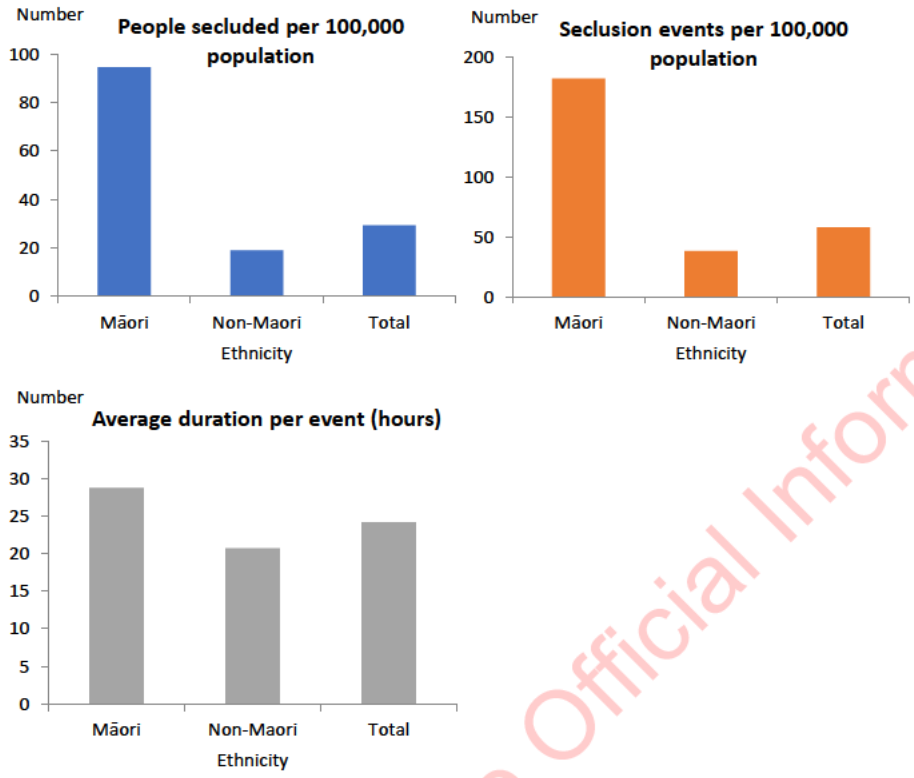
Source: PRIMHD data, extracted 29 July 2019, and manual data from La es, Nelson Marlborough, Southern and Waitematā DHBs.

### Seclusion and ethnicity

In 2018, Māori were five times more likely to be secluded in adult inpatient services than people from other ethnic groups. Figure 31 shows seclusion indicators for Māori and non-Māori during 2018. Māori were secluded at a rate of 94.5 people per 100,000 and non-Māori at a rate of 19 people per 100 000 population.[30]

[30] T is report, like previous reports from the Office, measures rates of people secluded and seclusion events per 100,000 population. Other publications may measure rates of seclusion events against the population of the inpatient service. Both measures are useful. This data excludes two outliers.

**Figure 31: Seclusion indicators for adult inpatient services, Māori and non-Māori, 1 January to 31 December 2018**

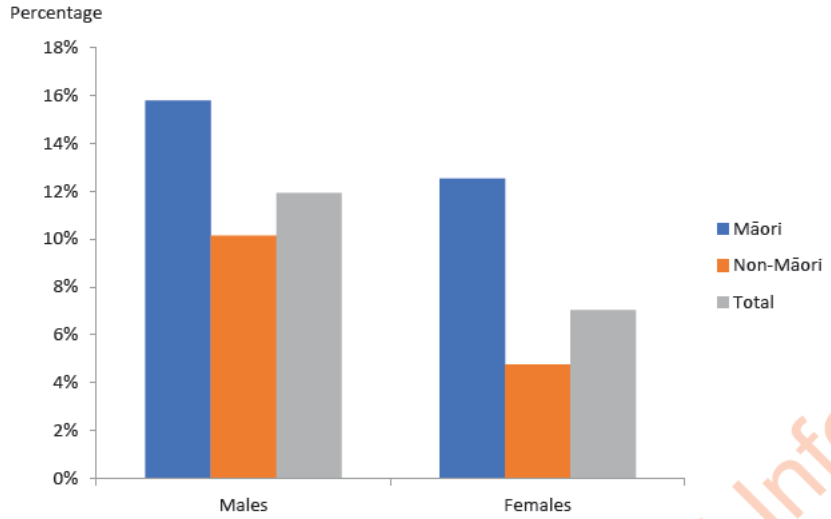



Note: This data excludes two outliers and forensic services. It include patients who have a legal status under the Mental Health Act but are treated in RIDSS. This excludes those wi h a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

Figure 32 shows the percentage of Māori and non-Māori male and female service users secluded in adult inpatient se vices in 2018. It indicates that a greater proportion of Māori were secluded than non-Māori, and that across ethnicities males were more likely to be secluded (12 percent) than females (7 percent). However, Māori females in adult inpatient services experience higher seclusion rates than non-Māori males.

**Figure 32: Percentage of people spending time in seclusion in adult inpatient services, Māori and non-Māori males and females, 1 January to 31 December 2018**



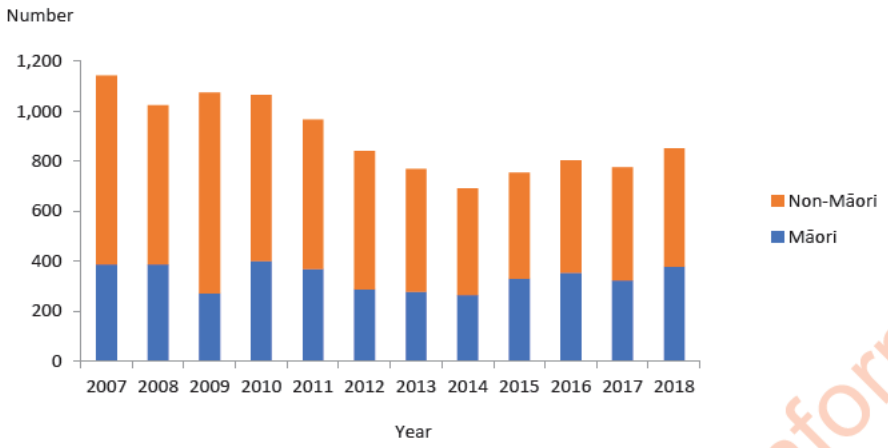

Note: This data excludes two outliers and forensic services. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS. This excludes those with a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

Figure 33 shows the number of Māori and non-Māori aged 20–64 years secluded in adult inpatient services from 2007 to 2018. Nationally over this time, the number of people secluded decreased by 25 percent. The number of people secluded who identified as Māori decreased by 3 percent over the same time

Against this trend, however, the total number of adult patients secluded increased by 10 percent from 2017 to 2018. The number of Māori patients increased by 17 percent over the same period.

**Figure 33: Number of Māori and non-Māori aged 20–64 years secluded in adult inpatient services, 2007–2018**




Note: This data excludes two outliers and forensic services. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS. This excludes those with a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

### Seclusion in forensic units

Five DHBs provide specialist inpatient forensic services: Canterbury, Capital & Coast, Southern, Waikato and Waitematā.[31] These services provide mental health treatment in a secure environment for prisoners with mental disorders and for people defined as special or restricted patients under the Mental Health Act.

These forensic services also provide care for people (care recipients or special care recipients) under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCC&R Act). The Ministry of Health purchases this care under the High and Complex Framework. The facilities that these services offer vary. Some services provide beds within existing forensic mental health infrastructure; others provide them in purpose-built facilities. Some RIDSS also have 'step-down' facilities, which are medium secure 'cottages' intended to provide a more home-like environment as care recipients move towards a transition to the community.

[31] Capital & Coast DHB also operates a forensic service at Whanganui.

We report on seclusion data for those under the IDCC&R Act separately from the data for patients under the Mental Health Act to give a better understanding of the use of seclusion for each group (see below).

As we noted previously, the seclusion data presented for intellectual disabilities is specific to care recipients with a legal status under the IDCC&R Act. The seclusion data for mental health services includes patients who have a legal status under the Mental Health Act but receive treatment from RIDSS.

Care recipients being cared for under the IDCC&R Act and the Mental Health Act may only be subject to seclusion in hospital-level secure services that meet requirements in the Mental Health Act.

A small number of care recipients currently in secure care have not made significant rehabilitative gains towards transitioning to community placement. These clients have intellectual disabilities and/or mental health conditions of such severity that they have been subject to long-term hospital-level care, and it is highly likely they will continue to require long-term secure care and more restrictive practices. Tables 7, 8 and 9 reflect these circumstances.

Table 7 presents data on the number of seclusion events for people with intellectual disabilities in each DHB, while Table 8 presents data on seclusion hours for this group in 2018.

**Table 7: Number of seclusion events for people with intellectual disabilities, by DHB, 1 January to 31 December 2018**

**Commented [HR36]:** Need to discuss whether to show this data as a break down by service, or as comprehensive numbers

| DHB | Number of beds* | Number of people | Number of events | Median of number of events | Average number of events per person |
|---|---|---|---|---|---|
| Canterbury | 8 | 4 | 29 | 4 | 7 |
| Capital & Coast | 32 | 5 | 14 | 2 | 3 |
| Southern | 11 | 2 | 31 | 16 | 16 |
| Waikato | 3 | 3 | 36 | 12 | 12 |
| Waitematā | 12 | 6 | 151 | 10 | 25 |

Note: This data presents seclusion data only for care recipients with a legal status under the IDCC&R Act.

Source: All DHB data supplied manually.

**Table 8: Seclusion hours for people with intellectual disabilities, by DHB, 1 January to 31 December 2018**

| DHB | Total seclusion hours (hours) | Median duration of seclusion events (hours: minutes) | Average duration of seclusion events (hours: minutes) |
|---|---|---|---|
| Canterbury | 233 | 3:07 | 8:02 |
| Capital & Coast | 213 | 16:40 | 15:13 |
| Southern | 142 | 2:55 | 4:34 |
| Waikato | 590 | 4:31 | 16:22 |
| Waitematā | 1868 | 7:29 | 12:22 |

Note: This data presents seclusion data only for care recipients with a legal status under the IDCC&R Act.

Source: All DHB data supplied manually.

Table 9 presents seclusion indicators for forensic mental health services in each DHB for 2018. These indicators cannot be compared with adult service indicators because they have a different client base. A few individuals who were secluded significantly more often or for longer than others can substantially affect the rates of seclusion for the relatively small group of people in the care of forensic mental health services.

**Table 9: Seclusion indicators for forensic mental health services, by DHB, 1 January to 31 December 2018**

| DHB | Number of clients secluded | Number of events | Total hours | Average duration per event (hours) |
|---|---|---|---|---|
| Canterbury | 22 | 85 | 7,741 | 91.1 |
| Capital & Coast | 6 | 24 | 662 | 27.6 |
| Southern | 2 | 9 | 530 | 58.9 |
| Waikato | 26 | 68 | 4,906 | 72.2 |
| Waitematā | 43 | 338 | 6,262 | 18.5 |
| **Total** | **99** | **524** | **20,101** | **38.4** |

Notes: The sum of the total clients does not match the total reported because one client was seen by both Canterbury and Capital & Coast DHBs. In the 20 7 Annual Report, the last column was mislabelled 'Average duration per client (hours)'. The correct label for hat c lumn is 'Average duration per event (hours)', making it comparable with other years' data. Data for the Whanganui forensic mental health service has been included with Capital & Coast.

Clients are aged 20–64 yea s. Clients are mental health service users only.

Source: PRIMHD data extracted on 29 July 2019; manual data submitted by Southern and Waitematā DHBs.

## ~~Special and restricted patients~~

~~Under New Zealand law, people who have been charged with committing crimes while severe mental illness is influencing their judgement may be treated in a secure mental health facility, instead of going to prison. These people are given 'special patient' status. Ensuring~~

**Commented [HR37]:** Need to discuss whether to show this data as a break down by service, or as comprehensive numbers

**Commented [HR38]:** Need to discuss whether to show this data as a break down by service, or as comprehensive numbers

**Commented [HR39]:** I think we might be able to present the background information about special patients on a dedicated page on our website, and it should be considered whether this data is better removed and provided on a request basis

special patients are treated for their illness is an important step towards improving their wellbeing and preventing re-offending.

**Special patients**[32] include:

- people charged with, or convicted of, a criminal offence and remanded to a hospital for a psychiatric report
- remanded or sentenced prisoners transferred from prison to a hospital
- defendants found not guilty by reason of insanity
- defendants who are unfit to stand trial
- people who have been convicted of a criminal offence and both sentenced to a term of imprisonment and placed under a compulsory treatment order.

**Restricted patients** are people detained in forensic mental health services, by court order, because they pose a danger to others. They may have also been transferred from prison or previously had a special patient status that was changed when their sentence ended. Restricted patients are generally subject to the same leave provisions as the provisions that apply to special patients.

For more information about special and restricted patients, see Appendix 3.

**Forensic mental health services**

Forensic mental health services are responsible for the care and treatment of special patients and restricted patients within the legislative framework of the Mental Health Act and the Criminal Procedure (Mentally Impaired Persons) Act 2003 (the CP (MIP) Act).

Special and restricted patients are detained in the care of one of five regional forensic psychiatry services throughout New Zealand unde- the jurisdiction of Waitematā, Waikato, Capital & Coast, Canterbury and Southern DHBs.[33] These services develop management plans to progressively reintegrate people i- to the community as treatment improves their mental health.

Forensic mental health services must carefully balance the rights, treatment and rehabilitative needs of the individual patient against the safety of the public and the concerns of any victims.

The role of clinical management of special and restricted patients lies with the patient's responsible clinician. However, before anyone gets permission for leave in the community or changes to thei- legal status as a special or restricted patient, the Director of Mental Health,

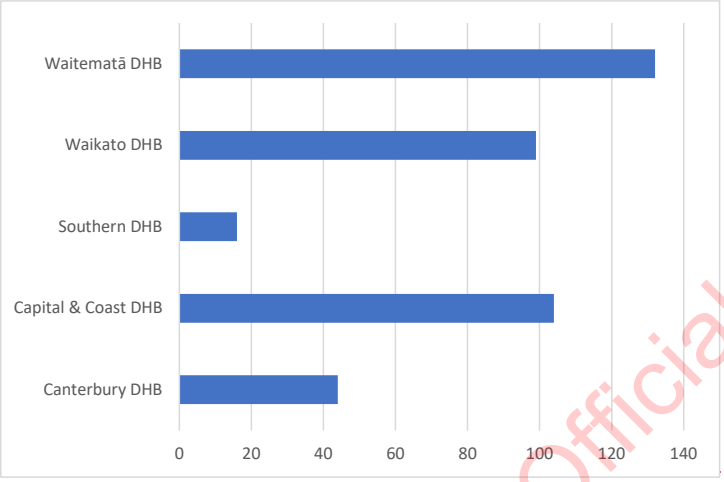
[32] As set out in section 2(1) of the Mental Health Act. For the purposes of this report, the data does not include people subject to section 191(2)(a) of the Armed Forces Discipline Act 1971 or section 136(5)(a) of the IDCC&R Act.

[33] A smaller inpatient forensic service in Whanganui also operates under the Capital & Coast DHB's forensic services. Additionally, in some circumstances, certain special patient orders can enable a court to direct treatment outside a regional forensic service.

and (depending on the legal status of the patient) the Minister of Health and/or the Attorney-General must consider and approve the case. The legal requirement for these senior government officials to consider such cases reflects the risks in treating special and restricted patients, and the need to ensure a wide range of factors are considered when making decisions about these patients.

Figure 34 presents the total number of special patients in the care of each of the DHBs that provide regional forensic psychiatry services.

**Figure 34: Total number of special patients, by DHB, 1 January to 31 December 2018**




Notes: Due to their relatively small numbers of special patients, Whanganui DHB is included under Capital & Coast DHB and Nelson Marlborough is included under Canterbury DHB.

Source: PRIMHD collection, extracted 29 July 2019.

Special and restricted patients may be detained for short-term or extended care.

***Extended forensic care special patients***

Extended forensic care patients include special patients who have been found not guilty by reason of insanity or unfit to stand trial under section 24(2)(a) of the CP (MIP) Act 2003. Restricted patients under section 55 of the Mental Health Act are also subject to extended forensic care.

In 2018, New Zealand had 156 extended forensic care special patients. Table 10 presents the number of these patients in the care of each of the DHBs that provide regional forensic psychiatry services.

***Short-term forensic care special patients***

Short-term forensic care patients include people transferred to a forensic mental health service from prison. Once a person has been sentenced to a term of imprisonment, any compulsory mental health treatment order relating to them no longer applies. Remand

prisoners may remain on a pre-existing compulsory treatment order, but it is unlawful to enforce compulsory treatment in the prison environment. However, a court may make a 'hybrid order' under section 34(1)(a)(i) of the CP (MIP) Act 2003, sentencing an offender to a term of imprisonment while also ordering their detention in hospital as a special patient.

If a mentally disordered prisoner requires compulsory assessment and/or treatment, section 45 of the Mental Health Act provides for their transfer to hospital. Section 46 allows for voluntary admission to hospital with the approval of the prison superintendent. Services must notify the Director of Mental Health of all such admissions. On advice from services, the Director can direct the person's return to prison under section 47 of the Mental Health Act.

In 2018, New Zealand had a total of 251 short-term forensic care special patients. Table 10 presents the number of these patients in the care of each of the DHBs that provide regional forensic psychiatry services. Figure 35 shows the percentage of court orders given for short-term forensic care legal status relative to those for extended forensic care legal status in each of these DHBs.

**Table 10: Number of extended and short-term forensic care special patients, by DHB, 1 January to 31 December 2018**

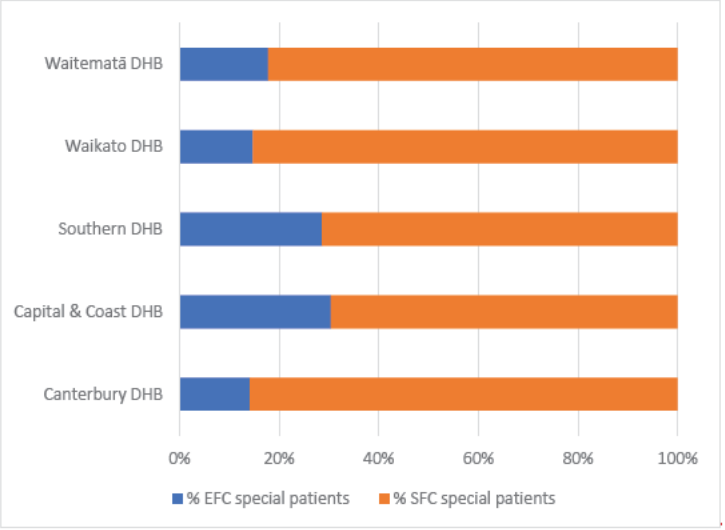
| Forensic services | EFC special patients | SFC special patients | Total special patients |
|---|---|---|---|
| Canterbury DHB | 16 | 30 | 44 |
| Capital & Coast DHB | 50 | 60 | 104 |
| Southern DHB | 10 | 7 | 16 |
| Waikato DHB | 32 | 72 | 99 |
| Waitematā DHB | 52 | 85 | 132 |

Notes: EFC – extended forensic care; SFC – short-term forensic care. People are counted as special patients in more than one DHB when they receive treatment with more than one DHB. For this reason, the total of this data is higher than the national total. Due to their relatively small numbers of special patients, Whanganui DHB is included under Capital & Coast DHB and Nelson Marlborough is included under Canterbury DHB.

Under certain special patient orders, a court can direct treatment outside a regional forensic service. We have excluded this data because it involves only a few patients and it is necessary to protect patient confidentiality.

Source: PRIMHD collection, extracted on 29 July 2019.

**Figure 35: Percentage of court orders given for extended forensic care relative to short-term forensic care, by DHB, 1 January to 31 December 2018**



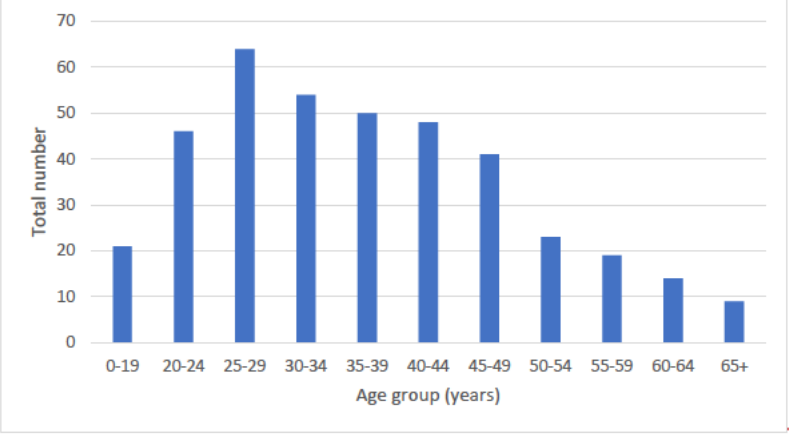

Note: Unlike previous data in this section, the data in this figure is based on a count of court orders for legal status rather than a count of people with a special patient legal status. One special patient may have many court orders for their legal status in the year, which could include both extended forensic care (EFC) and short- or long-term forensic care (SFC), but each special patient's legal status can only be in one category at any one time – EFC or SFC. Please use caution when comparing the counts of court orders for legal status with the counts of people with the EFC or SFC legal status. Due to their relatively small numbers of special patients, Whanganui DHB is included under Capital & Coast DHB and Nelson Marlborough is included under Canterbury DHB.

Source: PRIMHD collection, extracted on 29 July 2019.

**Sex, age and ethnicity of special patients**

In 2018, special patients were almost five times more likely to be male (86 percent) than female (14 percent). The most common age group for special patients was 25–29 years old (see Figure 36).

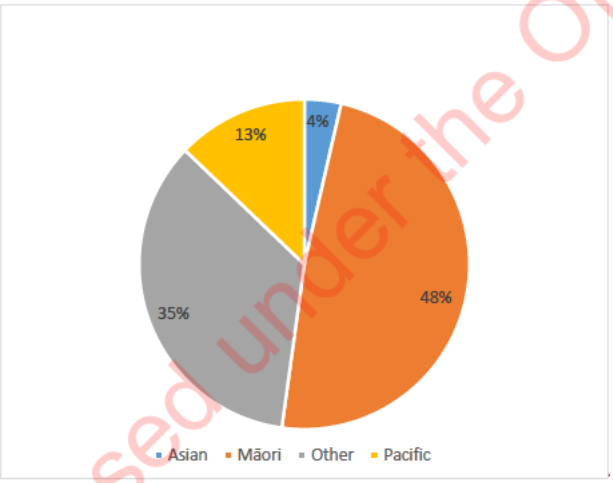
**Figure 36: Total number of special patients, by age group, 1 January to 31 December 2018**




Source: PRIMHD collection, extracted on 29 July 2019.

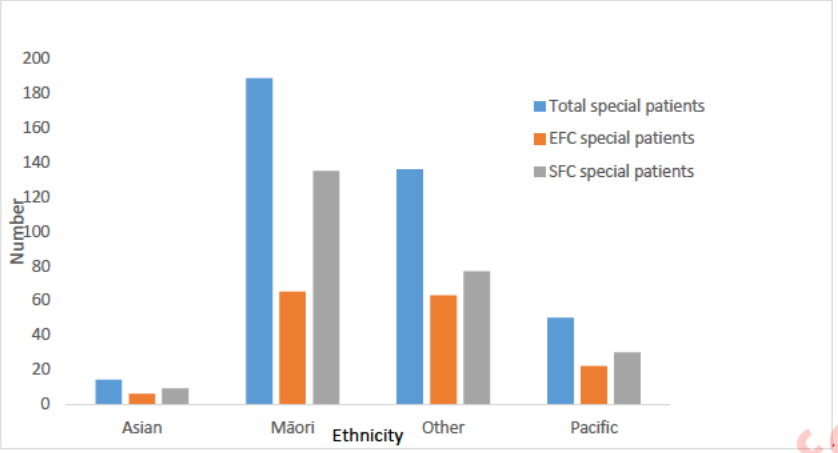
In 2018, the ethnic group with the highest proportion of people subject to a special patient order was Māori (48 percent) (see Figure 37). Māori represent the highest proportion of both extended forensic care (42%) and short-term forensic care (54%) special patients. Figure 38 shows the number of special patients in each ethnic group for each of these types of forensic care.

**Figure 37: Percentage of special patients, by ethnicity, 1 January to 31 December 2018**




Source: PRIMHD collection, extracted on 27 July 2019.

**Figure 38: Number of special patients, by ethnicity and special patient type, 1 January to 31 December 2018**




Notes: EFC = extended forensic care; SFC = short-term forensic care. A patient may be represented under both the extended forensic care and short-term forensic care categories in this graph.

Source: PRIMHD collection, extracted on 29 July 2019.

**Decisions about leave and change of legal status for special and restricted patients**

The Director of Mental Health has a central role in managing special patients and restricted patients. The Director must be notified of the admission, discharge or transfer of special and restricted patients, and certain incidents involving these people (section 43 of the Mental Health Act). The Director may authorise the transfer of patients between DHBs under section 49 of the Mental Health Act or grant leave for any period no longer than seven days for certain special and restricted patients (section 52).

Leave is an important part of a special patient's rehabilitation and occurs in a carefully stepped manner. Patients usually begin by having walks on the hospital grounds escorted by forensic service staff. If appropriate, patients progress to unescorted ground leave and then to escorted and unescorted community leave. This leave is typically used to attend appointments, work or rehabilitation programmes or to visit family. After increasing periods of successful unescorted leave, it may be appropriate for some individuals to progress to a less secure setting. Individuals may move to an open hospital unit and eventually live in the community, often in supported accommodation or with family. It is important to note that not all special patients will be eligible for leave, and that there is no requirement for a special patient to progress towards less secure conditions if risk assessment or the patient's progress does not support this.

Under section 50 of the Mental Health Act, the Minister of Health can grant periods of leave for longer than seven days to certain categories of special patients. The Director briefs the

Minister of Health when requests for leave are made. The first period of ministerial section 50 leave is usually granted for a period of six months, with the possibility of further applications for ministerial leave for a period of 12 months.

While on leave, special patients are subject to leave conditions and regular monitoring by their treating team. If a special patient breaches their leave conditions or they must return to hospital because of their mental state, leave may be recalled. Special patients are subject to a high degree of monitoring and are not able to exit forensic services or travel overseas without permission. Border alerts are in place for special patients when they have been granted unescorted leave in the community.

Special patients found not guilty by reason of insanity may be considered for a change of legal status if it is determined that their detention as a special patient is no longer necessary to safeguard the interests of the person or the public. This will usually occur after the person has been living successfully in the community on ministerial long leave for several years. Services send applications for changes of legal status to the Director of Mental Health. After careful consideration, the Director makes a recommendation for the Minister's decision about a person's legal status.

Following a change of legal status, mental health services continue to support former special patients in the community. Many former special patients remain under compulsory mental health treatment orders for extended periods. For more information about special patients, see Appendix 3.

Table 11 shows the number of applications for section 50 long leave, revocation and reclassification that the Office processed during 2018.

**Table 11: Number of applications for section 50 long leave, revocation and reclassification sent to the Minister of Health for special patients and restricted patients, 1 January to 31 December 2018**

| Type of request | Number |
|---|---|
| First ministerial section 50 leave applications | 13 |
| First ministerial section 50 leave applications not approved | 0 |
| Ministerial section 50 leave revocations (initial and further) | 2 |
| Further ministerial section 50 leave applications | 13 |
| Further ministerial section 50 applications not approved | 0 |
| Change of legal status applications approved | 9 |
| Change of legal status applications not approved | 0 |

Note: Numbers do not include the number of applications that were withdrawn before the Minister of Health received them.

Source: Office of the Director of Mental Health and Addiction Services records.

## Mental health and addiction adverse event reporting

### Deaths reported to the Director of Mental Health

New Zealand has two major national reporting mechanisms for adverse events relating to mental health.[34] These are that DHBs must:

1. notify the Director of Mental Health of the death of any person or special patient under the Mental Health Act
2. report all adverse events rated Severity Assessment Code (SAC)[35] 1 or 2 to the HQSC in line with the National Adverse Events Reporting Policy (HQSC 2018). Mental health services that are not funded by DHBs are encouraged but not required to report adverse events to the HQSC. (Due to small numbers, the data from the latter group of services is not reported here.)

Please note that deaths of people subject to the Mental Health Act may be reported to both agencies where the death meets the SAC1 criteria.

Under section 132 of the Mental Health Act, services must notify the Director of Mental Health within 14 days of the death of any person or special patient who is subject to the Mental Health Act. Such a notification must identify the apparent cause of death.[36]

If the circumstances surrounding a death cause concern, the relevant DHB may initiate an inquiry. The Director of Mental Health can also initiate an investigation under section 95 of the Mental Health Act and, in rare cases, the Minister or Director-General of Health can initiate an inquiry under section 72 of the New Zealand Public Health and Disability Act 2000. The Director of Mental Health works to ensure that DHBs follow up on recommendations.

In 2018, the Director of Mental Health received 57 death notifications related to people under the Mental Health Act (see Table 12). Of these, 17 were about people who were reported to have died by suspected suicide.[37] The remaining 40 people reportedly died by other means, including natural causes and illnesses unrelated to mental health status.

**Commented [HR40]:** Worth a conversation about whether this is necessary for public reporting or if it can be provided on a request basis

[34] An adverse event is an event that results in harm or has the potential to result in harm to a consumer.

[35] SAC is a numerical rating of how severe an adverse event is and, as a consequence, identifies what level of reporting and investigation needs to be undertaken for that event.

[36] Any suicides or suspected suicides under the Mental Health Act also come under the serious adverse event reporting requirements of the HQSC.

[37] In New Zealand, a coroner only officially classifies a death as suicide after completing their inquiry. Only those deaths that the coroner decides are 'intentionally self-inflicted' will receive a final verdict of suicide. A coronial inquiry is unlikely to occur within a calendar year of an event occurring; for this reason, when a death appears to be self-inflicted but the coroner has not yet established the person's intent, it is called a 'suspected suicide'.

**Table 12: Outcomes of reportable death notifications under section 132 of the Mental Health Act, 1 January to 31 December 2018**

| Reportable death outcome | Number |
|---|---|
| Suspected suicide | 17 |
| Other deaths | 40 |
| **Total** | **57** |

Source: Office of the Director of Mental Health and Addiction Services records.

### Deaths reported to the Director of Addiction Services

For deaths relating to substance use and addiction, the Substance Addiction Act makes no provision for DHBs or approved providers to report deaths of patients. Nonetheless, the Office encourages them to report adverse events to the Director of Addiction Services.

After the Substance Addiction Act came into force on 21 February 2018, no deaths to people subject to that Act occurred during 2018 while they were subject to that Act.

**Commented [HR41]:** Doesn't appear to be required reporting for our SACAT obligations

### Adverse events reported to the Health Quality & Safety Commission

Adverse event reporting encourages health and disability services to identify and review the events with the aim of preventing similar occurrences in the future and helping health care for New Zealanders to be better and safer.

In New Zealand, adverse events have been reported publicly since 2006.[38] Since reporting began, the number of adverse events that DHBs report has increased. This increase is not necessarily because adverse events have become more frequent; we consider that at least part of the explanation may be that DHBs have improved their reporting systems and created a stronger culture of transparency and commitment to learning.

Additionally, it is important to note that the reporting periods for adverse events differ between the Ministry and HQSC. The Ministry collects data over the calendar year, whereas HQSC collects data over the financial year.

### Adverse events reported by district health board mental health services

Table 13 provides a breakdown of the types of adverse events relating to mental health that DHBs reported to the HQSC during 2018. Table 14 shows the number of events reported for each DHB.

Comparing individual DHBs based on this data is not straightforward. As noted above, high numbers can indicate a DHB has a good reporting culture rather than that it has more actual adverse events compared with other DHBs. In addition, DHBs that serve a larger population

[38] Before the HQSC's first publication in 2010, the Quality Improvement Committee published reports on adverse events.

or provide more complex mental health services may report a higher number of adverse events.

For more information about adverse events in mental health and addiction services, we recommend reading HQSC (2018) *Learning from Adverse Events*.

**Table 13: Number of mental health adverse events that DHBs reported to the Health Quality & Safety Commission, by type of event, 1 January to 31 December 2018**

| Type of event | Outpatient | Inpatient | On approved leave | Inpatient (AWOL) | Total |
|---|---|---|---|---|---|
| Suspected suicide | 176 | 7 | 0 | 4 | 187 |
| Serious self-harm | 9 | 9 | 0 | 1 | 19 |
| Se ious adve se behaviou | 4 | 6 | 0 | 0 | 10 |
| **Total** | **189** | **22** | **0** | **5** | **216** |

Note: AWOL = absent without leave.

Source: HQSC adverse event data, extracted on 2 September 2019

**Table 14: Mental health adverse events that DHBs reported to the Health Quality & Safety Commission, by DHB, 1 January to 31 December 2018**

| DHB | Number of events | DHB | Number of events |
|---|---|---|---|
| Auckland | 25 | Northland | 6 |
| Bay of Plenty | 8 | South Canterbu y | 3 |
| Canterbury | 24 | Southern | 29 |
| Capital & Coast | 15 | Tairāwhiti | 7 |
| Counties Manukau | 13 | Tara aki | 4 |
| Hawke's Bay | 6 | Wa ato | 17 |
| Hutt Valley | 4 | Wai a apa | 0 |
| Lakes | 9 | Waitematā | 26 |
| MidCentral | 10 | West Coast | 3 |
| Nelson Marlborough | 3 | Whanganui | 4 |
| | | **New Zealand total** | **216** |

Source: HQSC adverse event ata, tracted on 2 September 2019

## Death by suicide

Suicide is a serious concern for New Zealand. Around 500 New Zealanders die by suicide every year. Suicide affects the lives of many others as well – whānau, families, friends, colleagues and communities. For more information about suicide prevention work in 2018, see page 12 in the 'Activities for 2018' section.

**Commented [HR42]:** Has this data been provided already elsewhere? Consider potentially reporting somewhere else since we are so far out from 2018 and might be confusing if the SPO is now reporting - this comment applies to all of the data in this section

Here we provide a brief overview of suicide deaths and deaths of undetermined intent, with a particular focus on people who had contact with specialist mental health services (including services treating people with alcohol and other drugs (AOD) addiction) in the year before their death.[39] Here we refer to people with no history of mental health service use in the year before their death as 'non-service users', although we acknowledge that some of these 'non-service users' may have used mental health or AOD services at some earlier time in their lives. This overview uses data from 2016 as it can take several years for a coroner to complete an investigation into a suicide.

Suicide has no single cause – it is usually the end result of interactions between many different factors that impact different people in different ways. Mental disorders (in particular, mood disorders, substance use disorders and antisocial behaviours) are one set of factors that can make suicidal behaviour more likely (Beautrais et al 2005).

In summary, in 2016:[40]

- 552 people died by suicide and the mortality database recorded a further 26 deaths of undetermined intent[41]
- about 42 percent of those who died by suicide or undetermined intent (among those aged 10–64 years) were mental health service users
- mental disorders were one of the factors that made suicidal behaviour more likely
- males were more likely to die by suicide than females.

**Prevalence of suicide in the population**

At the time the data was extracted, the mortality database had recorded 552 suicides for 2016[42] and a further 26 deaths of undetermined intent, which we include in this report. Of this initial total of 578 deaths, 63 involved people who were aged 65 years and over. The following discussion excludes these deaths.[43]

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[39] For more detailed information on deaths by suicide, please visit 'Understanding suicide in New Zealand' at https://www.health.govt.nz/our-work/mental-health-and-addictions/suicide-prevention-new-zealand/understanding-suicide-new-zealand

[40] Ministry of Health mortality database, extracted on 27 June 2019.

[41] Suicide is a death where evidence shows that the person deliberately brought about their own death as determined by coronial ruling. A coroner decides a death is of undetermined intent in circumstances where intent was not determined or not enough information has been gathered about likely intent.

[42] These numbers are subject to change. The mortality database is a dynamic collection, and changes can be made even after the data is considered nominally final.

[43] We have excluded the deaths of people aged 65 and over because in the Central and Southern regions, health services for older people rather than mental health services provide older people's mental health treatment and their data was not necessarily recorded in PRIMHD. Each year, deaths of children under 10 years of age are also excluded because 'undetermined intent' deaths in this age group are unlikely to be caused by suicide. The data was drawn from information provided to the Ministry's national mortality database and PRIMHD.

Table 15 sets out statistics on the remaining 515 deaths. Of these 515 people, 219 (40 percent) had had contact with mental health services in the year before their death.

**Table 15: Number and age-standardised rate of suicide, by service use, people aged 10–64 years, 2016**

| | Number | Age-standardised rate[a] |
|---|---|---|
| **Deaths due to intentional self-harm** | | |
| Service users[b] | 209 | 127.1 |
| Non-service users | 280 | 6.9 |
| Total | 489 | 12.2 |
| **Deaths of undetermined intent** | | |
| Service users | 10 | 6.3 |
| Non-service users | 16 | 0.4 |
| Total | 26 | 0.6 |
| **Total deaths** | | |
| Service users | 219 | 133.3 |
| Non-service users | 296 | 7.2 |
| Total | 515 | 12.. |

Notes:

a Age-standardised rate is per 100,000, standardised to the World Health Organization standard population aged 0–64 years.

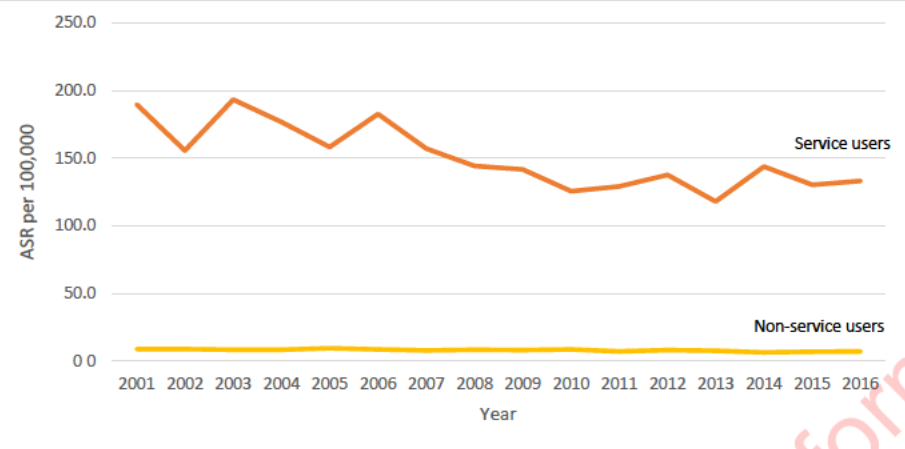
b Service user denominator excludes service users of unknown age.

Source: Ministry of Health mortality database, extracted on 27 June 2019.

**Changes in number of suicides over time**

Figure 39 shows the changes in the rates of suicide by service users and non-service users between 2001 and 2016.

**Figure 39: Age-standardised rate of suicide of people aged 10–64 years, by service use, 2001–2016**




Notes: Age-standardised rate (ASR) is per 100,000 population, standardised to the World Health Organi-ati-n standard population aged 0–64 years.

The service user population is much smaller than the non-service user population and so their ates are more prone to fluctuation from year to year.

Source: Ministry of Health mortality database, extracted on 27 June 2019.

## Sex and age in relation to suicide

As Table 16 and Figure 40 show, 2.7 times more males than females died by suicide in 2016. Of the service users who died by suicide in 2016, 27.2 percent were female and 72.8 percent were male.

When considering these numbers, it is important to note that these age-standardised rates are highly variable over time because they come from a small service-user population.

**Table 16: Number and age-standardised rate of suicide of people aged 10–64 years, by service use and sex, 2016**

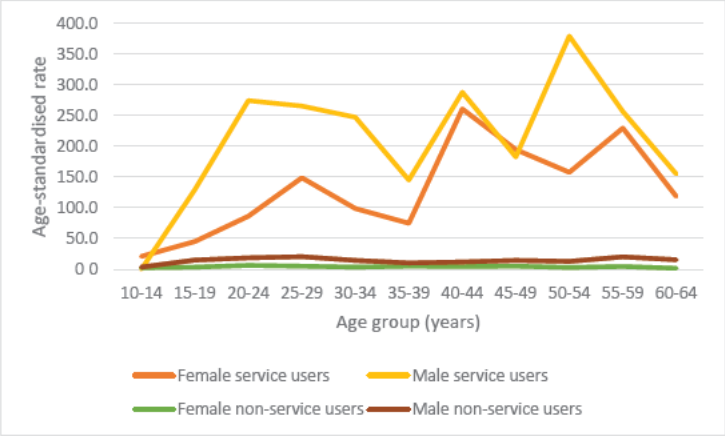
| Sex | Service users | | Non-service users | | Total | |
|---|---|---|---|---|---|---|
| | Number | ASR | Number | ASR | Number | ASR |
| Males | 146 | 165.0 | 229 | 11.3 | 375 | 17.8 |
| Females | 73 | 97.5 | 67 | 3.5 | 140 | 6.5 |
| Total | 219 | 133.2 | 296 | 7.2 | 515 | 12.1 |

Notes: Includes deaths of undetermined intent. Age-standardised rate (ASR) is per 100,000 population, standardised to the Wo-d He-lth Organization standard population aged 0–6 years.

Service-user denominator excludes service users of unknown age.

Sourc-: Ministry of Health mortality database, extracted on 27 June 2019.

**Figure 40: Age-standardised rate of suicide of people aged 10–64 years, by age group, sex and service use, 2016**




Source: Ministry of Health mortality database, extracted on 27 June 2019.

As Table 17 shows, the age-standardised rate of suicide among female service users was highest for those aged 40–44 years, at 260.4 per 100,000 population. The rate among male service users was highest for those aged 50–54 years, at 378.9 per 100,000 population.

For female non-service users, the age-standardised rate of suicide was highest in those aged 20–24 years, at 6.2 per 100,000 population. For male non-service users, the rate was highest in those aged 25–29 years, at 20.4 per 100,000 population.

**Table 17: Number and age-standardised rate of suicide, by age group, sex and service use, of people aged 10–64 years, 2016**

| Age band (years) | Service users | | | | Non-service users | | | | Total number |
|---|---|---|---|---|---|---|---|---|---|
| | Female | | Male | | Female | | Male | | |
| | Number | ASR | Number | ASR | Number | ASR | Number | ASR | |
| 10–14 | 1 | 20.9 | 0 | 0.0 | 3 | 2.2 | 5 | 3.5 | 9 |
| 15–19 | 5 | 44.9 | 12 | 129.4 | 5 | 3.5 | 23 | 14.9 | 45 |
| 20–24 | 6 | 86.1 | 24 | 274.1 | 10 | 6.2 | 32 | 18.4 | 72 |
| 25–29 | 10 | 148.4 | 22 | 265.4 | 8 | 4.9 | 33 | 20.4 | 73 |
| 30–34 | 6 | 98.9 | 17 | 246.9 | 5 | 3.4 | 20 | 14.5 | 48 |
| 35–39 | 4 | 74.5 | 9 | 144.8 | 7 | 5.0 | 13 | 10.2 | 33 |
| 40–44 | 13 | 260.4 | 18 | 287.6 | 7 | 4.6 | 16 | 11.6 | 54 |
| 45–49 | 10 | 194.6 | 11 | 182.5 | 8 | 5.0 | 21 | 14.4 | 50 |
| 50–54 | 7 | 157.6 | 19 | 378.9 | 5 | 3.1 | 19 | 12.8 | 50 |
| 55–59 | 8 | 229.6 | 10 | 256.6 | 7 | 4.7 | 28 | 20.1 | 53 |
| 60–64 | 3 | 118.2 | 4 | 154.7 | 2 | 1.5 | 19 | 15.6 | 28 |

Notes: ASR = Age-standardised rate.
Includes deaths of undetermined intent.
Source: Ministry of Health mortality database, extracted on 27 June 2019.

### Ethnicity and suicide

As Table 18 indicates, among people using mental health services in 2016, the age-standardised rate of suicide was higher for Māori (127.6 per 100,000 population) than for Pacific peoples (35.2 per 100,000 population). The age-standardised rate for those in the 'Other' ethnic category was 140.1 per 100,000 population. The suicide rate for Māori non-service users was higher than for all non-Māori non-service users. (Note: the suicide rate for Pacific peoples is highly variable over time.)

**Table 18: Number and age-standardised rate of suicide and deaths of undetermined intent, of people aged 10–64 years, by ethnicity and service use 2016**

| Ethnicity | Service users | | Non-service users | | Total | |
|---|---|---|---|---|---|---|
| | Number of deaths | ASR | Number of deaths | ASR | Number of deaths | ASR |
| Māori | 66 | 127.6 | 74 | 13.0 | 140 | 26.– |
| Pacific | 4 | 35.2 | 13 | 4.7 | 17 | 7.2 |
| Other | 149 | 140.1 | 209 | 6.2 | 358 | 10.7 |
| **Total** | **219** | **133.3** | **296** | **7.2** | **515** | **12.1** |

Note: ASR = Age-standardised rate.
Source: Ministry of Health mortality database, extracted on 27 June 20–9.

### Service users who died by suicide

Of the 219 service users who died by suicide in 2016, four died while they were inpatients,[44] seven died within a week of being discharged[45] and 47 died within 12 months of discharge.[46]

---

[44] This figure is calculated from the number of people who had an inpatient activity on the day they died; PRIMHD cannot identify the number of people who died at an inpatient unit. In addition to capturing suicide de-ths that occurred in inpatient facilities, this figure may capture people who:

- received care in an inpatient facility, were discharged and died by suicide in the community later that day
- attempted suicide in the community and later died in hospital
- died by suicide in the community while on leave from an inpatient facility.

Note that these figures should not be compared with those of previous annual reports, as in this report we have updated the definitions for 'inpatient' and 'community service user'.

[45] Excluding those who received treatment on the day of their death.

[46] Excluding those who received treatment on the day of their death and those who died within a week of being discharged from an inpatient service.

~~From 2001 to 2016, a total of 2,841 service users died by suicide.[47] Of this total, 54 service users (1.9 percent) died while inpatients, 179 (6.3 percent) died within a week of discharge from inpatient care and 815 (28.7 percent) died within 12 months of discharge from inpatient care.~~

~~Of the 2,841 service user suicides since 2001, 2,803 people had received treatment from a specialist service community team in the 12 months before their death and 679 had received treatment from a specialist AOD team in the 12 months before their death.~~

## Substance use treatment

### Substance Addiction (Compulsory Assessment and Treatment) Act 2017

In February 2018, the Substance Addiction Act came into force, replacing the Alcoholism and Drug Addiction Act 1966. The Substance Addiction Act is designed to help people with a severe substance addiction and impaired capacity to make decisions about engaging in treatment. This new legislation is better equipped to protect the human rights and cultural needs of patients and whānau, and places greater emphasis on a mana-enhancing and health-based approach.

***Severe substance addiction***

Section 8 states the meaning of severe substance addiction. It is a continuous or intermittent condition that is of such severity that it poses a serious danger to the health and safety of the person and seriously diminishes their ability to care for themselves. It manifests itself in the compulsive use of a substance that is characterised by at least two of the following features:

- neuro-adaptation to the substance
- craving for the substance
- unsuccessful efforts to control the use of substance
- use of the substance despite suffering harmful consequences.

***Criteria for compulsory treatment***

Section 7 states the criteria for compulsory treatment, all of which must apply.

- The person has a severe substance addiction.
- The person's capacity to make informed decisions about treatment for that addiction is severely impaired.
- Compulsory treatment of the person is necessary.
- Appropriate treatment for the person is available.

~~[47] This total includes deaths of undetermined intent.~~

***Key stages of the treatment process under the Substance Addiction Act***

| | |
|---|---|
| **APPLICATION** | **Section 14** |
| | An applicant who believes that a person has a severe substance addiction may apply to the Director of Area Addiction Services to have the person assessed. |
| **ASSESSMENT** | **Section 22** |
| | An approved specialist assesses whether a person has a severe substance addiction.<br><br>If the approved specialist considers that the person has a severe substance addiction, they must then assess whether that person's capacity to make informed decisions about treatment has been severely impaired. |
| **CERTIFICATION** | **Section 23** |
| | After assessment, if the approved specialist considers that the person meets the criteria for compulsory treatment, they sign a compulsory treatment certificate. The person is detained at a health care service for a period of stabilisation while arrangements are made to admit them to a treatment centre. |
| **TREATMENT PLAN** | **Section 29** |
| | The responsible clinician must prepare a treatment plan for the patient, arrange for the patient to be admitted into a treatment centre and apply to the court for a review of the compulsory status of the patient. |
| **DETENTION** | **Section 30** |
| | The responsible clinician must direct that the patient be detained and treated in a treatment centre. The primary treatment centre is Nova Supported Treatment and Recovery (Nova STAR) in Christchurch. |
| **REVIEW** | **Section 32** |
| | The court reviews the compulsory status of the patient. If the judge is satisfied the patient meets the criteria for compulsory treatment, they can make a compulsory treatment order, which lasts 56 days. These orders may be extended for a further 56 days. |

Statutory roles within this process ensure that health professionals: involve family and whānau; help the person to engage in voluntary treatment; and take a mana-enhancing approach. These roles include authorised officers, approved specialists, responsible clinicians, Directors of Area Addiction Services and district inspectors.

For more information about the Substance Addiction Act and these roles, visit the Ministry of Health website (www.health.govt.nz) and search for 'SACAT resources'.

***Nova Trust***

Nova Trust is the primary approved provider of treatment for people detained under the Substance Addiction Act. The Trust operates a nine-bed inpatient unit in Christchurch, Nova STAR, which offers medical care, cognitive assessments, remediation interventions, occupational therapy and relapse prevention support. Health care services can apply to be an approved provider if they meet certain criteria under section 92 of the Substance Addiction Act.

**Commented [HR43]:** This data is required but this section can likely be significantly condensed

***Statutory reporting***

Section 119 of the Substance Addiction Act requires the Ministry to publish all of the following information:

- the number of people who were detained under the Substance Addiction Act
- the length of their detention
- the number of compulsory treatment orders made
- the number of compulsory treatment orders extended
- the number of discharged patients who chose to have voluntary residential treatment and outpatient services.

Because the Substance Addiction Act was only introduced in 2018, this report may contain minor data discrepancies. In future reports, we aim to have strengthened the data reporting process.

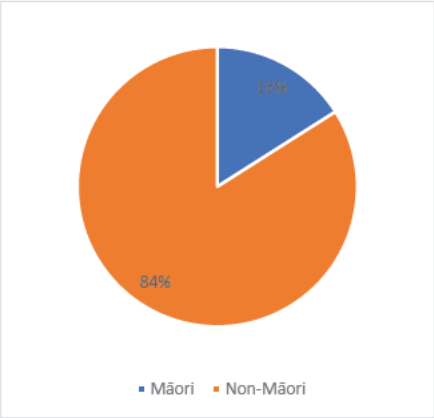
In 2018, 25 people were detained under the Substance Addiction Act.[48] This report interprets 'detained' to mean an approved specialist has signed a compulsory treatment certificate for the person. It is important to note that 'detention' may not solely refer to treatment at Nova STAR. After an approved specialist has signed a compulsory treatment certificate, most patients first need detention in a medical ward or a specialist withdrawal management ward for a period of stabilisation because of their severe physical health needs (Ministry of Health 2017, p 17).

Among those subject to compulsory treatment certificates, 12 were women and 13 were men.[49] They tended to be in older age groups, with 60 percent over 50 years old. The most

[48] PRIMD data, extracted 12 September 2019.
[49] PRIMD data, extracted 12 September 2019.

common ethnic group in this cohort was New Zealand European.[50] Nearly half of all patients with compulsory treatment certificates were referred from DHBs in the greater Auckland region (Auckland, Waitematā and Counties Manukau).[51] In 2018, the courts made 15 compulsory treatment orders and extended 10 compulsory treatment orders.

**Figure 41: Percentage of patients subject to compulsory treatment certificates, by ethnicity, 1 January to 31 December 2018**

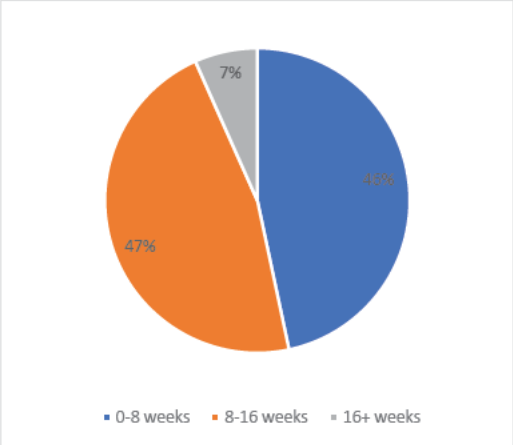



Source: PRIMHD data, extracted 12 September 2019.

The average length of detention was seven weeks and four days. Among these patients, 46 percent were detained for a period of less than eight weeks, which is within the first period of compulsory treatment set out in the Act. Another 47 percent of patients were detained for a period of between 8 and 16 weeks, requiring a compulsory treatment order extension. Seven percent of patients were detained for a period of longer than 16 weeks (see Figure 42).

[50] PRIMD data, extracted 12 September 2019.
[51] PRIMD data, extracted 12 September 2019.

**Figure 42: Percentage of patients subject to compulsory treatment certificates, by number of weeks in detention, 2018**




Source: PRIMHD data, extracted 12 September 2019.

Section 43 of the Substance Addiction Act describes the threshold for release from compulsory status. The responsible clinician must order the release of a patient if the responsible clinician is satisfied that the patient no longer meets the criter a for compulsory treatment or that no useful purpose would be served by continui g with compulsory treatment of the patient. Section 43 does not use the term d scharge'. However, we use it in this report to mean that a patient is no longer under a compulsory treatment certificate, compulsory treatment order or compulsory treatment order extension.

PRIMHD records show that in 2018, among servi e users who were discharged from the Substance Addiction Act:

- 36 percent received additional inpatient care[52]
- 64 percent engaged with individual treatments in outpatient services
- 44 percent had family meetings arranged
- 36 percent had Supplementary Consumer Records
- 25 percent had wellness plans.[53]

Note that this data represents the 2018 calendar year. If a service user was discharged in late December, they are unlikely to have had enough time to engage with outpatient services during the repo ting period. For this reason, it may be difficult to draw meaningful conclusions about a service user's recovery journey from the information above.

[52] PRIMHD data, prepared 30 October 2019.
[53] PRIMHD data, prepared 20 November 2019.

Additionally, data from PRIMHD is only able to measure mental health outcomes, so these results may not fully encompass other sources of support for people recovering from severe substance addiction – for example, support for access to housing.

### Land Transport Act 1998

In 2018, the Office continued to work with the New Zealand Transport Agency (NZTA), Ministry of Transport and dapaanz to monitor the reinstatement of drivers disqualified for offences involving alcohol or drugs and to approve assessment centres as stated under section 65A. Section 65 of the Land Transport Act 1998 provides for the mandatory indefinite disqualification of drivers' licences and assessment for repeat driving offenders involving drugs or alcohol. For a licence to be reinstated, the person must attend an approved assessment centre and undergo an assessment of how well they are managing their substance use or addictive behaviour issues. The assessment centres send copies of their reports to NZTA, which decides whether to reinstate the person's licence.

The Director-General of Health approves assessment centres. Establishments and individuals applying to be an approved assessment centre must demonstrate that they are competent in assessing alcohol and other drug problems, and are a registered and experienced alcohol and drug practitioner.

### Opioid substitution treatment

Opioid dependence is a complex, relapsing condition requiring a model of treatment and care much like any other chronic health problem. Opioid substitution treatment (OST) helps people with opioid dependence to access treatment, including substitution therapy, that provides them with the opportunity to recover their health and wellbeing.

Specialist OST services are specified by the Minister of Health under section 24 of the Misuse of Drugs Act 1975, and notified in the *New Zealand Gazette*. OST services in New Zealand are expected to provide a standardised approach underpinned by concepts of person-, family- and whānau-centred treatment, recovery, wellbeing and citizenship. To help services take this approach, *New Zealand Practice Guidelines for Opioid Substitution Treatment* (Ministry of Health 2014a) provides clinical and procedural guidance for specialist services and primary care providers who deliver OST.

In 2018:

- 5,573 people received OST
- 80.4 percent of these people were New Zealand European, 14.9 percent were Māori, 1.3 percent were Pacific peoples and 3.3 percent were of another ethnicity
- 61.7 percent of clients receiving OST were over 45 years old

- 27.3 percent of people receiving OST were being treated by a general practitioner in a shared-care arrangement.[54]

The Medical Officer of Health, acting under delegated authority from the Minister of Health, designates specialist services and lead clinicians to provide treatment with controlled drugs to people who are dependent on controlled drugs, according to section 24A(7)(b) of the Misuse of Drugs Act 1975. For this purpose, the Officer undertakes site visits, focusing on building relationships and improving service quality. These services are also subject to a Ministry audit every three years, through the *Specialist Opioid Substitution Treatment Service Audit and Review Tool* (Ministry of Health 2014b).

***Service providers***

Three types of providers undertake OST services.

**Specialist services**. Specialist OST services are the entry point for nearly all people requiring treatment with controlled drugs. Specialist OST services will comprehensively assess the needs of clients, provide specialist interventions and stabilise clients. This creates a pathway for recovery planning, referrals for co-existing health needs and social support, and eventually the transfer of treatment to a primary health provider or withdrawal from treatment altogether.

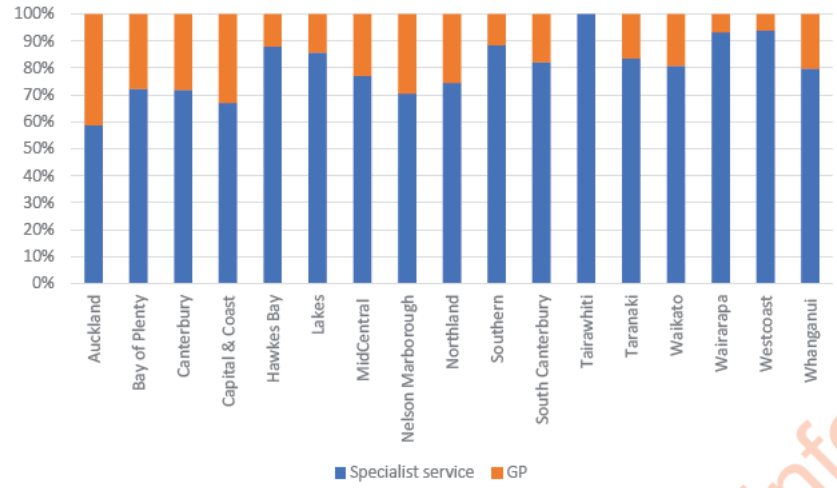
**Primary health**. Specialist addiction services work together with primary health care. This approach allows specialist services to focus on clients with the highest need and normalises the treatment process. In 2018, 27.3 percent of clients receiving OST had that treatment from their general practitioner. The Ministry's target for service provision is 50:50 between primary and specialist health care services. Figure 43 presents the percentage of people receiving OST from specialist services and general practice in each DHB in 2018.

**Department of Corrections**. When a person receiving OST goes to prison, the Department of Corrections ensures that the person continues to receive OST services, including psychosocial support and treatment from specialist services. In 2018, 1.3 percent of clients receiving OST had that treatment from the Department of Corrections. Service providers and the Department of Corrections are also working together to initiate OST as appropriate for people who are imprisoned

Figure 44 shows the number of people receiving OST from each of these types of providers each year from 2008 to 2018.

[54] Data provided by OST services in six-monthly reports. These six-monthly reports do not collect data by National Health Index (NHI) numbers. The New Zealand total is a sum of the DHB figures and so it double-counts people who had services from more than one DHB.

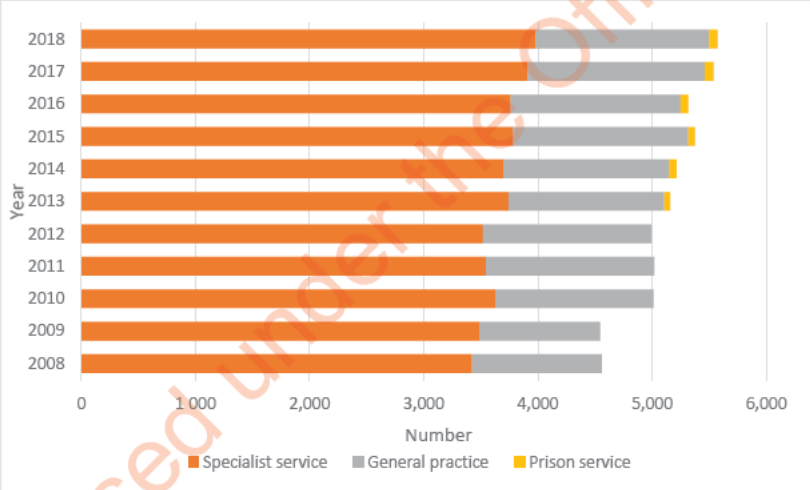
**Figure 43: Percentage of people receiving opioid substitution treatment from specialist services and general practice, by DHB, 1 January to 31 December 2018**




Note: GP = general practitioner.

Source: Data provided by OST services in six-monthly reports.

**Figure 44: Number of people receiving opioid substitution treatment from a specialist service, general practice or prison service, 2008–2018**




Note: Data for clients seen in prison collected from July 2013.

Source: Data provided by OST services in six-monthly reports.

***Prescribing opioid treatments***

Replacing addictive substances like opioids with prescribed drugs is called pharmacotherapy. The purpose of this treatment is to stabilise the opioid user's life and reduce harms related to drug use, such as the risk of overdose, blood-borne virus transmission and substance-related criminal activity.

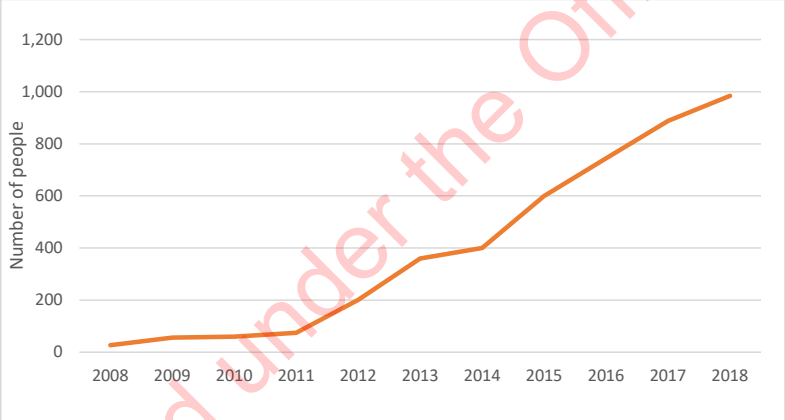
The two types of pharmacotherapy are:

1. maintenance therapy – using opioid substitutes for the purpose of remaining on a stable dose
2. detox – using opioid substitutes for the purpose of gradually withdrawing from the substitute so the client is free of all opioid substances.

Methadone has historically been the main opioid substitution treatment available. Clients need a daily dose, which in turn makes it necessary to place limits on prescribing and dispensing.

In 2012, PHARMAC began funding a buprenorphine-naloxone (suboxone) combination. Suboxone can be administered in cumulative doses that last several days, which reduces the risk of drug diversion and offers clients more normality in their lives. Figure 45 p esents the number of people prescribed suboxone from 2008 to 2018. In 2018, 17.7 percent of clients were prescribed suboxone.

**Figure 45: Number of people prescribed suboxone, 2008–2018**



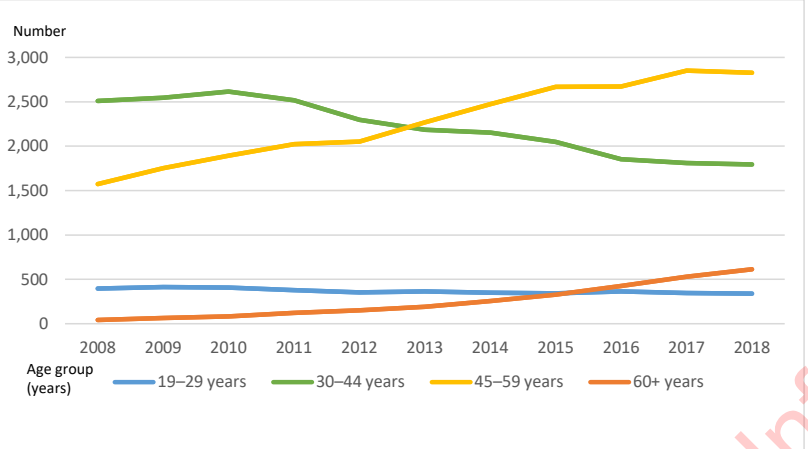

Source: Data provided by OST services in July to December six-monthly reports.

***The ageing population of OST clients***

OST clients are an ageing population; Figure 46 shows how clients in older age groups have been increasing in number from 2008 to 2018 to the point that those over 45 years of age are now the most likely to be receiving treatment. In 2018, 61.7 percent of clients were over

45 years old, and only one service had less than half of its clients over 45 years old. Treating an ageing population also brings with it more health complications.

**Figure 46: Number of opioid substitution treatment clients, by age group, 2008–2018**




Source: Data provided by OST services in July to December six-monthly reports.

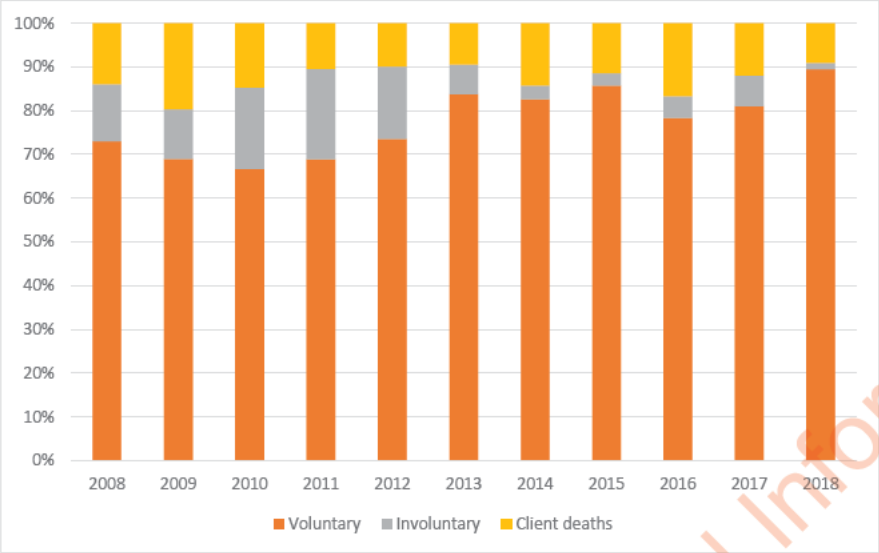
***Exit from OST***

In 2018, 403 people voluntarily withdrew from OST, which accounts for 90 percent of all people who exited from OST that year. Seven withdrawals (2 percent of all withdrawals) were involuntary. Involuntary withdrawals are the result of behavioural risks that jeopardise the safety of the client or others.

In 2018, 43 people receiving OST died. A small proportion of these people died of a suspected overdose. When a client dies of a suspected overdose, the Ministry requires services to conduct an incident review and report it to the Medical Officer of Health. The remaining deaths had a range of other causes, such as cancer and cardiovascular disease.

Figure 47 gives an overview of the reasons for withdrawal (voluntary, involuntary or death) over time, from 2008 to 2018.

**Figure 47: Percentage of withdrawals from opioid substitution treatment programmes, by reason (voluntary, involuntary or death), 2008–2018**




Source: Data provided by OST services from the sum of January to June and July to December six-monthly reports.

## Electroconvulsive therapy

Commented [HR44]: I know we get asked about the use of ECT so worth continuing to provide some data, but should consider whether DHB breakdowns are appropriate to continue

Electroconvulsive therapy (ECT) is a therapeutic procedure that delivers a brief pulse of electricity to a person's brain in order to produce a seizure. It can be an effective treatment for depression, mania, catatonia and other serious neuropsychiatric conditions. It is often effective as a last resort in cases where medication is contraindicated or is not relieving symptoms sufficiently. It can only be given with the consent of the person receiving it, other than in certain carefully defined circumstances.

In 2018:

- 265 people received ECT (5.4 people per 100,000)
- services administered a total of 2,990 treatments of ECT
- those treated received an average of 11.3 administrations of ECT over the year
- females were more likely to receive ECT than males, making up 61 percent of ECT patients
- older people were more likely to receive ECT than younger people, with those over 50 years old making up 61 percent of ECT patients.

Medical staff administer ECT under anaesthesia in an operating theatre, making use of muscle relaxants. The person who has received ECT wakes unable to recall the details of the

procedure. The most common side effects of ECT are confusion, disorientation and memory loss. Confusion and disorientation typically clear within an hour, but memory loss can be persistent and in some cases even permanent (American Psychiatric Association 2001; Ministry of Health 2004).

Significant advances have been made in improving ECT techniques and reducing side effects over the last 20 years. Seven out of 10 patients receiving ECT achieve complete remission (Ministry of Health 2009). Despite these improvements, ECT remains a controversial treatment. In 2003, in response to petition 1999/30 of Anna de Jonge and others about ECT, the Health Committee recommended carrying out an independent review on the safety and efficacy of ECT and the adequacy of regulatory controls on its use in New Zealand. The review concluded that ECT continues to have a place as a treatment option for consumers of mental health services in New Zealand, and that banning its use would deprive some seriously ill people of a potentially effective and sometimes life-saving means of treatment (Ministry of Health 2004).

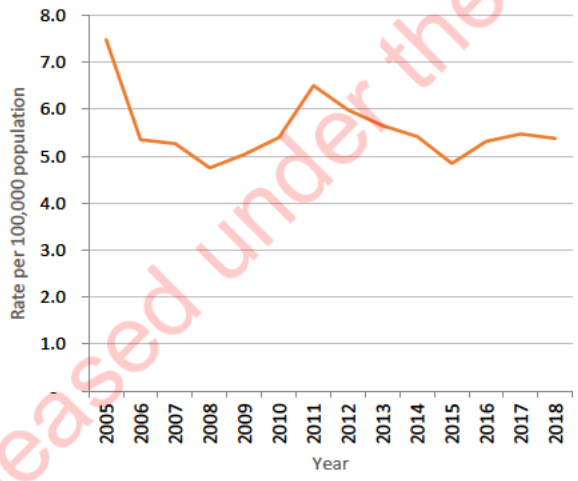
For more information about ECT use in New Zealand, we recommend *Electroconvulsive Therapy (ECT) in New Zealand: What you and your family and whānau need to know* (Ministry of Health 2009).

### ECT treatments in 2018

The number of people treated with ECT in New Zealand has remained relatively stable since 2006. Around 200 to 300 people receive the treatment each year  During 2018, 265 people received ECT, which is a rate of 5.4 people per 100,000 population (see Figure 48).

**Figure 48: Rate of people treated with electroconvulsive therapy per 100,000 population, 2005–2018**

Commented [HR45]: Add 2019?



Source: PRIMHD data, extracted on 29 July 2019, except for Lakes, MidCentral Nelson Marlborough, Southern and Waitematā DHBs, which submitted data manually.

## ECT by region

In 2018, services administered a total of 2,990 ECT treatments. The number and rate of ECT treatments vary regionally (see Table 19 and Figure 49). In interpreting these differences, it is important to consider several factors that help to explain these variations. First, regions with smaller populations are more vulnerable to annual variations (according to the needs of the population at any given time). In addition, people receiving continuous or maintenance treatment will typically receive more treatments in a year than those treated with an acute course. Finally, populations in some DHBs have better access to ECT services than others.

**Table 19: Electroconvulsive therapy indicators, by DHB of domicile, 1 January to 31 December 2018**

| DHB of domicile | Number of people treated with ECT | Number of treatments | Mean number of treatments per person (range) |
|---|---|---|---|
| Auckland | 20 | 265 | 13 (2–31) |
| Bay of Plenty | 13 | 225 | 17 (5–56) |
| Canterbury | 21 | 230 | 11 (3–30) |
| Capital & Coast | 27 | 254 | 9 (1–33) |
| Counties Manukau | 25 | 274 | 11 (1–45) |
| Hawke's Bay | 7 | 27 | 4 (1–7) |
| Hutt Valley | 17 | 149 | 9 (1–22) |
| Lakes | 5 | 34 | 7 (1–19) |
| MidCentral | 9 | 124 | 14 (2,38) |
| Nelson Marlborough | 4 | 36 | 9 (1–12) |
| Northland | 13 | 150 | 12 (1–25) |
| South Canterbury | 0 | 0 | 0 |
| Southern | 36 | 425 | 12 (1–49) |
| Tairāwhiti | 1 | 6 | 6 (6–6) |
| Taranaki | 3 | 27 | 9 (6–15) |
| Waikato | 38 | 522 | 14 (2–46) |
| Wairarapa | 0 | 0 | 0 |
| Waitematā | 27 | 236 | 9 (1–26) |
| West Coast | 1 | 6 | 6 (6–6) |
| Whanganui | 0 | 0 | 0 |
| **New Zealand total** | **265** | **2,990** | **11 (1–56)** |

Notes: In 2018, 20 people were treated out of area, as follows.

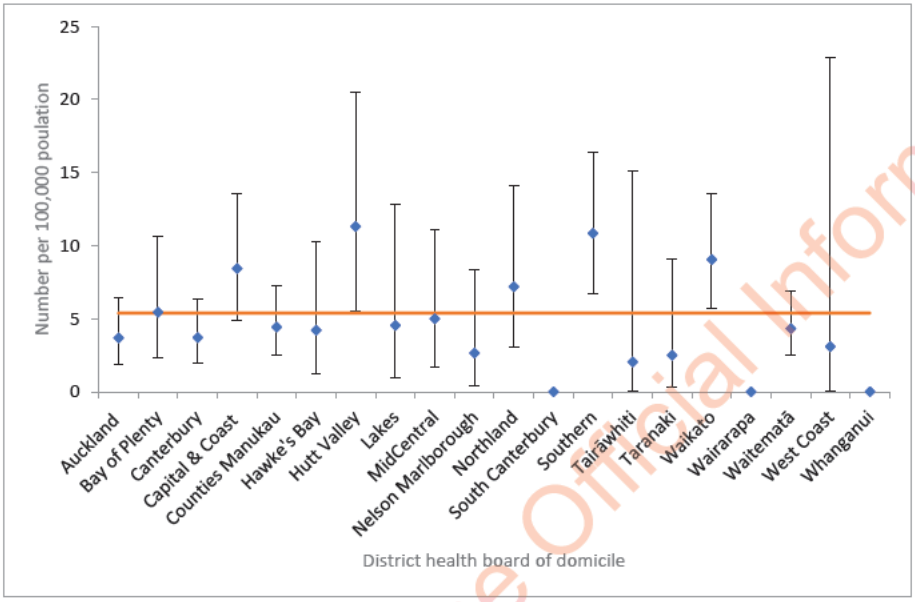
- Auckland DHB saw one person from Bay of Plenty DHB, one person from Counties Manukau DHB and three from Waitematā DHB.
- Bay of Plenty DHB saw one person from Tairāwhiti DHB.
- Canterbury DHB saw one person from West Coast DHB.

Commented [HR46]: Consider emoving

- Capital & Coast DHB saw five people from Hutt Valley DHB.
- Counties Manukau DHB saw three people from Auckland DHB.
- Hutt Valley DHB saw one person from Capital & Coast DHB.
- Lakes DHB saw two people from Taranaki DHB.
- Waikato DHB saw one person from Taranaki DHB.
- Waitematā DHB saw one person from Waikato DHB.

Source: PRIMHD data, extracted on 22 May 2019, except for Lakes, MidCentral, Nelson Marlborough, Southern and Waitematā DHBs, which submitted data manually.

**Figure 49: Number of people who received electroconvulsive therapy per 100,000 population, by DHB of domicile, 1 January to 31 December 2018**




Notes: As the numbers of people receiving ECT by DHB are so small, it is difficult to make meaningful comparisons between DHBs using rates per 100,000 population.

This graph uses confidence intervals (for 99 perce t confidence) to help in interpreting the data. Where a DHB region's confidence interval crosses the national average, his means the DHB's rate was not statistically significantly different from the national average.

Source: PRIMHD data, extracted on 29 July 20 9, except for Lakes, MidCentral, Nelson Marlborough, Southern and Waitematā DHBs, which submitted d m ually.

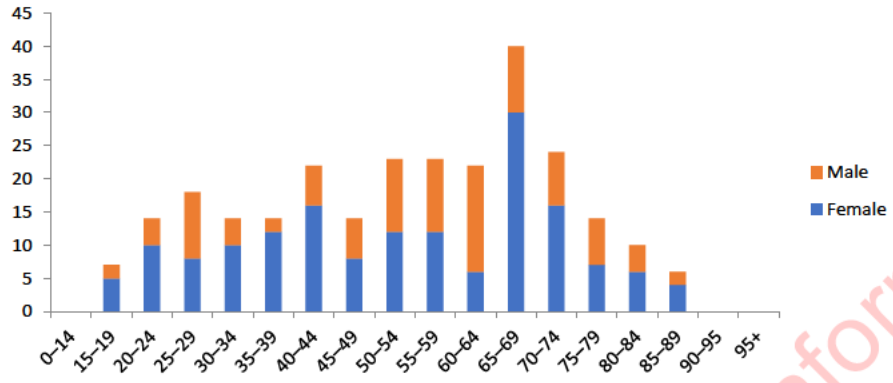
### Sex and age of people receiving ECT

In 2018, women were more likely to receive ECT than men, representing 61 percent of patients. The main reason for this difference is that more females present to mental health services with dep essive disorders, one of the conditions that is responsive to ECT. This ratio is similar to that reported in other countries.

Olde people were more likely to receive ECT than younger people, with patients over 50 yea s old representing 61 percent of all patients (see Figure 50). A likely explanation is that medications used to treat severe depression might interact adversely with medications for

physical illnesses that are more prevalent in older people, like heart disease. Therefore ECT may be a suitable alternative treatment.

**Figure 50: Number of people treated with electroconvulsive therapy, by age group and sex, 1 January to 31 December 2018**




Source: PRIMHD data, extracted on 29 July 2019, except for Lakes, MidCentral, Nelson Marlborough, Southern and Waitematā DHBs, which submitted data manually.

### Ethnicity of people treated with electroconvulsive therapy

Table 20 indicates that Asian, Māori and Pacific peoples are less likely to receive ECT than those of other ethnicities, such as New Zealand European. However, the numbers involved are so small that it is not statistically appropriate to compare the percentages of people receiving ECT in each ethnic group with the proportion of each ethnic group in the total population of New Zealand.

**Table 20: Number of people treated with electroconvulsive therapy, by ethnicity, 1 January to 31 December 2018**

| Ethnicity | Number |
|---|---|
| Asian | 21 |
| Māori | 33 |
| Pacific | 8 |
| Other | 203 |
| **Total** | **265** |

Source: PRIMHD data, extracted on 29 July 2019, except for Lakes, MidCentral, Nelson Marlborough, Southern and Waitematā DHBs, which submitted data manually.

### Consent to treatment

Under the Mental Health Act, a person can be treated with ECT if they consent in writing, or if an independent psychiatrist appointed by the Mental Health Review Tribunal considers this treatment to be in the person's interests. An independent psychiatrist cannot be the patient's responsible clinician or part of the patient's clinical team.

**Commented [HR47]:** Suggest keeping the sum total information reflected in the text below as I know there is interest in this data, but not broken down by DHB (although we should continue to monitor DHB numbers internally)

An example of a patient too unwell to consent is someone experiencing a catatonic stupor in which they withdraw from necessary activities of life including moving, eating and drinking and may not have capacity to consent. In such cases, DHBs get second opinions from independent psychiatrists to safeguard the patient's treatment. Independent psychiatrists should decide whether ECT is in the interests of the person after discussing the options with family and whānau and considering any relevant advance directives the person has made (see Ministry of Health 2012d).

During 2018, services administered ECT to 99 people who could not consent to treatment. The total number of ECT treatments administered without consent was 1,024, a slight decrease from 1,137 treatments in 2017. An additional 23 treatments were administered to two people who did have capacity to consent but refused, after the DHB gained a second opinion.

Table 21 shows the number of treatments administered without consent during 2018.

**Table 21: Electroconvulsive therapy administered under second opinion without consent, by DHB of service, 1 January to 31 December 2018**

| DHB of service | Second opinion where patient did not have the capacity to consent | | Second opinion where patient had capacity and refused to consent | |
|---|---|---|---|---|
| | Number of people given ECT | Number of treatments administered | Number of people given ECT | Number of treatments administered |
| Auckland | 11 | 97 | 0 | 0 |
| Bay of Plenty | 2 | 24 | 0 | 0 |
| Canterbury | 10 | 118 | 2 | 23 |
| Capital & Coast | 5 | 49 | 0 | 0 |
| Counties Manukau | 14 | 146 | 0 | 0 |
| Hawke's Bay | 1 | 22 | 0 | 0 |
| Hutt Valley | 7 | 42 | 0 | 0 |
| Lakes | 0 | 0 | 0 | 0 |
| MidCentral | 4 | 65 | 0 | 0 |
| Nelson Marlborough | 0 | 0 | 0 | 0 |
| Northland | 5 | 49 | 0 | 0 |
| South Canterbury | 0 | 0 | 0 | 0 |
| Southern | 10 | 140 | 0 | 0 |
| Tairāwhiti | 0 | 0 | 0 | 0 |
| Taranaki | 0 | 0 | 0 | 0 |
| Waikato | 14 | 178 | 0 | 0 |
| Wairarapa | – | – | – | – |
| Waitematā | 16 | 94 | 0 | 0 |
| West Coast | – | – | – | – |

| | | | | |
|---|---|---|---|---|
| Whanganui | – | – | – | – |
| **New Zealand total** | **99** | **1,024** | **2** | **23** |

Notes: The data in this table cannot be reliably compared with the data in Table 19, as it relates to DHB of service rather than DHB of domicile.

A dash ( ) indicates the DHB does not perform ECT and instead sends people to other DHBs for treatment.

Source: Manual data from all DHBs.

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# Appendix 1: Key databases and caveats

### The Programme for the Integration of Mental Health Data

The Programme for the Integration of Mental Health Data, or PRIMHD (pronounced 'primed'), is the Ministry of Health's national collection for mental health and addiction service data. PRIMHD data reporting collects information about the types of services provided by DHBs and NGOs, the engagement of service users and the outcomes for service users in their care. These reports enable mental health and addiction service providers to carry out better service planning and decision-making at the local, regional and national levels (Ministry of Health 2019).

Since 2008 it has been mandatory for all 20 DHBs to report to PRIMHD. An increasing number of NGO service providers – 204 as of December 2018 – also voluntarily report to PRIMHD.

Due to the enormous complexities of creating and maintaining a national data collection, keep in mind the following caveats when reviewing statistics generated using PRIMHD data.

- Shifts or patterns in the data after 2008 may reflect how service providers have been gradually adapting to the PRIMHD system, in addition to, or i stead of, showing any trend in mental health service use or consumer outcomes
- PRIMHD is a living data collection that continues to be revised and updated as data reporting processes are improved. For this reason, previously published data may be amended later.
- Statistical variance between services may reflect different models of practice and different consumer populations. Howeve it may also result from differences in data entry processes and information management.
- For PRIMHD to function as a national collection, it is necessary to integrate a wide range of person management systems ac oss hundreds of unique service providers. As these services adjust to reporting to PRIMHD, we expect that the quality of the data will improve.
- For high-quality, accurate statistical reporting, the services that report to PRIMHD must be consistent, orrect and timely in their data entry. The Ministry is actively engaged in ongoing work to eview and improve the data quality of PRIMHD. It considers this work to be a p io ity given the importance of mental health data in providing information about mental health service users and outcomes, and in generating conversations and publ c debate about how to improve mental health care for New Zealanders.

To demonstrate how much data can vary over time, Table A1 presents the rate ratio of Māori to non-Māori who were subject to a compulsory treatment order (section 29) under the Mental Health Act from 2013 to 2018.

**Table A1: Rate ratio Māori to non-Māori subject to a compulsory treatment order (section 29) under the Mental Health Act, 2013–2018**

| Year | Rate ratio (Māori:non-Māori) | | | | | |
|---|---|---|---|---|---|---|
| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual reports | 2.9 | 2.9 | 3.6 | 3.6 | 3.9 | 4.0 |
| Retrospective extraction | 3.6 | 3.8 | 3.9 | 3.9 | 4.0 | 4.0 |

Source: PRIMHD data, extracted on 1 August 2019.

From the data in our 2013 to 2018 annual reports, it appears the rate ratio between Māori and non-Māori has increased by just over 1 point. However, this change may be explained by differing sources of information about ethnicity. PRIMHD reporting uses the ethnicity recorded against a person's National Health Index (NHI) number, rather than the ethnicity recorded against the person at the time of the event. Therefore, people who have subsequently recorded Māori as an additional ethnicity on their NHI when previously they just recorded New Zealand European will be recorded as Māori on all ethnicity reports extracted after that change was made. This happens constantly as people engage more with health services and more information is collected. In 2017, ethnicity was taken from primary health organisation records and combined with the NHI – resulting in approximately 10,000 additional people categorised as Māori nationwide.

For more information on PRIMHD, the following resou ces may be helpful:

- For the sector: Ministry of Health. 2015. *Guide to PRIMHD Activity Collection and Use* (Version 1.0). Wellington: Ministry of Health.
- For consumers: Ministry of Health. 2016. What happens to your mental health and addiction information? Wellington: Ministry of Health.

The data for this report that has been sourced from PRIMHD has been retrieved over a range of dates from 2019 to 2020

### The Alcohol and Drug Outcome Measure

In July 2015, the Alcohol and Drug Outcome Measure (ADOM) was mandated for use in community outpatient settings. ADOM measures alcohol and drug use, as well as lifestyle, wellbeing and ecovery outcomes. Examples of outcomes it collects data on include:

- num er of days of AOD use
- AOD impact on relationships with family and friends
- AOD impact on criminal activity.

This data is useful to gain a broader understanding of patients' progress through outpatient care.

In 2018, 14 DHBs reported ADOM data to PRIMHD. Some DHBs do not collect ADOM data because they do not offer AOD services. Among NGO services, 49 reported ADOM data.

For more information about ADOM information collected by PRIMHD, we recommend reading the resources available on the website of Te Pou o te Whakaaro Nui (https://www.tepou.co.nz).

# Appendix 2: Additional statistics

### The Mental Health Review Tribunal

During the year ended 30 June 2018, the Mental Health Review Tribunal (the Tribunal) received 131 applications under the Mental Health Act. Table A2 presents the types of applications received (by governing section of the Act) and the outcomes of these applications.

**Table A2: Outcome of the Mental Health Act applications received by the Mental Health Review Tribunal, 1 July 2017 to 30 June 2018**

| Outcome | Section 79 | Section 80 | Section 81 | Section 75 | Total |
|---|---|---|---|---|---|
| Deemed ineligible | 0 | 0 | 0 | 0 | 0 |
| Withdrawn | 55 | 2 | 0 | 0 | 57 |
| Held over to the next report year | 0 | 0 | 0 | 0 | 0 |
| Heard in the report year | 64 | 9 | 0 | 1 | 74 |
| **Total** | **119** | **11** | **0** | **1** | **131** |

Source: Annual report of the Mental Health Review Tribunal, 1 July 2017 to 30 June 2018.

During the year ended 30 June 2018, the Tribunal heard 64 applications under section 79 of the Mental Health Act. Table A3 presents the results of those cases.

**Table A3: Results of inquiries under section 79 of the Mental Health Act held by the Mental Health Review Tribunal, 1 July 2017 to 30 June 2018**

| Result | Number |
|---|---|
| Not fit to be released from compulsory status | 58 |
| Fit to be released from compulsory status | 5 |
| **Total** | **63** |

Note: Number of results does not always match the number of applications heard under section 79 as decisions may be reserved until a date outside of the reporting time frame.

Source: Annual report of the Mental Health Review Tribunal, 1 July 2017 to 30 June 2018.

Table A4 shows the ethnicity for 109 people whose application to the Tribunal identified their ethnicity (83 percent of applications) in the year ended 30 June 2018. A person is not required to disclose their ethnicity on their application.

**Table A4: Number and percentage of people in Mental Health Review Tribunal applications, by ethnicity, 1 July 2017 to 30 June 2018**

| Ethnicity | Number | Percentage |
|---|---|---|
| New Zealand European | 68 | 51.9 |
| Māori | 18 | 13.7 |
| Pacific | 7 | 5.3 |

| | | |
|---|---|---|
| African | 6 | 4.6 |
| Asian | 5 | 3.8 |
| Other | 5 | 3.8 |
| Unknown | 22 | 16.8 |
| **Total** | **131** | **100** |

Source: Annual report of the Mental Health Review Tribunal, 1 July 2017 to 30 June 2018.

Of the 131 Mental Health Act applications the Tribunal received during the year ended 30 June 2018, 83 (63.3 percent) were from males and 48 (36.6 percent) from females. Table A5 presents these figures broken down by the subject of the application.

**Table A5: Sex of people making Mental Health Review Tribunal applications, 1 July 2017 to 30 June 2018**

| Subject of application | Total number (percentage) | Sex | Number |
|---|---|---|---|
| Community treatment order | 91 (69.5%) | Female | 38 |
| | | Male | 53 |
| Inpatient treatment order | 29 (22.1%) | Female | 6 |
| | | Male | 23 |
| Special patient order | 11 (8.4%) | Female | 4 |
| | | Male | 7 |
| Restricted person order | 0 (0%) | Female | 0 |
| | | Male | 0 |

Source: Annual report of the Mental Health Review Tribunal, 1 July 20 7 to 30 June 2018.

Under the Mental Health Act, the Tribunal must hear applications within 21 days, or 28 days with an extension. However, due to scheduling issues among the small number of Tribunal appointees based throughout the country meeting this requirement has proved difficult. From July 2016, the Tribunal has increased its effort to address delays in hearing applications. By the final quarter of the year ended 30 June 2018, the Tribunal was hearing 91 percent of applications within 28 days see Table A6).

**Table A6: Timeliness of applications heard by the Mental Health Review Tribunal, July 2016 to June 2018**

| Report quarter | Total number of applications | Number of withdrawn applications | Number of applications to be heard | Number of applications heard within 28 days | Percentage of applications heard within 28 days |
|---|---|---|---|---|---|
| 31 Jul 2016 – 30 Sep 2016 | 34 | 17 | 17 | 7 | 41 |
| 1 Oct 20 6 – 31 Dec 2016 | 23 | 10 | 13 | 8 | 62 |
| 1 Jan 2017 – 31 Mar 2017 | 40 | 23 | 17 | 11 | 65 |
| 1 Apr 2017 – 30 Jun 2017 | 42 | 17 | 25 | 19 | 76 |
| 31 Jul 2017 – 30 Sep 2017 | 37 | 12 | 25 | 23 | 92 |

| | | | | | |
|---|---|---|---|---|---|
| 1 Oct 2017 – 31 Dec 2017 | 41 | 15 | 26 | 19 | 73 |
| 1 Jan 2018 – 31 Mar 2018 | 36 | 16 | 19 | 17 | 89 |
| 1 Apr 2018 – 30 Jun 2018 | 40 | 15 | 22 | 20 | 91 |

Source: Annual report of the Mental Health Review Tribunal, 1 July 2017 to 30 June 2018.

### Ministry of Justice

Table A7 presents data on applications for a compulsory treatment order from 2004 to 2018. Table A8 shows the types of orders granted over the same period.

**Table A7: Applications for compulsory treatment orders or extensions, 2004–2018**

| Year | Number of applications for a CTO, or extension to a CTO | Number of applications granted or granted with consent | Number of applications dismissed or struck out | Number of applications withdrawn, lapsed or discontinued | Number of applications transferred to the High Court |
|---|---|---|---|---|---|
| 2004 | 4,443 | 3,863 | 100 | 460 | 0 |
| 2005 | 4,298 | 3,682 | 100 | 520 | 0 |
| 2006 | 4,254 | 3,643 | 109 | 515 | 1 |
| 2007 | 4,535 | 3,916 | 99 | 542 | 0 |
| 2008 | 4,633 | 3,969 | 103 | 486 | 0 |
| 2009 | 4,564 | 4,039 | 54 | 494 | 0 |
| 2010 | 4,783 | 4,156 | 74 | 523 | 1 |
| 2011 | 4,781 | 4,215 | 70 | 5 6 | 0 |
| 2012 | 4,885 | 4,343 | 71 | 443 | 0 |
| 2013 | 5,062 | 4,607 | 68 | 411 | 0 |
| 2014 | 5,227 | 4,632 | 47 | 577 | 0 |
| 2015 | 5,368 | 4,748 | 52 | 550 | 0 |
| 2016 | 5,601 | 4,927 | 70 | 549 | 0 |
| 2017 | 5,566 | 4,940 | 69 | 583 | 0 |
| 2018 | 5,646 | 5,002 | 77 | 542 | 0 |

Notes: CTO = compulsory treatment order. The table presents applications that had been processed at the time of data extraction on 24 June 2019. The yea is det mined by the final outcome date.

The case management system (CMS) is a live operational database. Figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System, which uses data entered into the CMS.

**Table A8: Types of compulsory treatment orders made on granted applications, 2004–2018**

| Year | Number of granted applications for orders | Number of community CTOs or extensions | Number of inpatient CTOs or extensions | Number of orders recorded as both community and inpatient CTOs or extension | Number of other orders | Number of applications where type of order was not recorded |
|---|---|---|---|---|---|---|
| 2004 | 3,863 | 1,831 | 1,533 | 119 | 12 | 368 |
| 2005 | 3,682 | 1,575 | 1,438 | 93 | 10 | 566 |
| 2006 | 3,643 | 1,614 | 1,384 | 91 | 14 | 540 |
| 2007 | 3,916 | 1,714 | 1,336 | 118 | 24 | 724 |
| 2008 | 3,969 | 1,841 | 1,431 | 120 | 13 | 564 |
| 2009 | 4,039 | 2,085 | 1,565 | 106 | 15 | 268 |
| 2010 | 4,156 | 2,252 | 1,624 | 113 | 9 | 158 |
| 2011 | 4,215 | 2,255 | 1,677 | 90 | 8 | 185 |
| 2012 | 4,343 | 2,436 | 1,684 | 80 | 4 | 139 |
| 2013 | 4,607 | 2,639 | 1,765 | 73 | 1 | 129 |
| 2014 | 4,632 | 2,658 | 1,784 | 84 | 1 | 105 |
| 2015 | 4,748 | 2,801 | 1,787 | 70 | 1 | 89 |
| 2016 | 4,927 | 2,894 | 1,722 | 66 | 3 | 242 |
| 2017 | 4,940 | 2,612 | 1,691 | 57 | 3 | 577 |
| 2018 | 5,002 | 2,633 | 1,753 | 46 | 3 | 567 |

Notes: CTO = compulsory treatment order. The table presents applications that had been processed at the time of data extraction on 24 June 2019. The year is determined by the date the application was granted.

Where more than one type of order is shown, it is likely to be because new orders are being linked to a previous application in the case management system (CMS). The CMS is a live operational database. Figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System, which uses data entered into the CMS.

### Seclusion data incorporating outlier data

In 2018, Capital & Coast and Nelson Marlborough DHBs provided data that each included a single client with a high number of seclusion hours. We have treated the data on each of these clients as an outlier because including it in the national statistics would skew the overall data and create a different picture of mental health services. To highlight how influential this discrepancy is, we present some of the data that includes the outliers in the table below.

**Table A9: Seclusion data in New Zealand mental health services, 1 January to 31 December 2018**

| | **Excluding** outliers[55] | **Including** outliers[56] |
|---|---|---|
| Number of people secluded in adult services | 852 people | 854 people |
| Number of hours of seclusion in adult services | 40,649 hours | 46,312 hours |
| Number of seclusion events in adult services | 1,678 events | 2,719 events |
| Average number of seclusion events per person | 2.0 events | 3.2 events |
| Number of seclusion events per 1,000 bed nights | 6.9 events | 9.9 events |
| Number of people secluded per 100,000 population | 29.4 people | 29.4 people |
| Number of seclusion events per 100,000 population | 57.8 events | 93.5 events |
| Average duration per seclusion event | 24.2 hours | 17.1 hours |
| Percentage of seclusion events lasting less than 24 hours | 72 percent | 80 percent |
| Percentage of seclusion events lasting more than 48 hours | 14 percent | 10 percent |
| Number of seclusion events per 1,000 bed nights | 6.9 events | 9.9 events |
| Decrease in hours spent in seclusion since 2009 | 55 percent | 49 percent |
| Increase in hours spent in seclusion since 2017 | 10 percent | 25 percent |
| Increase in seclusion events from 2017 | 7 percent | 26 percent |

The Director of Mental Health and the Office of the Ombudsman closely monitor individuals with high records of seclusion.

[55] This excludes outlier data. Source: PRIMHD data extracted 29 July 2019, except for Lakes, Nelson Marlborough, Southern, and Waitematā DHBs which provided manual data.
[56] This includes outlier data. Source: PRIMHD data extracted 29 July 2019, except for Lakes, Nelson Marlborough, Southern, and Waitematā DHBs which provided manual data.

# Appendix 3: Special patients

### The insanity defence

Under section 23: Insanity of the Crimes Act 1961:

1. Every one shall be presumed to be sane at the time of doing or omitting any act until the contrary is proved.
2. No person shall be convicted of an offence by reason of an act done or omitted by him or her when labouring under natural imbecility or disease of the mind to such an extent as to render him or her incapable –
   a. of understanding the nature and quality of the act or omission; or
   b. of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.

This defence originates from the *M'Naghten* Rule, a British precedent dating from 1843. The *M'Naghten* Rule is a test that assumes a person accused of a crime is sane, and therefore capable of being criminally responsible of a crime, unless the defendant can show otherwise.

For more information about the insanity defence, we recommend *Mental Impairment Decision-making and the Insanity Defence* (New Zealand Law Commission 2010).

The section 23 insanity defence may be used to inform further actions under the Criminal Procedure (Mentally Impaired Persons) Act 2003 and the Mental Health Act. Special and restricted patients subject to these orders are categorised as requiring either short-term or extended forensic care. Short-term care typically refers to patients who have been transferred to forensic mental health care from prison. Extended care includes patients who have been found unfit to stand trial or have been acquitted by reason of insanity. This category also includes restricted patients.

Table A10 lists the types of orders made under these statutes.

**Table A10: Types of orders that an insanity defence may inform**

| Act | Section | Action | Special patient type |
|---|---|---|---|
| CP (MIP) Act | 24 | Detention of person unfit to stand trial or acquitted on account of insanity | EFC |
| CP (MIP) Act | 44 | Detention of person pending hearing or trial | SFC |
| CP (MIP) Act | 34 | Detention of convicted person | SFC |
| CP (MIP) Act | 23 | Inquiry about person found unfit to stand trial or acquitted on account of insanity | SFC |
| CP (MIP) Act | 35 | Inquiry about a convicted person | SFC |
| Mental Health Act | 55 | Court orders restricted patient status | EFC |

| | | | |
|---|---|---|---|
| Mental Health Act | 45 | Application for special patient status for person detained in prison | SFC |

Note: CP (MIP) Act = Criminal Procedure (Mentally Impaired Persons) Act; Mental Health Act = Mental Health (Compulsory Assessment and Treatment) Act; EFC = extended forensic care; SFC = short-term forensic care.

### Victims' rights

Registered victims of a person who is a special patient have the right to be notified when:

- the person is granted their first period of unescorted leave from the hospital grounds
- the person is granted their first period of unescorted overnight leave from hospital
- the person is discharged from hospital
- the person dies
- their sentence ends (where they received a sentence for the offence).

In the rare event that the person leaves hospital without permission or fails to return from leave, victims will be told when the person leaves and when the person returns.

Information that may be provided to registered victims is limited because the pe son is receiving health care, which is confidential health information.

For more information about victims and their rights, and further insight into special patients in the context of the Victims' Rights Act 2002, see:
https://www.health.govt.nz/publication/victims-rights-health system

# Appendix 4: Further reading

### Legislation

Criminal Procedure (Mentally Impaired Persons) Act 2003

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

Mental Health (Compulsory Assessment and Treatment) Act 1992

Substance Addiction (Compulsory Assessment and Treatment) Act 2017

### Publications


Government Inquiry into Mental Health and Addiction. 2018. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington: New Zealand Government.

Huriwai T, Baker M. 2016. *Manaaki: Mana enhancing and mana protecting practice*. Wellington: Te Rau Matatini.

Mental Health Review Tribunal. 2018. *Annual Report: 1 July 2017 to 30 June 2018*. Wellington: Mental Health Review Tribunal.

Ministry of Health. 2009. *Electroconvulsive Therapy (ECT) in New Zealand: What you and your family and whānau need to know*. Wellington: Ministry of Health.

Ministry of Health. 2015. *Guide to PRIMHD Activity Collection and Use* (Version 1.0). Wellington: Ministry of Health.

Ministry of Health. 2016. What happens to your mental health and addiction information? Wellington: Ministry of Health.

Ministry of Health. 2018. *Victims' Rights in the Health System: Your rights as a registered victim of a person detained in hospital for mental health treatment*. Wellington: Ministry of Health.

Ministry of Health. 2019. *Every Life Matters - He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand*. Wellington: Ministry of Health.

Opai K. 2017. *Te Reo Hāpai: The language of enrichment*. Wellington: Te Pou o te Whakaaro Nui.


### Websites

Health Promotion Agency, https://www.hpa.org.nz/

Health Quality & Safety Commission, http://www.hqsc.govt.nz

Le Va, https://www.leva.co.nz/

Like Minds, Like Mine, https://www.likeminds.org.nz/

The Lowdown, https://thelowdown.co.nz/

Mental Health Review Tribunal – selected cases, http://www.nzlii.org/nz/cases/NZMHRTcases/NZMHRT

Ministry of Health – Mental health and addictions, https://www.health.govt.nz/our-work/mental-health-and-addictions

National Depression Initiative, https://depression.org.nz/

Te Rau Ora, https://terauora.com/

Te Pou o te Whakaaro Nui, https://www.tepou.co.nz/

Sent by: xxxx.xxxxxxxx@xxxxxx.xxxx.nz

25/11/2020 07:25 am

To: xxxx.xxxxxxxxx@xxxxxx.xxxx.xx
cc: xxxxxxx.xxxxxxx@xxxxxx.xxxx.xx
bcc:

Subject: ODMHAS 2018 annual report - suggested streamlining

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Hi Toni,

Apologies, I've been a bottle neck with this one. Heather has had a go at suggesting data and content that could be condensed or removed to help streamline the report – please see attached Word doc with tracked changes and comments, as well as the final PDF with your original comments (note there is some variation between the Word version and the final PDF, but not substantial in terms of the content covered).

There's potentially more that could be stripped back, and for some of the data, there's a question of whether we need to include DHB breakdowns. As discussed, it makes sense to me to include both 2018 and 2019 data in this report, and to use graphs/visuals of data over time where possible which would also help with cutting narrative descriptions.

Once the data to be included is confirmed, the Data and Analysis Team could start working through presenting both years of data. We can also work on the narrative to go with it, including a clear context section upfront about the shift in approach with reporting this data and current context vs. 2018 (and 2019 TBC) data.

Happy to set up some time to discuss preferred approach and next steps, just let me know.

Cheers,

Kiri

**Kiri Richards l** Group Manager, Mental Health and Addiction Strategy and Policy **l** Mental Health and Addiction Directorate **l** Ministry of Health **l** Cell: +s 9(2)(a)
Note: If this email reaches you out of hours, I don't expect a response outside of your office hours. It's just a convenient time for me to send an email.

- ODMHAS annual report final (002) HMR edits.docx - ODMH Annual Report 2018 V5 - TG and HMR data comments.pdf - put-in-cabinet-data.json

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# Disclaimer

The purpose of this publication is to inform discussion about mental health and addiction services and outcomes in New Zealand, and to assist in policy development.

This publication reports information provided by district health boards and non-governmental organisations via the Programme for the Integration of Mental Health Data (PRIMHD). It is important to note that, because PRIMHD is a dynamic collection, it was necessary to wait some time before publishing a record of the information contained in that collection. This means that it is less likely that the information will need to be amended after publication (see Appendix 1).

Although every care has been taken in preparing this document, the Ministry of Health cannot accept legal liability for any errors, omissions or damages resulting from reliance on the information it contains.

# A note on the cover

**'Butterflies and Bees' by Sarah Jordon**

Sarah has always had a passion for painting and attended the Elam School of Fine Arts. She says, 'My life revolves around filling canvasses with colour!'

Vincents Art Workshop is a community art space in Wellington established in 1985. A number of people who attend the workshop have had experience of mental health services or have a disability, and all people are welcome. Vincents models the philosophy of inclusion and celebrates the development of creative potential and growth. vincents.co.nz

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MINISTRY OF HEALTH
MANATŪ HAUORA

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# Foreword

Tēnā koutou.

Nau mai ki tēnei tekau mā whā o ngā Rīpoata ā Tau a te Āpiha Kaitohu Tari Hauora Hinengaro mō te Manatū Hauora. Kei tēnei tūnga te mana whakaruruhau kia tika ai te tiaki i te hunga e whai nei i te oranga hinengaro me te waranga. I a tau ka pānuitia tēnei rīpoata kia mārama ai te kaitiakitanga me te takohanga o te āpiha nei ki te katoa.

Welcome to the 14th annual report of the Office of the Director of the Mental Health and Addiction Services. It presents information about specialist mental health and addiction services as a monitoring exercise, to ensure that all New Zealanders have access to high-quality care.

In October 2018, the Office of the Director of Mental Health and Addiction Services (the Office) moved from the Protection, Regulation and Assurance business unit of the Ministry of Health (the Ministry) into the newly established Mental Health and Addiction Directorate. The new structure expanded the mental health and addictions workforce within the Ministry, and helped staff work collaboratively across a range of issues.

In November 2018, the final report of the Government Inquiry into Mental Health and Addiction in New Zealand, *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga),* was published. Some of its key themes relating to the work of the Office are equity, human rights in care, and mental health legislation.

Significant concerns around the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) include its implications for meeting our human rights obligations, being culturally responsive and meeting family and whānau obligations, to name a few. While it will be necessary to amend the legislation to resolve some of these issues fully, we have begun to address them by updating the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health 2012d) for those who administer the Mental Health Act, in order to place human rights at the forefront of care.

*He Ara Oranga* also amplified concerns around the use of indefinite treatment orders. For this reason, this report includes information about indefinite orders, categorised by the duration of the order, district health board, ethnicity and sex. We hope that reflecting on the past will help the sector to consider the future in more depth and improve services.

The Office continues to work towards ensuring patient safety and equity in care. We hope that the information in this report will build on the kōrero around improving the sector that *He Ara Oranga* has led.

This report can only provide a snapshot of mental health and addiction services in New Zealand. The scope of the mental health and addiction sector is broad, with many issues falling outside the parameters of our work. Appendix 4 offers suggestions for further reading. We hope this report will provide a detailed foundation on specialist services that encourages interest in the sector, so we can all work together to transform mental health and addiction outcomes.

Noho ora mai

Dr John Crawshaw

Director of Mental Health

Director of Addiction Services

# Contents



**List of figures**

**List of tables**

Me mātau ki te whetū,

I mua I te kōkiri o te haere

Before you set forth on a journey, be sure you know the stars.

# Executive summary

- In the 2018 calendar year, 182,233 people accessed specialist mental health and addiction services. Most accessed services in the community.
- In 2018, 80 percent of consumers were satisfied with mental health and addiction services.
- In 2018, a small proportion of all service users received compulsory assessment and/or treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act).
- Māori continue to be over-represented under the Mental Health Act. Reducing the disparity in mental health outcomes for Māori is a priority action for the Ministry of Health and district health boards.
- In 2018, the use of seclusion in adult mental health inpatient units increased, following an overall decline in the last decade. The Ministry, services and non-governmental organisations continue to work together to eliminate seclusion practices. Māori continued to be over-represented in the seclusion figures.
- In 2018, 265 people received electroconvulsive the apy (ECT) in mental health services. Females were more likely to receive ECT than males, and older people were more likely to receive ECT than younger people.
- In 2016,[1] a total of 552 people died by suicide. Mental disorders are one of the factors that can make suicidal behaviour more likely.
- In 2018, 25 people were detained under the new Substance Addiction (Compulsory Assessment and Treatment) Act 2017 for inpatient care.



[1] We present data from 2016 because it can take over two years for a coroner to complete an investigation into a suicide.

# Introduction

## Objectives

The objectives of this report are to:

- publish information about clinical activities and statutory officers reportable to the Director of Mental Health under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act)
- publish information about clinical activities and statutory officers reportable to the Director of Addiction Services under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Substance Addiction Act)
- contribute to improving quality and equity in care for people with mental illness and addiction by monitoring services against targets and performance indicators set by the Ministry of Health
- inform mental health and addiction service users, their families and whānau, service providers and members of the public about the role, function and activities of the Office of the Director of the Mental Health and Addiction Services (the Office).

## Structure of this report

This report is divided into three main sections

- 'Context' provides an overview of the legislative and service delivery contexts in which the Office operates.
- 'Activities for 2018' describes key initiatives and projects the Office carried out in 2018.
- 'Ensuring service quality' provides information used to monitor the quality of care that specialist services provided, such as treatment under compulsory treatment orders, seclusion and electroconvulsive therapy. This section also includes statutory reporting, such as on suicide and adverse events.

# Context

## Ministry of Health

The Ministry of Health (the Ministry) improves, promotes and protects the wellbeing and independence of New Zealanders by:

- providing whole-of-sector leadership of the New Zealand health and disability system
- advising the Minister of Health and the Government on mental health and addiction issues and priorities
- directly purchasing a range of important national mental health and addiction services
- providing health-sector information and payment services.

## Office of the Director of Mental Health and Addiction Services

The Office works within the Mental Health and Addiction Directorate at the Ministry. The Directorate is responsible for overseeing the 'end-to-end' activities and functions for mental health and addiction services and leading the response to the Government Inquiry into Mental Health and Addictions, *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga)*.

The Director of Mental Health and the Director of Addiction Services are statutory roles appointed by the Director-General of Health, in accordance with section 91 of the Mental Health Act and section 86 of the Substance Addiction Act, respectively. These roles are both currently held by Dr John Crawshaw. Duties of the Director of Mental Health and Addiction Services include:

- issuing guidelines on the Mental Health Act and the Substance Addiction Act, and standards on the care and treatment of patients subject to either of these Acts
- approving activities in relation to special patients under the Mental Health Act
- visiting mental health and addiction treatment centres for monitoring purposes
- overseeing and liaising with services in order to improve patient safety and equity in care.

The Office supports the Director in this work.

## Mental health and addiction sector overview in 2018

Over the last 50 years, mental health services have moved from an institutional model of care to a recovery model of care. Compulsory inpatient treatment has largely given way to voluntary engagement with services in community settings. Services are also increasingly recognising the importance of cultural identity and family and whānau support. Throughout this period, much public discussion has focused on providing high-quality mental health services and identifying the needs of the community, prompting public inquiries and new legislation and services aiming to address concerns raised.

On 23 January 2018, the Government announced details of the Government Inquiry into Mental Health and Addiction (the Inquiry). The purpose of the Inquiry was to identify unmet needs and make recommendations for a better mental health and addiction system for New Zealand. Former Health and Disability Commissioner, Professor Ron Paterson, chaired the Inquiry.

The Inquiry panel travelled throughout New Zealand to hear from people with mental health and addiction challenges, their families and whānau, service providers, advocates, organisations, institutions and experts. It received 5,500 submissions and conducted 400 meetings (including 26 public meetings, which together drew an audience of over 2,000 people).

On 4 December 2018, the Inquiry published its findings in *He Ara Oranga,* which included 40 recommendations for the Government. On 29 May 2019, the Government released its response to the Inquiry, accepting 38 out of the 40 recommendations. We look forward to providing further detail in the 2019 report on ways the Office has supported the implementation of these recommendations.

In February 2018, the Substance Addiction Act came into effect. This legislation replaced the Alcoholism and Drug Addiction Act 1966. The Substance Addiction Act deals with consumers with severe addictions who do not have the capacity to make informed decisions about their care. The Substance Addiction Act contains a high threshold for detaining service users and strives to affirm their cultural identity. For more information about the Substance Addiction Act, see page 73.

The Office recognises human rights, quality and equity of patient care, and community outreach as key issues in the mental health and addiction sector. In 2018, this commitment was mirrored in the wider Mental Health and Addiction Directorate.

- The Office started to revise the Guidelines to the Mental Health Act in response to concerns that the United Nations' Committee on the Rights of Persons with Disabilities identified in 2014.
- The Office continued to carefully monitor disparities in rates of Māori service users, as well as communicating the importance of whānau engagement with the sector.

- The Office recognised that many factors can influence mental health and addictions and so maintained relationships with other ministries and non-governmental organisations (NGOs) to understand how to improve the wellbeing of New Zealanders from different angles.

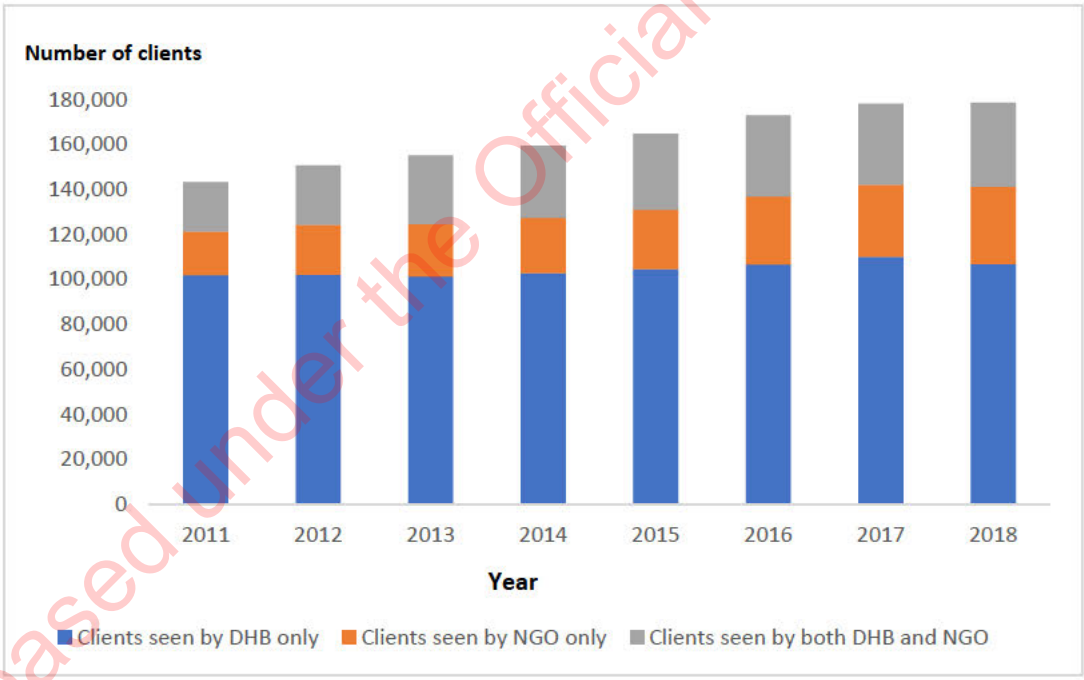
Looking forward, the Office will continue its monitoring and regulatory role to inform and improve the quality and equity of care and protection of rights of clients.

### Specialist mental health and addiction services

In 2018, specialist mental health and addiction services engaged with 182,233 people (3.7 percent of the New Zealand population).[2] Of these, 106,789 clients saw their district health board (DHB) only, 34,431 saw an NGO, and 37,394 saw both their DHB and NGO.[3]

Figure 1 shows that the number of people engaging with specialist services gradually increased from 2011 to 2018. Several changes could explain this rise; for example, data collection has become more accurate; the New Zealand population is growing;[4] services are more visible and accessible; and providers have stronger referral relationships.

**Figure 1: Number of people engaging with specialist services each year, 2011–2018**




Note: DHB = district health board; NGO = non-governmental organisation.

Source: PRIMHD data, extracted 29 July 2019.

[2] Programme for the Integration of Mental Health Data (PRIMHD) as at 12 February 2020.

[3] These numbers do not include clients with no domiciled DHB on record (because they are overseas clients or their DHB of domicile is unknown).

[4] Between 2011 and 2018, the total New Zealand population increased by approximately 12 percent.

# Mental Health (Compulsory Assessment and Treatment) Act 1992

The Mental Health Act defines the circumstances in which people may be subject to compulsory mental health assessment and treatment. It provides a framework for balancing personal rights with public interests when a person is a serious danger to themselves or others due to mental illness.

The long title of the Act states that its purpose is to:

> redefine the circumstances in which and the conditions under which persons may be subjected to compulsory psychiatric assessment and treatment, to define the rights of such persons and to provide better protection for those rights, and generally to reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder.

See the 'Ensuring service quality' section of this report for data on the use of the Mental Health Act.

### Administering the Mental Health Act

The chief statutory officer under the Mental Health Act is the Director of Mental Health (the Director), appointed under section 91 of the Mental Health Act. The Director is responsible for the general administration of the Mental Health Act under the direction of the Minister of Health and Director-General of Health. The Director's functions and powers under the Mental Health Act allow the Ministry to provide guidance to mental health services.

In each DHB, the Director-General of Health appoints a Director of Area Mental Health Services (DAMHS) under section 92 of the Mental Health Act. The DAMHS is a senior mental health clinician responsible for administering the Mental Health Act within their DHB area. They must report to the Director quarterly on the exercise of their powers, duties and functions under the Mental Health Act (Ministry of Health 2012a).

Each DAMHS must appoint responsible clinicians and assign them to lead the treatment of every person subject to compulsory assessment or treatment (Ministry of Health 2012a). The DAMHS also appoints competent health practitioners as 'duly authorised officers' to respond to people experiencing mental illness in the community who are in need of intervention. Duly authorised officers are required to provide general advice and assistance in response to requests from members of the public and the New Zealand Police. If a duly authorised officer believes that a person may be mentally disordered, is considered a danger to themselves or other people and may benefit from a compulsory assessment, the Mental Health Act grants powers to the officer to arrange for a medical examination (Ministry of Health 2012c).

## Protecting the rights of people subject to compulsory treatment

### *District inspectors*

Although under the Mental Health Act the Ministry expects each DAMHS to protect the rights of people in their area, the Mental Health Act also provides for independent monitoring mechanisms. The Minister appoints qualified lawyers as district inspectors to protect people's rights under section 94 of the Mental Health Act.

District inspectors protect specific rights and investigate alleged breaches of rights under the Mental Health Act, address concerns of family and whānau and monitor services to check they are complying with the Mental Health Act process. For a list of current district inspectors, see the 'Mental health district inspectors' section of the Ministry of Health's website.[6]

Under the Mental Health Act, district inspectors must report to the DAMHS in their area within 14 days of inspecting a mental health service. They must also report monthly to the Director on the exercise of their powers, duties and functions. These reports provide the Director with an overview of mental health services and any problems that may be developing.

The Office's responsibilities in relation to district inspectors include:

- coordinating the appointment and reappointment of district inspectors
- managing district inspector remuneration
- receiving and responding to monthly reports from district inspectors
- organising twice-yearly national meetings of district inspectors
- facilitating inquiries under section 95 of the Mental Health Act
- implementing the findings of section 95 inquiries.

### *Section 95 inquiries*

The Director will occasionally require a district inspector to carry out an inquiry under section 95 of the Mental Health Act (Ministry of Health 2012b). These inquiries investigate systemic issues across one or more mental health services. The district inspector will then make specific recommendations about the services.

The Director considers the recommendations, and actions any of them that are relevant to the Ministry or the mental health sector. Later, the Director will audit the DHBs for their implementation of the recommendations. The inquiry process is not completed until the

[6] https://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-district-inspectors/mental-health-district-inspectors-list

Director considers that the DHBs and, if appropriate, the Ministry have successfully implemented the recommendations.

No section 95 inquiries were completed during 2018. Table 1 shows the number of completed section 95 inquiry reports that the Director of Mental Health received between 2003 and 2018.

***New Zealand Mental Health Review Tribunal***

The New Zealand Mental Health Review Tribunal (the Tribunal) is a specialist independent tribunal empowered by law to review compulsory treatment orders, special patient orders and restricted patient orders. If a person disagrees with their treatment under the Mental Health Act, they can apply to the Tribunal to examine their condition and whether it is necessary to continue compulsory treatment. Where the Tribunal considers it appropriate, it may release the person from compulsory treatment status.

The Tribunal has three members: one must be a lawyer, one a psychiatrist and one a community member. A number of deputy members are also appointed to each position, to act where a particular member is not available. The Minister of Health appoints or reappoints members and deputy members, who typically hold office for three-year terms. The Minister has to be satisfied that the members provide a well-balanced Tribunal before agreeing to their appointment. On 19 September 2018, the current Tribunal had had four new appointments and fifteen reappointments since the end of the previous term.

A selection of the Tribunal's published cases is available online.[7] The Tribunal carefully anonymises these cases to respect the privacy of the individuals and family and whānau involved. In publishing these cases, the Tribunal aims to improve public understanding of both its own work and mental health law and practices.

The main function of the Tribunal is to review the condition of people, in keeping with sections 79 and 80 of the Mental Health Act. Section 79 relates to people who are subject to ordinary compulsory treatment orders, and section 80 relates to the status of special patients. During the year ending 30 June 2018, the Tribunal heard sixty-four section 79 reviews and found five of these applicants fit to be released. In the same year, the Tribunal heard nine section 80 reviews and found one person fit to be released.

Other important functions of the Tribunal include:

- appointing psychiatrists authorised to offer second opinions (sections 59–61)
- reviewing district inspector investigations (section 75)
- recommending changes to the legal status of special patients (section 80)
- reviewing the condition of restricted patients (section 81).

For more information about the Tribunal's activities for the year ending 30 June 2018, see Appendix 2.

[7] See www.nzlii.org/nz/cases/NZMHRT

# Substance Addiction (Compulsory Assessment and Treatment) Act 2017

The Substance Addiction Act came into force in February 2018. Its purpose is to enable people to receive compulsory treatment for severe substance addiction. Section 3 of the Act states the role of the Act is to:

- protect patients from harm
- comprehensively assess patients' needs
- treat and stabilise patients
- protect and enhance the mana and dignity of patients
- restore the capacity of patients to make informed decisions about substance use and future treatment
- help patients to transition to voluntary treatment.

See the 'Ensuring service quality' section of this report for data on uses of the Substance Addiction Act that must be published in line with section 119 of the Act.

### Administering the Substance Addiction Act

The chief statutory officer under the Substance Addiction Act is the Director of Addiction Services, appointed under section 86 of the Act. The Director of Addiction Services is responsible for the general administration of the Substance Addiction Act under the direction of the Minister and the Director-General of Health.

Directors of Area Addiction Services  Area Directors) are appointed under section 88 of the Substance Addiction Act. Area Directors are experienced addiction treatment professionals who hold a senior role in a DHB addiction treatment service. Their primary statutory obligations are to administer and give clinical oversight of the Substance Addiction Act within their region.

### Protecting the rights of people subject to compulsory treatment

The Minister appoints district inspectors under section 90 of the Substance Addiction Act. These inspectors perform similar duties to mental health district inspectors in that they uphold the rights of patients who are subject to compulsory assessment and treatment under the Substance Addiction Act. They too hold office for a three-year term.

# Ensuring service quality

Providing timely access to high-quality mental health and addiction services is a priority goal of the wider health sector. The Ministry, DHBs and NGOs work collaboratively to achieve this goal.

The Ministry – and the wider government – set goals and targets for the health sector that are aimed at improving outcomes for people using mental health services. Reporting from the health sector is integral to this process, as it allows the Ministry to measure progress against these goals. Independent institutions, such as district inspectors and the Office of the Ombudsman, also monitor the sector's progress.

This section presents statistics on mental health and addiction services. These include mechanisms of the Mental Health Act and the Substance Addiction Act, as well as consumer satisfaction, waiting times, transition plans, special patients, serious adverse events and specialist treatment regimes.

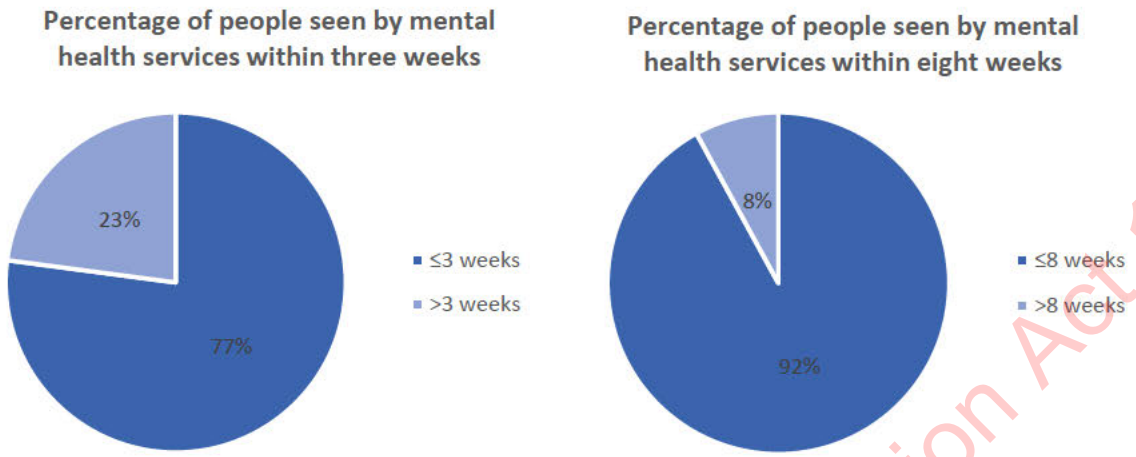
## Specialist mental health and addiction services

### Waiting times

Waiting times measure how long new clients wait to be seen by mental health and addiction services. New clients are defined as people who have not accessed mental health or addiction services in the past year. Waiting time is measured as the length of time from the day mental health and addiction services receive a referral to the day the person first receives a service.

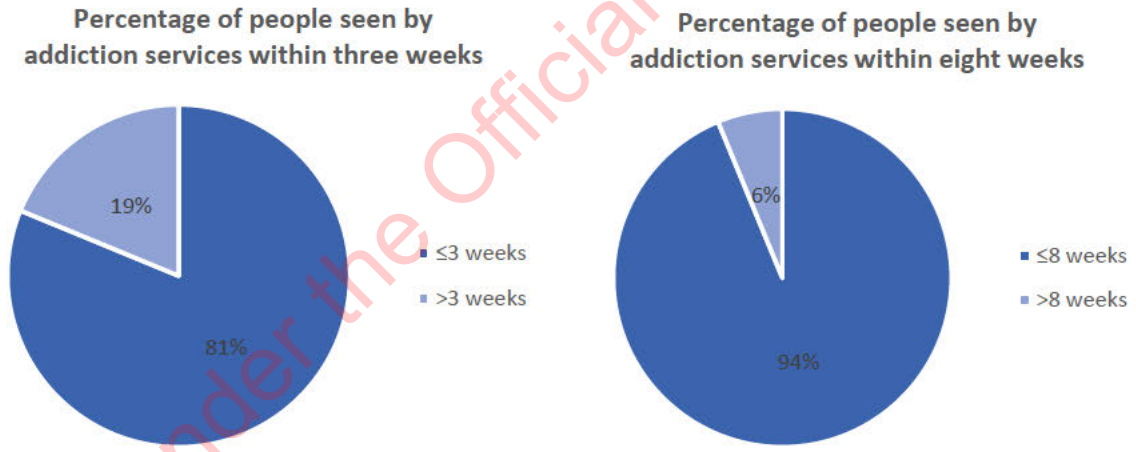
A sector-wide target for DHBs is that mental health or addiction services should see 80 percent of people referred for services within three weeks, and 95 percent within eight weeks. They must see certain types of referrals within 48 hours.

**Figure 4: Percentage of people seen by mental health services within three weeks (left) and within eight weeks (right), 1 January to 31 December 2018**




Source: PRIMHD data as at 19 February 2019.

**Figure 5: Percentage of people seen by addiction services within three weeks (left) and within eight weeks (right), 1 January to 31 December 2018**




Source: PRIMHD data as at 19 February 2019.

### Transition (discharge) plans

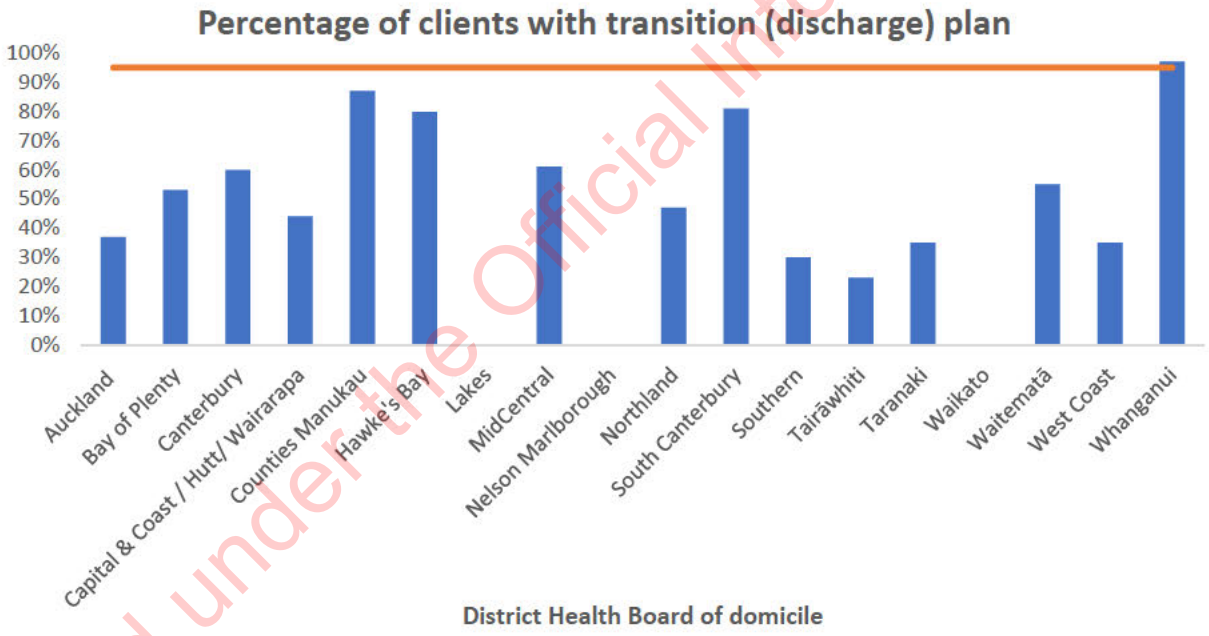
In 2014, the Ministry introduced a target of ensuring at least 95 percent of all people who have used mental health and addiction services have a transition (discharge) plan. Transition planning aims to:

- match the service as closely as possible to the needs of the individual, delivered by the most appropriate service provider

- make individuals and their families and whānau the key decision-makers about the services they receive
- deliver care across a dynamic continuum of specialist and primary health care services and base decisions on the needs and wishes of individuals and their families and whānau (not on service boundaries)
- have processes in place to identify and respond early if mental health or alcohol and other drugs concerns emerge again.

Figure 6 shows the percentage of all service users with a transition plan as of 31 December 2018 within each DHB. Currently, the DHBs do not use a uniform reporting system, and 0 percent indicates the DHB has not collected data rather than that it has no transition plan. Additionally, some DHBs contract with NGOs to streamline care and reintegration of the patient. This means that Figure 6 is likely to show an underestimate of how many services users have transition plans.

**Figure 6: Percentage of service users with a transition plan, by DHB, 1 January to 31 December 2018**




Note: 0 percent indicates the DHB does not collect this data. DHBs have been required to report this data since 1 July 2017 and are working hard to improve their methods of gathering it.

Source: DHB Quarterly Database (manual data), Q2 2018/19.

## Use of the Mental Health (Compulsory Assessment and Treatment) Act 1992

The Mental Health Act defines the circumstances under which an individual may be subject to compulsory mental health assessment and treatment.

In summary, in 2018:

- 10,631 people (5.8 percent of specialist mental health and addiction service users) were subject to the Mental Health Act[9] and on the last day of 2018 approximately 5,083 people were subject to either compulsory assessment or compulsory treatment under the Mental Health Act
- DHBs varied in their use of the Mental Health Act
- males were more likely to be subject to the Mental Health Act than females
- people aged 25–34 years were the most likely to be subject to compulsory treatment and people over 65 years of age were the least likely
- Māori were more likely to be assessed or treated under the Mental Health Act than non-Māori.

***Compulsory treatment***

There are two types of compulsory treatment orders: one for treatment in the community (section 29 of the Mental Health Act); and the other for treatment in an inpatient unit (section 30 of the Mental Health Act). An individual's responsible clinician can convert an inpatient treatment order into a community treatment order at any time. A responsible clinician may also grant an individual leave from the inpatient unit for treatment in the community for up to three months (section 31 of the Mental Health Act).

### 2018 summary

On the last day of 2018, a total of 5,083 people were subject to either compulsory assessment or compulsory treatment[10] under the Mental Health Act.

On average within each month of 2018, New Zealand service providers applied the assessment provisions of the Mental Health Act as follows.

| | | |
|---|---|---|
| Section 11 | 618<br>people were subject to an initial assessment | 13 people per 100,000 population |
| Section 13 | 621 | 13 people per 100,000 population |

[9] Mental Health Act sections 11, 13, 14(4), 15(1), 15(2), 29, 30 and 31.
[10] PRIMHD data extracted on 29 July 2019, except for Auckland, Lakes, Nelson Marlborough and Waitematā DHBs, which supplied manual data.

| | | |
|---|---|---|
| | people were subject to a second period of assessment | |
| Section 14(4) | 443<br>people were subject to an application for a compulsory treatment order | 9 people per 100,000 population |

Source: PRIMHD data extracted on 29 July 2019, except for Auckland, Lakes, Nelson Marlborough and Waitematā DHBs, which supplied manual data.

In New Zealand, on the average day in 2018, service providers applied the treatment provisions of the Mental Health Act as follows.

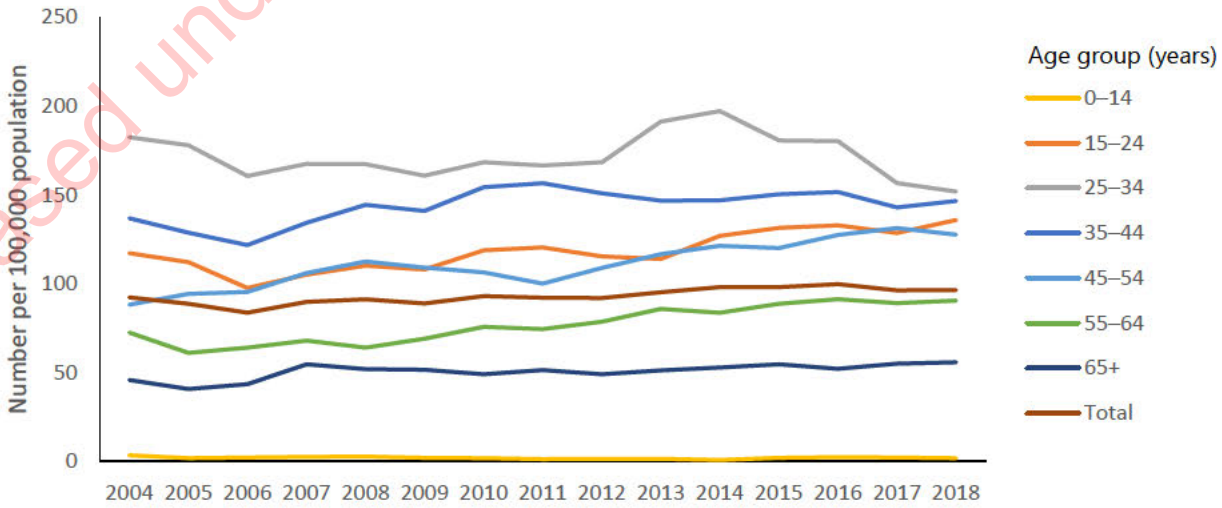
| | | |
|---|---|---|
| Section 29 | 5,349<br>people were subject to a community treatment order | 109 people per 100,000 population |
| Section 30 | 791<br>people were subject to an inpatient treatment order | 16 people per 100,000 population |
| Section 31 | 201<br>people were on temporary leave from an inpatient unit | 4 people per 100,000 population |

Note: 'On a given day' is the average of the last day of each month.

Source: PRIMHD data extracted on 29 July 2019, except for Auckland, Lakes, Nelson Marlborough and Waitematā DHBs, which supplied manual data.

## Compulsory treatment by age and sex

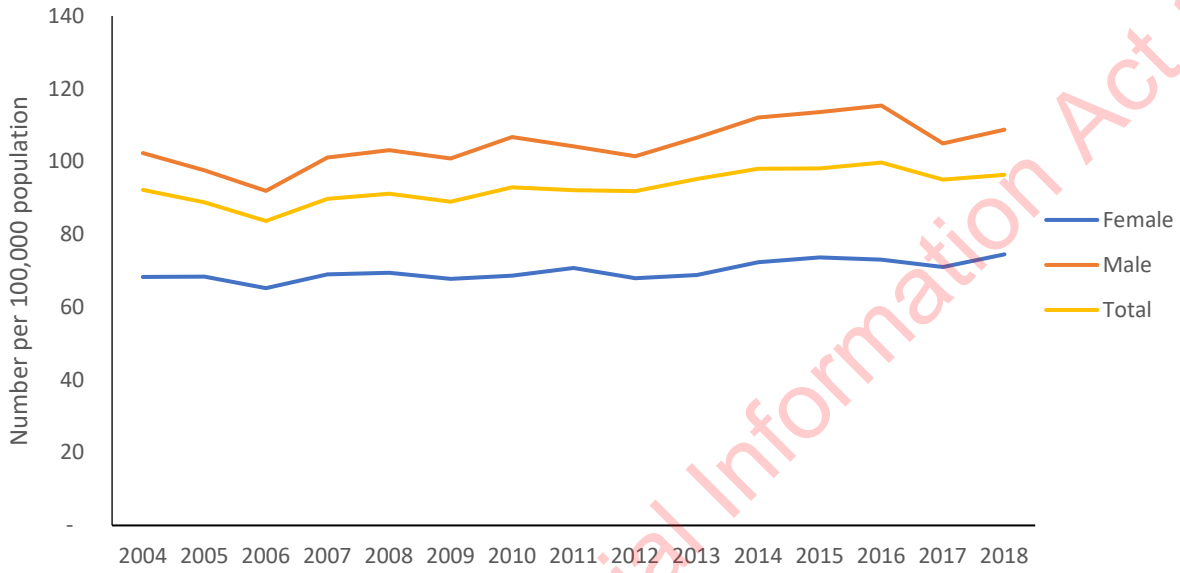
**Figure 10: Rate of people subject to compulsory treatment order applications (including extensions) per 100,000 population, by age group, 2004–2018**



Note: This system uses data entered into the case management system (CMS). The CMS is a live operational database. Figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System as at 24 June 2019.

**Figure 11: Rate of people subject to compulsory treatment order applications (including extensions) per 100,000 population, by sex, 2004–2018**

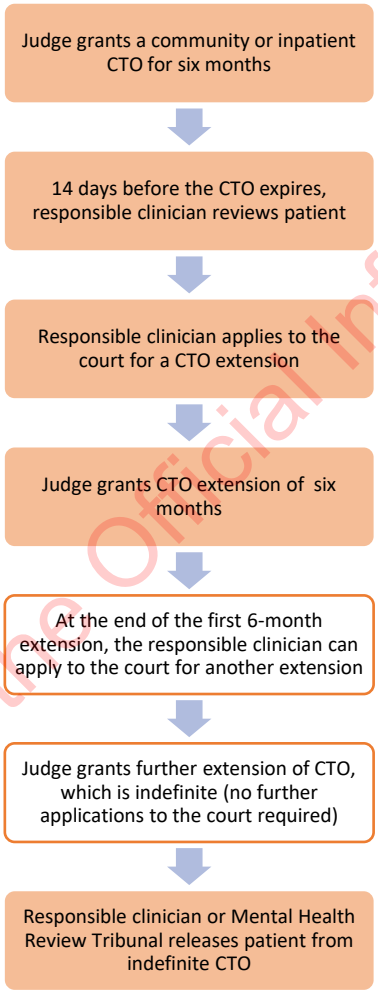



Note: This system uses data entered into the case management system (CMS). The CMS is a live operational database. Figures are subject to minor changes at any time

Source: Ministry of Justice Integrated Sector Intelligence System as at 24 June 2019.

### Indefinite compulsory treatment orders

A compulsory treatment order lasts for a period of six months. However, a responsible clinician may review the patient's progress under section 76 of the Act and apply to the court for an extension of the compulsory treatment order for a further six months. After the second period of six months of compulsory treatment expires, the court can grant another extension. If the court grants the second extension, the compulsory treatment order continues indefinitely and is not subject to another review by a judge. Under section 35 of the Act, a patient may be released from a compulsory treatment order by their responsible clinician, or when the Mental Health Review Tribunal considers that the patient is 'fit to be released' from compulsory status (section 79).

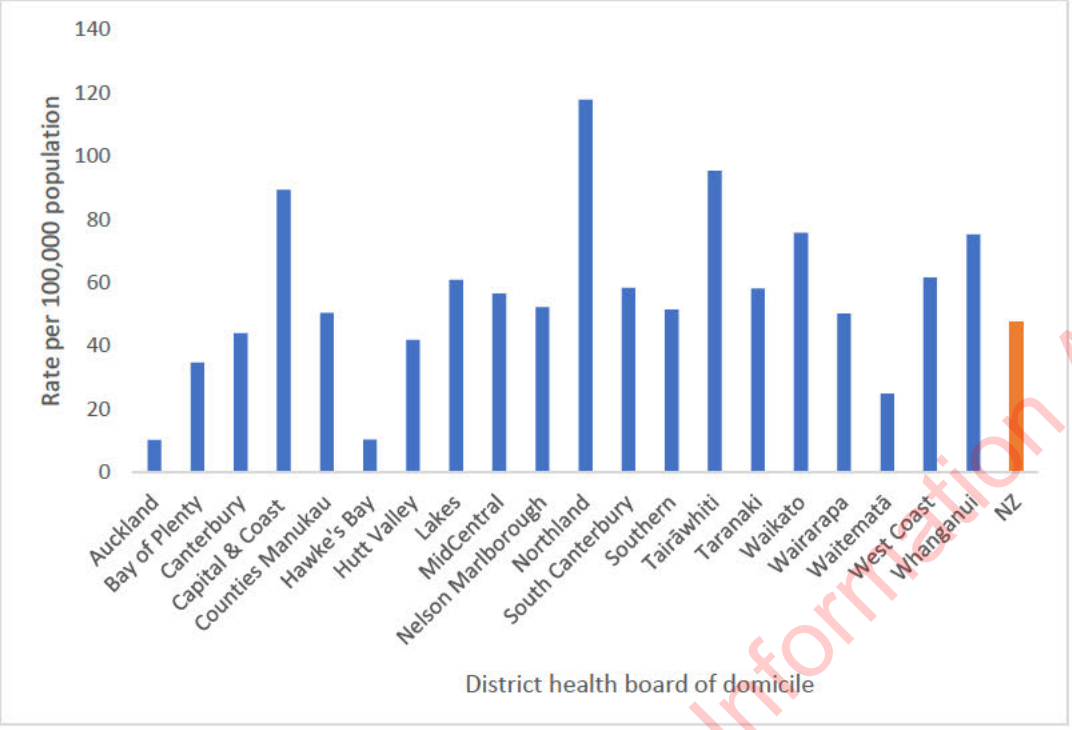



Note: CTO = compulsory treatment order.

### *Indefinite community treatment orders*

. Figure 12 shows the rates of indefinite community treatment orders in each DHB, per 100,000 of the general population.

**Figure 12: Rate of people subject to indefinite community treatment orders per 100,000 population, by DHB, open on 31 December 2018**




Source: PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes and Waitematā DHBs.

Nationwide, Māori were 3.5 times more likely to be subject to an indefinite community treatment order than non-Māori. Table 4 shows the rate ratio of Māori to non-Māori in each DHB, per 100,000 people subject to indefinite community treatment orders.

**Table 4: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, open on 31 December 2018**

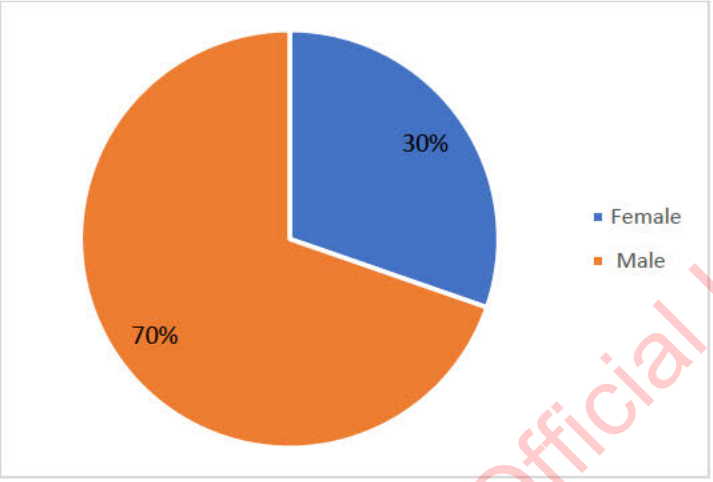
| DHB of Service | Māori | Non-Māori | Rate Ratio Māori: Non-Māori |
|---|---|---|---|
| Auckland | 51 | 7 | 7.7 |
| Bay of Plenty | 84 | 18 | 4.6 |
| Canterbury | 96 | 39 | 2.5 |
| Capital & Coast | 210 | 74 | 2.8 |
| Counties Manukau | 139 | 34 | 4.1 |
| Hawke's Bay | 16 | 8 | 2.0 |
| Hutt Valley | 77 | 35 | 2.2 |
| Lakes | 123 | 28 | 4.4 |
| Mid Central | 116 | 42 | 2.8 |
| Nelson Marlborough | 107 | 46 | 2.3 |
| Northland | 221 | 66 | 3.4 |
| South Canterbury | 133 | 51 | 2.6 |
| Southern | 138 | 42 | 3.3 |
| Tairāwhiti | 142 | 49 | 2.9 |
| Taranaki | 108 | 46 | 2.3 |
| Waikato | 185 | 43 | 4.3 |
| Wairarapa | 177 | 24 | 7.5 |

| | | | |
|---|---|---|---|
| Waitematā | 65 | 21 | 3.1 |
| West Coast | 129 | 52 | 2.4 |
| Whanganui | 98 | 67 | 1.5 |
| **NZ** | **119** | **34** | **3.5** |

Source: PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes and Waitematā DHBs.

In 2018, 70 percent of people subject to indefinite community treatment orders were male (see Figure 13). This trend is consistent with the higher rate of males subject to compulsory treatment order applications.

**Figure 13: Percentage of people subject to indefinite community treatment orders, by sex, 1 January to 31 December 2018**

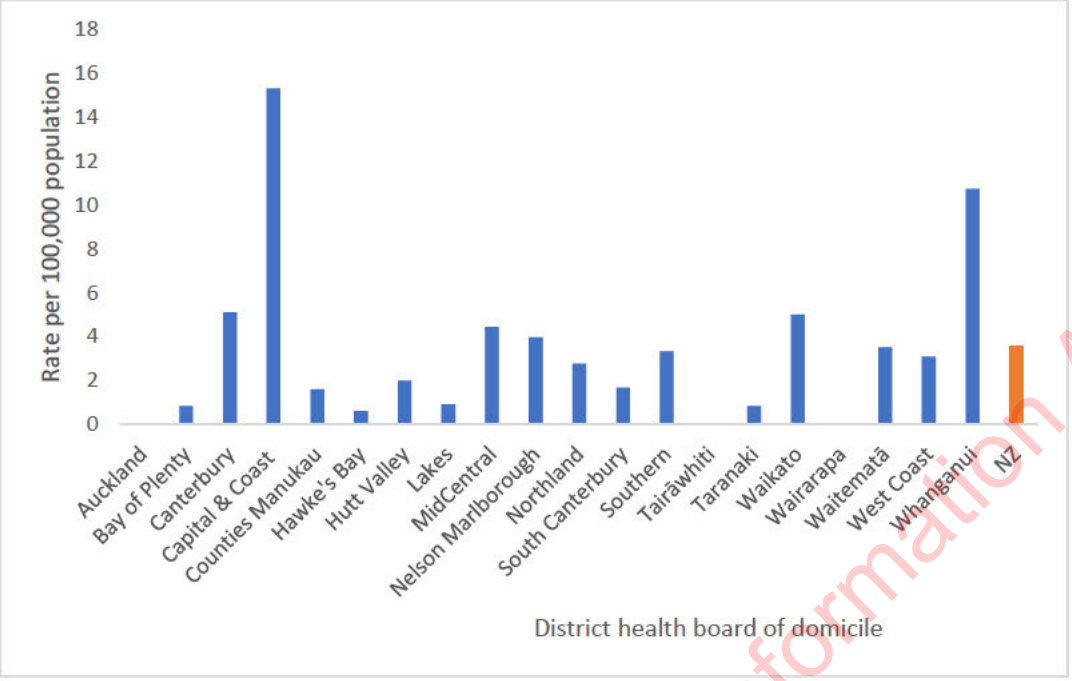



Source: PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs.

### *Indefinite inpatient treatment orders*

In 2018, 3.5 people per 100,000 across New Zealand were subject to indefinite inpatient treatment orders. Some services may have higher rates of inpatient indefinite orders because they care for more patients with forensic and intellectual disability needs. Smaller services may be less likely to offer long-term inpatient care for people with complex needs. Figure 14 shows the rates of indefinite inpatient treatment orders in each DHB, per 100,000 of the general population.

**Figure 14: Number of people subject to indefinite inpatient treatment orders per 100,000 population, by DHB, 1 January to 31 December 2018**




Note: Wairarapa DHB does not have an inpatient service.

Source: PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes and Waitematā DHBs.

Nationwide, Māori were 2.8 times more likely to be subject to an indefinite community treatment order than non-Māori. Table 5 shows the rate ratio of Māori to non-Māori in each DHB per 100,000 people subject to indefinite inpatient treatment orders.

**Table 5: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, 1 January to 31 December 2018**

| DHB of Service | Māori | Non-Māori | Rate Ratio Māori: Non-Māori |
|---|---|---|---|
| Bay of Plenty | 2 | 1 | 3.0 |
| Canterbury | 10 | 5 | 2.1 |
| Capital & Coast | 47 | 11 | 4.2 |
| Counties Manukau | 6 | 1 | 6.7 |
| Hawke's Bay | - | 1 | - |
| Hutt Valley | 4 | 2 | 2.4 |
| Lakes | 3 | - | - |
| Mid Central | 14 | 2 | 6.7 |
| Nelson Marlborough | - | 4 | - |
| Northland | 7 | 1 | 7.9 |
| South Canterbury | - | 2 | - |
| Southern | 3 | 3 | 0.9 |
| Taranaki | 4 | - | - |
| Waikato | 14 | 2 | 5.5 |
| Waitematā | 11 | 3 | 4.3 |

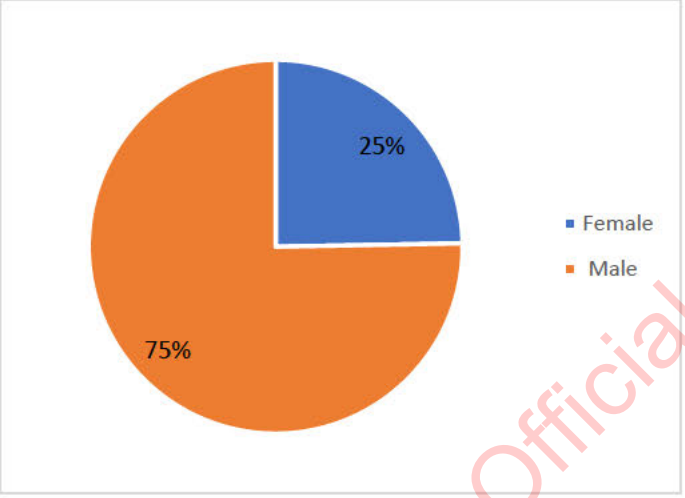
| | | | |
|---|---|---|---|
| West Coast | - | 3 | - |
| Whanganui | 6 | 13 | 0.5 |
| **NZ** | **8** | **3** | **2.8** |

Note: Auckland, Tairāwhiti, and Wairarapa DHBs do not have indefinite inpatient treatment orders.

Source: PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes and Waitematā DHBs.

In 2018, 75 percent of people subject to indefinite inpatient treatment orders were male (see Figure 15). Similar to the findings for indefinite community treatment orders, this trend is consistent with the higher rate of males subject to compulsory treatment order applications.

**Figure 15: Percentage of people subject to indefinite inpatient treatment orders, by sex, 1 January to 31 December 2018**




Source: PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs.

## Tāngata whaiora

### *Māori and mental health*

Māori make up approximately 16 percent of New Zealand's population, yet they account for 28 percent of all mental health service users.[13]

The national mental health prevalence study, *Te Rau Hinengaro* (Oakley Browne et al 2006), showed that Māori experience the highest levels of mental health disorder among any ethnic group overall. They are also more likely to experience serious and concurrent disorders than non-Māori. Research suggests Māori may access services later than non-Māori and so present as more acutely unwell (Kingi et al 2018, p 177).

A 2018 survey *Te Oranga Hinengaro – Māori Mental Wellbeing*, published by the Health Promotion Agency, found that Māori were more likely than non-Māori to experience symptoms of depression, anxiety and psychological distress (Russell 2018).

A Māori person is 4 times more likely than a non-Māori to be subject to a community treatment order and 3.7 times more likely to be subject to an inpatient treatment order in their lifetime.

For community treatment orders that began between 2009 and 2016,[14] 70.3 percent of Māori and 74.4 percent of non-Māori under a community treatment order were subject to the order for less than a year. Another 11.2 percent of Māori and 8.9 percent of non-Māori remained under an order for between one and two years, and 18.6 percent of Māori and 16.7 percent of non-Māori remained under an order for more than two years.

For inpatient treatment orders that began between 2009 and 2016, 94.5 percent of Māori and 95.7 percent of non-Māori were subject to the order for less than a year. Another 2.8 percent of Māori and 2.2 percent of non-Māori remained under an order for between one and two years, and 2.7 percent of Māori and 2.1 percent of non-Māori remained under an order for more than two years.

### *Some reasons for differences in outcomes for tāngata whaiora*

Some demographic features relevant to the high rate of Māori mental health service users are that a high proportion of the Māori population is young and Māori are over-represented in low socioeconomic groups.

In 2018, approximately half of all Māori service users were under 25 years of age, compared with approximately 30 percent of non-Māori service users.[15]

---

[13]: PRIMHD data, extracted on 29 July 2019. This applies to both voluntary service users and those treated under the Mental Health Act.

[14] This analysis uses 2016 as the most recent year because at least two years must have passed to identify how many people have remained on a treatment order for two or more years.

[15] PRIMHD data, extracted on 29 July 2019.

Māori are also over-represented in the most deprived areas as identified in the New Zealand Deprivation Index. This tool measures indicators of social and material deprivation such as unemployment, low income, unsuitable housing and lack of access to transport or the internet (Atkinson et al 2014, p 19). Among service users under a community treatment order, 52 percent of Māori live in the most deprived deciles (8–10), compared with 32 percent of non-Māori.[16]

However, these demographic factors do not completely explain why the rates for Māori with serious mental illness are higher than the rates for non-Māori (Oakley Browne et al 2006). Elder and Tapsell (2013) suggest other factors are that the:

- treatment Māori receive in the mental health system may be different from the treatment that others receive
- mental health workforce lacks cultural competency, leading to cultural bias
- mental health system does not engage with tāngata whaiora and whānau.

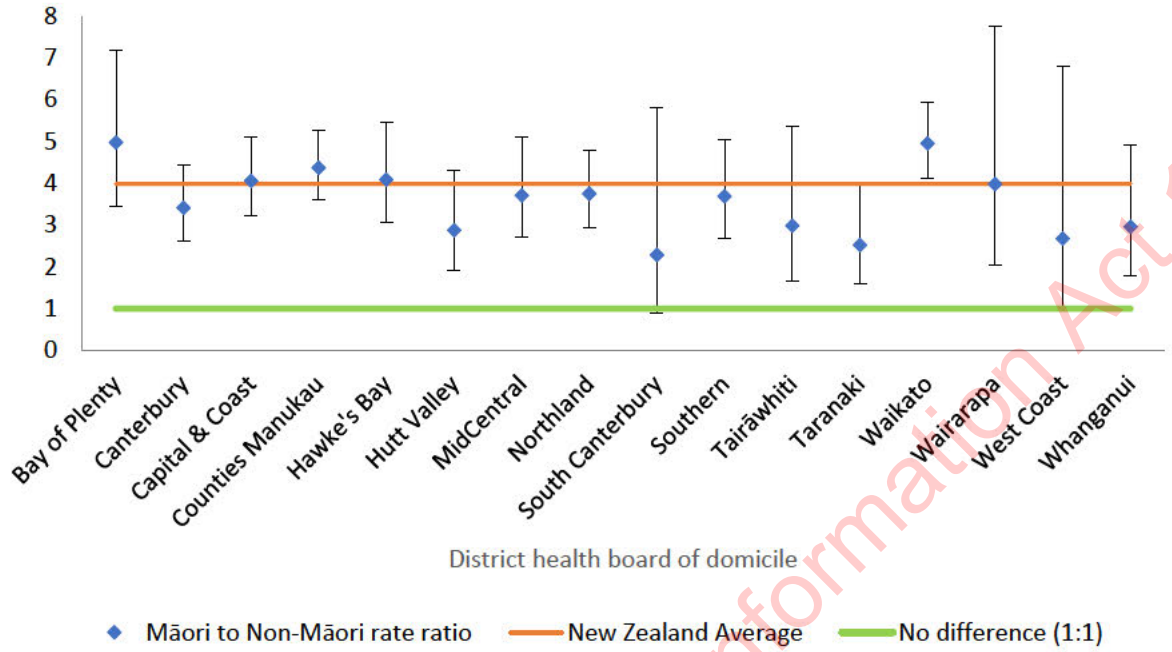
***Māori and compulsory treatment orders***

In 2018, Māori were more likely to be subject to community and inpatient treatment orders than non-Māori. Figures 16 and 17 show the rate ratio of Māori to non-Māori subject to these orders for each DHB. It is difficult to interpret the range of rates because the proportions of different ethnic groups within a population vary greatly across DHBs so it is hard to define an ideal rate ratio for a given population or DHB. However, to help make the comparison, each figure includes a line of 'no difference' to indicate where Māori and non-Māori would be subject to compulsory treatment orders at the same rate. The figures emphasise the need for in-depth, area-specific knowledge to understand why differences occur in each district and how to address them at a local level.



[16]: PRIMHD data, extracted on 29 July 2019. Deprivation deciles are ranked 1 to 10, where 1 represents areas with the least deprived scores and 10 the areas with the most deprived scores.

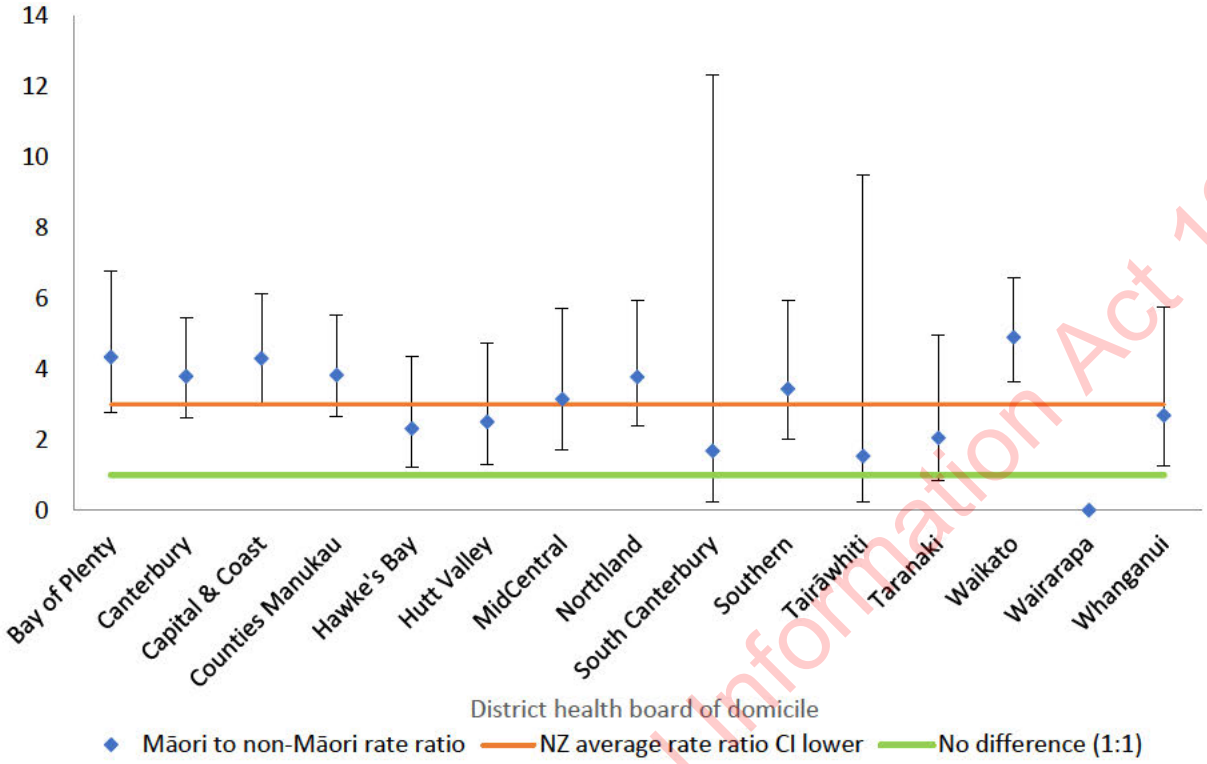
**Figure 16: Rate ratio of Māori to non-Māori subject to a community treatment order (section 29) under the Mental Health Act per 100,000 population, by DHB, 1 January to 31 December 2018**




Note: The graph shows confidence intervals (for 99 percent confidence) to help in interpreting the data. Where a DHB's confidence interval crosses the national average, this means the DHB's rate per 100,000 was not statistically significantly different from the national average. These are age-standardised rates.

Source: PRIMHD data extracted on 29 July 2019, except for Auckland, Lakes, Nelson Marlborough and Waitematā DHBs, which supplied manual data (and so are excluded from this graph as we do not have their age-standardised rates).

**Figure 17: Rate ratio of Māori to non-Māori subject to an inpatient treatment order (section 30) under the Mental Health Act per 100,000 population, by DHB, 1 January to 31 December 2018**




Notes: The graph uses confidence intervals (for 99 percent confidence) to help in interpreting the data. Where a DHB's confidence interval crosses the national average, this means the DHB's rate per 100,000 was not statistically significantly different from the national average. These are age-standardised rates.

Because West Coast DHB has a small population, its rates are volatile and error bars of the resulting calculations are large. For this reason, this graph does not include its data to avoid skewing the overall results.

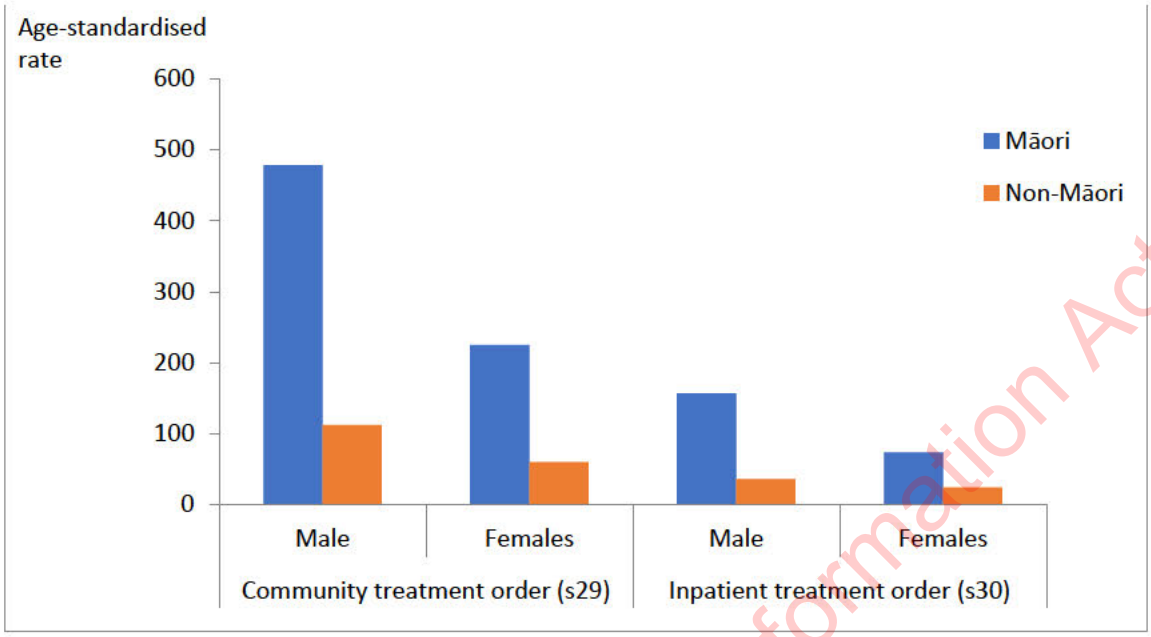
Source: PRIMHD data extracted on 29 July 2019 except for Auckland, Lakes, Nelson Marlborough and Waitematā DHBs, which supplied manual data (and so are excluded from this graph as we do not have their age-standardised rates).

### *Sex, ethnicity and compulsory treatment*

In 2018, Māori males were the population group most likely to be subject to compulsory treatment orders. Māori males were 4.3 times more likely to be subject to a community treatment order (section 29) and to an inpatient treatment order (section 30) than non-Māori males.

Table 6 and Figure 18 present information on age-standardised rates of community and inpatient treatment orders for Māori and non-Māori males and females.

**Figure 18: Age-standardised rates of Māori and non-Māori subject to community and inpatient treatment orders (sections 29 and 30 respectively) under the Mental Health Act, by sex, 1 January to 31 December 2018**

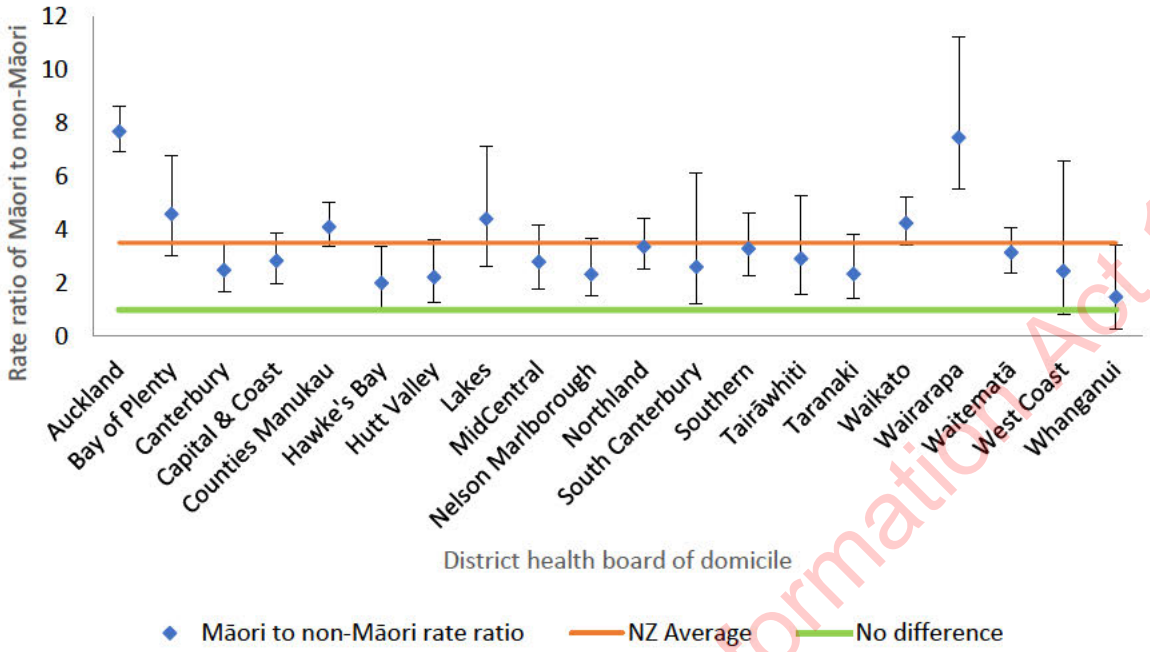



Note: Rates per 100,000 are age-standardised (ASR).

Source: PRIMHD data, extracted on 29 July 2019.

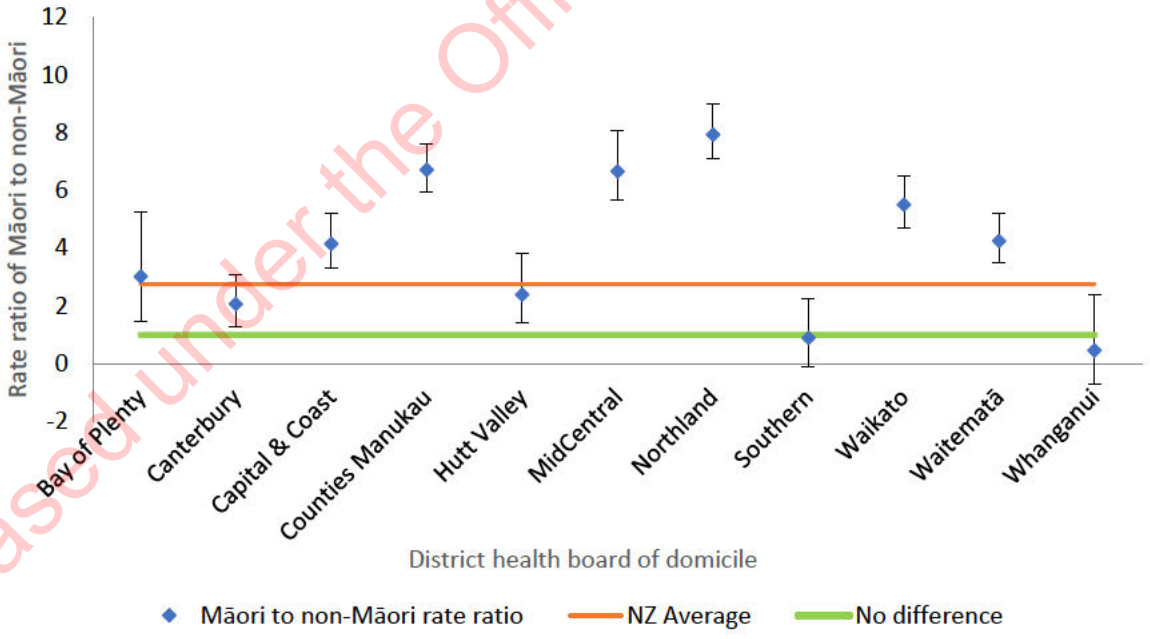
Nationwide, Māori were 3.5 times more likely to be subject to an indefinite community treatment order than non-Māori. Furthermore, Māori were 2.8 times more likely to be subject to an indefinite inpatient treatment order than non-Māori. The following figures show the rate ratio of Māori to non-Māori subject to indefinite community treatment orders (Figure 20) and indefinite inpatient treatment orders (Figure 21) for each DHB per 100,000 people.

**Figure 20: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, by DHB, 1 January to 31 December 2018**




Source: PRIMHD data, extracted 29 July 2019, and manual data submitted from Auckland, Lakes and Waitematā DHBs.

**Figure 21: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, by DHB, 1 January to 31 December 2018**




Note: Auckland, Tairāwhiti and Wairarapa DHBs have no indefinite inpatient treatment orders. In Hawke's Bay, Lakes, Nelson Marlborough, South Canterbury, Taranaki and West Coast DHBs, the rate ratio is zero. These DHBs have been excluded from this graph.

Source: PRIMHD data, extracted 29 July 2019, except manual data submitted from Auckland, Lakes and Waitematā DHBs.

***Future focus***

Reducing the differences between Māori and non-Māori mental health outcomes continues to be a priority for the Ministry. Publishing data on the rate of Māori subject to compulsory treatment is just one aspect of what needs to be a wider kōrero around Māori over-representation in compulsory assessment and treatment under the Mental Health Act.[17]

The Office will continue to work alongside DHBs, other ministries and other government groups to ensure we are working towards the best possible mental health outcomes for Māori in New Zealand.

## Use of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017

### Mana-enhancing practice

In February 2018, the Substance Addiction Act came into force. One of its important purposes is to protect and enhance the mana of tāngata whaiora receiving compulsory treatment (section 3(d)).

Under the Substance Addiction Act, Area Directors must report to the Director of Addiction Services each quarter. Their report must detail how services are offering mana-enhancing and mana-protecting practices during the following stages:

- initial engagement
- assessment by authorised officers
- court hearings
- transfer of care to a designated residential facility.

As the Act is relatively new, we do not yet hold in-depth reporting on mana-enhancing practice in services. We anticipate providing more detail on mana-enhancing practices in the 2019 report.

For more information about mana-enhancing practice for implementing the Substance Addiction Act, see: Terry Huriwai and Maria Baker. 2016. *Manaaki: Mana enhancing and mana protecting practice*. Wellington: Te Rau Matatini (now Te Rau Ora).

[17] The Ministry has been leading Action 9(d) of the Disability Action Plan 2014–18 (Office for Disability Issues 2015), to explore how the Mental Health Act relates to the New Zealand Bill of Rights Act 1990 and the Convention on the Rights of Persons with Disabilities. This work is expected to contribute in a meaningful way to this conversation.

### Consultation with families and whānau

Section 12 of the Substance Addiction Act states that a person exercising powers that they are given under the Act must properly recognise the patient's whānau, hapū and iwi. The legislation requires DHBs to consult whānau or family in the following circumstances:

- applying for assessment
- compulsory treatment certification
- court-directed compulsory treatment orders
- release from the Act.

The Director of Area Addiction Services from each DHB reports the details of family and whānau engagement to the Ministry, including reasons why a service provider did not consult with a patient's family or whānau.

In 2018, not enough DHBs recorded meaningful consultation data to allow the Ministry to analyse whānau and family consultation across New Zealand as a whole. Some DHBs reported comprehensively involving whānau and families as a natural extension of care consistent with the consultation obligations set out in section 12 of the Substance Addiction Act. However, other DHBs emphasised consultation difficulties, such as in circumstances where the patient is estranged from their whānau or family or where DHBs had very little interaction with prospective patients. As the Substance Addiction Act is still relatively new, the addiction sector as a whole is learning the key processes and obligations related to it.

The Office anticipates publishing a more thorough analysis of family and whānau consultation in the Annual Report 2019, after more services begin providing meaningful data.

## Seclusion

Standards New Zealand (2008a) defines seclusion as a situation where a service user is 'placed alone in a room or area, at any time and for any duration, from which they cannot freely exit'. Seclusion should be an uncommon event, and services should use it only when the individual or others are at an imminent risk of harm and no other safe and effective alternative is possible.

The data captured in this section focuses mainly on people under the Mental Health Act in adult inpatient wards who have been secluded. However, some patients who are secluded may be receiving treatment in another type of service, for example the Regional Intellectual Disability Secure Services (RIDSS), even though they are a patient under the Mental Health Act. While the Ministry is working to capture clearer seclusion data, this section does contain data that demonstrates such overlaps.

In this analysis, we have purposely left out data from two outliers, where a high proportion of recorded seclusion hours from Capital & Coast and Nelson Marlborough DHBs relate to a single client in each of these DHBs. For more information about this outlier data, please see Appendix 2.

In summary, in adult inpatient services[18] in 2018[19]:

- the total number of people who experienced seclusion while receiving mental health treatment in an adult inpatient service has decreased by 21 percent since 2009[20]
- the total number of hours spent in seclusion has decreased by 55 percent since 2009
- the number of adult inpatient clients secluded increased by 10 percent from 2017 to 2018, and the number of hours spent in seclusion also increased by 10 percent
- 72 percent of all seclusion events lasted for less than 24 hours and 14 percent lasted for longer than 48 hours
- males were more than twice as likely as females to spend time in seclusion
- people aged 20–24 years were more likely to spend time in seclusion than those in any other age group
- Māori were more likely than non-Māori to have been secluded, have more seclusion events (as a rate per 100,000 population) and have longer periods of seclusion on average
- inpatients had an average of 6.9 seclusion events for every 1,000 bed nights they spent in adu t inpatient units.

[18] Adult mental health services generally care for people aged 20–64 years. Adult inpatient services are distinct from forensic services, youth services, intellectual disability services and services for older people. Additionally, this data includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

[19] This excludes outlier data. Source: PRIMHD data extracted 29 July 2019, except for Lakes, Nelson Marlborough, Southern, and Waitematā DHBs which provided manual data.

[20] We are comparing with 2009 because that is the year when seclusion reduction policies were introduced.

### Seclusion under the Mental Health Act

Section 71 of the Mental Health Act describes a person's rights relating to seclusion. It states that seclusion can only occur where, and for as long as, it is necessary for the care or treatment of the person, or to protect other people.

Seclusion rooms must be designated by the relevant DAMHS and can be used only with the authority of a person's responsible clinician. In an emergency, a nurse may place a person in a seclusion room; however, if they do, they must immediately notify the responsible clinician.

Clinicians must record the duration and circumstances of each episode of seclusion in a register that must be available for district inspectors to review. It is important to note that the seclusion of an individual in a non-designated room must still be recorded as a seclusion event. Seclusion should never be used for discipline, coercion or staff convenience, or as a substitute for adequate levels of staff or active treatment.

### Changes in seclusion use

The Ministry, services and relevant agencies are working together to reduce seclusion.

The Health and Disability Services (Restraint Minimisation and Safe Practices) Standards came into effect on 1 June 2009 (Standards New Zealand 2008b). Their intent is to 'reduce the use of restraint in all its forms and to encourage the use of least restrictive practices'.

In 2010, the Ministry published the revised guidelines *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. With the aim of decreasing seclusion, these guidelines identified best practice methods for clinicians using seclusion in mental health inpatient units.

In December 2012, the Government announced a five-year service development plan for mental health and addiction services, including an action to reduce and eliminate the use of seclusion and restraint. Te Pou o te Whakaaro Nui supported this action, publishing the resource *Towards Restraint-free Mental Health Practice: Supporting the reduction and prevention of personal restraint in mental health inpatient settings* (Te Pou 2015) and developing the Safe Practice Effective Communication (SPEC) training programme for services staff.[21]

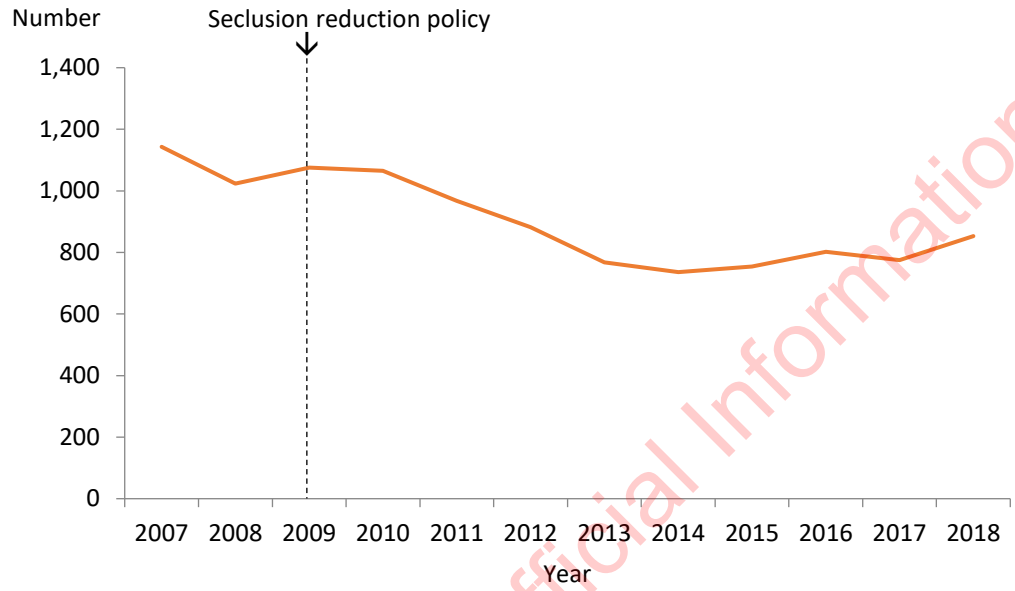
In March 2018, the Health Quality & Safety Commission (HQSC), in partnership with Te Pou, launched a national collaborative project called 'Zero Seclusion: towards the elimination of seclusion by 2020'. In collaboration with DHBs, service providers and tāngata whaiora, the Zero Seclusion project takes a recovery approach that includes a strong focus on the role of consumers, families and whānau. The project uses quality improvement methods to test and

[21] For additional information about Te Pou's work on restraint and seclusion, see www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/102

implement evidence-based strategies to reduce and eliminate the use of seclusion. For more information about Zero Seclusion, see www.hqsc.govt.nz

Since the seclusion reduction policy began in 2009, the total number of people secluded in adult inpatient services decreased by 21 percent nationally (see Figure 25). Also at a national level, the total number of hours of seclusion in adult inpatient services has decreased by 55 percent (see Figure 26).

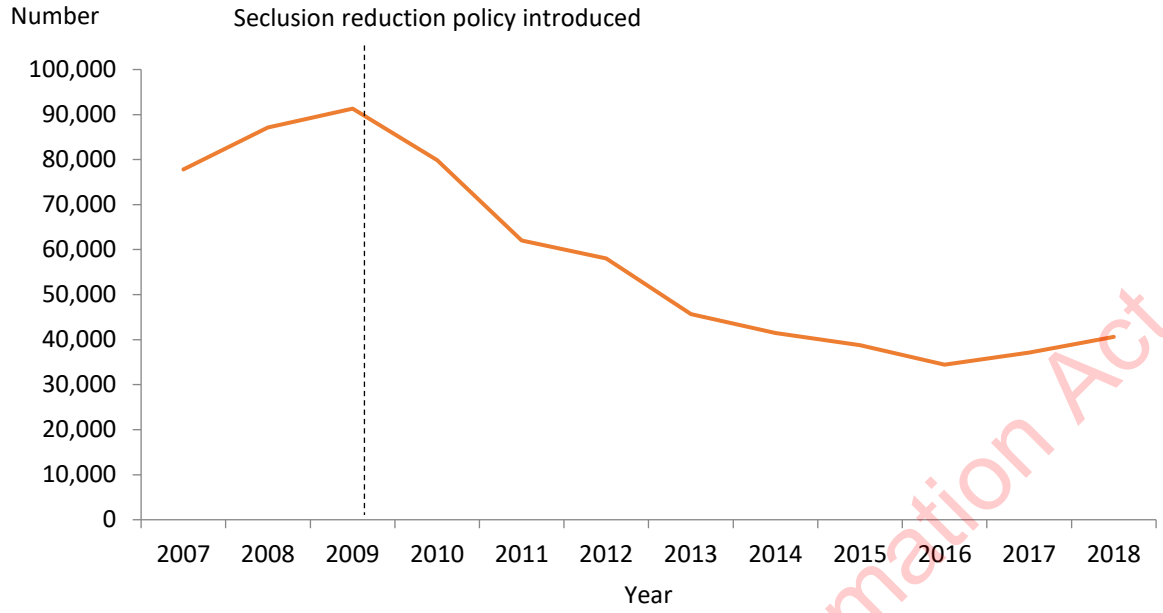
**Figure 25: Number of people secluded in adult inpatient services nationally, 2007–2018**




Note: This data excludes forensic inpatient services and two outliers. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

**Figure 26: Total number of seclusion hours in adult inpatient services nationally, 2007–2018**




Note: This data excludes forensic inpatient services and two outliers. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

Against these positive trends, however, between 2017 and 2018, the total number of people who were secluded in adult inpatient services increased by 10 percent, and the number of hours spent in seclusion also increased by 10 percent.

To reduce (and eventually eliminate) seclusion, we will need strong local leadership and resourcing, evidence-based initiatives to reduce seclusion, ongoing workforce development and significant organisational commitment. In line with the findings of *He Ara Oranga*, the Office will continue to focus on service improvements that prioritise human rights and equity. We maintain close working relationships with agencies like HQSC and Te Pou and will continue to provide leadership in the project to eliminate seclusion by publishing new guidance on restrictive practices and introducing a monitoring regime for overnight seclusion events ('night safety procedures').

### Seclusion in New Zealand mental health services

Between 1 January and 31 December 2018, New Zealand adult mental health services (excluding forensic and other regional rehabilitation services) accommodated 8,768 people

for a total of 245,290 bed nights.[22] Of these people, 852[23] (9.7 percent) were secluded at some stage during the reporting period.

Among the adults who were secluded, many were secluded more than once (on average two times).[24] For this reason, the number of seclusion events in adult inpatient services (1,678) was higher than the number of people secluded (852).[25]

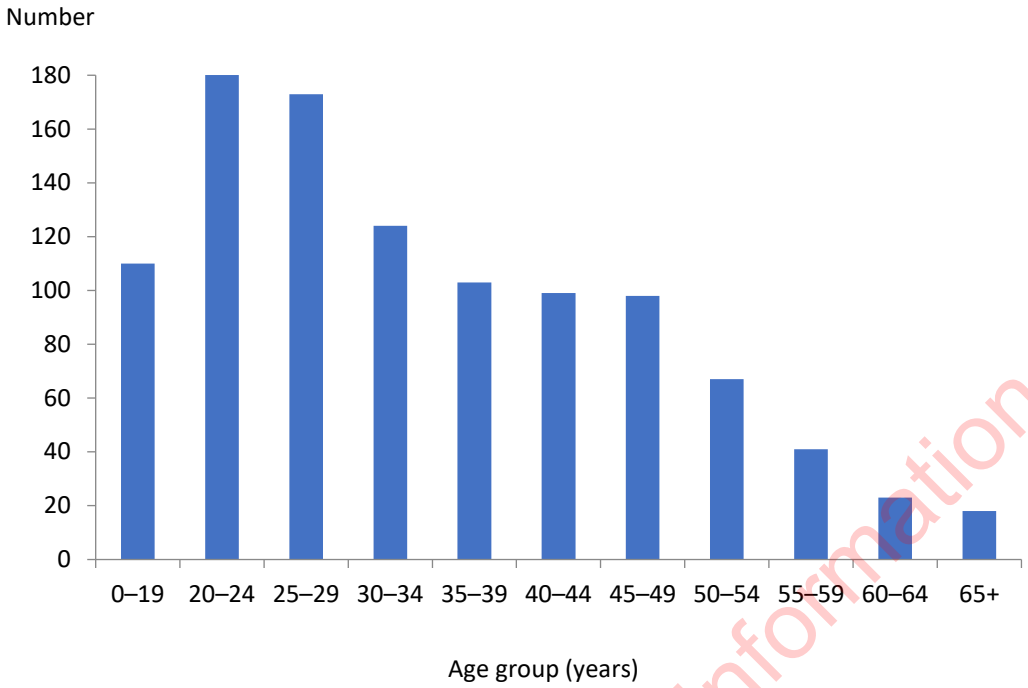
In 2018, there were 6.9 seclusion events per 1,000 bed nights in adult inpatient units. This means that – nationally and on average – for every 1,000 bed nights a person spent in an inpatient unit, the person would have 6.9 seclusion events.[26]

Across all inpatient services, including forensic, intellectual disability and youth services, 1,066 people experienced at least one seclusion event.[27] Of those secluded, 69 percent were male and 31 percent were female. The most common age group for those secluded was 20–24 years (see Figure 27). A total of 110 young people (aged 19 years and under) were secluded during the 2018 year in 290 seclusion events.[28]



[22] PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern, and Waitematā DHBs. This data excludes two outliers and forensic services. Bed nights are measured by team types that provide seclusion. This figure cannot be compared with years before 2017, when bed nights were measured by acute and sub-acute bed nights.
[23] PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs. Excludes two outliers and forensic services.
[24] PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs. Excludes two outliers and forensic services.
[25] PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs. Excludes two outliers and forensic services.
[26] PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs. Excludes two outliers and forensic services.
[27] PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs. Excludes two outliers.
[28] Of the 110 young people spending time in seclusion, 32 were in the country's specialist facilities for children and young people (in Christchurch, Auckland and Wellington). Of the 290 seclusion events, 108 occurred in those specialist facilities.

**Figure 27: Number of people secluded across all inpatient services (adult, forensic, intellectual disability, and youth), by age group, 1 January to 31 December 2018**

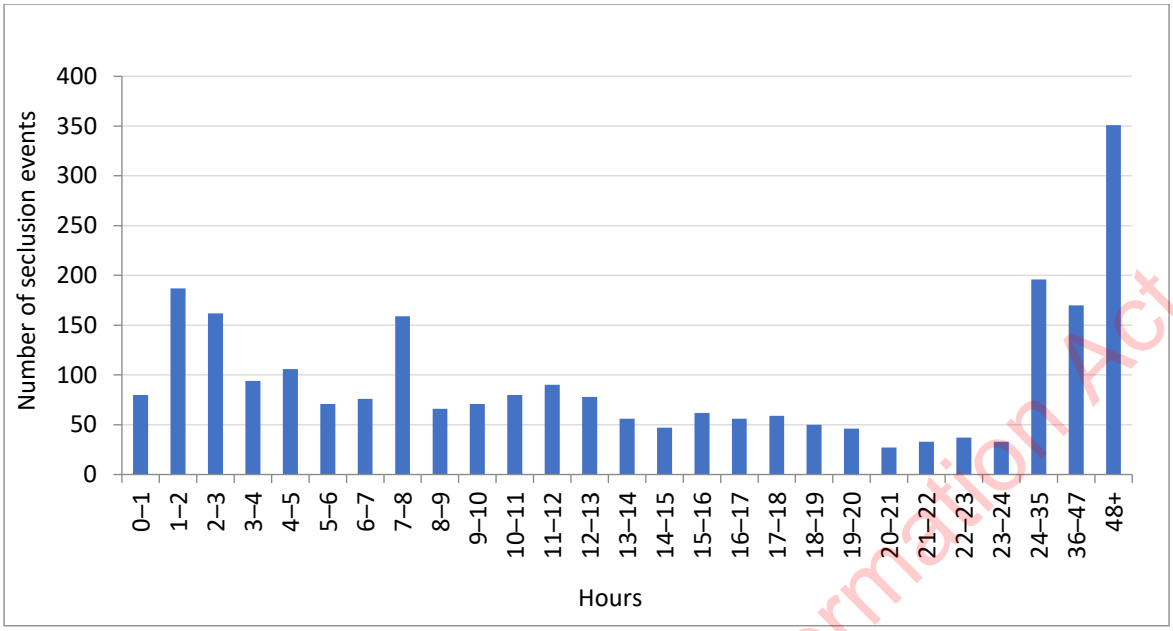



Note: This data excludes two outliers. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

The length of time spent in seclusion varied considerably. Most seclusion events (72 percent) lasted for less than 24 hours. Some (14 percent) lasted for longer than 48 hours. Figure 28 shows the number of seclusion events by the length of the event in 2018.

**Figure 28: Number of seclusion events across all inpatient services (adult, forensic, intellectual disability and youth), by duration of event, 1 January to 31 December 2018**




Note: This data excludes two outliers. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

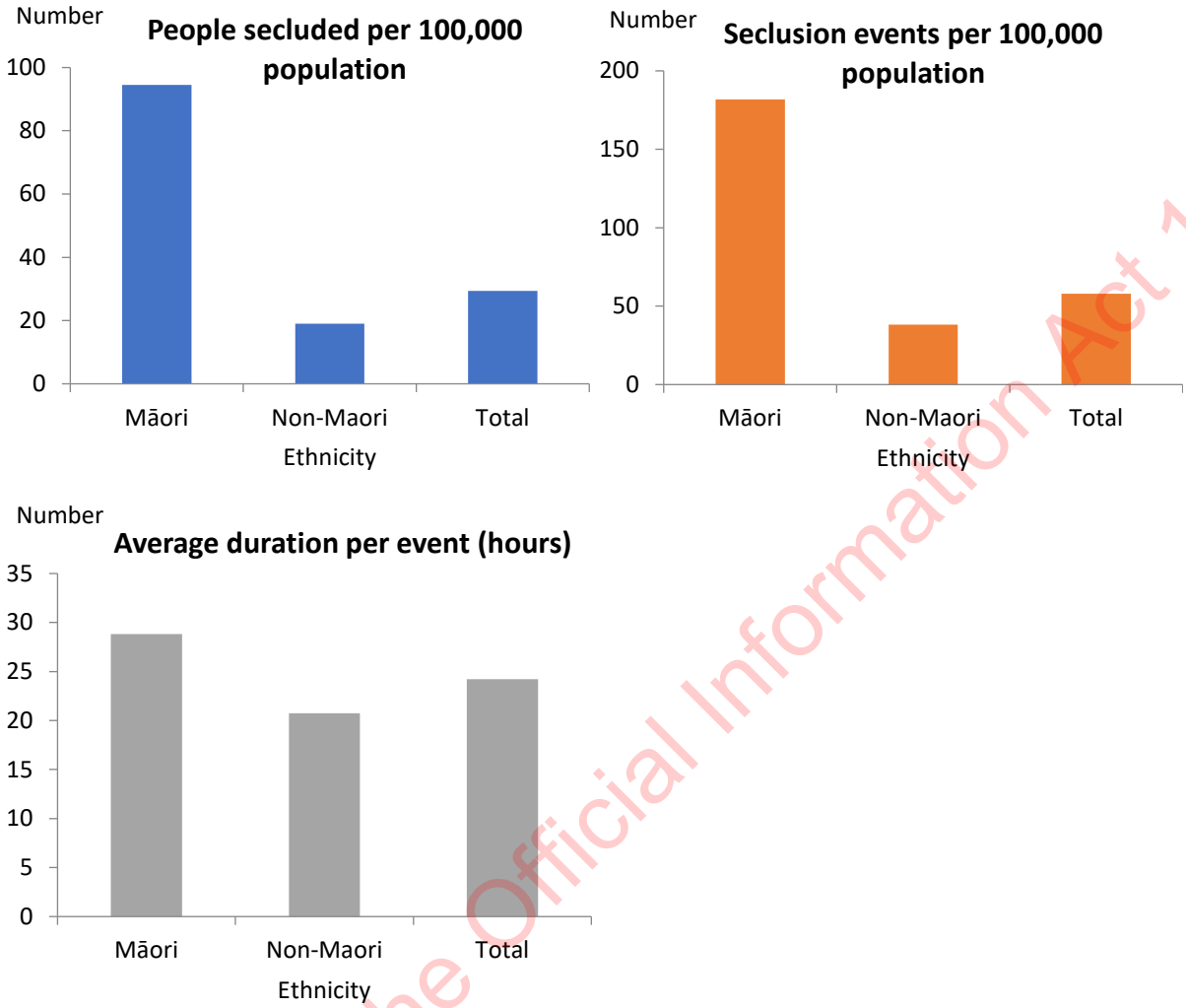
Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

## Seclusion and ethnicity

In 2018, Māori were five times more likely to be secluded in adult inpatient services than people from other ethnic groups. Figure 31 shows seclusion indicators for Māori and non-Māori during 2018. Māori were secluded at a rate of 94.5 people per 100,000 and non-Māori at a rate of 19 people per 100,000 population.[30]

[30] This report, like previous reports from the Office, measures rates of people secluded and seclusion events per 100,000 population. Other publications may measure rates of seclusion events against the population of the inpatient service. Both measures are useful. This data excludes two outliers.

**Figure 31: Seclusion indicators for adult inpatient services, Māori and non-Māori, 1 January to 31 December 2018**

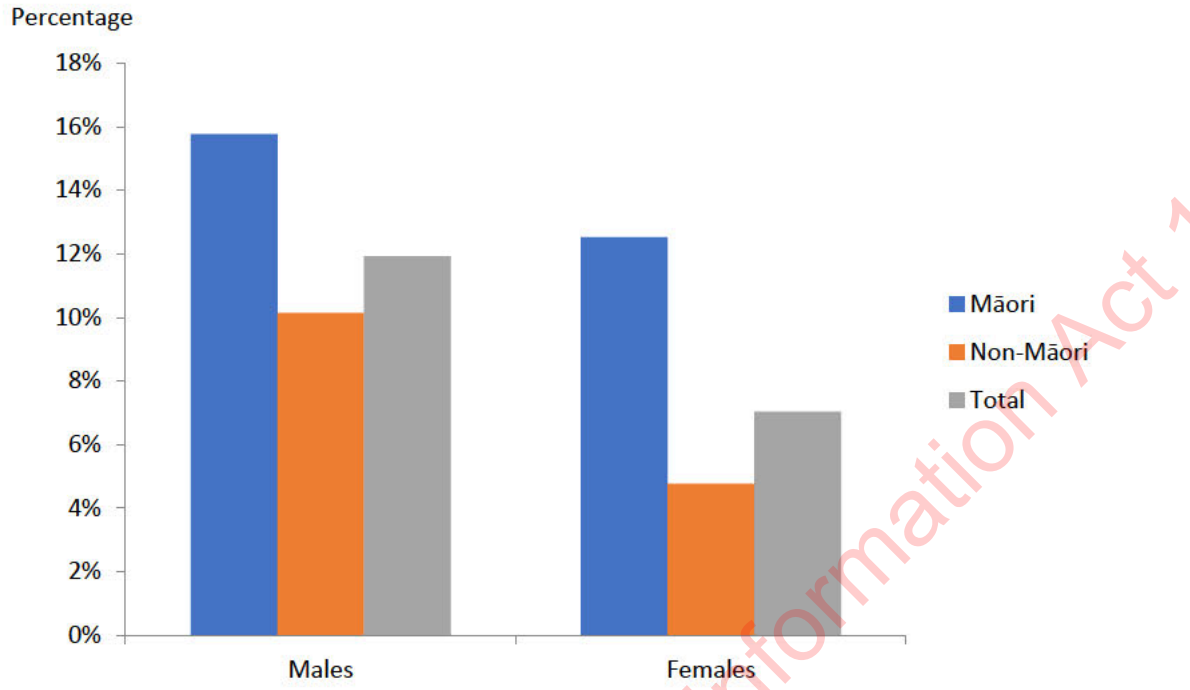



Note: This data excludes two outliers and forensic services. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS. This excludes those with a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

Figure 32 shows the percentage of Māori and non-Māori male and female service users secluded in adult inpatient services in 2018. It indicates that a greater proportion of Māori were secluded than non-Māori, and that across ethnicities males were more likely to be secluded (12 percent) than females (7 percent). However, Māori females in adult inpatient services experience higher seclusion rates than non-Māori males.

**Figure 32: Percentage of people spending time in seclusion in adult inpatient services, Māori and non-Māori males and females, 1 January to 31 December 2018**



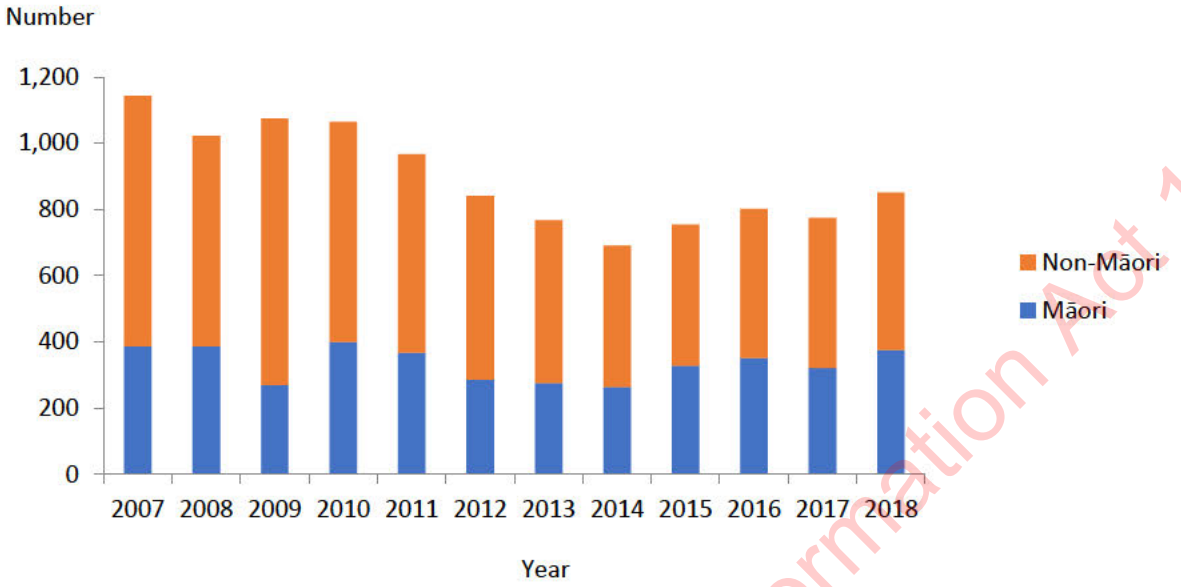

Note: This data excludes two outliers and forensic services. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS. This excludes those with a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

Figure 33 shows the number of Māori and non-Māori aged 20–64 years secluded in adult inpatient services from 2007 to 2018. Nationally over this time, the number of people secluded decreased by 25 percent. The number of people secluded who identified as Māori decreased by 3 percent over the same time.

Against this trend, however, the total number of adult patients secluded increased by 10 percent from 2017 to 2018. The number of Māori patients increased by 17 percent over the same period.

**Figure 33: Number of Māori and non-Māori aged 20–64 years secluded in adult inpatient services, 2007–2018**




Note: This data excludes two outliers and forensic services. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS. This excludes those with a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act.

Source: PRIMHD data, extracted 29 July 2019, and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs.

## Seclusion in forensic units

Five DHBs provide specialist inpatient forensic services: Canterbury, Capital & Coast, Southern, Waikato and Waitematā.[31] These services provide mental health treatment in a secure environment for prisoners with mental disorders and for people defined as special or restricted patients under the Mental Health Act.

These forensic services also provide care for people (care recipients or special care recipients) under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCC&R Act). The Ministry of Health purchases this care under the High and Complex Framework. The facilities that these services offer vary. Some services provide beds within existing forensic mental health infrastructure; others provide them in purpose-built facilities. Some RIDSS also have 'step-down' facilities, which are medium secure 'cottages' intended to provide a more home-like environment as care recipients move towards a transition to the community.

[31] Capital & Coast DHB also operates a forensic service at Whanganui.

We report on seclusion data for those under the IDCC&R Act separately from the data for patients under the Mental Health Act to give a better understanding of the use of seclusion for each group (see below).

As we noted previously, the seclusion data presented for intellectual disabilities is specific to care recipients with a legal status under the IDCC&R Act. The seclusion data for mental health services includes patients who have a legal status under the Mental Health Act but receive treatment from RIDSS.

Care recipients being cared for under the IDCC&R Act and the Mental Health Act may only be subject to seclusion in hospital-level secure services that meet requirements in the Mental Health Act.

A small number of care recipients currently in secure care have not made significant rehabilitative gains towards transitioning to community placement. These clients have intellectual disabilities and/or mental health conditions of such severity that they have been subject to long-term hospital-level care, and it is highly likely they will continue to require long-term secure care and more restrictive practices. Tables 7, 8 and 9 reflect these circumstances.

Table 7 presents data on the number of seclusion events for people with intellectual disabilities in each DHB, while Table 8 presents data on seclusion hours for this group in 2018.

**Table 7: Number of seclusion events for people with intellectual disabilities, by DHB, 1 January to 31 December 2018**

| DHB | Number of beds* | Number of people | Number of events | Median of number of events | Average number of events per person |
|---|---|---|---|---|---|
| Canterbury | 8 | 4 | 29 | 4 | 7 |
| Capital & Coast | 32 | 5 | 14 | 2 | 3 |
| Southern | 11 | 2 | 31 | 16 | 16 |
| Waikato | 3 | 3 | 36 | 12 | 12 |
| Waitematā | 12 | 6 | 151 | 10 | 25 |

Note: This data presents seclusion data only for care recipients with a legal status under the IDCC&R Act.

Source: All DHB data supplied manually.

**Table 8: Seclusion hours for people with intellectual disabilities, by DHB, 1 January to 31 December 2018**

| DHB | Total seclusion hours (hours) | Median duration of seclusion events (hours: minutes) | Average duration of seclusion events (hours: minutes) |
|---|---|---|---|
| Canterbury | 233 | 3:07 | 8:02 |
| Capital & Coast | 213 | 16:40 | 15:13 |
| Southern | 142 | 2:55 | 4:34 |
| Waikato | 590 | 4:31 | 16:22 |
| Waitematā | 1868 | 7:29 | 12:22 |

Note: This data presents seclusion data only for care recipients with a legal status under the IDCC&R Act.

Source: All DHB data supplied manually.

Table 9 presents seclusion indicators for forensic mental health services in each DHB for 2018. These indicators cannot be compared with adult service indicators because they have a different client base. A few individuals who were secluded significantly more often or for longer than others can substantially affect the rates of seclusion for the relatively small group of people in the care of forensic mental health services.

**Table 9: Seclusion indicators for forensic mental health services, by DHB, 1 January to 31 December 2018**

| DHB | Number of clients secluded | Number of events | Total hours | Average duration per event (hours) |
|---|---|---|---|---|
| Canterbury | 22 | 85 | 7,741 | 91.1 |
| Capital & Coast | 6 | 24 | 662 | 27.6 |
| Southern | 2 | 9 | 530 | 58.9 |
| Waikato | 26 | 68 | 4,906 | 72.2 |
| Waitematā | 43 | 338 | 6,262 | 18.5 |
| **Total** | **99** | **524** | **20,101** | **38.4** |

Notes: The sum of the total clients does not match the total reported because one client was seen by both Canterbury and Capital & Coast DHBs. In the 2017 Annual Report, the last column was mislabelled 'Average duration per client (hours)'. The correct label for that column is 'Average duration per event (hours)', making it comparable with other years' data. Data for the Whanganui forensic mental health service has been included with Capital & Coast.

Clients are aged 20–64 years. Clients are mental health service users only.

Source: PRIMHD data extracted on 29 July 2019; manual data submitted by Southern and Waitematā DHBs.

# Substance use treatment

## Substance Addiction (Compulsory Assessment and Treatment) Act 2017

In February 2018, the Substance Addiction Act came into force, replacing the Alcoholism and Drug Addiction Act 1966. The Substance Addiction Act is designed to help people with a severe substance addiction and impaired capacity to make decisions about engaging in treatment. This new legislation is better equipped to protect the human rights and cultural needs of patients and whānau, and places greater emphasis on a mana-enhancing and health-based approach.

### *Severe substance addiction*

Section 8 states the meaning of severe substance addiction. It is a continuous or intermittent condition that is of such severity that it poses a serious danger to the health and safety of the person and seriously diminishes their ability to care for themselves. It manifests itself in the compulsive use of a substance that is characterised by at least two of the following features:

- neuro-adaptation to the substance
- craving for the substance
- unsuccessful efforts to control the use of substance
- use of the substance despite suffering harmful consequences.

### *Criteria for compulsory treatment*

Section 7 states the criteria for compulsory treatment, all of which must apply.

- The person has a severe substance addiction.
- The person's capacity to make informed decisions about treatment for that addiction is severely impaired
- Compulsory treatment of the person is necessary.
- Appropriate treatment for the person is available.

### *Key stages of the treatment process under the Substance Addiction Act*

| | |
|---|---|
| **APPLICATION** | **Section 14** |
| | An applicant who believes that a person has a severe substance addiction may apply to the Director of Area Addiction Services to have the person assessed. |
| **ASSESSMENT** | **Section 22** |
| | An approved specialist assesses whether a person has a severe substance addiction. |

| | |
|---|---|
| | If the approved specialist considers that the person has a severe substance addiction, they must then assess whether that person's capacity to make informed decisions about treatment has been severely impaired. |
| **CERTIFICATION** | **Section 23**<br><br>After assessment, if the approved specialist considers that the person meets the criteria for compulsory treatment, they sign a compulsory treatment certificate. The person is detained at a health care service for a period of stabilisation while arrangements are made to admit them to a treatment centre. |
| **TREATMENT PLAN** | **Section 29**<br><br>The responsible clinician must prepare a treatment plan for the patient, arrange for the patient to be admitted into a treatment centre and apply to the court for a review of the compulsory status of the patient. |
| **DETENTION** | **Section 30**<br><br>The responsible clinician must direct that the patient be detained and treated in a treatment centre. The primary treatment centre is Nova Supported Treatment and Recovery (Nova STAR) in Christchurch. |
| **REVIEW** | **Section 32**<br><br>The court reviews the compulsory status of the patient. If the judge is satisfied the patient meets the criteria for compulsory treatment, they can make a compulsory treatment order, which lasts 56 days. These orders may be extended for a further 56 days. |

Statutory roles within this process ensure that health professionals: involve family and whānau; help the person to engage in voluntary treatment; and take a mana-enhancing approach. These roles include authorised officers, approved specialists, responsible clinicians, Directors of Area Addiction Services and district inspectors.

For more information about the Substance Addiction Act and these roles, visit the Ministry of Health website (www.health.govt.nz) and search for 'SACAT resources'.

***Nova Trust***

Nova Trust is the primary approved provider of treatment for people detained under the Substance Addiction Act. The Trust operates a nine-bed inpatient unit in Christchurch, Nova STAR, which offers medical care, cognitive assessments, remediation interventions, occupational therapy and relapse prevention support. Health care services can apply to be an

approved provider if they meet certain criteria under section 92 of the Substance Addiction Act.

***Statutory reporting***

Section 119 of the Substance Addiction Act requires the Ministry to publish all of the following information:

- the number of people who were detained under the Substance Addiction Act
- the length of their detention
- the number of compulsory treatment orders made
- the number of compulsory treatment orders extended
- the number of discharged patients who chose to have voluntary residential treatment and outpatient services.

Because the Substance Addiction Act was only introduced in 2018, this report may contain minor data discrepancies. In future reports, we aim to have strengthened the data reporting process.

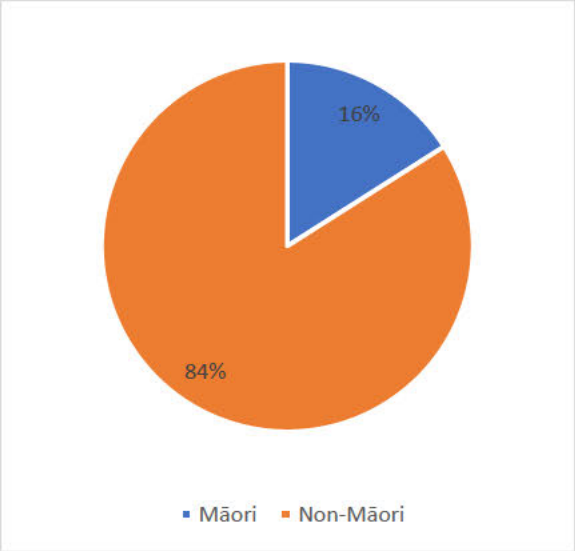
In 2018, 25 people were detained under the Substance Addiction Act.[48] This report interprets 'detained' to mean an approved specialist has signed a compulsory treatment certificate for the person. It is important to note that 'detention' may not solely refer to treatment at Nova STAR. After an approved specialist has signed a compulsory treatment certificate, most patients first need detention in a medical ward or a specialist withdrawal management ward for a period of stabilisation because of their severe physical health needs (Ministry of Health 2017, p 17).

Among those subject to compulsory treatment certificates, 12 were women and 13 were men.[49] They tended to be in older age groups, with 60 percent over 50 years old. The most common ethnic group in this cohort was New Zealand European.[50] Nearly half of all patients with compulsory treatment certificates were referred from DHBs in the greater Auckland region (Auckland, Waitematā and Counties Manukau).[51] In 2018, the courts made 15 compulsory treatment orders and extended 10 compulsory treatment orders.



[48] PRIMD data, extracted 12 September 2019.
[49] PRIMD data, extracted 12 September 2019.
[50] PRIMD data, extracted 12 September 2019.
[51] PRIMD data, extracted 12 September 2019.

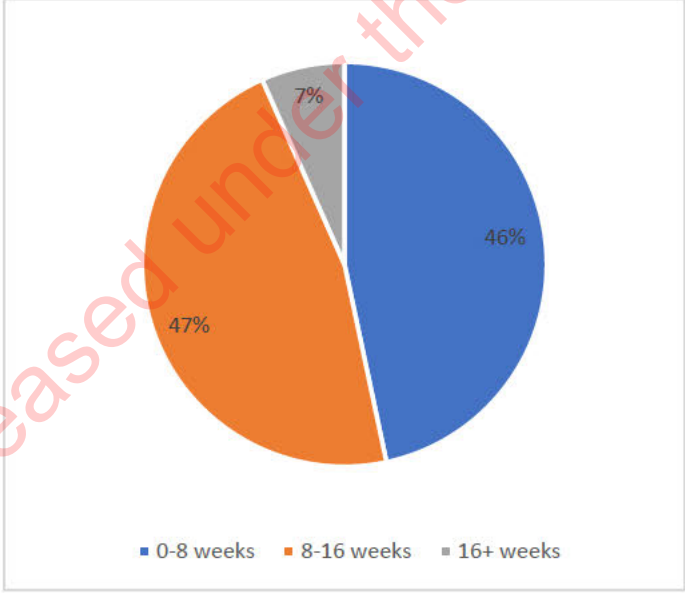
**Figure 41: Percentage of patients subject to compulsory treatment certificates, by ethnicity, 1 January to 31 December 2018**




Source: PRIMHD data, extracted 12 September 2019.

The average length of detention was seven weeks and four days. Among these patients, 46 percent were detained for a period of less than eight weeks, which is within the first period of compulsory treatment set out in the Act. Another 47 percent of patients were detained for a period of between 8 and 16 weeks, requiring a compulsory treatment order extension. Seven percent of patients were detained for a period of longer than 16 weeks (see Figure 42).

**Figure 42: Percentage of patients subject to compulsory treatment certificates, by number of weeks in detention, 2018**




Source: PRIMHD data, extracted 12 September 2019.

Section 43 of the Substance Addiction Act describes the threshold for release from compulsory status. The responsible clinician must order the release of a patient if the responsible clinician is satisfied that the patient no longer meets the criteria for compulsory treatment or that no useful purpose would be served by continuing with compulsory treatment of the patient. Section 43 does not use the term 'discharge'. However, we use it in this report to mean that a patient is no longer under a compulsory treatment certificate, compulsory treatment order or compulsory treatment order extension.

PRIMHD records show that in 2018, among service users who were discharged from the Substance Addiction Act:

- 36 percent received additional inpatient care[52]
- 64 percent engaged with individual treatments in outpatient services
- 44 percent had family meetings arranged
- 36 percent had Supplementary Consumer Records
- 25 percent had wellness plans.[53]

Note that this data represents the 2018 calendar year. If a service user was discharged in late December, they are unlikely to have had enough time to engage with outpatient services during the reporting period. For this reason, it may be difficult to draw meaningful conclusions about a service user's recovery journey from the information above.

Additionally, data from PRIMHD is only able to measure mental health outcomes, so these results may not fully encompass other sources of support for people recovering from severe substance addiction – for example, support for access to housing.

### Land Transport Act 1998

In 2018, the Office continued to work with the New Zealand Transport Agency (NZTA), Ministry of Transport and dapaanz to monitor the reinstatement of drivers disqualified for offences involving alcohol or drugs and to approve assessment centres as stated under section 65A. Section 65 of the Land Transport Act 1998 provides for the mandatory indefinite disqualification of drivers' licences and assessment for repeat driving offenders involving drugs or alcohol. For a licence to be reinstated, the person must attend an approved assessment centre and undergo an assessment of how well they are managing their substance use or addictive behaviour issues. The assessment centres send copies of their reports to NZTA, which decides whether to reinstate the person's licence.

The Director-General of Health approves assessment centres. Establishments and individuals applying to be an approved assessment centre must demonstrate that they are competent in

[52] PRIMHD data, prepared 30 October 2019.
[53] PRIMHD data, prepared 20 November 2019.

assessing alcohol and other drug problems, and are a registered and experienced alcohol and drug practitioner.

### Opioid substitution treatment

Opioid dependence is a complex, relapsing condition requiring a model of treatment and care much like any other chronic health problem. Opioid substitution treatment (OST) helps people with opioid dependence to access treatment, including substitution therapy, that provides them with the opportunity to recover their health and wellbeing.

Specialist OST services are specified by the Minister of Health under section 24 of the Misuse of Drugs Act 1975, and notified in the *New Zealand Gazette*. OST services in New Zealand are expected to provide a standardised approach underpinned by concepts of person-, family- and whānau-centred treatment, recovery, wellbeing and citizenship. To help services take this approach, *New Zealand Practice Guidelines for Opioid Substitution Treatment* (Ministry of Health 2014a) provides clinical and procedural guidance for specialist services and primary care providers who deliver OST.

In 2018:

- 5,573 people received OST
- 80.4 percent of these people were New Zealand European, 14.9 percent were Māori, 1.3 percent were Pacific peoples and 3.3 percent were of another ethnicity
- 61.7 percent of clients receiving OST were over 45 years old
- 27.3 percent of people receiving OST were being treated by a general practitioner in a shared-care arrangement.[54]

The Medical Officer of Health, acting under delegated authority from the Minister of Health, designates specialist services and lead clinicians to provide treatment with controlled drugs to people who are dependent on controlled drugs, according to section 24A(7)(b) of the Misuse of Drugs Act 1975. For this purpose, the Officer undertakes site visits, focusing on building relationships and improving service quality. These services are also subject to a Ministry audit every three years, through the *Specialist Opioid Substitution Treatment Service Audit and Review Tool* (Ministry of Health 2014b).

#### *Service providers*

Three types of providers undertake OST services.

**Specialist services.** Specialist OST services are the entry point for nearly all people requiring treatment with controlled drugs. Specialist OST services will comprehensively assess the needs of clients, provide specialist interventions and stabilise clients. This creates a pathway for recovery planning, referrals for co-existing health needs and social support, and

[54] Data provided by OST services in six-monthly reports. These six-monthly reports do not collect data by National Health Index (NHI) numbers. The New Zealand total is a sum of the DHB figures and so it double-counts people who had services from more than one DHB.

eventually the transfer of treatment to a primary health provider or withdrawal from treatment altogether.

**Primary health.** Specialist addiction services work together with primary health care. This approach allows specialist services to focus on clients with the highest need and normalises the treatment process. In 2018, 27.3 percent of clients receiving OST had that treatment from their general practitioner. The Ministry's target for service provision is 50:50 between primary and specialist health care services. Figure 43 presents the percentage of people receiving OST from specialist services and general practice in each DHB in 2018.

**Department of Corrections.** When a person receiving OST goes to prison, the Department of Corrections ensures that the person continues to receive OST services, including psychosocial support and treatment from specialist services. In 2018, 1.3 percent of clients receiving OST had that treatment from the Department of Corrections. Service providers and the Department of Corrections are also working together to initiate OST as appropriate for people who are imprisoned.

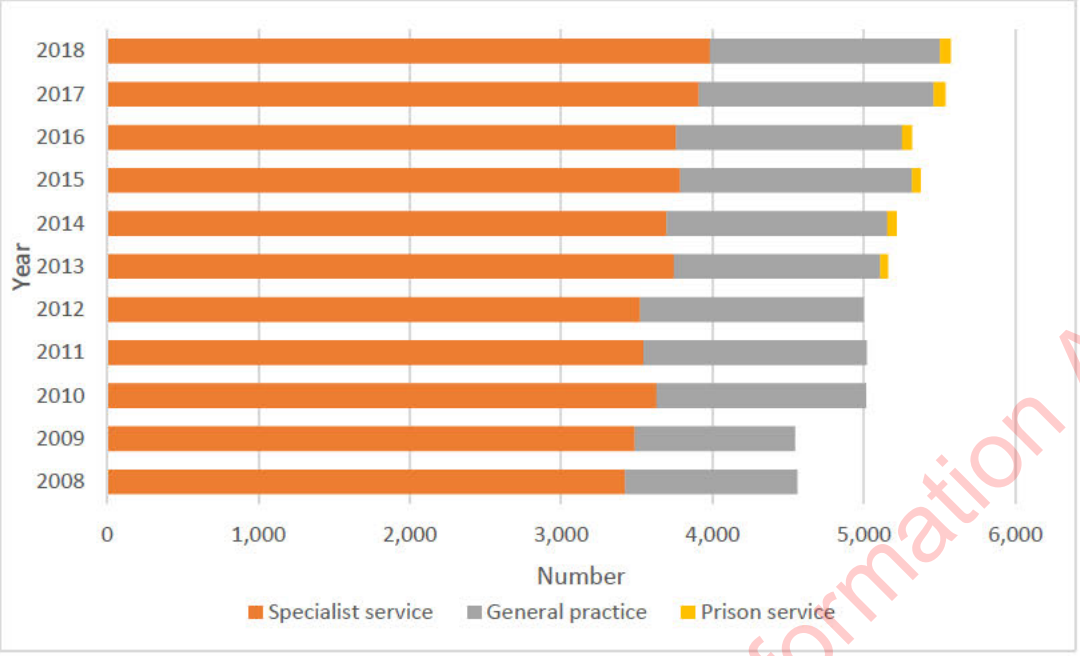
Figure 44 shows the number of people receiving OST from each of these types of providers each year from 2008 to 2018.

**Figure 43: Percentage of people receiving opioid substitution treatment from specialist services and general practice, by DHB, 1 January to 31 December 2018**


Note: GP = general practitioner.

Source: Data provided by OST services in six-monthly reports.

**Figure 44: Number of people receiving opioid substitution treatment from a specialist service, general practice or prison service, 2008–2018**




Note: Data for clients seen in prison collected from July 2013.

Source: Data provided by OST services in six-monthly reports.

### *Prescribing opioid treatments*

Replacing addictive substances like opioids with prescribed drugs is called pharmacotherapy. The purpose of this treatment is to stabilise the opioid user's life and reduce harms related to drug use, such as the risk of overdose, blood-borne virus transmission and substance-related criminal activity.

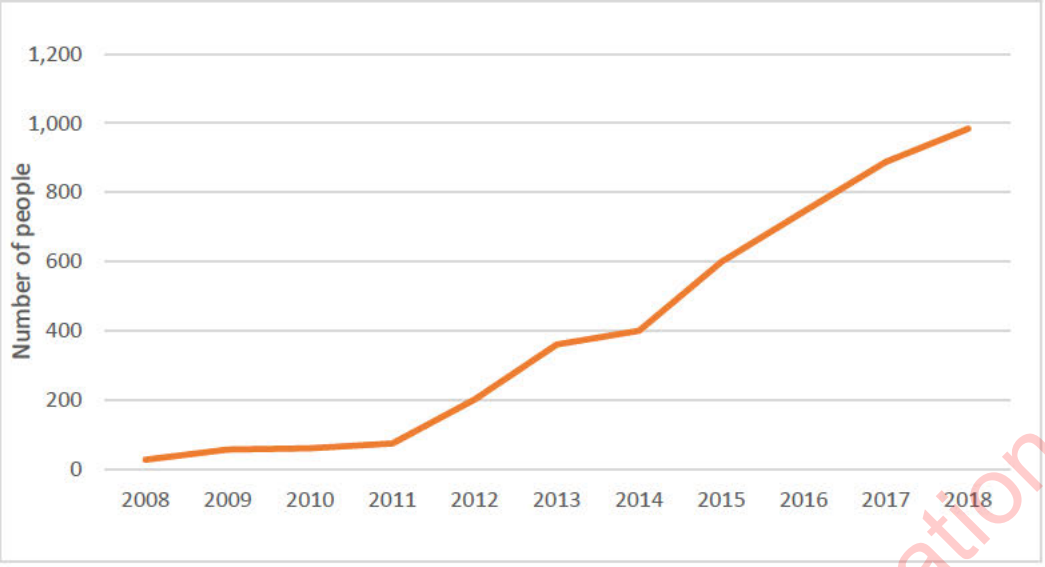
The two types of pharmacotherapy are:

1. maintenance therapy – using opioid substitutes for the purpose of remaining on a stable dose
2. detox – using opioid substitutes for the purpose of gradually withdrawing from the substitute so the client is free of all opioid substances.

Methadone has historically been the main opioid substitution treatment available. Clients need a daily dose, which in turn makes it necessary to place limits on prescribing and dispensing.

In 2012, PHARMAC began funding a buprenorphine-naloxone (suboxone) combination. Suboxone can be administered in cumulative doses that last several days, which reduces the risk of drug diversion and offers clients more normality in their lives. Figure 45 presents the number of people prescribed suboxone from 2008 to 2018. In 2018, 17.7 percent of clients were prescribed suboxone.

**Figure 45: Number of people prescribed suboxone, 2008–2018**

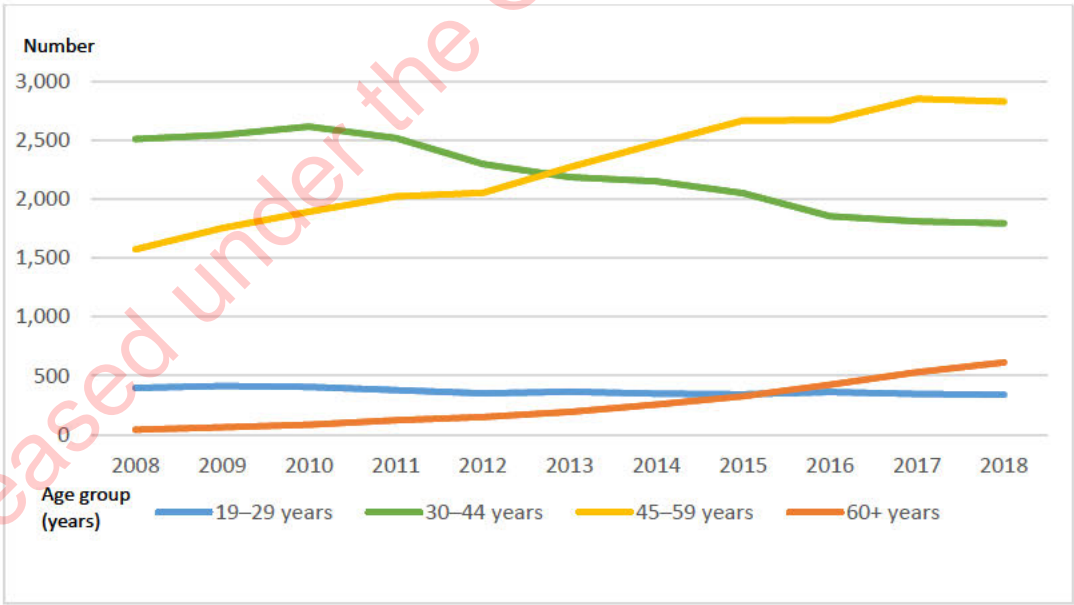



Source: Data provided by OST services in July to December six-monthly reports.

### *The ageing population of OST clients*

OST clients are an ageing population; Figure 46 shows how clients in older age groups have been increasing in number from 2008 to 2018 to the point that those over 45 years of age are now the most likely to be receiving treatment. In 2018, 61.7 percent of clients were over 45 years old, and only one service had less than half of its clients over 45 years old. Treating an ageing population also brings with it more health complications.

**Figure 46: Number of opioid substitution treatment clients, by age group, 2008–2018**




Source: Data provided by OST services in July to December six-monthly reports.

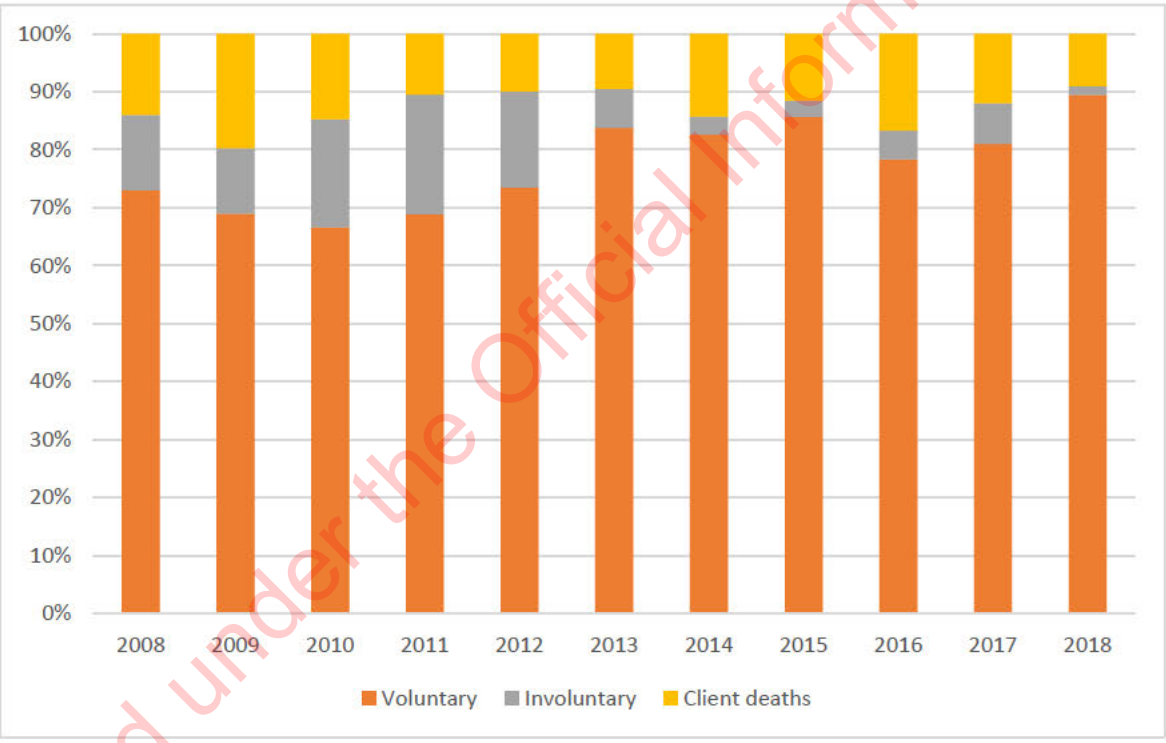
***Exit from OST***

In 2018, 403 people voluntarily withdrew from OST, which accounts for 90 percent of all people who exited from OST that year. Seven withdrawals (2 percent of all withdrawals) were involuntary. Involuntary withdrawals are the result of behavioural risks that jeopardise the safety of the client or others.

In 2018, 43 people receiving OST died. A small proportion of these people died of a suspected overdose. When a client dies of a suspected overdose, the Ministry requires services to conduct an incident review and report it to the Medical Officer of Health. The remaining deaths had a range of other causes, such as cancer and cardiovascular disease.

Figure 47 gives an overview of the reasons for withdrawal (voluntary, involuntary or death) over time, from 2008 to 2018.

**Figure 47: Percentage of withdrawals from opioid substitution treatment programmes, by reason (voluntary, involuntary or death), 2008–2018**




Source: Data provided by OST services from the sum of January to June and July to December six-monthly reports.

## Electroconvulsive therapy

Electroconvulsive therapy (ECT) is a therapeutic procedure that delivers a brief pulse of electricity to a person's brain in order to produce a seizure. It can be an effective treatment for depression, mania, catatonia and other serious neuropsychiatric conditions. It is often effective as a last resort in cases where medication is contraindicated or is not relieving

symptoms sufficiently. It can only be given with the consent of the person receiving it, other than in certain carefully defined circumstances.

In 2018:

- 265 people received ECT (5.4 people per 100,000)
- services administered a total of 2,990 treatments of ECT
- those treated received an average of 11.3 administrations of ECT over the year
- females were more likely to receive ECT than males, making up 61 percent of ECT patients
- older people were more likely to receive ECT than younger people, with those over 50 years old making up 61 percent of ECT patients.

Medical staff administer ECT under anaesthesia in an operating theatre, making use of muscle relaxants. The person who has received ECT wakes unable to recall the details of the procedure. The most common side effects of ECT are confusion, disorientation and memory loss. Confusion and disorientation typically clear within an hour, but memory loss can be persistent and in some cases even permanent (American Psychiatric Association 2001; Ministry of Health 2004).

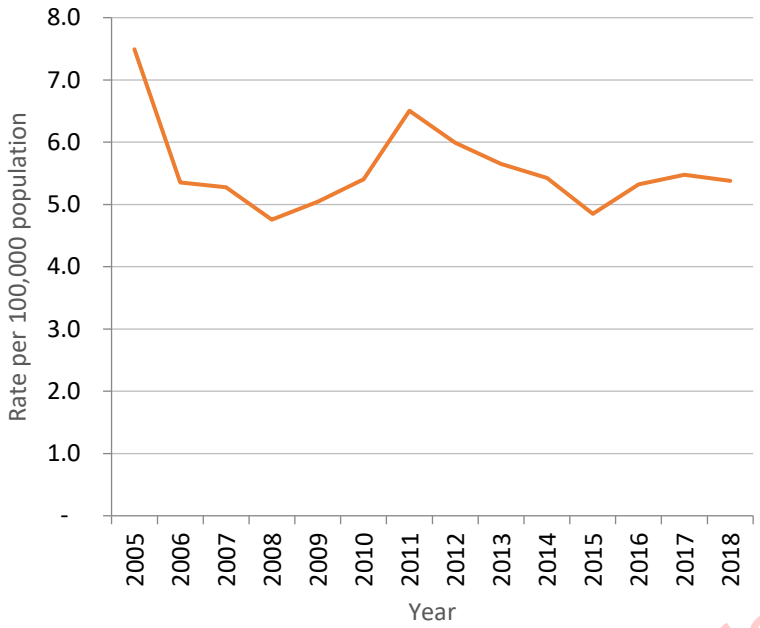
Significant advances have been made in improving ECT techniques and reducing side effects over the last 20 years. Seven out of 10 patients receiving ECT achieve complete remission (Ministry of Health 2009). Despite these improvements, ECT remains a controversial treatment. In 2003, in response to petition 1999/30 of Anna de Jonge and others about ECT, the Health Committee recommended carrying out an independent review on the safety and efficacy of ECT and the adequacy of regulatory controls on its use in New Zealand. The review concluded that ECT continues to have a place as a treatment option for consumers of mental health services in New Zealand, and that banning its use would deprive some seriously ill people of a potentially effective and sometimes life-saving means of treatment (Ministry of Health 2004).

For more information about ECT use in New Zealand, we recommend *Electroconvulsive Therapy (ECT) in New Zealand: What you and your family and whānau need to know* (Ministry of Health 2009).

### ECT treatments in 2018

The number of people treated with ECT in New Zealand has remained relatively stable since 2006. Around 200 to 300 people receive the treatment each year. During 2018, 265 people received ECT, which is a rate of 5.4 people per 100,000 population (see Figure 48).

**Figure 48: Rate of people treated with electroconvulsive therapy per 100,000 population, 2005–2018**



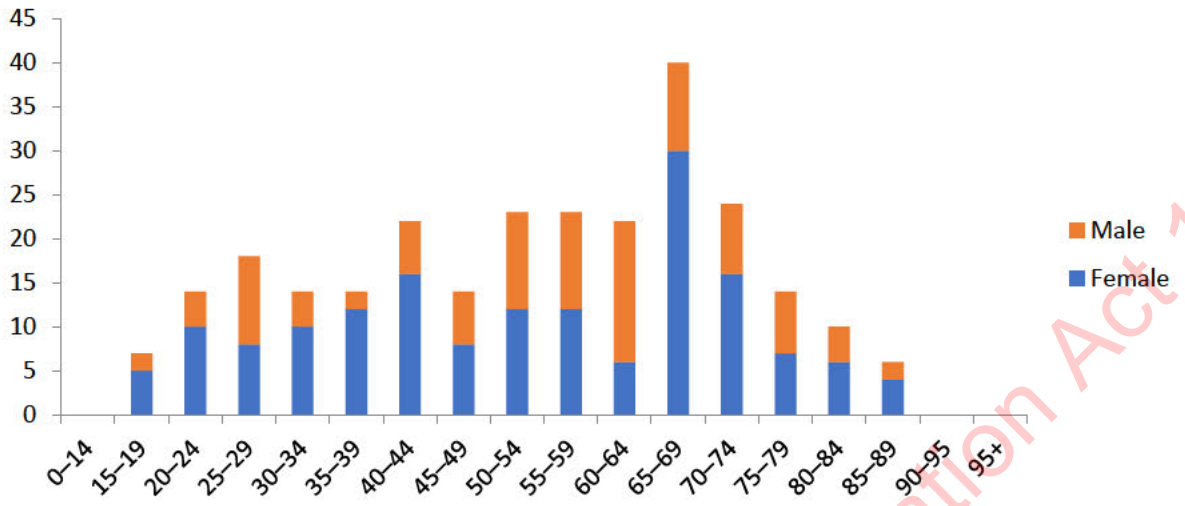

Source: PRIMHD data, extracted on 29 July 2019, except for Lakes, MidCentral Nelson Marlborough, Southern and Waitematā DHBs, which submitted data manually.

### Sex and age of people receiving ECT

In 2018, women were more likely to receive ECT than men, representing 61 percent of patients. The main reason for this difference is that more females present to mental health services with depressive disorders, one of the conditions that is responsive to ECT. This ratio is similar to that reported in other countries.

Older people were more likely to receive ECT than younger people, with patients over 50 years old representing 61 percent of all patients (see Figure 50). A likely explanation is that medications used to treat severe depression might interact adversely with medications for physical illnesses that are more prevalent in older people, like heart disease. Therefore ECT may be a suitable alternative treatment.

**Figure 50: Number of people treated with electroconvulsive therapy, by age group and sex, 1 January to 31 December 2018**




Source: PRIMHD data, extracted on 29 July 2019, except for Lakes, MidCentral, Nelson Marlborough, Southern and Waitematā DHBs, which submitted data manually.

## Ethnicity of people treated with electroconvulsive therapy

Table 20 indicates that Asian, Māori and Pacific peoples are less likely to receive ECT than those of other ethnicities, such as New Zealand European. However, the numbers involved are so small that it is not statistically appropriate to compare the percentages of people receiving ECT in each ethnic group with the proportion of each ethnic group in the total population of New Zealand.

**Table 20: Number of people treated with electroconvulsive therapy, by ethnicity, 1 January to 31 December 2018**

| Ethnicity | Number |
|---|---|
| Asian | 21 |
| Māori | 33 |
| Pacific | 8 |
| Other | 203 |
| **Total** | **265** |

Source: PRIMHD data, extracted on 29 July 2019, except for Lakes, MidCentral, Nelson Marlborough, Southern and Waitematā DHBs, which submitted data manually.

## Consent to treatment

Under the Mental Health Act, a person can be treated with ECT if they consent in writing, or if an independent psychiatrist appointed by the Mental Health Review Tribunal considers this treatment to be in the person's interests. An independent psychiatrist cannot be the patient's responsible clinician or part of the patient's clinical team.

An example of a patient too unwell to consent is someone experiencing a catatonic stupor in which they withdraw from necessary activities of life including moving, eating and drinking and

may not have capacity to consent. In such cases, DHBs get second opinions from independent psychiatrists to safeguard the patient's treatment. Independent psychiatrists should decide whether ECT is in the interests of the person after discussing the options with family and whānau and considering any relevant advance directives the person has made (see Ministry of Health 2012d).

During 2018, services administered ECT to 99 people who could not consent to treatment. The total number of ECT treatments administered without consent was 1,024, a slight decrease from 1,137 treatments in 2017. An additional 23 treatments were administered to two people who did have capacity to consent but refused, after the DHB gained a second opinion.

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# Appendix 1: Key databases and caveats

### The Programme for the Integration of Mental Health Data

The Programme for the Integration of Mental Health Data, or PRIMHD (pronounced 'primed'), is the Ministry of Health's national collection for mental health and addiction service data. PRIMHD data reporting collects information about the types of services provided by DHBs and NGOs, the engagement of service users and the outcomes for service users in their care. These reports enable mental health and addiction service providers to carry out better service planning and decision-making at the local, regional and national levels (Ministry of Health 2019).

Since 2008 it has been mandatory for all 20 DHBs to report to PRIMHD. An increasing number of NGO service providers – 204 as of December 2018 – also voluntarily report to PRIMHD.

Due to the enormous complexities of creating and maintaining a national data collection, keep in mind the following caveats when reviewing statistics generated using PRIMHD data.

- Shifts or patterns in the data after 2008 may reflect how service providers have been gradually adapting to the PRIMHD system in addition to, or instead of, showing any trend in mental health service use or consumer outcomes.
- PRIMHD is a living data collection that continues to be revised and updated as data reporting processes are improved. For this reason, previously published data may be amended later.
- Statistical variance between services may reflect different models of practice and different consumer populations. However, it may also result from differences in data entry processes and information management.
- For PRIMHD to function as a national collection, it is necessary to integrate a wide range of person management systems across hundreds of unique service providers. As these services adjust to reporting to PRIMHD, we expect that the quality of the data will improve.
- For high-quality, accurate statistical reporting, the services that report to PRIMHD must be consistent, correct and timely in their data entry. The Ministry is actively engaged in ongoing work to review and improve the data quality of PRIMHD. It considers this work to be a priority given the importance of mental health data in providing information about mental health service users and outcomes, and in generating conversations and public debate about how to improve mental health care for New Zealanders.

To demonstrate how much data can vary over time, Table A1 presents the rate ratio of Māori to non-Māori who were subject to a compulsory treatment order (section 29) under the Mental Health Act from 2013 to 2018.

**Table A1: Rate ratio Māori to non-Māori subject to a compulsory treatment order (section 29) under the Mental Health Act, 2013–2018**

| Year | Rate ratio (Māori:non-Māori) | | | | | |
|---|---|---|---|---|---|---|
| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
| Annual reports | 2.9 | 2.9 | 3.6 | 3.6 | 3.9 | 4.0 |
| Retrospective extraction | 3.6 | 3.8 | 3.9 | 3.9 | 4.0 | 4.0 |

Source: PRIMHD data, extracted on 1 August 2019.

From the data in our 2013 to 2018 annual reports, it appears the rate ratio between Māori and non-Māori has increased by just over 1 point. However, this change may be explained by differing sources of information about ethnicity. PRIMHD reporting uses the ethnicity recorded against a person's National Health Index (NHI) number, rather than the ethnicity recorded against the person at the time of the event. Therefore, people who have subsequently recorded Māori as an additional ethnicity on their NHI when previously they just recorded New Zealand European will be recorded as Māori on all ethnicity reports extracted after that change was made. This happens constantly as people engage more with health services and more information is collected. In 2017, ethnicity was taken from primary health organisation records and combined with the NHI – resulting in approximately 10,000 additional people categorised as Māori nationwide.

For more information on PRIMHD, the following resources may be helpful:

- For the sector: Ministry of Health. 2015. *Guide to PRIMHD Activity Collection and Use* (Version 1.0). Wellington: Ministry of Health.
- For consumers: Ministry of Health. 2016. What happens to your mental health and addiction information? Wellington: Ministry of Health.

The data for this report that has been sourced from PRIMHD has been retrieved over a range of dates from 2019 to 2020.

### The Alcohol and Drug Outcome Measure

In July 2015, the Alcohol and Drug Outcome Measure (ADOM) was mandated for use in community outpatient settings. ADOM measures alcohol and drug use, as well as lifestyle, wellbeing and recovery outcomes. Examples of outcomes it collects data on include:

- number of days of AOD use
- AOD impact on relationships with family and friends
- AOD impact on criminal activity.

This data is useful to gain a broader understanding of patients' progress through outpatient care.

In 2018, 14 DHBs reported ADOM data to PRIMHD. Some DHBs do not collect ADOM data because they do not offer AOD services. Among NGO services, 49 reported ADOM data.

For more information about ADOM information collected by PRIMHD, we recommend reading the resources available on the website of Te Pou o te Whakaaro Nui (https://www.tepou.co.nz).

# Appendix 2: Additional statistics

### The Mental Health Review Tribunal

During the year ended 30 June 2018, the Mental Health Review Tribunal (the Tribunal) received 131 applications under the Mental Health Act. Table A2 presents the types of applications received (by governing section of the Act) and the outcomes of these applications.

**Table A2: Outcome of the Mental Health Act applications received by the Mental Health Review Tribunal, 1 July 2017 to 30 June 2018**

| Outcome | Section 79 | Section 80 | Section 81 | Section 75 | Total |
|---|---|---|---|---|---|
| Deemed ineligible | 0 | 0 | 0 | 0 | 0 |
| Withdrawn | 55 | 2 | 0 | 0 | 57 |
| Held over to the next report year | 0 | 0 | 0 | 0 | 0 |
| Heard in the report year | 64 | 9 | 0 | 1 | 74 |
| **Total** | **119** | **11** | **0** | **1** | **131** |

Source: Annual report of the Mental Health Review Tribunal, 1 July 2017 to 30 June 2018.

During the year ended 30 June 2018, the Tribunal heard 64 applications under section 79 of the Mental Health Act. Table A3 presents the results of those cases.

**Table A3: Results of inquiries under section 79 of the Mental Health Act held by the Mental Health Review Tribunal, 1 July 2017 to 30 June 2018**

| Result | Number |
|---|---|
| Not fit to be released from compulsory status | 58 |
| Fit to be released from compulsory status | 5 |
| **Total** | **63** |

Note: Number of results does not always match the number of applications heard under section 79 as decisions may be reserved until a date outside of the reporting time frame.

Source: Annual report of the Mental Health Review Tribunal, 1 July 2017 to 30 June 2018.

Table A4 shows the ethnicity for 109 people whose application to the Tribunal identified their ethnicity (83 percent of applications) in the year ended 30 June 2018. A person is not required to disclose their ethnicity on their application.

**Table A4: Number and percentage of people in Mental Health Review Tribunal applications, by ethnicity, 1 July 2017 to 30 June 2018**

| Ethnicity | Number | Percentage |
|---|---|---|
| New Zealand European | 68 | 51.9 |
| Māori | 18 | 13.7 |
| Pacific | 7 | 5.3 |

| | | |
|---|---|---|
| African | 6 | 4.6 |
| Asian | 5 | 3.8 |
| Other | 5 | 3.8 |
| Unknown | 22 | 16.8 |
| **Total** | **131** | **100** |

Source: Annual report of the Mental Health Review Tribunal, 1 July 2017 to 30 June 2018.

Of the 131 Mental Health Act applications the Tribunal received during the year ended 30 June 2018, 83 (63.3 percent) were from males and 48 (36.6 percent) from females. Table A5 presents these figures broken down by the subject of the application.

**Table A5: Sex of people making Mental Health Review Tribunal applications, 1 July 2017 to 30 June 2018**

| Subject of application | Total number (percentage) | Sex | Number |
|---|---|---|---|
| Community treatment order | 91 (69.5%) | Female | 38 |
| | | Male | 53 |
| Inpatient treatment order | 29 (22.1%) | Female | 6 |
| | | Male | 23 |
| Special patient order | 11 (8.4%) | Female | 4 |
| | | Male | 7 |
| Restricted person order | 0 (0%) | Female | 0 |
| | | Male | 0 |

Source: Annual report of the Mental Health Review Tribunal, 1 July 2017 to 30 June 2018.

Under the Mental Health Act, the Tribunal must hear applications within 21 days, or 28 days with an extension. However, due to scheduling issues among the small number of Tribunal appointees based throughout the country, meeting this requirement has proved difficult. From July 2016, the Tribunal has increased its effort to address delays in hearing applications. By the final quarter of the year ended 30 June 2018, the Tribunal was hearing 91 percent of applications within 28 days (see Table A6).

**Table A6: Timeliness of applications heard by the Mental Health Review Tribunal, July 2016 to June 2018**

| Report quarter | Total number of applications | Number of withdrawn applications | Number of applications to be heard | Number of applications heard within 28 days | Percentage of applications heard within 28 days |
|---|---|---|---|---|---|
| 31 Jul 2016 – 30 Sep 2016 | 34 | 17 | 17 | 7 | 41 |
| 1 Oct 2016 – 31 Dec 2016 | 23 | 10 | 13 | 8 | 62 |
| 1 Jan 2017 – 31 Mar 2017 | 40 | 23 | 17 | 11 | 65 |
| 1 Apr 2017 – 30 Jun 2017 | 42 | 17 | 25 | 19 | 76 |
| 31 Jul 2017 – 30 Sep 2017 | 37 | 12 | 25 | 23 | 92 |

| | | | | | |
|---|---|---|---|---|---|
| 1 Oct 2017 – 31 Dec 2017 | 41 | 15 | 26 | 19 | 73 |
| 1 Jan 2018 – 31 Mar 2018 | 36 | 16 | 19 | 17 | 89 |
| 1 Apr 2018 – 30 Jun 2018 | 40 | 15 | 22 | 20 | 91 |

Source: Annual report of the Mental Health Review Tribunal, 1 July 2017 to 30 June 2018.

## Ministry of Justice

Table A7 presents data on applications for a compulsory treatment order from 2004 to 2018. Table A8 shows the types of orders granted over the same period.

**Table A7: Applications for compulsory treatment orders or extensions, 2004–2018**

| Year | Number of applications for a CTO, or extension to a CTO | Number of applications granted or granted with consent | Number of applications dismissed or struck out | Number of applications withdrawn, lapsed or discontinued | Number of applications transferred to the High Court |
|---|---|---|---|---|---|
| 2004 | 4,443 | 3,863 | 100 | 460 | 0 |
| 2005 | 4,298 | 3,682 | 100 | 520 | 0 |
| 2006 | 4,254 | 3,643 | 109 | 515 | 1 |
| 2007 | 4,535 | 3,916 | 99 | 542 | 0 |
| 2008 | 4,633 | 3,969 | 103 | 486 | 0 |
| 2009 | 4,564 | 4,039 | 54 | 494 | 0 |
| 2010 | 4,783 | 4,156 | 74 | 523 | 1 |
| 2011 | 4,781 | 4,215 | 70 | 516 | 0 |
| 2012 | 4,885 | 4,343 | 71 | 443 | 0 |
| 2013 | 5,062 | 4,607 | 68 | 411 | 0 |
| 2014 | 5,227 | 4,632 | 47 | 577 | 0 |
| 2015 | 5,368 | 4,748 | 52 | 550 | 0 |
| 2016 | 5,601 | 4,927 | 70 | 549 | 0 |
| 2017 | 5,566 | 4,940 | 69 | 583 | 0 |
| 2018 | 5,646 | 5,002 | 77 | 542 | 0 |

Notes: CTO = compulsory treatment order. The table presents applications that had been processed at the time of data extraction on 24 June 2019. The year is determined by the final outcome date.

The case management system (CMS) is a live operational database. Figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System, which uses data entered into the CMS.

**Table A8: Types of compulsory treatment orders made on granted applications, 2004–2018**

| Year | Number of granted applications for orders | Number of community CTOs or extensions | Number of inpatient CTOs or extensions | Number of orders recorded as both community and inpatient CTOs or extension | Number of other orders | Number of applications where type of order was not recorded |
|---|---|---|---|---|---|---|
| 2004 | 3,863 | 1,831 | 1,533 | 119 | 12 | 368 |
| 2005 | 3,682 | 1,575 | 1,438 | 93 | 10 | 566 |
| 2006 | 3,643 | 1,614 | 1,384 | 91 | 14 | 540 |
| 2007 | 3,916 | 1,714 | 1,336 | 118 | 24 | 724 |
| 2008 | 3,969 | 1,841 | 1,431 | 120 | 13 | 564 |
| 2009 | 4,039 | 2,085 | 1,565 | 106 | 15 | 268 |
| 2010 | 4,156 | 2,252 | 1,624 | 113 | 9 | 158 |
| 2011 | 4,215 | 2,255 | 1,677 | 90 | 8 | 185 |
| 2012 | 4,343 | 2,436 | 1,684 | 80 | 4 | 139 |
| 2013 | 4,607 | 2,639 | 1,765 | 73 | 1 | 129 |
| 2014 | 4,632 | 2,658 | 1,784 | 84 | 1 | 105 |
| 2015 | 4,748 | 2,801 | 1,787 | 70 | 1 | 89 |
| 2016 | 4,927 | 2,894 | 1,722 | 66 | 3 | 242 |
| 2017 | 4,940 | 2,612 | 1,691 | 57 | 3 | 577 |
| 2018 | 5,002 | 2,633 | 1,753 | 46 | 3 | 567 |

Notes: CTO = compulsory treatment order. The table presents applications that had been processed at the time of data extraction on 24 June 2019. The year is determined by the date the application was granted.

Where more than one type of order is shown, it is likely to be because new orders are being linked to a previous application in the case management system (CMS). The CMS is a live operational database. Figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System, which uses data entered into the CMS.

### Seclusion data incorporating outlier data

In 2018, Capital & Coast and Nelson Marlborough DHBs provided data that each included a single client with a high number of seclusion hours. We have treated the data on each of these clients as an outlier because including it in the national statistics would skew the overall data and create a different picture of mental health services. To highlight how influential this discrepancy is, we present some of the data that includes the outliers in the table below.

**Table A9: Seclusion data in New Zealand mental health services, 1 January to 31 December 2018**

| | **Excluding** outliers[55] | **Including** outliers[56] |
|---|---|---|
| Number of people secluded in adult services | 852 people | 854 people |
| Number of hours of seclusion in adult services | 40,649 hours | 46,312 hours |
| Number of seclusion events in adult services | 1,678 events | 2,719 events |
| Average number of seclusion events per person | 2.0 events | 3.2 events |
| Number of seclusion events per 1,000 bed nights | 6.9 events | 9.9 events |
| Number of people secluded per 100,000 population | 29.4 people | 29.4 people |
| Number of seclusion events per 100,000 population | 57.8 events | 93.5 events |
| Average duration per seclusion event | 24.2 hours | 17.1 hours |
| Percentage of seclusion events lasting less than 24 hours | 72 percent | 80 percent |
| Percentage of seclusion events lasting more than 48 hours | 14 percent | 10 percent |
| Number of seclusion events per 1,000 bed nights | 6.9 events | 9.9 events |
| Decrease in hours spent in seclusion since 2009 | 55 percent | 49 percent |
| Increase in hours spent in seclusion since 2017 | 10 percent | 25 percent |
| Increase in seclusion events from 2017 | 7 percent | 26 percent |

The Director of Mental Health and the Office of the Ombudsman closely monitor individuals with high records of seclusion.



[55] This excludes outlier data. Source: PRIMHD data extracted 29 July 2019, except for Lakes, Nelson Marlborough, Southern, and Waitematā DHBs which provided manual data.
[56] This includes outlier data. Source: PRIMHD data extracted 29 July 2019, except for Lakes, Nelson Marlborough, Southern, and Waitematā DHBs which provided manual data.

# Appendix 3: Special patients

### The insanity defence

Under section 23: Insanity of the Crimes Act 1961:

1. Every one shall be presumed to be sane at the time of doing or omitting any act until the contrary is proved.
2. No person shall be convicted of an offence by reason of an act done or omitted by him or her when labouring under natural imbecility or disease of the mind to such an extent as to render him or her incapable –
   a. of understanding the nature and quality of the act or omission; or
   b. of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.

This defence originates from the *M'Naghten* Rule, a British precedent dating from 1843. The *M'Naghten* Rule is a test that assumes a person accused of a crime is sane, and therefore capable of being criminally responsible of a crime, unless the defendant can show otherwise.

For more information about the insanity defence, we recommend *Mental Impairment Decision-making and the Insanity Defence* (New Zealand Law Commission 2010).

The section 23 insanity defence may be used to inform further actions under the Criminal Procedure (Mentally Impaired Persons) Act 2003 and the Mental Health Act. Special and restricted patients subject to these orders are categorised as requiring either short-term or extended forensic care. Short-term care typically refers to patients who have been transferred to forensic mental health care from prison. Extended care includes patients who have been found unfit to stand trial or have been acquitted by reason of insanity. This category also includes restricted patients.

Table A10 lists the types of orders made under these statutes.

**Table A10: Types of orders that an insanity defence may inform**

| Act | Section | Action | Special patient type |
|---|---|---|---|
| CP (MIP) Act | 24 | Detention of person unfit to stand trial or acquitted on account of insanity | EFC |
| CP (MIP) Act | 44 | Detention of person pending hearing or trial | SFC |
| CP (MIP) Act | 34 | Detention of convicted person | SFC |
| CP (MIP) Act | 23 | Inquiry about person found unfit to stand trial or acquitted on account of insanity | SFC |
| CP (MIP) Act | 35 | Inquiry about a convicted person | SFC |
| Mental Health Act | 55 | Court orders restricted patient status | EFC |

| | | | |
|---|---|---|---|
| Mental Health Act | 45 | Application for special patient status for person detained in prison | SFC |

Note: CP (MIP) Act = Criminal Procedure (Mentally Impaired Persons) Act; Mental Health Act = Mental Health (Compulsory Assessment and Treatment) Act; EFC = extended forensic care; SFC = short-term forensic care.

### Victims' rights

Registered victims of a person who is a special patient have the right to be notified when:

- the person is granted their first period of unescorted leave from the hospital grounds
- the person is granted their first period of unescorted overnight leave from hospital
- the person is discharged from hospital
- the person dies
- their sentence ends (where they received a sentence for the offence)

In the rare event that the person leaves hospital without permission or fails to return from leave, victims will be told when the person leaves and when the person returns.

Information that may be provided to registered victims is limited because the person is receiving health care, which is confidential health information.

For more information about victims and their rights, and further insight into special patients in the context of the Victims' Rights Act 2002, see:
https://www.health.govt.nz/publication/victims-rights-health-system

# Appendix 4: Further reading

### Legislation

Criminal Procedure (Mentally Impaired Persons) Act 2003

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

Mental Health (Compulsory Assessment and Treatment) Act 1992

Substance Addiction (Compulsory Assessment and Treatment) Act 2017

### Publications

Government Inquiry into Mental Health and Addiction. 2018. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington: New Zealand Government.

Huriwai T, Baker M. 2016. *Manaaki: Mana enhancing and mana protecting practice*. Wellington: Te Rau Matatini.

Mental Health Review Tribunal. 2018. *Annual Report: 1 July 2017 to 30 June 2018*. Wellington: Mental Health Review Tribunal.

Ministry of Health. 2009. *Electroconvulsive Therapy (ECT) in New Zealand: What you and your family and whānau need to know*. Wellington: Ministry of Health.

Ministry of Health. 2015. *Guide to PRIMHD Activity Collection and Use* (Version 1.0). Wellington: Ministry of Health.

Ministry of Health. 2016. What happens to your mental health and addiction information? Wellington: Ministry of Health.

Ministry of Health. 2018. *Victims' Rights in the Health System: Your rights as a registered victim of a person detained in hospital for mental health treatment*. Wellington: Ministry of Health.

Ministry of Health. 2019. *Every Life Matters - He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand*. Wellington: Ministry of Health.

Opai K. 2017. *Te Reo Hāpai: The language of enrichment*. Wellington: Te Pou o te Whakaaro Nui.

### Websites

Health Promotion Agency, https://www.hpa.org.nz/

Health Quality & Safety Commission, http://www.hqsc.govt.nz

Le Va, https://www.leva.co.nz/

Like Minds, Like Mine, https://www.likeminds.org.nz/

The Lowdown, https://thelowdown.co.nz/

Mental Health Review Tribunal – selected cases, http://www.nzlii.org/nz/cases/NZMHRTcases/NZMHRT

Ministry of Health – Mental health and addictions, https://www.health.govt.nz/our-work/mental-health-and-addictions

National Depression Initiative, https://depression.org.nz/

Te Rau Ora, https://terauora.com/

Te Pou o te Whakaaro Nui, https://www.tepou.co.nz/