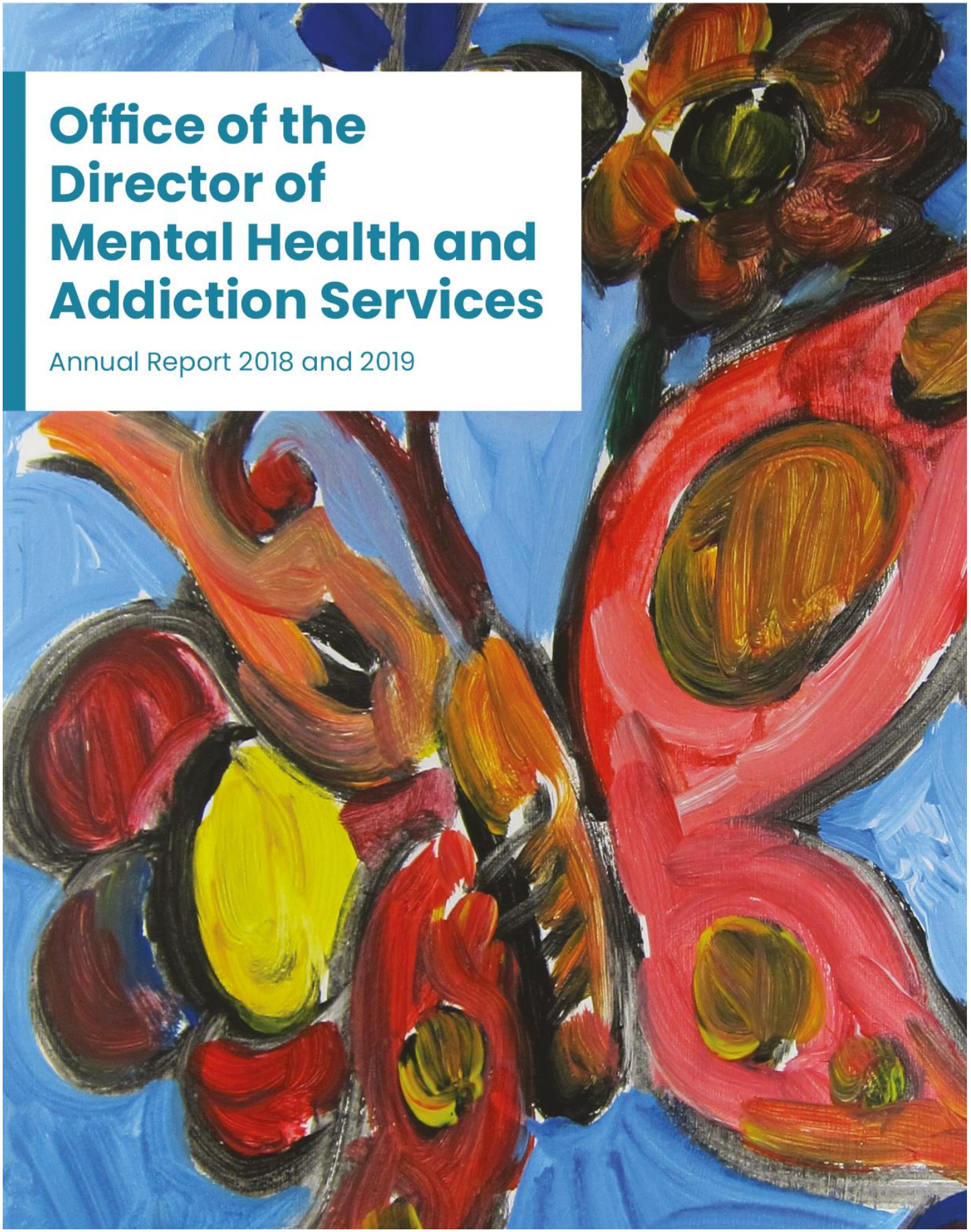
New Zealand Government

MINISTRY OF HEALTH
MANATŪ HAUORA

Office of the Director of Mental Health and Addiction Services

Annual Report 2018 and 2019



Disclaimer

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.

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 canvases with colour!" Sarah created this work at Vincents Art Workshop (Vincents).

Vincents 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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Foreword

Presented here is the Office of the Director of Mental Health and Addiction Services Annual Report for the calendar years 2018 and 2019. This annual report presents data about the use of compulsory assessment and treatment legislation in Aotearoa New Zealand, including the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act), the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Substance Addiction Act), and some statistics of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

While the content of this report shows some positive trends, it also highlights areas where further work is required to improve outcomes for New Zealanders with complex mental health and addiction needs, and for Māori in particular.

The Ministry of Health, alongside the Health Quality and Safety Commission's work to eliminate seclusion, has a large programme of work underway to help address these issues. This includes work to repeal and replace the Mental Health Act.

Repealing and replacing the Mental Health Act involves diverse perspectives and complex ethical, legal and policy issues that require careful consideration to avoid unintended consequences. This will take some time to work through, and will include wide engagement with stakeholders, so the Ministry has taken immediate steps to improve current practice.

In recognition of the need to shift to a more human rights-centred approach to compulsory assessment and treatment, the Office of the Director of Mental Health and Addiction Services undertook a key initiative to revise the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. The final revisions were published on 8 September 2020 as a set of two documents designed to work together, and collectively referred to as 'the Guidelines'.

The Guidelines emphasise the growing influence of rights-based approaches and how these can be better promoted within the parameters of the current Mental Health Act; the need to meet our obligations to Māori under Te Tiriti o Waitangi; and the impact of *He Ara Oranga* and the feedback from people with lived experience and families and whānau on how they experience the current administration of the Mental Health Act. We thank all those who contributed during the consultation stages for their guidance and advice.

The Government has also committed to making initial amendments to the Mental Health Act to address pressing issues while work to fully repeal and replace the Act progresses. The Mental Health (Compulsory Assessment and Treatment) Amendment Bill proposes to amend the Mental Health Act to improve the protection of individual rights and the safety of patients and the public, and enable more effective application of the Act. This includes an amendment to eliminate indefinite treatment orders, which have been criticised as a serious breach of human rights.

The Ministry is also progressing work to facilitate training to support the workforce to reduce restrictive practice and embed human rights-based approaches.

Previously, the Office of the Director of Mental Health and Addiction Services Annual Reports have covered mental health and addiction service activity broader than compulsory assessment and treatment legislation. However, with the establishment of the Mental Health and Addiction Directorate within the Ministry, commentary on wider mental health and addiction activities is covered in other reports. For example, the *Mental Health and Wellbeing Year in Review* published on the Ministry's website, which provides a holistic view of activities, investment and service delivery.

The Office of the Director of Mental Health and Addiction Services Annual Report is normally published in the year after the reporting period, reflecting the time required to receive data from district health boards (DHBs) and the necessary review and quality assurance processes to ensure all data is accurate and reported consistently across DHBs.

The 2018 Annual Report was in the final stages of preparation for publication in early 2020 when it became necessary to focus on responding to COVID-19, including supporting mental health and addiction services across the country to continue delivering care safely throughout all alert levels. During the COVID-19 response, a decision was made to further delay release of the 2018 data to enable the joint publication of 2018 and 2019 data.

Future reporting on compulsory assessment and treatment legislation will be released as web-based reports, which will include a suite of reports on accountability and monitoring and will shift from the calendar year basis to the financial year.

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Use of the Mental Health Act

In summary, in 2018:

- 10,631 people (5.8 percent of specialist mental health and addiction service users) were subject to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act),[1] 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
- 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.

In 2019:

- 10,892 people (5.8 percent of specialist mental health and addiction service users) were subject to the Mental Health Act, and on the last day of 2019 approximately 5,450 people were subject to either compulsory assessment or compulsory treatment under 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.

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

The Mental Health Act process

Compulsory assessment

In summary, in 2018:[2]

- 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).
- Approximately 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.

In 2019:[3]

- Clinicians made 5,617 applications for compulsory treatment or extensions under the Mental Health Act. Of these applications, the courts granted 4,984 (88.7 percent).
- Approximately 1,266 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 35 cases and dismissed 674. The remaining applications were withdrawn.

Compulsory treatment

2018 summary

- On the last day of 2018, a total of 5,083 people were subject to either compulsory assessment or compulsory treatment[4] under the Mental Health Act.
- On average within each month of 2018, the assessment provisions of the Mental Health Act were applied as follows.

[2] Source: Ministry of Justice's Case Management System data (extracted 24 June 2019).

[3] Source: Ministry of Justice's Case Management System data (extracted 1 February 2021).

[4] Sources: Data from the Programme for the Integration of Mental Health Data (PRIMHD) (extracted 29 July 2019) and manual data from Auckland, Lakes, Nelson Marlborough and Waitematā district health boards (DHBs).

Section 11	618 people were subject to an initial assessment	13 people per 100,000 population
Section 13	621 people were subject to a second period of assessment	13 people per 100,000 population
Section 14(4)	443 people were subject to an application for a compulsory treatment order	9 people per 100,000 population

Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs.

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

Section 29	5,349 people were subject to a community treatment order	109 people per 100,000 population
Section 30	791 people were subject to an inpatient treatment order	16 people per 100,000 population
Section 31	201 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.

Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs.

2019 summary

- On the last day of 2019, a total of 5,450 people were subject to either compulsory assessment or compulsory treatment under the Mental Health Act.
- On average within each month of 2019, the assessment provisions of the Mental Health Act were applied as follows.

Section 11	637 people were subject to an initial assessment	13 people per 100,000 population
Section 13	637 people were subject to a second period of assessment	13 people per 100,000 population
Section 14(4)	445 people were subject to an application for a compulsory treatment order	9 people per 100,000 population

Source: PRIMHD data (extracted 19 October 2020).

- In New Zealand, on the average day in 2019, service providers applied the treatment provisions of the Mental Health Act as follows.

Section 29	4,446 people were subject to a community treatment order	90 people per 100,000 population
Section 30	634 people were subject to an inpatient treatment order	13 people per 100,000 population
Section 31	169 people were on temporary leave from an inpatient unit	3 people per 100,000 population

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

Sources: PRIMHD data (extracted 19 October 2020) and manual data from Auckland DHB.

Comparing compulsory assessment and treatment among DHBs

Tables 1 and 2 show the average number of people per month in 2018 and 2019 who were required to undergo assessment under the Mental Health Act in each DHB. Tables 3 and 4 show the average number of people subject to a compulsory treatment order on a given day in 2018 and 2019 in each DHB. Figures 1 to 4 present the average number of people subject to a compulsory treatment order on a given day, focusing specifically on either community treatment orders or inpatient treatment orders.

Table 1: 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	11
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
Tairāwhiti	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 sections 15(1) and 15(2). The latter provisions describe similar circumstances in which a patient is waiting for a court decision on compulsory treatment. Volumes of section 14(4) in some DHBs may be higher due to reporting extension and indefinite order applications under section 14(4) in addition to original compulsory treatment order applications. This is down to local reporting variation.

Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes and Nelson Marlborough DHBs.

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 2019

DHB	s 11	s 13	s 14(4)
Auckland	15	16	11
Bay of Plenty	15	13	6
Canterbury	12	12	8
Capital & Coast	13	14	10
Counties Manukau	11	12	8
Hawke's Bay	11	10	6
Hutt Valley	17	18	9
Lakes	15	11	7
MidCentral	15	11	9
Nelson Marlborough	11	10	11

DHB	s 11	s 13	s 14(4)
Northland	16	20	23
South Canterbury	6	5	4
Southern	11	10	7
Tairāwhiti	17	13	6
Taranaki	16	12	6
Waikato	19	18	12
Wairarapa	7	3	9
Waitematā	11	13	9
West Coast	11	9	9
Whanganui	16	14	12
National average	**13**	**13**	**9**

Note: Section 14(4) data may also include PRIMHD records for sections 15(1) and 15(2). The latter provisions describe similar circumstances in which a patient is waiting for a court decision on compulsory treatment. Volumes of section 14(4) in some DHBs may be higher due to reporting extension and indefinite order applications under section 14(4) in addition to original compulsory treatment order applications. This is down to local reporting variation.

Source: PRIMHD data (extracted 19 October 2020).

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
Tairāwhiti	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.

Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs.

Table 4: 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 2019

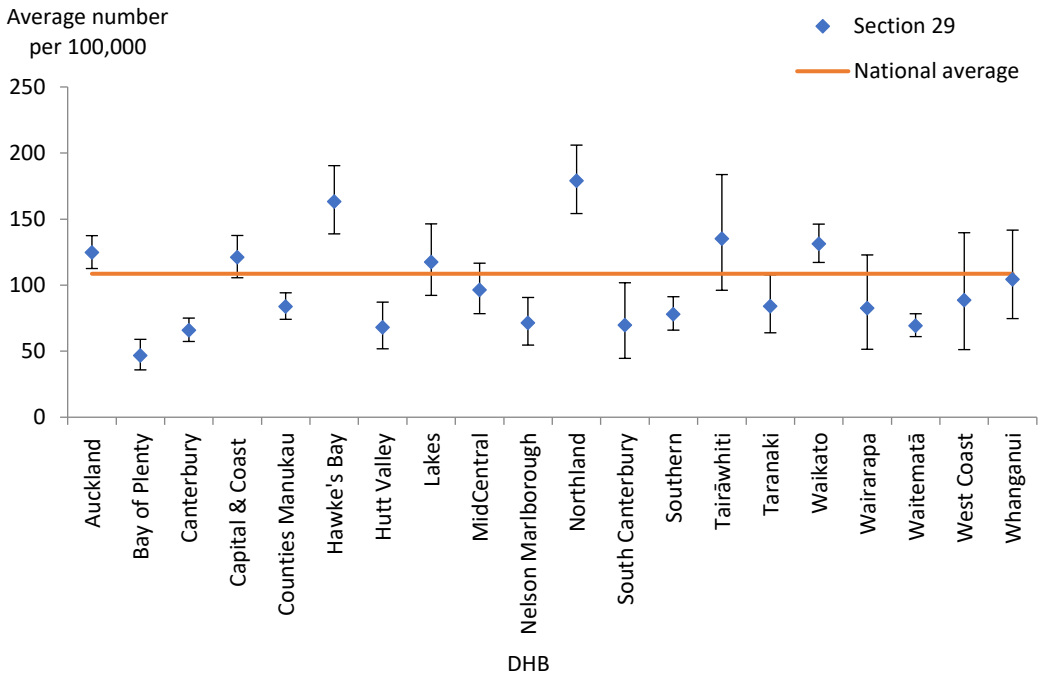
DHB	s 29	s 30	s 31
Auckland	112	10	4
Bay of Plenty	51	10	3
Canterbury	63	19	8
Capital & Coast	136	29	3
Counties Manukau	76	11	2
Hawke's Bay	162	20	16
Hutt Valley	80	9	2
Lakes	77	7	3
MidCentral	99	5	1
Nelson Marlborough	75	9	–

DHB	s 29	s 30	s 31
Northland	181	12	3
South Canterbury	74	5	3
Southern	76	12	2
Tairāwhiti	110	3	2
Taranaki	88	5	3
Waikato	127	16	2
Wairarapa	53	–	–
Waitematā	74	12	2
West Coast	80	14	6
Whanganui	107	26	6
National average	**90**	**13**	**3**

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

Sources: PRIMHD data (extracted 19 October 2020) and manual data from Auckland DHB.

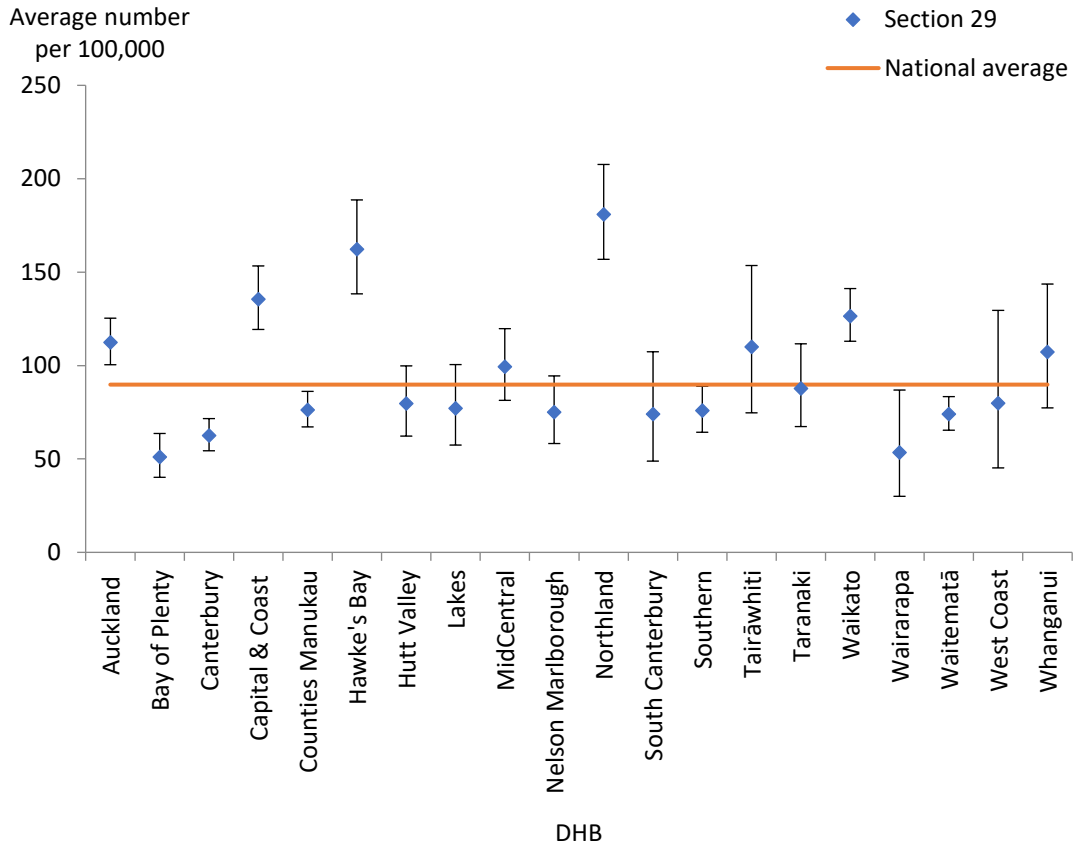
Figure 1: Average number of people on a given day subject to a community treatment order (section 29 of the Mental Health Act) per 100,000 population, by DHB, 1 January to 31 December 2018



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 different from the national average.

Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs.

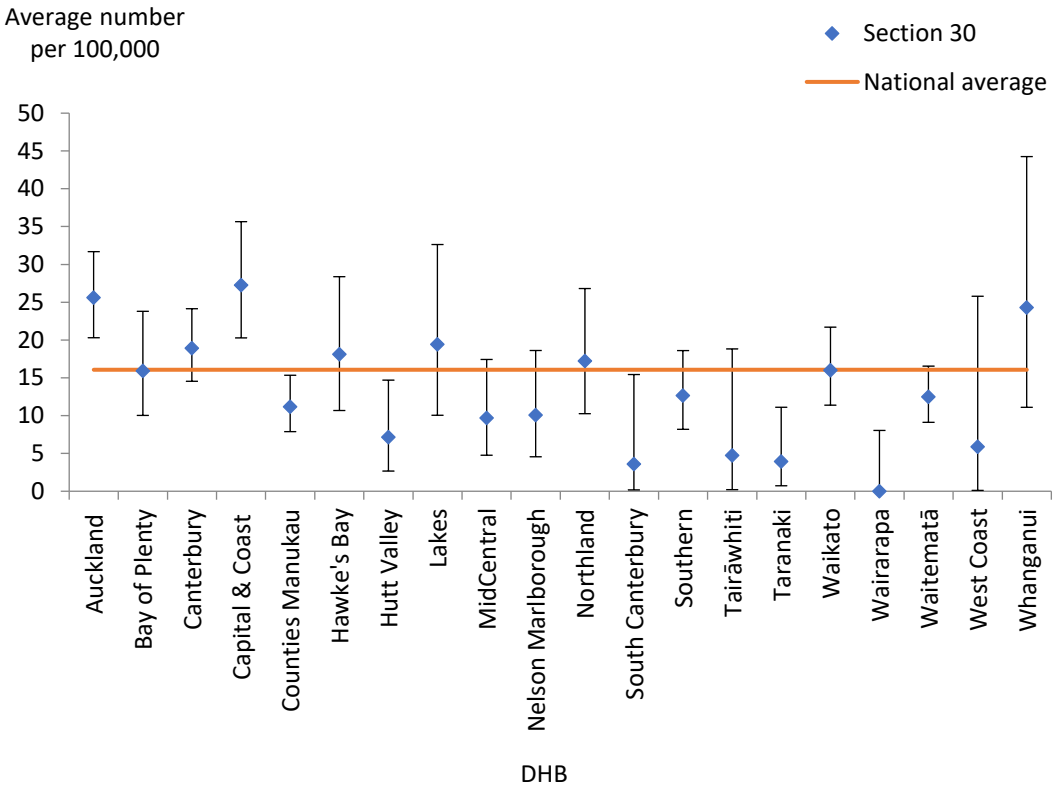
Figure 2: Average number of people on a given day subject to a community treatment order (section 29 of the Mental Health Act) per 100,000 population, by DHB, 1 January to 31 December 2019



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 different from the national average.

Source: PRIMHD data (extracted 19 October 2020).

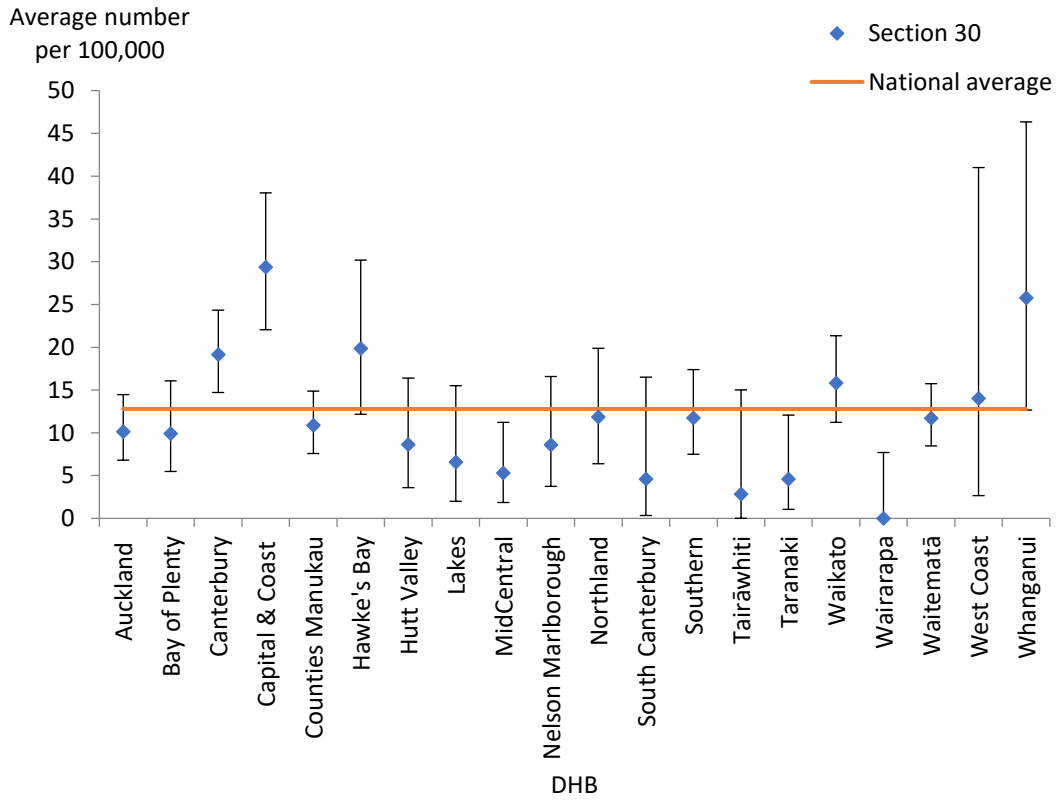
Figure 3: Average number of people on a given day subject to an inpatient treatment order (section 30 of the Mental Health Act) per 100,000 population, by DHB, 1 January to 31 December 2018



Notes: 'On a given day' is the average of the last day of each 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 different from the national average.

Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes and Nelson Marlborough DHBs.

Figure 4: 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 2019



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 different from the national average.

Source: PRIMHD data (extracted 19 October 2020).

Compulsory treatment by age and sex

During 2018:[5]

- people aged 25–34 years were the most likely to be subject to a compulsory treatment order (152 per 100,000), while people over 65 years of age were the least likely (56 per 100,000) (see Figure 5)
- males were more likely to be subject to a compulsory treatment order (109 per 100,000) than females (75 per 100,000) (see Figure 6).

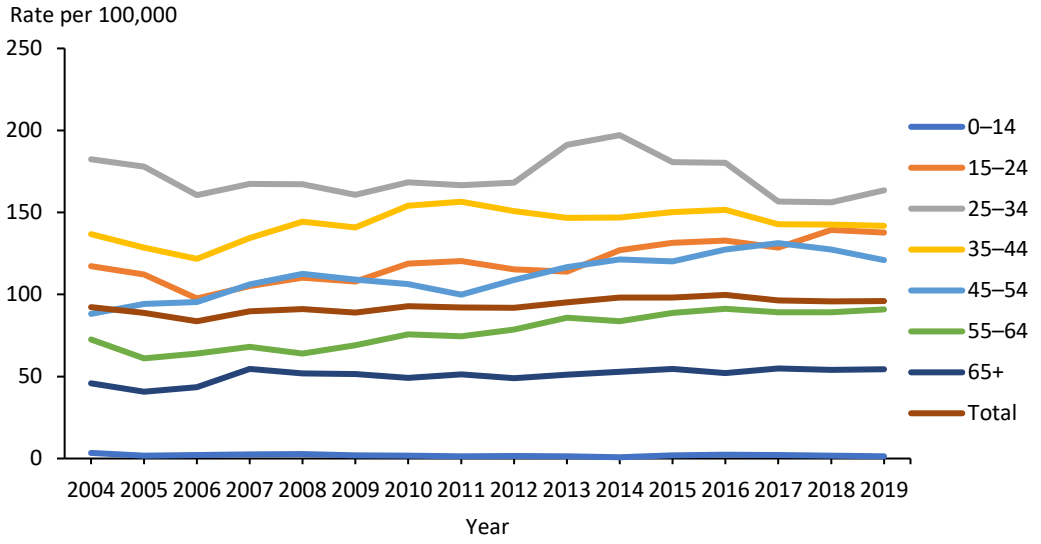
During 2019:[6]

[5] Source: Ministry of Justice's Case Management System data (extracted 24 June 2019).

[6] Source: Ministry of Justice's Case Management System data (extracted 1 February 2021).

- people aged 25–34 years were the most likely to be subject to a compulsory treatment order (164 per 100,000), while people over 65 were the least likely (54 per 100,000) (see Figure 5)
- males were more likely to be subject to a compulsory treatment order (108 per 100,000) than females (76 per 100,000) (see Figure 6).

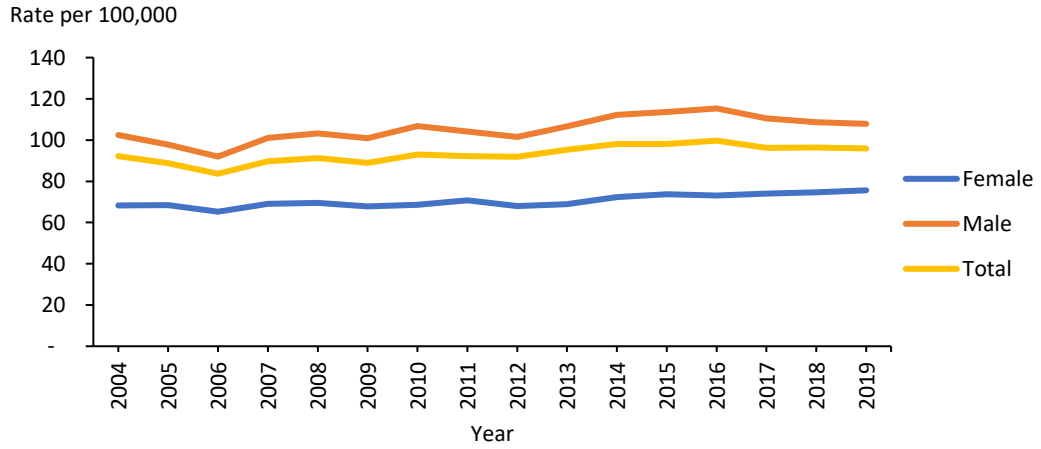
Figure 5: Rate of people subject to compulsory treatment order applications (including extensions) per 100,000 population, by age group, 2004–2019



Notes: 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 for years 2004–2018 and 1 February 2021 for year 2019.

Figure 6: Rate of people subject to compulsory treatment order applications (including extensions) per 100,000 population, by sex, 2004–2019



Notes: 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 1 February 2021.

Indefinite compulsory treatment orders

In summary, on 31 December 2018:[7]

- 2,497 clients were subject to indefinite compulsory treatment orders
- 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 1,193 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 609 days, and the maximum period was 7,693 days (approximately 21 years).

On 31 December 2019:[8]

- 2,866 clients were subject to indefinite compulsory treatment orders
- 2,699 clients (60 percent of all clients on community treatment orders) were subject to indefinite community treatment orders
- 187 clients were subject to indefinite inpatient treatment orders – this represents 28 percent of all clients on inpatient treatment orders
- the average period for which a client was subject to an indefinite community treatment order was 1,562 days, and the maximum period was 9,556 days (approximately 26 years)
- the average period for which a client was subject to an indefinite inpatient treatment order was 1,364 days, and the maximum period was 7,384 days (approximately 20 years).

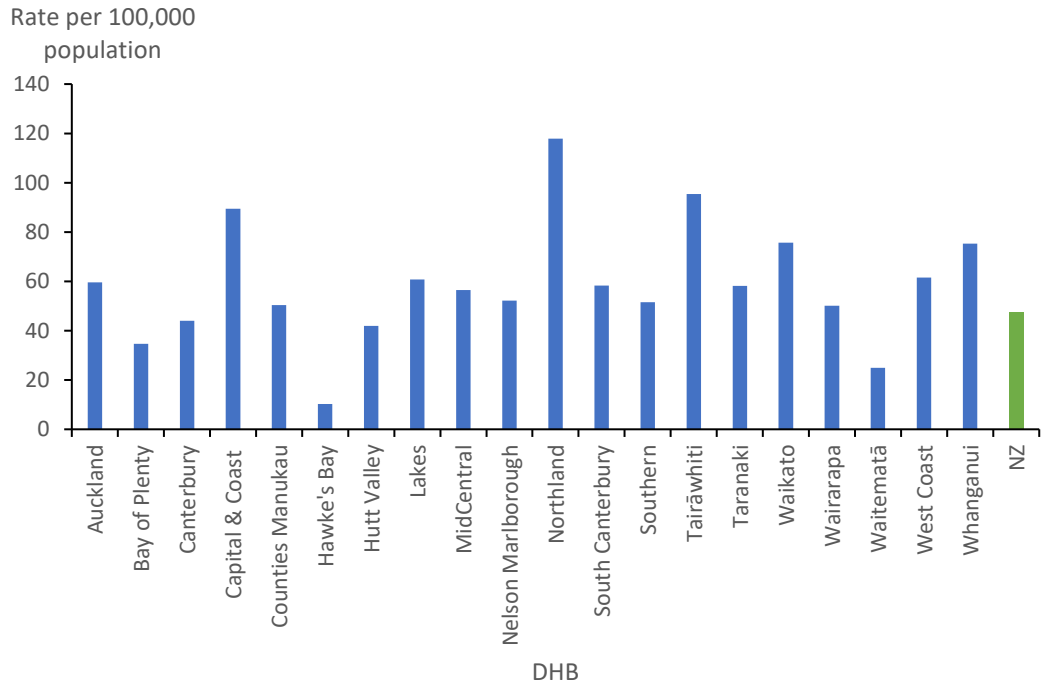
Indefinite community treatment orders

In 2018, 47.3 people per 100,000 population across New Zealand were subject to indefinite community treatment orders. Figure 7 shows the rates of indefinite community treatment orders in each DHB, per 100,000 of the general population.

[7] Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs.

[8] Source: PRIMHD data (extracted 19 October 2020).

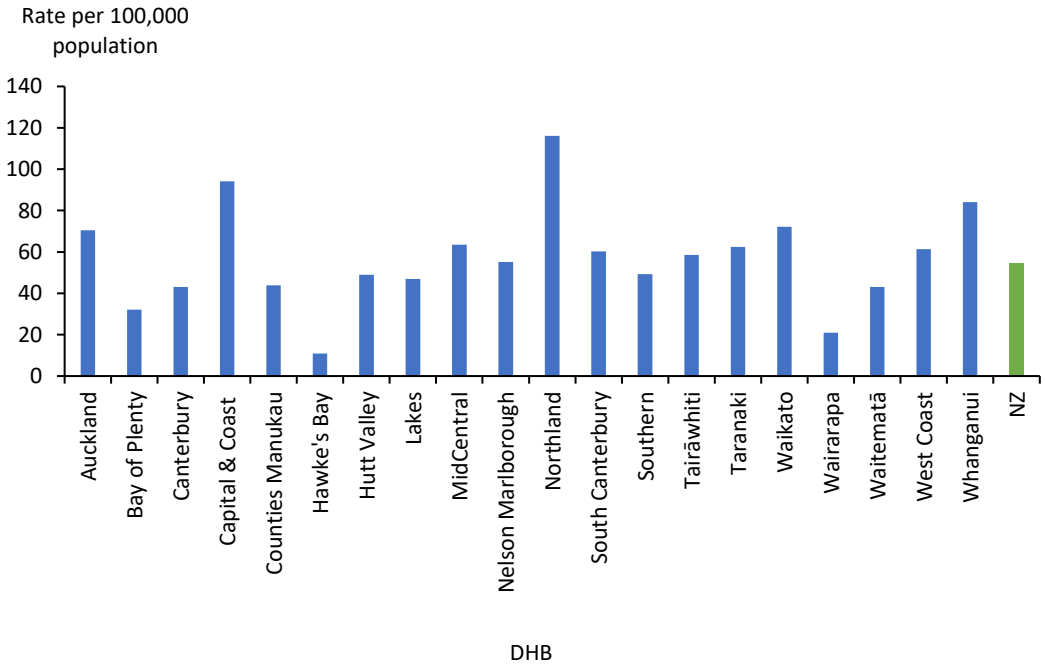
Figure 7: Rate of people subject to indefinite community treatment orders per 100,000 population, by DHB, open on 31 December 2018



Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs.

In 2019, 54.5 people per 100,000 population across New Zealand were subject to indefinite community treatment orders. Figure 8 shows the rates of indefinite community treatment orders in each DHB, per 100,000 of the general population.

Figure 8: Rate of people subject to indefinite community treatment orders per 100,000 population, by DHB, open on 31 December 2019



Source: PRIMHD data (extracted 19 October 2020).

In 2018, nationwide, Māori were 3.5 times more likely to be subject to an indefinite community treatment order than non-Māori. In 2019, Māori were 2.9 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 community treatment orders.

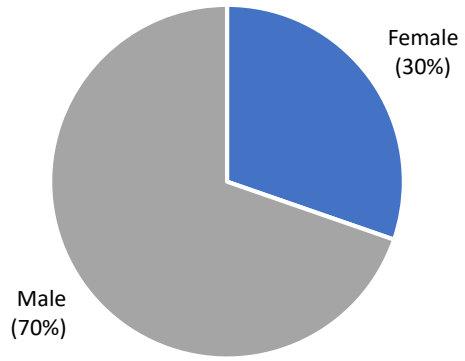
Table 5: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, open on 31 December 2018 and 31 December 2019

	Orders open on 31 December 2018			Orders open on 31 December 2019		
DHB of service	**Māori**	**Non-Māori**	**Rate ratio Māori:Non-Māori**	**Māori**	**Non-Māori**	**Rate ratio Māori:Non-Māori**
Auckland	51	7	7.7	180	61	3.0
Bay of Plenty	84	18	4.6	80	16	5.0
Canterbury	96	39	2.5	92	38	2.4
Capital & Coast	210	74	2.8	209	79	2.7
Counties Manukau	139	34	4.1	108	31	3.4
Hawke's Bay	16	8	2.0	25	5	4.6
Hutt Valley	77	35	2.2	101	38	2.7
Lakes	123	28	4.4	88	23	3.8
Mid Central	116	42	2.8	120	49	2.5
Nelson Marlborough	107	46	2.3	132	46	2.9
Northland	221	66	3.4	204	67	3.0
South Canterbury	133	51	2.6	127	54	2.4
Southern	138	42	3.3	124	40	3.1
Tairāwhiti	142	49	2.9	80	34	2.3
Taranaki	108	46	2.3	121	48	2.5
Waikato	185	43	4.3	176	40	4.4
Wairarapa	177	24	7.5	34	18	1.9
Waitematā	65	21	3.1	113	35	3.2
West Coast	129	52	2.4	103	56	1.9
Whanganui	98	67	1.5	135	65	2.1
NZ	119	34	3.5	120	41	2.9

Sources: For 2018: PRIMHD data, extracted 29 July 2019, and manual data from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs. For 2019: PRIMHD data, extracted 19 October 2020.

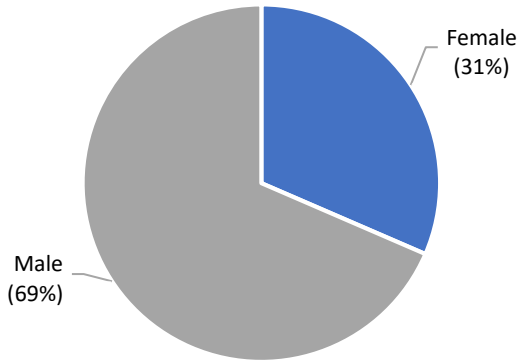
In 2018, 70 percent of people subject to indefinite community treatment orders were male (see Figure 9). In 2019, 69 percent of people subject to indefinite community treatment orders were male (see Figure 10). These trends are consistent with the higher rate of males subject to compulsory treatment order applications.

Figure 9: Percentage of people subject to indefinite community treatment orders, by sex, 1 January to 31 December 2018



Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs.

Figure 10: Percentage of people subject to indefinite community treatment orders, by sex, 1 January to 31 December 2019



Source: PRIMHD data (extracted 19 October 2020).

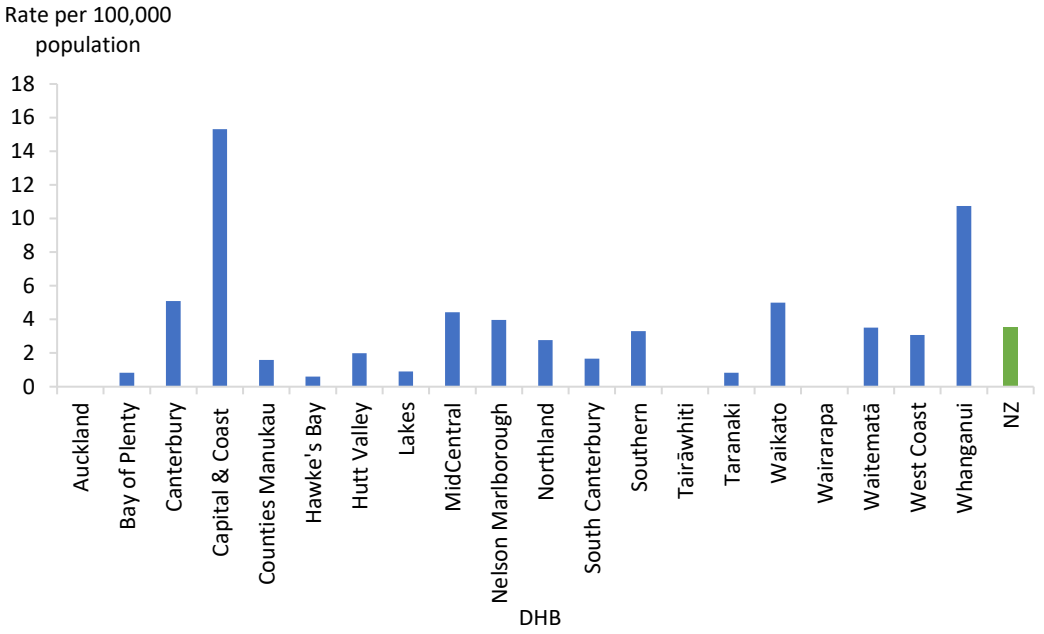
Indefinite inpatient treatment orders

In 2018, 3.5 people per 100,000 across New Zealand were subject to indefinite inpatient treatment orders. Figure 11 shows the rates of indefinite inpatient treatment orders in each DHB, per 100,000 of the general population for 2018.

In 2019, 3.8 people per 100,000 across New Zealand were subject to indefinite inpatient treatment orders. Figure 12 shows the rates of indefinite inpatient treatment orders in each DHB, per 100,000 of the general population for 2019.

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.

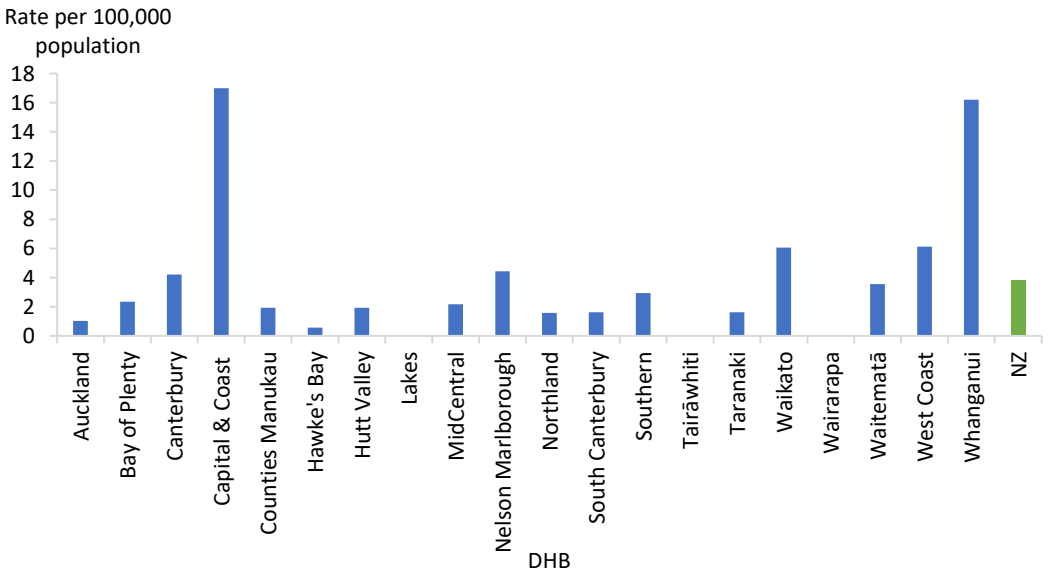
Figure 11: Number of people subject to indefinite inpatient treatment orders per 100,000 population, by DHB, 1 January to 31 December 2018



Note: Wairarapa DHB does not have an inpatient service. Auckland and Tairāwhiti DHBs have no indefinite inpatient treatment orders.

Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes and Waitematā DHBs.

Figure 12: Number of people subject to indefinite inpatient treatment orders per 100,000 population, by DHB, 1 January to 31 December 2019



Note: Wairarapa DHB does not have an inpatient service. Tairāwhiti DHB has no indefinite inpatient treatment orders.

Source: PRIMHD data (extracted 19 October 2020).

Nationwide in 2018, Māori were 2.8 times more likely to be subject to an indefinite inpatient treatment order than non-Māori. In 2019, Māori were 2.7 times more likely to be subject to an indefinite inpatient treatment order than non-Māori. Table 6 shows the rate ratio of Māori to non-Māori in each DHB per 100,000 people subject to indefinite inpatient treatment orders for both years.

Table 6: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, open on 31 December 2018 and 31 December 2019

	Orders open on 31 December 2018			Orders open on 31 December 2019		
DHB of service	**Māori**	**Non-Māori**	**Rate ratio Māori:Non-Māori**	**Māori**	**Non-Māori**	**Rate ratio Māori:Non-Māori**
Auckland	–	–	–	2	1	2.8
Bay of Plenty	2	1	3.0	5	2	2.9
Canterbury	10	5	2.1	5	4	1.3
Capital & Coast	47	11	4.2	62	11	5.6
Counties Manukau	6	1	6.7	4	1	2.9
Hawke's Bay	–	1	–	–	1	–
Hutt Valley	4	2	2.4	4	2	2.3
Lakes	3	–	–	–	–	–
Mid Central	14	2	6.7	5	1	3.8
Nelson Marlborough	–	4	–	–	5	–
Northland	7	1	7.9	–	2	–
South Canterbury	–	2	–	–	2	–
Southern	3	3	0.9	–	3	–
Taranaki	4	–	–	4	1	4.0
Waikato	14	2	5.5	17	3	6.0
Waitematā	11	3	4.3	13	3	5.1
West Coast	–	3	–	–	7	–
Whanganui	6	13	0.5	8	3	2.7
NZ	**8**	**3**	**2.8**	**8**	**3**	**2.7**

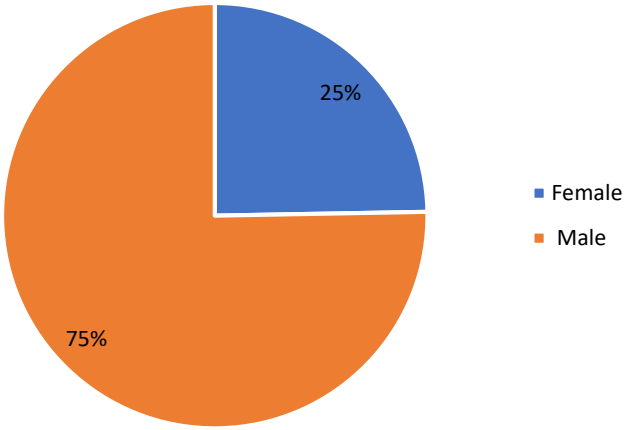
Note: Tairāwhiti and Wairarapa DHBs do not have indefinite inpatient treatment orders and are not included in this table.

Sources: For 2018: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes and Waitematā DHBs. For 2019: PRIMHD data (extracted 19 October 2020).

In 2018, 75 percent of people subject to indefinite inpatient treatment orders were male (see Figure 13). In 2019, 80 percent of people subject to indefinite inpatient treatment orders were male (see Figure 14).

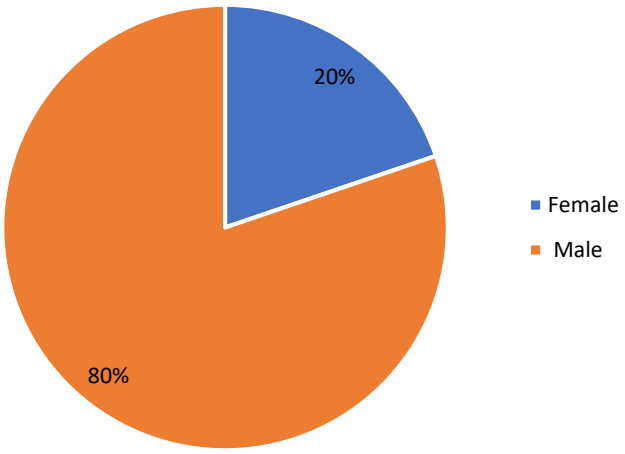
Similar to the findings for indefinite community treatment orders, this trend is consistent with the higher rate of males subject to compulsory treatment order applications.

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



Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs.

Figure 14: Percentage of people subject to indefinite inpatient treatment orders, by sex, 1 January to 31 December 2019



Source: PRIMHD data (extracted 19 October 2020).

Tāngata whaiora

This section presents statistics on tāngata whaiora (people seeking treatment) under the Mental Health Act and the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (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[9]
- 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 made up approximately 16 percent of New Zealand's population, yet they accounted for 28 percent of all mental health service users
- approximately half of all Māori service users were under 25 years of age, compared with approximately 30 percent of non-Māori service users
- among service users under a community treatment order, 52 percent of Māori were living in the most deprived deciles (8–10), compared with 32 percent of non-Māori.[10]

In 2019:

- 6.6 percent of Māori accessed mental health and addiction services, compared with 3.2 percent of non-Māori

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

[10] Source: PRIMHD data (extracted 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.

- Māori were 3.8 times more likely than non-Māori to be subject to a community treatment order and 3.6 times more likely to be subject to an inpatient treatment order[11]
- 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 2.9 times more likely to be subject to indefinite community treatment orders than non-Māori, and 2.7 times more likely to be subject to indefinite inpatient treatment orders than non-Māori
- Māori made up approximately 17 percent of New Zealand's population, yet they accounted for 29 percent of all mental health service users
- approximately half of all Māori service users were under 25 years of age, compared with approximately 29 percent of non-Māori service users
- among service users under a community treatment order, 79 percent of Māori were living in the most deprived deciles (8–10), compared with 30 percent of non-Māori.[12]

Māori and compulsory treatment orders

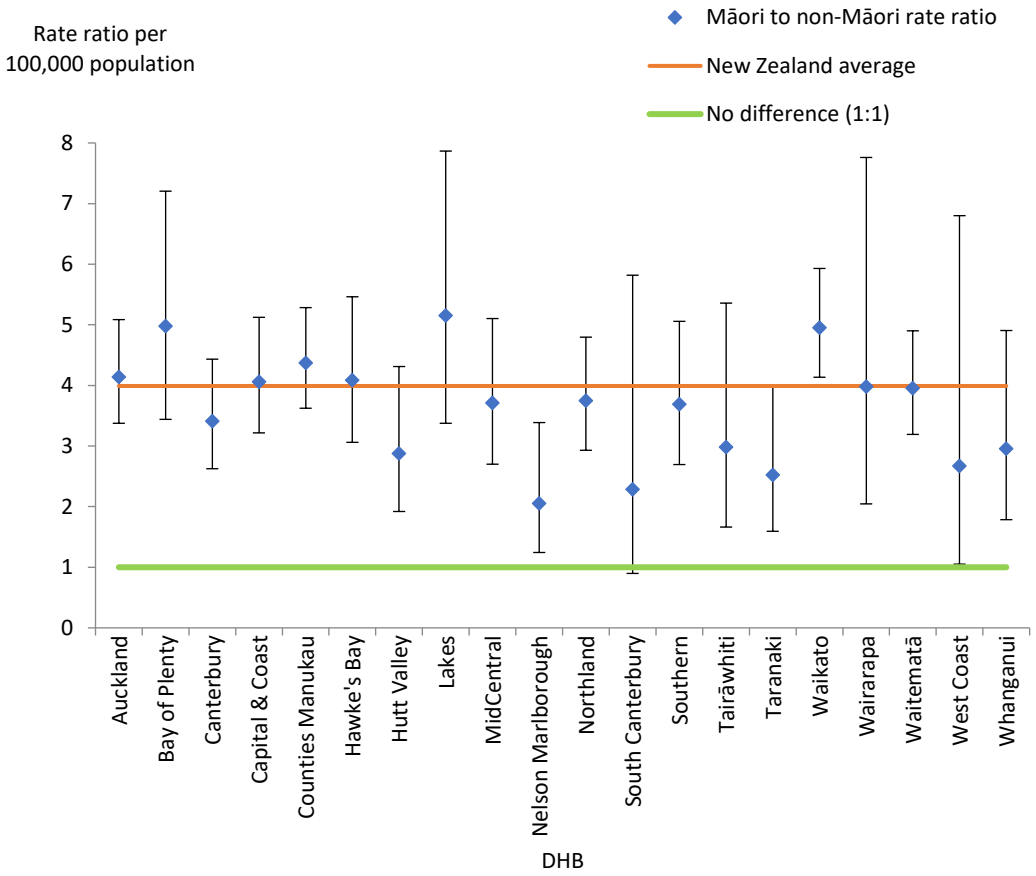
In 2018 and 2019, Māori were more likely to be subject to community and inpatient treatment orders than non-Māori. Figures 15 to 18 show the rate ratio of Māori to non-Māori subject to these orders for each DHB.

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.

[11] These ratios are based on the age-standardised rates of the Māori and non-Māori populations. Source: PRIMHD data (extracted 19 October 2020). See the Appendix for a time-series extraction and analysis of the rate ratio between Māori and non-Māori under section 29 of the Mental Health Act.

[12] Source: PRIMHD data (extracted 19 October 2020). 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.

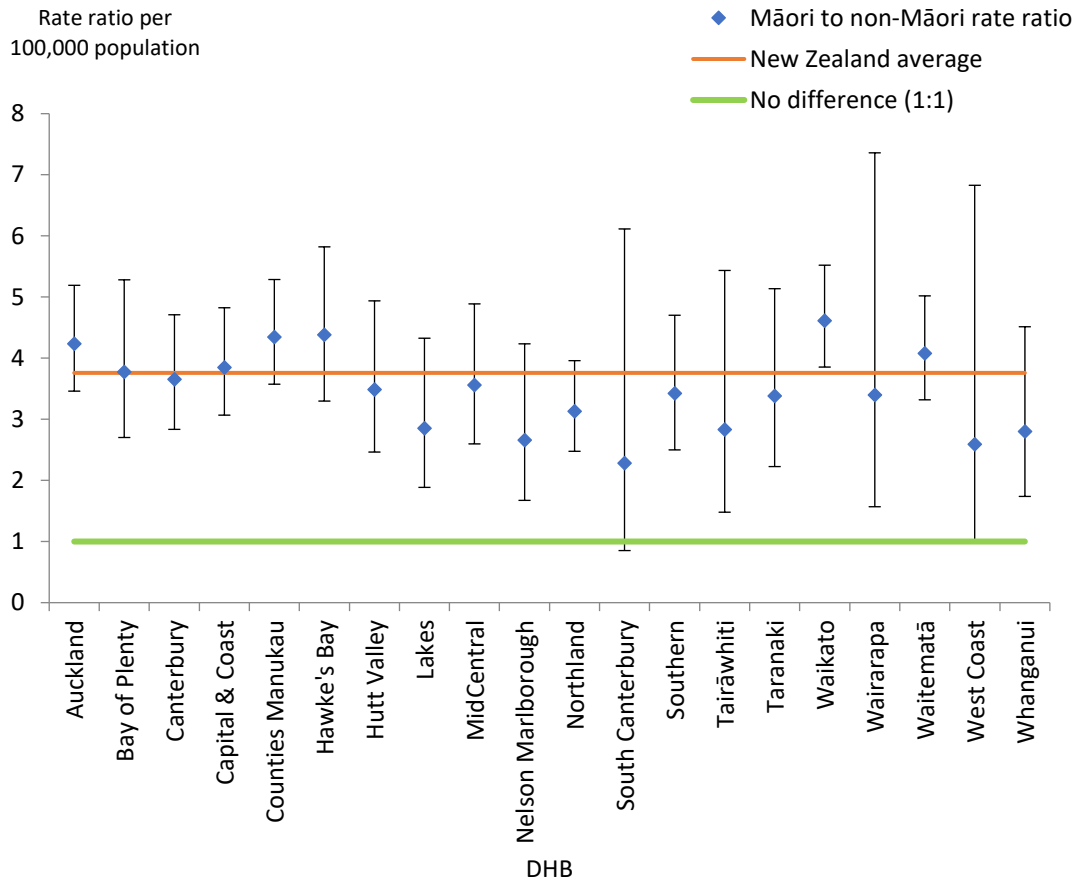
Figure 15: Rate ratio of Māori to non-Māori subject to a community treatment order (section 29) under the Mental Health Act per 100,000 population, by DHB, 1 January to 31 December 2018



Note: Confidence intervals (for 99 percent confidence) have been used to aid interpretation. Where a DHB's confidence interval crosses the national average, the DHB's rate per 100,000 is not statistically different to the national average. These are age-standardised rates.

Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs (which are excluded from this graph because we do not have their age-standardised rates).

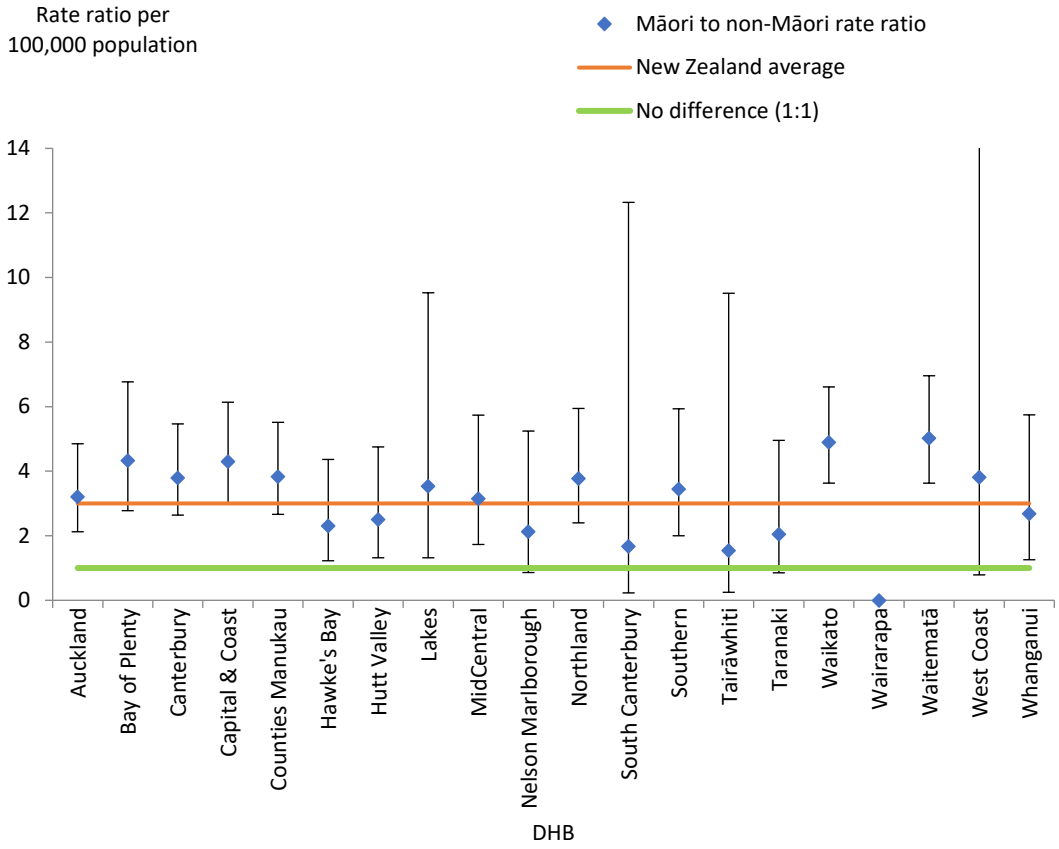
Figure 16: Rate ratio of Māori to non-Māori subject to a community treatment order (section 29) under the Mental Health Act per 100,000 population, by DHB, 1 January to 31 December 2019



Note: Confidence intervals (for 99 percent confidence) have been used to aid interpretation. Where a DHB's confidence interval crosses the national average, the DHB's rate per 100,000 is not statistically different to the national average. These are age-standardised rates.

Source: PRIMHD data (extracted 19 October 2020).

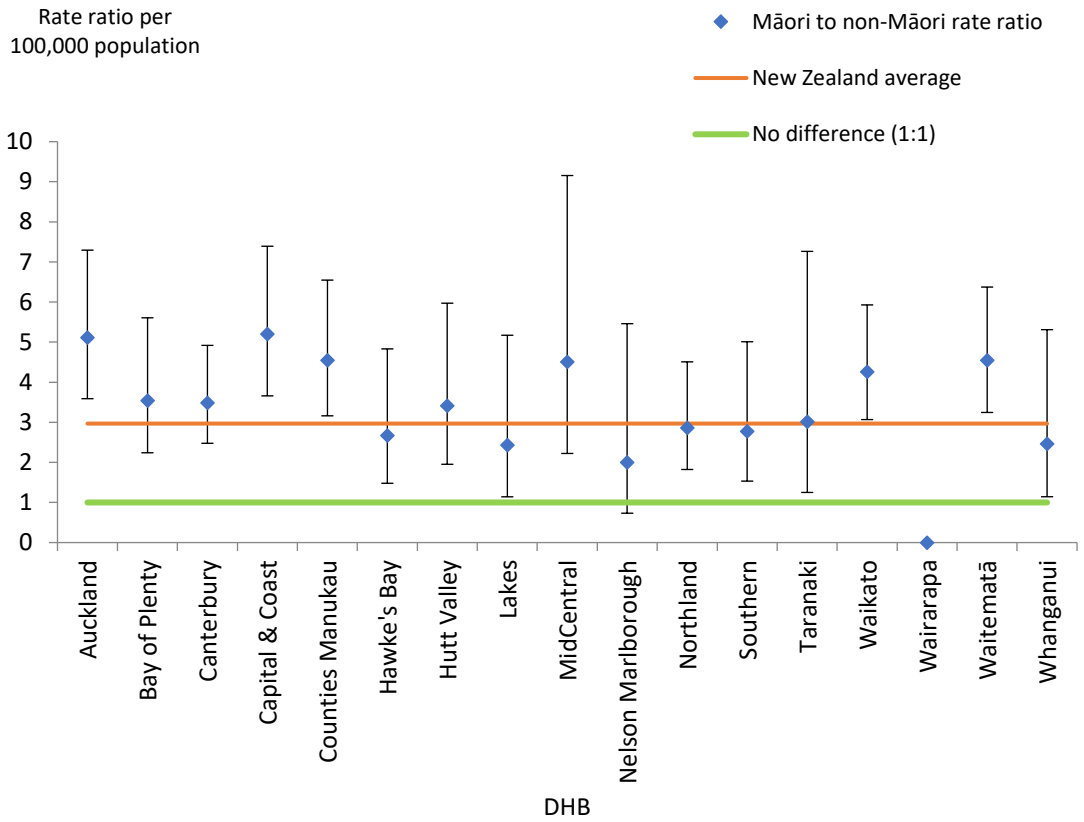
Figure 17: Rate ratio of Māori to non-Māori subject to an inpatient treatment order (section 30) under the Mental Health Act per 100,000 population, by DHB, 1 January to 31 December 2018



Note: Confidence intervals (for 99 percent confidence) have been used to aid interpretation. Where a DHB's confidence interval crosses the national average, the DHB's rate per 100,000 is not statistically different to the national average. These are age-standardised rates. Because West Coast DHB has a small population, its rates are very volatile and error bars of the resulting calculations are large. This graph does not include its data to avoid skewing the overall results.

Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes, Nelson Marlborough and Waitematā DHBs (which are excluded from this graph because we do not have their age-standardised rates).

Figure 18: 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 2019



Note: Confidence intervals (for 99 percent confidence) have been used to aid interpretation. Where a DHB's confidence interval crosses the national average, the DHB's rate per 100,000 is not statistically different to the national average. These are age-standardised rates. Because South Canterbury, Tairāwhiti and West Coast DHBs have small populations, their rates are very volatile and error bars of the resulting calculations are large. This graph does not include their data to avoid skewing the overall results.

Source: PRIMHD data (extracted 19 October 2020).

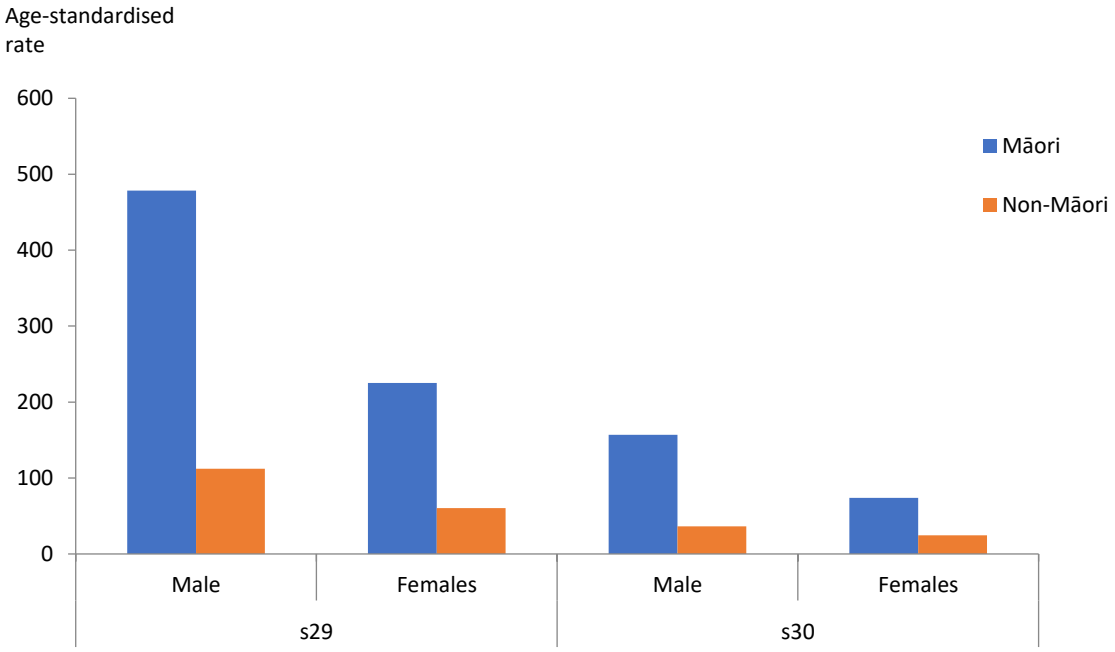
Table 7: Age-standardised rates of Māori and non-Māori subject to community and inpatient treatment orders (sections 29 and 30 respectively) under the Mental Health Act, by sex, 1 January to 31 December 2018

	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
Māori to non-Māori rate ratio	4.3:1	3.7:1	4.3:1	3:1

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

Source: PRIMHD data (extracted 29 July 2019). Excludes manual data.

Figure 19: 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.

Source: PRIMHD data (extracted 29 July 2019). Excludes manual data.

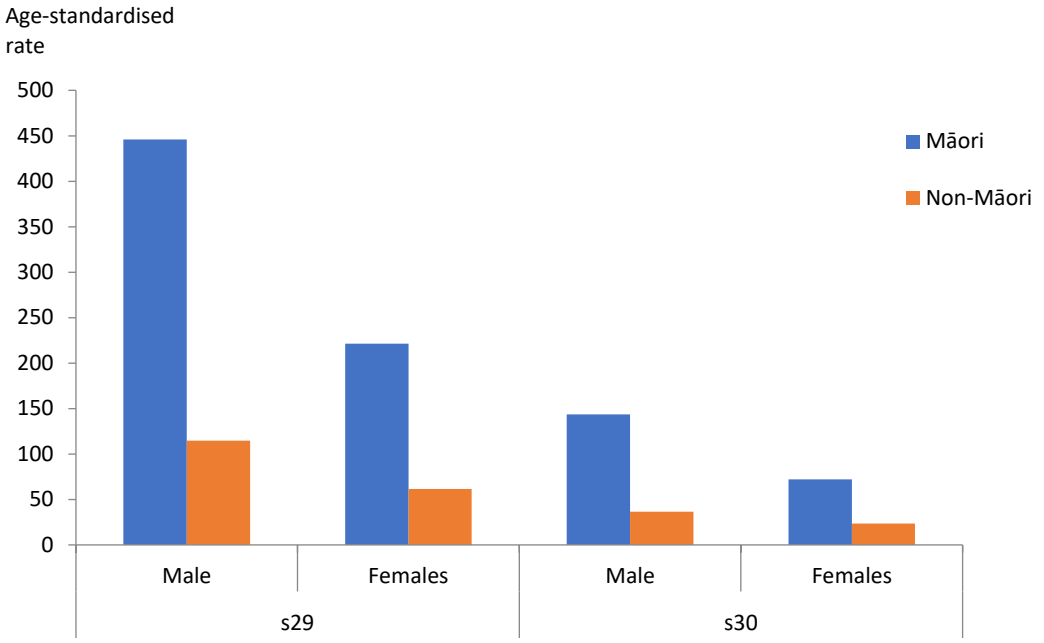
Table 8: Age-standardised rates of Māori and non-Māori subject to community and inpatient treatment orders (sections 29 and 30 respectively) under the Mental Health Act, by sex, 1 January to 31 December 2019

	Community treatment orders		Inpatient treatment orders	
	Male	Female	Male	Female
Māori	446.1	221.4	143.4	72.2
Non-Māori	114.6	61.5	36.5	23.4
Māori to non-Māori rate ratio	3.9:1	3.6:1	3.9:1	3.1:1

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

Source: PRIMHD data (extracted 19 October 2020).

Figure 20: 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 2019



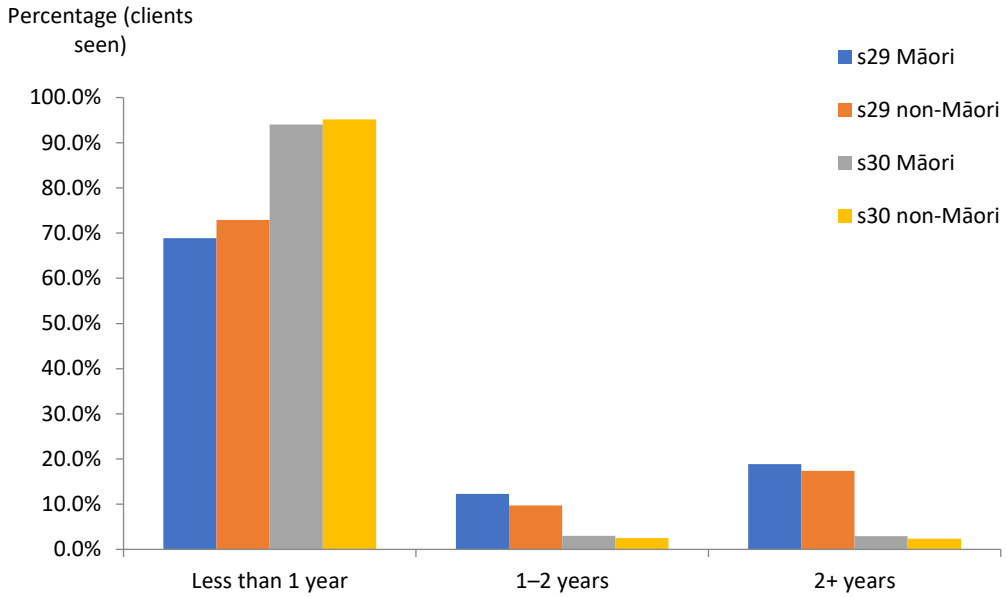
Note: Rates per 100,000 are age-standardised.

Source: PRIMHD data (extracted 19 October 2020).

Length of time spent subject to compulsory treatment orders

On average, Māori and non-Māori remain on compulsory treatment orders for a similar amount of time (see Figure 21). For community treatment orders commenced between 2009 and 2017, 69 percent of Māori and 73 percent of non-Māori were subject to the order for less than a year. For inpatient orders commenced between 2009 and 2017, 95 percent of Māori and non-Māori were subject to the order for less than a year.

Figure 21: 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, 2009–2017

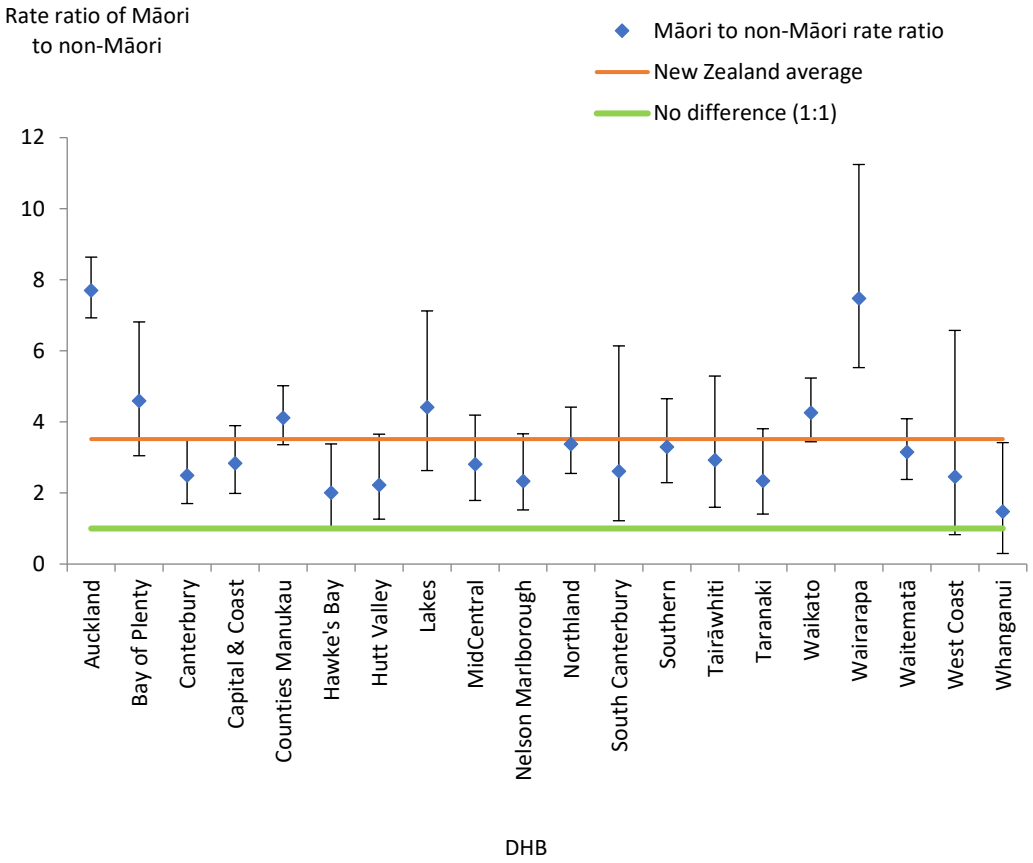


Note: The data refers to treatment orders started between 2009 and 2017. This analysis uses 2017 as the most recent year because at least two years must have passed to identify how many people remained on a treatment order for two or more years. Please note this graph is not comparable with Figure 15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

Source: PRIMHD data (extracted 19 October 2020).

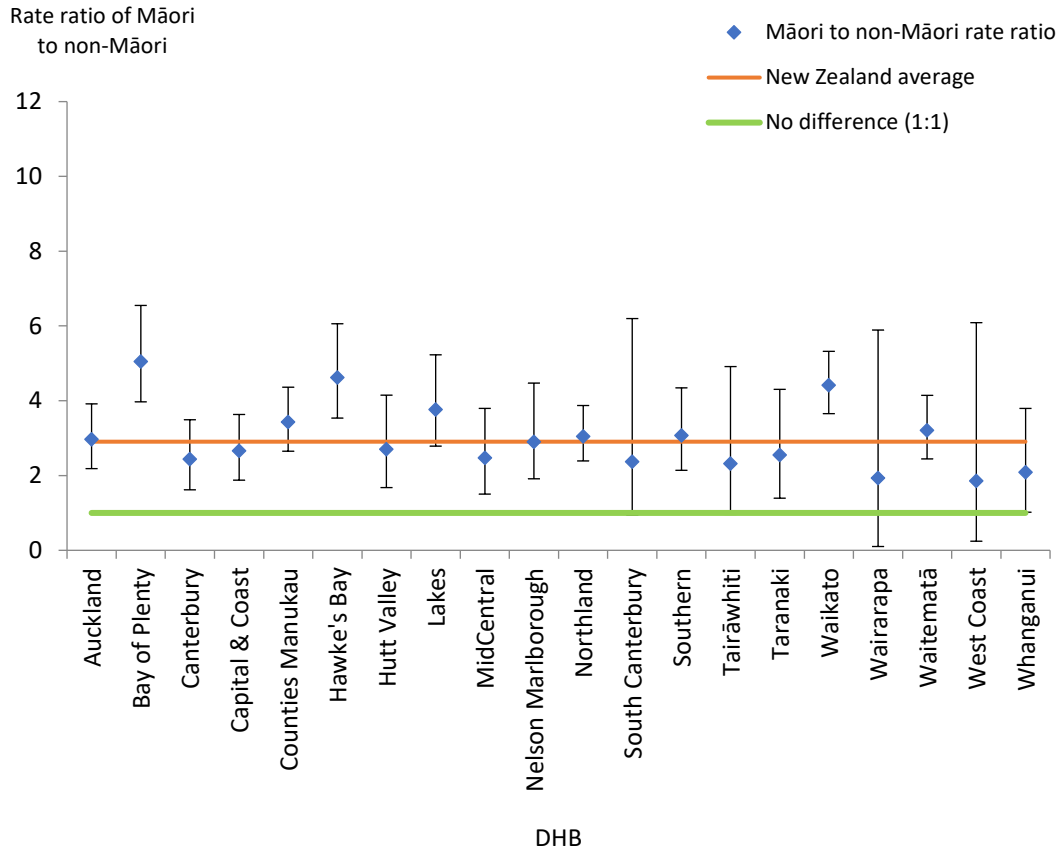
The following figures show the rate ratio of Māori to non-Māori subject to indefinite community treatment orders (Figures 22 and 23) and indefinite inpatient treatment orders (Figures 24 and 25) for each DHB per 100,000 people in 2018 and 2019 respectively.

Figure 22: 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



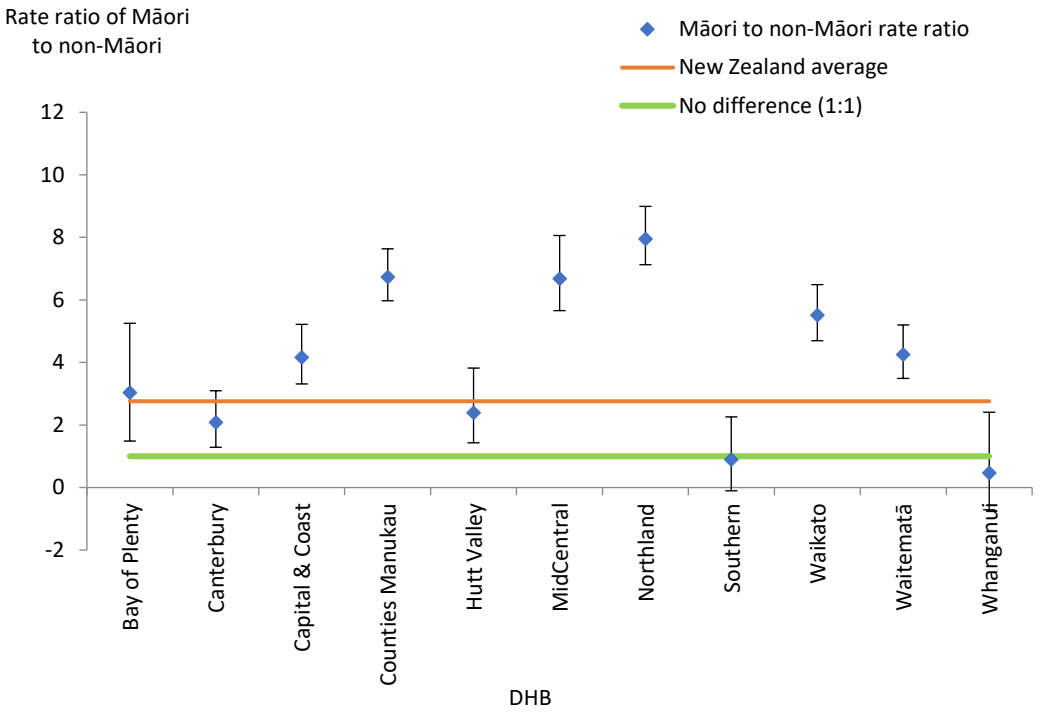
Sources: PRIMHD data (extracted 29 July 2019) and manual data from Auckland, Lakes and Waitematā DHBs.

Figure 23: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, by DHB, 1 January to 31 December 2019



Source: PRIMHD data (extracted 19 October 2020).

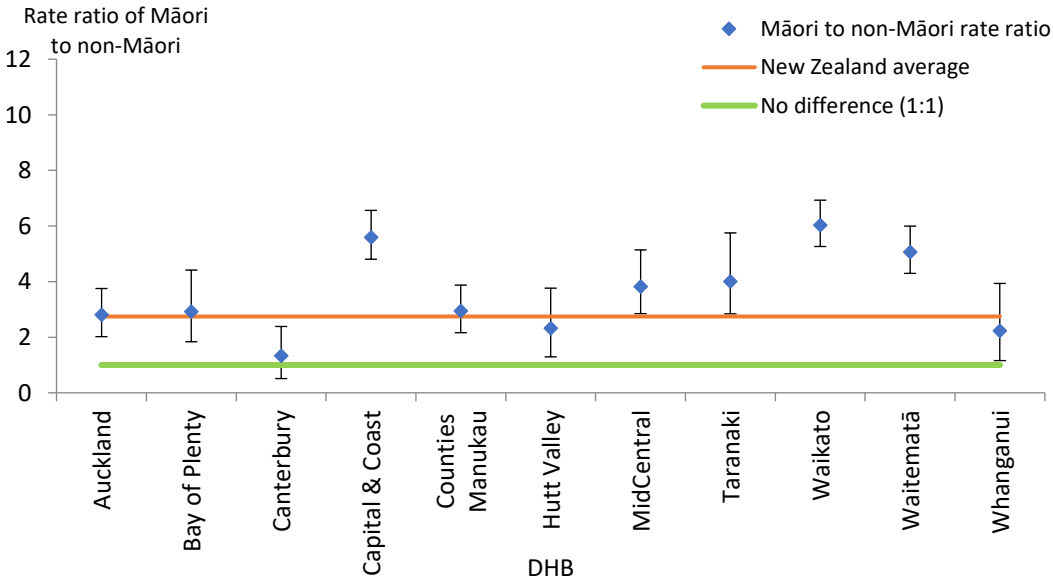
Figure 24: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, by DHB, 1 January to 31 December 2018



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.

Sources: PRIMHD data (extracted 29 July 2019) and manual data from Waitematā DHB.

Figure 25: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, by DHB, 1 January to 31 December 2019



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

Source: PRIMHD data (extracted 19 October 2020).

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 deemed not reasonably practicable or not in the interests of the person being assessed or receiving the treatment.

In summary, in 2018:

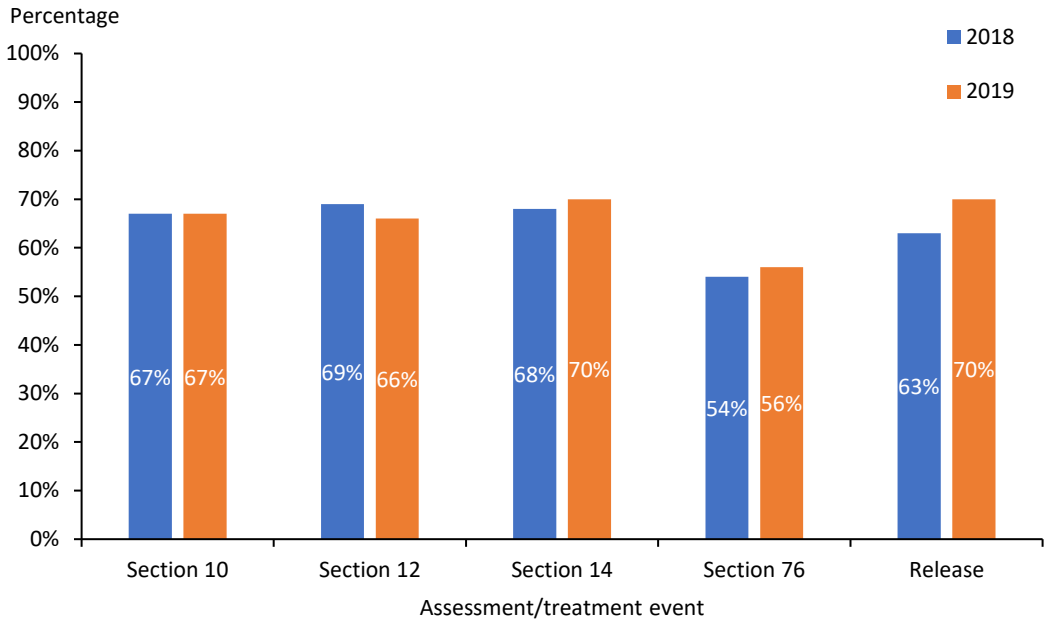
- on average nationally, 62 percent of families and whānau were consulted about Mental Health Act assessment/treatment events
- of all the steps in the Mental Health Act treatment process, family and whānau were most likely to be consulted at a person's certificate for further assessment (section 12)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

In 2019:

- on average nationally, 64 percent of families and whānau were consulted about Mental Health Act assessment/treatment events
- of all the steps in the Mental Health Act treatment process, family and whānau were most likely to be consulted at a person's certificate of final assessment (section 14)
- DHBs varied in their consultation with families and whānau
- 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.

Figure 26 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 and 2019.

Figure 26: Average national percentage of family/whānau consultation for particular assessment/treatment events, 1 January to 31 December 2018 and 1 January to 31 December 2019

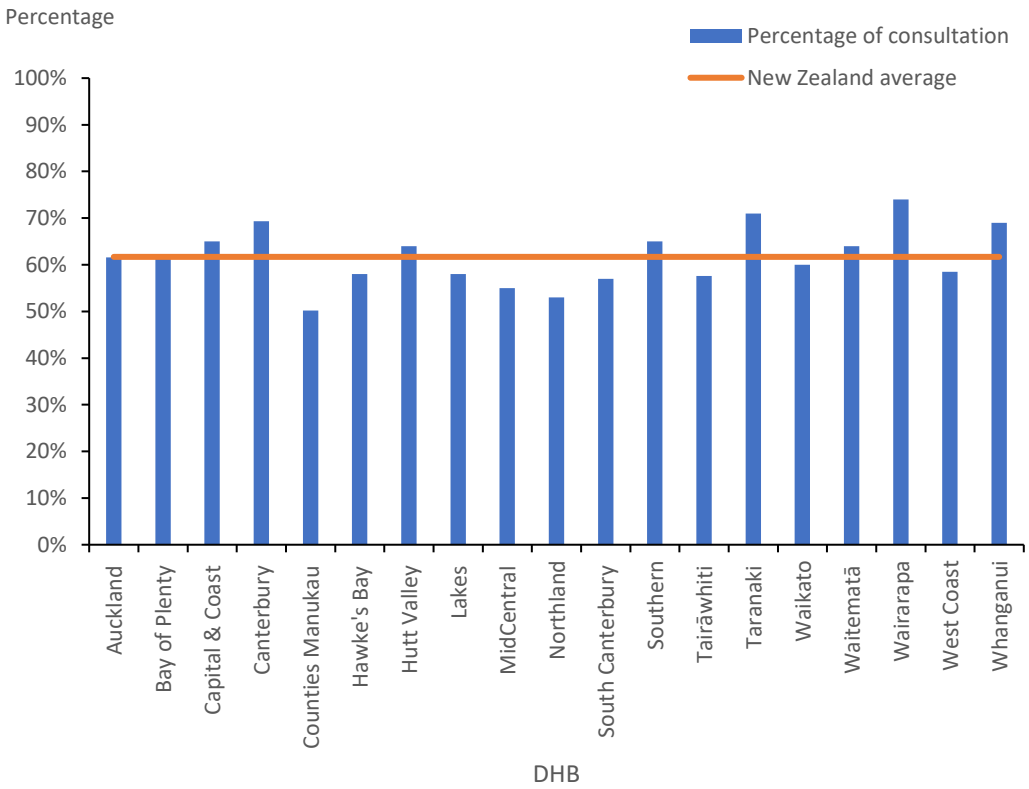


Note: Nelson Marlborough DHB submitted no data in 2018 and 2019, and Hawke's Bay, Northland, Tairāwhiti and Waitematā DHBs' data is incomplete, therefore, this graph is not comparable to equivalent published in previous reports.

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 and 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 27).

Figure 27: Average percentage of family/whānau consultation across all assessment/treatment events, by DHB, 1 January to 31 December 2018

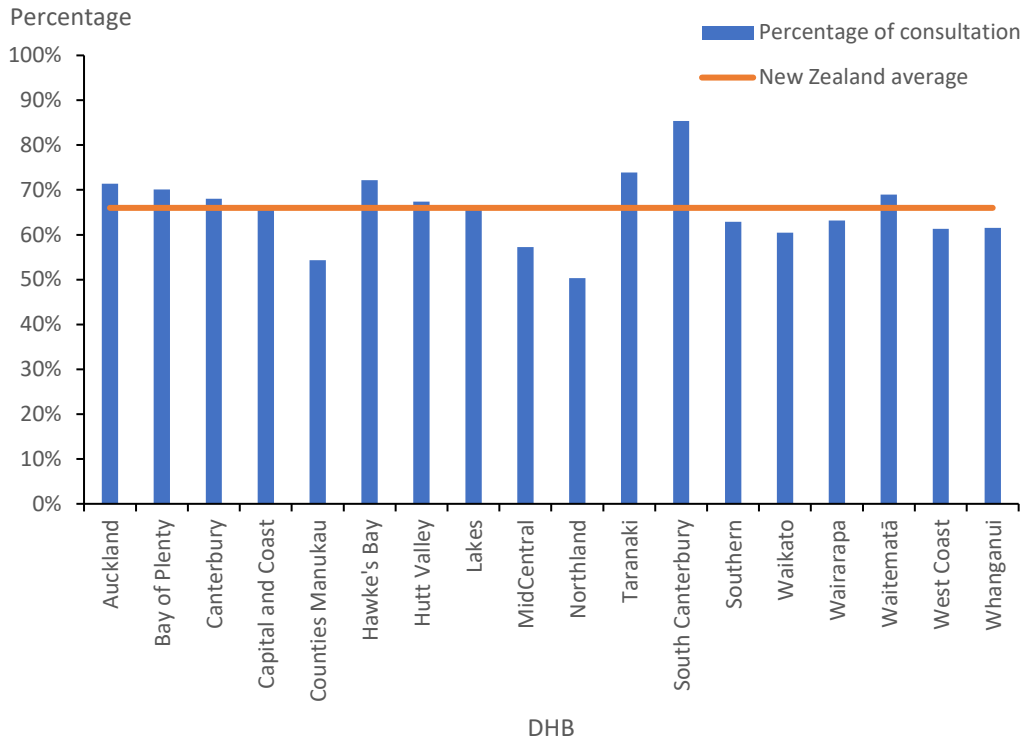


Note: Nelson Marlborough DHB submitted no data in 2018, and data for Hawke's Bay, Northland and Waitematā DHBs is incomplete, so this graph is not comparable to equivalent published in previous reports.

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

On average nationally during 2019, 64 percent of cases included consultation with family and whānau across all assessment and treatment events. Among DHBs, South Canterbury DHB had the highest rate of consultation at 85 percent, and Northland DHB had the lowest at 50 percent (see Figure 28).

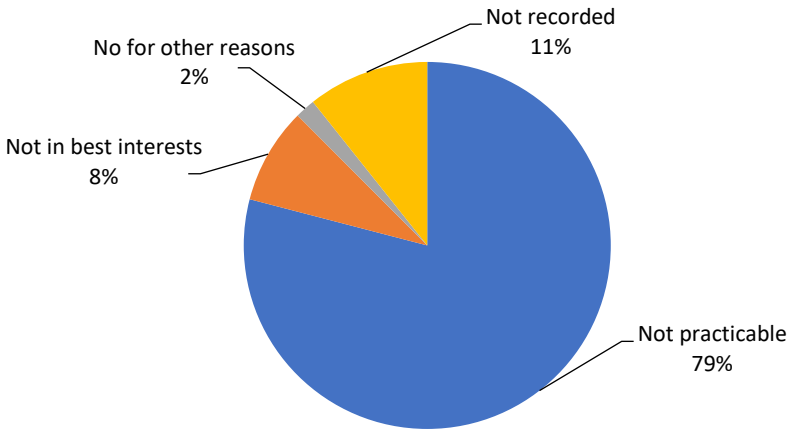
Figure 28: Average percentage of family/whānau consultation across all assessment/treatment events, by DHB, 1 January to 31 December 2019



Note: Nelson Marlborough DHB submitted no data in 2019, and data for Tairāwhiti DHB was incomplete, so these DHBs have not been included in this graph. As such, this graph is not comparable to equivalent graphs published in previous reports.

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

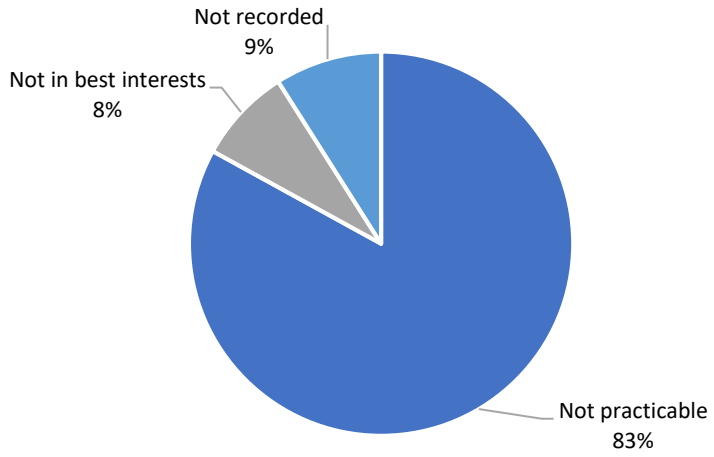
Figure 29: Reasons for not consulting families and whānau, 1 January to 31 December 2018



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

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

Figure 30: Reasons for not consulting families and whānau, 1 January to 31 December 2019



Note: Nelson Marlborough DHB submitted no data in 2019, and Tairāwhiti DHB's data is incomplete, so this graph is not comparable to equivalent graphs published in previous reports. In 2019, no DHBs reported under 'No for other reasons'.

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

Seclusion

The data captured in this section focuses on people under the Mental Health Act in adult inpatient wards who have been secluded. Standards New Zealand 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'.[13]

In the 2018 and 2019 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 respectively. For more information about this outlier data, please see the Appendix.

In summary, in adult inpatient services in 2018:[14]

- 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[15]
- 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 adult inpatient units.

In adult inpatient services in 2019:[16]

- the total number of people who experienced seclusion while receiving mental health treatment in an adult inpatient service has decreased by 14 percent since 2009[17]

13 Standards New Zealand. 2008. *Health and Disability Services (General) Standard*. Wellington: Standards Council.

14 Sources: PRIMHD data (extracted 29 July 2019) and manual data from Lakes, Nelson Marlborough, Southern and Waitematā DHBs. Excludes outlier data.

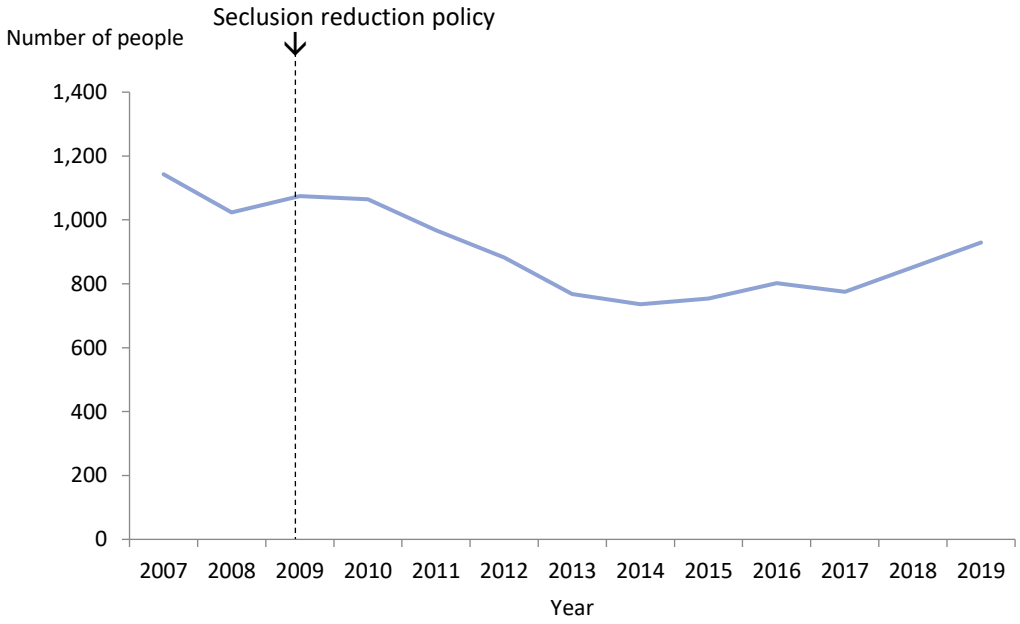
15 We are comparing with 2009 because that is the year when seclusion reduction policies were introduced.

16 Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern and Whanganui DHBs. Excludes outlier data.

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

- the total number of hours spent in seclusion has decreased by 47 percent since 2009
- the number of adult inpatient clients secluded increased by 9 percent from 2018 to 2019, and the number of hours spent in seclusion increased by 19 percent
- 70 percent of all seclusion events lasted for less than 24 hours, and 16 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 11.4 seclusion events for every 1,000 bed nights they spent in adult inpatient units.

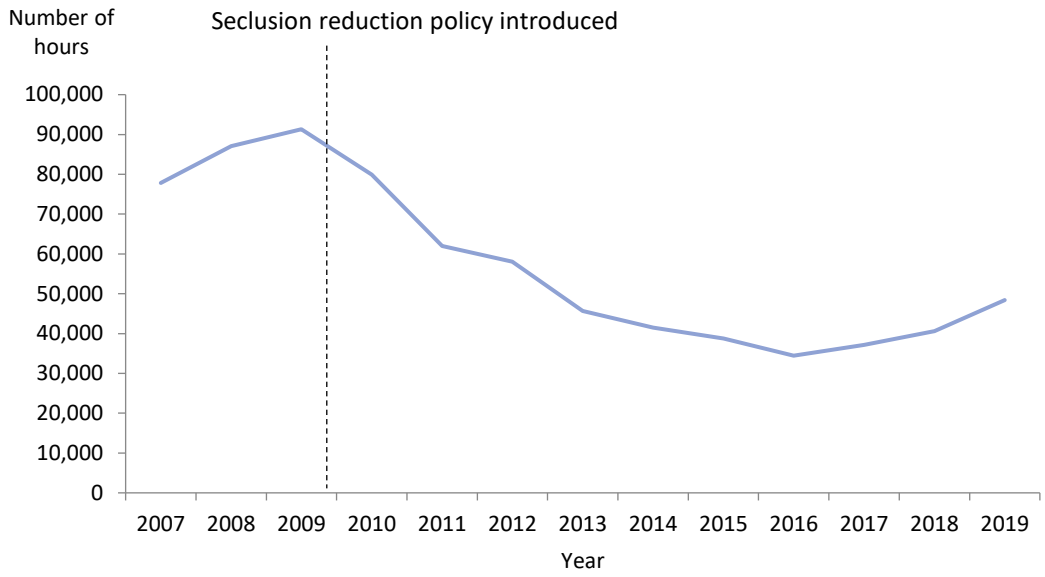
Figure 31: Number of people secluded in adult inpatient services nationally, 2007–2019



Note: Excludes forensic inpatient services and two outliers for 2018 and 2019. Includes patients who have a legal status under the Mental Health Act but are treated in Regional Intellectual Disability Secure Services (RIDSS).

Sources: For 2019: PRIMHD data (extracted 19 October 2020) and manual data from Southern and Whanganui DHBs. For 2018: PRIMHD data (extracted 29 July 2019) and manual data from Lakes, Nelson Marlborough, Southern, and Waitematā DHBs. For years 2007–2017, see previous reports.

Figure 32: Total number of seclusion hours in adult inpatient services nationally, 2007–2019



Note: Excludes forensic inpatient services and two outliers for 2018 and 2019. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

Sources: For 2019: PRIMHD data (extracted 19 October 2020) and manual data from Southern and Whanganui DHBs. For 2018: PRIMHD data (extracted 29 July 2019) and manual data from Lakes, Nelson Marlborough, Southern, and Waitematā DHBs. For years 2007–2017, see previous reports.

Seclusion in New Zealand mental health services

2018 summary[18]

- 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. Of these people, 852 (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). For this reason, the number of seclusion events in adult inpatient services (1,678) was higher than the number of people secluded.
- 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.
- Across all inpatient services, including forensic, intellectual disability and youth services, 1,066 people experienced at least one seclusion event. Of those secluded, 69 percent were male and 31 percent were female. The most common age group

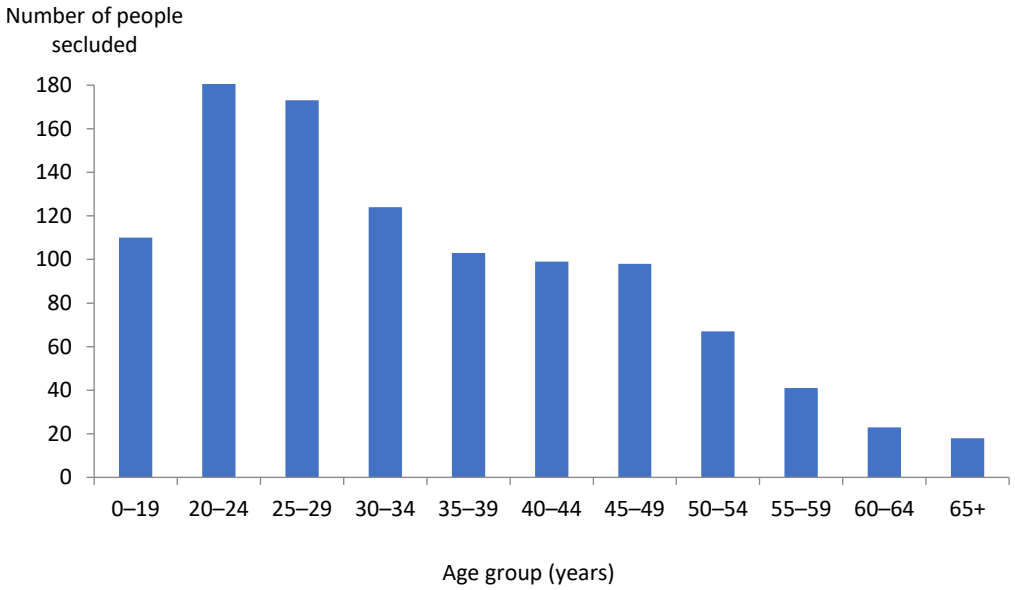
[18] Sources: PRIMHD data (extracted 29 July 2019) and manual data from Lakes, Nelson Marlborough, Southern, and Waitematā DHBs. Excludes two outliers and forensic services. Bed nights are measured by team types that provide seclusion. This figure cannot be compared with years before 2017, when bed nights were measured by acute and sub-acute bed nights.

for those secluded was 20–24 years. A total of 110 young people (aged 19 years and under) were secluded during the 2018 year in 290 seclusion events.

2019 summary[19]

- Between 1 January and 31 December 2019, New Zealand adult mental health services (excluding forensic and other regional rehabilitation services) accommodated 8,922 people for a total of 252,636 bed nights. Of these people, 929 (10.4 percent) were secluded at some stage during the reporting period.
- Among the adults who were secluded, many were secluded more than once (on average three times). For this reason, the number of seclusion events in adult inpatient services (2,885) was higher than the number of people secluded.
- In 2019, there were 11.4 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 11.4 seclusion events.
- Across all inpatient services, including forensic, intellectual disability and youth services, 1,159 people experienced at least one seclusion event. Of those secluded, 68 percent were male and 32 percent were female. The most common age group for those secluded was 20–24 years. A total of 95 young people (aged 19 years and under) were secluded during the 2019 year in 263 seclusion events.

Figure 33: Number of people secluded across all inpatient services (adult, forensic, intellectual disability and youth), by age group, 1 January to 31 December 2018

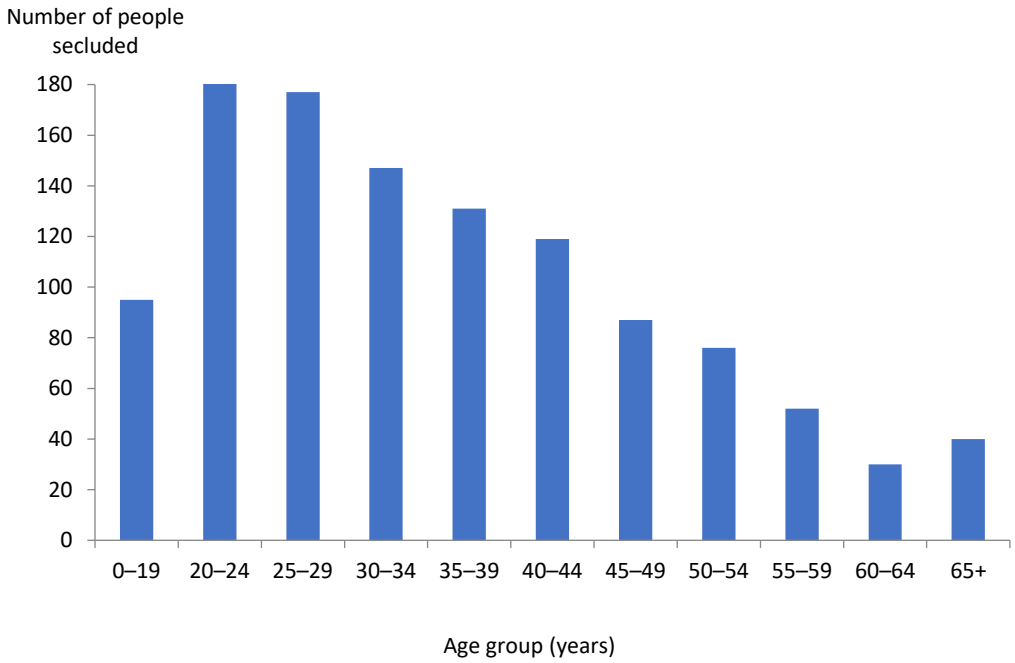


Note: Excludes two outliers. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

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

[19] Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern and Whanganui DHBs. Excludes two outliers and forensic services.

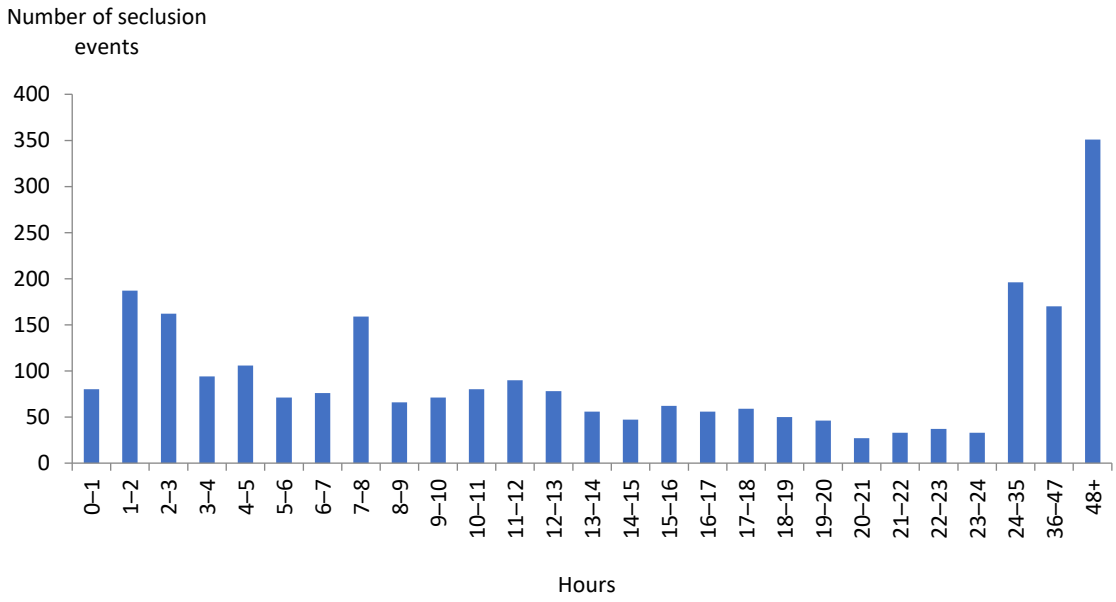
Figure 34: Number of people secluded across all inpatient services (adult, forensic, intellectual disability and youth), by age group, 1 January to 31 December 2019



Note: Excludes two outliers. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern and Whanganui DHBs.

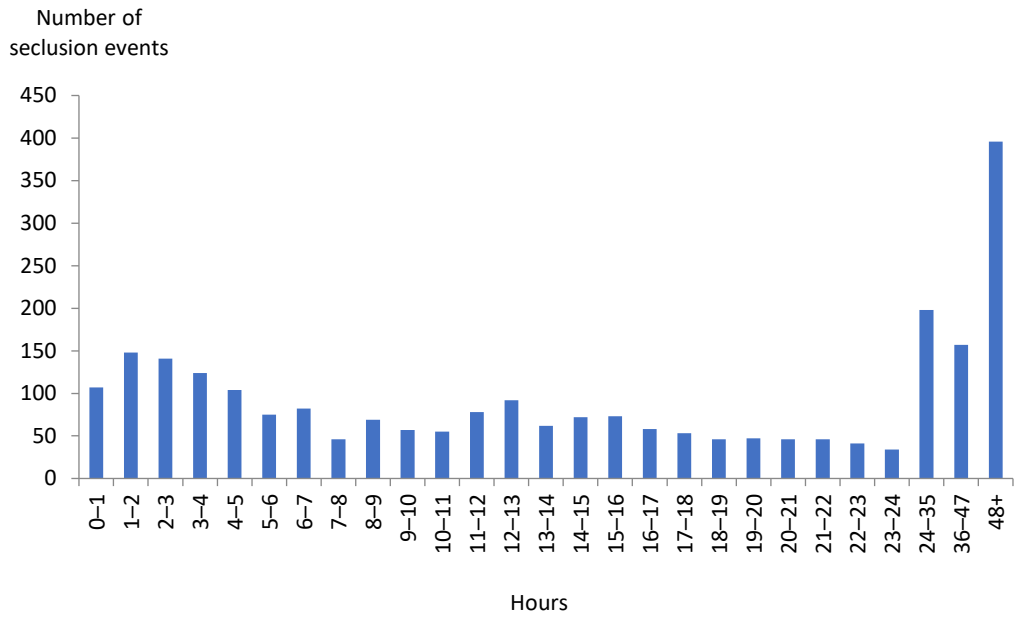
Figure 35: Number of seclusion events across all inpatient services (adult, forensic, intellectual disability and youth), by duration of event, 1 January to 31 December 2018



Note: Excludes two outliers. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

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

Figure 36: Number of seclusion events across all inpatient services (adult, forensic, intellectual disability and youth), by duration of event, 1 January to 31 December 2019



Note: Excludes two outliers. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern and Whanganui DHBs.

Use of seclusion by DHBs

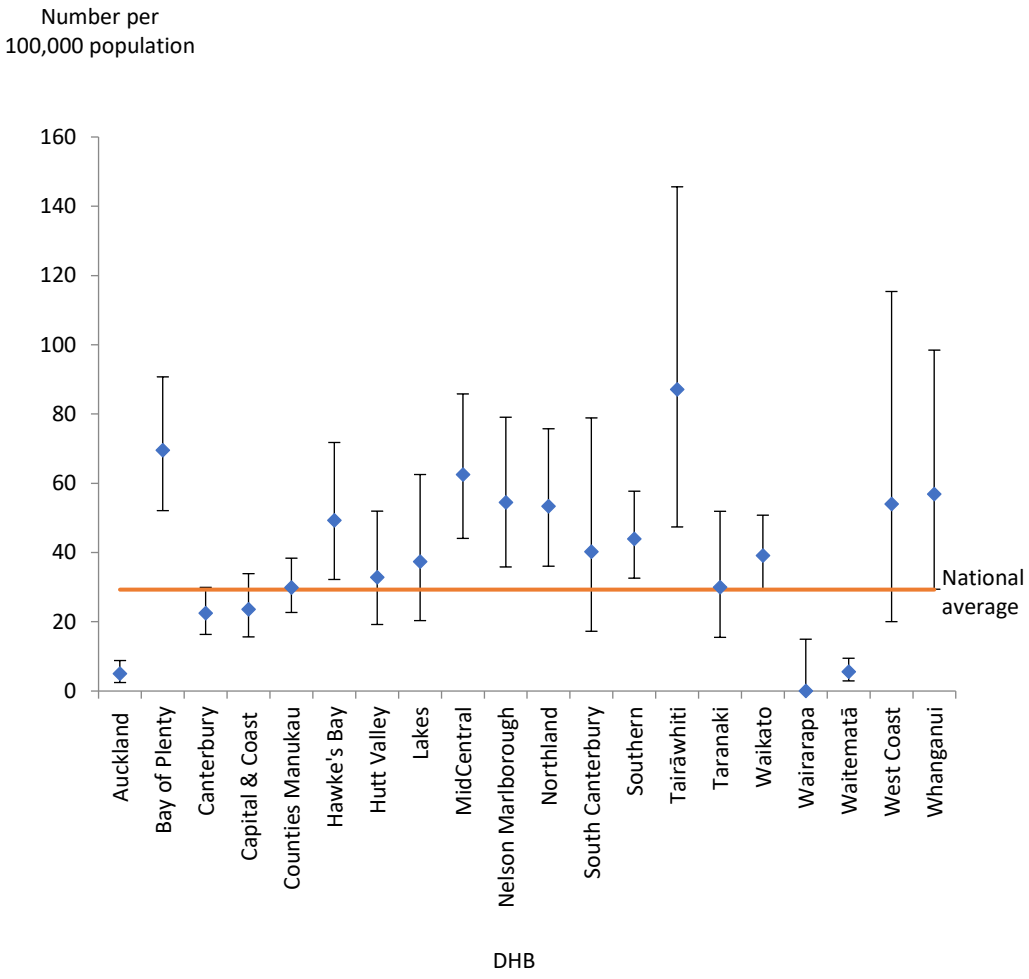
All DHBs except for Wairarapa DHB (which has no mental health inpatient service) use seclusion.[20]

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.

In 2019, the national average number of people secluded in adult inpatient services was 32.2 per 100,000 population, and the average number of seclusion events was 99.8 per 100,000 population.

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

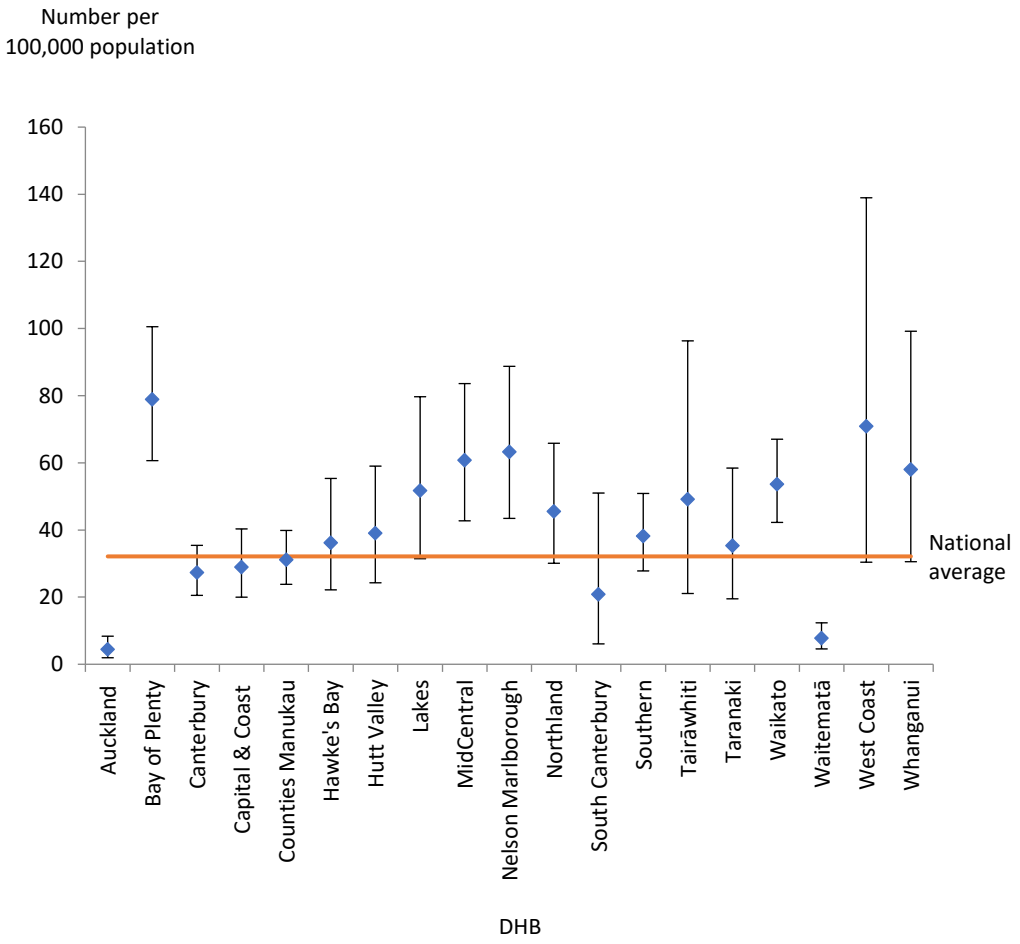
Figure 37: Number of people secluded in adult inpatient services per 100,000 population, by DHB, 1 January to 31 December 2018



Notes: The graph uses confidence intervals (for 99 percent 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. This data excludes two outliers. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS. Wairarapa DHB does not have an inpatient unit, so they have been removed from this graph.

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

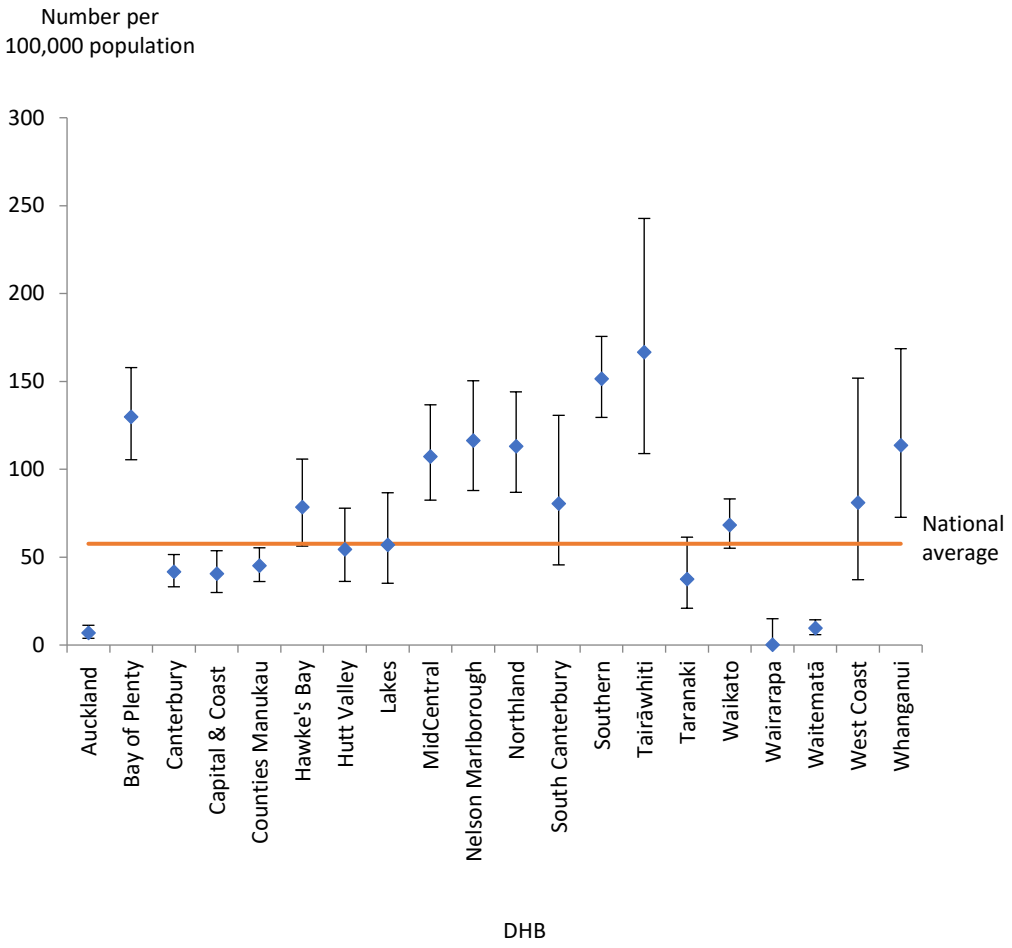
Figure 38: Number of people secluded in adult inpatient services per 100,000 population, by DHB, 1 January to 31 December 2019



Notes: The graph uses 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. This data excludes two outliers. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS. Wairarapa DHB does not have an inpatient unit, so they have been removed from this graph.

Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern and Whanganui DHBs.

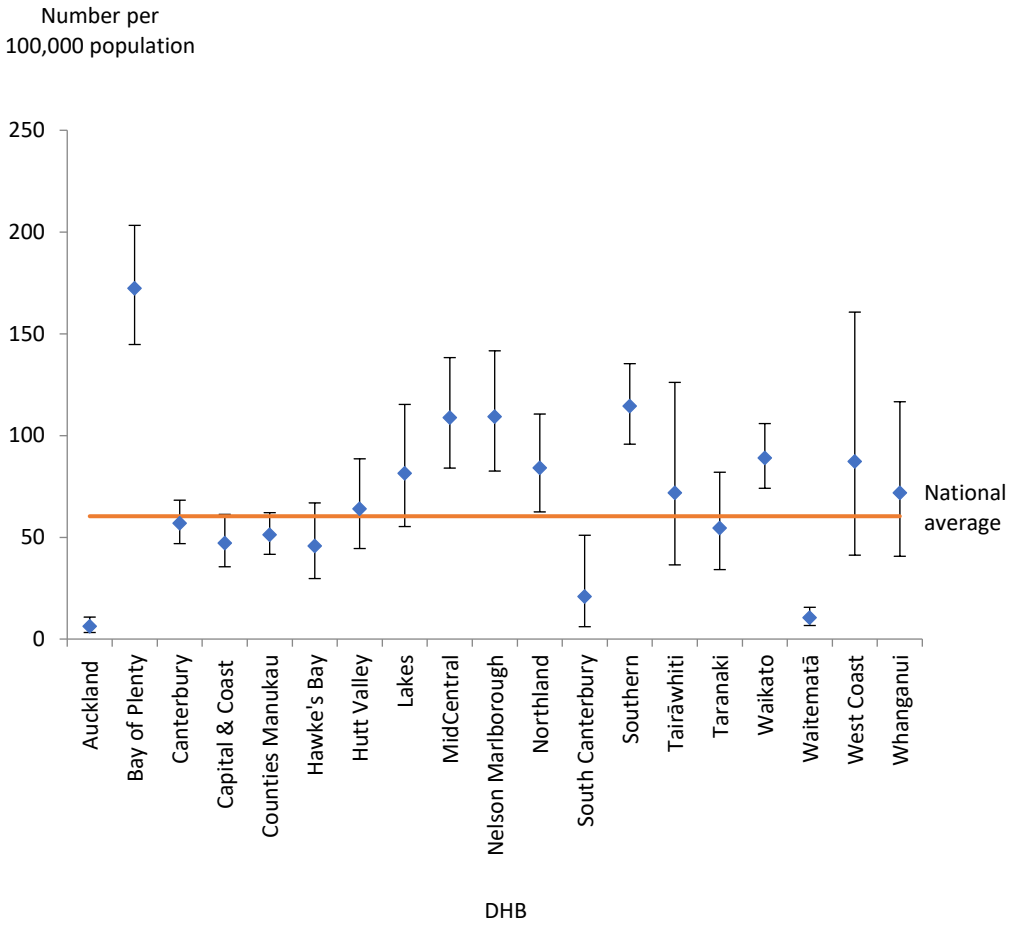
Figure 39: Number of seclusion events in adult inpatient services per 100,000 population, by DHB, 1 January to 31 December 2018



Notes: The graph uses confidence intervals (for 99 percent 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. This data excludes two outliers. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS. Wairarapa DHB does not have an inpatient unit, so they have been removed from this graph.

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

Figure 40: Number of seclusion events in adult inpatient services per 100,000 population, by DHB, 1 January to 31 December 2019



Notes: The graph uses 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. This data excludes two outliers. It includes patients who have a legal status under the Mental Health Act but are treated in RIDSS. Wairarapa DHB does not have an inpatient unit, so they have been removed from this graph.

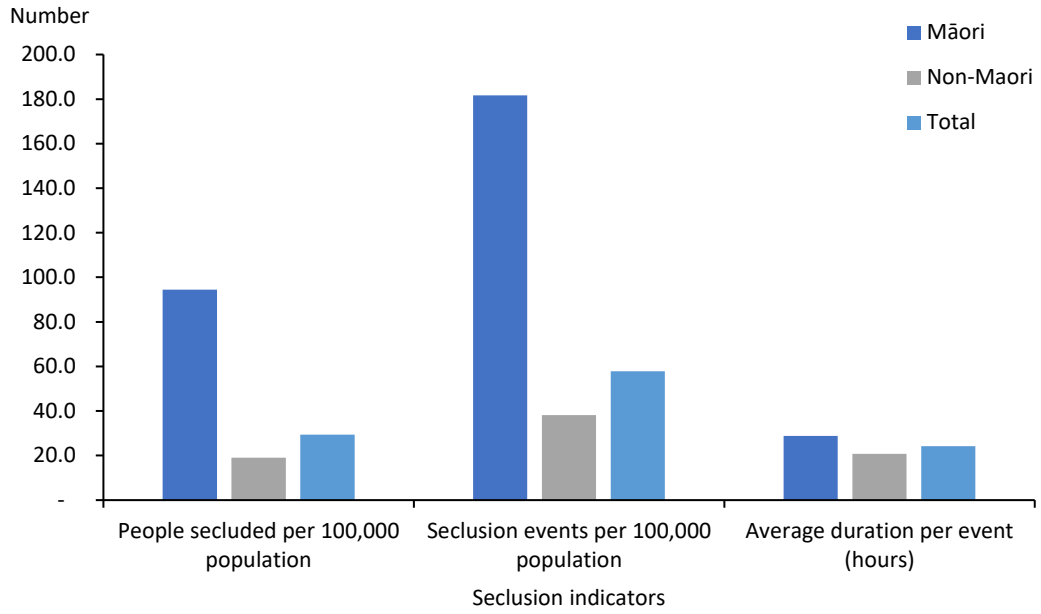
Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern and Whanganui DHBs.

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 41 shows seclusion indicators for Māori and non-Māori during 2018. Māori were secluded at a rate of 94.5 people per 100,000 population and non-Māori at a rate of 19 people per 100,000 population.

In 2019, Māori were five times more likely to be secluded in adult inpatient services than people from other ethnic groups. Figure 42 shows seclusion indicators for Māori and non-Māori during 2019. Māori were secluded at a rate of 100.7 people per 100,000 population and non-Māori at a rate of 20.1 people per 100,000 population.

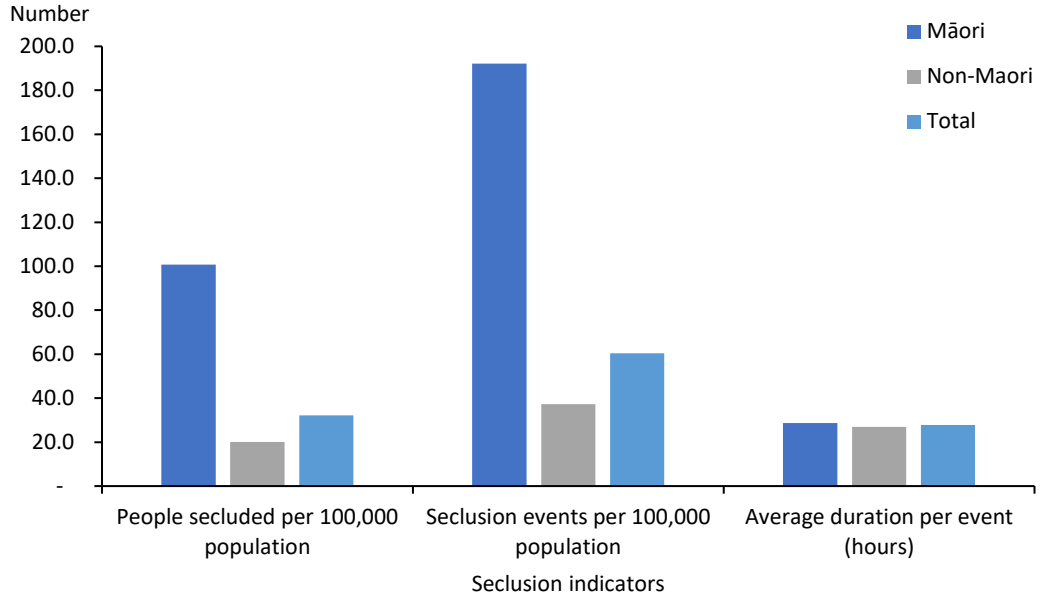
Figure 41: Seclusion indicators for adult inpatient services, Māori and non-Māori, 1 January to 31 December 2018



Note: Excludes two outliers, forensic services, and patients who have a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

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

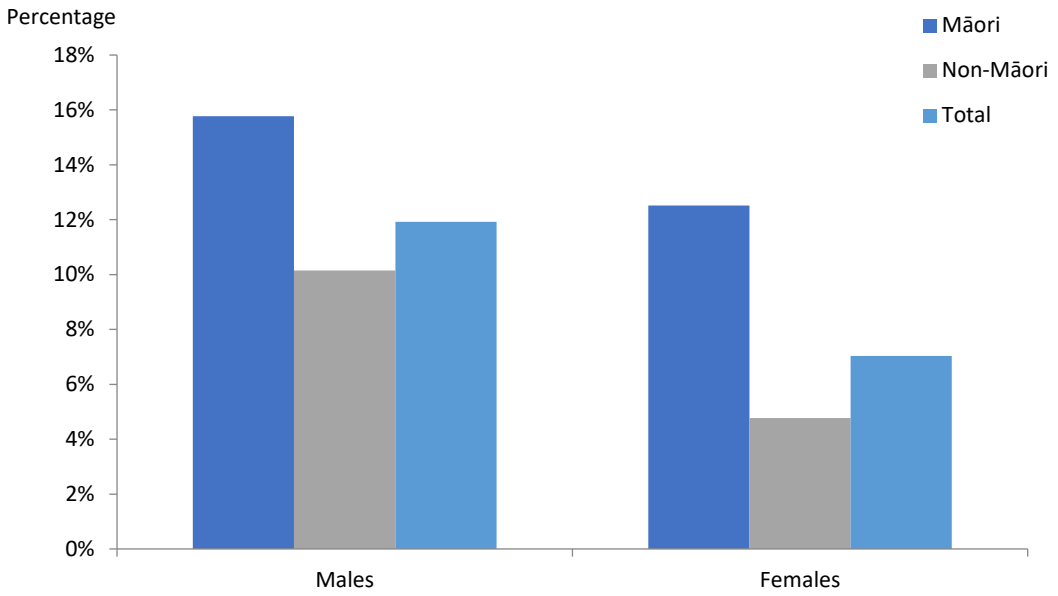
Figure 42: Seclusion indicators for adult inpatient services, Māori and non-Māori, 1 January to 31 December 2019



Note: Excludes two outliers, forensic services, and patients who have a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern and Whanganui DHBs.

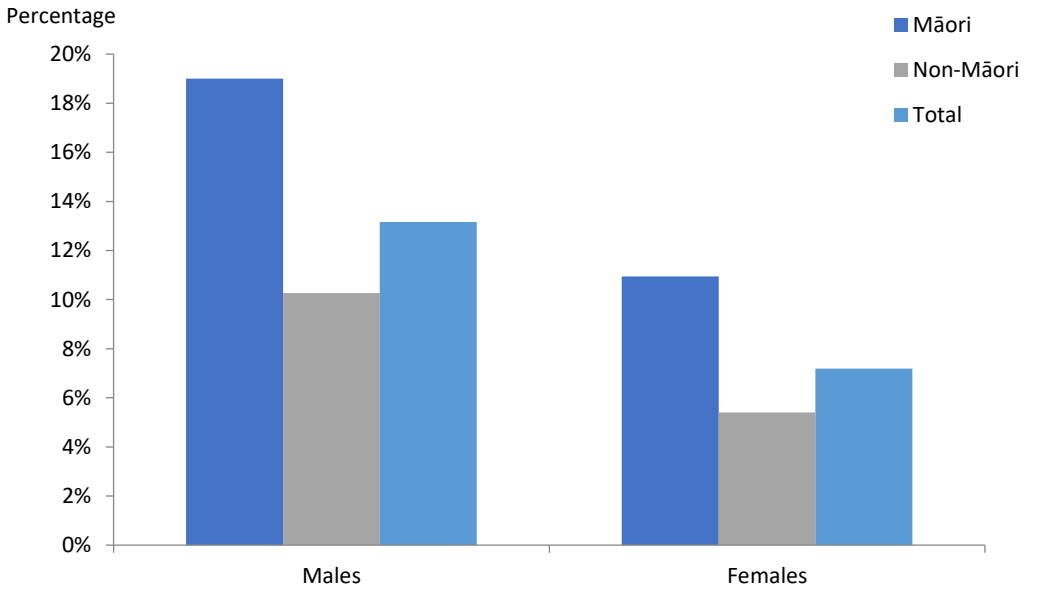
Figure 43: Percentage of people spending time in seclusion in adult inpatient services, Māori and non-Māori males and females, 1 January to 31 December 2018



Note: Excludes two outliers, forensic services, and patients who have a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

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

Figure 44: Percentage of people spending time in seclusion in adult inpatient services, Māori and non-Māori males and females, 1 January to 31 December 2019



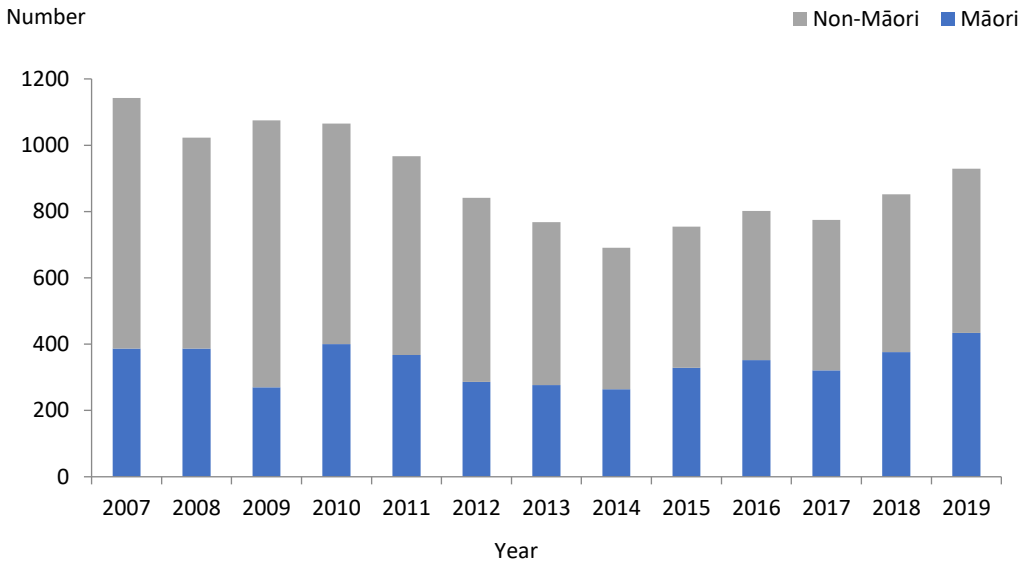
Note: Excludes two outliers, forensic services, and patients who have a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern and Whanganui DHBs.

Figure 45 shows the number of Māori and non-Māori aged 20–64 years secluded in adult inpatient services from 2007 to 2019. Nationally over this time, the number of people secluded decreased by 19 percent. The number of people secluded who identified as Māori increased by 12 percent over the same time.

The total number of adult patients secluded increased by 20 percent from 2017 to 2019.[21] The number of Māori patients increased by 35 percent over the same period.

Figure 45: Number of Māori and non-Māori aged 20–64 years secluded in adult inpatient services, 2007–2019



Note: Excludes two outliers, forensic services, and patients who have a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSS.

Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern and Whanganui DHBs.

Seclusion in forensic units

Five DHBs provide specialist inpatient forensic services: Canterbury, Capital & Coast, Southern, Waikato and Waitematā.[22] These services provide mental health treatment in a secure environment for prisoners with mental disorders and for people defined as special or restricted patients.

Tables 9 and 10 present seclusion indicators for forensic mental health services in each DHB for 2018 and 2019 respectively. 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

[21] The year 2017 is used here because it was the year of the previous Office of the Director of Mental Health and Addiction Services Annual Report.

[22] Capital & Coast DHB also operates a forensic service in Whanganui.

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	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 to other years' data. Data for the Whanganui forensic mental health service has been included with Capital & Coast DHB. Clients are aged 20–64 years. Clients are mental health service users only.

Sources: PRIMHD data (extracted 29 July 2019) and manual data from Southern and Waitematā DHBs.

Table 10: Seclusion indicators for forensic mental health services, by DHB, 1 January to 31 December 2019

DHB	Clients secluded	Number of events	Total hours	Average duration per event (hours)
Canterbury	30	157	14,835	94.5
Capital & Coast	4	5	102	20.4
Southern	4	13	287	22.1
Waikato	23	113	4,659	41.2
Waitematā	41	110	5,596	50.8
Total	**102**	**398**	**25,479**	**64.0**

Notes: Data for the Whanganui forensic mental health service has been included with Capital & Coast DHB. Clients are aged 20–64 years. Clients are mental health service users only.

Source: PRIMHD data (extracted 19 October 2020).

Special and restricted patients

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

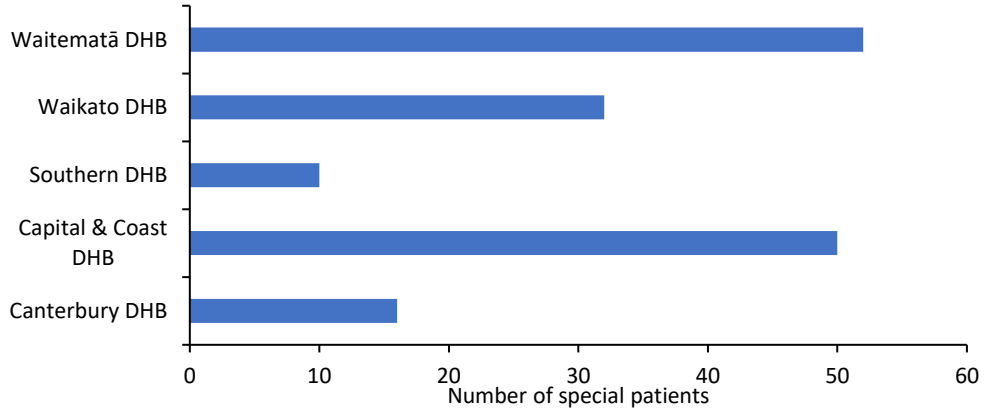
Special patients include:

- 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 not be charged with or convicted of a crime. 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.

Figures 46 and 47 present the total number of special patients in the care of each of the DHBs that provide regional forensic psychiatry services.

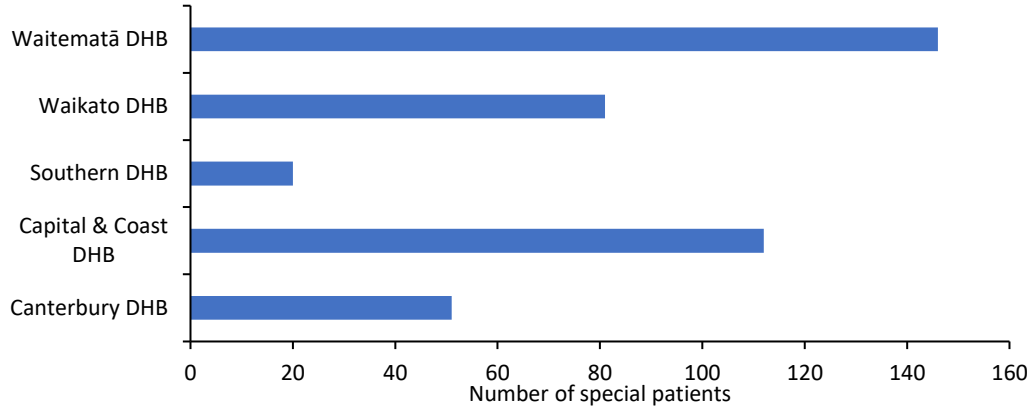
Figure 46: Total number of special patients, by DHB, 1 January to 31 December 2018



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

Source: PRIMHD data (extracted 29 July 2019).

Figure 47: Total number of special patients, by DHB, 1 January to 31 December 2019



Note: Due to their relatively small numbers of special patients, Whanganui, MidCentral and Hawke's Bay DHBs are included under Capital & Coast DHB, and Nelson Marlborough DHB is included under Canterbury DHB.

Source: PRIMHD data (extracted 19 October 2020).

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 Criminal Procedure (Mentally Impaired Persons) 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. In 2019, there were 165 extended forensic care special patients. Tables 11 and 12 show the number of these patients in the care of each of the DHBs that provide regional forensic psychiatry services per year.

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 Criminal Procedure (Mentally Impaired Persons) Act 2003, sentencing an offender to a term of imprisonment while also ordering their detention in hospital as a special patient.

In 2018, New Zealand had a total of 251 short-term forensic care special patients. In 2019, there were 256 short-term forensic care special patients. Tables 11 and 12 show the number of these patients in the care of each of the DHBs that provide regional forensic psychiatry services. Figures 48 and 49 show 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 11: Total number of special patients, by type and 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 DHB 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 data (extracted 29 July 2019).

Table 12: Total number of special patients, by type and DHB, 1 January to 31 December 2019

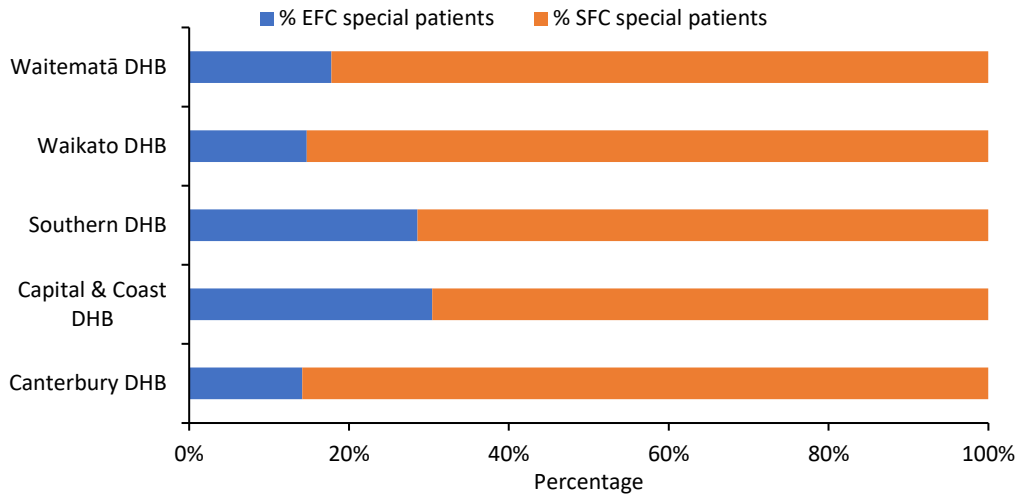
Forensic services	EFC special patients	SFC special patients	Total special patients
Canterbury DHB	15	37	51
Capital & Coast DHB	54	62	112
Southern DHB	10	10	20
Waikato DHB	39	51	81
Waitematā DHB	50	99	146

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, MidCentral and Hawke's Bay DHBs are included under Capital & Coast DHB, and Nelson Marlborough DHB 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 data (extracted 19 October 2020).

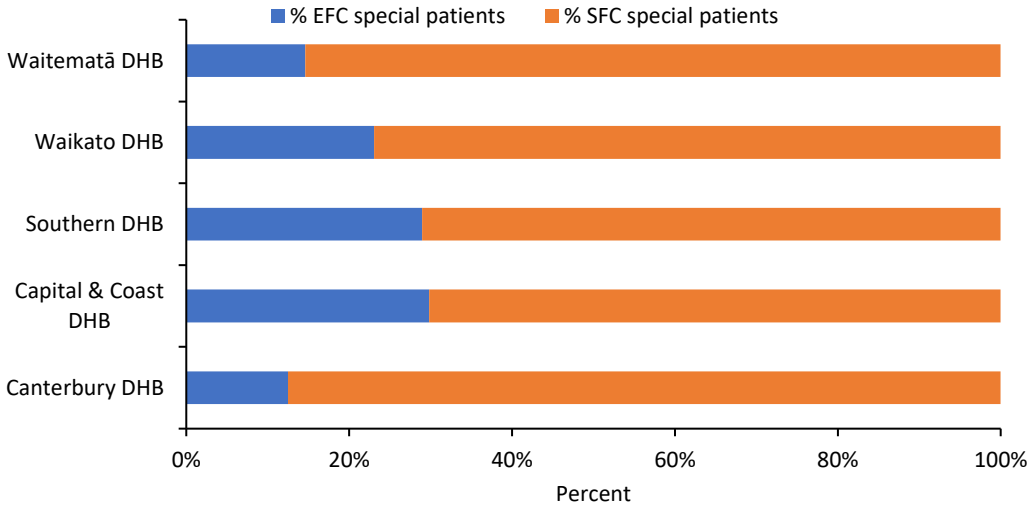
Figure 48: Percentage of court orders given for extended forensic care relative to short-term forensic care legal statuses, by DHB, 1 January to 31 December 2018



Note: Unlike previous data in this section, the data in this figure is based on a count of court orders for legal statuses 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-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 either 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 DHB is included under Canterbury DHB.

Source: PRIMHD data (extracted 29 July 2019).

Figure 49: Percentage of court orders given for extended forensic care relative to short-term forensic care legal statuses, by DHB, 1 January to 31 December 2019



Note: Unlike previous data in this section, the data in this figure is based on a count of court orders for legal statuses 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-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 either EFC or SFC legal status. Due to their relatively small numbers of special patients, Whanganui, MidCentral and Hawke's Bay DHBs are included under Capital & Coast DHB, and Nelson Marlborough DHB is included under Canterbury DHB.

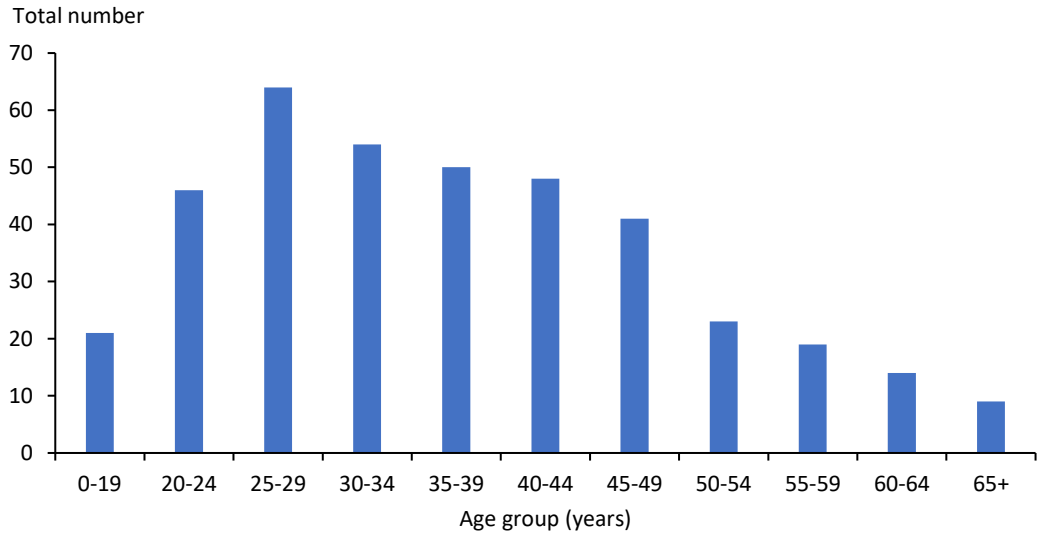
Source: PRIMHD data (extracted 19 October 2020).

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 in 2018 for special patients was 25–29 years old (see Figure 50).

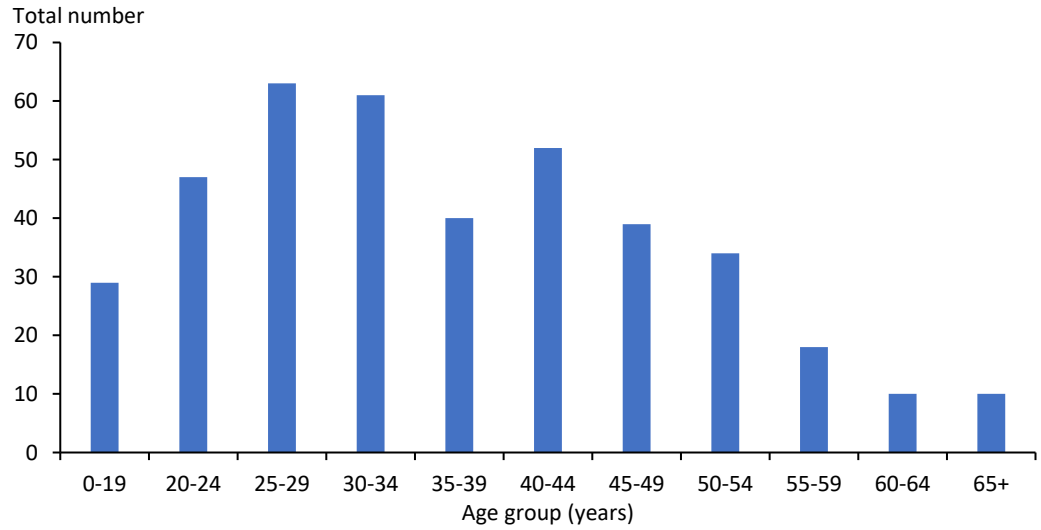
In 2019, special patients were more likely to be male (84 percent) than female (16 percent). The most common age group in 2019 for special patients was 25–29 years old (see Figure 51).

Figure 50: Total number of special patients, by age group, 1 January to 31 December 2018



Source: PRIMHD data (extracted 29 July 2019).

Figure 51: Total number of special patients, by age group, 1 January to 31 December 2019

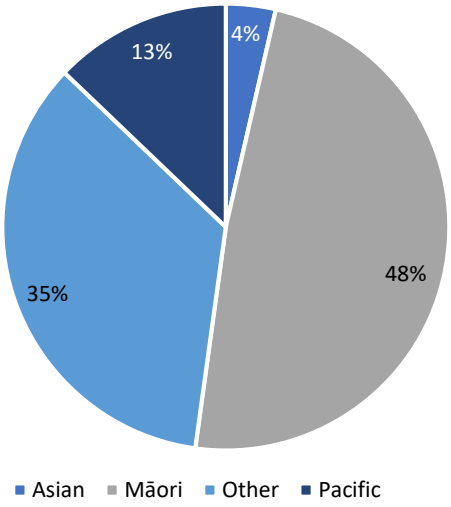


Source: PRIMHD data (extracted 19 October 2020).

In 2018, the ethnic group with the highest proportion of people subject to a special patient order was Māori (48 percent) (see Figure 52). Māori represented the highest proportion of both extended forensic care (42 percent) and short-term forensic care (54 percent) special patients. Figure 54 shows the number of special patients in each ethnic group for each of these types of forensic care in 2018.

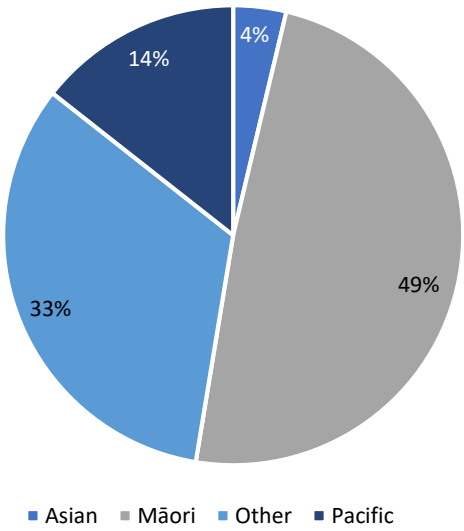
In 2019, the ethnic group with the highest proportion of people subject to a special patient order was Māori (49 percent) (see Figure 53). Māori represented the highest proportion of both extended forensic care (43 percent) and short-term forensic care (53 percent) special patients. Figure 55 shows the number of special patients in each ethnic group for each of these forensic care types in 2019.

Figure 52: Percentage of special patients, by ethnicity, 1 January to 31 December 2018



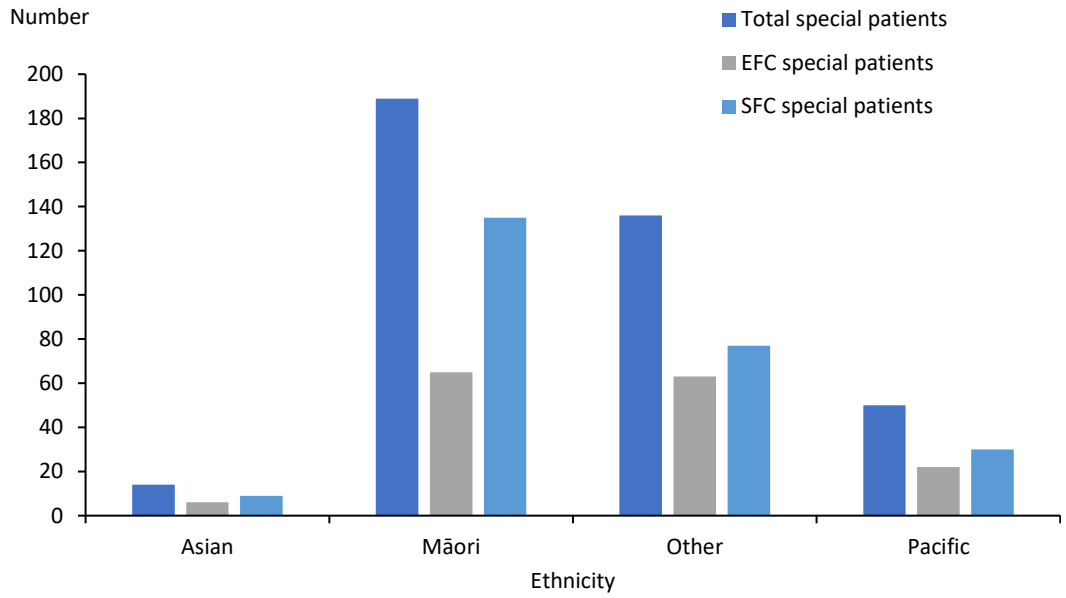
Source: PRIMHD data (extracted 27 July 2019).

Figure 53: Percentage of special patients, by ethnicity, 1 January to 31 December 2019



Source: PRIMHD data (extracted 19 October 2020).

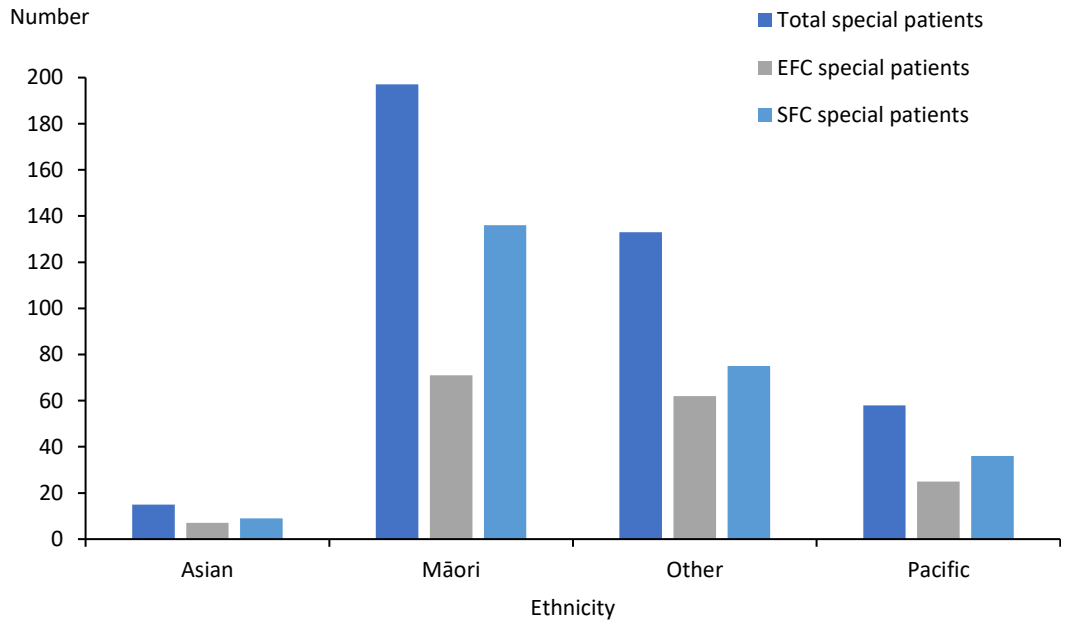
Figure 54: Number of special patients, by ethnicity and special patient type, 1 January to 31 December 2018



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

Source: PRIMHD data (extracted 29 July 2019).

Figure 55: Number of special patients, by ethnicity and special patient type, 1 January to 31 December 2019



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

Source: PRIMHD data (extracted 19 October 2020).

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).

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.

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.

Table 13 shows the number of applications for section 50 long leave, revocation of leave and reclassification that the Office processed during 2018 and 2019.

Table 13: Number of section 50 long leave, revocation and reclassification applications sent to the Minister of Health for special patients and restricted patients, 1 January to 31 December 2018

Type of request	Number completed in 2018	Number completed in 2019
Initial ministerial section 50 leave applications approved	9	13
Initial ministerial section 50 leave applications not approved	0	1
Ministerial section 50 leave revocations (initial and further)	1	1
Further ministerial section 50 leave applications approved	17	21
Further ministerial section 50 applications not approved	0	0
Change of legal status applications approved	5	6
Change of legal status applications not approved	4	1
Total applications approved or not approved	**36**	**43**

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

New Zealand has two major national reporting mechanisms for adverse events relating to mental health.[23] 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)[24] 1 or 2 to the Health Quality & Safety Commission (HQSC) in line with the National Adverse Events Reporting Policy.[25] Mental health services that are not funded by DHBs are encouraged but not required to report adverse events to the HQSC.

In New Zealand, adverse events have been reported publicly since 2006. 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.

Adverse events reported by DHB mental health services

Tables 14 and 15 provide a breakdown of the types of adverse events relating to mental health that DHBs reported to HQSC during 2018 and 2019. Tables 16 and 17 show 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 it has more adverse events compared with other DHBs. In addition, DHBs that serve a larger population or provide more complex mental health services may report a higher number of adverse events.

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

[24] 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.

[25] See **https://www.hqsc.govt.nz/our-programmes/adverse-events/national-adverse-events-policy/**

Table 14: Number of mental health adverse events that DHBs reported to the HQSC, 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
Serious adverse behaviour	4	6	0	0	10
Total	**189**	**22**	**0**	**5**	**216**

Note: AWOL = absent without leave.

Source: HQSC adverse event data (extracted 2 September 2019).

Table 15: Number of mental health adverse events that DHBs reported to the HQSC, by type of event, 1 January to 31 December 2019

Type of event	Outpatient	Inpatient	On approved leave	Inpatient (AWOL)	Total
Suspected suicide	156	6	5	4	171
Serious self-harm	10	6	1	1	18
Serious adverse behaviour	3	3	0	0	6
Total	**169**	**15**	**6**	**5**	**195**

Note: AWOL = absent without leave.

Source: HQSC adverse event data (extracted 26 January 2021).

Table 16: Mental health adverse events that DHBs reported to the HQSC, by DHB, 1 January to 31 December 2018

DHB	Number of events
Auckland	25
Bay of Plenty	8
Canterbury	24
Capital & Coast	15
Counties Manukau	13
Hawke's Bay	6
Hutt Valley	4
Lakes	9
MidCentral	10
Nelson Marlborough	3

DHB	Number of events
Northland	6
South Canterbury	3
Southern	29
Tairāwhiti	7
Taranaki	4
Waikato	17
Wairarapa	0
Waitematā	26
West Coast	3
Whanganui	4
New Zealand total	**216**

Source: HQSC adverse event data (extracted 2 September 2019).

Table 17: Mental health adverse events that DHBs reported to the HQSC, by DHB, 1 January to 31 December 2019

DHB	Number of events	DHB	Number of events
Auckland	14	Northland	10
Bay of Plenty	3	South Canterbury	3
Canterbury	23	Southern	15
Capital & Coast	16	Tairāwhiti	4
Counties Manukau	18	Taranaki	2
Hawke's Bay	7	Waikato	19
Hutt Valley	7	Wairarapa	4
Lakes	5	Waitematā	22
MidCentral	9	West Coast	2
Nelson Marlborough	7	Whanganui	5
		New Zealand total	**195**

Source: HQSC adverse event data (extracted 26 January 2021).

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 can only be given with the consent of the person receiving it, other than in carefully defined circumstances.

In summary, in 2018:

- 265 people received ECT (5.4 people per 100,000 population)
- services administered a total of 2,990 treatments of ECT
- those treated received an average of 11.3 treatments 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.

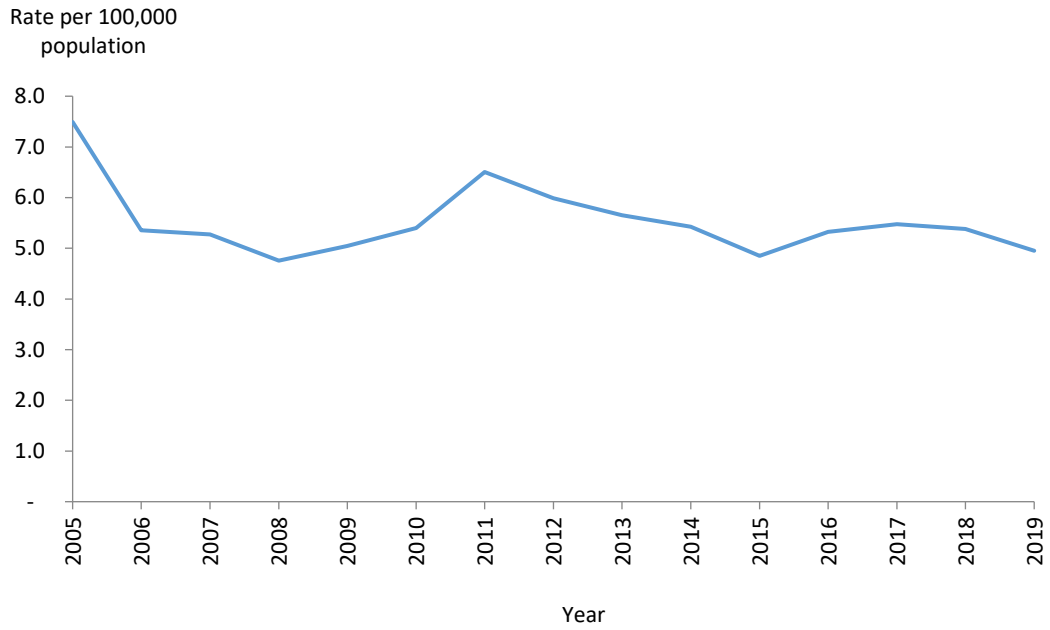
In 2019:

- 245 people received ECT (4.9 people per 100,000 population)
- services administered a total of 2,797 treatments of ECT
- those treated received an average of 11.4 administrations of ECT over the year
- females were more likely to receive ECT than males, making up 64 percent of ECT patients
- older people were more likely to receive ECT than younger people, with those over 50 years old making up 65 percent of ECT patients.

ECT treatments in 2018 and 2019

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.

Figure 56: Rate of people treated with ECT per 100,000 population, 2005–2019



Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern DHB.

ECT by region

The number and rate of ECT treatments vary regionally (see Tables 18 and 19 and Figures 57 and 58). 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 18: ECT 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
- 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.

Sources: PRIMHD data (extracted 29 July 2019) and manual data from Lakes, MidCentral, Nelson Marlborough, Southern and Waitematā DHBs.

Table 19: ECT indicators, by DHB of domicile, 1 January to 31 December 2019

DHB of domicile	Number of people treated with ECT	Number of treatments	Mean number of treatments per person (range)
Auckland	21	259	12 (3–43)
Bay of Plenty	19	236	12 (6–49)
Canterbury	21	193	9 (1–61)
Capital & Coast	20	278	14 (1–58)
Counties Manukau	20	169	8 (1–28)
Hawke's Bay	1	10	10 (10–10)
Hutt Valley	13	79	6 (2–12)
Lakes	9	51	6 (1–15)
MidCentral	11	69	6 (1–16)
Nelson Marlborough	0	0	0
Northland	10	131	13 (3–25)
South Canterbury	0	0	0
Southern	32	454	14 (1–60)
Tairāwhiti	4	28	7 (4–12)
Taranaki	2	10	5 (5–5)
Waikato	37	470	13 (1–36)
Wairarapa	0	0	0
Waitematā	24	334	14 (2–36)
West Coast	2	15	8 (4–11)
Whanganui	1	11	11 (11–11)
New Zealand total	**246**	**2797**	**11 (1–61)**

Notes: In 2019, 16 people were treated out of area, as follows:

- Auckland DHB saw one person from Counties Manukau DHB
- Bay of Plenty DHB saw four people from Tairāwhiti DHB
- Canterbury DHB saw one person from Southern DHB and two people from West Coast DHB
- Capital & Coast DHB saw one person from Hutt Valley DHB
- Counties Manukau DHB saw one person from Auckland DHB and one person from Lakes DHB
- Hutt Valley DHB saw one person from MidCentral DHB
- MidCentral DHB saw one person from Whanganui DHB
- Waikato DHB saw one person from Taranaki DHB
- Waitematā DHB saw one person from Auckland DHB and one person from Waikato DHB.

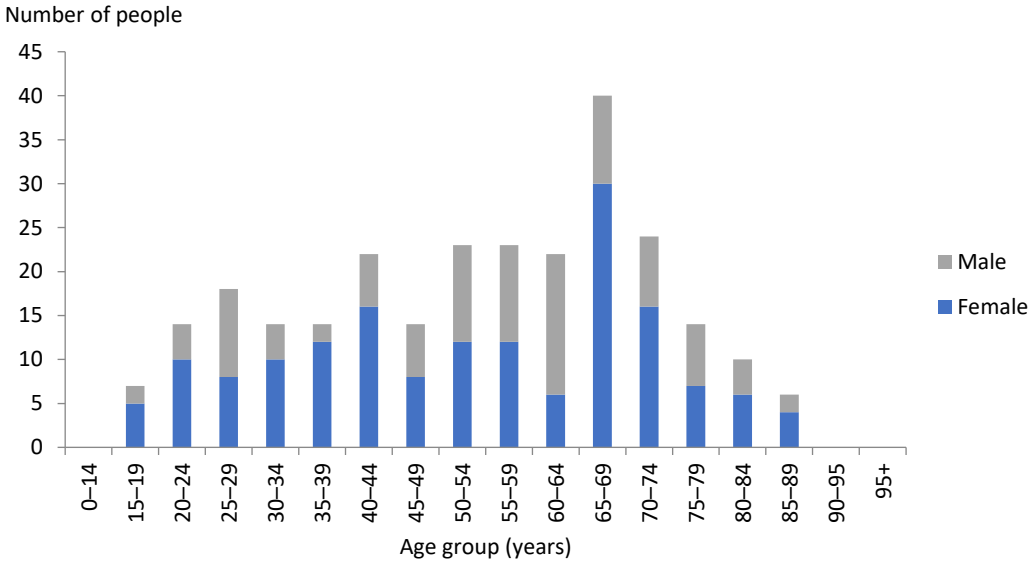
Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern DHB.

Sex and age of people receiving ECT

In 2018 and 2019, women were more likely to receive ECT than men. This ratio is similar to that reported in other countries.

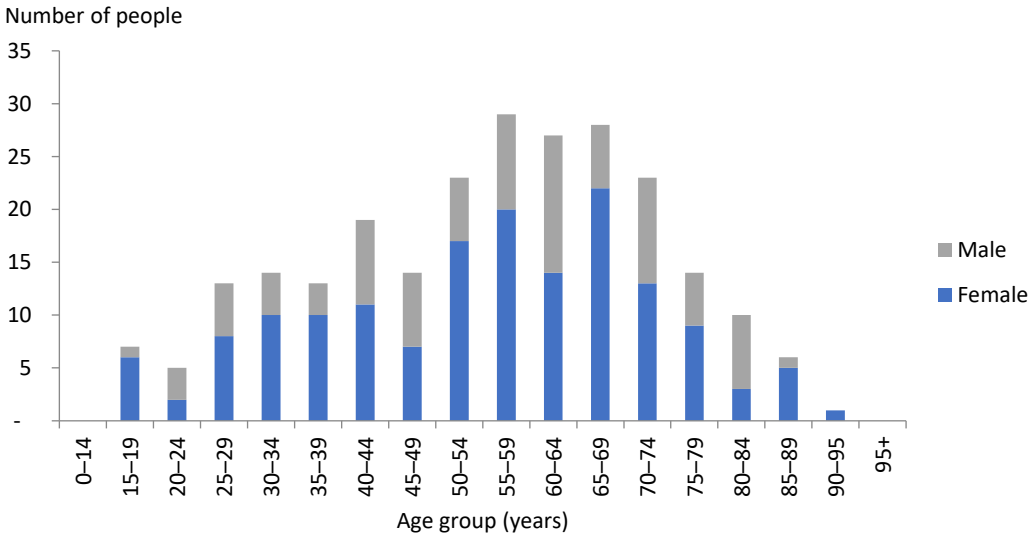
Older people were more likely to receive ECT than younger people, with patients over 50 years old representing 61 percent of all patients in 2018 and 65 percent of all patients in 2019.

Figure 57: Number of people treated with ECT, by age group and sex, 1 January to 31 December 2018



Sources: PRIMHD data (extracted 29 July 2019) and manual data from Lakes, MidCentral, Nelson Marlborough, Southern and Waitematā DHBs.

Figure 58: Number of people treated with ECT, by age group and sex, 1 January to 31 December 2019



Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern DHB.

Ethnicity of people treated with ECT

Tables 20 and 21 indicate 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 ECT, by ethnicity, 1 January to 31 December 2018

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

Sources: PRIMHD data (extracted 29 July 2019) and manual data from Lakes, MidCentral, Nelson Marlborough, Southern and Waitematā DHBs.

Table 21: Number of people treated with ECT, by ethnicity, 1 January to 31 December 2019

Ethnicity	Number
Asian	15
Māori	23
Pacific	6
Other	202
Total	**246**

Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern DHB.

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.

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 from an independent psychiatrist.

During 2019, services administered ECT to 88 people who could not consent to treatment. The total number of ECT treatments administered without consent was 838, a decrease from 2018. An additional 36 treatments were administered to four people who did have capacity to consent but refused after the DHB gained a second opinion from an independent psychiatrist.

Tables 22 and 23 show the number of treatments administered without consent during 2018 and 2019.

Table 22: ECT 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	**99**	**1,024**	**2**	**23**

Notes: The data in this table cannot be reliably compared with the data in Table 18 because it relates to DHB of service rather than DHB of domicile.

A dash (–) indicates the DHB does not perform ECT. In this case, the DHB sends people to other DHBs for treatment.

Source: Manual data from DHBs.

Table 23: ECT administered under second opinion without consent, by DHB of service, 1 January to 31 December 2019

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	6	50	0	0
Bay of Plenty	2	30	0	0
Canterbury	10	44	4	36
Capital & Coast	4	26	0	0
Counties Manukau	10	74	0	0
Hawke's Bay	1	8	0	0
Hutt Valley	5	21	0	0
Lakes	0	0	0	0
MidCentral	4	26	0	0
Nelson Marlborough	0	0	0	0
Northland	5	62	0	0
South Canterbury	0	0	0	0
Southern	12	198	0	0
Tairāwhiti	0	0	0	0
Taranaki	0	0	0	0
Waikato	12	114	0	0
Wairarapa	–	–	–	–
Waitematā	17	184	0	0
West Coast	–	–	–	–
Whanganui	–	–	–	–
New Zealand	**88**	**838**	**4**	**36**

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

A dash (–) indicates the DHB does not perform ECT. In this case, the DHB sends people to other DHBs for treatment.

Source: Manual data from DHBs.

2018 and 2019 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 it places greater emphasis on a mana-enhancing and health-based approach.

Severe substance addiction

Section 8 of the Substance Addiction Act 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-adaption to the substance
- craving for the substance
- unsuccessful efforts to control the use of the substance
- use of the substance despite suffering harmful consequences.

Criteria for compulsory treatment

Section 7 of the Substance Addiction Act states the criteria for compulsory treatment, all of which must apply:

- the person has a severe substance addiction; and
- the person's capacity to make informed decisions about treatment for that addiction is severely impaired; and
- compulsory treatment of the person is necessary; and
- 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** 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, then 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 offices, 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 (health.govt.nz) and search '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 introduced in 2018, this report may contain minor data discrepancies. We aim to strengthen the data reporting process for future reports.

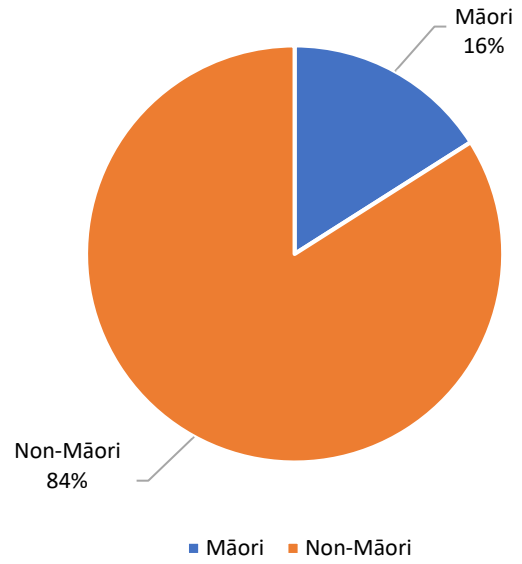
Substance Addiction Act in 2018

In 2018, 25 people were detained under the Substance Addiction Act.[26] 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.

Among those subject to compulsory treatment certificates, 12 were women and 13 were men. 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. Nearly half of all patients with compulsory treatment certificates were referred from DHBs in the greater Auckland region (Auckland, Waitematā and Counties Manukau). The courts made 15 compulsory treatment orders and extended 10 compulsory treatment orders.

[26] Source: PRIMHD data (extracted 12 September 2019).

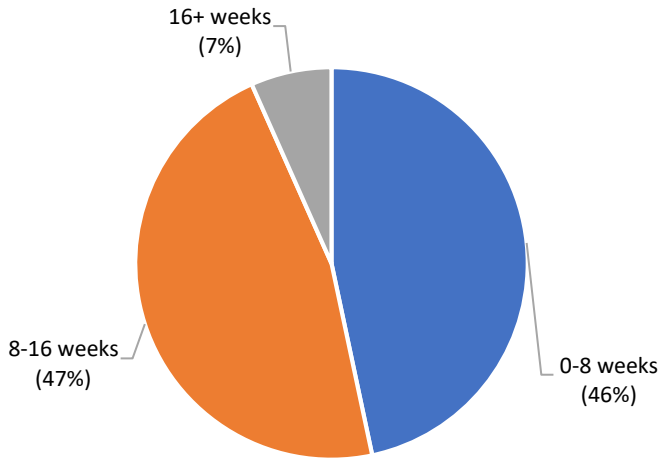
Figure 59: Percentage of patients subject to compulsory treatment certificates, by ethnicity, 1 January to 31 December 2018



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 Substance Addiction 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 60).

Figure 60: Percentage of patients subject to compulsory treatment certificates, by number of weeks in detention, 1 January to 31 December 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[27]
- 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.[28]

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.

Substance Addiction Act in 2019

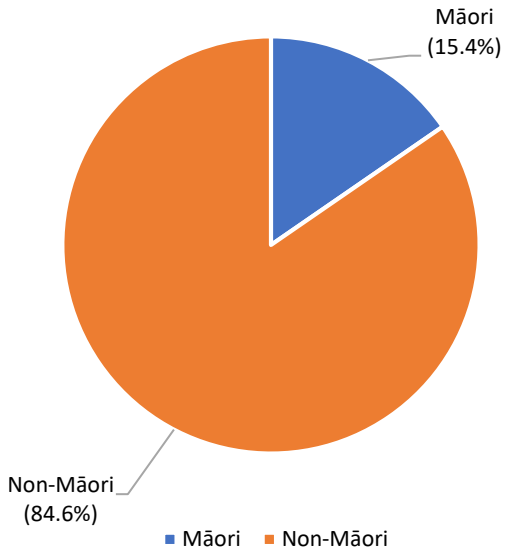
In 2019, 26 people were detained under the Substance Addiction Act.[29] Among those subject to compulsory treatment certificates, 12 were women and 14 were men. They tended to be in older age groups, with 54 percent over 50 years old. The most common ethnic group in this cohort was New Zealand European. Half of all patients with compulsory treatment certificates were referred from DHBs in the greater Auckland region (Auckland, Counties Manukau and Waitematā). The courts made 16 compulsory treatment orders and extended 10 compulsory treatment orders.

27 Source: PRIMHD data (extracted 30 October 2019).

28 Source: PRIMHD data (extracted 20 November 2019).

29 For the purposes of this report, 'detained' means an approved specialist has signed a compulsory treatment certificate. Source: PRIMHD data (extracted 2 September 2020).

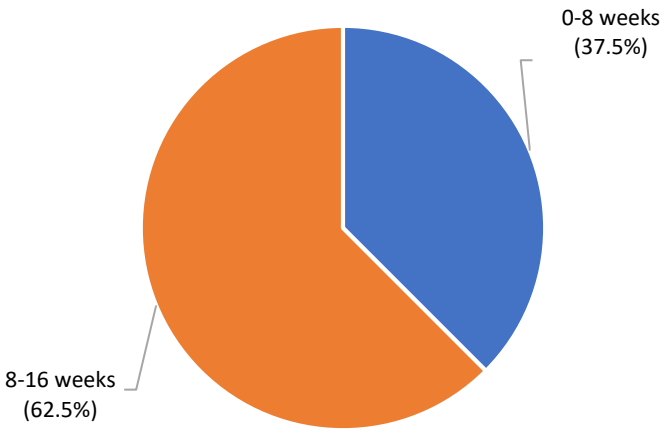
Figure 61: Percentage of patients subject to compulsory treatment certificates, by ethnicity, 1 January to 31 December 2019



Source: PRIMHD data (extracted 2 September 2020).

The average length of detention was 10 weeks and six days. Among these patients, 37.5 percent were detained for a period of less than eight weeks, which is within the first period of compulsory treatment set out in the Substance Addiction Act. The other 62.5 percent of patients were detained for a period of between 8 and 16 weeks, requiring a compulsory treatment order extension (see Figure 62).

Figure 62: Percentage of patients subject to compulsory treatment certificates, by number of weeks in detention, 1 January to 31 December 2019



Source: PRIMHD data (extracted 2 September 2020).

PRIMHD records show that in 2019, among service users who were discharged from the Substance Addiction Act:

- 40.6 percent received additional inpatient care[30]

[30] Source: PRIMHD data (extracted 3 February 2021).

- 75 percent engaged with individual treatments in outpatient services
- 50 percent had family meetings arranged
- 37.5 percent had Supplementary Consumer Records
- 28.1 percent had wellness plans.[31]

Note that this data represents the 2019 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.

Land Transport Act 1998

In 2018 and 2019, the Office of the Director of Mental Health and Addiction Services continued to work with Waka Kotahi NZ Transport Agency, the Ministry of Transport and the Drug and Alcohol Practitioners' Association Aotearoa–New Zealand (DAPAANZ) to monitor the reinstatement of drivers disqualified for offences involving alcohol or drugs and to approve assessment centres as stated under section 65A of the Land Transport Act 1998. This section provides for the mandatory indefinite disqualification of driver 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 behaviours. The assessment centres send copies of their reports to Waka Kotahi, 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 24A 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, the *New Zealand Practice Guidelines for Opioid Substitution Treatment* provides clinical and procedural guidance for specialist services and primary care providers who deliver OST.

[31] Source: PRIMHD data (extracted 3 February 2021).

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. These services are also subject to a Ministry audit every three years, through the Specialist Opioid Substitution Treatment Service Audit and Review Tool.

In summary, 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.[32]

In 2019:

- 5,548 people received OST
- 79.6 percent of these people were New Zealand European, 15.2 percent were Māori, 1.1 percent were Pacific peoples and 4.1 percent were of another ethnicity
- 63.3 percent of clients receiving OST were over 45 years old
- 27.5 percent of people receiving OST were being treated by a general practitioner in a shared-care arrangement.[33]

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, and in 2019 this number was 24 percent. The Ministry's target for service provision is 50:50 between primary and specialist health care services. Figures 63 and 64 present the percentage of people receiving OST from specialist services and general practice in each DHB in 2018 and 2019.

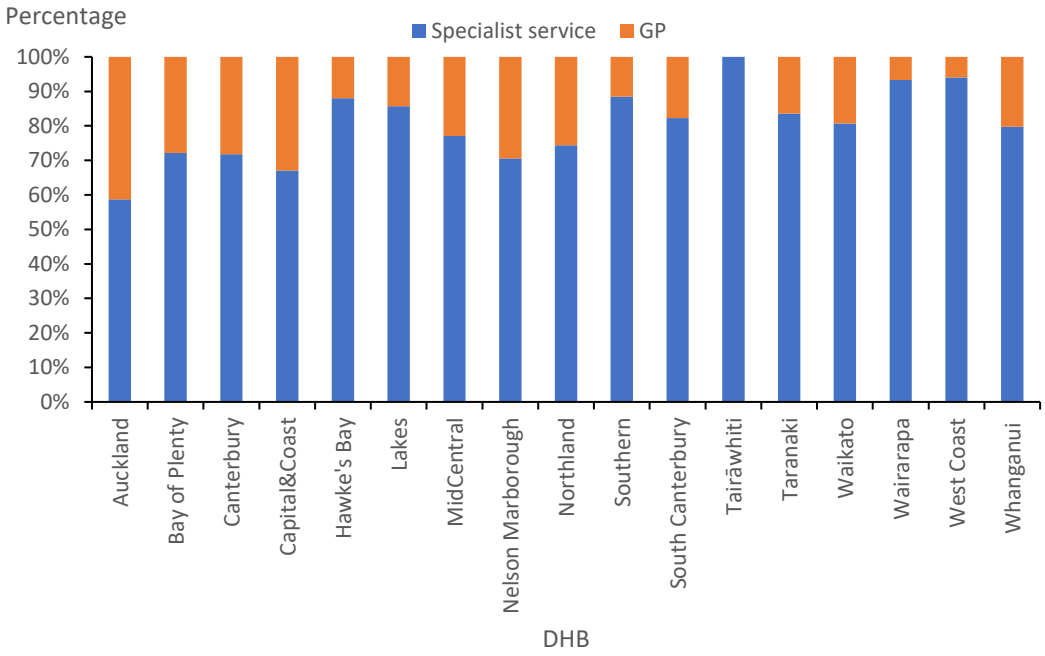
[32] Data provided by OST services in six-monthly reports. These six-monthly reports do not collect data by National Health Index (NHI) numbers. The New Zealand total is a sum of the DHB figures, so it can double-count people who had services from more than one DHB.

[33] Data provided by OST services in six-monthly reports.

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. In 2019, 1.2 percent of clients received this treatment from the Department of Corrections. Service providers and the Department of Corrections work together to initiate OST as appropriate for people who are imprisoned.

Figure 65 shows the number of people receiving OST from each of these types of providers each year from 2008 to 2019.

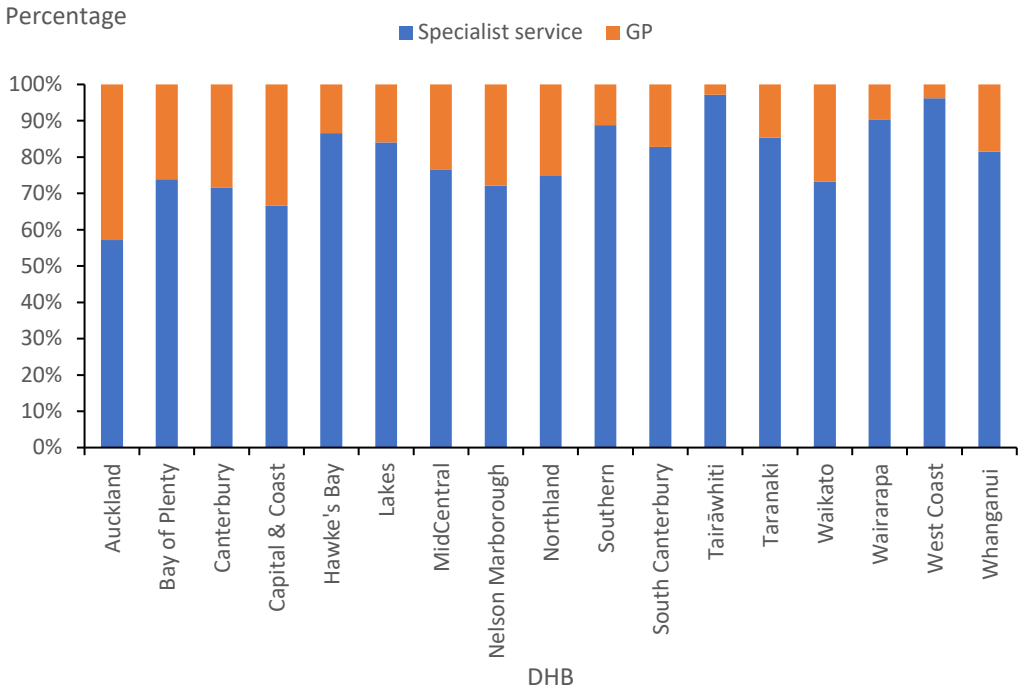
Figure 63: Percentage of people receiving opioid substitution treatment from specialist services and general practice, by DHB, 1 January to 31 December 2018



Note: GP = general practitioner. 'Auckland' includes Auckland, Counties Manukau and Waitematā DHBs. 'Capital & Coast' includes Capital & Coast and Hutt Valley DHBs.

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

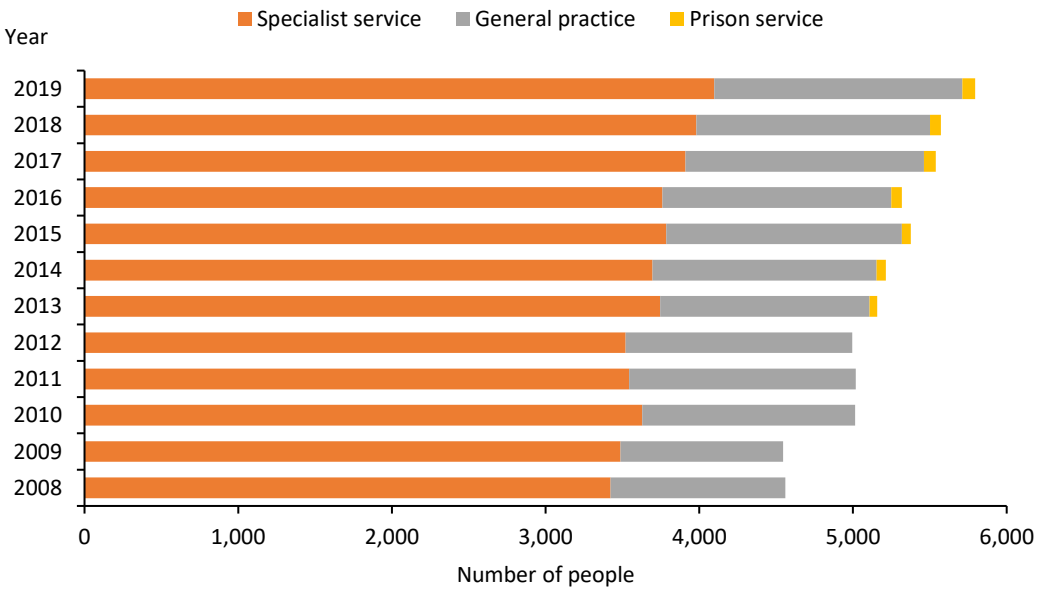
Figure 64: Percentage of people receiving opioid substitution treatment from specialist services and general practice, by DHB, 1 January to 31 December 2019



Note: GP = general practitioner. 'Auckland' includes Auckland, Counties Manukau and Waitematā DHBs. 'Capital & Coast' includes Capital & Coast and Hutt Valley DHBs.

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

Figure 65: Number of people receiving opioid substitution treatment from a specialist service, general practice or prison service, 2008–2019



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.

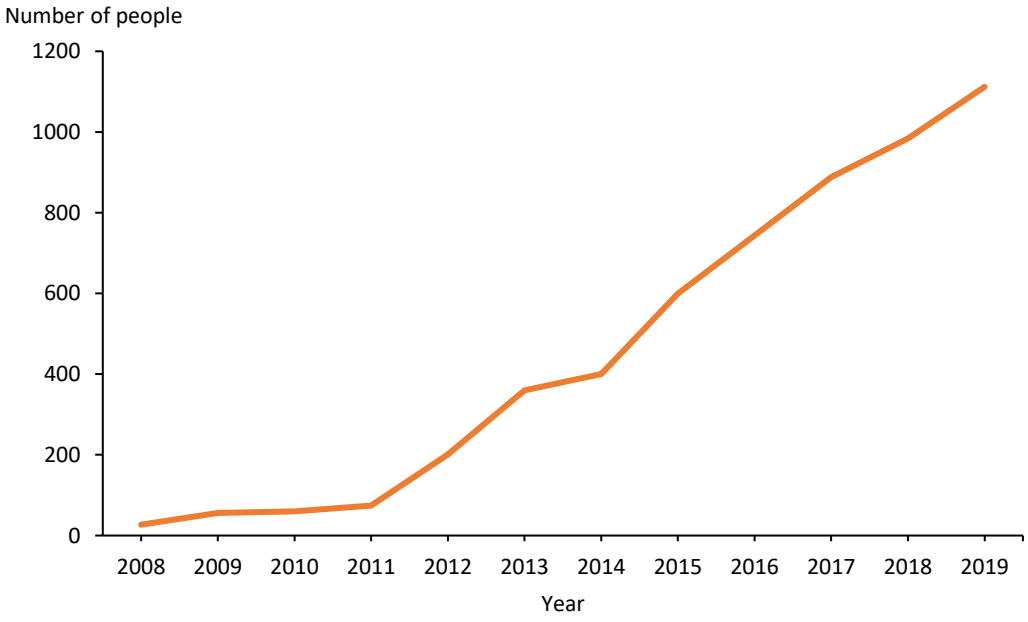
The two types of pharmacotherapy are:

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 66 presents the number of people prescribed suboxone from 2008 to 2019. In 2018, 17.7 percent of clients were prescribed suboxone. In 2019, 20 percent of clients were prescribed suboxone.

Figure 66: Number of people prescribed suboxone, 2008–2019

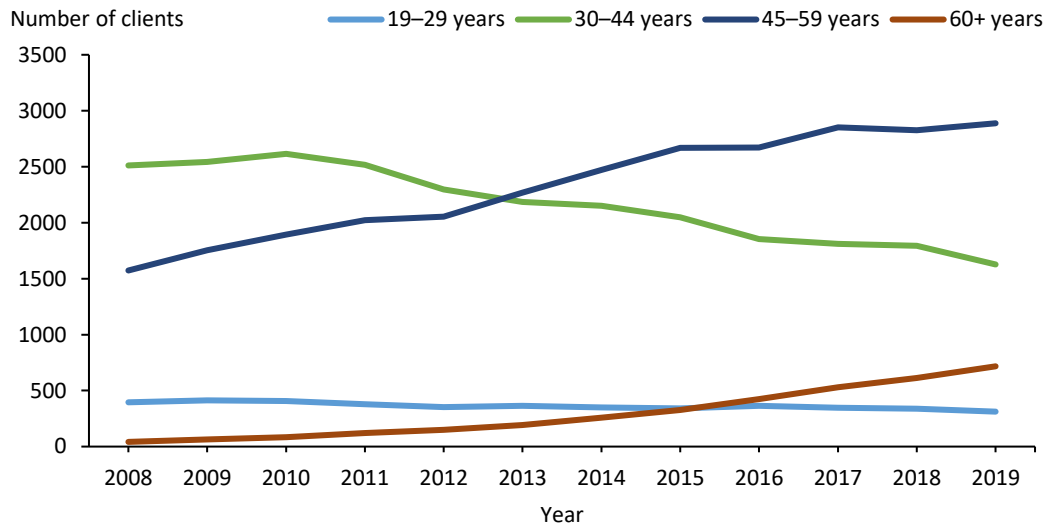


Source: Data provided by OST services in July to December six-monthly reports.

The ageing population of OST clients

OST clients are an ageing population. Figure 67 shows how clients in older groups have been increasing in number from 2008 to 2019 to the point that those over 45 years of age are now the most likely to be receiving treatment. In 2019, 63.3 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 67: Number of opioid substitution treatment clients, by age group, 2008–2019



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

Exit from OST

In summary, in 2018:

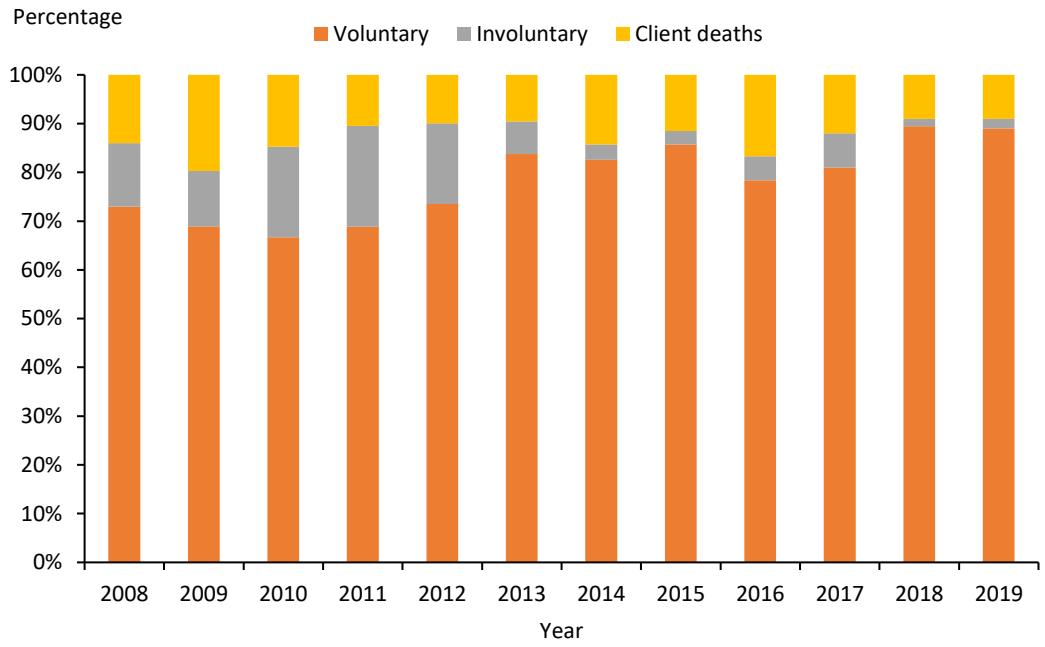
- 403 people voluntarily withdrew from OST, which accounted for 90 percent of all people who exited from OST that year. Seven withdrawals (2 percent of all withdrawals) were involuntary. Involuntary withdrawals are the result of behavioural risks that jeopardise the safety of the client or others.
-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

In 2019:

- 448 people voluntarily withdrew from OST, which accounted for 89 percent of all people who exited from OST that year. Thirteen 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.
- 44 people receiving OST died. A small proportion of these people died of a suspected overdose. The remaining deaths had a range of other natural causes.

Figure 68 gives an overview of the reasons for withdrawal (voluntary, involuntary or death) over time, from 2008 to 2019.

Figure 68: Percentage of withdrawals from OST programmes, by reason (voluntary, involuntary or death), 2008–2019



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

Appendix: Additional statistics

Ministry of Justice

Table A1 presents data on applications for a compulsory treatment order from 2004 to 2019. Table A2 shows the types of orders granted over the same period.

Table A1: Applications for compulsory treatment orders or extensions, 2004–2019

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
2019	5,617	4,984	48	618	0

Notes: CTO = compulsory treatment order. The table presents applications that had been processed at the time of data extraction on 1 February 2021. 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 (extracted 1 February 2021).

Table A2: Types of compulsory treatment orders made on granted applications, 2004–2019

Year	Number of granted applications for orders	Number of compulsory community treatment orders (or extension)	Number of compulsory inpatient treatment orders (or extension)	Number of orders recorded as both compulsory community and inpatient treatment orders (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
2019	4,984	2,780	1,796	56	1	351

Notes: The table presents applications that had been processed at the time of data extraction on 1 February 2021. 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 and 2019, Capital & Coast DHB and Nelson Marlborough DHB each provided data that 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 Tables A3 and A4 below.

Table A3: Seclusion data in New Zealand mental health services, 1 January to 31 December 2018

	Excluding outliers	Including outliers
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 under 24 hours	72 percent	80 percent
Percentage of seclusion events lasting over 48 hours	14 percent	10 percent
Decrease in people secluded in adult services since 2009	25 percent	25 percent
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 since 2017	7 percent	26 percent

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

Table A4: Seclusion data in New Zealand mental health services, 1 January to 31 December 2019

	Excluding outliers	Including outliers
Number of people secluded in adult services	929 people	931 people
Number of hours of seclusion in adult services	48,418 hours	55,805 hours
Number of seclusion events in adult services	1,745 events	2,885 events
Average number of seclusion events per person	1.9 events	3.1 events
Number of seclusion events per 1,000 bed nights	11.4 events	11.3 event
Number of people secluded per 100,000 population	32.1 people	32.2 people
Number of seclusion events per 100,000 population	60.4 events	99.8 events
Average duration per seclusion event	27.7 hours	19.3 hours
Percentage of seclusion events lasting under 24 hours	70 percent	78 percent
Percentage of seclusion events lasting over 48 hours	16 percent	11 percent
Decrease in people secluded in adult services since 2009	19 percent	19 percent
Decrease in hours spent in seclusion since 2009	47 percent	39 percent
Increase in hours spent in seclusion since 2018	19 percent	20 percent
Increase in seclusion events since 2018	4 percent	6 percent

Sources: PRIMHD data (extracted 19 October 2020) and manual data from Southern and Whanganui DHBs.

[Added April 2021] **Deaths reported to the Director of Mental Health**

Section 132 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 requires the Director of Mental Health to be notified within 14 days of the death of any person or special patient under the Mental Health Act. Such a notification must identify the apparent cause of death.

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'.

In 2018, the Director of Mental Health received 58 death notifications related to people under the Mental Health Act (see Table 1). Of these, 19 related to people who were reported to have died by suspected suicide. The remaining 39 reportedly died by other means, including natural causes and illnesses unrelated to mental health status.
In 2019, the Director of Mental Health received 48 death notifications related to people under the Mental Health Act (see Table 2). Of these, 17 related to people who were reported to have died by suspected suicide. The remaining 31 reportedly died by other means, including natural causes and illnesses unrelated to mental health status.

Table A5: Outcomes of reportable death notifications under section 132 of the Mental Health Act, 1 January to 31 December 2018

Reportable death outcome	Number of deaths
Suspected suicide	19
Other deaths	39
Total	**58**

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

Table A6: Outcomes of reportable death notifications under section 132 of the Mental Health Act, 1 January to 31 December 2019

Reportable death outcome	Number of deaths
Suspected suicide	17
Other deaths	31
Total	**48**

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 (Compulsory Assessment and Treatment) Act 2017 makes no provision for DHBs or approved providers to report deaths of patients. Nonetheless, the Office of the Director of Mental Health and Addiction Services encourages services to report adverse events to the Director of Addiction Services.

The Substance Addiction Act came into force on 21 February 2018, no deaths of people occurred during 2018 or 2019 while they were subject to that Act.