

# 2020 Regulatory Report

Office of the Director of Mental  
Health and Addiction Services

Citation: Ministry of Health. 2021. *Office of the Director of Mental Health and Addiction Services 2020 Regulatory Report*. Wellington: Ministry of Health.

Published in November 2021 by the Ministry of Health  
PO Box 5013, Wellington 6140, New Zealand

ISBN 978-1-99-100788-9 (online)  
HP 7961



This document is available at [health.govt.nz](https://health.govt.nz)



This work is licensed under the Creative Commons Attribution 4.0 International licence. In essence, you are free to: share ie, copy and redistribute the material in any medium or format; adapt ie, remix, transform and build upon the material. You must give appropriate credit, provide a link to the licence and indicate if changes were made.

# Foreword

Welcome to our regulatory report for 2020. I recommend you read this report in conjunction with the mental health and wellbeing year in review report and quarterly updates to get a full picture of mental health and addiction supports and services in Aotearoa New Zealand over the 2020 year.<sup>1</sup> This report is in a new format and continues the data series of the annual reports for this Office published since 2006.

The report provides information relating to my role in the mental health and addiction sector – it 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) and the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Substance Addiction Act).

As the Director of both Mental Health and Addiction Services, I am the chief statutory officer under the Mental Health and Substance Addiction Acts. I am responsible for the general administration this legislation under the direction of the Minister of Health and the Director-General of Health. My functions and powers under the Mental Health Act allow the Ministry of Health (the Ministry) to provide guidance and oversight to mental health services. I also provide the overall regulation of the services and have powers that enable intervention when required.

My office has responsibilities in relation to district inspectors, who play a critical role in protecting the rights of people who are subject to compulsory treatment. These responsibilities include:

- coordinating the appointment and reappointment of district inspectors
- receiving and responding to monthly reports from district inspectors
- facilitating inquiries under section 95 of the Mental Health Act
- implementing the findings of section 95 inquiries.

We are transforming Aotearoa New Zealand's approach to mental health and addiction so that people get the support they need, when and where they need it. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga)*<sup>2</sup> and the investment in mental health through Budget 2019 has resulted in a significant amount of work to improve mental health and addiction supports and services.

<sup>1</sup> See: Ministry of Health. 2020. Mental health and wellbeing year in review. URL: [www.health.govt.nz/publication/mental-health-and-wellbeing-year-review](http://www.health.govt.nz/publication/mental-health-and-wellbeing-year-review).

<sup>2</sup> Government Inquiry into Mental Health and Addiction. 2018. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington: Government Inquiry into Mental Health and Addiction. URL: [www.mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf](http://www.mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf) (accessed 26 October 2021).

There is acknowledgement that improving the mental wellbeing of all New Zealanders requires activities to support people to proactively manage their own wellbeing through mental health promotion and prevention as well as strengthening specialist services for whānau and individuals who are experiencing complex mental health and addiction needs. You can read more about our long-term pathway to mental wellbeing in *Kia Manawanui Aotearoa*, which was released in September 2021.<sup>3</sup>

My office is very focused on the care of the 6 percent of New Zealanders using specialist mental health and addiction services who are receiving treatment under the Mental Health Act, as well as the small number of people under the Substance Addiction Act.

In the 2020 year, we have seen an increase in the number of people treated under the Mental Health Act. This is not unexpected – demand for specialist mental health and addiction services has been increasing over time. This is likely due to population growth, improved visibility and access to services and stronger referral relationships between health providers (as well as improvements in data reporting).

Reducing and eliminating seclusion continue to be a focus for my office and the wider mental health and addictions directorate. In 2009, the Ministry introduced a seclusion reduction policy, and it has been working with district health boards (DHBs) to reduce the practice of seclusion. As a result, seclusion rates have steadily decreased and now plateaued. The Health Quality & Safety Commission New Zealand (HQSC) is coordinating a mental health and addiction quality improvement programme. The programme began in 2017 and includes a collaborative project between the HQSC, Te Pou (the national workforce development organisation for mental health, addiction and disability) and DHBs to continue the focus on eliminating seclusion in Aotearoa New Zealand, with a particular focus on reducing seclusion rates for Māori and Pacific service users.<sup>4</sup>

We are currently consulting on repealing and replacing the Mental Health Act, which was recommended in *He Ara Oranga*, as it has not kept pace with the shift towards a recovery and wellbeing approach to care and has never been comprehensively reviewed. To this end, we need to think about how we provide the least restrictive mental health care while still keeping individuals, whānau and our communities safe, as well as how to set in place clear guidelines for minimising restrictive practices and support specific populations within our society. We have the opportunity to create new mental health legislation that respects family and whānau, recognises Te Tiriti o Waitangi and improves equity. The legislation should be a last resort for people in a vulnerable and distressed state: it should not be used as a way for a person to access treatment and services. You can find out more about the public consultation and make a submission on our website (<https://www.health.govt.nz/our-work/mental-health-and-addiction/mental-health-legislation/repealing-and-replacing-mental-health-act>).

<sup>3</sup> Ministry of Health. 2021. *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*. Wellington: Ministry of Health. URL: [www.health.govt.nz/publication/kia-manawanui-aotearoa-long-term-pathway-mental-wellbeing](https://www.health.govt.nz/publication/kia-manawanui-aotearoa-long-term-pathway-mental-wellbeing) (accessed 26 October 2021).

<sup>4</sup> For more information on the programme, see the Mental Health & Addiction Quality Improvement webpage on the HQSC website at: [www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/news-and-events/news/4143/](https://www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/news-and-events/news/4143/).

Amendments to the Mental Health Act were recently passed into legislation to eliminate indefinite treatment orders, allow family members of patients to attend meetings audio-visually and ensure 'special patients' experiencing severe mental illness are safer when being transported. This is an important step to ensure patient safety until the whole Act can be replaced.

I'd like to take this opportunity thank the mental health and addiction workforce in Aotearoa New Zealand. This dedicated group does incredible work to support those who need help. There is increasing demand for services, and the COVID-19 pandemic is also highlighting the importance of having supports in place to help people with their mental wellbeing. We know there is more to do to better strengthen and grow this workforce and we've got programmes underway to achieve this.

Noho ora mai

Dr John Crawshaw  
Director of Mental Health  
Director of Addiction Services



# Contents

<b>Foreword</b>	<b>iii</b>
<b>Use of the Mental Health Act</b>	<b>1</b>
<b>The Mental Health Act process</b>	<b>2</b>
Compulsory assessment in 2020	2
Compulsory treatment in 2020	2
Comparing compulsory assessment and treatment among DHBs	4
Compulsory treatment by age and sex in 2020	7
<b>Tāngata whai ora</b>	<b>9</b>
Compulsory assessment	10
Compulsory treatment orders	10
Length of time spent subject to compulsory treatment orders	13
Family and whānau consultation under the Mental Health Act	16
<b>Indefinite compulsory treatment orders</b>	<b>19</b>
Indefinite community treatment orders	19
Indefinite inpatient treatment orders	22
<b>Seclusion</b>	<b>26</b>
Seclusion in Aotearoa New Zealand mental health services in 2020	28
Use of seclusion by DHBs in 2020	30
Seclusion and ethnicity in 2020	32
Seclusion in forensic units in 2020	35
People with intellectual disabilities cared for in an intellectual disability forensic service	36
Night safety procedures	38
<b>Special and restricted patients</b>	<b>39</b>
Extended forensic care special patients	40
Short-term forensic care special patients	41
Sex, age and ethnicity of special patients in 2020	43
Decisions about leave and change of legal status for special and restricted patients	45
<b>Mental health and addiction adverse event reporting</b>	<b>47</b>
Adverse events reported by DHB mental health services	47
Deaths reported to the Director of Mental Health	49

Section 95 inquiries	49
<b>Electroconvulsive therapy</b>	<b>51</b>
ECT treatments in 2020	51
ECT by region	52
Sex and age of people receiving ECT	55
Ethnicity of people treated with ECT	56
Consent to treatment	56
<b>2020 substance use treatment</b>	<b>58</b>
Substance Addiction (Compulsory Assessment and Treatment) Act 2017	58
Land Transport Act 1998	59
Opioid substitution treatment	59
<b>Appendix: Additional statistics</b>	<b>65</b>
Ministry of Justice	65
Seclusion data incorporating outlier data	67
Substance Addiction (Compulsory Assessment and Treatment) Act 2017 data covering 1 July 2020 to 30 June 2021	68

## List of Tables

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 2020	5
Table 2:	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 2020	5
Table 3:	Number of people required to undergo assessment under sections 11, 13 and 14(4) of the Mental Health Act, by ethnicity, 1 January to 31 December 2020	10
Table 4:	Number of people subject to a compulsory treatment order under sections 29 or 30 of the Mental Health Act, by ethnicity, 1 January to 31 December 2020	10
Table 5:	Age-standardised rates of Māori, Pacific peoples and other ethnicities subject to community and inpatient treatment orders (sections 29 and 30 respectively) under the Mental Health Act, by sex, 1 January to 31 December 2020	12
Table 6:	Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, orders open at 31 December 2020	21
Table 7:	Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, orders open at 31 December 2020	24



Table 8:	Seclusion indicators for forensic mental health services, by DHB, 1 January to 31 December 2020	35
Table 9:	Seclusion indicators for people with intellectual disabilities, by DHB, 1 January to 31 December 2020	36
Table 10:	Seclusion duration for people with intellectual disabilities, by DHB, 1 January to 31 December 2020	37
Table 11:	Seclusion indicators for people with intellectual disabilities, by ethnicity, 1 January to 31 December 2020	37
Table 12:	Total number of special patients, by type and DHB, 1 January to 31 December 2020	41
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 2020	46
Table 14:	Number of mental health adverse events that DHBs reported to the HQSC, by type of event, 1 January to 31 December 2020	48
Table 15:	Mental health adverse events that DHBs reported to the HQSC, by DHB, 1 January to 31 December 2020	48
Table 16:	Outcomes of reportable death notifications under section 132 of the Mental Health Act, 1 January to 31 December 2020	49
Table 17:	Number of completed section 95 inquiry reports received by the Director of Mental Health, 2005–2020	50
Table 18:	ECT indicators, by DHB of domicile, 1 January to 31 December 2020	53
Table 19:	Number of people treated with ECT, by ethnicity, 1 January to 31 December 2020	56
Table 20:	ECT administered under second opinion without consent, by DHB of service, 1 January to 31 December 2020	57
Table A1:	Applications for compulsory treatment orders or extensions, 2004–2020	65
Table A2:	Types of compulsory treatment orders made on granted applications, 2004–2020	66
Table A3:	Seclusion data in Aotearoa New Zealand mental health services, 1 January to 31 December 2020	67

## List of Figures

Figure 1:	Applications for compulsory treatment orders and extensions, 2004–2020	3
Figure 2:	Number of granted compulsory treatment orders and extensions, 2004–2020	4
Figure 3:	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 2020	6

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 2020	7
Figure 5:	Rate of people subject to compulsory treatment order applications (including extensions) per 100,000 population, by age group, 2004–2020	8
Figure 6:	Rate of people subject to compulsory treatment order applications (including extensions) per 100,000 population, by sex, 2004–2020	8
Figure 7:	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 2020	11
Figure 8:	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 2020	12
Figure 9:	Age-standardised rates of Māori, Pacific peoples and other ethnicities subject to community and inpatient treatment orders (sections 29 and 30 respectively) under the Mental Health Act, by sex, 1 January to 31 December 2020	13
Figure 10:	Length of time spent subject to community orders (section 29) under the Mental Health Act for Māori, Pacific peoples and people of other ethnicities, 2009–2018	14
Figure 11:	Length of time spent subject to inpatient orders (section 30) under the Mental Health Act for Māori, Pacific peoples and people of other ethnicities, 2009–2018	14
Figure 12:	Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, by DHB, 1 January to 31 December 2020	15
Figure 13:	Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, by DHB, 1 January to 31 December 2020	16
Figure 14:	Average national percentage of family/whānau consultation for particular assessment/treatment events, sections 10, 12, 14 and 76, 1 January to 31 December 2020	17
Figure 15:	Average percentage of family/whānau consultation across all assessment/treatment events, by DHB, 1 January to 31 December 2020	18
Figure 16:	Reasons for not consulting families and whānau, 1 January to 31 December 2020	18
Figure 17:	Number of people subject to indefinite community treatment orders per 100,000 population, by DHB, orders open at 31 December 2020	20
Figure 18:	Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, orders open at 31 December 2020	21

Figure 19:	Number of people subject to indefinite community treatment orders, by sex, 1 January to 31 December 2020	22
Figure 20:	Number of people subject to indefinite inpatient treatment orders per 100,000 population, by DHB, 1 January to 31 December 2020	23
Figure 21:	Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, orders open at 31 December 2020	24
Figure 22:	Number of people subject to indefinite inpatient treatment orders, by sex, 1 January to 31 December 2020	25
Figure 23:	Number of people secluded in adult inpatient services nationally, 2007–2020	27
Figure 24:	Total number of seclusion hours in adult inpatient services nationally, 2007–2020	27
Figure 25:	Number of people secluded across all inpatient services (adult, forensic, intellectual disability and youth), by age group, 1 January to 31 December 2020	28
Figure 26:	Number of seclusion events across all inpatient services (adult, forensic, intellectual disability and youth), by duration of event, 1 January to 31 December 2020	29
Figure 27:	Number of people secluded in adult inpatient services per 100,000 population, by DHB, 1 January to 31 December 2020	30
Figure 28:	Number of seclusion events in adult inpatient services per 100,000 population, by DHB, 1 January to 31 December 2020	31
Figure 29:	Number of people secluded, by ethnicity, 1 January to 31 December 2020	32
Figure 30:	Seclusion indicators for adult inpatient services, Māori, Pacific peoples and other ethnicities, 1 January to 31 December 2020	33
Figure 31:	Percentage of people with inpatient admissions that spent time in seclusion in adult inpatient services, Māori, Pacific peoples and other ethnicities, males and females, 1 January to 31 December 2020	33
Figure 32:	Number of Māori and non-Māori aged 20–64 years secluded in adult inpatient services, 2007–2020	34
Figure 33:	Total number of special patients, by DHB, 1 January to 31 December 2020	40
Figure 34:	Percentage of court orders given for extended forensic care relative to short-term forensic care legal statuses, by DHB, 1 January to 31 December 2020	42
Figure 35:	Number of special patients, by sex, 1 January to 31 December 2020	43
Figure 36:	Total number of special patients, by age group, 1 January to 31 December 2020	43
Figure 37:	Percentage of special patients, by ethnicity, 1 January to 31 December 2020	44

Figure 38: Number of special patients, by ethnicity and special patient type, 1 January to 31 December 2020	44
Figure 39: Rate of people treated with ECT per 100,000 population, 2005–2020	52
Figure 40: Number of people per 100,000 population treated with ECT, by DHB, 1 January to 31 December 2020	54
Figure 41: Number of people treated with ECT, by age group and sex, 1 January to 31 December 2020	55
Figure 42: Percentage of people receiving opioid substitution treatment from specialist services and general practice, by DHB, 1 January to 31 December 2020	61
Figure 43: Number of people receiving opioid substitution treatment from a specialist service, general practice or prison service, 2008–2020	62
Figure 44: Number of people prescribed suboxone, 2008–2020	63
Figure 45: Number of opioid substitution treatment clients, by age group, 2008–2020	63
Figure 46: Percentage of withdrawals from opioid substitution treatment programmes, by reason (voluntary, involuntary or death), 2008–2020	64
Figure A1: Percentage of patients subject to compulsory treatment certificates, by ethnicity, 1 July 2020 to 30 June 2021	71
Figure A2: Percentage of patients subject to compulsory treatment certificates, by referring region, 1 July 2020 to 30 June 2021	71
Figure A3: Percentage of patients subject to compulsory treatment orders, by number of weeks in detention, 1 July 2020 to 30 June 2021	72

# Use of the Mental Health Act

In summary, in 2020:

- 11,146 people (6.0 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),<sup>5</sup> and on the last day of 2020, approximately 5,655 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 age group to be subject to compulsory treatment, and people aged 65 years and over were the least likely
- Māori were more likely to be assessed or treated under the Mental Health Act than Pacific peoples and other ethnicities.<sup>6,7</sup>

<sup>5</sup> Mental Health Act sections 11, 13, 14(4), 15(1), 15(2), 29, 30 and 31.

<sup>6</sup> In this report, we are distinguishing data for Pacific peoples for the first time, when appropriate to do so without making it identifiable. This means that 'other ethnicities' encompasses all ethnicities except for Māori and Pacific peoples.

<sup>7</sup> Source: Data from the Programme for the Integration of Mental Health Data (PRIMHD) (extracted 1 July 2021).

# The Mental Health Act process

## Compulsory assessment in 2020<sup>8</sup>

- Clinicians made 5,874 applications for compulsory treatment or extensions under the Mental Health Act. Of these applications, the courts granted 5,137 (87.5 percent).
- Approximately 1,422 applications were filed for a judge’s review of the patient’s condition, in line with section 16 of the Mental Health Act. Of these applications, judges issued an order to release a person from compulsory status in 39 cases (2.7 percent) and dismissed 747 applications (52.5 percent). The remaining applications were withdrawn.

## Compulsory treatment in 2020

- On the last day of 2020, a total of 5,655 people were subject to either compulsory assessment or compulsory treatment under the Mental Health Act.<sup>9</sup>
- On average within each month of 2020, the assessment provisions of the Mental Health Act were applied as follows.

<b>Section 11</b>	644 people were subject to an initial assessment.	13 people per 100,000 population
<b>Section 13</b>	667 people were subject to a second period of assessment.	13 people per 100,000 population
<b>Section 14(4)</b>	463 people were subject to an application for a compulsory treatment order.	9 people per 100,000 population

Source: PRIMHD data (extracted 1 July 2021)

<sup>8</sup> Source: Ministry of Justice’s Case Management System data (extracted 1 February 2021).

<sup>9</sup> Sources: PRIMHD (extracted 1 July 2021) and manual data from Counties Manukau DHB for section 30 only.

- In Aotearoa New Zealand, on an average day in 2020, the treatment provisions of the Mental Health Act were applied as follows.

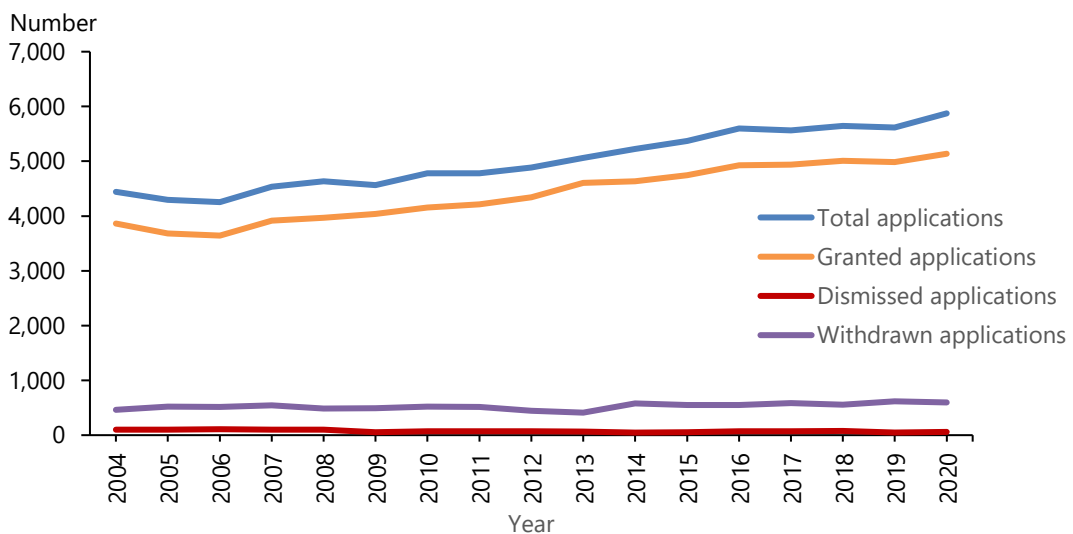
<b>Section 29</b>	4,627 people were subject to a community treatment order.	91 people per 100,000 population
<b>Section 30</b>	609 people were subject to an inpatient treatment order.	12 people per 100,000 population
<b>Section 31</b>	157 people were on temporary leave from an inpatient unit.	3 people per 100,000 population

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

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Counties Manukau District Health Board (DHB) (section 30 only)

Figure 1 shows that the number of compulsory treatment orders and extensions being applied for and being granted has gradually increased since 2004, while the number of applications being dismissed or withdrawn has remained relatively stable.

**Figure 1: Applications for compulsory treatment orders and extensions, 2004–2020**

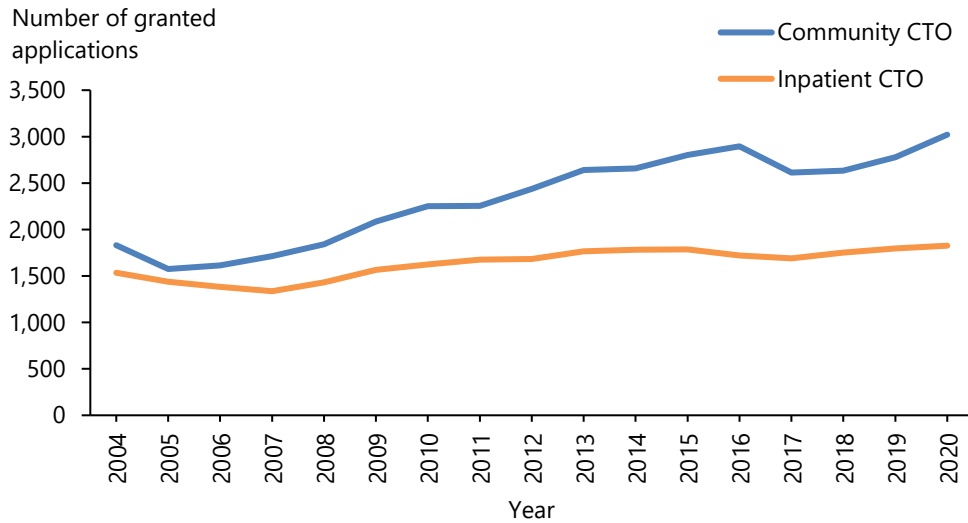


Notes: This figure represents data entered into the case management system (CMS). The CMS is a live operational database. Figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System as at 1 February 2021.

The gap between community-based compulsory treatment orders and inpatient compulsory treatment orders appears to be increasing slowly over time. Figure 2 shows the number of granted applications for community and inpatient compulsory treatment orders since 2004.

**Figure 2: Number of granted compulsory treatment orders and extensions, 2004–2020**



Notes: CTO = compulsory treatment order. This figure represents 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.

## Comparing compulsory assessment and treatment among DHBs

Table 1 shows the average number of people per month in 2020 who were required to undergo assessment under the Mental Health Act in each district health board (DHB). Table 2 shows the average number of people subject to a compulsory treatment order on a given day in 2020 in each DHB. Figures 3 and Figure 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 2020**

DHB	s 11	s 13	s 14(4)	DHB	s 11	s 13	s 14(4)
Auckland	16	17	12	Northland	16	20	17
Bay of Plenty	14	12	5	South Canterbury	6	5	4
Canterbury	11	12	8	Southern	11	9	6
Capital & Coast	12	14	11	Tairāwhiti	20	14	7
Counties Manukau	11	12	9	Taranaki	16	12	5
Hawke's Bay	15	10	6	Waikato	20	20	13
Hutt Valley	14	16	9	Wairarapa	8	5	9
Lakes	15	11	7	Waitematā	11	13	9
MidCentral	13	13	10	West Coast	10	9	5
Nelson Marlborough	11	10	10	Whanganui	13	14	9
				<b>National average</b>	<b>13</b>	<b>13</b>	<b>9</b>

Notes: 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 1 July 2021).

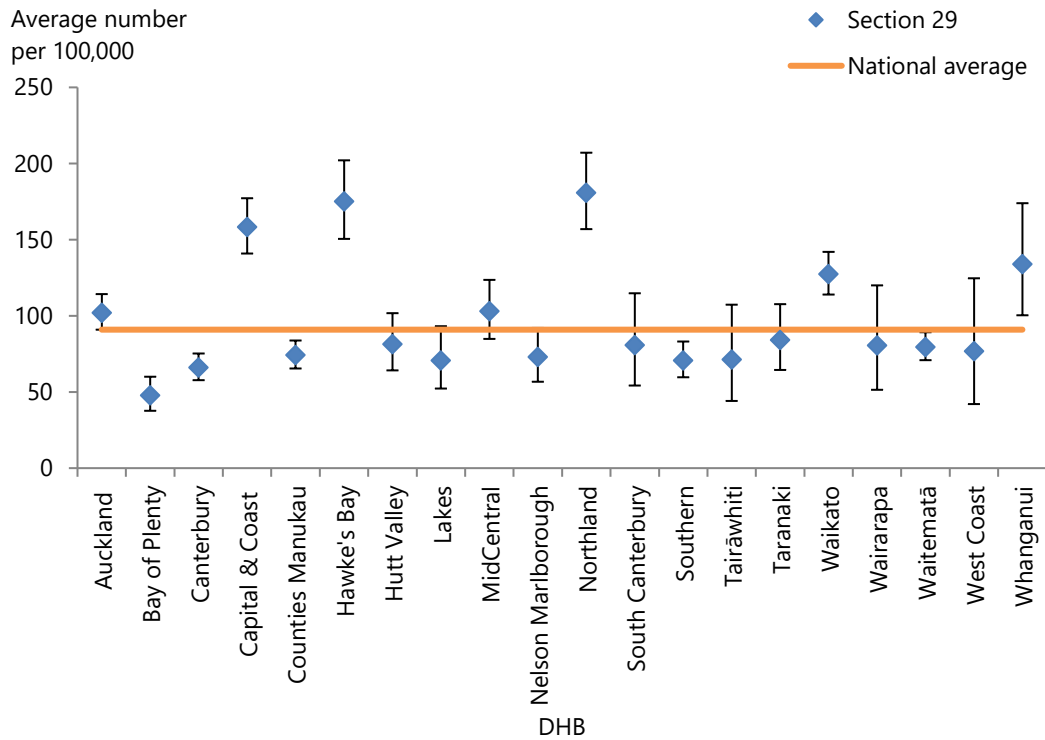
**Table 2: Average number of people on a given day subject to sections 29, 30 and 31 of the Mental Health Act per 100,000 population, by DHB, 1 January to 31 December 2020**

DHB	s 29	s 30	s 31	DHB	s 29	s 30	s 31
Auckland	102	11	1	Northland	181	9	2
Bay of Plenty	48	7	2	South Canterbury	81	6	3
Canterbury	66	17	7	Southern	71	12	3
Capital & Coast	158	36	5	Tairāwhiti	72	4	3
Counties Manukau	74	3	1	Taranaki	84	5	2
Hawke's Bay	175	22	17	Waikato	128	15	3
Hutt Valley	81	7	2	Wairarapa	81	2	2
Lakes	71	7	3	Waitematā	80	12	2
MidCentral	103	8	2	West Coast	77	13	5
Nelson Marlborough	73	8	–	Whanganui	134	23	5
				<b>National average</b>	<b>91</b>	<b>12</b>	<b>3</b>

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

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Counties Manukau DHB for section 30 only.

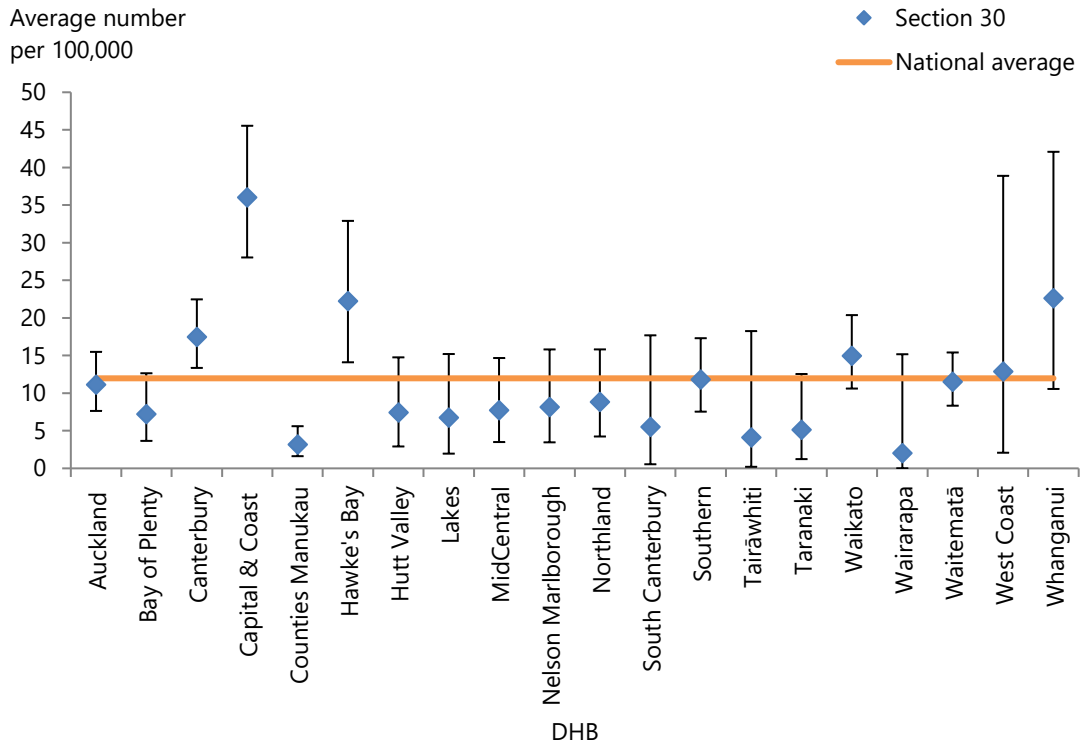
**Figure 3: Average number of people on a given day subject to a community treatment order (section 29 of the Mental Health Act) per 100,000 population, by DHB, 1 January to 31 December 2020**



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 1 July 2021).

**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 2020**



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.

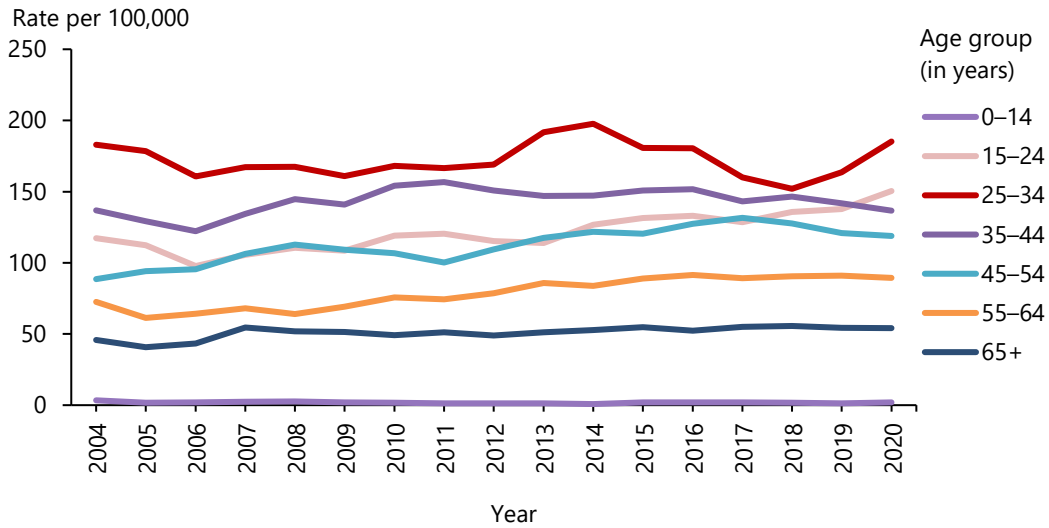
Sources: PRIMHD data (extracted 1 July 2021) and manual data from Counties Manukau DHB.

## Compulsory treatment by age and sex in 2020<sup>10</sup>

- People aged 25–34 years were the most likely age group to be subject to a compulsory treatment order (185.2 per 100,000), while people over 65 years of age were the least likely (54.2 per 100,000) (see Figure 5).
- Males were more likely to be subject to a compulsory treatment order (108 per 100,000) than females (80 per 100,000) (see Figure 6).

<sup>10</sup> Source: Ministry of Justice's Case Management System data (extracted 1 February 2021).

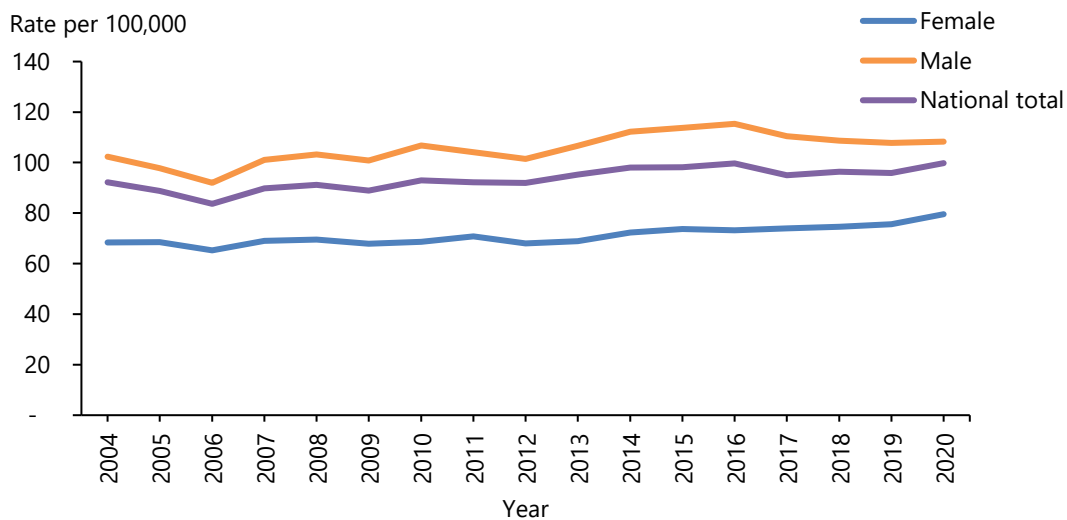
**Figure 5: Rate of people subject to compulsory treatment order applications (including extensions) per 100,000 population, by age group, 2004–2020**



Notes: This figure represents 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.

**Figure 6: Rate of people subject to compulsory treatment order applications (including extensions) per 100,000 population, by sex, 2004–2020**



Notes: This figure represents 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.

# Tāngata whai ora

This section presents statistics on tāngata whai ora (people seeking wellness) under the Mental Health Act. This information underlines the need for mental health services to take meaningful actions to address the disparity in outcomes for Māori and Pacific peoples in Aotearoa New Zealand.

In summary, in 2020:

- 6.1 percent of Māori accessed mental health and addiction services, compared with 3.09 percent of non-Māori
- Māori were 1.8 times more likely than Pacific peoples to be subject to a community treatment order and 4.1 times more likely than other ethnicities<sup>11</sup>
- Māori were 1.8 times more likely than Pacific peoples to be subject to an inpatient treatment order and 3.5 times more likely than other ethnicities
- of all population groups, Māori males were the group most likely to be subject to community and inpatient treatment orders
- DHBs varied in their ratio of Māori, Pacific peoples and other ethnicities subject to community and inpatient treatment orders
- on average, Māori, Pacific peoples and other ethnicities 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 and indefinite inpatient treatment orders than non-Māori
- Māori made up approximately 17 percent of Aotearoa New Zealand's population, yet they accounted for 28.5 percent of all mental health service users
- Pacific peoples made up approximately 7 percent of Aotearoa New Zealand's population and accounted for 5.8 percent of all mental health service users
- for service users, 29.4 percent of Māori, 27.1 percent of Pacific peoples and 26.9 percent of other ethnicities were under 20 years of age
- among service users under a community treatment order, 76 percent of Māori and 75 percent of Pacific Peoples were living in the most deprived deciles (8–10), compared with 56 percent of non-Māori and non-Pacific peoples.<sup>12</sup>

<sup>11</sup> These ratios are based on the age-standardised rates of the Māori, Pacific peoples and other populations. Source: PRIMHD data (extracted 1 July 2021). See the Appendix: Additional statistics for a time-series extraction and analysis of the rate ratio between Māori and non-Māori under section 29 of the Mental Health Act.

<sup>12</sup> Source: PRIMHD data (extracted 1 July 2021). Deprivation deciles are ranked 1–10, where 1 represents areas with the least deprived scores and 10 areas with the most deprived scores.

## Compulsory assessment

Māori were more likely to undergo compulsory assessment in 2020 than other ethnicities. Table 3 shows the number of people subject to compulsory assessment on a national level by ethnicity and the rate per 100,000 population.

**Table 3: Number of people required to undergo assessment under sections 11, 13 and 14(4) of the Mental Health Act, by ethnicity, 1 January to 31 December 2020**

Ethnicity	Section 11		Section 13		Section 14(4)	
	Number	Rate	Number	Rate	Number	Rate
Māori	2,038	239.5	1,764	207.3	1,265	148.7
Pacific peoples	403	117.4	377	109.8	298	86.8
Other	3,592	92.3	2,999	77.0	1,918	49.3
National total	6,033	–	5,140	–	3,481	–

Notes: 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 extensions 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 1 July 2021).

## Compulsory treatment orders

Table 4 shows that Māori were more likely to be subject to community and inpatient treatment orders than non-Māori. These figures represent those who were subject to a compulsory treatment order during the 2020 year – not the number of individuals who had a compulsory treatment order issued.

**Table 4: Number of people subject to a compulsory treatment order under sections 29 or 30 of the Mental Health Act, by ethnicity, 1 January to 31 December 2020**

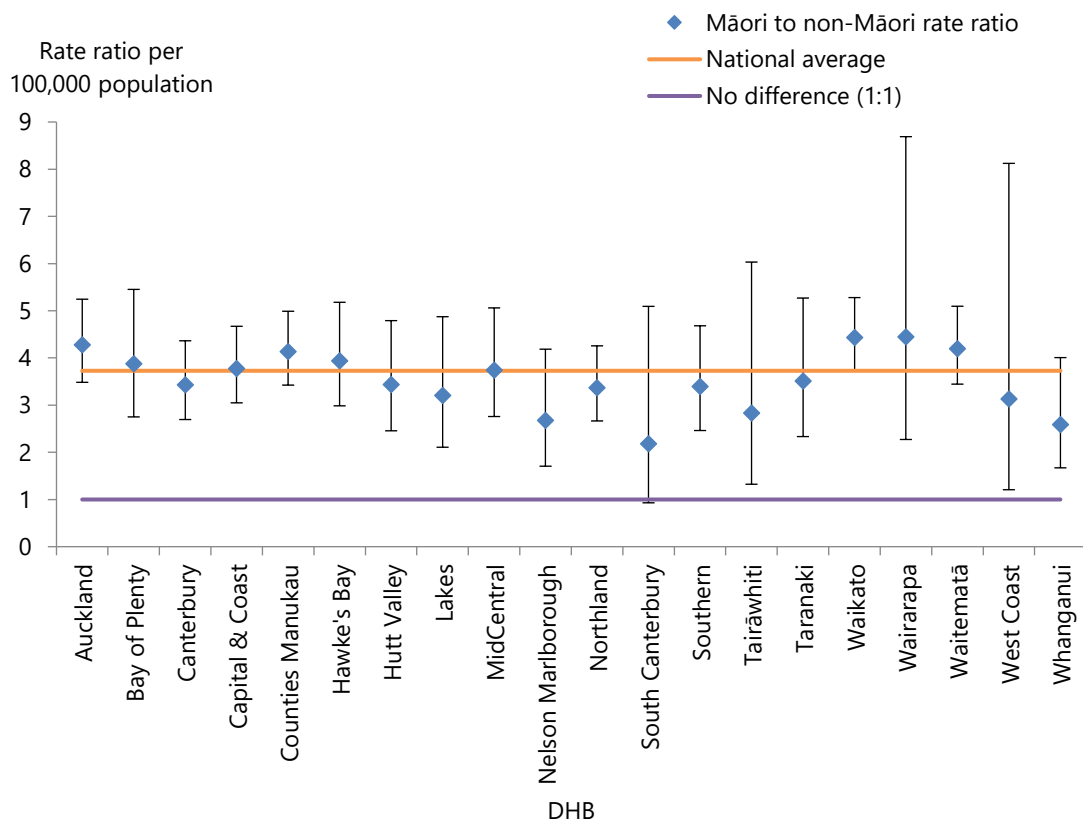
Ethnicity	Section 29		Section 30	
	Number	Rate	Number	Rate
Māori	2,643	310.6	714	83.9
Pacific people	634	184.7	154	44.9
Other	3,451	88.6	1,159	29.8
National total	6,728	–	2,027	–

Source: PRIMHD data (extracted 1 July 2021) and manual data from Counties Manukau DHB for section 30.

Figures 7 and Figure 8 show the rate ratio of Māori to non-Māori subject to community and inpatient treatment orders respectively 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 DHB region and how to address them at a local level.

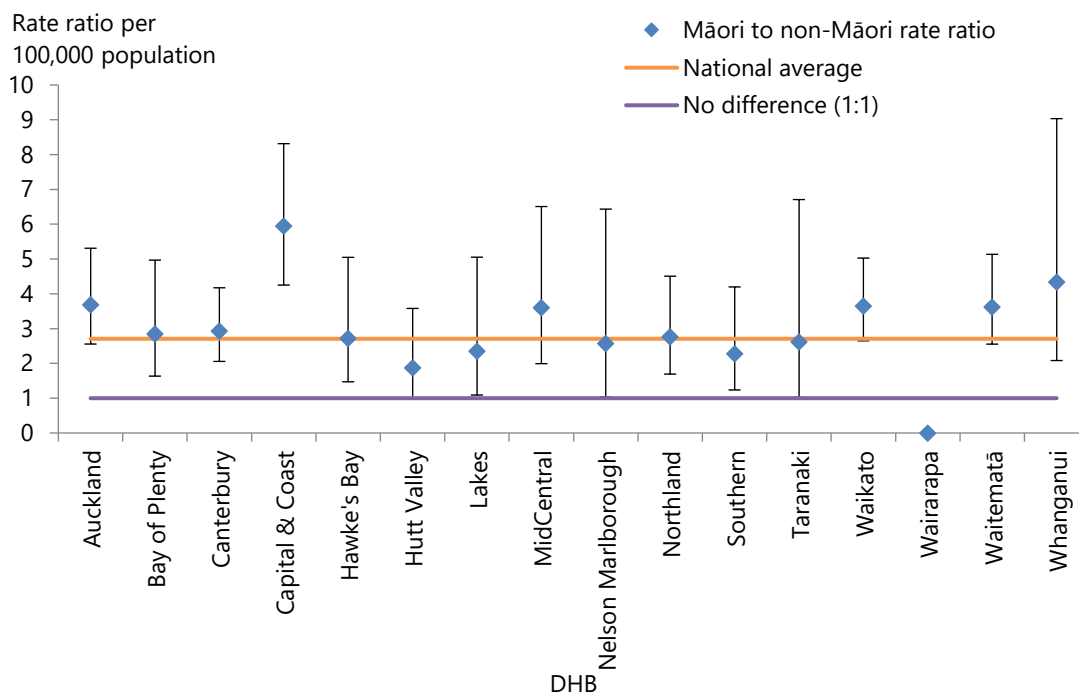
**Figure 7: Rate ratio of Māori to non-Māori subject to a community treatment order (section 29) under the Mental Health Act per 100,000 population, by DHB, 1 January to 31 December 2020**



Notes: 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 1 July 2021).

**Figure 8: 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 2020**



Notes: 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 and West Coast DHBs have a small population, their rates are very volatile and error bars of the resulting calculations are large. Tairāwhiti DHB had an extremely high upper confidence interval limit. This graph does not include the data for South Canterbury, Tairāwhiti and West Coast DHBs to avoid skewing the overall results.

Sources: PRIMHD data (1 July 2021) and manual data from Counties Manukau DHB (which is excluded from this graph because we do not have their age-standardised rates).

**Table 5: Age-standardised rates of Māori, Pacific peoples and other ethnicities subject to community and inpatient treatment orders (sections 29 and 30 respectively) under the Mental Health Act, by sex, 1 January to 31 December 2020**

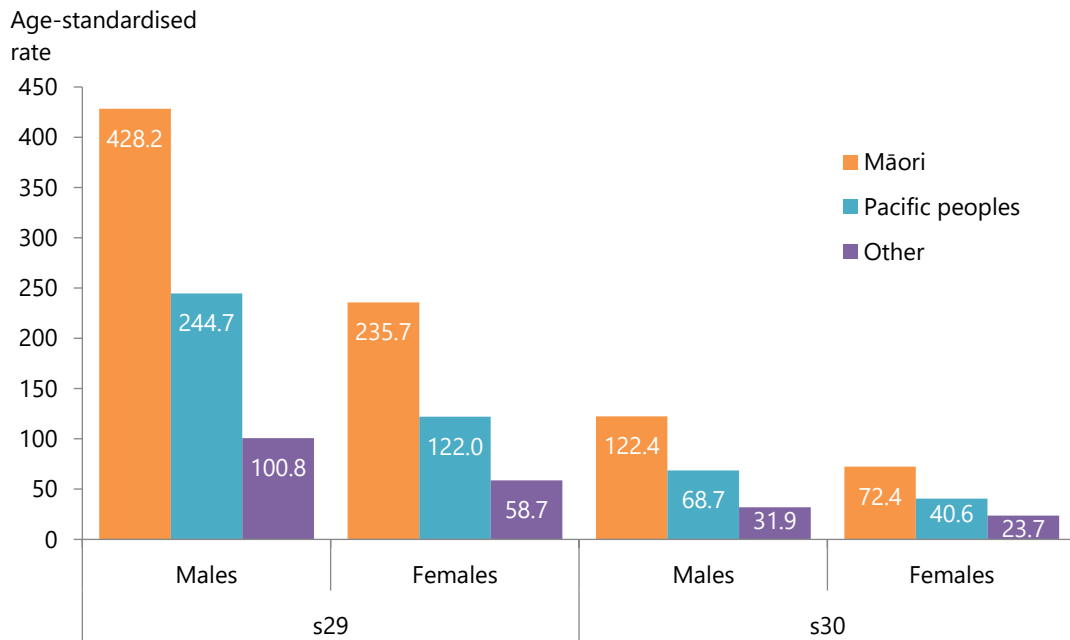
	Community treatment orders		Inpatient treatment orders	
	Male	Female	Male	Female
Māori	428.2	235.7	122.4	72.4
Pacific peoples	244.7	122.0	68.7	40.6
Other ethnicities	100.8	58.7	31.9	23.7
Māori to Pacific peoples rate ratio	1.7:1	1.9:1	1.8:1	1.8:1
Pacific peoples to other ethnicities rate ratio	2.4:1	2.1:1	2.2:1	1.7:1
Māori to other ethnicities rate ratio	4.2:1	4:1	3.8:1	3.1:1

Notes: Rates per 100,000 are age standardised. 'Other ethnicities' are all ethnicities excluding Māori and Pacific peoples.

Source: PRIMHD data (extracted 1 July 2021). Excludes manual data.



**Figure 9: Age-standardised rates of Māori, Pacific peoples and other ethnicities subject to community and inpatient treatment orders (sections 29 and 30 respectively) under the Mental Health Act, by sex, 1 January to 31 December 2020**



Note: Rates per 100,000 are age standardised.

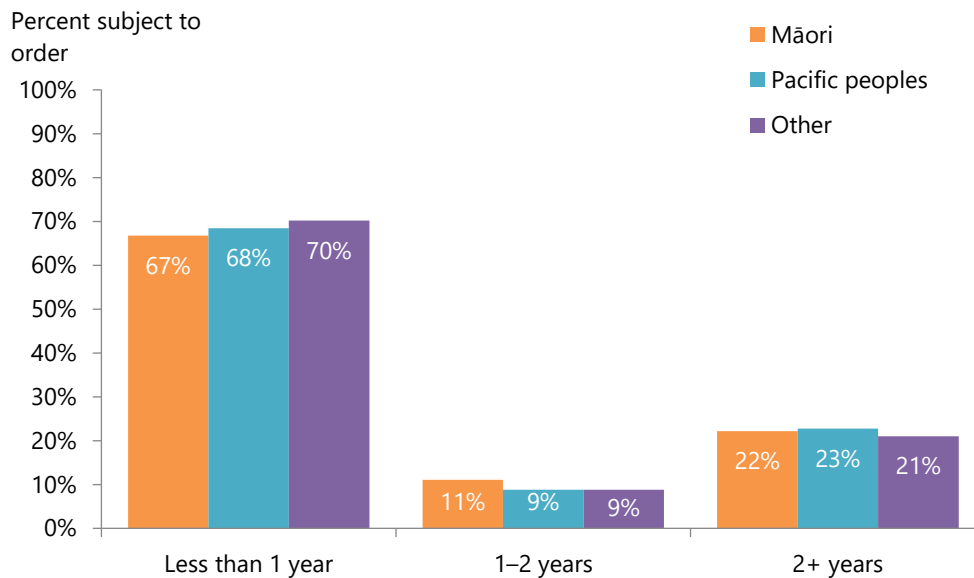
Source: PRIMHD data (extracted 1 July 2021). Excludes manual data.

## Length of time spent subject to compulsory treatment orders

On average, Māori, Pacific peoples and other ethnicities remain on compulsory treatment orders for a similar amount of time (see Figure 10). For community treatment orders that began between 2009 and 2018, 67 percent of Māori, 68 percent of Pacific peoples and 70 percent of people from other ethnicities were subject to the order for less than a year.

For inpatient orders that began between 2009 and 2018, 92 percent of Māori, 93 percent of Pacific peoples and 94 percent of people from other ethnicities were subject to the order for less than a year.

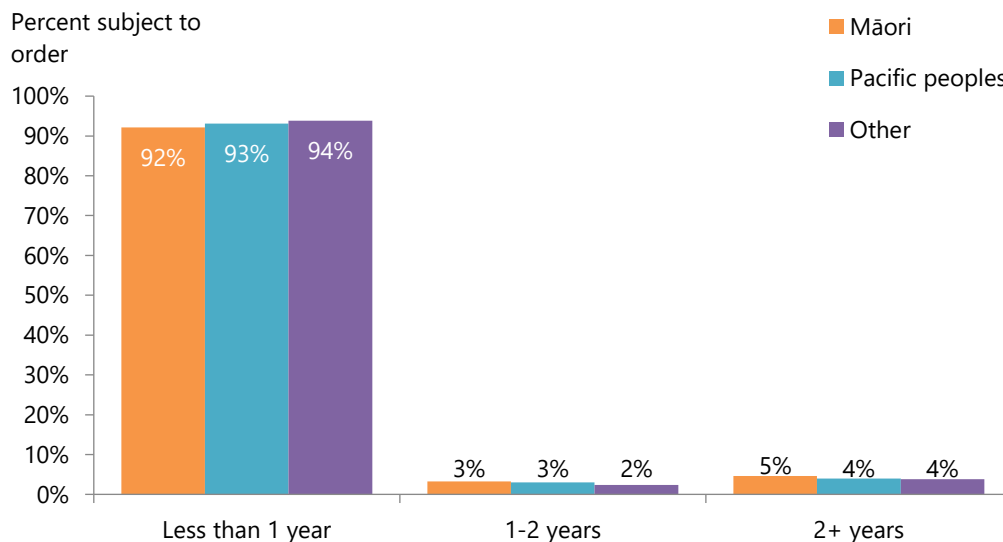
**Figure 10: Length of time spent subject to community orders (section 29) under the Mental Health Act for Māori, Pacific peoples and people of other ethnicities, 2009–2018**



Notes: The data refers to treatment orders started between 2009 and 2018. This analysis uses 2018 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.

Source: PRIMHD data (extracted 1 July 2021).

**Figure 11: Length of time spent subject to inpatient orders (section 30) under the Mental Health Act for Māori, Pacific peoples and people of other ethnicities, 2009–2018**

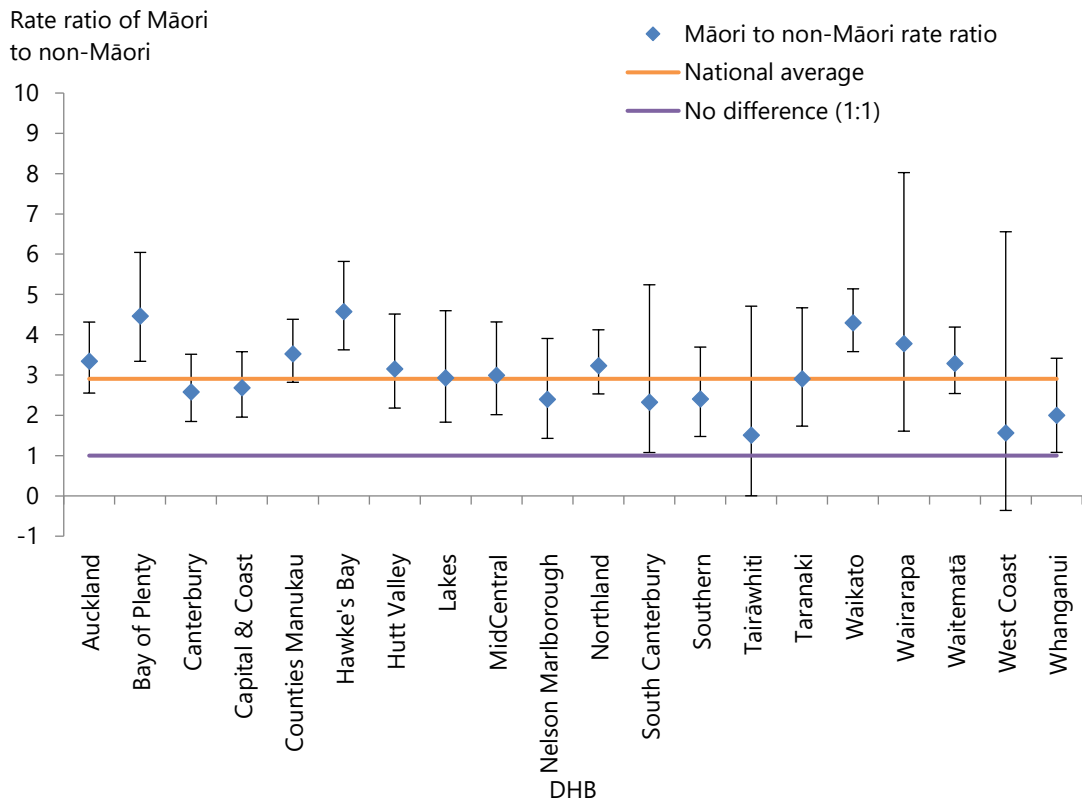


Notes: The data refers to treatment orders started between 2009 and 2018. This analysis uses 2018 as the most recent year because at least two years must have passed to identify how many people remained on a treatment order for two or more years.

Source: PRIMHD data (extracted 1 July 2021).

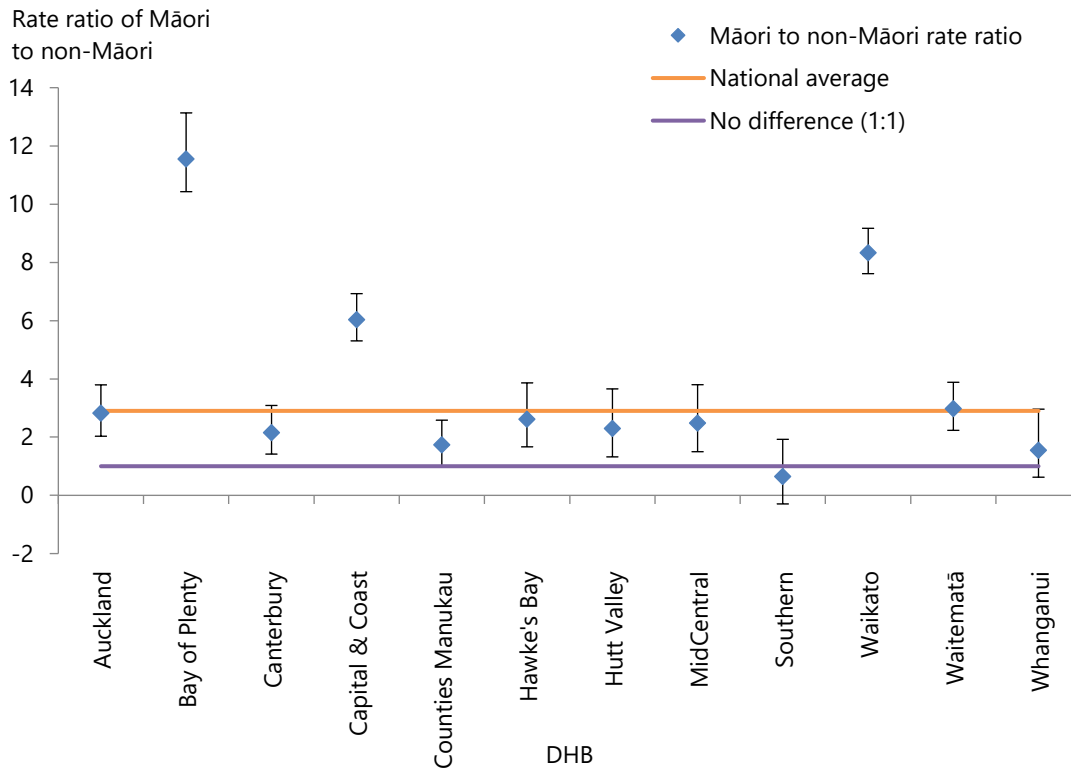
The following figures show the rate ratio of Māori to non-Māori subject to indefinite community treatment orders (Figure 12) and indefinite inpatient treatment orders (Figure 13) for each DHB per 100,000 people.

**Figure 12: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, by DHB, 1 January to 31 December 2020**



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

**Figure 13: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, by DHB, 1 January to 31 December 2020**



Notes: Lakes, Northland, South Canterbury, Tairāwhiti and Wairarapa DHBs have no indefinite orders. In Nelson Marlborough, Taranaki and West Coast DHBs, the rate ratio is zero. These DHBs have been excluded from this graph.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Counties Manukau DHB.

## 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. Clinicians are encouraged to consider that the term 'whānau' could include any set of relationships a patient or proposed patient recognises as their closest connections, with no limitation to blood ties.

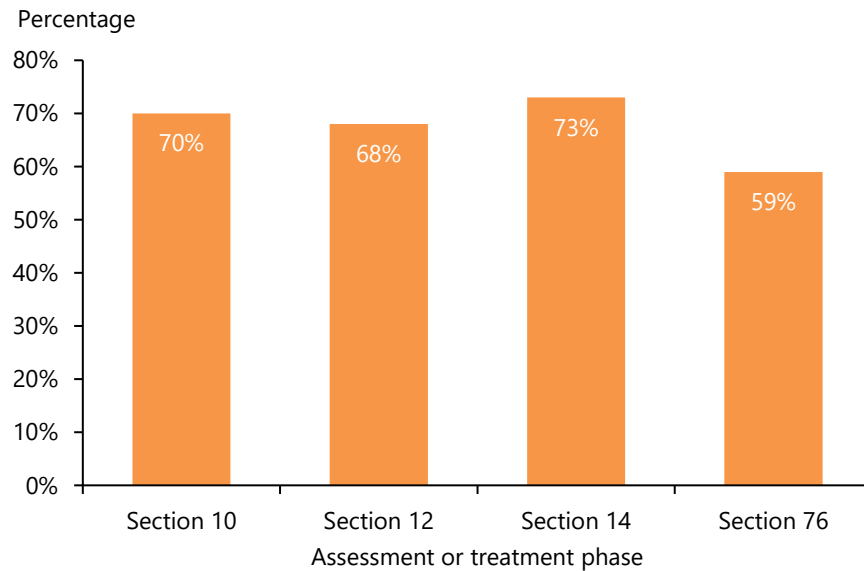
In summary, in 2020:

- on average nationally, 69 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 the extent to which they consulted 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 14 shows the percentage of cases in which consultation with families and whānau occurred at four points in the assessment and treatment process.

**Figure 14: Average national percentage of family/whānau consultation for particular assessment/treatment events, sections 10, 12, 14 and 76, 1 January to 31 December 2020**

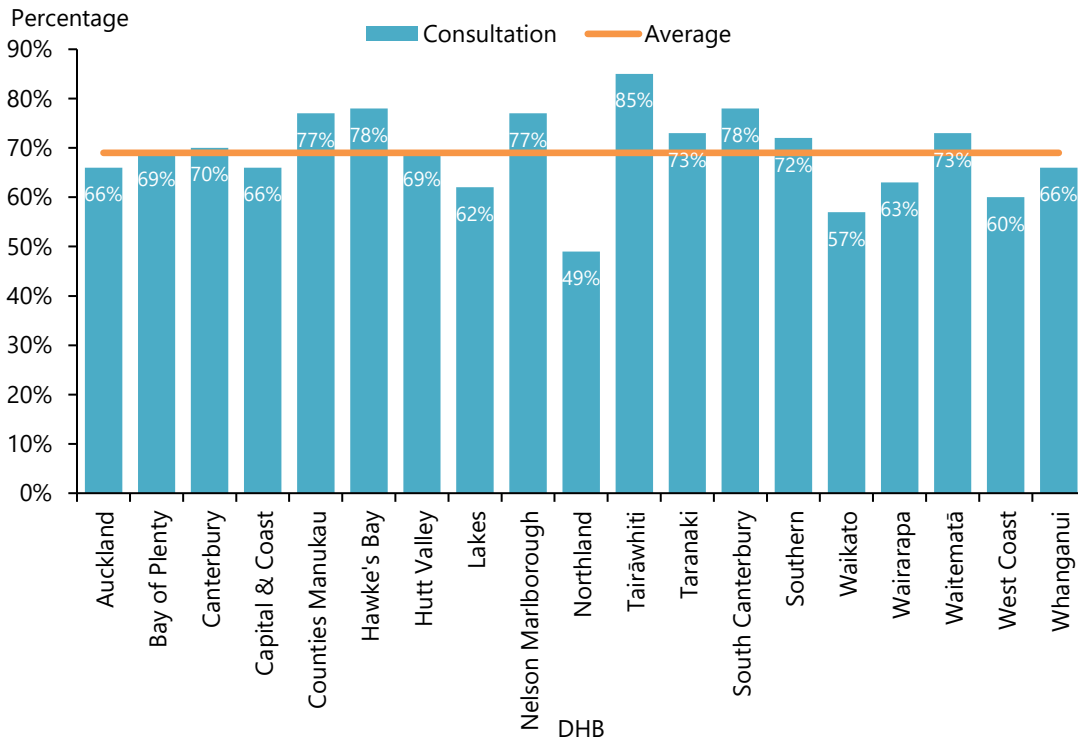


Notes: MidCentral DHB did not submitted data in 2020, therefore this graph is not comparable with equivalent data published in previous reports. Part way through 2020, there was a change to the consultation with family and whānau data that the Office of the Director of Mental Health and Addiction Services collects. The decision was made to no longer record consultation on release and instead record consultation at section 29(3)(a). As the annual data set for consultation on release and consultation at section 29(3)(a) are both incomplete, neither of these are presented. Consultation at section 29(3)(a) will be included in future data reporting.

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

On average nationally during 2020, 69 percent of cases included consultation with family and whānau across all assessment and treatment events. Tairāwhiti DHB had the highest rate of consultation at 85 percent, and Northland DHB had the lowest at 49 percent (see Figure 15).

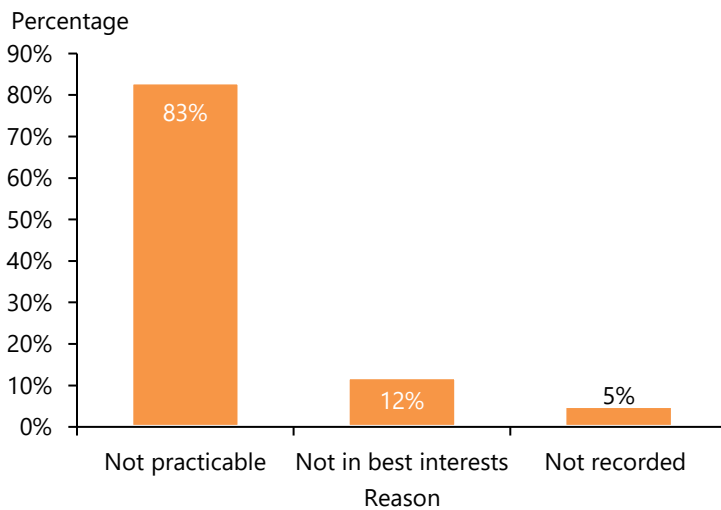
**Figure 15: Average percentage of family/whānau consultation across all assessment/treatment events, by DHB, 1 January to 31 December 2020**



Note: MidCentral DHB did not submit data in 2020, so this graph is not comparable with equivalent data published in previous reports.

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

**Figure 16: Reasons for not consulting families and whānau, 1 January to 31 December 2020**



Note: MidCentral DHB did not submit data in 2020, so this graph is not comparable with equivalent data published in previous reports.

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

# Indefinite compulsory treatment orders

In summary, on 31 December 2020:

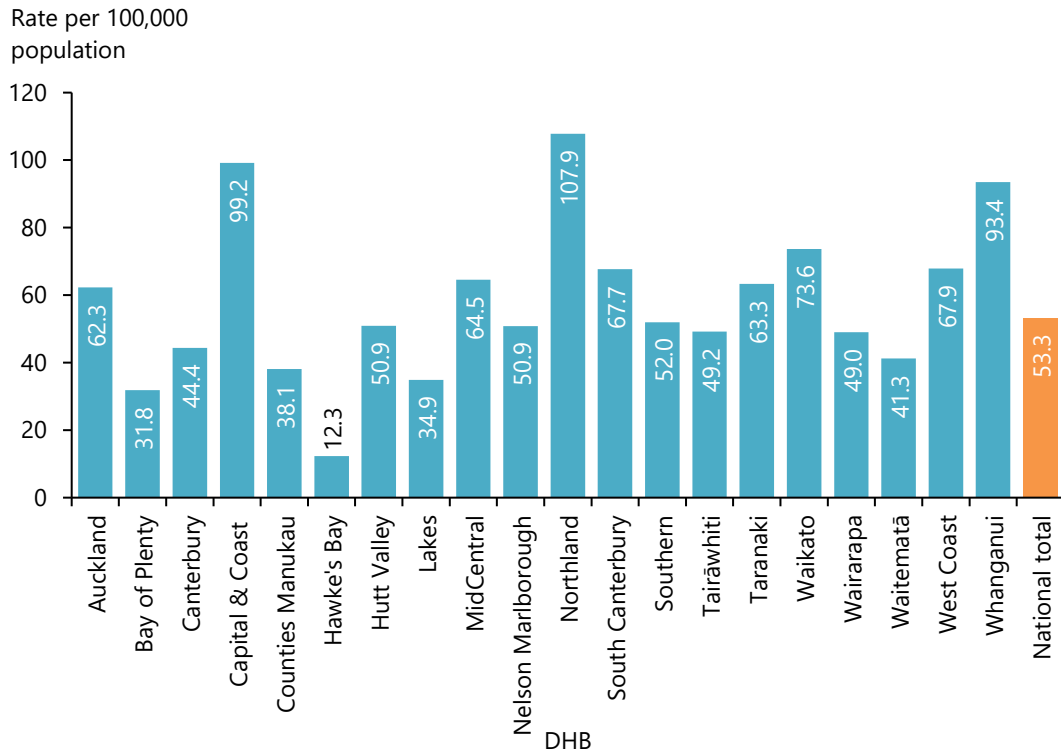
- 2,886 people were subject to indefinite compulsory treatment orders
- 2,713 people (57 percent of all individuals on community treatment orders) were subject to indefinite community treatment orders
- 182 people were subject to indefinite inpatient treatment orders – this represents 29 percent of all individuals on inpatient treatment orders
- the average period for which a person was subject to an indefinite community treatment order was 1,561 days, and the maximum period was 9,922 days (approximately 27 years)
- the average period for which a person was subject to an indefinite inpatient treatment order was 1,508 days, and the maximum period was 7,750 days (approximately 21 years).<sup>13</sup>

## Indefinite community treatment orders

In 2020, 53.3 people per 100,000 population across Aotearoa New Zealand were subject to indefinite community treatment orders. Figure 17 shows the rates of indefinite community treatment orders in each DHB, per 100,000 of the general population.

<sup>13</sup> Sources: PRIMHD data (extracted 1 July 2021) and manual data from Counties Manukau DHB for section 30 only.

**Figure 17: Number of people subject to indefinite community treatment orders per 100,000 population, by DHB, orders open at 31 December 2020**



Source: PRIMHD data (extracted 1 July 2021).

In 2020 nationwide, for orders open at the end of the year, Māori were 2.9 times more likely to be subject to an indefinite community 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 community treatment orders.

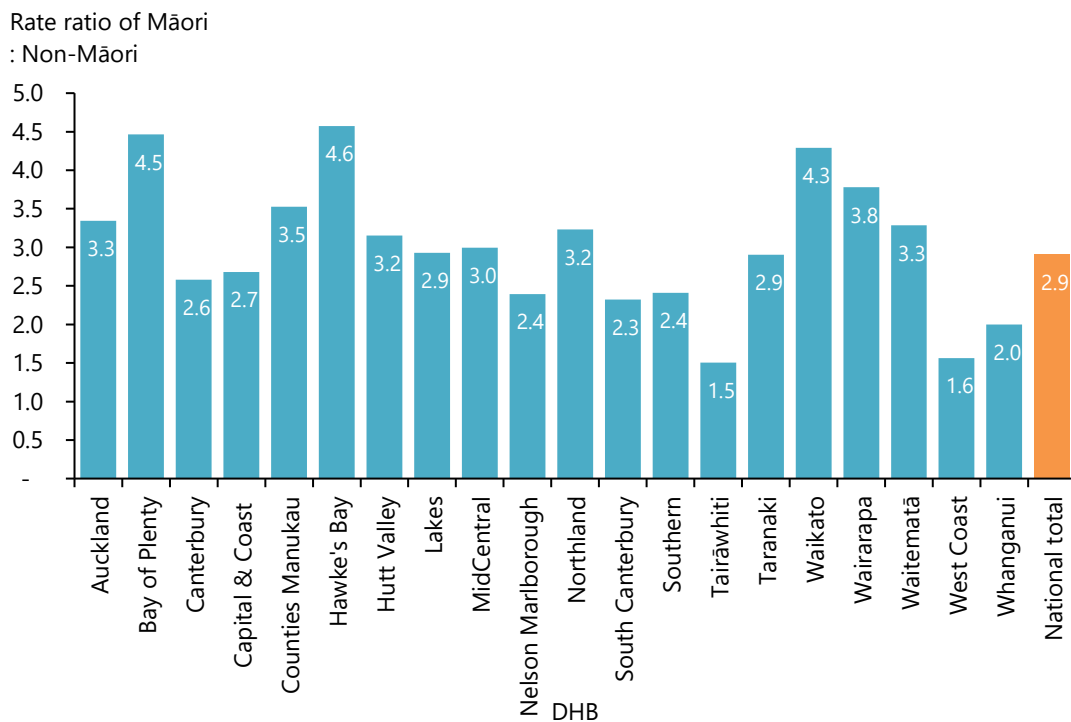


**Table 6: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, orders open at 31 December 2020**

DHB of service	Māori	Non-Māori	Rate ratio Māori : non-Māori	DHB of service	Māori	Non-Māori	Rate ratio Māori : non-Māori
Auckland	175	52	3.3	Northland	193	60	3.2
Bay of Plenty	75	17	4.5	South Canterbury	140	60	2.3
Canterbury	99	38	2.6	Southern	109	45	2.4
Capital & Coast	222	83	2.7	Tairāwhiti	58	39	1.5
Counties Manukau	95	27	3.5	Taranaki	132	45	2.9
Hawke's Bay	28	6	4.6	Waikato	176	41	4.3
Hutt Valley	116	37	3.2	Wairarapa	123	32	3.8
Lakes	60	20	2.9	Waitematā	110	34	3.3
MidCentral	136	45	3.0	West Coast	99	63	1.6
Nelson Marlborough	105	44	2.4	Whanganui	146	73	2.0
				<b>National total</b>	<b>118</b>	<b>40</b>	<b>2.9</b>

Source: PRIMHD data, extracted 1 July 2021.

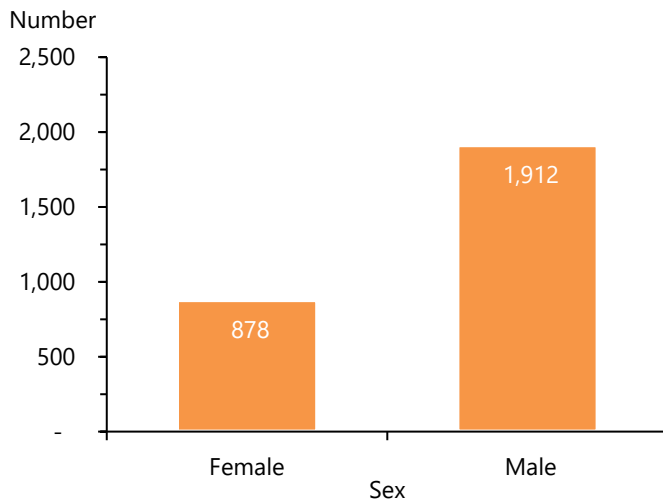
**Figure 18: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, orders open at 31 December 2020**



Source: PRIMHD data, extracted 1 July 2021.

In 2020, 69 percent of people subject to indefinite community treatment orders were male (see Figure 19). These trends are consistent with the higher rate of males subject to compulsory treatment order applications.

**Figure 19: Number of people subject to indefinite community treatment orders, by sex, 1 January to 31 December 2020**



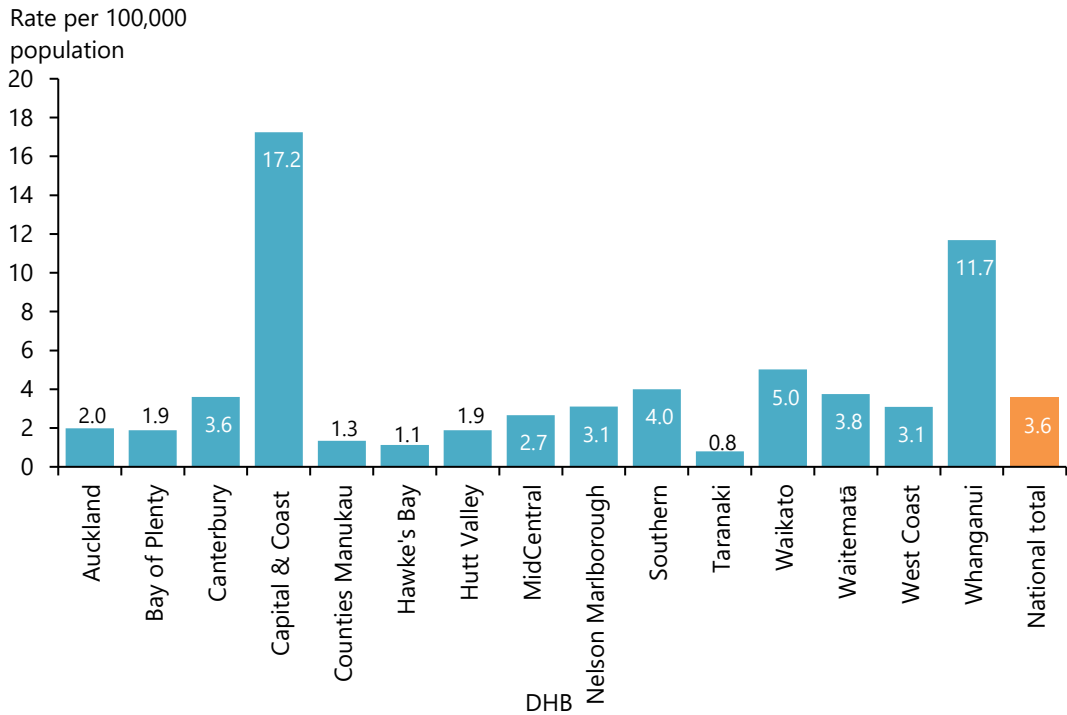
Source: PRIMHD data (extracted 1 July 2021).

## Indefinite inpatient treatment orders

In 2020 across Aotearoa New Zealand, 3.6 people per 100,000 were subject to indefinite inpatient treatment orders. Figure 20 shows the rates of indefinite inpatient treatment orders in each DHB, per 100,000 of the general population for 2020.

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 20: Number of people subject to indefinite inpatient treatment orders per 100,000 population, by DHB, 1 January to 31 December 2020**



Note: Wairarapa DHB does not have an inpatient service and Lakes, Northland, South Canterbury and Tairāwhiti DHBs have no indefinite inpatient treatment orders so none of these DHBs have been included in this figure.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Counties Manukau DHB.

Nationwide in 2020, Māori were 2.9 times more likely to be subject to an indefinite inpatient treatment order than non-Māori. Table 7 shows the rate ratio of Māori to non-Māori in each DHB per 100,000 people subject to indefinite inpatient treatment orders.

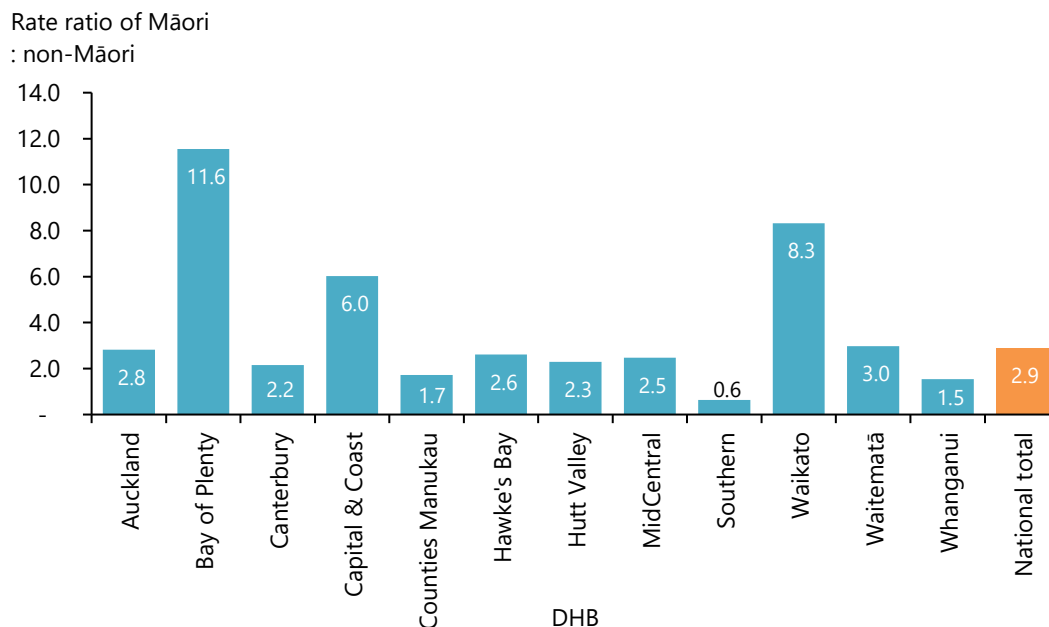
**Table 7: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, orders open at 31 December 2020**

DHB of service	Māori	Non-Māori	Rate ratio Māori : non-Māori	DHB of service	Māori	Non-Māori	Rate ratio Māori : non-Māori
Auckland	5	2	2.8	Nelson Marlborough	–	3	–
Bay of Plenty	6	1	11.6	Southern	3	4	0.6
Canterbury	7	3	2.2	Taranaki	–	1	–
Capital & Coast	65	11	6.0	Waikato	15	2	8.3
Counties Manukau	2	1	1.7	Waitematā	9	3	3.0
Hawke's Bay	2	1	2.6	West Coast	–	4	–
Hutt Valley	4	2	2.3	Whanganui	16	10	1.5
MidCentral	5	2	2.5	National total	8	3	2.0

Note: Lakes, Northland, South Canterbury, Tairāwhiti and Wairarapa DHBs do not have indefinite inpatient treatment orders and are not included in this table.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Counties Manukau DHB.

**Figure 21: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, orders open at 31 December 2020**

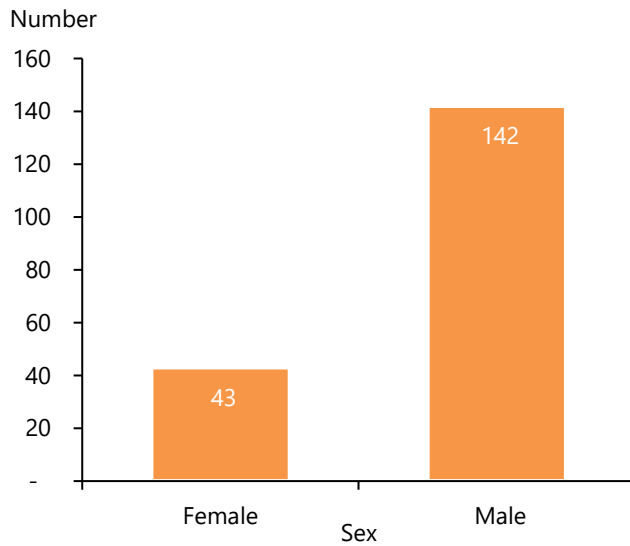


Note: Lakes, Northland, South Canterbury, Tairāwhiti and Wairarapa DHBs do not have indefinite inpatient treatment orders, and Nelson Marlborough, Taranaki and West Coast DHBs have no Māori subject to indefinite inpatient treatment orders, so none of these DHBs have been included in this figure.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Counties Manukau DHB.

In 2020, males made up 77 percent of people subject to indefinite inpatient treatment orders (see Figure 22). 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 22: Number of people subject to indefinite inpatient treatment orders, by sex, 1 January to 31 December 2020**



Sources: PRIMHD data (extracted 1 July 2021) and manual data from Counties Manukau DHB.

# 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'.<sup>14</sup>

In the 2020 analysis, we have purposely left out data from an outlier, where a high proportion of recorded seclusion hours from Capital & Coast DHB relates to a single client. For more information about this outlier data, please see the Appendix: Additional statistics.

In summary, in adult inpatient services in 2020:

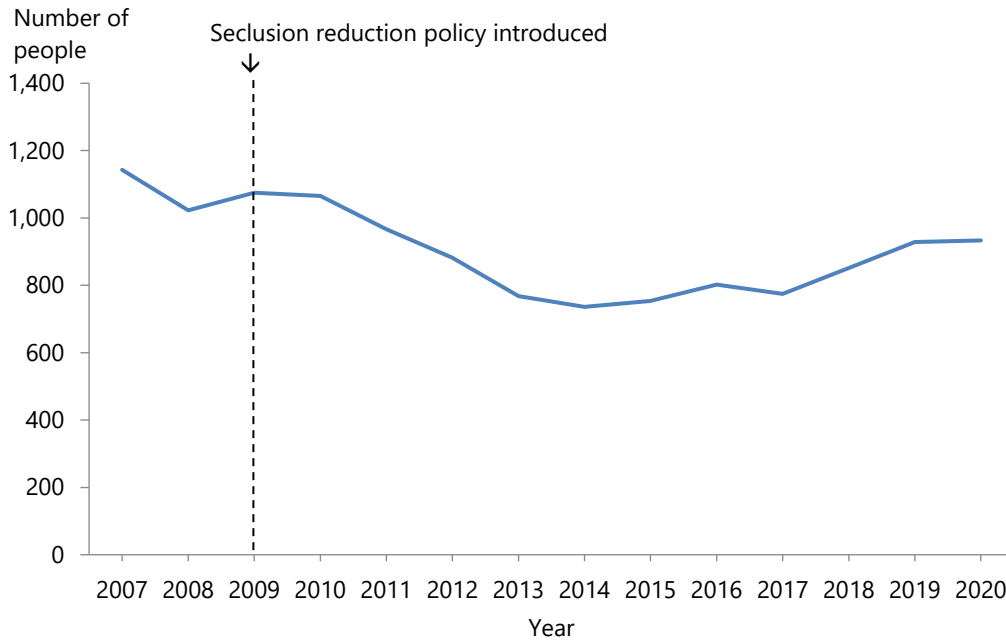
- the total number of people who experienced seclusion while receiving mental health treatment in an adult inpatient service has decreased by 13 percent since 2009<sup>15</sup>
- the total number of hours spent in seclusion has decreased by 51 percent since 2009
- there was no discernible percentage difference in the number of adult inpatient clients secluded from 2019 to 2020, however the number of hours spent in seclusion decreased by 7 percent
- 75 percent of all seclusion events lasted for less than 24 hours, and 13 percent lasted for longer than 48 hours
- males were twice as likely as females to spend time in seclusion
- people aged 20–29 years were more likely to spend time in seclusion than people 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 8.7 seclusion events for every 1,000 bed nights they spent in adult inpatient units.<sup>16</sup>

<sup>14</sup> Standards New Zealand. 2021. *Ngā Paerewa Health and Disability Services Standard*. Wellington: Standards New Zealand.

<sup>15</sup> We are comparing with 2009 because that is the year when seclusion reduction policies were introduced in Aotearoa New Zealand.

<sup>16</sup> Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs. Excludes outlier data.

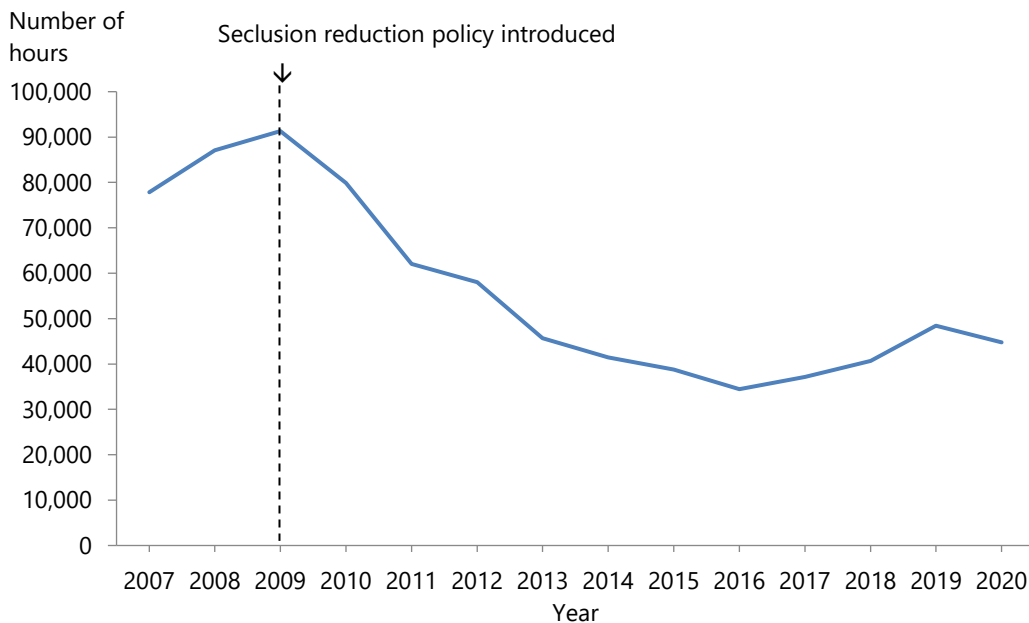
**Figure 23: Number of people secluded in adult inpatient services nationally, 2007–2020**



Notes: Excludes forensic inpatient services and an outlier. Includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services (RIDSSs).

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs.

**Figure 24: Total number of seclusion hours in adult inpatient services nationally, 2007–2020**



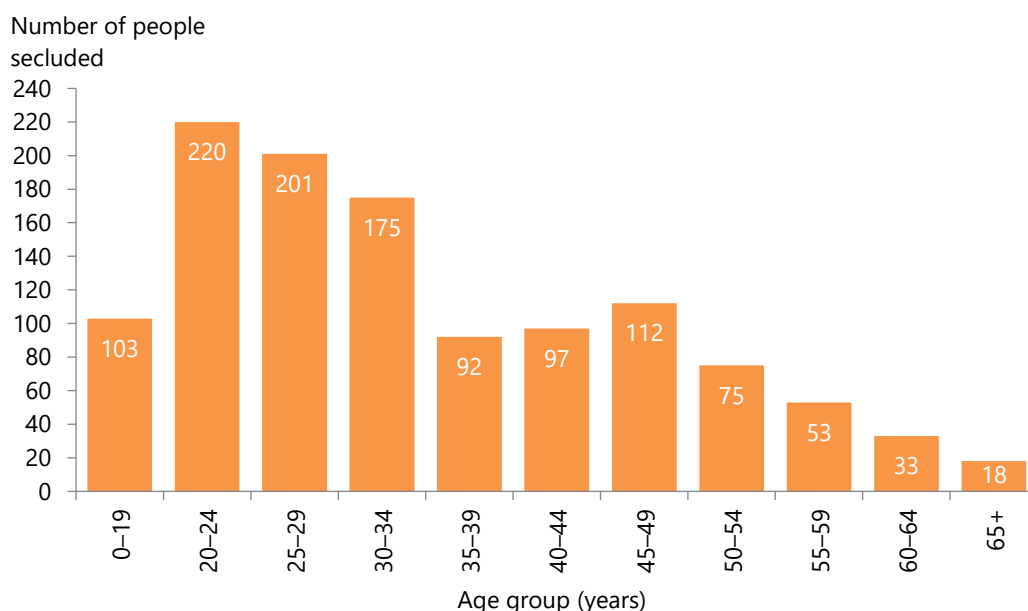
Notes: Excludes forensic inpatient services and an outlier. Includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services (RIDSSs).

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs.

# Seclusion in Aotearoa New Zealand mental health services in 2020<sup>17</sup>

- Between 1 January and 31 December 2020, Aotearoa New Zealand adult mental health services (excluding forensic and other regional rehabilitation services) accommodated 8,651 people for a total of 237,968 bed nights. Of these people, 933 (10.8 percent) were secluded at some stage during the reporting period.
- Among the adults who were secluded, many were secluded more than once (on average 2.2 times). For this reason, the number of seclusion events in adult inpatient services (2,075) was higher than the number of people secluded.
- There were 10.7 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 10.7 seclusion events.
- Across all inpatient services, including forensic, intellectual disability and youth services, 1,179 people experienced at least one seclusion event. Of those secluded, 66 percent were male, and 34 percent were female. The most common age group for those secluded was 20–24 years. A total of 103 young people (aged 19 years and under) were secluded during the 2020 year in 147 seclusion events.

**Figure 25: Number of people secluded across all inpatient services (adult, forensic, intellectual disability and youth), by age group, 1 January to 31 December 2020**



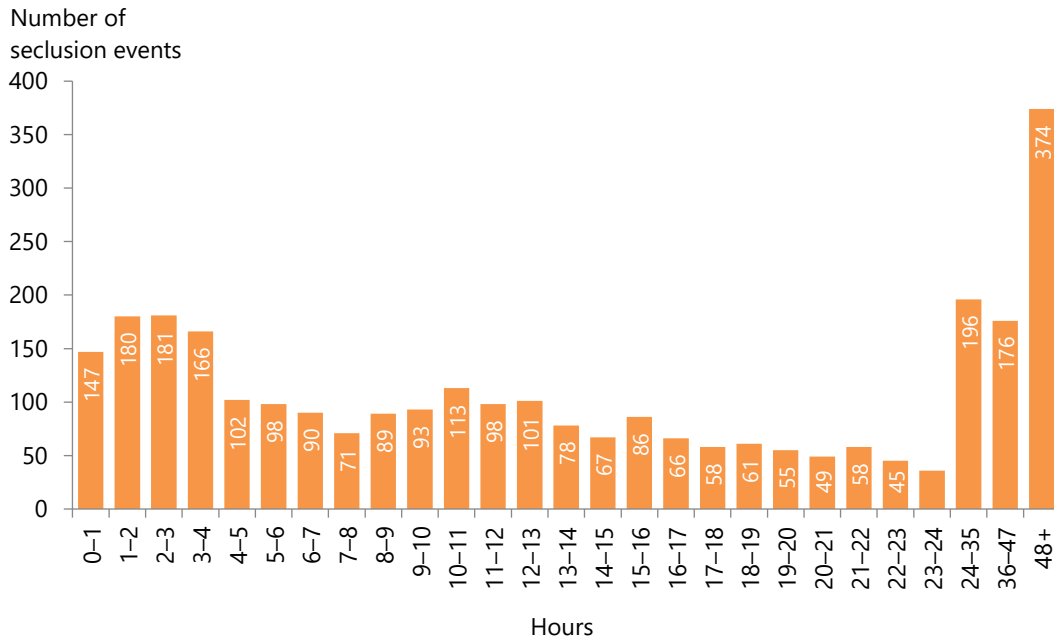
Notes: Excludes an outlier. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSSs.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs.

<sup>17</sup> Notes: Excludes an outlier and forensic services. Bed nights are measured by team types that use seclusion. This figure cannot be compared with years before 2017, when bed nights were measured by acute and sub-acute bed nights. Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs.



**Figure 26: Number of seclusion events across all inpatient services (adult, forensic, intellectual disability and youth), by duration of event, 1 January to 31 December 2020**



Notes: Excludes an outlier. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSSs. The lower limit is the lowest included time, for example 0-1 hours includes any time up to 59 minutes.

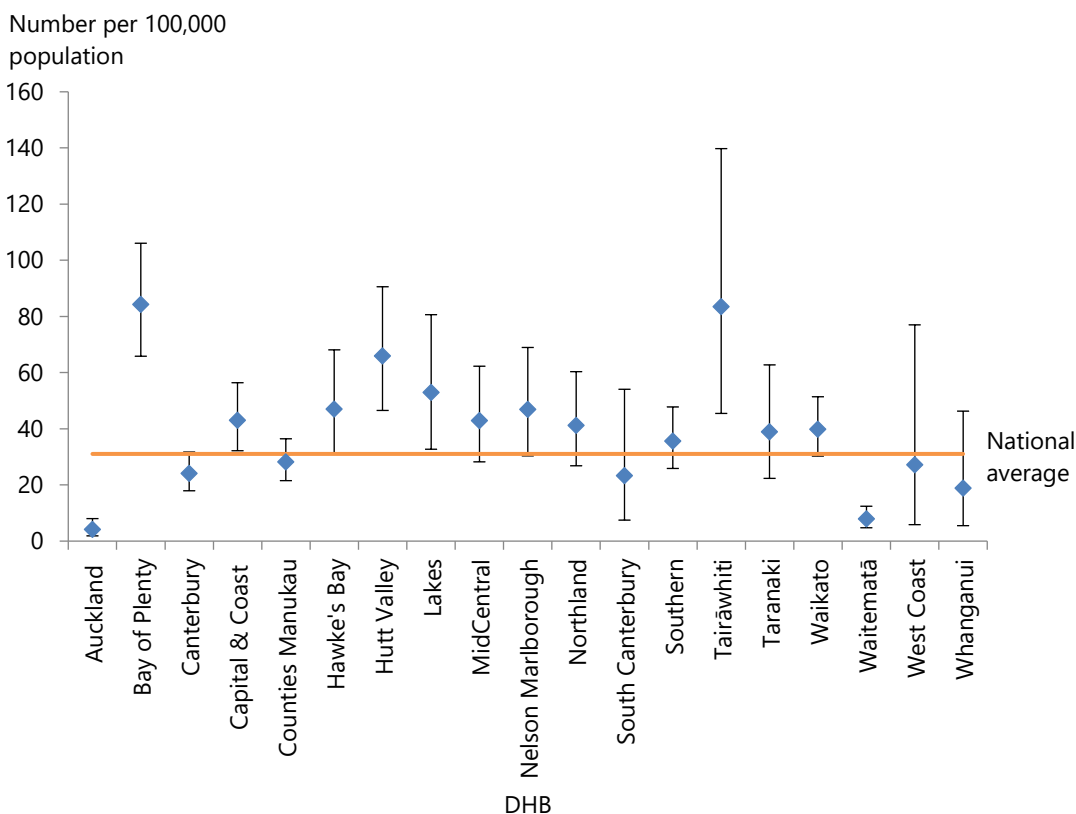
Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs.

# Use of seclusion by DHBs in 2020

All DHBs except for Wairarapa DHB (which has no mental health inpatient service) use seclusion.<sup>18</sup>

The national average number of people secluded in adult inpatient services in 2020 was 31 per 100,000 population, and the average number of seclusion events was 69.1 per 100,000 population.

**Figure 27: Number of people secluded in adult inpatient services per 100,000 population, by DHB, 1 January to 31 December 2020**

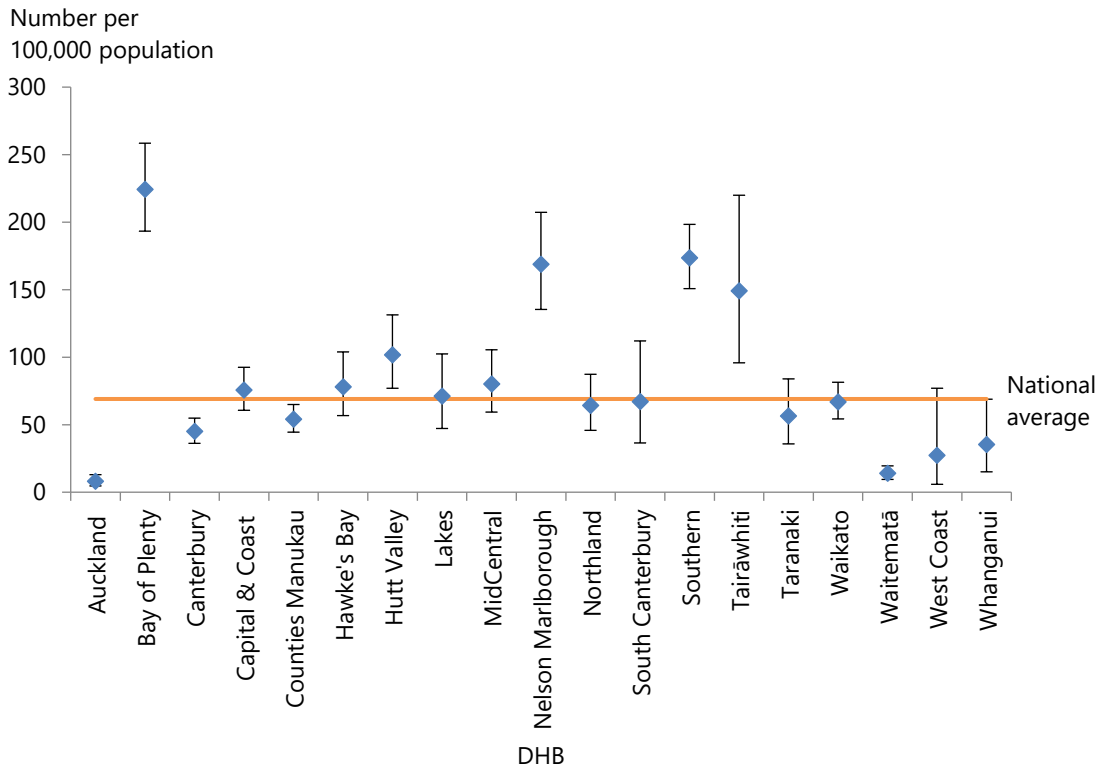


Notes: The graph uses confidence intervals (for 99 percent confidence) to help in interpreting the data. Where a DHB region's confidence interval crosses the national average, this means the DHB's rate was not statistically significantly different from the national average. This data excludes an outlier.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

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs.

<sup>18</sup> 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 any seclusion statistics relating to these service users would appear on that DHB's database.

**Figure 28: Number of seclusion events in adult inpatient services per 100,000 population, by DHB, 1 January to 31 December 2020**



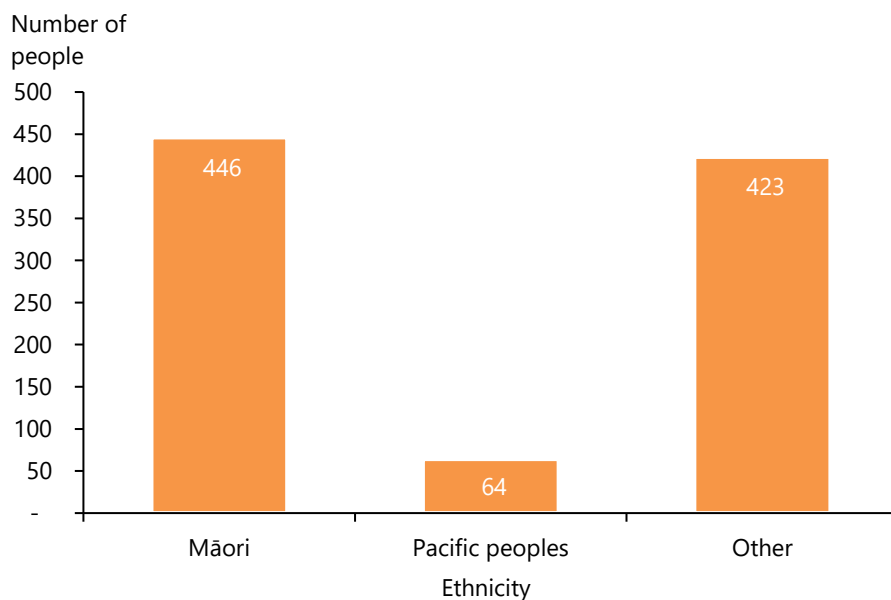
Notes: The graph uses confidence intervals (for 99 percent confidence) to help in interpreting the data. Where a DHB region's confidence interval crosses the national average, this means the DHB's rate was not statistically significantly different from the national average. This data excludes an outlier.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

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs.

## Seclusion and ethnicity in 2020

Māori were 5.1 times more likely to be secluded in adult inpatient services than non-Māori and non-Pacific peoples. Pacific peoples were 1.1 times more likely to be secluded than non-Pacific peoples and non-Māori. Figure 29 shows the number of people secluded by ethnicity.

**Figure 29: Number of people secluded, by ethnicity, 1 January to 31 December 2020**

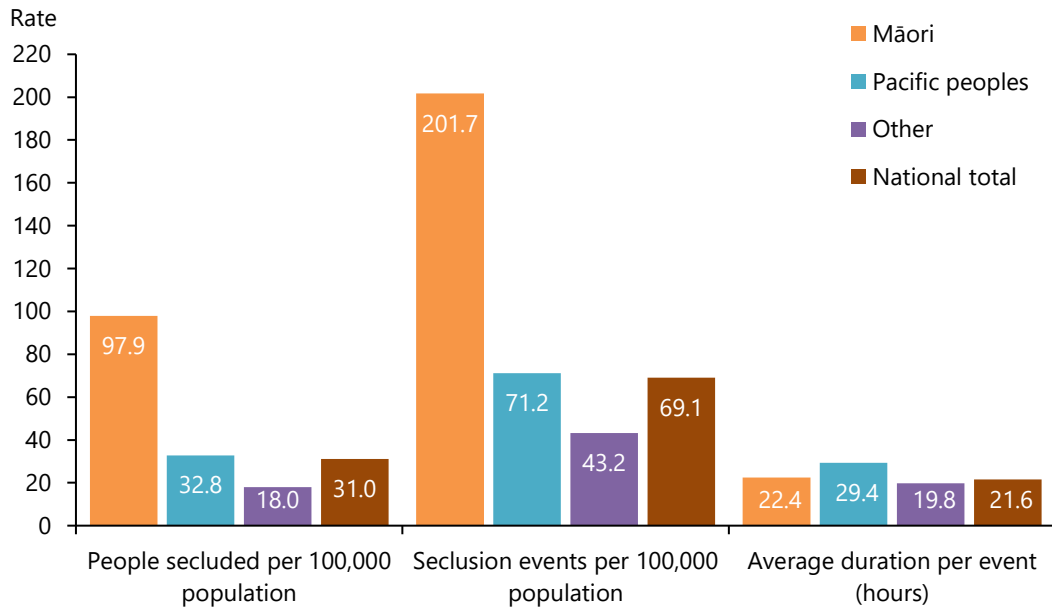


Notes: Excludes an outlier, forensic services and patients who have a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSSs.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs.

Figure 30 shows seclusion indicators for Māori, Pacific peoples and other during 2020. Māori were secluded at a rate of 97.9 people per 100,000 population, Pacific peoples at 32.8 people per 100,000 population and other ethnicities at a rate of 18.0 people per 100,000 population.

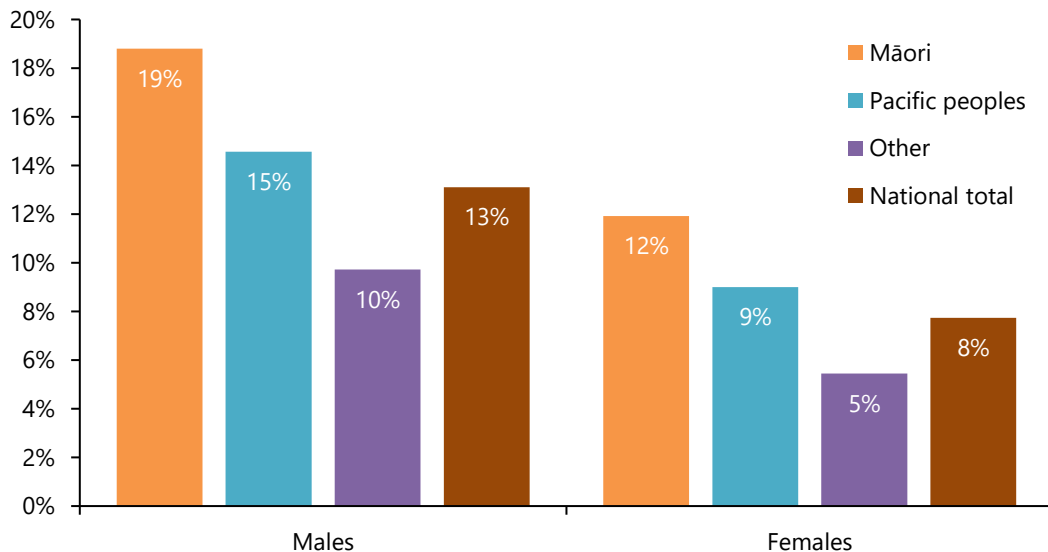
**Figure 30: Seclusion indicators for adult inpatient services, Māori, Pacific peoples and other ethnicities, 1 January to 31 December 2020**



Notes: Excludes an outlier, 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 RIDSSs.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs.

**Figure 31: Percentage of people with inpatient admissions that spent time in seclusion in adult inpatient services, Māori, Pacific peoples and other ethnicities, males and females, 1 January to 31 December 2020**

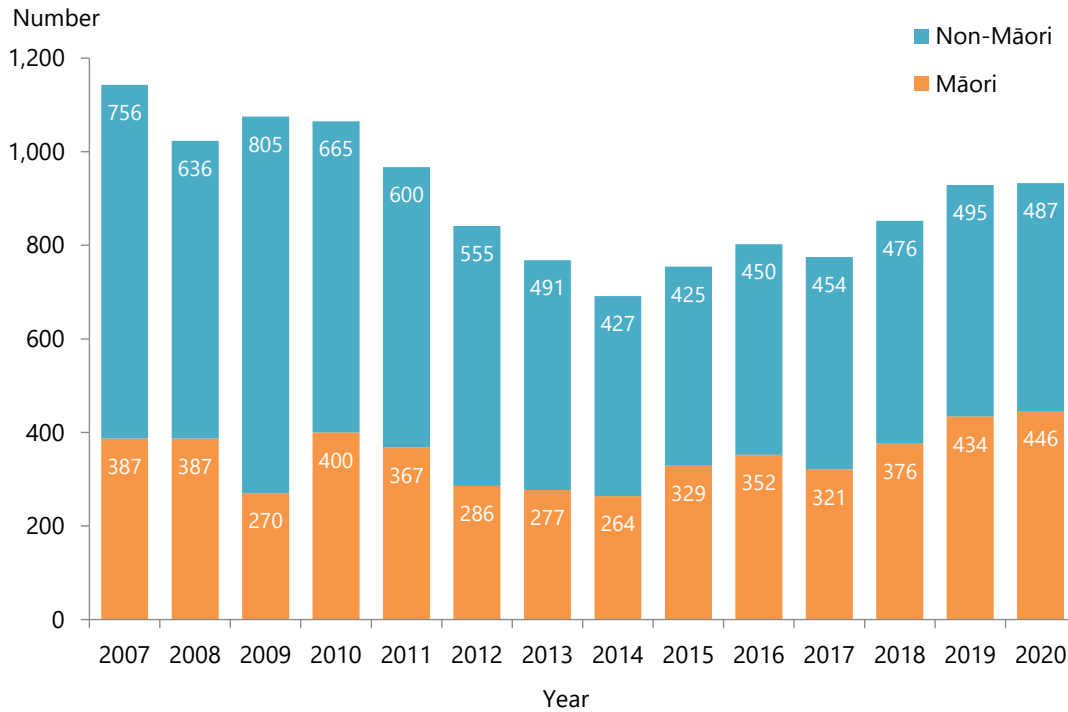


Notes: Excludes an outlier, forensic services and patients who have a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Includes patients who have a legal status under the Mental Health Act but are treated in RIDSSs.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs.

Figure 32 shows the number of Māori and non-Māori aged 20–64 years secluded in adult inpatient services from 2007 to 2020. Nationally over this time, the number of people secluded decreased by 18 percent. However, the number of people secluded who identified as Māori increased by 15 percent over the same period.

**Figure 32: Number of Māori and non-Māori aged 20–64 years secluded in adult inpatient services, 2007–2020**



Notes: Excludes an outlier, 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 RIDSSs.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs.

## Seclusion in forensic units in 2020

Five DHBs provide specialist inpatient forensic services: Canterbury, Capital & Coast, Southern, Waikato and Waitematā.<sup>19</sup> These services provide mental health treatment in a secure environment for prisoners with mental disorders and for people defined as special or restricted patients.

Table 8 presents seclusion indicators for forensic mental health services in each DHB. These indicators cannot be compared with adult service indicators because they have a different client base. A few individuals who have been secluded significantly more often or for longer than others can substantially affect the rates of seclusion for the relatively small group of people in the care of forensic mental health services.

**Table 8: Seclusion indicators for forensic mental health services, by DHB, 1 January to 31 December 2020**

DHB	Clients secluded	Number of events	Total hours	Average duration per event (hours)
Canterbury	27	89	10,598	119.1
Capital & Coast	16	30	839	28.0
Southern	7	20	350	17.5
Waikato	42	78	5,533	70.9
Waitematā	55	230	6,505	28.3
<b>National total</b>	<b>147</b>	<b>447</b>	<b>23,825</b>	<b>53.3</b>

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.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs.

<sup>19</sup> Capital & Coast DHB also operates a forensic service in Whanganui.

# People with intellectual disabilities cared for in an intellectual disability forensic service

The five DHBs listed above as providing specialist inpatient forensic services also provide forensic intellectual disability services for people with an intellectual disability under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the ID(CC&R) Act), as care recipients or special care recipients. Individuals become subject to the ID(CC&R) Act following engagement in criminal offending, with compulsory care being provided as an alternative to a prison sentence. A small number of individuals in forensic intellectual disability services are under the Mental Health Act.

The seclusion data presented for people with intellectual disabilities is for individuals with a legal status under the ID(CC&R) Act and the Mental Health Act. Care recipients being cared for under these Acts may only be subject to seclusion in hospital-level secure services that meet specific requirements. In this analysis, we have purposely left out data from an outlier, where a high proportion of recorded seclusion hours from Capital & Coast DHB relates to a single client.

**Table 9: Seclusion indicators for people with intellectual disabilities, by DHB, 1 January to 31 December 2020**

Legal Act	DHB	Number of people secluded	Number of events	Median number of events	Average number of events per person
ID(CC&R)	Canterbury	4	37	8	9
	Capital & Coast	3	27	2	9
	Southern	8	45	3	6
	Waikato	3	6	1	2
	Waitematā	6	68	10	11
	<b>National total</b>		<b>23</b>	<b>183</b>	<b>3</b>
MHA	Canterbury	1	2	2	2
	Capital & Coast	1	2	2	2
	Southern	1	28	28	28
	Waikato	0	0	0	0
	Waitematā	1	49	49	49
	<b>National total</b>		<b>4</b>	<b>81</b>	<b>15</b>

Notes: ID(CC&R) = Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003; MHA = Mental Health (Compulsory Assessment and Treatment) Act 1992.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern and Waitematā DHBs.



**Table 10: Seclusion duration for people with intellectual disabilities, by DHB, 1 January to 31 December 2020**

Legal Act	DHB	Total seclusion hours	Median duration of seclusion events (hours: minutes)	Average duration of seclusion events (hours: minutes)
ID(CC&R)	Canterbury	1,047	10:35	4:17
	Capital & Coast	424	13:00	15:42
	Southern	709	3:45	15:45
	Waikato	50	4:28	8:21
	Waitematā	562	3:27	8:16
MHA	Canterbury	31	15:40	15:40
	Capital & Coast	5	2:17	2:17
	Southern	89	1:55	3:11
	Waikato	0	0:00	0:00
	Waitematā	1,404	13:25	4:39

Notes: ID(CC&R) = Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003; MHA = Mental Health (Compulsory Assessment and Treatment) Act 1992.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern and Waitematā DHBs.

**Table 11: Seclusion indicators for people with intellectual disabilities, by ethnicity, 1 January to 31 December 2020**

Legal Act	Ethnicity	Number of people secluded	Number of seclusion events	Median number of events	Average number of events per person
ID(CC&R)	Māori	6	52	6	8.7
	Non-Māori	17	131	3	7.7
MHA	Māori	0	0	0	0.0
	Non-Māori	4	81	15	20.3

Notes: ID(CC&R) = Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003; MHA = Mental Health (Compulsory Assessment and Treatment) Act 1992.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern and Waitematā DHBs.

## Night safety procedures

Night safety procedures is the practice of locking a patient in their bedroom overnight for the purposes of safety, either for themselves or for others in the unit. This practice is based on a 1995 Ministry of Health document *Night Safety Procedures*.<sup>20</sup>

This procedure, as it is currently constructed, is no longer fit for purpose, and the Ministry has signalled that this practice should cease by 31 December 2022. In 2018, the Ministry issued *Night Safety Procedures: Transitional guideline* to ensure patients receive adequate standards of care and monitoring as services transition to no longer using these procedures.<sup>21</sup>

In regions where night safety procedures are still being used, it has been reported that they are considered an essential component to providing a safe environment. Reasons cited include: issues with building design and lines of vision, staffing levels and the level of risk that patients present with.

Services have recently started manually providing data to the Office of the Director of Mental Health and Addiction Services on their use of night safety procedures. Due to this data not being submitted via PRIMHD and the need to undertake quality checks, the data set is not available at the time of publication. Data on the number of people who are subject to night safety procedures and the number of night safety events, will be published once it becomes available.

<sup>20</sup> Ministry of Health. 1995. *Night Safety Procedures*. Wellington: Ministry of Health. URL: [www.moh.govt.nz/notebook/nbbooks.nsf/0/FD5F690DFDAAD3EACC25737F007C2720/\\$file/nightsafety.pdf](http://www.moh.govt.nz/notebook/nbbooks.nsf/0/FD5F690DFDAAD3EACC25737F007C2720/$file/nightsafety.pdf) (accessed 27 October 2021).

<sup>21</sup> Ministry of Health. 2018. *Night Safety Procedures: Transitional guideline*. Wellington: Ministry of Health. URL: [www.health.govt.nz/system/files/documents/publications/night-safety-procedures-transitional-guideline-feb18.pdf](http://www.health.govt.nz/system/files/documents/publications/night-safety-procedures-transitional-guideline-feb18.pdf) (accessed 27 October 2021).

# Special and restricted patients

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

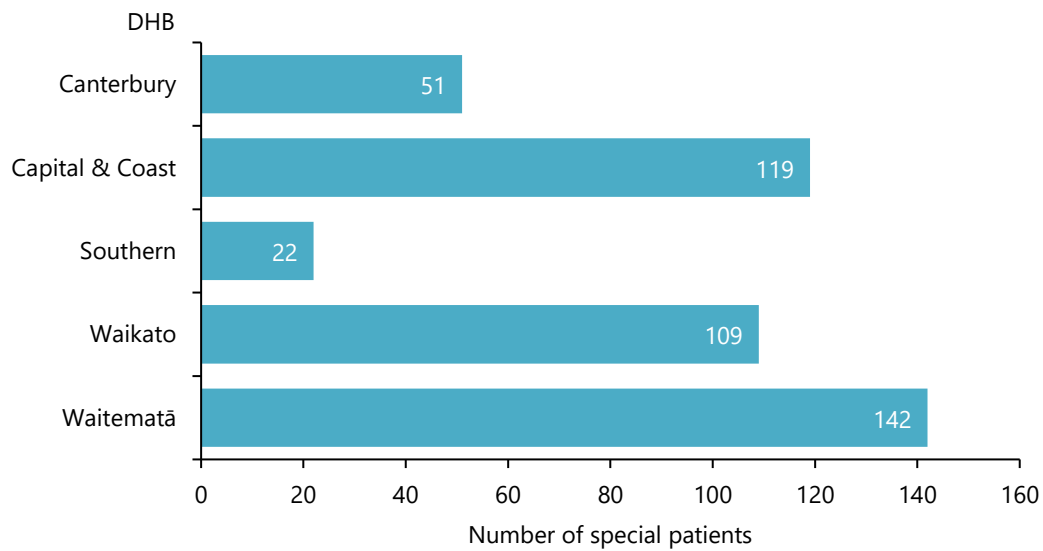
Special patients include:

- 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.

Figure 33 presents the total number of special patients in the care of each DHB that provides regional forensic psychiatry services. The number of unique special patients nationally, 438 in total, is lower than the number of unique special patients by DHB, as some may have transferred across services during the 2020 year.

**Figure 33: Total number of special patients, by DHB, 1 January to 31 December 2020**



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

Source: PRIMHD data (extracted 1 July 2021).

Special and restricted patients may be detained for extended or short-term 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 2020, Aotearoa New Zealand had 167 extended forensic care special patients. Table 12 shows the number of these patients in the care of each DHB that provides 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 2020, Aotearoa New Zealand had a total of 281 short-term forensic care special patients. Table 12 shows the number of these patients in the care of each DHB that provides regional forensic psychiatry services. Figure 34 shows the percentage of court orders given for short-term forensic care legal status relative to those for extended forensic care legal status in each relevant DHB.

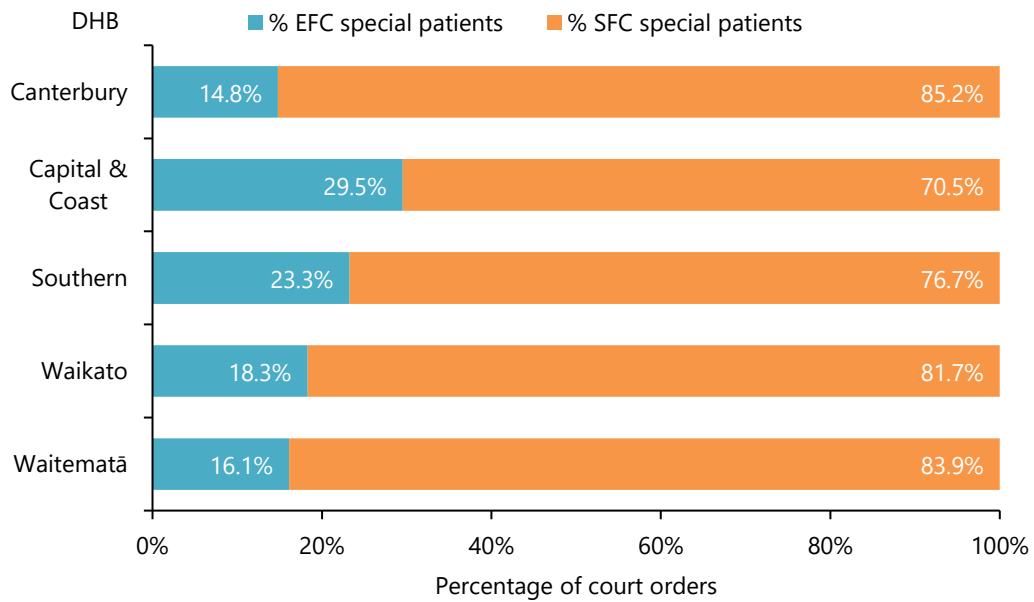
**Table 12: Total number of special patients, by type and DHB, 1 January to 31 December 2020**

Forensic services	EFC special patients	SFC special patients	Total special patients
Canterbury DHB	16	36	51
Capital & Coast DHB	55	66	119
Southern DHB	10	12	22
Waikato DHB	41	71	109
Waitematā DHB	48	97	142
<b>National total</b>	<b>167</b>	<b>281</b>	<b>438</b>

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, Hawke's Bay, MidCentral and Whanganui DHBs are included under Capital & Coast DHB, Taranaki DHB is included under Waikato DHB, and Nelson Marlborough DHB is included under Canterbury DHB. A patient may be represented under both the EFC and SFC categories in this table. 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 1 July 2021).

**Figure 34: Percentage of court orders given for extended forensic care relative to short-term forensic care legal statuses, by DHB, 1 January to 31 December 2020**



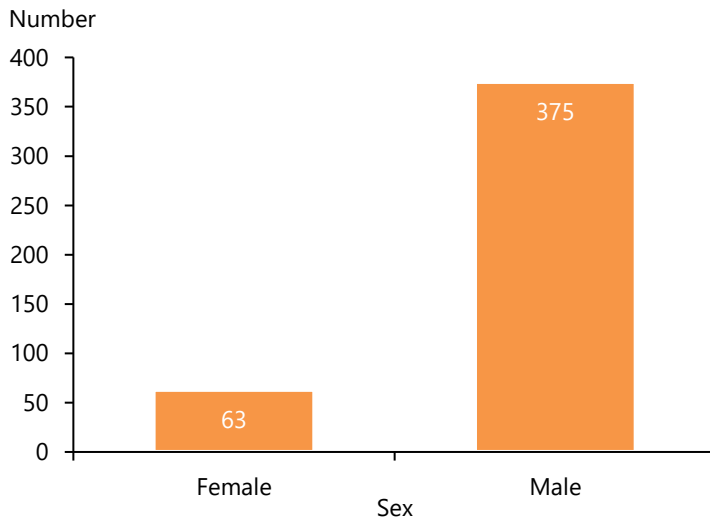
Notes: Unlike previous data in this section, the data in this figure is based on a count of court orders for legal statuses rather than a count of people with a special patient legal status. One special patient may have many court orders for their legal status in the year, which could include both extended 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, Hawke’s Bay, MidCentral and Whanganui DHBs are included under Capital & Coast DHB, Taranaki DHB is included under Waikato DHB, and Nelson Marlborough DHB is included under Canterbury DHB.

Source: PRIMHD data (extracted 1 July 2021).

# Sex, age and ethnicity of special patients in 2020

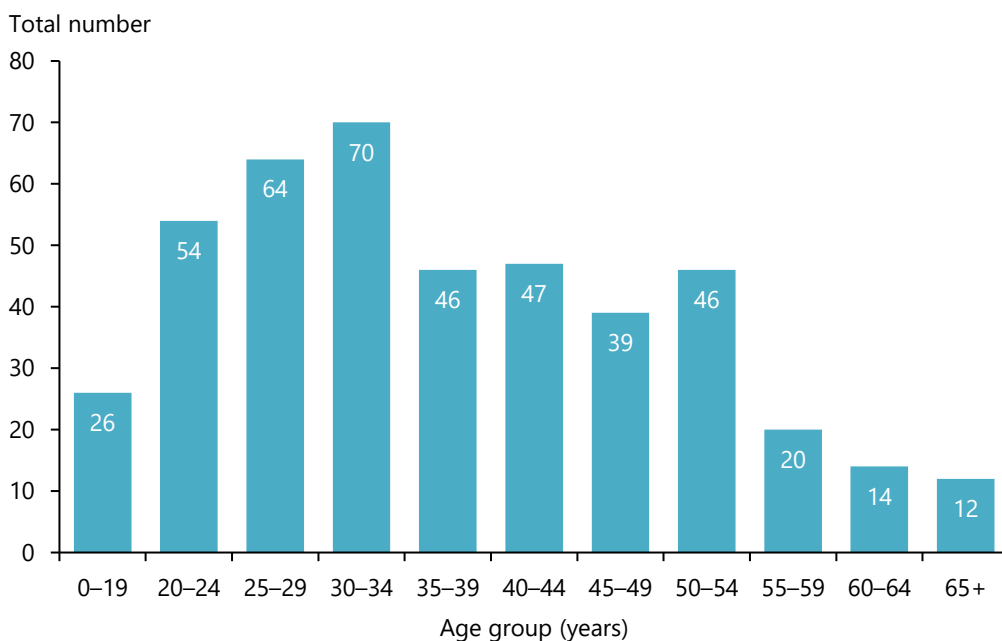
Special patients were more than five times more likely to be male (86 percent) than female (14 percent) (see Figure 35). The most common age group in 2020 for special patients was 30–34 years old (see Figure 36).

**Figure 35: Number of special patients, by sex, 1 January to 31 December 2020**



Source: PRIMHD data (extracted 1 July 2021).

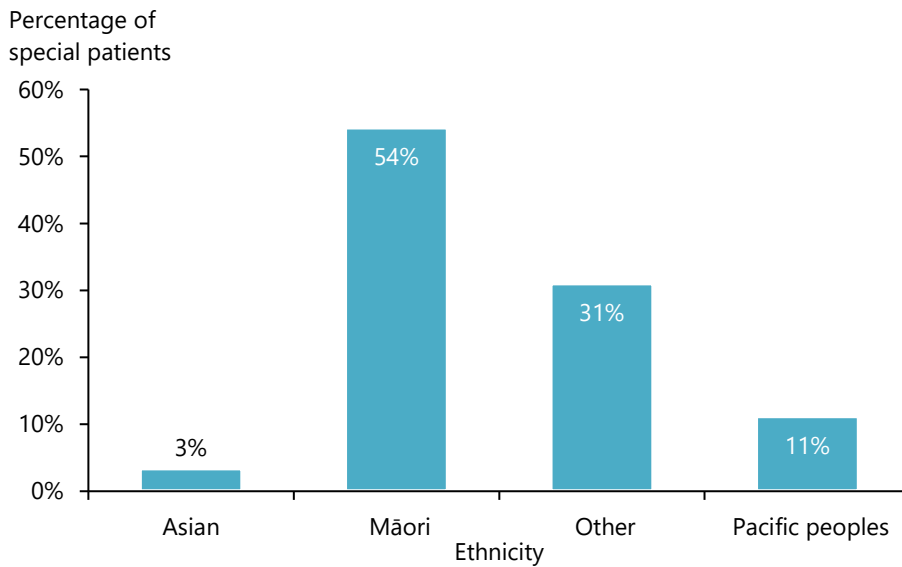
**Figure 36: Total number of special patients, by age group, 1 January to 31 December 2020**



Source: PRIMHD data (extracted 1 July 2021).

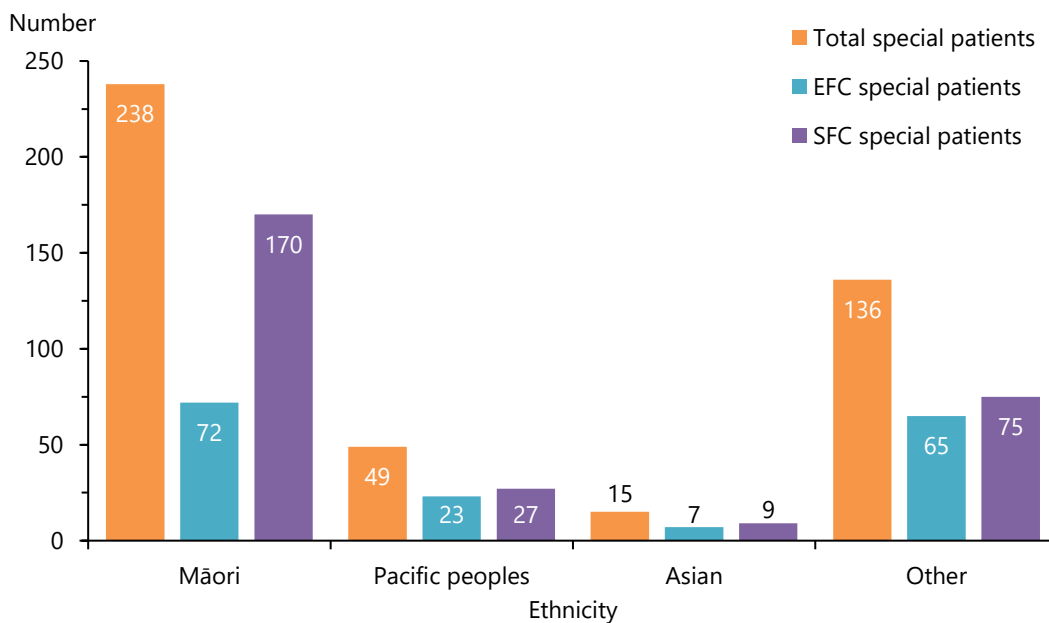
The ethnic group with the highest proportion of people subject to a special patient order was Māori (54 percent) (see Figure 37). Māori represented the highest proportion of both extended forensic care (43 percent) and short-term forensic care (60 percent) special patients. Figure 38 shows the number of special patients in each ethnic group for each of these types of forensic care.

**Figure 37: Percentage of special patients, by ethnicity, 1 January to 31 December 2020**



Source: PRIMHD data (extracted 1 July 2021).

**Figure 38: Number of special patients, by ethnicity and special patient type, 1 January to 31 December 2020**



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

Source: PRIMHD data (extracted 1 July 2021).



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

The Director of Mental Health (the Director) 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.

A special patient 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 themselves 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. After careful consideration, the Director makes a recommendation for the Minister of Health'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 of the Director of Mental Health and Addiction Services processed during 2020.

**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 2020**

<b>Type of request</b>	<b>Number completed in 2020</b>
Initial ministerial section 50 leave applications approved	11
Initial ministerial section 50 leave applications not approved	0
Ministerial section 50 leave revocations (initial and further)	2
Further ministerial section 50 leave applications approved	22
Further ministerial section 50 applications not approved	0
Change of legal status applications approved	12
Change of legal status applications not approved	3
<b>Total applications approved or not approved</b>	<b>50</b>

Note: Numbers do not include 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

Aotearoa New Zealand has two major national reporting mechanisms for adverse events relating to mental health.<sup>22</sup> 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)<sup>23</sup> 1 or 2 to the Health Quality & Safety Commission (HQSC) in line with the National Adverse Events Reporting Policy.<sup>24</sup> Mental health services that are not funded by DHBs are encouraged but not required to report adverse events to the HQSC.

In Aotearoa 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

Table 14 provides a breakdown of the types of adverse events relating to mental health that DHBs reported to HQSC during 2020. Table 15 shows the number of events reported for each DHB.

Comparing individual DHBs based on this data is not straightforward. As noted above, high numbers can indicate a DHB has a good reporting culture rather than having 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.

<sup>22</sup> An adverse event is an event that results in harm or has the potential to result in harm to a consumer.

<sup>23</sup> 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.

<sup>24</sup> See the National Adverse Events Reporting Policy webpage on the HQSC website at: [www.hqsc.govt.nz/our-programmes/adverse-events/national-adverse-events-policy/](http://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 2020**

Type of event	Outpatient	Inpatient	On approved leave	Inpatient (AWOL)	Total
Suspected suicide	162	3	2	1	168
Serious self-harm	24	3	1	1	29
Serious adverse behaviour	5	9	0	0	14
<b>National total</b>	<b>191</b>	<b>15</b>	<b>3</b>	<b>2</b>	<b>211</b>

Note: AWOL = absent without leave.

Source: HQSC adverse event data (extracted 6 August 2021).

**Table 15: Mental health adverse events that DHBs reported to the HQSC, by DHB, 1 January to 31 December 2020**

DHB	Number of events	DHB	Number of events
Auckland	22	Northland	10
Bay of Plenty	8	South Canterbury	2
Canterbury	17	Southern	17
Capital & Coast	19	Tairāwhiti	1
Counties Manukau	20	Taranaki	9
Hawke's Bay	7	Waikato	13
Hutt Valley	2	Wairarapa	1
Lakes	9	Waitematā	32
MidCentral	5	West Coast	4
Nelson Marlborough	9	Whanganui	4
		<b>National total</b>	<b>211</b>

Source: HQSC adverse event data (extracted 6 August 2021).

# Deaths reported to the Director of Mental Health

Section 132 of the Mental Health Act 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 Aotearoa 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 2020, the Director of Mental Health received 39 death notifications related to people under the Mental Health Act (see Table 16). Of these, 11 related to people who were reported to have died by suspected suicide. The remaining 18 reportedly died by other means, including natural causes and illnesses unrelated to their mental health status.

**Table 16: Outcomes of reportable death notifications under section 132 of the Mental Health Act, 1 January to 31 December 2020**

Reportable death outcome	Number of deaths
Suspected suicide	11
Other deaths	28
<b>National total</b>	<b>39</b>

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

## Section 95 inquiries

The Director of Mental Health will occasionally require a district inspector to carry out an inquiry under section 95 of the Mental Health Act. Such inquiries generally focus on systemic issues across one or more mental health service(s). They typically result in the district inspector making specific recommendations about the mental health services and/or their system.

The Director considers the recommendations and acts on any that have implications for the Ministry or the mental health sector. The Director later audits the DHB's implementation of the recommendations.

The inquiry process is not completed until the Director considers that the DHB concerned and, if appropriate, the Ministry and all other DHBs have satisfactorily implemented the recommendations.

No section 95 inquiries were completed during 2020. Table 17 shows the number of completed section 95 inquiry reports received by the Director between 2005 and 2020.

**Table 17: Number of completed section 95 inquiry reports received by the Director of Mental Health, 2005–2020**

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
1	4	1	1	3	2	1	1	0	0	1	2	0	0	0	0

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

# Electroconvulsive therapy

Electroconvulsive therapy (ECT) is a therapeutic procedure that delivers a brief pulse of electricity to a person's brain in order to generate a seizure. ECT 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.

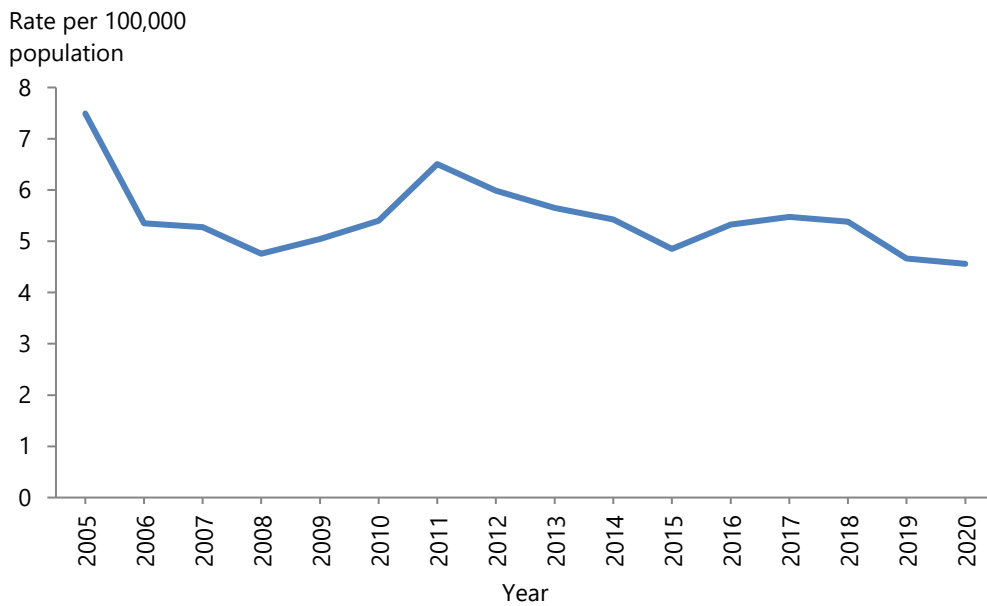
In summary, in 2020:

- 232 people received ECT (4.6 people per 100,000 population)
- services administered a total of 2,633 treatments of ECT
- the people treated each received an average of 11.3 treatments of ECT over the year
- females were more likely than males to receive ECT
- older people were more likely to receive ECT than younger people, with those over 50 years old making up 66 percent of ECT patients.

## ECT treatments in 2020

The number of people treated with ECT in Aotearoa New Zealand has remained relatively stable since 2006. Around 200 to 300 people receive the treatment each year.

**Figure 39: Rate of people treated with ECT per 100,000 population, 2005–2020**



Sources: PRIMHD data (extracted 1 July 2021) and manual data from MidCentral, Southern and Waitematā DHBs.

## ECT by region

The number and rate of ECT treatments vary regionally (see Table 18 and Figure 40). In interpreting these differences, it is important to consider several factors that help to explain these variations. 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 DHB areas have less barriers to accessing ECT services than those in other DHB areas.



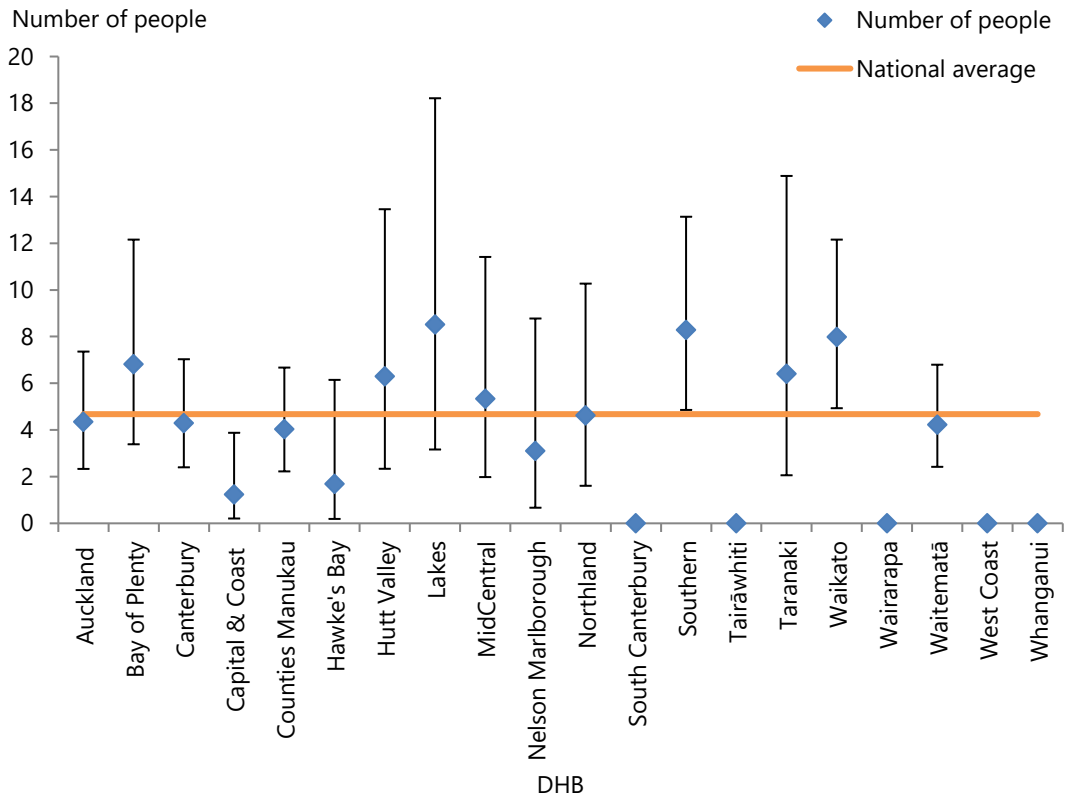
**Table 18: ECT indicators, by DHB of domicile, 1 January to 31 December 2020**

DHB of domicile	Number of people treated with ECT	Number of treatments	Mean number of treatments per person (range)
Auckland	22	256	12 (1–41)
Bay of Plenty	18	276	15 (4–52)
Canterbury	25	210	8 (1–39)
Capital & Coast	4	12	3 (1–6)
Counties Manukau	24	205	9 (1–35)
Hawke's Bay	3	33	11 (2–23)
Hutt Valley	10	104	10 (1–17)
Lakes	10	77	8 (2–14)
MidCentral	4	42	8 (1–18)
Nelson Marlborough	5	26	5 (1–9)
Northland	9	80	9 (1–16)
South Canterbury	–	–	–
Southern	29	470	16 (1–67)
Tairāwhiti	–	–	–
Taranaki	8	103	13 (1–41)
Waikato	35	360	10 (1–29)
Wairarapa	–	–	–
Waitematā	27	379	14 (1–39)
West Coast	–	–	–
Whanganui	–	–	–
<b>National total</b>	<b>233</b>	<b>2,633</b>	<b>(1–67)</b>

Note: In 2020, there were 14 people who were treated out of area, as follows: Auckland DHB saw two people from Waitematā DHB; Canterbury DHB saw two people from Nelson Marlborough DHB; Hutt Valley DHB saw three people from Capital & Coast DHB; MidCentral DHB saw one person from Hutt Valley DHB; Southern DHB saw one person from Nelson Marlborough DHB; Waikato DHB saw one person from Bay of Plenty DHB and one person from Taranaki DHB; Waitematā saw three people from Auckland DHB.

Sources: PRIMHD data (extracted 1 July 2021) and manual data from MidCentral, Southern and Waitematā DHBs.

**Figure 40: Number of people per 100,000 population treated with ECT, by DHB, 1 January to 31 December 2020**



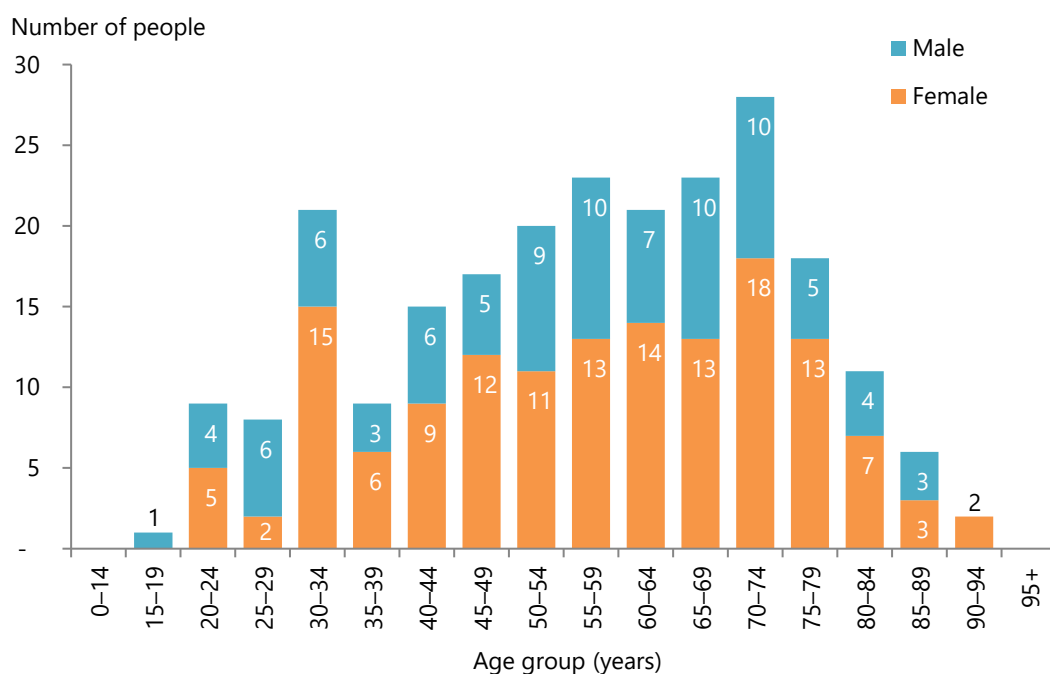
Sources: PRIMHD data (extracted 1 July 2021) and manual data from MidCentral, Southern and Waitematā DHBs.

# Sex and age of people receiving ECT

In 2020, 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 66 percent of all patients in 2020.

**Figure 41: Number of people treated with ECT, by age group and sex, 1 January to 31 December 2020**



Sources: PRIMHD data (extracted 1 July 2021) and manual data from MidCentral, Southern and Waitematā DHBs.

## Ethnicity of people treated with ECT

Table 19 indicates that Asian, Māori and Pacific peoples are less likely to receive ECT than 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 Aotearoa New Zealand.

**Table 19: Number of people treated with ECT, by ethnicity, 1 January to 31 December 2020**

Ethnicity	Number
Asian	17
Māori	25
Pacific peoples	5
Other	185
<b>National total</b>	<b>232</b>

Sources: PRIMHD data (extracted 1 July 2021) and manual data from MidCentral, Southern and Waitematā DHBs.

## 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<sup>25</sup> 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.

In 2020, services administered ECT to 102 people who could not consent to treatment. In total, 1,146 ECT treatments were administered without consent, an increase from 838 treatments in 2019. An additional 43 treatments were administered to six people who had the capacity to consent but refused (the DHBs gained a second opinion from an independent psychiatrist). Table 20 shows the number of treatments administered without consent during 2020.

<sup>25</sup> The Mental Health Review Tribunal (MHRT) is an independent body appointed by the Minister of Health under the Mental Health Act. For more information on the MHRT, see the Mental Health Review Tribunal webpage on the Ministry of Health website at: [www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/mental-health-review-tribunal](http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/mental-health-review-tribunal).

**Table 20: ECT administered under second opinion without consent, by DHB of service, 1 January to 31 December 2020**

DHB of service	Second opinion where patient did not have the capacity to consent		Second opinion where patient had the capacity but refused to consent	
	Number of people given ECT	Number of treatments administered	Number of people given ECT	Number of treatments administered
Auckland	11	130	0	0
Bay of Plenty	9	47	2	15
Canterbury	3	52	1	1
Capital & Coast	5	37	1	12
Counties Manukau	10	69	0	0
Hawke's Bay	1	36	0	0
Hutt Valley	4	25	2	15
Lakes	6	45	0	0
Nelson Marlborough	0	0	0	0
Northland	6	69	0	0
South Canterbury	0	0	0	0
Southern	15	232	0	0
Tairāwhiti	0	0	0	0
Taranaki	6	73	0	0
Waikato	12	148	0	0
Wairarapa	–	–	–	–
Waitematā	14	183	0	0
West Coast	–	–	–	–
Whanganui	–	–	–	–
<b>National total</b>	<b>102</b>	<b>1,146</b>	<b>6</b>	<b>43</b>

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. MidCentral DHB did not provide data for 2020 and so is excluded from this table.

A dash (–) indicates the DHB did not perform ECT in 2020 – they sent people to other DHBs for treatment.

Source: Manual data from DHBs.

# 2020 substance use treatment

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

In February 2018, the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Substance Addiction Act) came into force, replacing the Alcoholism and Drug Addiction Act 1996. The Substance Addiction Act is designed to help people who have a severe substance addiction and impaired capacity to make decisions about engaging in treatment. This legislation is better equipped to protect the human rights and cultural needs of patients and families and whānau, and it places greater emphasis on enhancing a mana-enhancing and following a health-based approach.

Section 119 of the Substance Addiction Act requires the Ministry to publish certain information in its annual report, such as the number of people who received compulsory treatment. The Ministry's annual report covers a financial year and is typically published a few months after the closure of that year. You can find the latest annual report by searching 'Annual Reports' on the Ministry's website.

In order to provide a comprehensive view of activities under the Substance Addiction Act, more data is provided on the Act in the Appendix: Additional statistics of this report. Please note, however, that this data covers the 1 July 2020 to 30 June 2021 financial year, as opposed to the 2020 calendar year. If you are interested in seeing data covering the six-month period from 1 January 2020 to 30 June 2020, search 'Substance Addiction data' on the Ministry's website.

# Land Transport Act 1998

In 2020, the Office of the Director of Mental Health and Addiction Services continued to work with Waka Kotahi New Zealand Transport Agency (Waka Kotahi), 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 driver licence to be reinstated, the person must undergo an assessment of how well they are managing their substance use or addictive behaviours at an approved assessment centre. 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 who have an opioid dependence to access treatment, including substitution therapy, which 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*.<sup>26</sup> OST services in Aotearoa New Zealand are expected to provide a standardised approach underpinned by concepts of centring the person, family and whānau at the heart of treatment, recovery, wellbeing and citizenship. To help services take this approach, the *New Zealand Practice Guidelines for Opioid Substitution Treatment*<sup>27</sup> provides clinical and procedural guidance for specialist services and primary health care providers who deliver OST.

<sup>26</sup> For more information about the *New Zealand Gazette*, see the Gazette website at: <https://gazette.govt.nz/>.

<sup>27</sup> Ministry of Health. 2014. *New Zealand Practice Guidelines for Opioid Substitution Treatment*. Wellington: Ministry of Health. URL: [www.health.govt.nz/publication/new-zealand-practice-guidelines-opioid-substitution-treatment-2014](http://www.health.govt.nz/publication/new-zealand-practice-guidelines-opioid-substitution-treatment-2014) (accessed 27 October 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 (OST) Service Audit and Review Tool.<sup>28</sup>

In summary, in 2020:

- 5,542 people received OST
- 79.6 percent of these people were New Zealand European, 15.6 percent were Māori, 1.3 percent were Pacific peoples and 3.5 percent were of other ethnicities
- 65.3 percent of clients receiving OST were over 45 years old
- 27.1 percent of people receiving OST were being treated by a general practitioner in a shared-care arrangement.<sup>29</sup>

## 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. In 2020, in all, 71.9 percent of OST clients received that treatment from specialist services.

**Primary health:** Specialist addiction services work together with primary health care. This approach allows specialist services to focus on clients who have the highest need and normalises the treatment process. In 2020, 27.1 percent of OST clients received that treatment from their general practitioner. The Ministry's target for service provision is 50 : 50 between primary and specialist health care services. Figure 42 presents the percentage of people receiving OST from specialist services and general practice in each DHB in 2020.

<sup>28</sup> For more information, see Ministry of Health. 2014. *Specialist Opioid Substitution Treatment (OST) Service Audit and Review Tool*. Wellington: Ministry of Health. URL: [www.health.govt.nz/publication/specialist-opioid-substitution-treatment-ost-service-audit-and-review-tool](http://www.health.govt.nz/publication/specialist-opioid-substitution-treatment-ost-service-audit-and-review-tool) (accessed 27 October 2021).

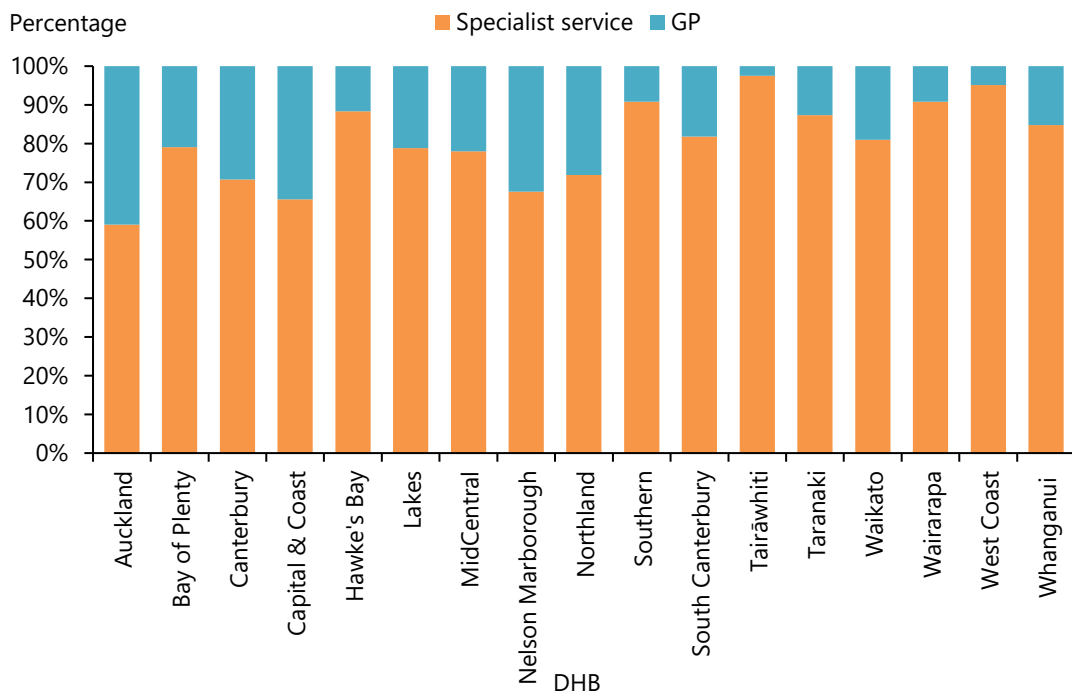
<sup>29</sup> Data provided by OST services in six-monthly reports. These six-monthly reports do not collect data by National Health Index (NHI) numbers. The Aotearoa New Zealand total is a sum of the DHB figures, so it can double count people who had services from more than one DHB.



**Te Kāwanatanga o Aotearoa, Department of Corrections:** When a person receiving OST goes to prison, Te Kāwanatanga o Aotearoa Department of Corrections (Te Kāwanatanga) ensures that the person continues to receive OST services, including psychosocial support and treatment from specialist services. In 2020, 1.0 percent of OST clients received that treatment from Te Kāwanatanga. Service providers and Te Kāwanatanga work together to initiate OST as appropriate for people who are imprisoned.

Figure 43 shows the number of people receiving OST from each of these types of providers each year from 2008 to 2020.

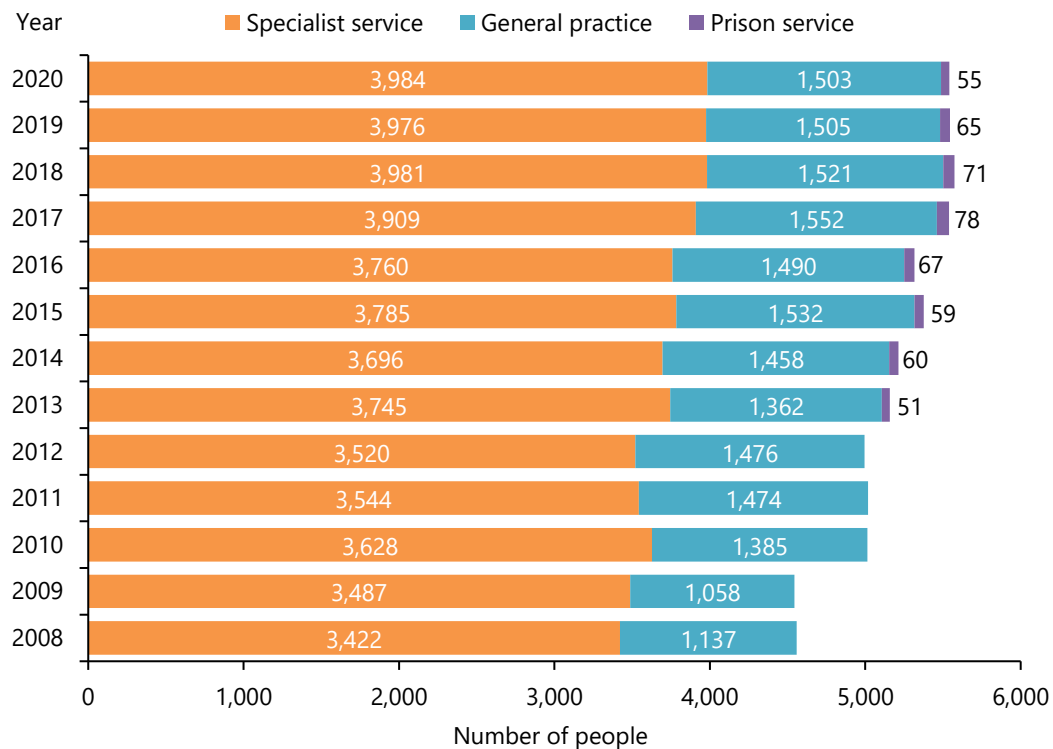
**Figure 42: Percentage of people receiving opioid substitution treatment from specialist services and general practice, by DHB, 1 January to 31 December 2020**



Notes: 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 43: Number of people receiving opioid substitution treatment from a specialist service, general practice or prison service, 2008–2020**



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.

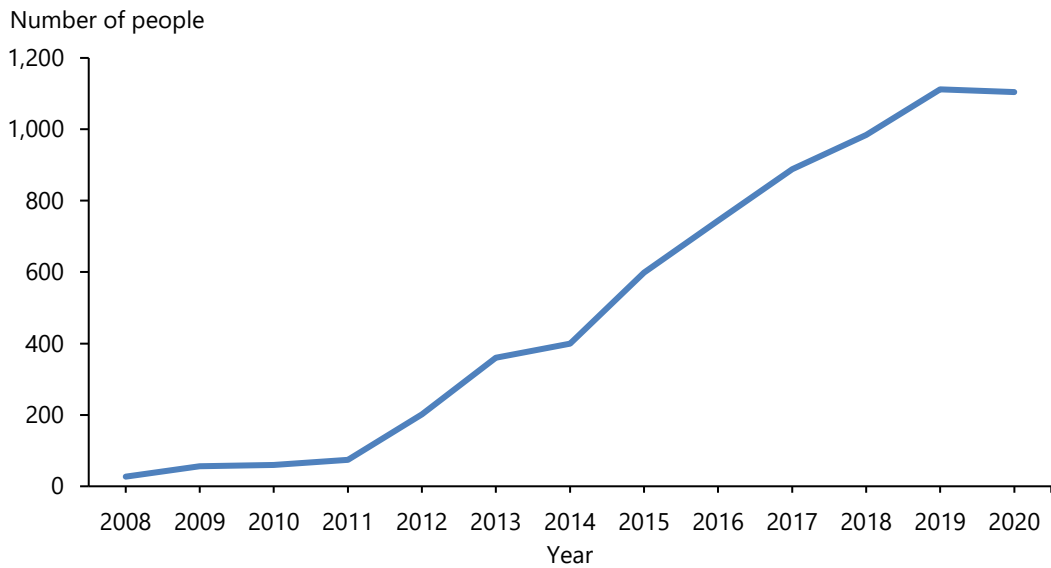
The two types of pharmacotherapy are:

1. maintenance therapy – using opioid substitutes to remain on a stable dose
2. detox – using opioid substitutes to gradually withdraw from the substitute so the client can be free of all opioid substances.

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

In 2012, the Pharmaceutical Management Agency (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 44 presents the number of people prescribed suboxone from 2008 to 2020. In 2020, 19.9 percent of clients were prescribed suboxone.

**Figure 44: Number of people prescribed suboxone, 2008–2020**

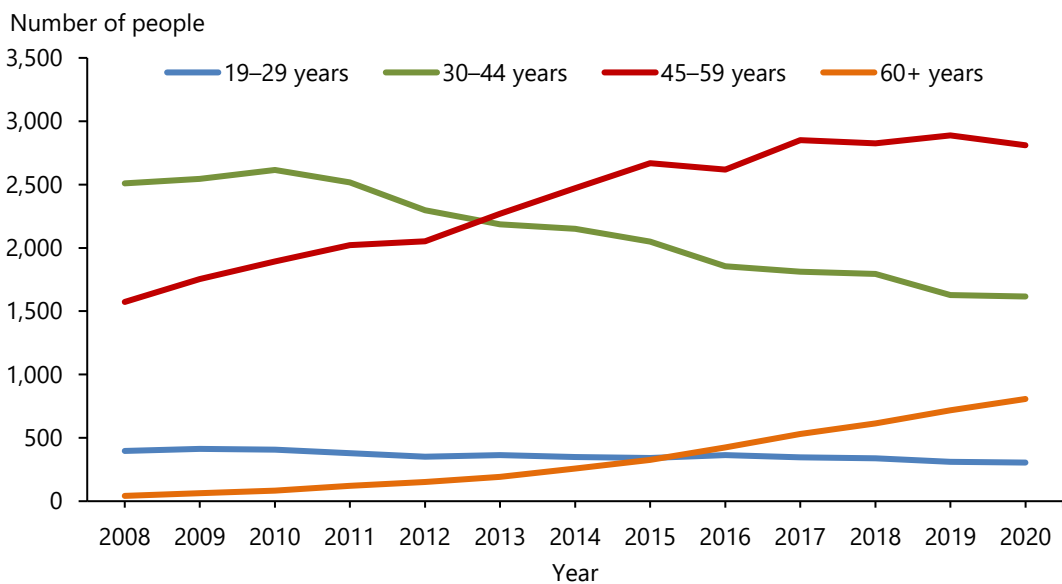


Source: Data provided by OST services in July to December six-monthly reports.

## The ageing population of opioid substitution treatment clients

OST clients are an ageing population. Figure 45 shows how clients in older groups have been increasing in number from 2008 to 2020 to the point that those over 45 years of age are now the most likely age group to be receiving OST. In 2020, the majority of clients (65.3 percent) were over 45 years old. Treating an ageing population brings with it more health complications.

**Figure 45: Number of opioid substitution treatment clients, by age group, 2008–2020**



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

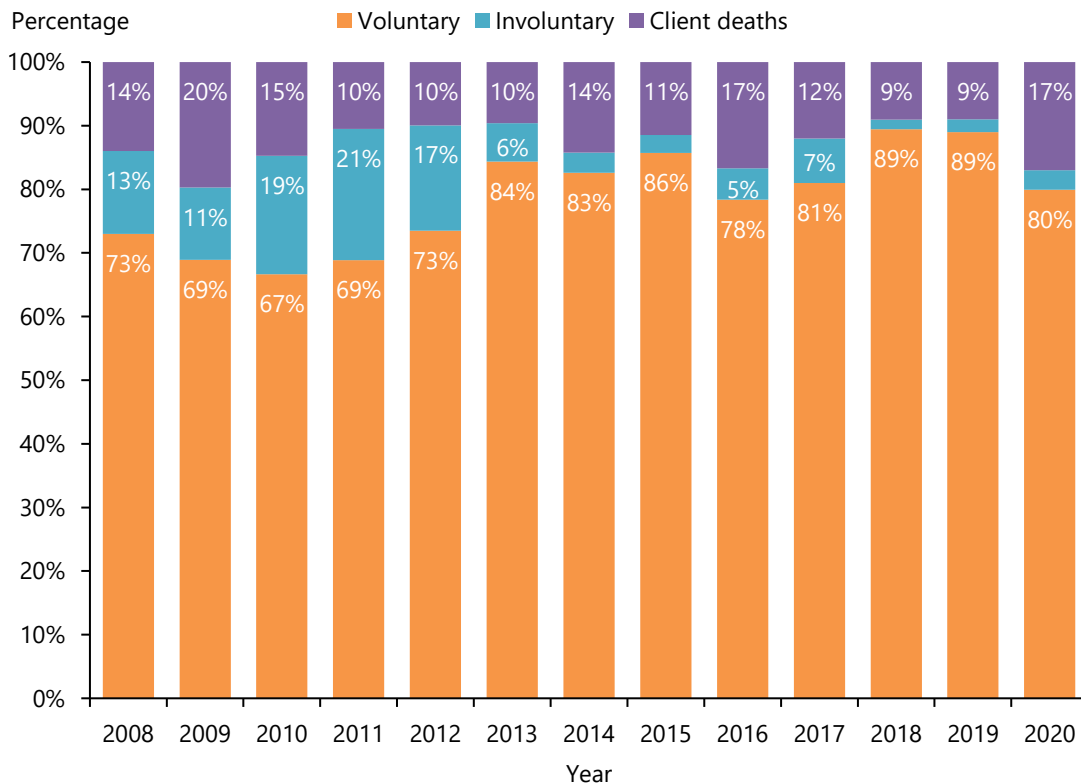
## Exit from opioid substitution treatment

In summary, in 2020:

- 287 people voluntarily withdrew from OST, which accounted for 80 percent of all people who exited from OST that year. There was a total of 11 involuntary withdrawals (3 percent of all withdrawals). Involuntary withdrawals are the result of behavioural risks that jeopardise the safety of the client or others.
- 61 people who had been 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 were the result of a range of other causes, such as cancer and cardiovascular disease.

Figure 46 gives an overview of the reasons for withdrawal (voluntary, involuntary or death) over time, from 2008 to 2020.

**Figure 46: Percentage of withdrawals from opioid substitution treatment programmes, by reason (voluntary, involuntary or death), 2008–2020**



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 2020. Table A2 shows the types of orders granted over the same period.

**Table A1: Applications for compulsory treatment orders or extensions, 2004–2020**

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
2020	5,874	5,137	62	599	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, 2004–2020**

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
2020	5,137	3,021	1,826	45	3	242

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 2020, Capital & Coast DHB provided data that included a single client with a high number of seclusion hours. We have treated the data on this client 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 Table A3 below.

**Table A3: Seclusion data in Aotearoa New Zealand mental health services, 1 January to 31 December 2020**

	Excluding outliers	Including outliers
Number of people secluded in adult services	933 people	934 people
Number of hours of seclusion in adult services	44,804 hours	47,195 hours
Number of seclusion events in adult services	2,075 events	2,555 events
Average number of seclusion events per person	2.2 events	2.7 events
Number of seclusion events per 1,000 bed nights	8.7 events	10.7 events
Number of people secluded per 100,000 population	31.0 people	31.1 people
Number of seclusion events per 100,000 population	69.1 events	85.0 events
Average duration per seclusion event	21.6 hours	18.5 hours
Percentage of seclusion events lasting under 24 hours	75 percent	78 percent
Percentage of seclusion events lasting over 48 hours	13 percent	11 percent
Decrease in people secluded in adult services since 2009	13 percent	13 percent
Decrease in hours spent in seclusion since 2009	51 percent	48 percent
Decrease in hours spent in seclusion since 2019	7 percent	15 percent
Increase in seclusion events since 2017	19 percent	minus 11 percent

Sources: PRIMHD data (extracted 1 July 2021) and manual data from Southern, Waitematā and Whanganui DHBs.

# Substance Addiction (Compulsory Assessment and Treatment) Act

## 2017 data covering 1 July 2020 to 30 June 2021

The following data covers only activities that occurred from 1 July 2020 to 30 June 2021. There may be cases where a person started the early stages under the Substance Addiction Act at the end of June 2020 and continued through 2021 or first came under the Act in June 2021. Due to this, there are discrepancies in reporting, where a higher number of people had compulsory treatment orders made or extended than were detained under the Substance Addiction Act.

### 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:

- neuro-adaption to the substance
- craving for the substance
- unsuccessful efforts to control the use of substance
- use of the substances 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 criteria are:

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



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

<b>Application</b>	<b>Section 14</b> 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.
<b>Assessment</b>	<b>Section 22</b> 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, the specialist must then assess whether that person's capacity to make informed decisions about treatment has been severely impaired.
<b>Certification</b>	<b>Section 23</b> After assessment, if the approved specialist considers that the person meets the criteria for compulsory treatment, the specialist signs 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.
<b>Treatment plan</b>	<b>Section 29</b> 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 patient's compulsory status.
<b>Detention</b>	<b>Section 30</b> 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.
<b>Review</b>	<b>Section 32</b> The court reviews the compulsory status of the patient. If the judge is satisfied that the patient meets the criteria for compulsory treatment, then that judge can make a compulsory treatment order (CTO), 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 an approach that aims to enhance mana. 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, search 'SACAT resources' on the Ministry of Health website ([health.govt.nz](https://www.health.govt.nz)).

## Nova Trust

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

## Substance Addiction Act usage from 1 July 2020 to 30 June 2021

This report interprets 'detained' to mean that an approved specialist has signed a compulsory treatment certificate for a patient.<sup>30</sup> After an approved specialist has signed a compulsory treatment certificate, most patients first need to be detained in a medical ward or a specialist withdrawal management facility for a period of stabilisation because of their co-occurring physical health needs. Following this, if it is found that the patient still requires compulsory treatment, a judge may grant a CTO.

In the period 1 July 2020 to 30 June 2021, there were 37 people detained under the Substance Addiction Act,<sup>31</sup> and 28 CTOs were made. The courts extended 20 compulsory treatment orders. Among those subject to compulsory treatment certificates, 21 were women and 16 were men. They tended to be in older age groups, with 51.4 percent over 50 years old. The most common ethnic group in this cohort was New Zealand European. Figure A1 demonstrates the ethnicity make-up of this group.

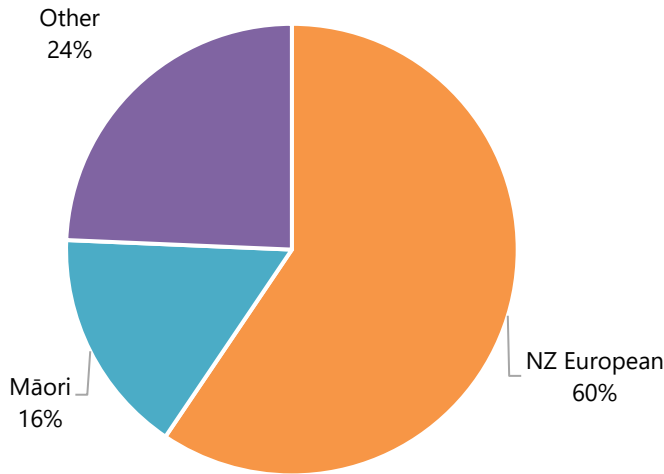
Over half of all patients with compulsory treatment certificates were referred from DHBs in the Northern region.<sup>32</sup>

<sup>30</sup> Note that 'detention' may not solely refer to treatment at Nova STAR.

<sup>31</sup> PRIMHD data, extracted 9 August 2021.

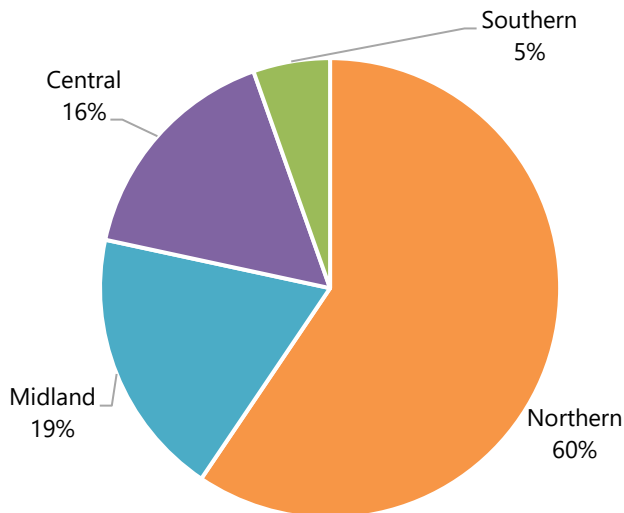
<sup>32</sup> The Northern region covers Auckland, Counties Manukau, Northland and Waitematā DHBs.

**Figure A1: Percentage of patients subject to compulsory treatment certificates, by ethnicity, 1 July 2020 to 30 June 2021**



Source: PRIMHD data, extracted 9 August 2021.

**Figure A2: Percentage of patients subject to compulsory treatment certificates, by referring region, 1 July 2020 to 30 June 2021**

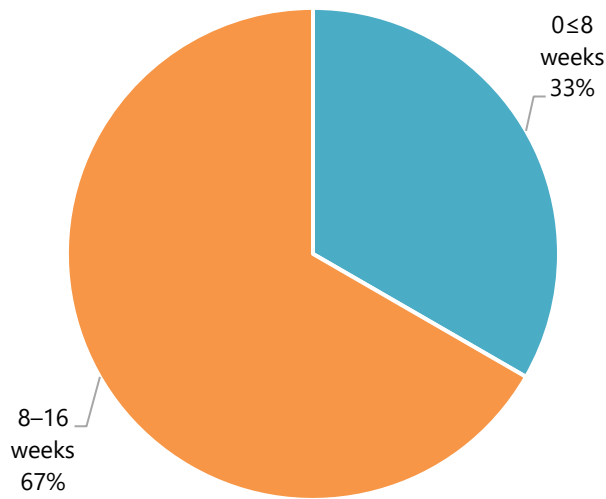


Notes: 'Northern' includes Auckland, Counties Manukau, Northland and Waitematā DHBs; 'Midland' includes Bay of Plenty, Lakes, Tairāwhiti, Taranaki and Waikato DHBs; 'Central' includes Capital & Coast, Hawke's Bay, Hutt Valley, MidCentral, Wairarapa and Whanganui DHBs; 'Southern' includes Canterbury, Nelson Marlborough, Southern, South Canterbury and West Coast DHBs.

Source: PRIMHD data, extracted 9 August 2021.

The average length of detention for those who had CTOs made or extended was 12 weeks and four days (89 days). Among these patients, 33 percent were detained for up to eight weeks, which is within the first period of compulsory treatment set out in the Substance Addiction Act, while 67 percent were detained for a period of between 8 and 16 weeks, requiring a CTO extension (see Figure A3).

**Figure A3: Percentage of patients subject to compulsory treatment orders, by number of weeks in detention, 1 July 2020 to 30 June 2021**



Source: PRIMHD data, extracted 9 August 2021.

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 that clinician is satisfied 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, CTO or CTO extension.

PRIMHD records show that among service users who were discharged from the Substance Addiction Act during this period:

- 30.2 percent received additional inpatient care<sup>33</sup>
- 74.4 percent engaged with individual treatments in outpatient services
- 46.5 percent had family meetings arranged
- 67.4 percent had supplementary consumer records<sup>34</sup>
- 62.8 percent had wellness plans.<sup>35</sup>

If a service user was discharged in late June 2021, 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.

Data from PRIMHD is only able to measure mental health and addiction 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.

<sup>33</sup> PRIMHD data, extracted 13 August 2021.

<sup>34</sup> Supplementary consumer records identify social indicators that can impact on the recovery of tāngata whai ora.

<sup>35</sup> PRIMHD data, extracted 13 August 2021.