



Office of the Director of Mental Health and Addiction Services

Regulatory Report
1 July 2020 to 30 June 2021

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Foreword

Welcome to our regulatory report for the financial year from 1 July 2020 to 30 June 2021. As we've indicated, we have changed the reporting period for this report to financial year rather than calendar year to align with other annual reporting from Manatū Hauora. This means data is not comparable with past reports from my office.

This report presents data about the use of compulsory assessment and treatment legislation in Aotearoa New Zealand, including the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the Intellectual Disability Care Act). To get a full picture of mental health and addiction services in Aotearoa New Zealand, I recommend you read this report in conjunction with updates on our website, in particular the **Mental Health and Addiction monitoring, reporting and data** page.

As the Director of Mental Health and Addiction, I am responsible for the general administration of the relevant legislation under the direction of the Minister of Health and the Director-General of Health. My functions and powers under the Acts listed above allow Manatū Hauora to provide guidance and oversight to mental health, addiction, and intellectual disability services. This means it is my role to make sure that anyone placed under compulsory treatment in Aotearoa New Zealand is well cared for and all legislative requirements are followed.

I also provide the overall regulation of the services and have powers that enable me to intervene when required. Since 1 July 2022, I also assumed duties under the Intellectual Disability Care Act.

Since 2005, the Office of the Director of Mental Health and Addiction Services has been reporting annually on the activities we undertake. The main purpose of the report is to present information and statistics that serve as barometers of quality for our mental health and addiction services. We actively monitor services so that we can be assured that people in Aotearoa New Zealand are receiving quality mental health care. It is encouraging to see a downward trend in the use of seclusion in this report, as we are committed to the goal of reducing and eventually eliminating seclusion. The use of compulsory assessment treatment remains steady with previous years, including the use of indefinite compulsory treatment orders. From October 2023, due to amendments to the Mental Health Act, these orders will not be legal and so services are encouraged to start work now on reducing the number of people who are under indefinite treatment orders.

Other activity in the Mental Health and Addiction group at Manatū Hauora is the work to repeal and replace the current Mental Health Act, as recommended in He Ara Oranga.¹ It is clear that this legislation has not kept pace with the shift towards a recovery and wellbeing approach to care. My office is working closely with the team developing the policy advice for this piece of work as part of Manatū Hauora's commitment to upholding the rights of

¹ 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.

tāngata whaiora and ensuring service quality. At the same time, we are also working on immediate, short-term improvements under the current legislation. In September 2020 we issued the first of a series of guidelines that can be used within the parameters of the current Mental Health Act to acknowledge rights-based approaches and give greater emphasis to our obligations under Te Tiriti o Waitangi.

On 1 July 2022, the health reforms came into effect with the establishment of Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority were established. My role as the Director of both Mental Health and Addiction Services has remained within the Ministry of Health, which will have a strengthened stewardship role in the health system.

The priorities for my office are to ensure there remains a consistent and high-quality level of care provided to tāngata whai ora receiving treatment under the Mental Health Act, Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (Substance Addiction Act), and Intellectual Disability Care Act through this period of change. We are also working closely with Te Whatu Ora, Te Aka Whai Ora, and Whaikaha – Ministry for Disabled People to identify opportunities through the reforms to improve care and services for these tāngata whai ora.

I'd like to take this opportunity to thank the mental health, addiction, and intellectual disability workforce in Aotearoa New Zealand. While the health system undergoes its largest ever reform programme, this dedicated group continues to provide a critical service to some of our most vulnerable. We know that there is always high demand for services, which are provided by an increasingly stretched workforce. There is always more to do to better grow, strengthen, and support our workforce, and we are working hard to ensure that the programmes underway are successful in providing sustainable solutions.

Noho ora mai

Dr John Crawshaw
Director of Mental Health
Director of Addiction Services

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Use of the Mental Health Act

In summary, in the period 1 July 2020 to 30 June 2021:

- 11,149 people (6.0% of specialist mental health and addiction service users) were subject to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act)²
- about 5,645 people were subject to either compulsory assessment or compulsory treatment under the Mental Health Act on the last day of this period
- 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 or 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.^{3, 4}

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

³ 'Other ethnicities' encompasses all ethnicities except for Māori and Pacific peoples.

⁴ Source: Programme for the Integration of Mental Health Data (PRIMHD) data (extracted 3 June 2022).

The Mental Health Act process

Court applications in 2020/21⁵

Clinicians made 5,902 applications for compulsory treatment orders or extensions under the Mental Health Act. Of these applications, the courts granted 5,241 (88.8%).

Approximately 1,330 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 29 cases (2.2%) and dismissed 731 applications (54.6%). The remaining applications were withdrawn.

Compulsory assessment and treatment in 2020/21

On the last day of the 2020/21 financial year, a total of 5,645 people were subject to either compulsory assessment or compulsory treatment under the Mental Health Act.⁶

On average within each month, the assessment provisions of the Mental Health Act were applied as follows.

| | | |
|----------------------|---|----------------------------------|
| Section 11 | 635 people were subject to an initial assessment. | 12 people per 100,000 population |
| Section 13 | 666 people were subject to a second period of assessment. | 13 people per 100,000 population |
| Section 14(4) | 465 people were subject to an application for a compulsory treatment order. | 9 people per 100,000 population |

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Waikato District Health Boards (DHBs).

⁵ Source: Ministry of Justice's case management system data (extracted 9 May 2022).

⁶ Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland, Lakes (compulsory treatment orders) and Waikato (assessments) DHBs.

In Aotearoa New Zealand, on an average day in the 2020/21 financial year, the treatment provisions of the Mental Health Act were applied as follows.

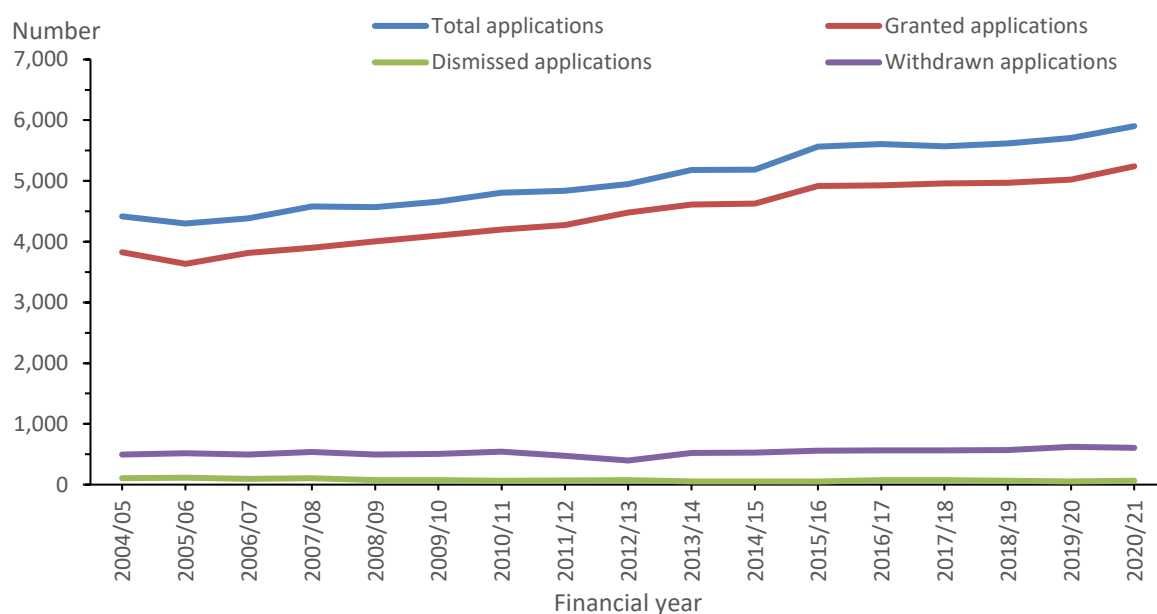
| | | |
|-------------------|--|----------------------------------|
| Section 29 | 4,608 people were subject to a community treatment order. | 90 people per 100,000 population |
| Section 30 | 673 people were subject to an inpatient treatment order. | 13 people per 100,000 population |
| Section 31 | 146 people were on temporary leave from an inpatient unit. | 3 people per 100,000 population |

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

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

Figure 1 shows that the number of compulsory treatment orders and extensions that clinicians have applied for and that the courts have granted since 2004/05. It also shows the number of applications that were dismissed or withdrawn.

Figure 1: Applications and outcomes for compulsory treatment orders and extensions, 2004/05–2020/21

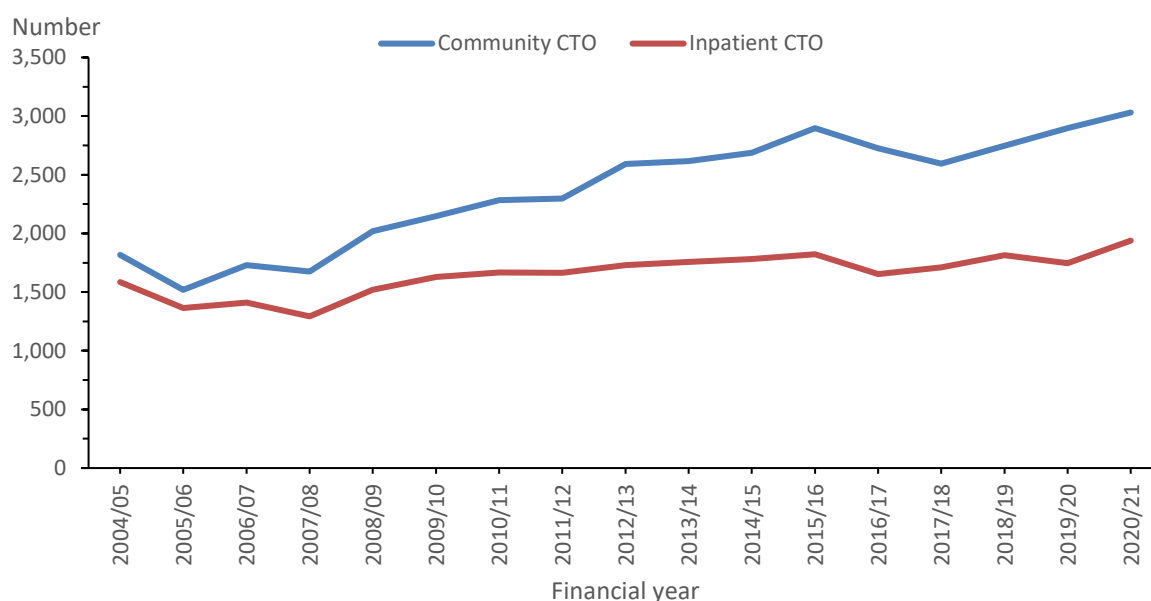


Notes: This figure represents data entered into the case management system (CMS). The CMS is a live operational database. Figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System as at 9 May 2022.

The gap between the number of community-based compulsory treatment orders and the number of inpatient compulsory treatment orders appears to be increasing slowly over time. Figure 2 shows the number of applications for community and inpatient compulsory treatment orders that courts have granted since 2004/05.

Figure 2: Number of granted compulsory treatment orders and extensions, community and inpatient, 2004/05–2020/21



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 9 May 2022.

Comparing compulsory assessment and treatment among DHBs

Table 1 shows the average number of people per month from 1 July 2020 to 30 June 2021 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 the same period in each DHB. The figures that follow present the average number of people subject to a compulsory treatment order on a given day, focusing specifically on either community treatment orders (Figure 3) or inpatient treatment orders (Figure 4).

Table 1: Average number of people each month required to undergo assessment under section 11, 13 or 14(4) of the Mental Health Act per 100,000 population, by DHB, 1 July 2020 to 30 June 2021

| DHB | s 11 | s 13 | s 14(4) | DHB | s 11 | s 13 | s 14(4) |
|--------------------|------|------|---------|-------------------------|-----------|-----------|----------|
| Auckland | 16 | 19 | 12 | Northland | 16 | 19 | 13 |
| Bay of Plenty | 15 | 12 | 6 | South Canterbury | 8 | 5 | 4 |
| Canterbury | 12 | 13 | 10 | Southern | 12 | 11 | 7 |
| Capital & Coast | 12 | 14 | 10 | Tairāwhiti | 19 | 12 | 7 |
| Counties Manukau | 9 | 11 | 8 | Taranaki | 17 | 13 | 6 |
| Hawke's Bay | 12 | 10 | 6 | Waikato | 20 | 19 | 13 |
| Hutt Valley | 16 | 17 | 9 | Wairarapa | 7 | 4 | 6 |
| Lakes | 14 | 12 | 7 | Waitematā | 10 | 13 | 10 |
| MidCentral | 10 | 9 | 8 | West Coast | 11 | 8 | 6 |
| Nelson Marlborough | 9 | 10 | 11 | Whanganui | 11 | 13 | 9 |
| | | | | National average | 12 | 13 | 9 |

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

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Waikato DHBs.

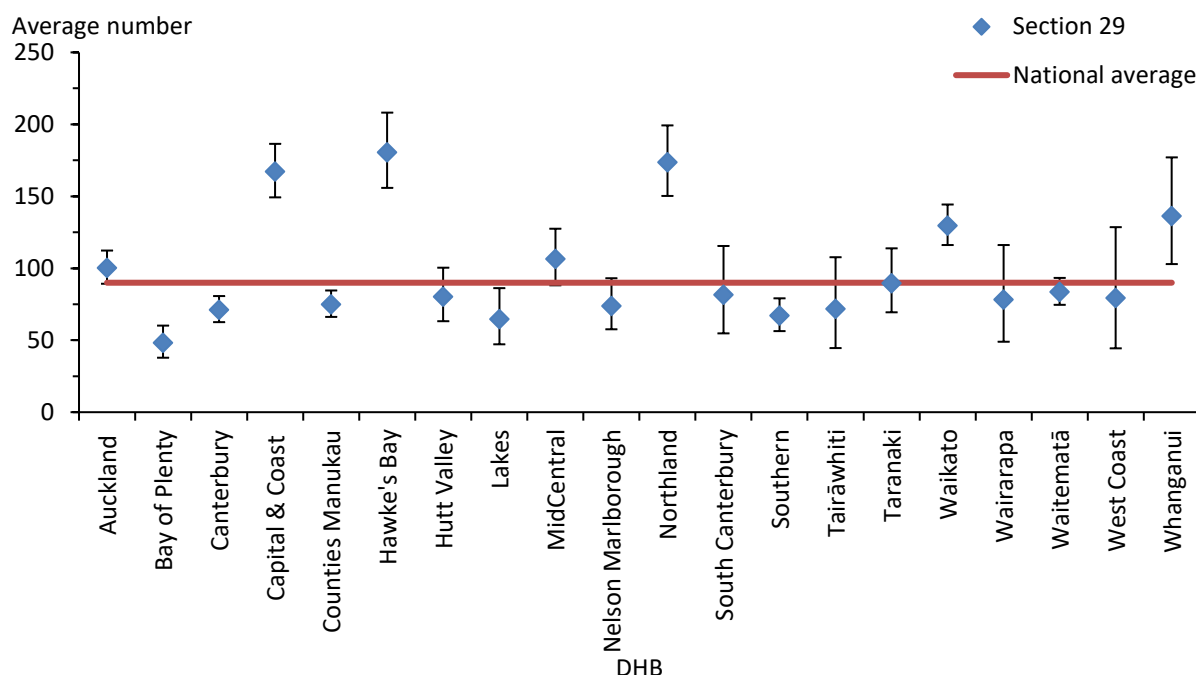
Table 2: Average number of people on a given day subject to section 29, 30 or 31 of the Mental Health Act per 100,000 population, by DHB, 1 July 2020 to 30 June 2021

| DHB | s 29 | s 30 | s 31 | DHB | s 29 | s 30 | s 31 |
|--------------------|------|------|------|-------------------------|-----------|-----------|----------|
| Auckland | 100 | 13 | 0 | Northland | 174 | 8 | 1 |
| Bay of Plenty | 48 | 9 | 4 | South Canterbury | 82 | 5 | 3 |
| Canterbury | 71 | 16 | 6 | Southern | 67 | 12 | 3 |
| Capital & Coast | 167 | 38 | 5 | Tairāwhiti | 72 | 4 | 3 |
| Counties Manukau | 75 | 12 | 1 | Taranaki | 90 | 5 | 1 |
| Hawke's Bay | 181 | 23 | 18 | Waikato | 130 | 16 | 2 |
| Hutt Valley | 80 | 8 | 2 | Wairarapa | 78 | 2 | 2 |
| Lakes | 65 | 5 | 2 | Waitematā | 84 | 11 | 1 |
| MidCentral | 107 | 9 | 2 | West Coast | 80 | 9 | 4 |
| Nelson Marlborough | 74 | 8 | - | Whanganui | 136 | 22 | 3 |
| | | | | National average | 90 | 13 | 3 |

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

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

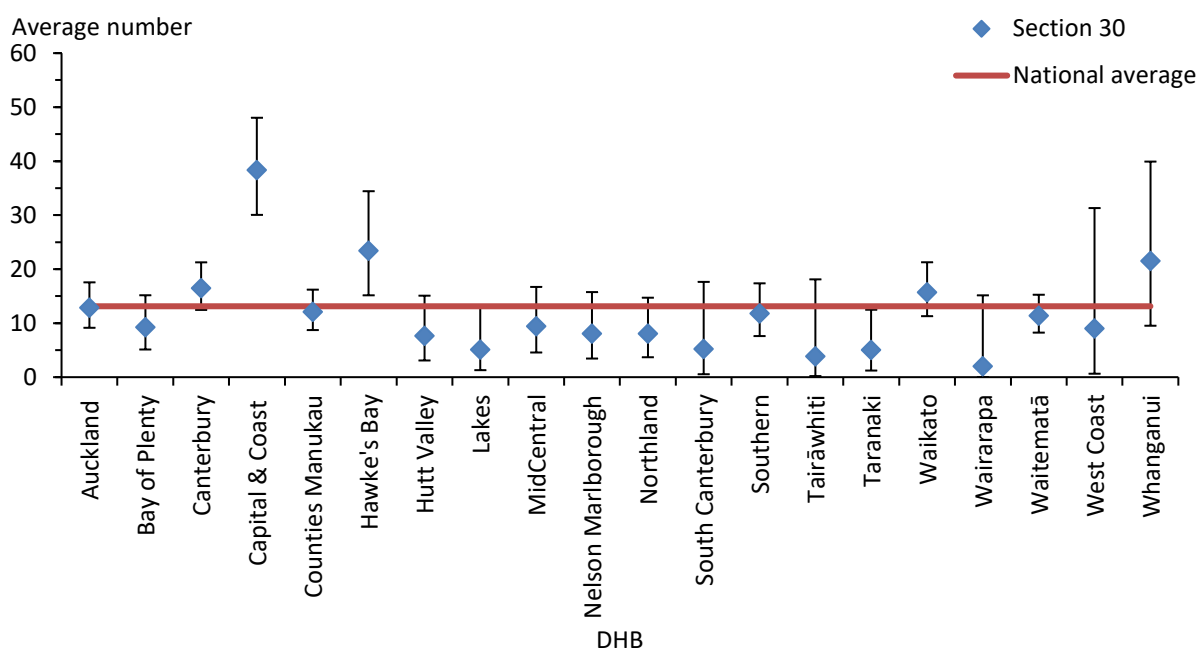
Figure 3: Average number of people on a given day subject to a community treatment order (section 29) per 100,000 population, by DHB, 1 July 2020 to 30 June 2021



Notes: 'On a given day' is the average of the last day of each month. This graph shows confidence intervals (for 99% 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 3 June 2022) and manual data from Auckland and Lakes DHBs.

Figure 4: Average number of people on a given day subject to an inpatient treatment order (section 30) per 100,000 population, by DHB, 1 July 2020 to 30 June 2021



Notes: 'On a given day' is the average of the last day of each month. This graph shows confidence intervals (for 99% 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.

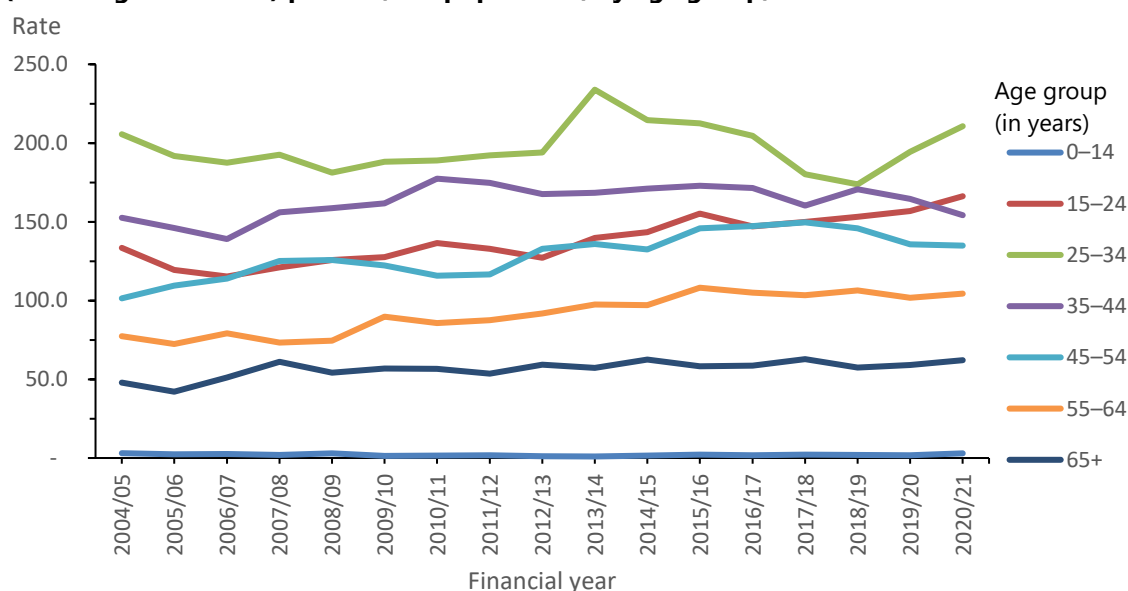
Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

Compulsory treatment by age and gender

Of people aged 15 years and over, those aged 25–34 years were the age group most likely to be subject to a compulsory treatment order (351 people per 100,000 population), while people aged 65 years or over were the least likely (129 per 100,000).⁷ Figure 5 shows the rate of people subject to compulsory treatment applications per 100,000 population by age group.

Males were more likely to be subject to a compulsory treatment order application (117 per 100,000 population) than females (86 per 100,000) (Figure 6).⁸

Figure 5: Rate of people subject to compulsory treatment order applications (including extensions) per 100,000 population, by age group, 2004/05–2020/21



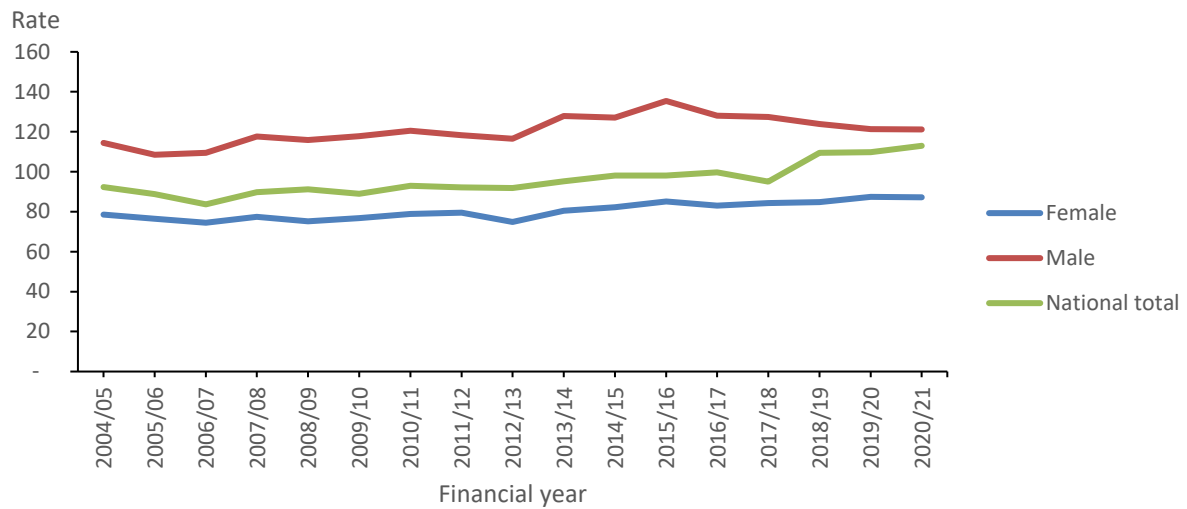
Notes: This figure represents data entered into the case management system (CMS). The CMS is a live operational database. Figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System as at 9 May 2022.

⁷ Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

⁸ Source: Ministry of Justice's case management system data (extracted 9 May 2022).

Figure 6: Rate of people subject to compulsory treatment order applications (including extensions) per 100,000 population, by gender, 2004/05–2020/21



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. Due to the design of the system, only 2 gender categories are represented here. The CMS includes an 'other' category; however, the size of this group is too small to appear on the figure.

Source: Ministry of Justice Integrated Sector Intelligence System as at 9 May 2022.

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.

In summary, in the period from 1 July 2020 to 30 June 2021:

- 6.1% of Māori accessed mental health and addiction services, compared with 3.1% of non-Māori
- Māori were 1.8 times more likely than Pacific peoples and 4.0 times more likely than other ethnicities to be subject to a community treatment order⁹
- Māori were 1.6 times more likely than Pacific peoples to be subject to an inpatient treatment order and 3.4 times more likely than other ethnicities
- of all population groups, Māori men were the 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 3.0 times more likely to be subject to indefinite community treatment orders than non-Māori, and 2.9 times more likely to be subject to indefinite inpatient treatment orders than non-Māori
- Māori made up about 17% of Aotearoa New Zealand's population, yet they accounted for 28.3% of all mental health service users
- Pacific peoples made up about 7% of Aotearoa New Zealand's population and accounted for 6.0% of all mental health service users
- among service users, 30.3% of Māori, 27.7% of Pacific peoples and 28.1% of other ethnicities were under 20 years of age
- among service users under a community treatment order, 51% of Māori and 53% of Pacific peoples were living in the most deprived areas (quintile 5), compared with 27% of non-Māori and non-Pacific peoples.¹⁰

⁹ These ratios are based on the age-standardised rates of the Māori, Pacific peoples and other populations. Source: PRIMHD data (extracted 3 June 2022). 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.

¹⁰ Source: PRIMHD data (extracted 3 June 2022). Deprivation quintiles are ranked 1–5, where 1 represents areas with the least deprived scores and 5 areas with the most deprived scores.

Compulsory assessment

From 1 July 2020 to 30 June 2021, Māori were more likely to undergo compulsory assessment than other ethnicities. Table 3 shows the number of people subject to compulsory mental health assessment on a national level by ethnicity and the rate per 100,000 population.

Table 3: Number and rate of people required to undergo assessment under section 11, 13 or 14(4) of the Mental Health Act, by ethnicity, 1 July 2020 to 30 June 2021

| Ethnicity | Section 11 | | Section 13 | | Section 14(4) | |
|-----------------------|--------------|----------|--------------|----------|---------------|----------|
| | Number | Rate | Number | Rate | Number | Rate |
| Māori | 1,991 | 229.1 | 1,772 | 203.9 | 1,252 | 144.1 |
| Pacific peoples | 381 | 109.1 | 375 | 107.3 | 306 | 87.6 |
| Other | 3,520 | 90.1 | 2,934 | 75.1 | 1,944 | 49.8 |
| National total | 5,892 | – | 5,081 | – | 3,502 | – |

Notes: Section 14(4) data may also include PRIMHD records for section 15(1) and 15(2). These section 15 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 occurs because of local differences in the approach to reporting.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Waikato DHB.

Compulsory treatment orders

Table 4 shows that Māori were more likely to be subject to community and inpatient treatment orders than Pacific peoples and other ethnicities. These figures represent people who were subject to a compulsory treatment order during the 2020/21 financial year, rather than the number of individuals who had a compulsory treatment order issued in the same timeframe.

Table 4: Number and rate of people subject to a compulsory treatment order under section 29 or 30 of the Mental Health Act, by ethnicity, 1 July 2020 to 30 June 2021

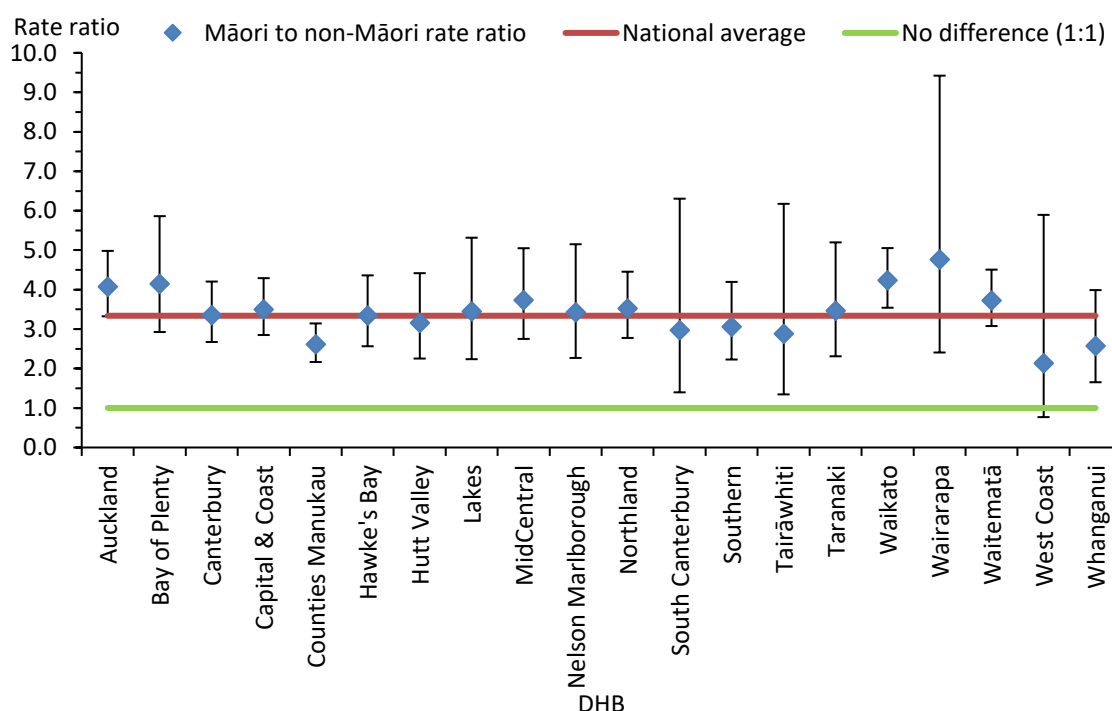
| Ethnicity | Section 29 | | Section 30 | |
|-----------------------|--------------|----------|--------------|----------|
| | Number | Rate | Number | Rate |
| Māori | 2,671 | 307.3 | 784 | 90.2 |
| Pacific peoples | 639 | 182.9 | 202 | 57.8 |
| Other | 3,507 | 89.8 | 1,215 | 31.1 |
| National total | 6,817 | – | 2,201 | – |

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

The following figures show the rate ratio of Māori to non-Māori subject to community treatment orders (Figure 7) and inpatient treatment orders (Figure 8) per 100,000 people in the general population for each DHB. Table 5 and Figure 9 then present the aged-standardised ratio for both community and inpatient treatment orders by ethnicity and gender.

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 a standard 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.

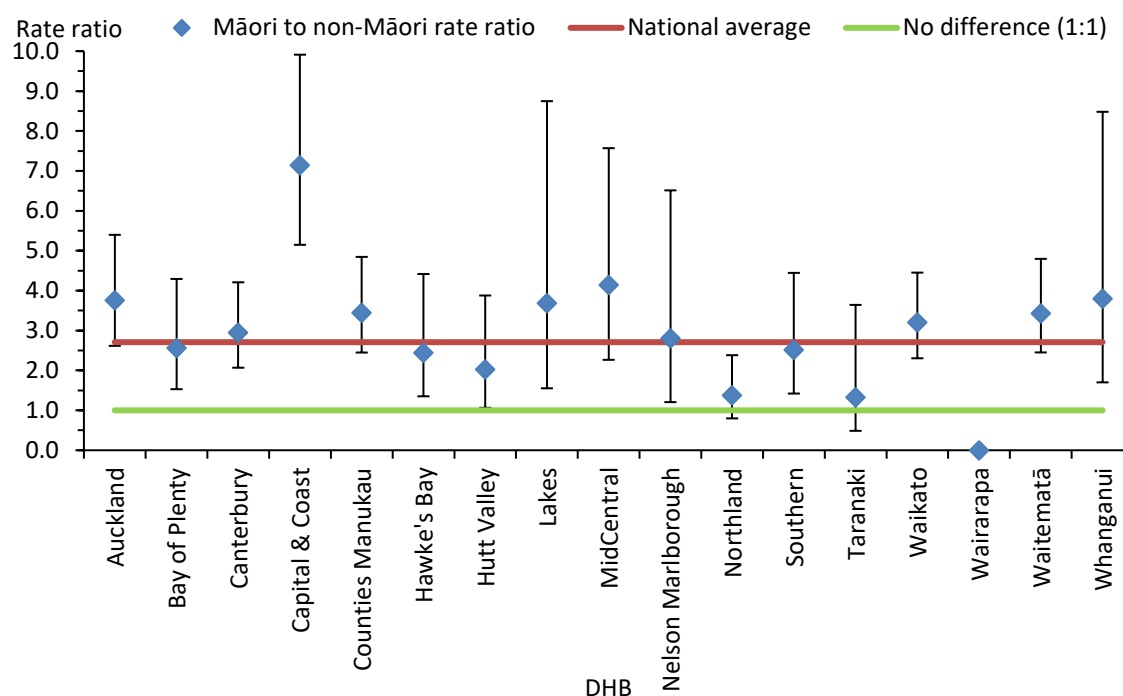
Figure 7: Rate ratio of Māori to non-Māori subject to a community treatment order (section 29) under the Mental Health Act per 100,000 population, by DHB, 1 July 2020 to 30 June 2021



Notes: Confidence intervals (for 99% confidence) have been used to help with 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 3 June 2022) and manual data from Auckland and Lakes DHBs.

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 July 2020 to 30 June 2021



Notes: Confidence intervals (for 99% confidence) have been used to help with 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 had a small population, their rates were very volatile and error bars of the resulting calculations were 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 (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

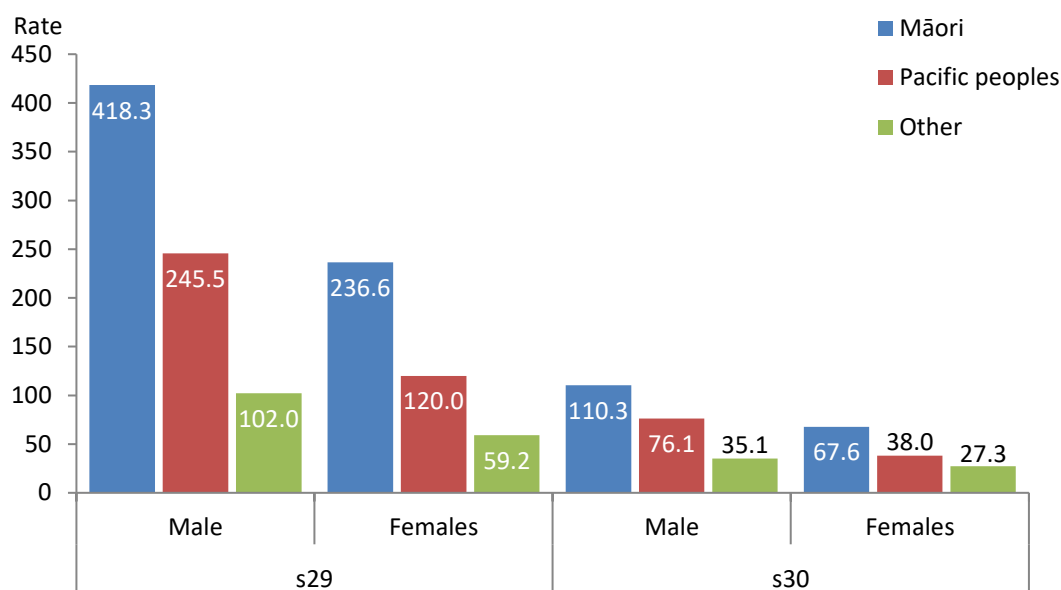
Table 5: Age-standardised rates of people subject to community (section 29) and inpatient (section 30) treatment orders under the Mental Health Act, by gender and ethnicity, 1 July 2020 to 30 June 2021

| | Community treatment orders | | Inpatient treatment orders | |
|---|----------------------------|---------|----------------------------|---------|
| | Male | Female | Male | Female |
| Māori per 100,000 population | 418.3 | 236.6 | 110.3 | 67.6 |
| Pacific peoples per 100,000 population | 245.5 | 120.0 | 76.1 | 38.0 |
| Other ethnicities per 100,000 population | 102.0 | 59.2 | 35.1 | 27.3 |
| Māori to Pacific peoples rate ratio | 1.7:1.0 | 2.0:1.0 | 1.4:1.0 | 1.8:1.0 |
| Pacific peoples to other ethnicities rate ratio | 2.4:1.0 | 2.0:1.0 | 2.2:1.0 | 1.4:1.0 |
| Māori to other ethnicities rate ratio | 4.1:1.0 | 4.0:1.0 | 3.1:1.0 | 2.5:1.0 |

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

Source: PRIMHD data (extracted 3 June 2022). Excludes manual data.

Figure 9: Age-standardised rates of people subject to community (section 29) and inpatient (section 30) treatment orders under the Mental Health Act, by gender and ethnicity, 1 July 2020 to 30 June 2021



Note: Rates per 100,000 are age standardised.

Source: PRIMHD data (extracted 3 June 2022). Excludes manual data.

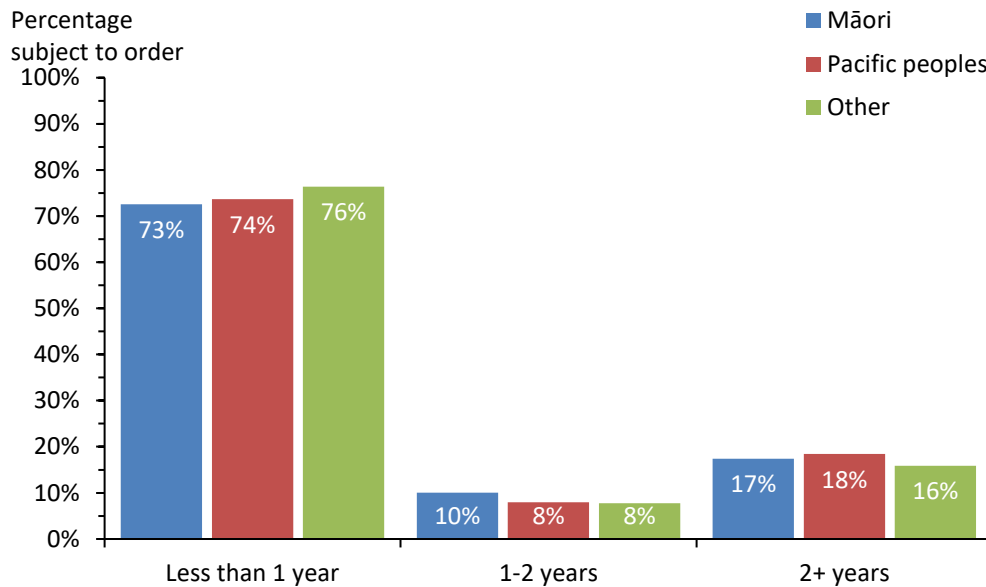
Length of time people are subject to compulsory treatment orders

On average, Māori, Pacific peoples and other ethnicities remain on compulsory treatment orders for a similar amount of time.

For community treatment orders current at any time during the period from 1 January 2009 to 30 June 2021, 72.6% of Māori, 73.6% of Pacific peoples and 76.4% of people from other ethnicities were subject to the order for less than a year (Figure 10).

For inpatient orders current at any time during the period from 2009 to 2020/21, 94.8% of Māori, 95% of Pacific peoples and 95.4% of people from other ethnicities were subject to the order for less than a year (Figure 11).

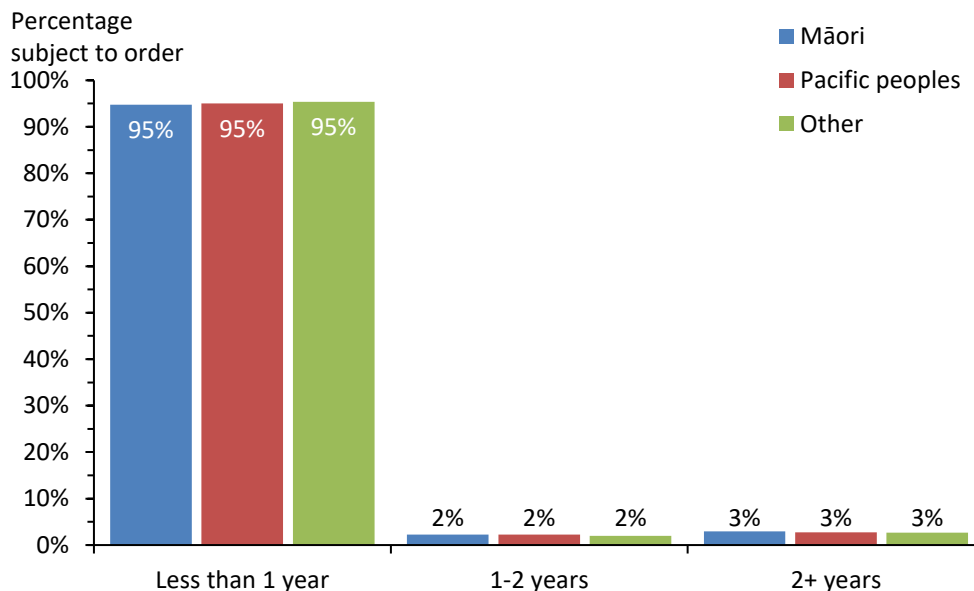
Figure 10: Length of time spent subject to community treatment orders (section 29) under the Mental Health Act, by ethnicity, 1 January 2009 to 30 June 2021



Notes: The data refers to treatment orders that were current at any point in the period from 1 January 2009 to 30 June 2021. Some orders current in this period will have started before 2009. The duration for some orders starting in the most recent 2 years is not yet known as the orders are still current.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

Figure 11: Length of time spent subject to inpatient treatment orders (section 30) under the Mental Health Act, by ethnicity, 1 January 2009 to 30 June 2021

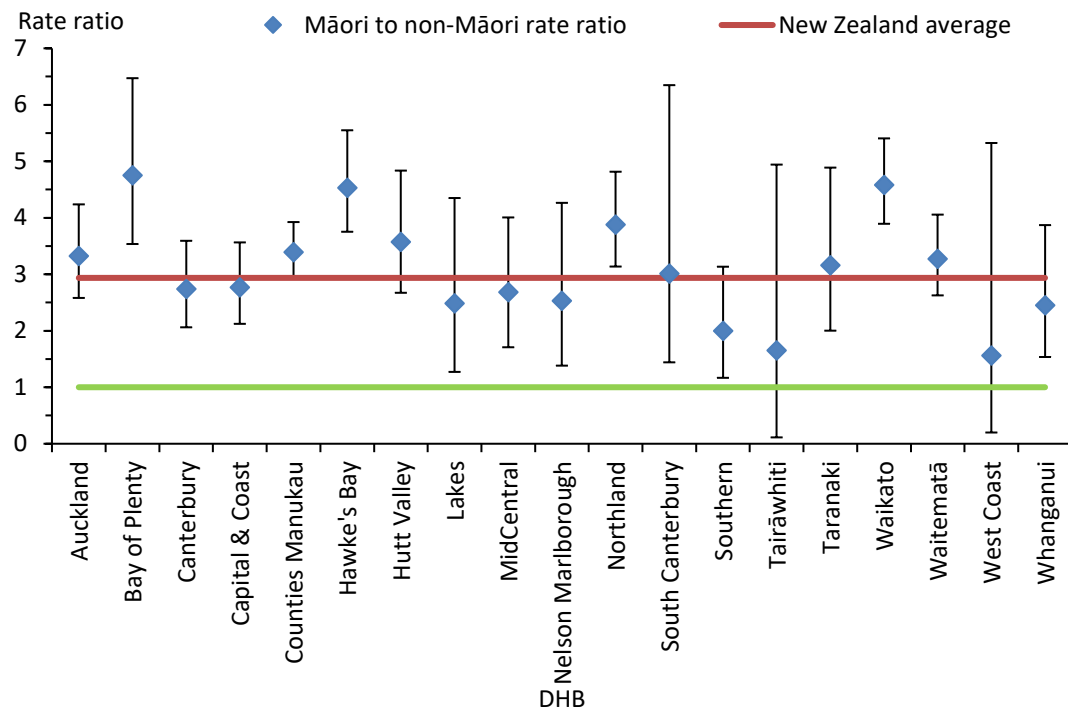


Notes: The data refers to treatment orders that were current at any point in the period from 1 January 2009 to 30 June 2021. Some orders current in this period will have started before 2009. The duration for some orders starting in the most recent 2 years is not yet known as the orders are still current.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

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 in the general population.

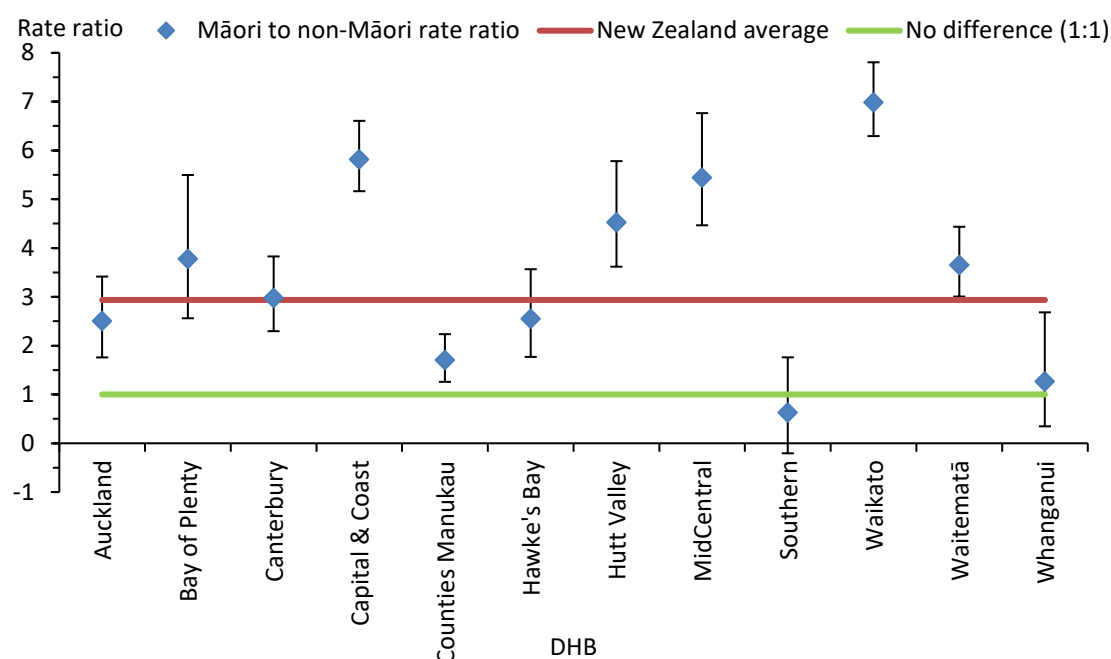
Figure 12: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, by DHB, 1 July 2020 to 30 June 2021



Note: Because small numbers substantially increased the size of its error bar, Wairarapa DHB has been excluded from this figure.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

Figure 13: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, by DHB, 1 July 2020 to 30 June 2021



Notes: Lakes, Northland, South Canterbury, Tairāwhiti and Wairarapa DHBs had no indefinite orders. In Nelson Marlborough, Taranaki and West Coast DHBs, the rate ratio was zero. These DHBs have been excluded from this graph. The ratios in this figure may be too small to be considered meaningful.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland DHB.

Family and whānau consultation under the Mental Health Act

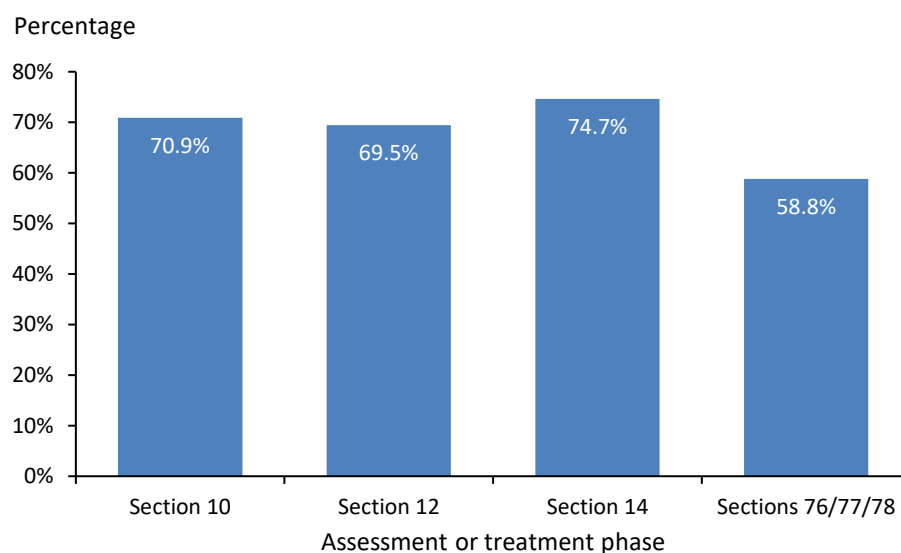
Section 7A of the Mental Health Act requires clinicians to consult family and whānau, unless service providers and clinicians consider it is not reasonably practicable or not in the interests of the person being assessed or receiving the treatment. Clinicians are encouraged to consider that the term '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, from 1 July 2020 to 30 June 2021:

- on average nationally, clinicians consulted 68.5% of families and whānau about Mental Health Act assessment or treatment events
- of all the steps in the Mental Health Act treatment process, clinicians were most likely to consult family and whānau at section 14, where a person is issued with a certificate of final assessment
- DHBs varied in the extent to which their clinicians consulted with families and whānau
- the most common reason why families and whānau were not consulted was that service providers and clinicians 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 4 points in the assessment and treatment process.

Figure 14: Average national percentage of family and whānau consultation for particular assessment or treatment events, sections 10, 12, 14, and 76, 77 and 78, 1 July 2020 to 30 June 2021



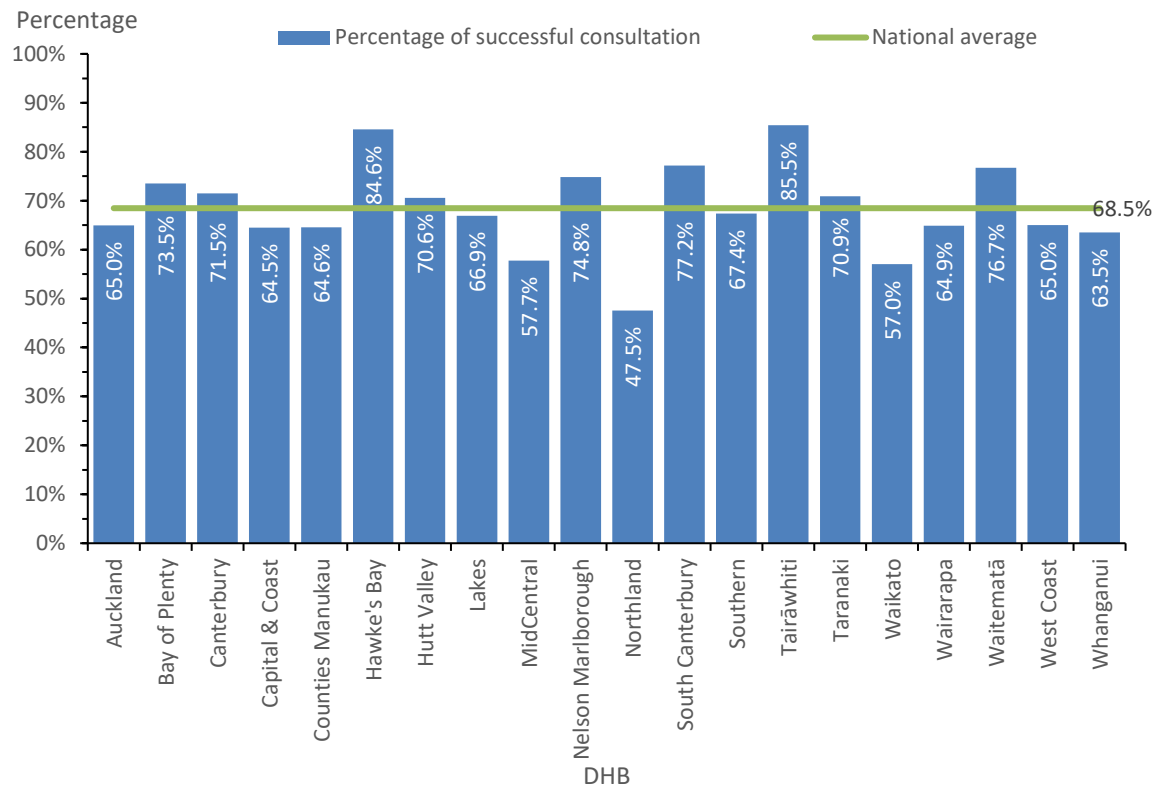
Note: Previous reports described 'sections 76/77/78' as 'section 76'. Section 76 relates to clinical reviews of people subject to compulsory treatment orders, whereas clinical review for special patients is covered in section 77 and for restricted patients is covered in section 78. The data for sections 77 and 78 was previously included under the title 'section 76', not excluded from the reporting completely.

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

On average nationally during this 12-month period, 66.8% of cases included consultation with family and whānau across the assessment and treatment events. Tairāwhiti had the highest rate of consultation at 85.5% and Northland had the lowest at 47.5% (Figure 15).

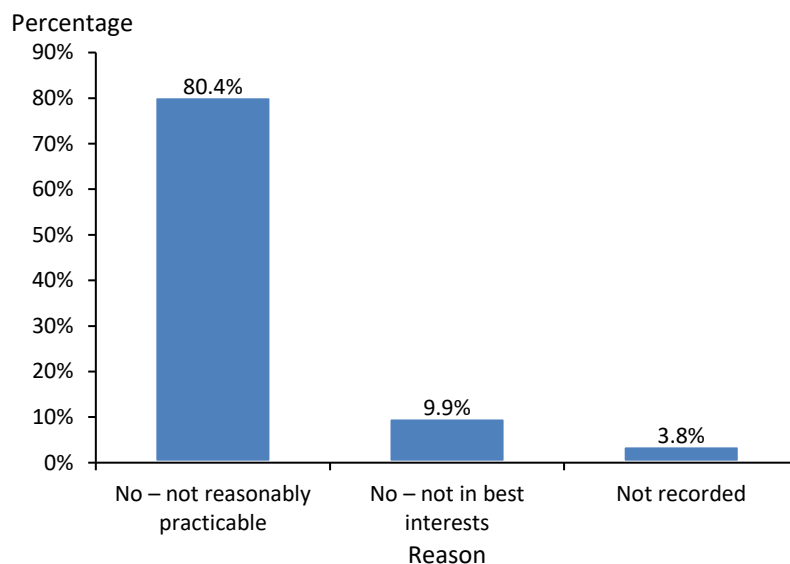
As Figure 16 shows, where families and whānau were not consulted, by far the most common reason (in 80.4% of cases) was that service providers and clinicians considered consultation was not reasonably practicable in the particular circumstance.

Figure 15: Average percentage of family and whānau consultation across all assessment and treatment events, by DHB, 1 July 2020 to 30 June 2021



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

Figure 16: Reasons for not consulting families and whānau, 1 July 2020 to 30 June 2021



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

Indefinite compulsory treatment orders

In summary, on 30 June 2021:¹¹

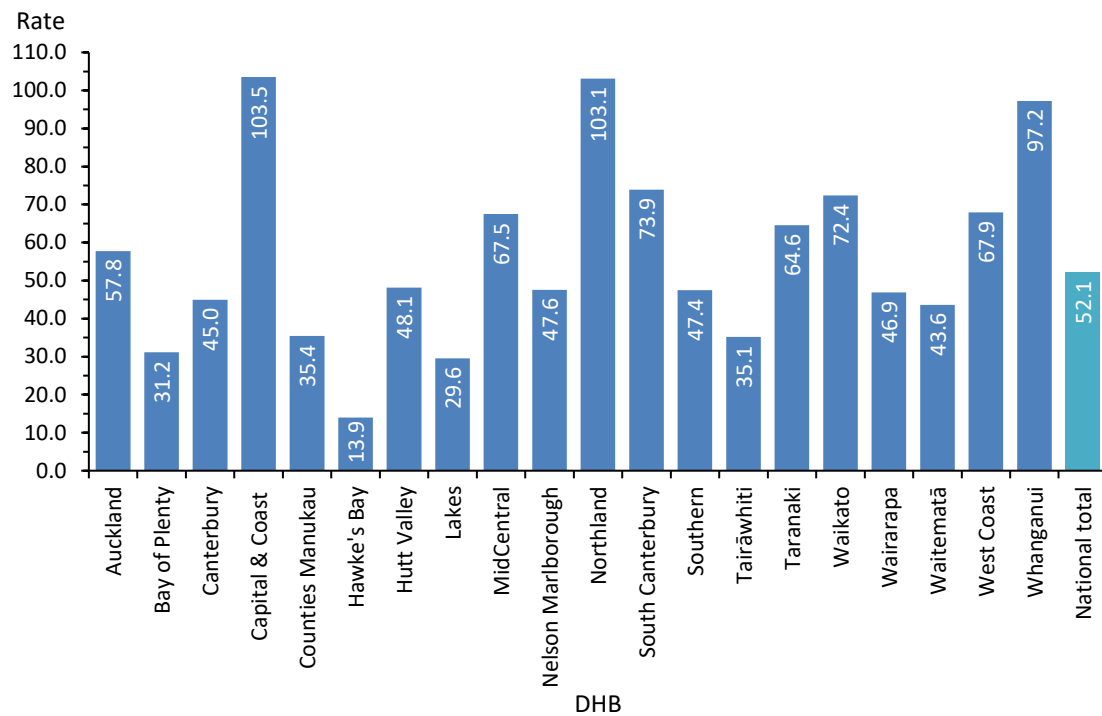
- 2,836 people were subject to indefinite compulsory treatment orders
- 2,668 people (56.9% of all individuals on community treatment orders) were subject to indefinite community treatment orders
- 192 people were subject to indefinite inpatient treatment orders — this represents 26.9% of all individuals on inpatient treatment orders
- the average period for which a person was subject to an indefinite community treatment order was 1,620 days (about 4 and a half years), and the maximum period was 10,103 days (about 27 and a half years)
- the average period for which a person was subject to an indefinite inpatient treatment order was 1,534 days (about 4 years) and the maximum period was 7,931 days (about 22 years).

Indefinite community treatment orders

From 1 July 2020 to 30 June 2021, 52.1 people per 100,000 population across Aotearoa 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.

¹¹ Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

Figure 17: Number of people subject to indefinite community treatment orders per 100,000 population, by DHB, orders open at 30 June 2021



Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

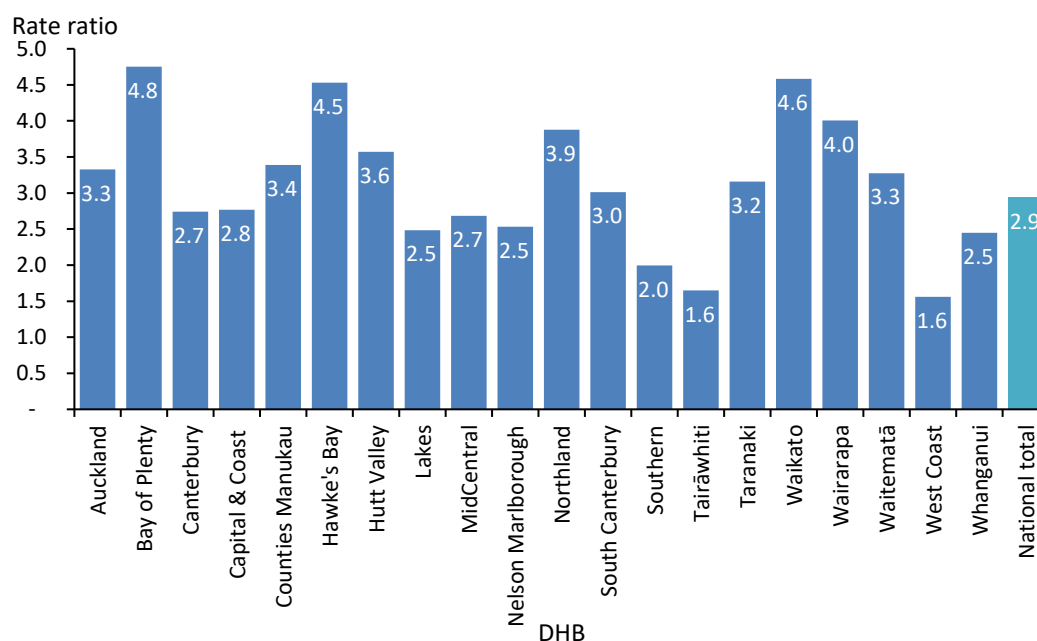
Nationwide, for orders open as of 30 June 2021, Māori were 2.9 times more likely to be subject to an indefinite community treatment order than non-Māori. Table 6 and Figure 18 show the rate ratio of Māori to non-Māori subject to indefinite community treatment orders in each DHB, per 100,000 people in the general population.

Table 6: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, by DHB, orders open at 30 June 2021

| DHB | Māori | Non-Māori | Rate ratio Māori : non-Māori | DHB | Māori | Non-Māori | Rate ratio Māori : non-Māori |
|--------------------|-------|-----------|------------------------------|-----------------------|------------|-----------|------------------------------|
| Auckland | 161 | 49 | 3.3 | Northland | 194 | 50 | 3.9 |
| Bay of Plenty | 75 | 16 | 4.8 | South Canterbury | 187 | 62 | 3.0 |
| Canterbury | 105 | 38 | 2.7 | Southern | 85 | 43 | 2.0 |
| Capital & Coast | 236 | 85 | 2.8 | Tairāwhiti | 43 | 26 | 1.6 |
| Counties Manukau | 86 | 25 | 3.4 | Taranaki | 140 | 44 | 3.2 |
| Hawke's Bay | 32 | 7 | 4.5 | Waikato | 176 | 38 | 4.6 |
| Hutt Valley | 117 | 33 | 3.6 | Wairarapa | 120 | 30 | 4.0 |
| Lakes | 47 | 19 | 2.5 | Waitematā | 116 | 35 | 3.3 |
| MidCentral | 133 | 49 | 2.7 | West Coast | 99 | 64 | 1.6 |
| Nelson Marlborough | 102 | 40 | 2.5 | Whanganui | 169 | 69 | 2.5 |
| | | | | National total | 115 | 39 | 2.9 |

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

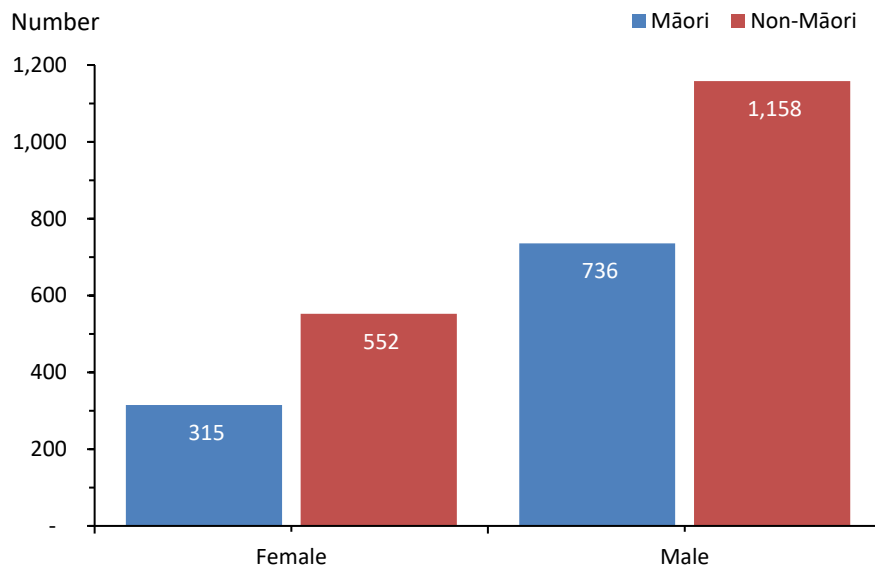
Figure 18: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, by DHB, orders open at 30 June 2021



Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

From 1 July 2020 to 30 June 2021, 68.6% of people subject to indefinite community treatment orders were male (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 gender and ethnicity, 1 July 2020 to 30 June 2021



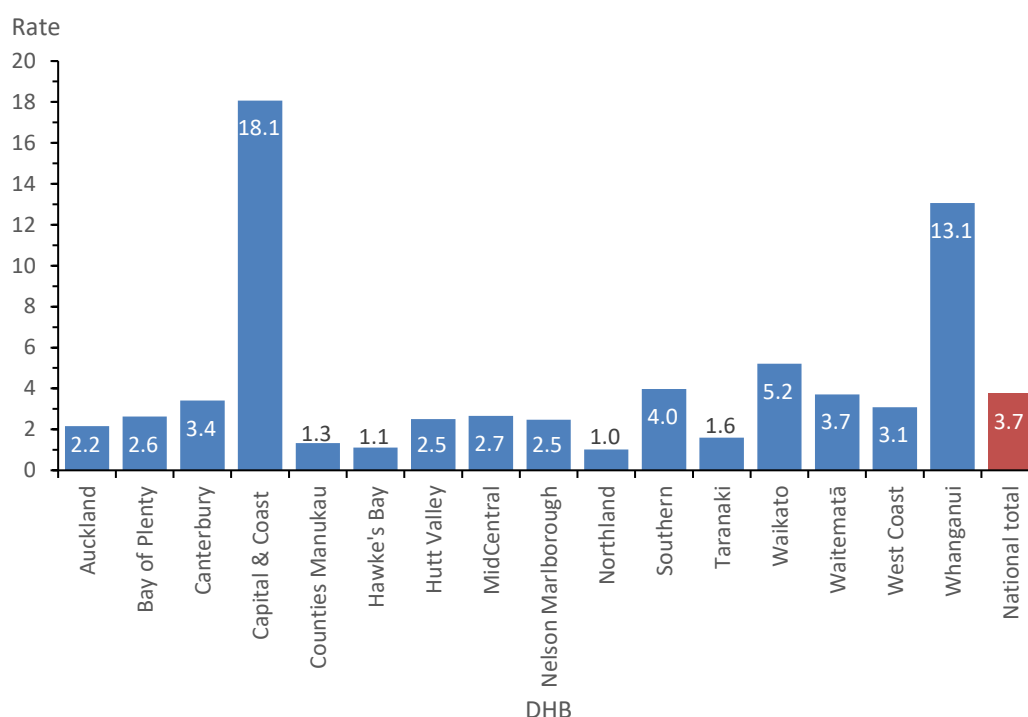
Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland and Lakes DHBs.

Indefinite inpatient treatment orders

Across Aotearoa, 3.7 people per 100,000 of the general population 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 the 12-month period from 1 July 2020 to 30 June 2021.

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 July 2020 to 30 June 2021



Note: Wairarapa DHB did not have an inpatient service and Lakes, South Canterbury and Tairāwhiti DHBs had no indefinite inpatient treatment orders so these DHBs have been excluded from this figure.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland DHB.

Nationwide during this time, Māori were 2.9 times more likely to be subject to an indefinite inpatient treatment order than non-Māori. Table 7 and Figure 21 show the rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders in each DHB per 100,000 people in the general population.

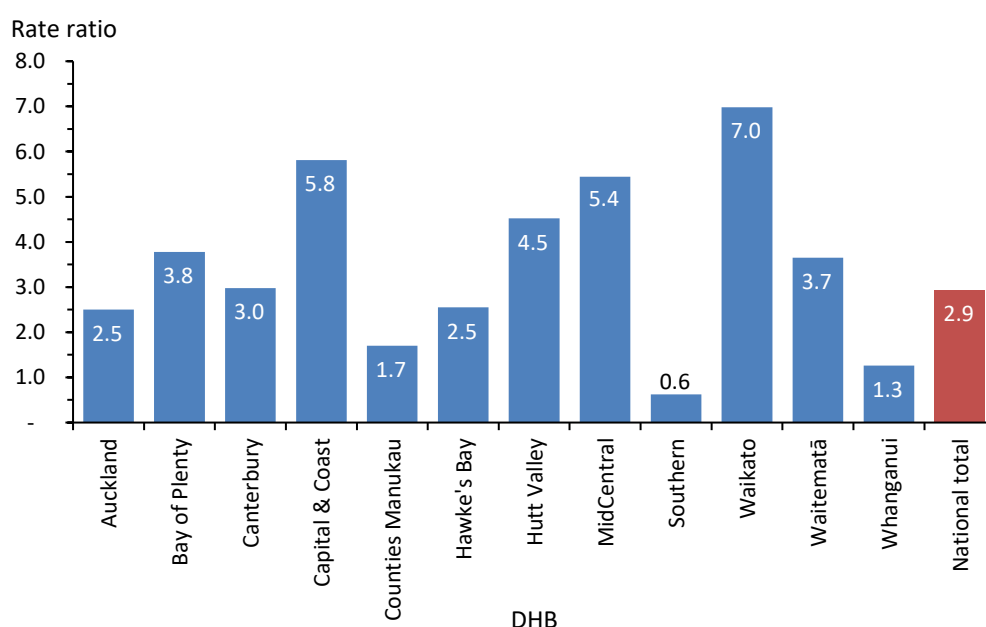
Table 7: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, by DHB, orders open at 30 June 2021

| DHB | Māori | Non-Māori | Rate ratio Māori : non-Māori | DHB | Māori | Non-Māori | Rate ratio Māori : non-Māori |
|------------------|-------|-----------|------------------------------|-----------------------|----------|-----------|------------------------------|
| Auckland | 5 | 2 | 2.5 | Nelson Marlborough | – | 3 | – |
| Bay of Plenty | 6 | 2 | 3.8 | Northland | – | 2 | – |
| Canterbury | 8 | 3 | 3.0 | Southern | 3 | 4 | 0.6 |
| Capital & Coast | 67 | 11 | 5.8 | Taranaki | – | 2 | – |
| Counties Manukau | 2 | 1 | 1.7 | Waikato | 15 | 2 | 7.0 |
| Hawke's Bay | 2 | 1 | 2.5 | Waitematā | 11 | 3 | 3.7 |
| Hutt Valley | 7 | 2 | 4.5 | West Coast | – | 4 | – |
| MidCentral | 7 | 1 | 5.4 | Whanganui | 15 | 12 | 1.3 |
| | | | | National total | 8 | 3 | 2.9 |

Note: Wairarapa DHB did not have an inpatient service and Lakes, South Canterbury and Tairāwhiti DHBs had no indefinite inpatient treatment orders and so are excluded from this table.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland DHB.

Figure 21: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, by DHB, orders open at 30 June 2021

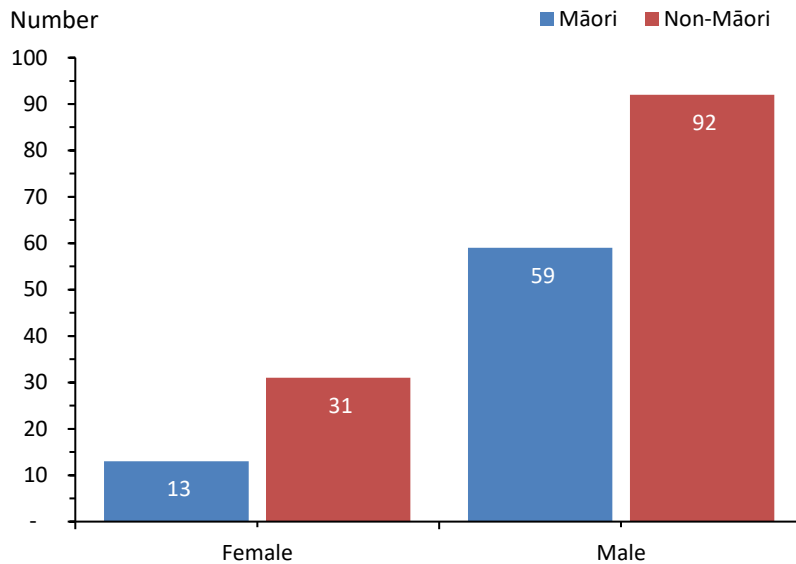


Notes: Wairarapa DHB did not have an inpatient service and Lakes, South Canterbury and Tairāwhiti DHBs had no indefinite inpatient treatment orders so these DHBs have been excluded from this figure. Nelson Marlborough, Northland, Taranaki and West Coast DHBs had a rate ratio of zero so are also excluded.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland DHB.

Overall, 151 males were subject to indefinite inpatient treatment orders, making up 77.4% of all people under these orders (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 orders.

Figure 22: Number of Māori and non-Māori subject to indefinite inpatient treatment orders, by gender, 1 July 2020 to 30 June 2021



Sources: PRIMHD data (extracted 3 June 2022) and manual data from Auckland 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'.¹²

In summary, in adult inpatient services from 1 July 2020 to 30 June 2021:¹³

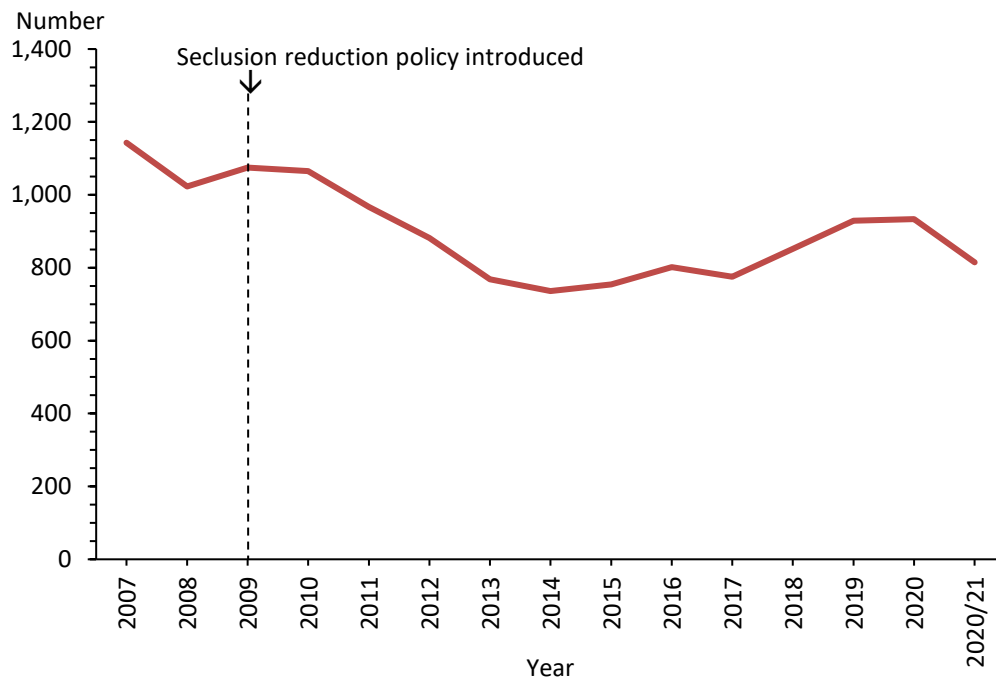
- the total number of people who experienced seclusion while receiving mental health treatment in an adult inpatient service had decreased by 24.2% since 2009¹⁴ (Figure 23)
- the total number of hours spent in seclusion had decreased by 59.9% since 2009 (Figure 24)
- the number of people secluded decreased by 12.6% compared with the 2020 calendar year
- the number of hours spent in seclusion decreased by 22.5% compared with the 2020 calendar year
- 77.0% of all seclusion events lasted for less than 24 hours, and 11.6% lasted for longer than 48 hours
- males were more than 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 7.5 seclusion events for every 1,000 bed nights they spent in adult inpatient units
- of the 11,189 admissions to adult inpatient units, 928 admission events (8.3%) had seclusion recorded at some point during the stay.

¹² Standards New Zealand. 2021. *Ngā Paerewa Health and Disability Services Standard*. Wellington: Standards New Zealand.

¹³ Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

¹⁴ We are comparing the latest data with 2009 because in that year seclusion reduction policies were introduced in Aotearoa.

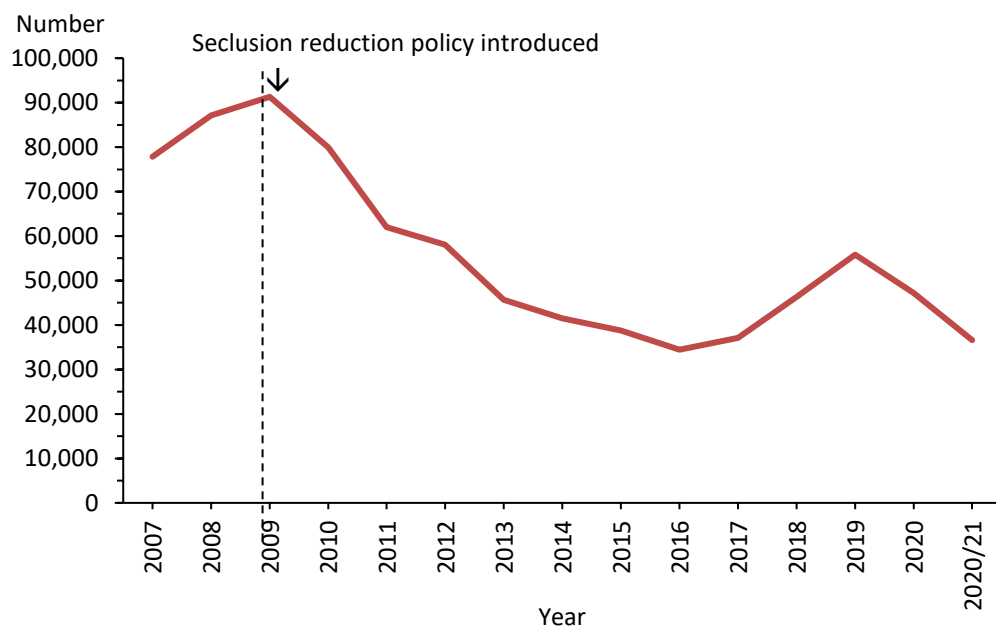
Figure 23: Number of people secluded in adult inpatient services nationally, 2007–2020/2021



Notes: The data excludes forensic inpatient services. It includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services. All years except 2020/21 are calendar years.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Figure 24: Number of seclusion hours in adult inpatient services nationally, 2007–2020/21



Notes: The data excludes forensic inpatient services. It includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services. All years except 2020/21 are calendar years.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Seclusion in Aotearoa mental health services¹⁵

Between 1 July 2020 and 30 June 2021, Aotearoa adult mental health services (excluding forensic and other regional rehabilitation services) accommodated 8,596 people for a total of 238,948 bed nights. Of these people, 815 (9.5%) were secluded at some stage during the reporting period.

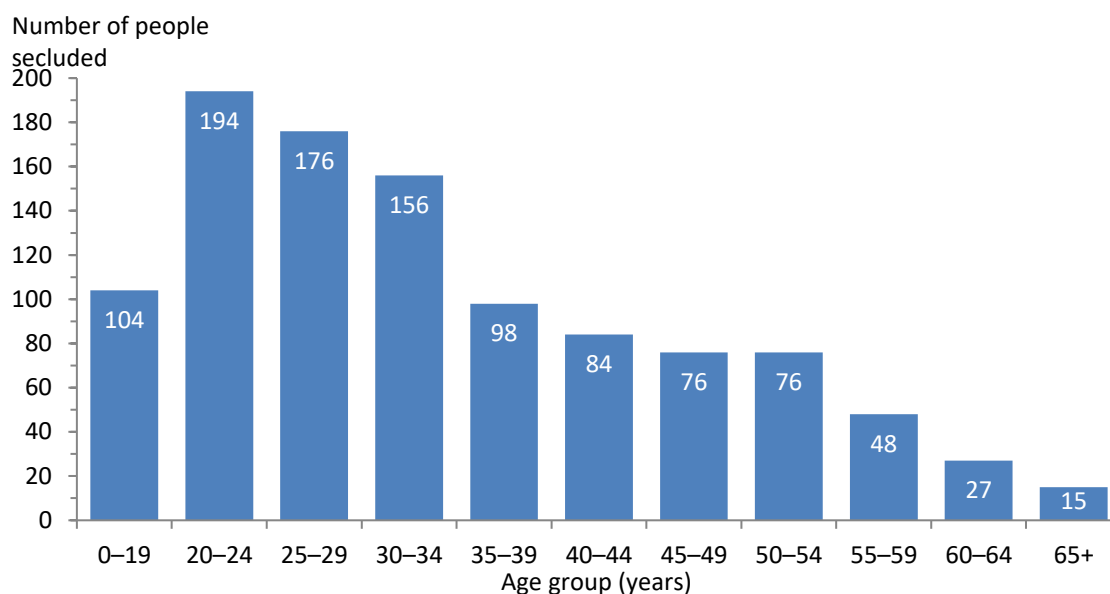
Among the adults who were secluded, many were secluded more than once (on average 2.2 times). For this reason, the number of seclusion events in adult inpatient services (1,802) was higher than the number of people secluded.

There were 7.5 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 7.5 seclusion events.

Across all inpatient services, including forensic, intellectual disability and youth services, 1,054 people experienced at least one seclusion event. Of those secluded, 69.1% were male, and 30.9% were female. The most common age group for those secluded was 20–29 years. A total of 104 young people (aged 19 years and under) were secluded in 279 seclusion events during the 12-month period (Figure 25).

¹⁵ Data in this section excludes forensic services unless specified otherwise. Bed nights are measured by team types that use seclusion. This may differ from denominator figures used in other entities' seclusion reporting. This data cannot be compared with years before 2017, when bed nights were measured by acute and sub-acute bed nights. Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

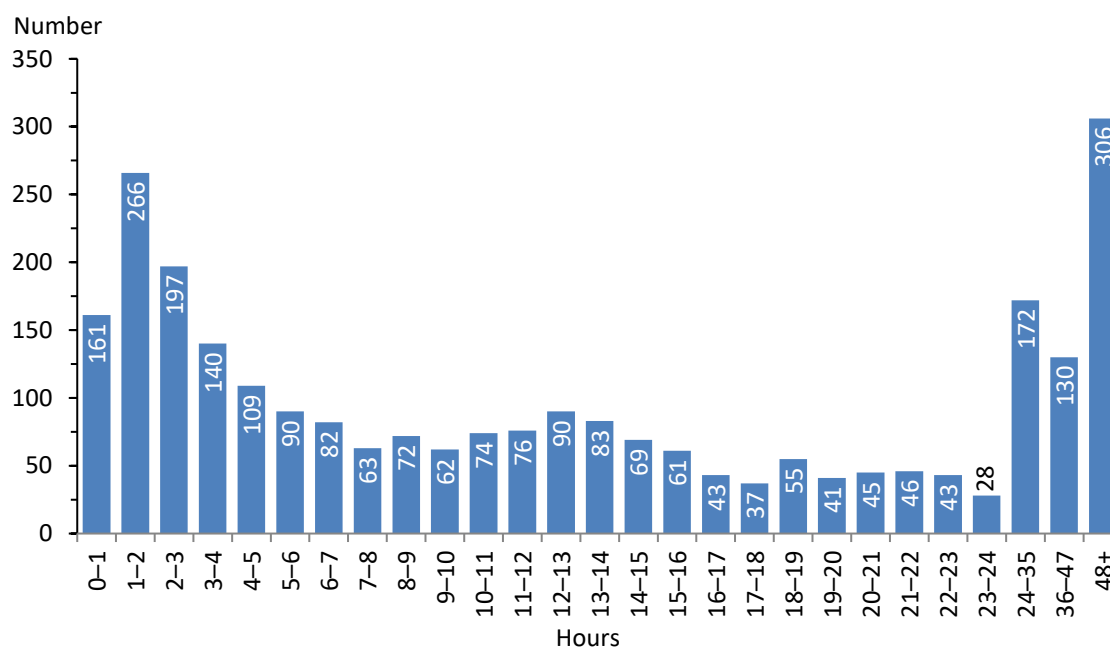
Figure 25: Number of people secluded across all inpatient services (adult, forensic, intellectual disability and youth), by age group, 1 July 2020 to 30 June 2021



Note: The data includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

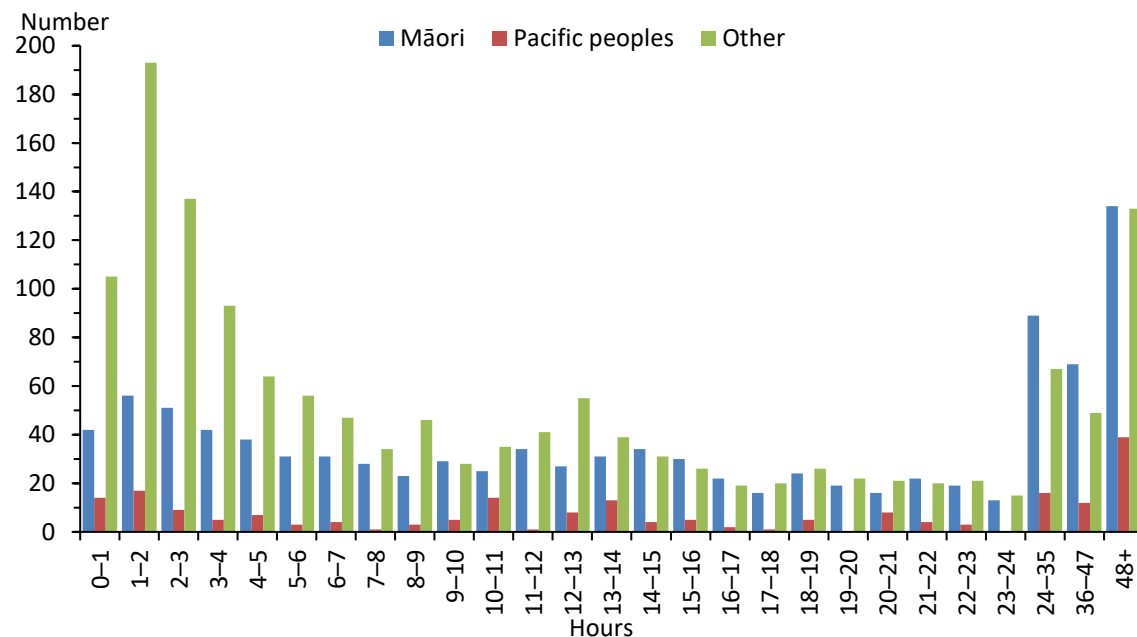
Figure 26: Number of seclusion events across all inpatient services (adult, forensic, intellectual disability and youth), by length of event, 1 July 2020 to 30 June 2021



Notes: The data includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services. The lower limit is the lowest included time, for example 0-1 hours includes any time up to 59 minutes.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Figure 27: Number of seclusion events across all inpatient services (adult, forensic, intellectual disability and youth), by ethnicity and length of event, 1 July 2020 to 30 June 2021



Notes: The data includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services. The lower limit is the lowest included time. For example, 0–1 hours includes any time up to 59 minutes.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Use of seclusion by DHBs

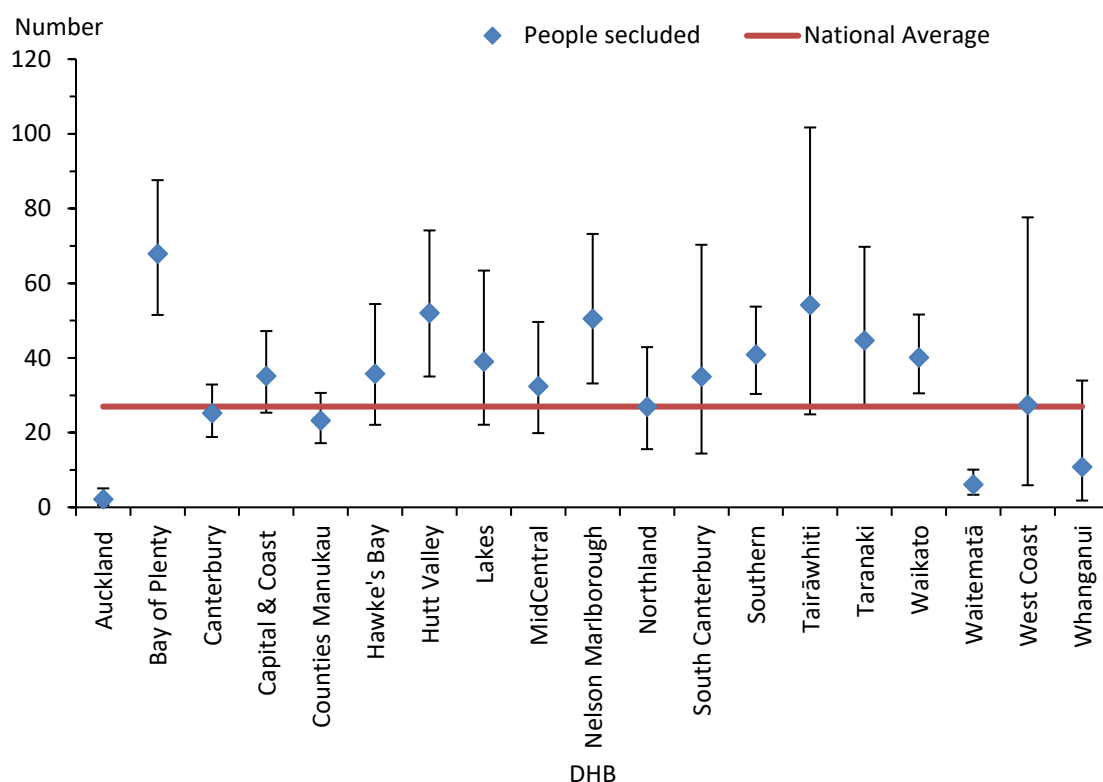
All DHBs except for Wairarapa DHB (which had no mental health inpatient service) used seclusion.¹⁶

At the national level from 1 July 2020 to 30 June 2021, the average number of people secluded in adult inpatient services was 27.0 per 100,000 population. Figure 28 shows how individual DHBs compare with this national average. Table 8 shows the seclusion rate for each DHB as a percentage of patients admitted to adult inpatient services who experienced seclusion during their admission.

Nationally, the average number of seclusion events was 59.6 per 100,000 population. Figure 29 breaks this rate down by DHB. The average length of a seclusion event nationwide was 20.3 hours.

¹⁶ If a person in Wairarapa DHB required admission to mental health inpatient services, they were transported to either Hutt Valley DHB or MidCentral DHB. In this case, any seclusion statistics relating to this service user would appear on the database of the DHB where they were receiving treatment.

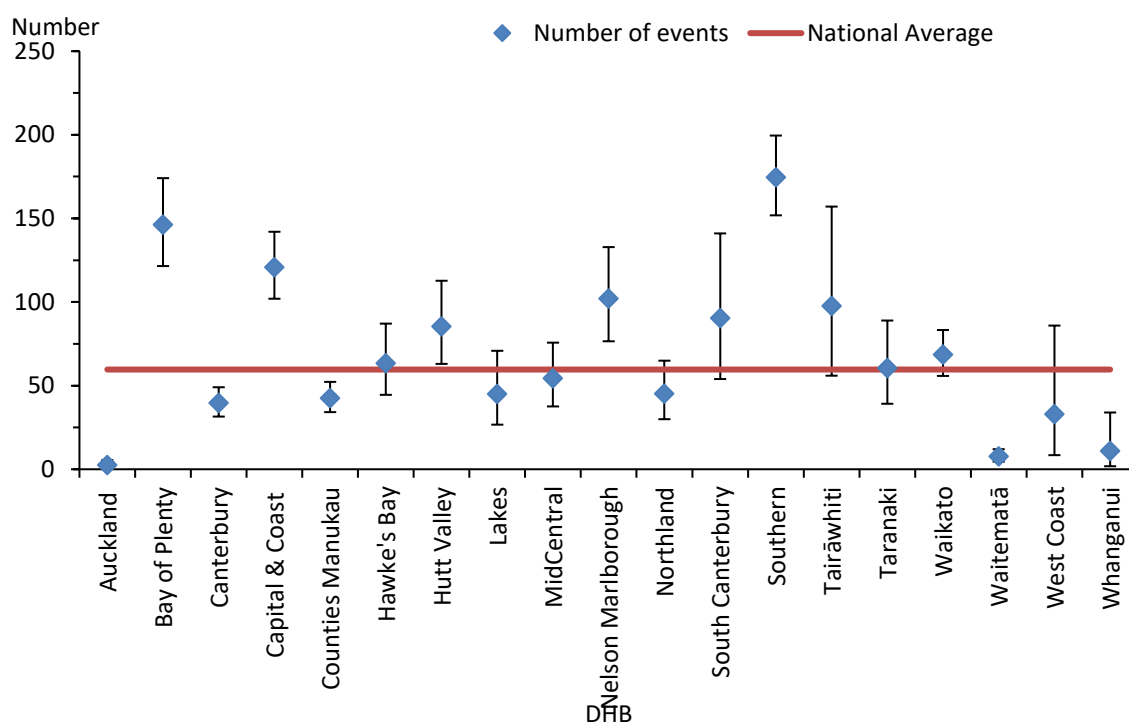
Figure 28: Number of people secluded in adult inpatient services per 100,000 population, by DHB, 1 July 2020 to 30 June 2021



Notes: The graph uses confidence intervals (for 99% 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. It includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services. Wairarapa DHB did not have an inpatient unit, so it has been excluded from this graph.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Figure 29: Number of seclusion events in adult inpatient services per 100,000 population, by DHB, 1 July 2020 to 30 June 2021



Notes: The graph uses confidence intervals (for 99% 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. It includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services. Wairarapa DHB did not have an inpatient unit, so it has been excluded from this graph.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Table 8: Percentage of admissions to adult inpatient services with seclusion recorded during admission, by DHB, 1 July 2020 to 30 June 2021

| DHB | Percentage | DHB | Percentage |
|--------------------|------------|-------------------------|-------------|
| Auckland | 1.0% | Northland | 3.2% |
| Bay of Plenty | 15.6% | South Canterbury | 9.6% |
| Canterbury | 6.6% | Southern | 10.1% |
| Capital & Coast | 12.2% | Tairāwhiti | 11.4% |
| Counties Manukau | 12.1% | Taranaki | 7.1% |
| Hawke's Bay | 10.2% | Waikato | 9.9% |
| Hutt Valley | 10.6% | Waitematā | 2.6% |
| Lakes | 11.1% | West Coast | 6.2% |
| MidCentral | 8.3% | Whanganui | 1.8% |
| Nelson Marlborough | 14.7% | National average | 8.3% |

Notes: The data excludes forensic inpatient services and Wairarapa DHB as they had no inpatient service. It includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services.

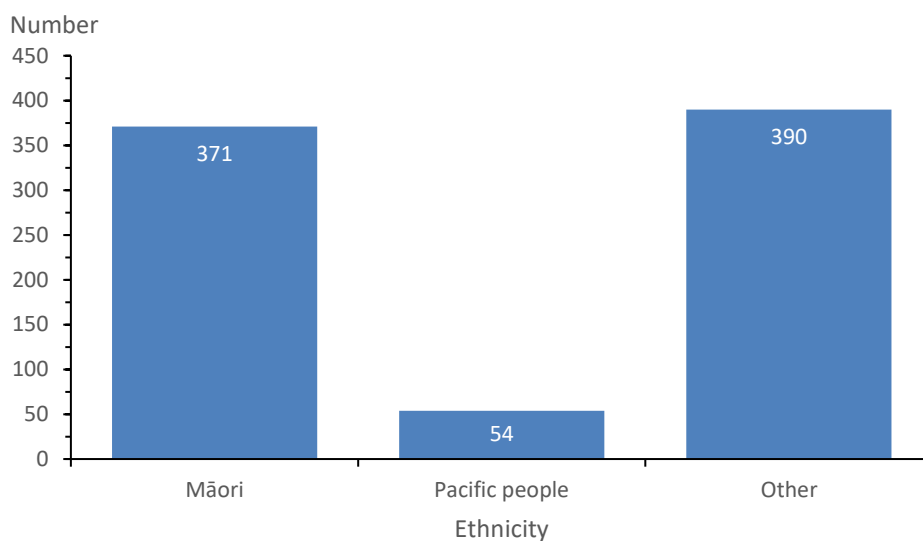
Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Seclusion and ethnicity

The rate of seclusion for Māori in adult inpatient services was 79.5 people per 100,000 in the general population. They were 4.6 times more likely to be secluded than non-Māori and non-Pacific peoples, who had a rate of 16.6 people per 100,000.

Pacific peoples were nearly twice as likely to be secluded as non-Pacific peoples and non-Māori, at a rate of 27.0 people per 100,000 (Figure 31). Figure 30 shows the number of people secluded by ethnicity.

Figure 30: Number of people secluded in adult inpatient services, by ethnicity, 1 July 2020 to 30 June 2021

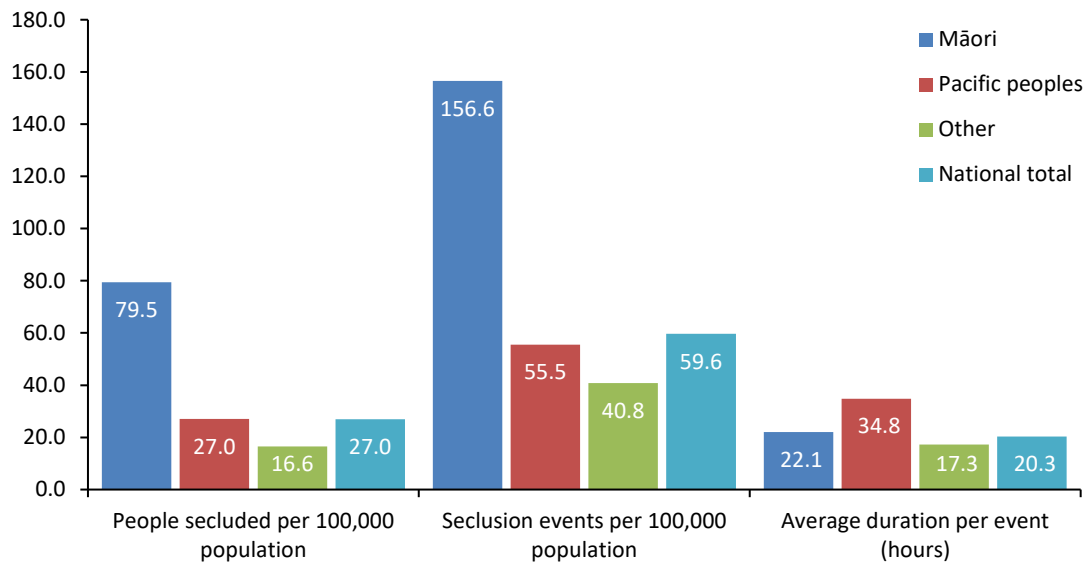


Notes: The data excludes forensic services and patients who have a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. It includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Figure 31 shows seclusion indicators for Māori, Pacific peoples and other ethnicities from 1 July 2020 to 30 June 2021. Māori were secluded at a rate of 79.5 people per 100,000 population, Pacific peoples at 27.0 people per 100,000 population and other ethnicities at a rate of 16.6 people per 100,000 population.

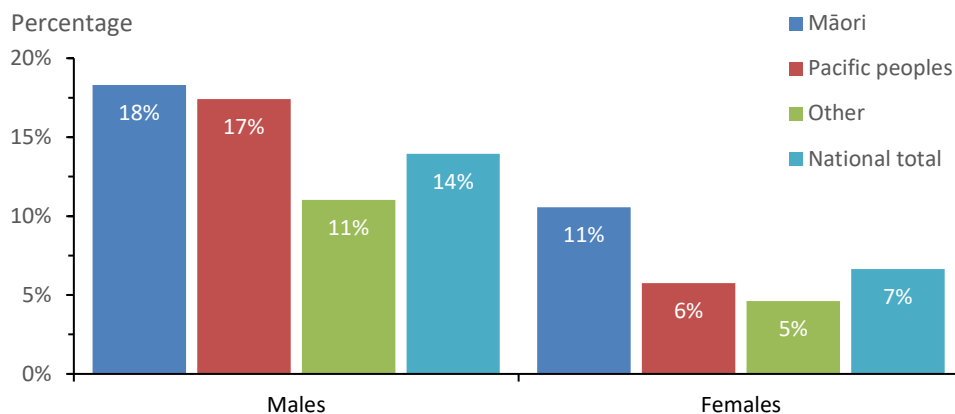
Figure 31: Seclusion indicators for adult inpatient services, by ethnicity, 1 July 2020 to 30 June 2021



Notes: The data excludes forensic services and patients who have a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. It includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Figure 32: Percentage of people with inpatient admissions that spent time in seclusion in adult inpatient services, by ethnicity and gender, 1 July 2020 to 30 June 2021

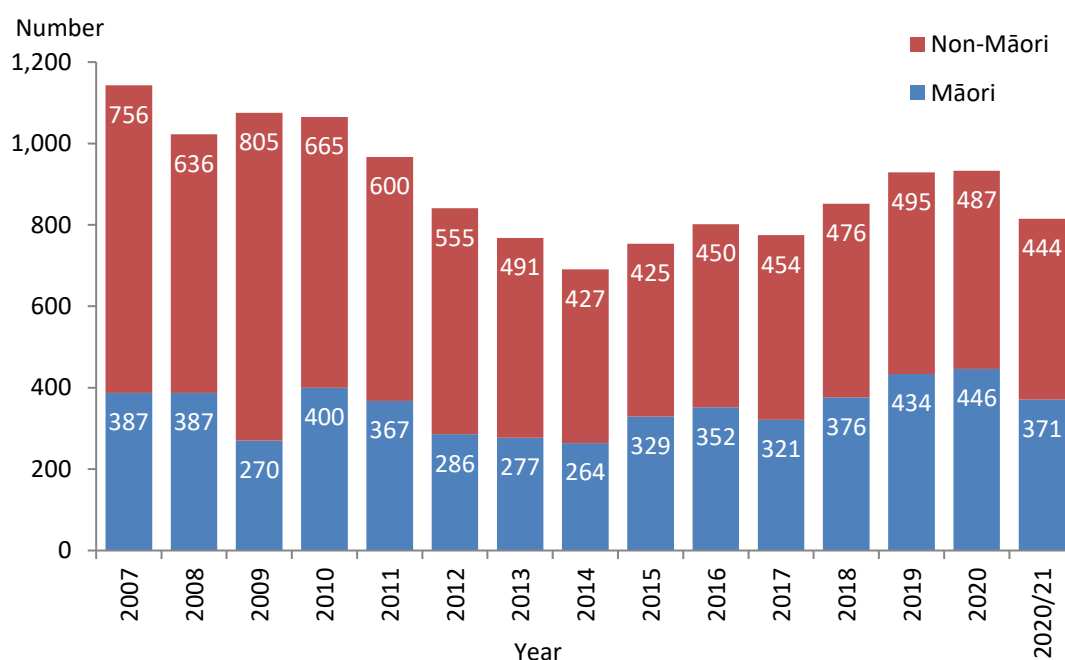


Notes: The data excludes forensic services and patients who have a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. It includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Figure 33 shows the number of Māori and non-Māori aged 20–64 years secluded in adult inpatient services from the 2007 calendar year to the 2020/21 financial year. Nationally over this time, the number of people secluded decreased by 28.7%. The number of people secluded who identified as Māori decreased by 4.1% over the same period.

Figure 33: Number of Māori and non-Māori aged 20–64 years secluded in adult inpatient services, 2007–2020/21



Notes: The data excludes an outlier, forensic services and patients who have a legal status under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. It includes patients who have a legal status under the Mental Health Act but are treated in regional intellectual disability secure services. All years except 2020/21 are calendar years.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Seclusion in forensic units

Five DHBs provided specialist inpatient forensic services: Canterbury, Capital & Coast, Southern, Waikato and Waitematā.¹⁷ These services provided mental health treatment in a secure setting for prisoners with mental disorders and for people defined as special or restricted patients.

Table 9 presents seclusion indicators for forensic mental health services in each DHB. Figure 34 presents a breakdown of the number of people secluded and number of events by ethnicity on a national level. Due to small numbers, presenting this data at a service level could make individuals identifiable. These indicators cannot be compared with adult inpatient service indicators because they have a different client base.

Table 9: Seclusion indicators for forensic mental health services, by DHB, 1 July 2020 to 30 June 2021

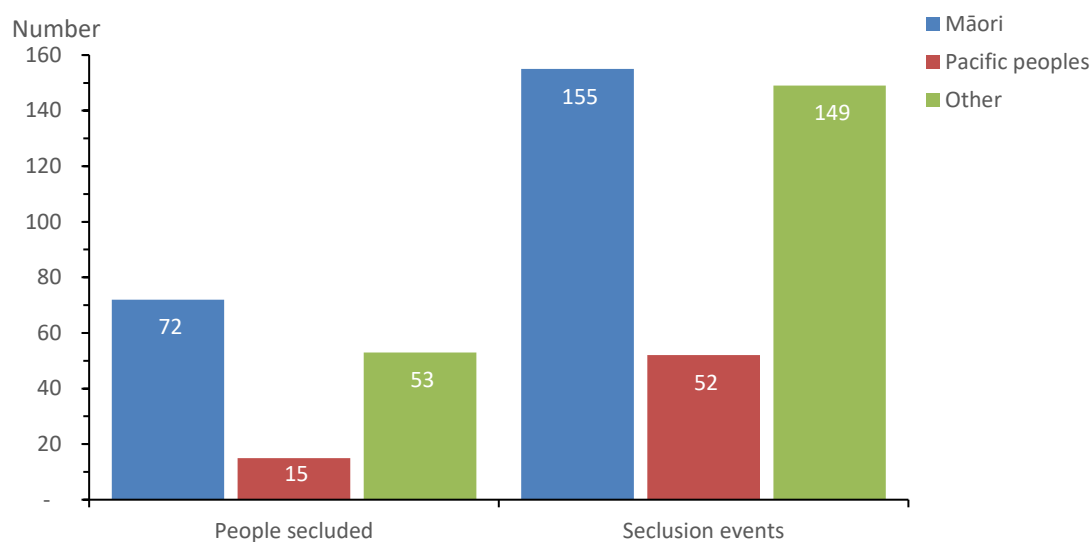
| DHB | Number of people secluded | Number of events | Total hours | Average duration per event (hours) |
|-----------------------|---------------------------|------------------|---------------|------------------------------------|
| Canterbury | 36 | 110 | 8,036 | 73.1 |
| Capital & Coast | 19 | 35 | 665 | 19.0 |
| Southern | 10 | 32 | 1,194 | 37.3 |
| Waikato | 33 | 61 | 3,916 | 64.2 |
| Waitematā | 43 | 118 | 5,246 | 44.5 |
| National total | 140 | 356 | 19,058 | 53.5 |

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

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

¹⁷ Capital & Coast DHB also operated a forensic service in Whanganui.

Figure 34: Seclusion indicators for forensic mental health services nationally, by ethnicity, 1 July 2020 to 30 June 2021



Notes: People in this figure are aged 20–64 years. People are mental health service users only.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

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

The 5 DHBs that provided specialist inpatient forensic services (as listed above) also provided forensic intellectual disability services for people with an intellectual disability under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the Intellectual Disability Care Act), as care recipients or special care recipients. Individuals become subject to the Intellectual Disability Care Act after they have been engaged in criminal offending, and compulsory care is 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 Intellectual Disability Care Act or the Mental Health Act. People receiving care under these Acts may only be subject to seclusion in hospital-level secure services that meet specific requirements. In the analysis in Tables 10, 11 and 12, 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 10: Seclusion indicators for people with intellectual disabilities, by DHB, 1 July 2020 to 30 June 2021

| Legal Act | DHB | Number of people secluded | Number of events | Median number of events | Average number of events per person |
|----------------------------------|-----------------------|---------------------------|------------------|-------------------------|-------------------------------------|
| Intellectual Disability Care Act | Canterbury | 5 | 7 | 1 | 1 |
| | Capital & Coast | 4 | 12 | 2 | 3 |
| | Southern | 7 | 15 | 2 | 2 |
| | Waikato | 2 | 7 | 4 | 4 |
| | Waitematā | 8 | 48 | 2 | 6 |
| | National total | 25 | 89 | 2 | 3.6 |
| Mental Health Act | Canterbury | 0 | 0 | 0 | 0 |
| | Capital & Coast | 1 | 1 | 1 | 1 |
| | Southern | 1 | 39 | 39 | 39 |
| | Waikato | 0 | 0 | 0 | 0 |
| | Waitematā | 1 | 147 | 147 | 147 |
| | National total | 3 | 187 | 39 | 62.3 |

Notes: Intellectual Disability Care Act = Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003; Mental Health Act = Mental Health (Compulsory Assessment and Treatment) Act 1992. One person had seclusion events in both Capital & Coast and Southern DHBs and therefore is counted under both.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Table 11: Length of seclusion for people with intellectual disabilities, by DHB, 1 July 2020 to 30 June 2021

| Legal Act | DHB | Total seclusion hours | Median length of seclusion events (hours: minutes) | Average length of seclusion events (hours: minutes) |
|----------------------------------|-----------------|-----------------------|--|---|
| Intellectual Disability Care Act | Canterbury | 727 | 12:00 | 7:50 |
| | Capital & Coast | 121 | 6:50 | 10:06 |
| | Southern | 524 | 3:50 | 10:56 |
| | Waikato | 60 | 3:18 | 8:35 |
| | Waitematā | 126 | 1:17 | 2:36 |
| Mental Health Act | Canterbury | 0 | 0:00 | 0:00 |
| | Capital & Coast | 3 | 2:50 | 2:50 |
| | Southern | 208 | 3:00 | 5:20 |
| | Waikato | 0 | 0:00 | 0:00 |
| | Waitematā | 580 | 1:30 | 3:56 |

Notes: Intellectual Disability Care Act = Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003; Mental Health Act = Mental Health (Compulsory Assessment and Treatment) Act 1992. The high seclusion hours for Canterbury and Southern DHBs are driven by one event in each DHB with very high seclusion hours, involving 636 and 165 hours respectively.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Table 12: Seclusion indicators for Māori and non-Māori with intellectual disabilities, 1 July 2020 to 30 June 2021

| Legal Act | Ethnicity | Number of people secluded | Number of seclusion events | Median number of events | Average number of events per person |
|----------------------------------|-----------|---------------------------|----------------------------|-------------------------|-------------------------------------|
| Intellectual Disability Care Act | Māori | 9 | 31 | 1 | 3.4 |
| | Non-Māori | 16 | 58 | 2 | 3.6 |
| Mental Health Act | Māori | 0 | 0 | 0 | 0.0 |
| | Non-Māori | 3 | 187 | 39 | 62.3 |

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

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Southern, Waikato and Waitematā DHBs.

Night safety procedures

Night safety procedures are 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*.¹⁸

This practice, as it is currently constructed, is no longer fit for purpose, and the Ministry has signalled that services should end it by 31 December 2022. In 2018, the Ministry issued *Night Safety Procedures: Transitional guideline* to ensure patients receive adequate standards of care and monitoring while services transition to no longer using these procedures.¹⁹

In regions that are still using night safety procedures, it has been reported that services consider them to be an essential component to providing a safe environment. Reasons they give for this view include issues with building design and lines of vision, staffing levels and the level of risk that patients present with.

Services provide data to the Office of the Director of Mental Health and Addiction Services on their use of night safety procedures. Because they do not submit this data via PRIMHD and it must undergo quality checks, the data set is not available at the time of publication.

¹⁸ 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).

¹⁹ 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 (accessed 27 October 2021).

Special and restricted patients

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

Special patients include:

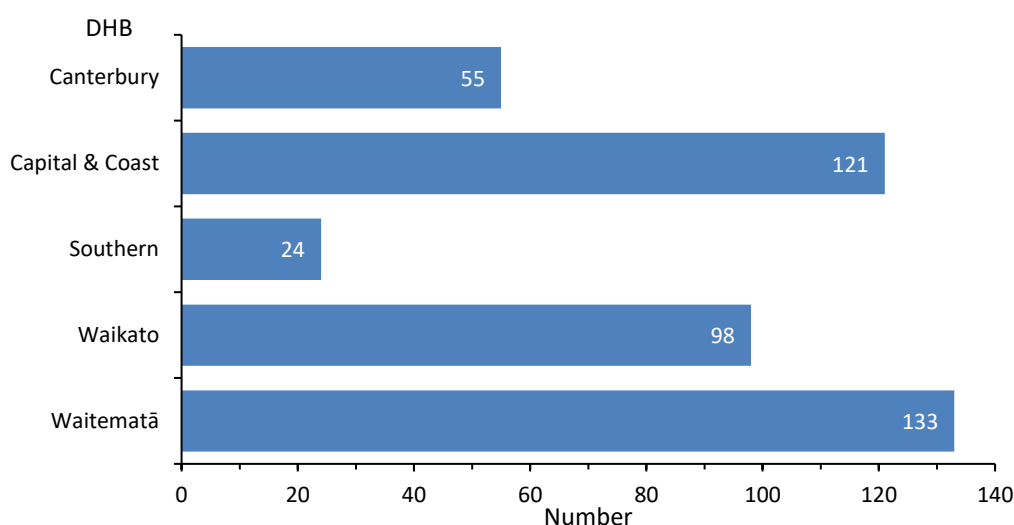
- people charged with, or convicted of, a criminal offence and remanded to a hospital for a psychiatric report
- remanded or sentenced prisoners transferred from prison to a hospital
- defendants found not guilty by reason of insanity
- defendants who are unfit to stand trial
- people who have been convicted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

Restricted patients are people detained in forensic mental health services, by court order, because they pose a danger to others. They have not necessarily have been charged with or convicted of a crime. They may have also been transferred from prison or previously had a special patient status that changed when their sentence ended.

The number of special patients nationally, 423 in total, is lower than the sum of special patients by DHB. The reason for the difference is that some may have transferred across services during the period from 1 July 2020 to 30 June 2021.

Figure 35 presents the total number of special patients in the care of each DHB that provided regional forensic psychiatry services.

Figure 35: Total number of special patients, by DHB, 1 July 2020 to 30 June 2021



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 3 June 2022).

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.

From 1 July 2020 to 30 June 2021, Aotearoa had 166 extended forensic care special patients.

Table 13 in the following section shows the number of these patients in the care of each DHB that provided regional forensic psychiatry services.

Short-term forensic care special patients

Short-term forensic care patients include people transferred from prison to a forensic mental health service. 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.

From 1 July 2020 to 30 June 2021, Aotearoa had a total of 269 short-term forensic care special patients.

Table 13 shows the number of these patients in the care of each DHB that provided regional forensic psychiatry services. Figure 36 shows the percentage of court orders given for short-term forensic care legal status relative to extended forensic care legal status in each of these DHBs.

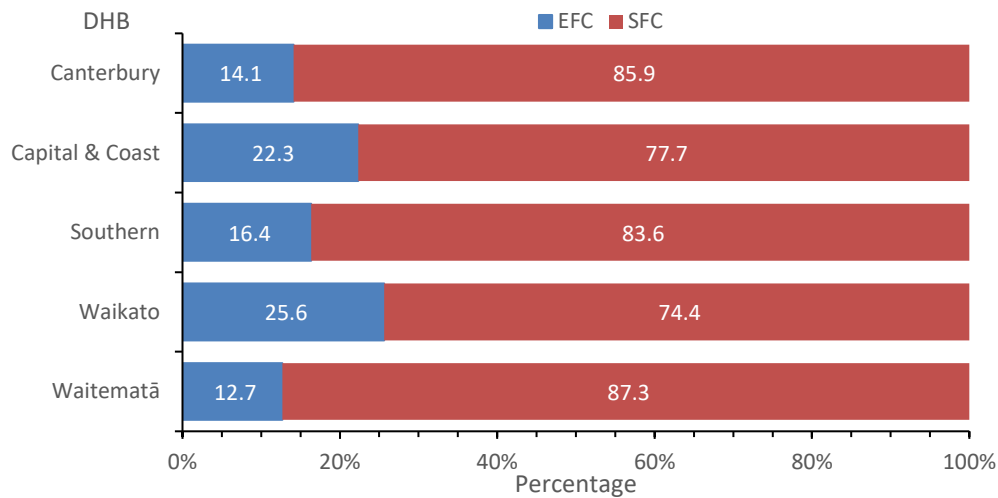
Table 13: Total number of special patients, by type and DHB, 1 July 2020 to 30 June 2021

| Forensic services | EFC special patients | SFC special patients | Total special patients |
|-----------------------|----------------------|----------------------|------------------------|
| Canterbury DHB | 16 | 41 | 55 |
| Capital & Coast DHB | 58 | 66 | 121 |
| Southern DHB | 9 | 15 | 24 |
| Waikato DHB | 40 | 59 | 98 |
| Waitematā DHB | 46 | 91 | 133 |
| National total | 166 | 269 | 423 |

Notes: EFC = extended forensic care; SFC = short-term forensic care. An individual is counted as a special patient in more than one DHB when they receive treatment with more than one DHB. For this reason, adding together the patients in the 5 DHBs produces a total 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 so we need to protect patient confidentiality.

Source: PRIMHD data (extracted 3 June 2022).

Figure 36: Percentage of court orders given for extended forensic care relative to short-term forensic care legal statuses, by DHB, 1 July 2020 to 30 June 2021



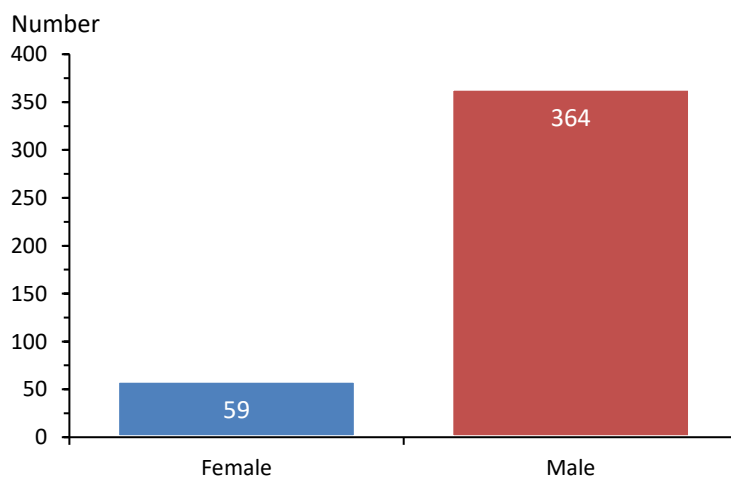
Notes: EFC = extended forensic care; SFC = short-term forensic care. Unlike previous data in this section, the data in this figure is based on a count of court orders for legal statuses rather than a count of people with a special patient legal status. One special patient may have many court orders for their legal status in the year, which could include both EFC and 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 3 June 2022).

Gender, age and ethnicity of special patients

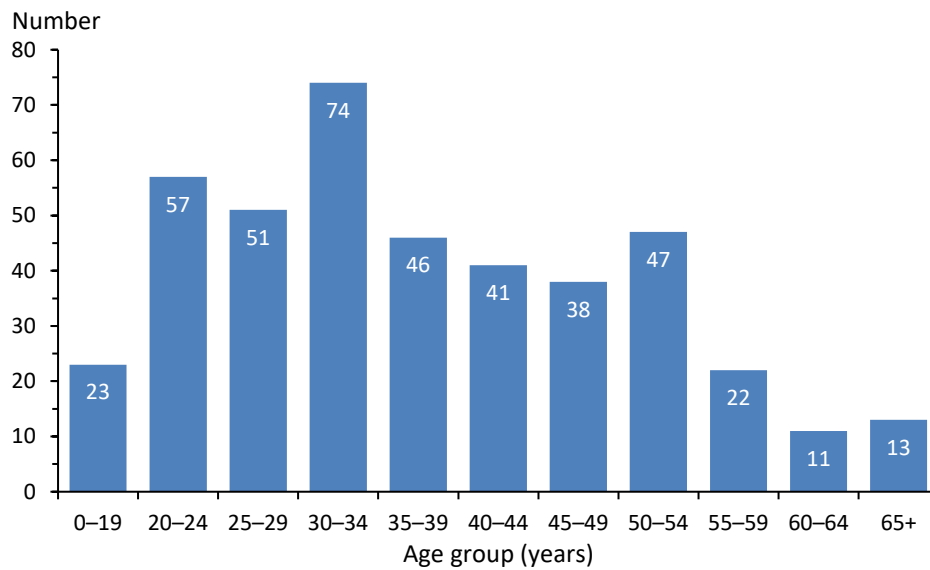
Special patients were over 6 times more likely to be male (86.1%) than female (13.9%) (Figure 37). The most common age group for special patients from 1 July 2020 to 30 June 2021 was 30–34 years (Figure 38).

Figure 37: Number of special patients, by gender, 1 July 2020 to 30 June 2021



Source: PRIMHD data (extracted 3 June 2022).

Figure 38: Total number of special patients, by age group, 1 July 2020 to 30 June 2021

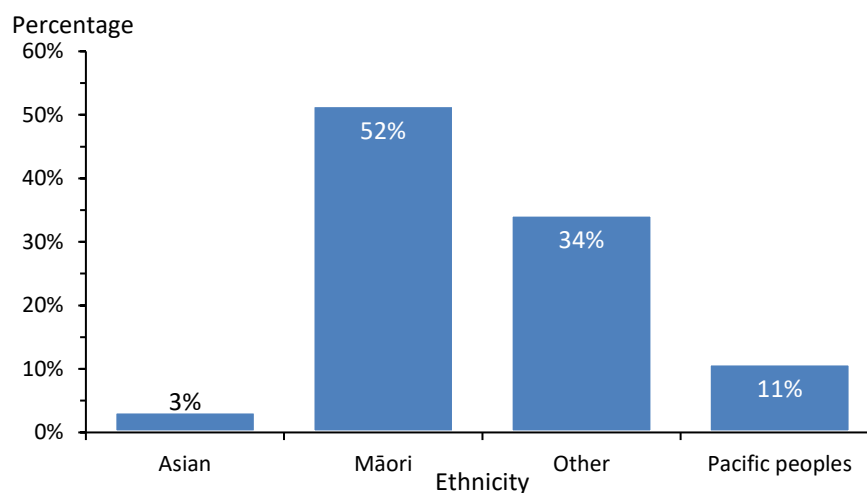


Source: PRIMHD data (extracted 3 June 2022).

Among people subject to a special patient order, most (51.5%) were Māori (Figure 39). Māori represented the highest proportion of both extended forensic care (43.4%) and short-term forensic care (56.1%) special patients.

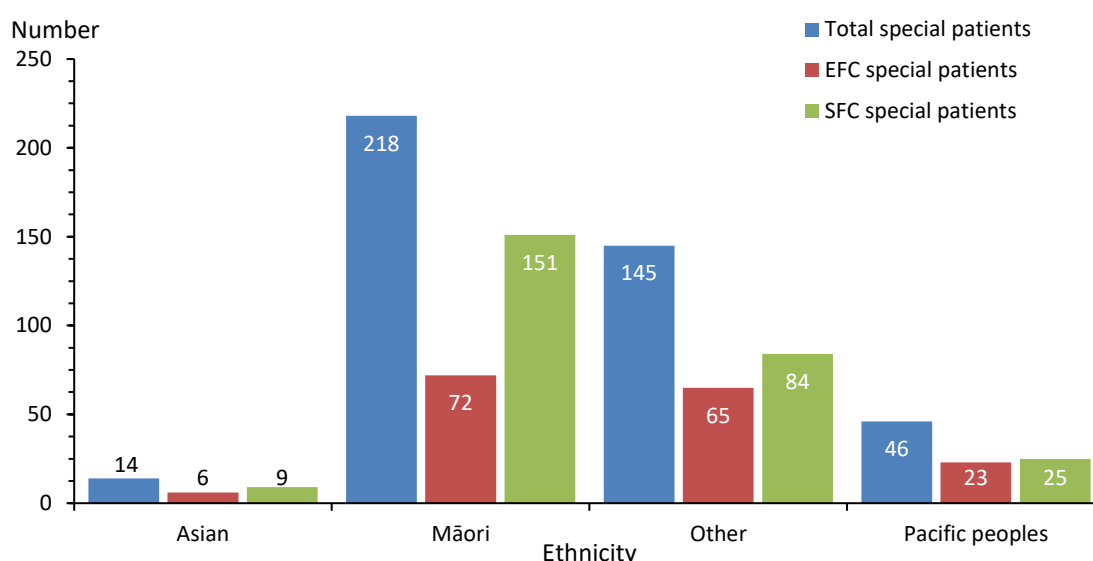
Figure 40 shows the number of special patients in each ethnic group for each of these patient types in forensic care.

Figure 39: Percentage of special patients, by ethnicity, 1 July 2020 to 30 June 2021



Source: PRIMHD data (extracted 3 June 2022).

Figure 40: Number of special patients, by ethnicity and special patient type, 1 July 2020 to 30 June 2021



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 3 June 2022).

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 when special and restricted patients are admitted, discharged or transferred and when certain incidents involving these people occur (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 7 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 7 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 6 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 14 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 through to the Minister of Health from 1 July 2020 to 30 June 2021.

Table 14: Number of section 50 long leave, revocation and reclassification applications received by the Minister of Health for special and restricted patients, 1 July 2020 to 30 June 2021

| Type of request | Number completed |
|--|------------------|
| Initial ministerial section 50 leave applications approved | 9 |
| Initial ministerial section 50 leave applications not approved | 0 |
| Ministerial section 50 leave revocations (initial and further) | 3 |
| Further ministerial section 50 leave applications approved | 23 |
| Further ministerial section 50 applications not approved | 0 |
| Change of legal status applications approved | 8 |
| Change of legal status applications not approved | 3 |
| Total applications approved or not approved | 46 |

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

Before the health system reforms, Aotearoa had 2 major national reporting mechanisms for adverse events relating to mental health.²⁰ These were that DHBs had to:

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 that are rated Severity Assessment Code²¹ 1 or 2 to the Health Quality & Safety Commission (HQSC) in line with the National Adverse Events Reporting Policy.²² Mental health services that were not funded by DHBs were encouraged but not required to report adverse events to the HQSC.

In Aotearoa, adverse events have been reported publicly since 2006. From the time reporting began until the reforms disestablished DHBs, the number of adverse events that DHBs reported increased. This increase was not necessarily because adverse events became more frequent; we consider that at least part of the explanation may be that DHBs improved their reporting systems and created a stronger culture of transparency and commitment to learning.

Adverse events reported by DHB mental health services

Table 15 provides a breakdown of the types of adverse events relating to mental health that DHBs reported to HQSC between 1 July 2020 and 30 June 2021. Table 16 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 had a good reporting culture rather than that it actually had more adverse events than other DHBs. In addition, DHBs that served a larger population or provided more complex mental health services may have reported a higher number of adverse events.

²⁰ An adverse event is an event that results in harm or has the potential to result in harm to a consumer.

²¹ A Severity Assessment Code is a numerical rating of how severe an adverse event is, which in turn indicates what level of reporting and investigation is needed for that event.

²² See the National Adverse Events Reporting Policy on the HQSC website at: www.hqsc.govt.nz/our-programmes/adverse-events/national-adverse-events-policy/.

Table 15: Number of mental health adverse events that DHBs reported to the HQSC, by type of event, 1 July 2020 to 30 June 2021

| Type of event | Outpatient/ community | Inpatient | On approved leave | Inpatient (AWOL) | Total |
|---------------------------|--------------------------|-----------|----------------------|---------------------|------------|
| Suspected suicide | 178 | 2 | 3 | 1 | 184 |
| Serious self-harm | 19 | 8 | 2 | 1 | 30 |
| Serious adverse behaviour | 3 | 7 | 0 | 0 | 10 |
| Restraint injuries | – | 3 | – | – | 3 |
| National total | 200 | 20 | 5 | 2 | 227 |

Note: AWOL = absent without leave.

Source: HQSC adverse event data (extracted 2 June 2022).

Table 16: Number of mental health adverse events that DHBs reported to the HQSC, by DHB, 1 July 2020 to 30 June 2021

| DHB | Number of events | DHB | Number of events |
|--------------------|------------------|-----------------------|------------------|
| Auckland | 19 | Northland | 9 |
| Bay of Plenty | 7 | South Canterbury | 9 |
| Canterbury | 16 | Southern | 6 |
| Capital & Coast | 17 | Tairāwhiti | 25 |
| Counties Manukau | 19 | Taranaki | 9 |
| Hawke's Bay | 2 | Waikato | 8 |
| Hutt Valley | 10 | Wairarapa | 0 |
| Lakes | 4 | Waitematā | 37 |
| MidCentral | 11 | West Coast | 2 |
| Nelson Marlborough | 14 | Whanganui | 3 |
| | | National total | 227 |

Source: HQSC adverse event data (extracted 2 June 2022).

Deaths reported to the Director of Mental Health

Section 132 of the Mental Health Act requires services to notify the Director of Mental Health 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, 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 the death in question; 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'. For more information and data on suicide statistics in Aotearoa, search for 'suicide statistics' on the Manatū Hauora's website (health.govt.nz).

Between 1 July 2020 and 30 June 2021, the Director of Mental Health received 32 death notifications related to people under the Mental Health Act (Table 17). Of these, 9 related to people who were reported to have died by suspected suicide. The remaining 23 reportedly died by other means, including natural causes and illnesses unrelated to their mental health status.

Table 17: Outcomes of reportable death notifications under section 132 of the Mental Health Act, 1 July 2020 to 30 June 2021

| Reportable death outcome | Number of deaths |
|--------------------------|------------------|
| Suspected suicide | 9 |
| Other deaths | 23 |
| National total | 32 |

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

Section 95 inquiries and section 99 inspections

The Director of Mental Health will occasionally require a district inspector to carry out an inquiry under section 95 of the Mental Health Act or undertake an inspection under section 99. Such inquiries and inspections generally focus on systemic issues across one or more mental health services. They typically result in the district inspector or Director 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 or section 99 inspections were completed from 1 July 2020 to 30 June 2021. Table 18 shows the number of completed section 95 inquiry reports the Director received, and the number of section 99 reports the Director received or completed between 1 July 2010 and 30 June 2021.

Table 18: Number of completed section 95 inquiries and section 99 inspections reports received or completed by the Director of Mental Health, 2010/11–2020/21

| 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|
| 1 | 1 | 0 | 0 | 1 | 2 | 0 | 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.

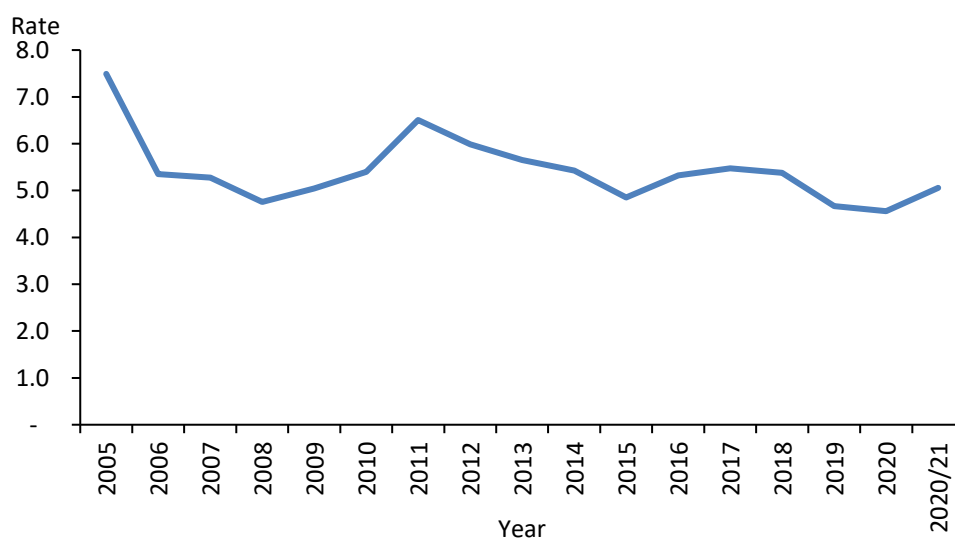
In summary, from 1 July 2020 to 30 June 2021:²³

- 259 people received ECT (5.1 people per 100,000 population)
- services administered a total of 3,043 treatments of ECT
- the people treated received an average of 23.4 treatments of ECT each 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 63.3% of ECT patients.

Number of people receiving ECT

The number of people treated with ECT in Aotearoa has remained relatively stable since 2006. Around 200 to 300 people receive the treatment each year (Figure 41).

Figure 41: Number of people treated with ECT per 100,000 population, 2005–2020/21



Sources: PRIMHD data (extracted 3 June 2022) and manual data from Lakes, Southern, Waikato and Waitematā DHBs. All years except 2020/21 are calendar years.

²³ Sources: PRIMHD data (extracted 3 June 2022) and manual data from Lakes, Southern, Waikato and Waitematā DHBs.

ECT by region

The number and rate of ECT treatments vary regionally (Table 19 and Figures 42, 43 and 44). Several factors help to explain these variations. First, regions with smaller populations are more vulnerable to annual variations (according to the needs of the population at any given time). In addition, people receiving continuous or maintenance treatment will typically receive more treatments in a year than those treated with an acute course. Finally, populations in some DHB areas have fewer barriers to accessing ECT services than those in other DHB areas. It is important to consider these factors when interpreting the following information.

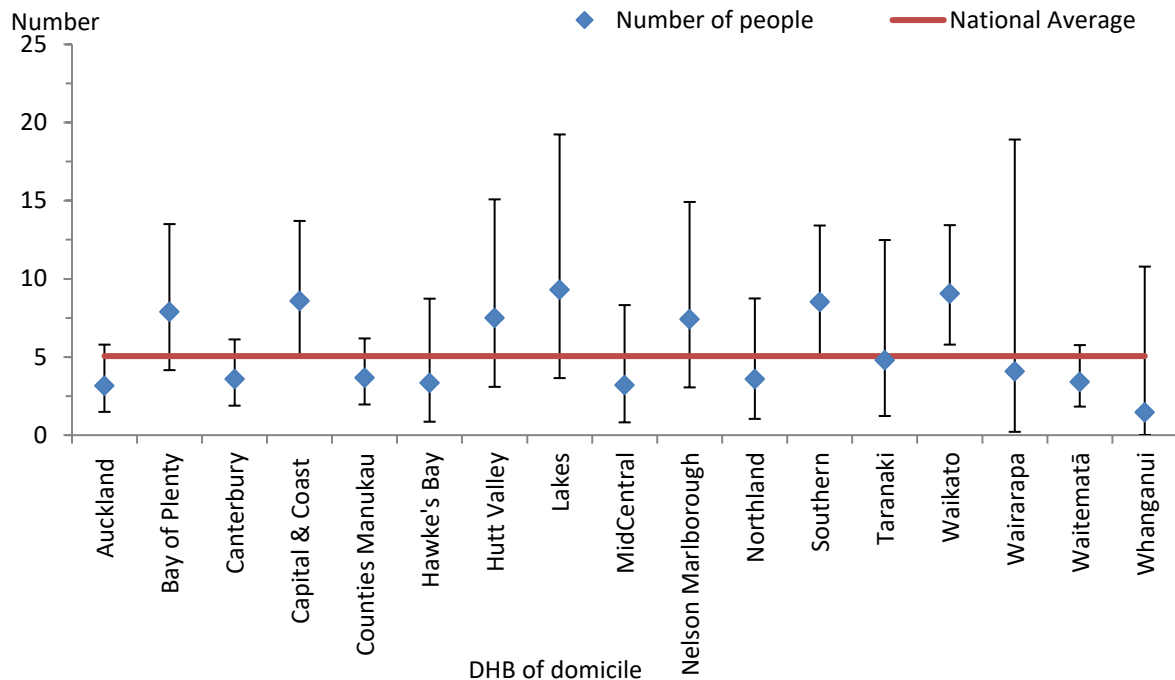
Table 19: ECT indicators, by DHB of domicile, 1 July 2020 to 30 June 2021

| DHB of domicile | Number of people treated with ECT | Number of treatments | Mean number of treatments per person (range) |
|-----------------------|-----------------------------------|----------------------|--|
| Auckland | 16 | 195 | 12 (1–48) |
| Bay of Plenty | 21 | 306 | 14 (1–60) |
| Canterbury | 21 | 145 | 7 (1–19) |
| Capital & Coast | 28 | 331 | 12 (2–31) |
| Counties Manukau | 22 | 179 | 9 (1–32) |
| Hawke's Bay | 6 | 70 | 8 (3–15) |
| Hutt Valley | 12 | 123 | 10 (3–16) |
| Lakes | 11 | 106 | 10 (4–16) |
| MidCentral | 6 | 67 | 11 (1–18) |
| Nelson Marlborough | 12 | 134 | 11 (1–23) |
| Northland | 7 | 55 | 14 (3–52) |
| South Canterbury | 0 | 0 | – |
| Southern | 30 | 481 | 14 (1–68) |
| Tairāwhiti | 0 | 0 | – |
| Taranaki | 6 | 70 | 12 (2–34) |
| Waikato | 40 | 436 | 11 (1–48) |
| Wairarapa | 2 | 30 | 12 (9–15) |
| Waitematā | 22 | 285 | 14 (1–39) |
| West Coast | 0 | 0 | – |
| Whanganui | 1 | 30 | 30 (30–30) |
| National total | 259 | 3,043 | 23 (1–68) |

Note: In 2020/21, there were 17 people who were treated out of area, as follows: Canterbury DHB saw one person from Counties Manukau and 3 people from Nelson Marlborough. Capital & Coast DHB saw 2 people from Wairarapa and one person from Whanganui. Hutt Valley DHB saw 2 people from Capital & Coast. Lakes DHB saw one person from Waikato. MidCentral DHB saw one person from Hutt Valley. Southern DHB saw one person from Hawke's Bay and one person from Waikato. Waikato DHB saw one person from Bay of Plenty and one person from Taranaki. Waitematā saw one person from Auckland and one person from Capital & Coast.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Lakes, Southern, Waikato and Waitematā DHBs.

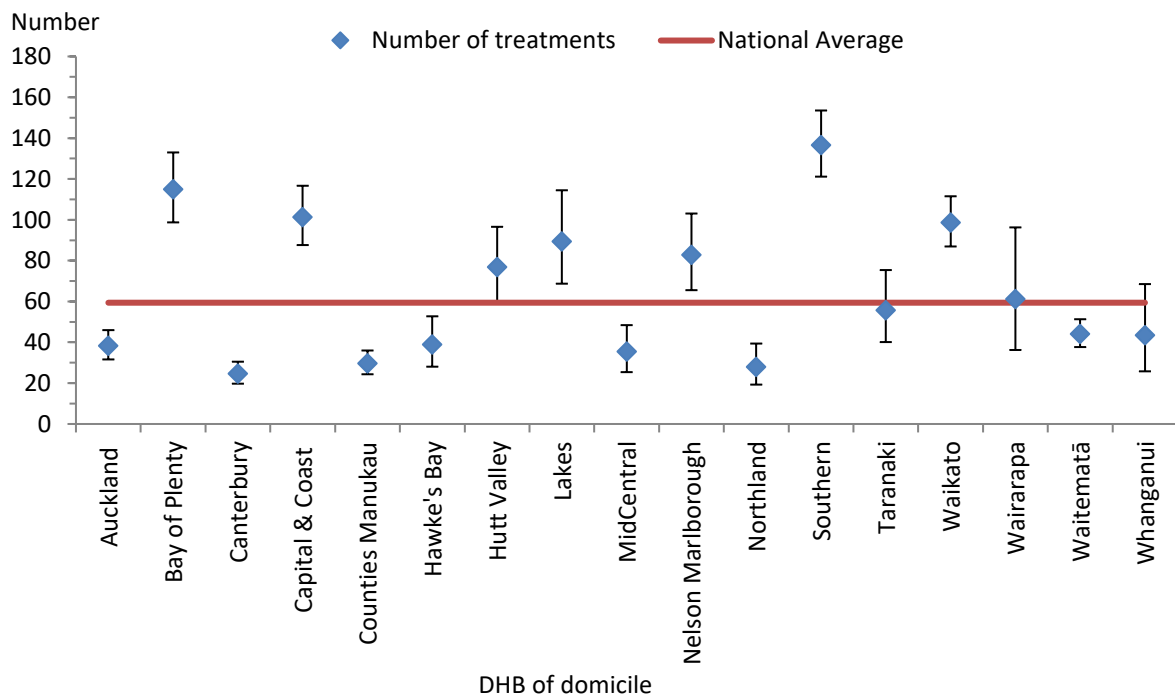
Figure 42: Number of people per 100,000 population treated with ECT, by DHB of domicile, 1 July 2020 to 30 June 2021



Note: No one living in South Canterbury, Tairāwhiti or West Coast DHBs received ECT treatment in the period and so these DHBs are excluded from this graph.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Lakes, Southern, Waikato and Waitematā DHBs.

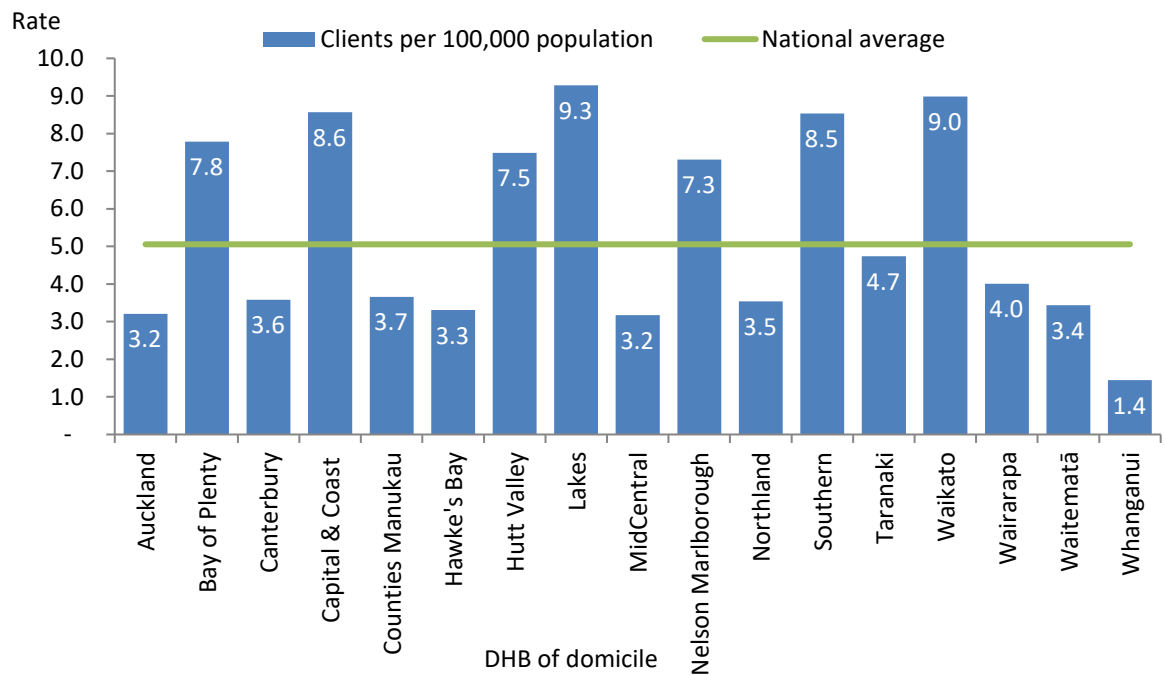
Figure 43: Number of ECT treatments per 100,000 population, by DHB of domicile, 1 July 2020 to 30 June 2021



Note: No one living in South Canterbury, Tairāwhiti or West Coast DHBs received ECT treatment in the period and so these DHBs are excluded from this graph.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Lakes, Southern, Waikato and Waitematā DHBs.

Figure 44: Rate of people treated with ECT per 100,000 population, by DHB of domicile, 1 July 2020 to 30 June 2021



Note: No one living in South Canterbury, Tairāwhiti or West Coast DHBs received ECT treatment in the period and so these DHBs are excluded from this graph.

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Lakes, Southern, Waikato and Waitematā DHBs.

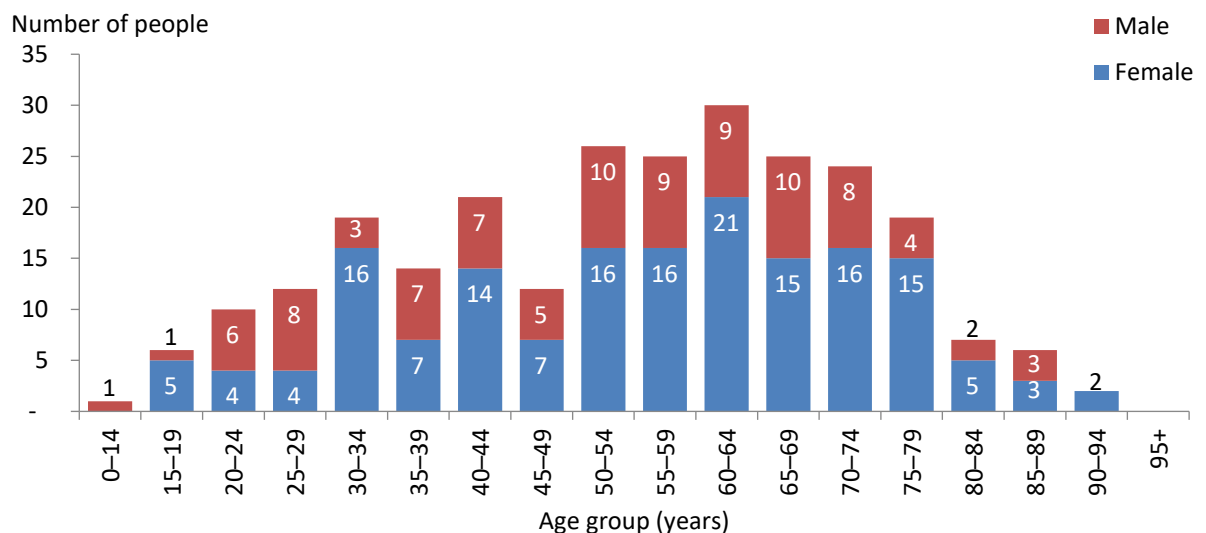
Age and gender of people receiving ECT

Between 1 July 2020 and 30 June 2021, women were more likely to receive ECT than men.

Older people were more likely to receive ECT than younger people. Patients over 50 years old represented 63.3% of all patients receiving ECT in this period.

Figure 45 presents the numbers broken down by age group and gender.

Figure 45: Number of people treated with ECT, by age group and gender, 1 July 2020 to 30 June 2021



Sources: PRIMHD data (extracted 3 June 2022) and manual data from Lakes, Southern, Waikato and Waitematā DHBs.

Ethnicity of people treated with ECT

Table 20 indicates that Asian, Māori and Pacific peoples were less likely to receive ECT than other ethnicities, such as New Zealand Europeans. 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.

Table 20: Number and rate per 100,000 population of people treated with ECT, by ethnicity, 1 July 2020 to 30 June 2021

| Ethnicity | Number | Rate per 100,000 |
|-----------------------|------------|------------------|
| Asian | 17 | 2.0 |
| Māori | 31 | 3.6 |
| Pacific peoples | 4 | 1.1 |
| Other | 207 | 6.8 |
| National total | 259 | 5.1 |

Sources: PRIMHD data (extracted 3 June 2022) and manual data from Lakes, Southern, Waikato and Waitematā DHBs.

Consent to ECT 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 Tribunal²⁴ 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.

Between 1 July 2020 and 30 June 2021, services administered ECT to 98 people who could not consent to treatment. In total, 1,191 ECT treatments were administered without the person's capacity to consent. An additional 18 treatments were administered to 4 people who had the capacity to consent but refused. In all of these cases, the DHBs gained a second opinion from an independent psychiatrist. Table 21 shows the number of treatments administered without consent during this period.

²⁴ The Mental Health Review Tribunal is an independent body appointed by the Minister of Health under the Mental Health Act. For more information, see the Mental Health Review Tribunal webpage on Manatū Hauora's website at: health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/mental-health-review-tribunal (accessed 21 September 2022).

Table 21: ECT administered under second opinion without consent, by DHB of service, 1 July 2020 to 30 June 2021

| 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 | 8 | 117 | 0 | 0 |
| Bay of Plenty | 3 | 8 | 0 | 0 |
| Canterbury | 6 | 86 | 0 | 0 |
| Capital & Coast | 5 | 58 | 0 | 0 |
| Counties Manukau | 13 | 95 | 0 | 0 |
| Hawke's Bay | 2 | 42 | 0 | 0 |
| Hutt Valley | 5 | 27 | 2 | 14 |
| Lakes | 5 | 39 | 0 | 0 |
| MidCentral | 3 | 20 | 0 | 0 |
| Nelson Marlborough | 1 | 1 | 0 | 0 |
| Northland | 6 | 85 | 0 | 0 |
| South Canterbury | 0 | 0 | 0 | 0 |
| Southern | 15 | 230 | 0 | 0 |
| Tairāwhiti | 1 | 8 | 1 | 3 |
| Taranaki | 4 | 50 | 0 | 0 |
| Waikato | 12 | 150 | 0 | 0 |
| Wairarapa | – | – | – | – |
| Waitematā | 10 | 160 | 1 | 1 |
| West Coast | – | – | – | – |
| Whanganui | – | – | – | – |
| National total | 98 | 1,173 | 4 | 18 |

Notes: The data in this table cannot be reliably compared with the data in Table 19 because it relates to DHB of service rather than DHB of domicile. The totals of people without capacity and people with capacity does not equal the number of individuals who received ECT without consent, as 2 individuals had fluctuating capacity.

A dash (–) indicates the DHB did not perform ECT in 2020/21; instead it sent people to other DHBs for treatment.

Source: Manual data from DHBs.

Substance use treatment

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*.²⁵ OST services in Aotearoa 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*²⁶ provides clinical and procedural guidance for specialist services and primary health care providers who deliver OST.

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 3 years, through the *Specialist Opioid Substitution Treatment (OST) Service Audit and Review Tool*.²⁷

In summary, from 1 July 2020 to 30 June 2021:²⁸

- 5,542 people received OST
- 78.7% of these people were New Zealand European, 16.2% were Māori, 1.3% were Pacific peoples and 3.8% were of other ethnicities
- 66.8% of clients receiving OST were over 45 years old
- 26.9% of people receiving OST were being treated by a general practitioner in a shared-care arrangement.

²⁵ For more information about the *New Zealand Gazette*, see the Gazette website at: [gazette.govt.nz](https://www.gazette.govt.nz) (accessed 21 September 2022).

²⁶ Ministry of Health. 2014. *New Zealand Practice Guidelines for Opioid Substitution Treatment*. Wellington: Ministry of Health. URL: [health.govt.nz/publication/new-zealand-practice-guidelines-opioid-substitution-treatment-2014](https://www.health.govt.nz/publication/new-zealand-practice-guidelines-opioid-substitution-treatment-2014) (accessed 17 June 2022).

²⁷ 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 (accessed 17 June 2022).

²⁸ Source: Data provided by OST services in 6-monthly reports. These 6-monthly reports do not collect data by National Health Index (NHI) numbers. The Aotearoa total is a sum of the DHB figures, so it can double count people who had services from more than one DHB.

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.

Between 1 July 2020 and 30 June 2021, 72.8% 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.

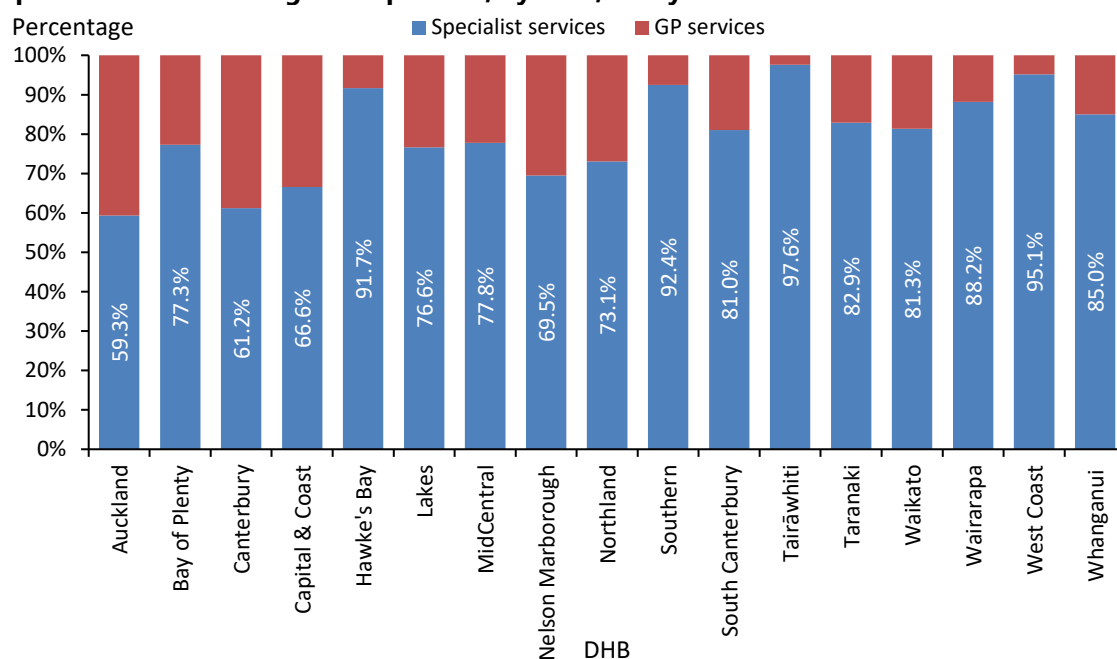
Between 1 July 2020 and 30 June 2021, 27.2% of OST clients received that treatment from their general practitioner. The Ministry's target for service provision is 50:50 between primary and specialist health care services.

Ara Poutama — Department of Corrections (Ara Poutama): When a person receiving OST goes to prison, Ara Poutama ensures that the person continues to receive OST services, including psychosocial support and treatment from specialist services.

Between 1 July 2020 and 30 June 2021, less than 1% of OST clients received that treatment from Ara Poutama. Service providers and Ara Poutama work together to initiate OST as appropriate for people who are imprisoned.

Figure 46 presents the percentage of people receiving OST from specialist services and general practice in each DHB in 2020/21. Figure 47 shows the number of people receiving OST from each of these types of providers from 2008/09 to 2020/21. This year-on-year data is different to that of past reports, as those used numbers from the July to December 6-monthly reports, and this report is now using numbers from the January to June 6-monthly reports.

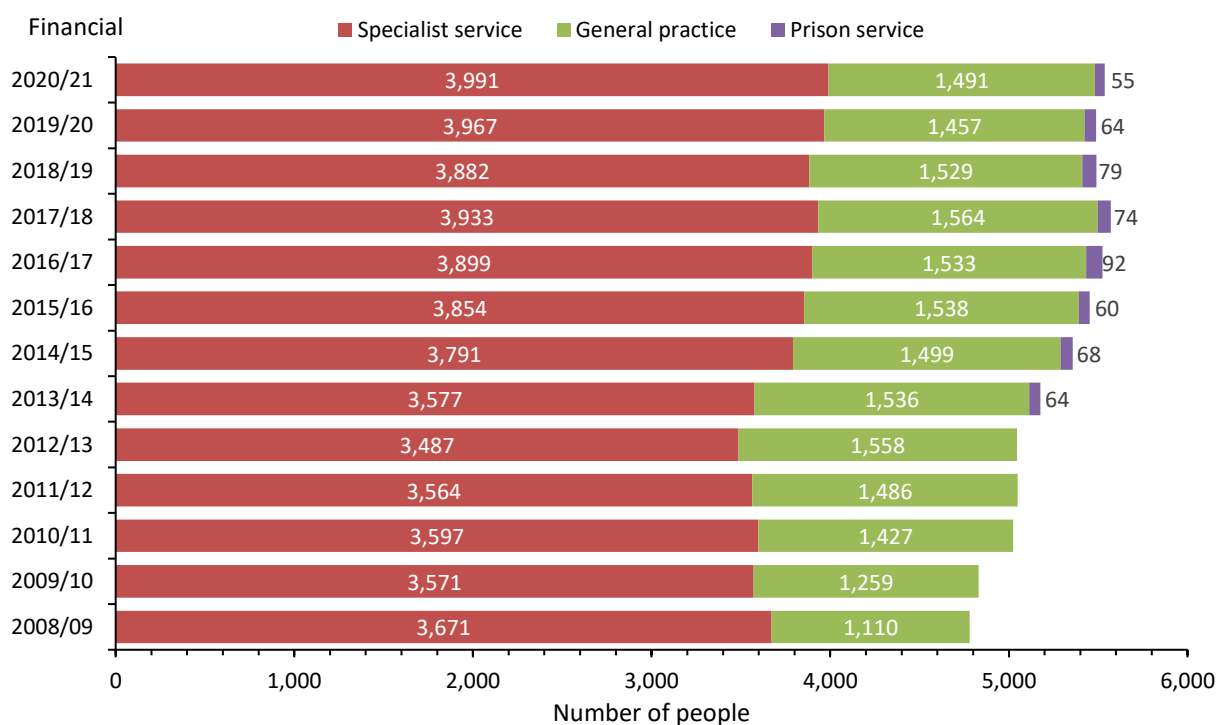
Figure 46: Percentage of people receiving opioid substitution treatment from specialist services and general practice, by DHB, 1 July 2020 to 30 June 2021



Notes: GP = general practitioner. 'Auckland' includes Auckland, Counties Manukau and Waitematā DHBs. 'Capital & Coast' includes Capital & Coast and Hutt Valley DHBs. 'Canterbury' includes one GP service operating in Christchurch.

Source: Data provided by OST services in January to June 6-monthly reports.

Figure 47: Number of people receiving opioid substitution treatment from a specialist service, general practice or prison service, 2008/09–2020/21



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

Source: Data provided by OST services in January to June 6-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 2 types of pharmacotherapy are:

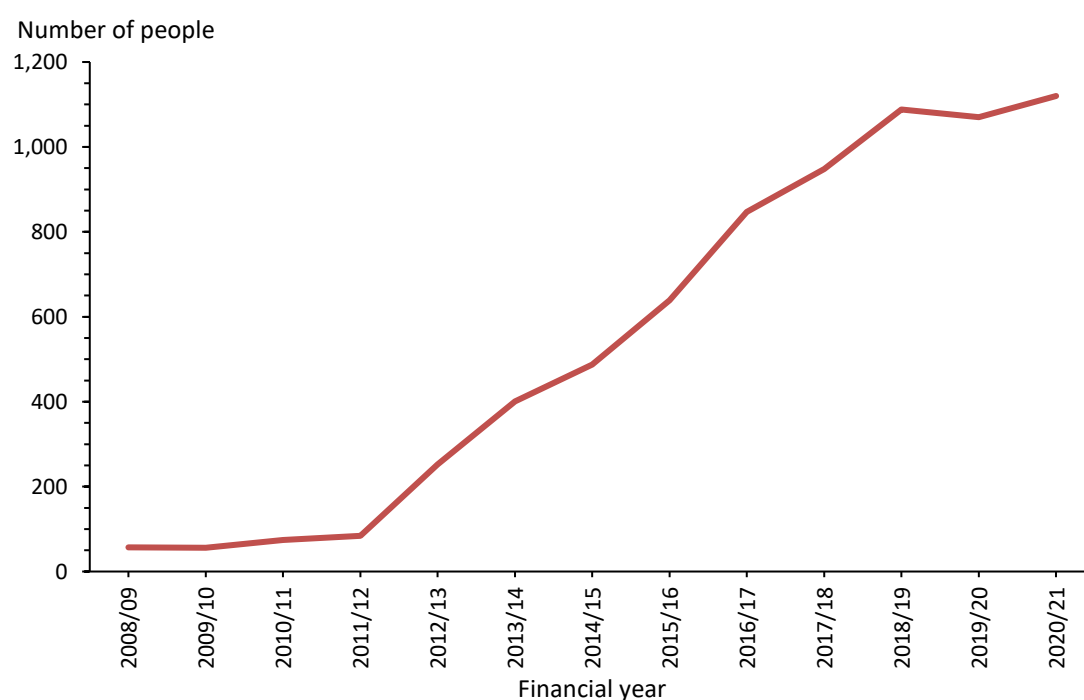
1. maintenance therapy — using opioid substitutes to remain on a stable dose
2. detox — using opioid substitutes to gradually withdraw from the substitute so the client can be free of all opioid substances.

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 Ltd (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 48 presents the number of people prescribed suboxone from 2008/09 to 2020/21.

In the period 1 July 2020 to 30 June 2021, 20.2% of OST clients were prescribed suboxone.

Figure 48: Number of people prescribed suboxone, 2008/09–2020/21



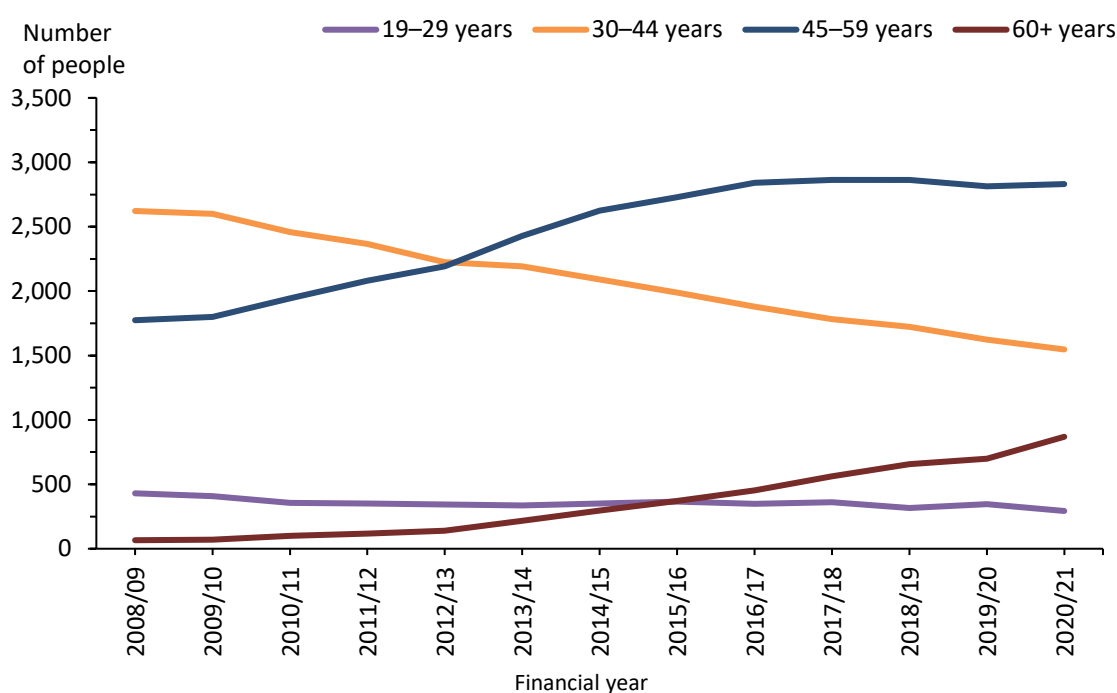
Source: Data provided by OST services in January to June 6-monthly reports.

The ageing population of opioid substitution treatment clients

OST clients are an ageing population. Figure 49 shows how clients in older groups have been increasing in number from 2008/09 to 2020/21 to the point that those over 45 years of age are now the most likely age group to be receiving OST.

Between 1 July 2020 and 30 June 2021, the majority of clients (66.8%) were over 45 years old. Treating an ageing population brings with it more health complications.

Figure 49: Number of opioid substitution treatment clients, by age group, 2008/09–2020/21



Source: Data provided by OST services in January to June 6-monthly reports.

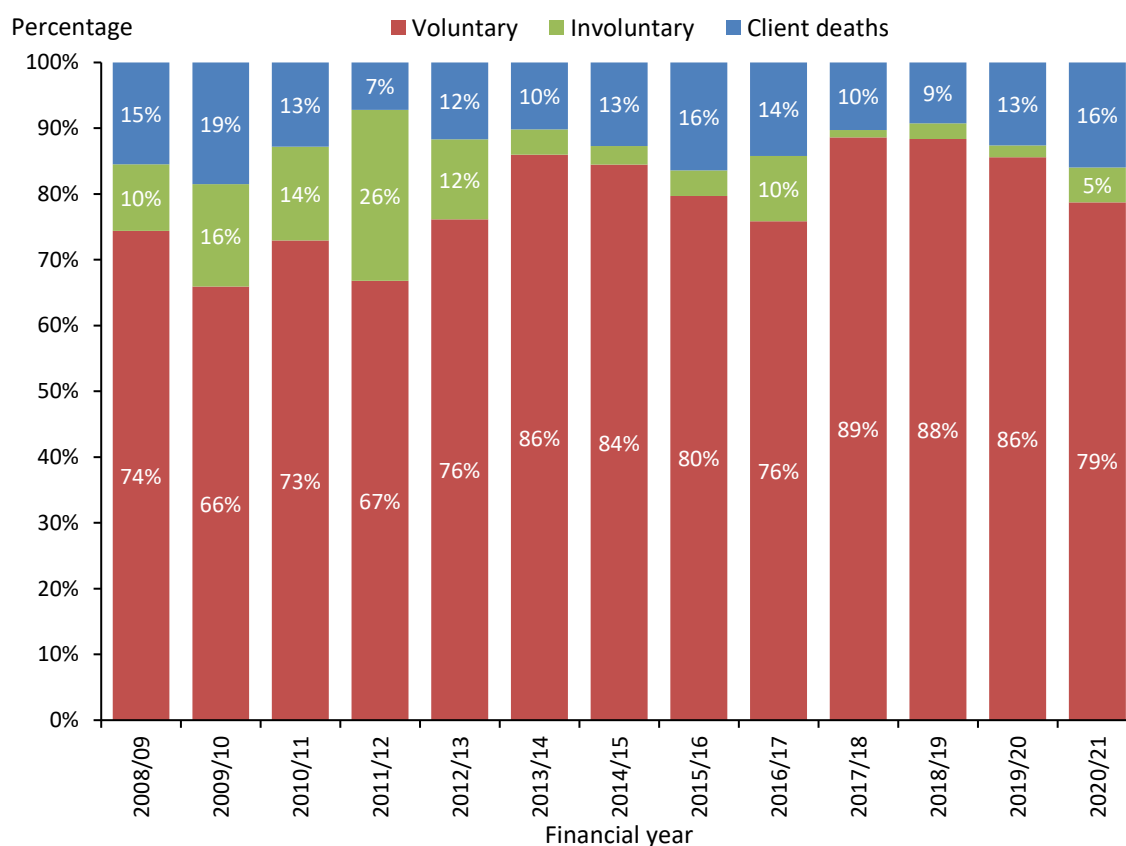
Exit from opioid substitution treatment

In summary, between 1 July 2020 and 30 June 2021:

- 311 people voluntarily withdrew from OST, which accounted for 93.7% of all people who exited from OST that year
- there was a total of 21 involuntary withdrawals (6.3% of all exits). Involuntary withdrawals are the result of behavioural risks that jeopardise the safety of the client or others
- 63 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 can be the result of a range of other causes, such as cancer and cardiovascular disease.

Figure 50 gives an overview of the reasons for exit from treatment (voluntary, involuntary or death) over time, from 2008/09 to 2020/21.

Figure 50: Percentage of exits from opioid substitution treatment programmes, by reason (voluntary, involuntary or death), 2008/09–2020/21



Source: Data provided by OST services in 6-monthly reports.

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 than the earlier Act to protect the human rights and cultural needs of patients and their families and whānau, and it places greater emphasis on enhancing mana 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. You can find the latest annual report, covering the 2020/21 financial year, by searching 'annual reports' on the Ministry's website, [health.govt.nz](https://www.health.govt.nz).

Land Transport Act 1998

In 2021, 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.

Appendix:

Additional statistics –

Ministry of Justice

Table A1 presents data on applications for a compulsory treatment order from the 2004/05 financial year to 2020/21. Table A2 shows the types of orders granted over the same period.

Table A1: Applications for compulsory treatment orders or extensions, 2004/05–2020/21

| Financial 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 |
|----------------|---|--|--|--|--|
| 2004/05 | 4,416 | 3,824 | 108 | 496 | 0 |
| 2005/06 | 4,299 | 3,635 | 114 | 519 | 1 |
| 2006/07 | 4,385 | 3,818 | 95 | 494 | 0 |
| 2007/08 | 4,579 | 3,899 | 105 | 540 | 0 |
| 2008/09 | 4,570 | 4,003 | 76 | 496 | 0 |
| 2009/10 | 4,661 | 4,101 | 72 | 507 | 0 |
| 2010/11 | 4,807 | 4,198 | 63 | 542 | 1 |
| 2011/12 | 4,838 | 4,272 | 69 | 475 | 0 |
| 2012/13 | 4,950 | 4,480 | 75 | 397 | 0 |
| 2013/14 | 5,181 | 4,610 | 53 | 522 | 0 |
| 2014/15 | 5,184 | 4,629 | 55 | 526 | 0 |
| 2015/16 | 5,564 | 4,918 | 51 | 560 | 0 |
| 2016/17 | 5,607 | 4,927 | 73 | 563 | 0 |
| 2017/18 | 5,570 | 4,959 | 74 | 566 | 0 |
| 2018/19 | 5,619 | 4,972 | 64 | 571 | 0 |
| 2019/20 | 5,710 | 5,021 | 52 | 622 | 0 |
| 2020/21 | 5,902 | 5,241 | 62 | 608 | 0 |

Notes: CTO = compulsory treatment order. The table presents applications that had been processed at the time of data extraction on 9 May 2022. 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 9 May 2022).

Table A2: Types of compulsory treatment orders made on granted applications, 2004/05–2020/21

| Financial year | Number of granted applications for orders | Number of community CTOs (or extension) | Number of inpatient CTOs (or extension) | Number of orders recorded as both community and inpatient CTOs (or extension) | Number of other orders | Number of applications where type of order was not recorded |
|----------------|---|---|---|---|------------------------|---|
| 2004/05 | 3,824 | 1,816 | 1,585 | 101 | 9 | 313 |
| 2005/06 | 3,635 | 1,519 | 1,364 | 104 | 14 | 634 |
| 2006/07 | 3,818 | 1,730 | 1,411 | 102 | 21 | 554 |
| 2007/08 | 3,899 | 1,676 | 1,293 | 127 | 22 | 781 |
| 2008/09 | 4,003 | 2,020 | 1,520 | 99 | 15 | 349 |
| 2009/10 | 4,101 | 2,148 | 1,628 | 116 | 6 | 203 |
| 2010/11 | 4,198 | 2,283 | 1,668 | 95 | 10 | 142 |
| 2011/12 | 4,272 | 2,297 | 1,664 | 97 | 8 | 206 |
| 2012/13 | 4,480 | 2,591 | 1,731 | 62 | 0 | 96 |
| 2013/14 | 4,610 | 2,616 | 1,756 | 88 | 2 | 148 |
| 2014/15 | 4,629 | 2,688 | 1,782 | 84 | 0 | 75 |
| 2015/16 | 4,918 | 2,897 | 1,822 | 59 | 4 | 136 |
| 2016/17 | 4,927 | 2,727 | 1,654 | 74 | 2 | 470 |
| 2017/18 | 4,959 | 2,594 | 1,710 | 48 | 4 | 603 |
| 2018/19 | 4,972 | 2,748 | 1,814 | 46 | 1 | 363 |
| 2019/20 | 5,021 | 2,898 | 1,747 | 63 | 0 | 313 |
| 2020/21 | 5,241 | 3,031 | 1,939 | 48 | 3 | 220 |

Notes: CTO = compulsory treatment order. The table presents applications that had been processed at the time of data extraction on 9 May 2022. 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 (extracted 9 May 2022).