



# **Special Patients and Restricted Patients**

Guidelines for Regional Forensic  
Mental Health Services

2024

## Disclaimer

While every care has been taken in the preparation of the information in this document, users are reminded that the Ministry of Health cannot accept legal liability for any errors, omissions or damages resulting from reliance on the information contained in this document.

Like all legislation, the Mental Health (Compulsory Assessment and Treatment) Act 1992 is subject to change. Every effort has been made to ensure that these guidelines are up to date. However, all users of these guidelines should ensure that they are aware of any changes to the legislation that affect their practice.

Please note that these guidelines are not intended as a substitute for an informed legal opinion. Any concerns you may have should be discussed with your legal advisors.

These guidelines have been issued by the Director-General of Health, pursuant to section 130(a) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

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# Foreword

These guidelines are mainly for clinical staff, mental health district inspectors<sup>1</sup> and any other parties who administer or work within the legal or clinical framework of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act or the Mental Health Act). Families and whānau, service users and tāngata whai ora, and members of the public may also find these guidelines useful. It should be noted that these guidelines are not clinical guidelines: they are issued under section 130(a) of the Mental Health Act and intended to support the lawful application of Part 4 of the Mental Health Act.

We last updated these guidelines in 2022 due to changes and emerging issues, including:

- the growing influence of rights-based approaches and the need to better promote these within the parameters of the current Mental Health Act
- the need to give greater emphasis to our obligations under Te Tiriti o Waitangi – the Treaty of Waitangi
- the impact of *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (Government Inquiry into Mental Health and Addiction 2018), particularly through feedback from people with lived experience and their families and whānau on how they experience current administration of the Act
- amendments to the Mental Health Act in October 2021
- amendments arising from the Rights for Victims of Insane Offenders Act 2021
- implementation of Ngā Paerewa Health and Disability Services Standard NZS 8134:2021.

The 2024 updates reflect technical changes to legislation as a result of the above amendments, and include some additional advice following various issues that the Director of Area Mental Health Services (DAMHS) has brought to our attention.

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

Regional forensic mental health services have a focus on recovery and rehabilitation, but also need to maintain safety and security for tāngata whaiora and the public. This involves physical, procedural and relational security and various levels of security and restrictions within RFMHS units, depending on tāngata whaiora's mental health, security and risk needs and legal restrictions.

New Zealand legislation specifically allows for people who have been charged with or convicted of an offence, and who meet certain criteria in terms of their mental illness, to be treated for that condition in hospital. Treatment of mental illness can be an

<sup>1</sup> Specific guidelines for district inspectors are available on the Ministry of Health website.

important step in helping an individual to acknowledge and address the reasons for their offending, and in doing so reduce the chances of future offending and significantly improve that individual's wellbeing.

The clinical management of special patients lies with the patient's responsible clinician. However, leave and change of legal status require consideration and approval by the Director of Mental Health and/or (depending on the legal status of the patient) the Minister of Health and/or the Attorney-General. This level of decision-making reflects the seriousness of special patients' status and the need to ensure that a wide range of factors are considered when making decisions about such patients.

These guidelines are intended to foster consistent decision-making by clinicians, facilitate the administration of matters relating to special patient leave and provide transparency on the processes used in reaching decisions about special patients.

Dr John Crawshaw

**Director of Mental Health**

# Abbreviations and definitions

AWOL	Absent without leave
CP(MIP) Act	Criminal Procedure (Mentally Impaired Persons) Act 2003
Code of Rights or Code	Code of Health and Disability Services Consumers' Rights
DAMHS	Director of Area Mental Health Services as defined in section 2(1) of the Mental Health Act
Director	Director of Mental Health
district inspector	a person appointed pursuant to section 94 of the Act to be a district inspector; includes a person appointed pursuant to that section to be a deputy district inspector
Duly authorised officer	person who, under section 93 of the Act, is authorised by the DAMHS to perform the functions and exercise the powers conferred on duly authorised officers by or under this Act
Health New Zealand/Te Whatu Ora	the Crown entity established under the Pae Ora (Healthy Futures) Act 2022
ITOC	Integrated Targeting Operations Centre
medical practitioner	as defined in section 2(1) of the Act, a health practitioner who is, or is deemed to be, registered with the Medical Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of medicine
Mental Health Act or the Act	Mental Health (Compulsory Assessment and Treatment) Act 1992
mental health practitioner	as defined in section 2 of the Act: <ul style="list-style-type: none"><li>• a medical practitioner or</li><li>• a nurse practitioner or</li><li>• a registered nurse practising in mental health (which is also defined in section 2 of the Act)</li></ul>
MFAT	Ministry of Foreign Affairs and Trade
NHI	National Health Index
NZBORA	New Zealand Bill of Rights Act 1990

<i>patient</i>	as defined in section 2(1) of the Act, a person who is: <ul style="list-style-type: none"> <li>(a) required to undergo assessment under section 11 or section 13; or</li> <li>(b) subject to a compulsory treatment order made under Part 2; or</li> <li>(c) a special patient</li> </ul>
<i>proposed patient</i>	as defined in section 2A of the Act, a person: <ul style="list-style-type: none"> <li>(a) starts being a <i>proposed patient</i> when an application is made under section 8A; and</li> <li>(b) stops being a <i>proposed patient</i> when a mental health practitioner records a finding— <ul style="list-style-type: none"> <li>(i) under section 10(1)(b)(i), in which case the person does not become a <i>patient</i>; or</li> <li>(ii) under section 10(1)(b)(ii), in which case the person becomes a <i>patient</i>.</li> </ul> </li> </ul>
responsible clinician	as defined in section 2(1) of the Act, in relation to a <i>patient</i> , the clinician in charge of the treatment of that <i>patient</i>
registered nurse practising in mental health	as defined in section 2 of the Act, a health practitioner who: <ul style="list-style-type: none"> <li>(a) is, or is deemed to be, registered with the Nursing Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of nursing and whose scope of practice includes the assessment of the presence of mental disorder as defined under this Act; and</li> <li>(b) holds a current practising certificate.</li> </ul>
RFMHS	Regional Forensic Mental Health Service
SPMS	Special Patient Management System
SPRP	Special Patient Review Panel

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# Introduction

## Definitions

### Special patient

The term 'special patient' refers to a person who is remanded to or detained in a hospital under specific legislative provisions. Table 1 sets out the most commonly used provisions in relation to special patients.

**Table 1: Common legislative provisions for detaining special patients**

<b>Criminal Procedure (Mentally Impaired Persons) Act 2003</b>	
Section 24(2)(a)	Persons found unfit to stand trial and made a special patient
Section 24(2)(a)	Persons acquitted on account of insanity and made a special patient
Section 34(1)(a)(i)	Persons sentenced to a term of imprisonment and detained as a special patient
Section 35	Inquiries about a person in respect of whom the court has proposed to make an order under section 34
Section 38(2)(c)	Persons remanded for the purpose of an assessment report
Section 44(1)	Persons remanded pending a hearing or trial
Section 23	Persons found unfit to stand trial or acquitted on account of their insanity, remanded while inquiries are made to determine the most suitable method of dealing with the person
<b>Mental Health (Compulsory Assessment and Treatment) Act 1992</b>	
Section 45	Remand or sentenced prisoners who require compulsory assessment and treatment for a mental disorder
Section 46	Remand or sentenced prisoners who are voluntarily admitted for treatment for a mental disorder

### Restricted patient

Restricted patients are patients who are declared to be restricted patients by the court in an order under section 55 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act). Such orders may be made where the court is satisfied that a patient presents special difficulties because of the danger they pose to others.

Restricted patients are generally subject to the same leave provisions as those applying to special patients. These guidelines use the term 'special patient'; other than where specifically stated, this should be read as also applying to restricted patients.

## 'Hybrid' orders

Sometimes the court will convict a person of an offence, but order them to be subject to a term of imprisonment and also detained as a special patient in hospital under section 34(1)(a)(i) of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP(MIP) Act). These are sometimes referred to as 'hybrid' orders.

When the special patient is no longer liable for the sentence imposed for the offence, they do not continue to be a special patient, and are placed on a compulsory treatment order under the Mental Health Act.

Where a person is under section 45(2) of the Mental Health Act but is no longer liable for the sentence imposed for the offence, they will remain on their compulsory treatment order under the Mental Health Act.

For advice on the requirements of a new compulsory treatment order, or an existing compulsory treatment order, refer to the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health 2022c).

## Purpose of the guidelines

The Ministry of Health intends that these guidelines will support regional forensic mental health services (RFMHSs) to work effectively with the Office of the Director of Mental Health (Office of the Director). Within these guidelines, the Director of Mental Health (the Director) provides guidance on what is expected from forensic services in support of applications for special patient leave (including medical and dental appointments) and transfer, and recommendations for change of legal status.

In particular, these guidelines aim to:

- minimise the risk of harm from forensic patients who are special patients as defined under the Mental Health Act
- support the care and rehabilitation of special patients
- describe the process for requests from RFMHSs relating to special patient movements
- provide transparency on the processes to be undertaken when seeking leave or considering a change of status for special patients.

## Context

The guidelines should be read within the context of the following legislation:

- the Mental Health Act
- the CP(MIP) Act
- the Victims' Rights Act 2002.

These guidelines complement the following guidelines, accessible from the Ministry of Health's webpage 'The Mental Health Act – guidelines and resources' (Ministry of Health 2020b):

- Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2022c)
- Guidelines for Reducing and Eliminating Seclusion and Restraint under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2023a). In addition, the use of seclusion and restraint is governed by the section related to here taratahi (restraint and seclusion) within the Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021)
- Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2020a)
- Guidelines for the Role and Function of Statutory Officers: Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2022a)
- Victims' Rights in the Health System: Guidance for Directors of Area Mental Health Services, compulsory care coordinators, care managers, victim coordinators (Ministry of Health 2023c).

## Scope of these guidelines

These guidelines apply to all RFMHSs as well as hospitals and other inpatient mental health services involved in the care of a special patient (such as during court processes). Other people or entities providing care for special care recipients may also find these guidelines helpful.

Special patients who are potentially affected by the guidelines are those in the following situations:

- special patients detained at an RFMHS under section 45 or 46 of the Mental Health Act (section 45 or 46 patients) who are granted leave under section 49 or 52 of the Mental Health Act to attend urgent medical or dental appointments
- section 45 or 46 patients being returned to prison under section 47 of the Mental Health Act
- section 45 or 46 patients required to appear before the court
- special patients detained under section 34(1)(a) of the CP(MIP) Act
- special patients remanded at an RFMHS under section 23(2)(b) or 35(2)(b) or detailed at an RFMHS under 38(2)(c) of the CP(MIP) Act
- special patients detained at an RFMHS under section 24(2)(a) of the CP(MIP) Act found unfit to stand trial or acquitted on account of insanity.

These guidelines also apply when special patients need to be transported from an RFMHS to another service; for example, transfers to:

- general hospital or specialist clinics for health treatment
- court in relation to charges against the individual, or as a witness

- prison or police custody where it is no longer necessary for a person to be treated by the RFMHS.

## Cultural and personal rights considerations

The *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health 2022c) contain a detailed description of the sections of the Mental Health Act and outline the importance of Te Tiriti and the constitutional constraints it imposes. It is especially important to follow these recommendations when applying these guidelines.

We know from data provided for the Office of the Director's annual reports that Māori are more likely to be assessed or treated under the Mental Health Act than non-Māori. The Director's 2023 report records that Māori are 2.9 times more likely to be subject to an indefinite community treatment order than non-Māori.

We also know that nationwide, Māori are 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.

Of specific significance to these guidelines, we note that the ethnic group with the highest proportion of people subject to a special patient order is Māori (54.2% in 2021/22) (Ministry of Health 2023b). In 2021/22, Māori represented the highest proportion of both extended forensic care (45.3%) and short-term forensic care (59.2%) special patients.

Therefore, it is imperative that RFMHSs are aware that equitable health and wellness outcomes are a priority within the Aotearoa New Zealand health system, and that they support the achievement of health equity.

Section 5 of the Mental Health Act requires powers under the Act to be exercised:

- a) with proper recognition of the importance and significance to the person of the person's ties with their family, whānau, hapū, iwi and family group
- b) with proper recognition of the contribution those ties make to the person's wellbeing
- c) with proper respect for the person's cultural and ethnic identity, language and religious or ethical beliefs.

Under section 65 of the Mental Health Act, every patient is entitled to be dealt with in a manner that accords with the spirit and intent of section 5 of that Act. This patient right is enforceable through the complaints procedures set out in section 75.

This patient right is reinforced by:

- Right 1(3) of the Code of Health and Disability Service Consumers' Rights, which states that 'every consumer has the right to be provided with services that take into

account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori'

- the rights within the New Zealand Bill of Rights Act 1990, including, for example:
  - section 15, which states that 'every person has the right to manifest that person's religion or belief in worship, observance, practice, or teaching, either individually or in community with others, and either in public or in private'
  - section 20, which states that 'A person who belongs to an ethnic, religious, or linguistic minority in New Zealand shall not be denied the right, in community with other members of that minority, to enjoy the culture, to profess and practise the religion, or to use the language, of that minority'.

Reports submitted with the objective of requesting a decision about special patients' treatment must address the person's cultural identity and any potential impact that the treatment decision will have in relation to that identity. Reports must show evidence of a cultural assessment and cultural considerations in recovery and rehabilitation plans. If there was no cultural assessment or cultural considerations, the reasons for this must also be documented.

# 1 Notification of admission of special patients

Section 42 of the Mental Health Act requires the Director of Area Mental Health Services (DAMHS) to ensure that the person in charge of a hospital to which a special patient is admitted sends the following information to the Director within 14 days after the patient is admitted:

- notice of the admission
- a copy of the order on which the patient was admitted
- a copy of the Mental Health Act certificates or clinical documentation accompanying the order, such as a section 45 form, section 8B certificate or section 10 certificate, and clinical particulars
- a statement of both the mental and physical condition of the patient at the time of admission (such as reports prepared for the court and reports from prison in-reach teams).

In practice, this information will be uploaded into the special patient management system (SPMS).

The Ministry of Health strongly recommends that a special patient's biometrical information (obtained pursuant to section 43A of the Mental Health Act) is provided to the Director as soon as practicable after admission.

This information forms the basis of the Ministry's special patient database.

Section 43 requires the DAMHS to ensure that the person in charge of a hospital sends notice to the Director of any of the following events that concern a special patient admitted to the hospital within 14 days of the occurrence of the event:

- discharge from the hospital
- transfer from the hospital
- absence on leave from the hospital
- cancellation of leave from the hospital
- return from leave
- escape from the hospital
- retaking after an escape.

Section 129 of the Mental Health Act requires DAMHSs to ensure that in every hospital or service the person in charge keeps a register of the admission and discharge of compulsory patients (including transfers and deaths), a register of restraint and



seclusion, and any other records required by the Director. In practice, this information is collected and held in the RFMHS reportable event database. The Ministry recommends that RFMHSs work with their data entry staff to ensure that a high quality of data is entered into PRIMHD<sup>2</sup> for this purpose.

<sup>2</sup> PRIMHD is the Ministry of Health's national collection of service activity and outcomes data on mental health and addiction services

# 2 Safety and security

## 2.1 Travel restrictions

As a part of their orientation into an RFMHS, special patients need to be informed of security and safety conditions relating to their legal status. The following matters need to be covered in a format suitable to the condition and language of each patient:

- the requirement to remain in a facility in Aotearoa New Zealand as a special patient unless granted leave
- the fact that they will not be able to leave Aotearoa New Zealand without specific approval by the Minister
- the fact that they may not leave the facility without leave being approved
- the fact that they will be returned if they escape or are outside the facility without leave
- the fact that their biometric information will be collected by the Director, the DAMHS or the person in charge of the hospital in which they are detained.

If the special patient is eligible for leave, they should be made aware that the leave will have conditions attached, including:

- the requirement that they do not travel overseas
- if they are on unescorted leave in the community (short or long), the fact that an overseas border alert will prevent them from departing Aotearoa New Zealand without permission
- the fact that they will be returned to hospital if they breach any conditions of their leave
- the requirement that they abstain from using alcohol or other illegal substances
- the requirement that they comply with any treatment their responsible clinician prescribes.

## 2.2 Photographing special patients

Under section 43A of the Mental Health Act, the Director, the DAMHS or the person in charge of a hospital may direct the collection of biometric information from special patients. Biometric information comprises one or more of:

- a photograph of a person's head and shoulders, according to passport requirements (see below)
- fingerprint impressions
- an iris scan
- an electronic record of the information capable of being used for biometric matching.

Photographing special patients will strengthen the management, safety and security of special patients by:

- identifying special patients to staff
- providing identification in the case of an emergency, including a natural disaster
- assisting in identification with the New Zealand Customs Service (Customs) if travel alerts are in place
- assisting other agencies (such as the New Zealand Police (the police)) to search for any special patient who is absent without leave (AWOL), and to warn the public if there are dangers in approaching the person.

The Ministry of Health suggests constructing a client profile that contains the following information, verified where possible, that can be used to assist biometric matching:

- name (registered at birth or on first entry to Aotearoa New Zealand)
- preferred name
- alternative names and aliases
- National Health Index (NHI) number
- photograph
- date photograph was taken
- date of birth
- place of birth
- type of leave currently on
- registered victim (Yes or No).

This information will make it easier to place overseas border alerts on special patients who are on ministerial long leave (see section 7) or unescorted short leave.

When a special patient first enters an RFMHS, the RFMHS should require them to sign a form authorising the provision of a photograph along with the supporting information. The form should include information for the special patient about what the information is likely to be used for, who it is likely to be shared with and why it is being collected. The special patient should be informed as a part of this process that refusal to provide this biometric information may have negative consequences for their subsequent leave applications (and why), and should also receive information on how they may request and access their own information if they want it.

Guidance on the appropriate quality for special patient photographs can be found on Internal Affairs' webpage 'Passport photos': [www.passports.govt.nz/passport-photos/](http://www.passports.govt.nz/passport-photos/).

Individual RFMHSs may develop their own processes for taking photographs, provided that they follow the consent, storage and disposal protocols set out in this section. Some RFMHSs may have the facility to take photographs; a photographer can attend the forensic unit. In such instances, photographs should be taken with a forensic staff member present. An alternative is to purchase a digital camera and have a staff member take the photograph. Personal cameras or cell phones should not be used.

Each photograph must be stored electronically and in hard copy. The profile form and photograph should be treated as part of the patient's record and be stored as part of the RFMHS's patient management system, to meet the requirements of the Public Records Act 2005 (and the Health Information Privacy Code 2020). The image on the camera should be deleted once the photograph has been taken.

Photographs should be updated at least every five years while the person remains a special patient.

The DAMHS must ensure that, if an individual's status as a special patient is lifted, all photographs (including any negatives or digital or other records of the photographs) taken during the special patient's detention will be kept in accordance with the relevant sector standards, the Privacy Act 2020 (and the Health Information Privacy Code 2020), the Public Records Act 2005 and the Health (Retention of Information) Regulations 1996.

If a special patient refuses to provide the biometric information requested for the purpose of section 43A of the Mental Health Act, the Director must be informed for the purpose of determining the conditions of subsequent leave applications.

## 2.3 Flight risk assessment

An RFMHS should conduct a flight risk assessment for every special patient on entry. The flight risk assessment should identify the level of risk (high, medium or low) and be supported by a summary of reasons underlying the assessed level of risk.

Factors to consider when assessing for flight risk include:

- dual citizenship
- relatives or connections overseas
- financial circumstances
- expressed desire to travel
- other incentives to travel
- possession of current passport/passports.

The patient's current management plan should indicate the steps that the RFMHS has taken to mitigate these risks.

### 2.3.1 Overseas border alerts

A planned overseas border alert needs to be in place for any special patient who has ministerial long leave or unescorted short leave in the community.

When a special patient is granted unescorted short leave for the first time, travel restrictions (an overseas border alert and passport block) need to be instigated. To do this, the Office of the Director will notify two external agencies, Interpol (overseeing border alerts) and the Department of Internal Affairs (overseeing passport blocks).

Emergency overseas border alerts can be placed where a special patient escapes or is otherwise AWOL.

The RFMHS is responsible for placing and removing emergency overseas border alerts for special patients. Section 6.3.1 of these guidelines sets out details of the process for placing an emergency overseas border alert.

In the rare event that a special patient is granted leave and approval to travel overseas, the overseas border alert needs to be removed for this purpose and then reinstated on the patient's return.

When a special patient is granted a change of status, the Office of the Director will remove travel restrictions (an overseas border alert and passport block) as soon as the Office of the Director is notified of the change of status.

## 2.3.2 Process when an overseas border alert is activated

If an overseas border alert is activated, Customs will contact police at the border. Police will check the photograph held by Customs to confirm the patient's identity. If the patient is subject to an overseas border alert, police will contact the Director or the relevant DAMHS.

If the patient is on short leave, their leave must immediately be cancelled by the Director or the DAMHS under section 52 of the Mental Health Act. If the patient is on ministerial long leave, the DAMHS must direct in writing that the patient be admitted or re-admitted to hospital (under section 51 of the Mental Health Act). If police need a copy of that direction, they will provide the DAMHS with an email address. Section 3 of these guidelines sets out further details.

The DAMHS (or the person acting on the authority of the DAMHS) must advise police of the RFMHS to which the patient is to be taken. Police and the RFMHS should agree on a transport plan, reflecting the Ministry's guidance on safe transportation of special patients: see *Guidelines for the Safe Transport of Special Patients in the Care of Regional Forensic Mental Health Services* (Ministry of Health 2022b).

# 3 Special patient reviews

Special patient review panels (SPRPs) originated from the recommendations of the *Report of the Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients* (known as the Mason Report) in 1988 (Ministry of Health 1988). These panels provide a useful source of information and advice to the Director on the progress of individual special patients. However, SPRPs are not legal entities and do not replace the decision-making responsibilities that the Mental Health Act places on responsible clinicians, DAMHSs and the Director.

The SPRP process is a useful source of advice for the Director; more importantly, it provides a mechanism for a multidisciplinary peer review of decisions about special patients. The information provided by SPRPs is a comprehensive, multidisciplinary update of a patient's progress, and often comprises supporting information for a request for ministerial long leave or change of legal status.

Special patient review panel reports should provide a comprehensive picture, over time, of the progress of individual special patients. In constructing a report, the SPRP should consider reports from all those involved in the patient's care, including:

- the responsible clinician
- the case manager / key worker
- nursing staff
- psychologists
- occupational therapists
- social workers
- cultural advisors / cultural workers
- lived experience advisors
- the patient's family/whānau
- the patient
- other service providers, as appropriate (eg, non-governmental organisations, employers).

The Ministry of Health recommends that SPRPs include an external member: preferably a psychiatrist with expertise in forensic psychiatry.

Patients may sometimes ask to have a support person, or their lawyer, present when the SPRP conducts its review. This decision should generally be respected: patients have the right to a lawyer under section 70 of the Mental Health Act as well as the right to natural justice and the right to have support (under Right 8 of the Code of Health and Disability Service Consumers' Rights).

The first report from the SPRP should provide a general comment about the leave plan, which should be provided in detail in the responsible clinician's report. This leave plan should be updated for subsequent SPRP reports. This will assist the RFMHS when seeking approval for leave by assuring the Office of the Director that each request for leave is part of a planned process.

Reports from SPRPs should include the information given in Table 2.

**Table 2: Information to include in special patient review panel reports**

First report	<ul style="list-style-type: none"> <li>• A covering letter, signed by the SPRP chair, outlining the key issues noted by the SPRP and including any recommendations on the patient's legal status or leave progress, including addiction issues and treatment plan if applicable</li> <li>• A report from the patient's responsible clinician</li> <li>• Summary reports from members of the multidisciplinary team</li> <li>• A proposed management and rehabilitation plan, including an integrated care plan, wellness and recovery plan and leave plan</li> <li>• The patient's history prior to becoming a special patient</li> <li>• The circumstances of the patient's offending</li> <li>• The patient's mental state on admission to hospital</li> <li>• Comment on matters relating to the offending (eg, insight into the offending, relationship with victims)</li> <li>• Family/whānau feedback on progress</li> </ul>
Subsequent reports	<ul style="list-style-type: none"> <li>• A covering report, signed by the SPRP chair, outlining the key issues noted by the SPRP and including any recommendations relating to the patient's legal status or leave progress</li> <li>• A report from the patient's responsible clinician, including an updated leave plan</li> <li>• Summary reports from members of the multidisciplinary team</li> </ul> <p>NB: Reports should not repeat previous information; nor should they consist of printouts from the patient's clinical file.</p>

The Ministry holds SPRP reports on its secure SPMS database; RFMHSs do not need to provide them with every request for leave once they have been entered into the SPMS.

It is important to note that RFMHSs will hold original SPRP documents. If a patient wishes to see these, they should make a privacy request to the service in the usual manner.

## 3.1 A note regarding risk assessments

Several clinical tools, including structured clinical judgement tools, may be used to assess risk. The decision about which one to use is the responsibility of the patient's responsible clinician, in line with practice in individual services, and will depend upon

the type of risk the individual presents. Both the HCR20<sup>3</sup> and START<sup>4</sup> are suitable structured clinical judgement risk assessment tools. Some RFMHSs are also effectively using the DUNDRUM<sup>5</sup> toolkit.

Note that a full risk assessment is not required for each leave application. However, the most recent assessment should be summarised, and a current summary of risk provided in support of any leave application. It is suggested that a full risk assessment be provided to each SPRP.

## 3.2 Timing of special patient reviews

Because the SPRP process is not specified in legislation, RFMHSs undertake these reviews at varying frequencies. As a general practice, the Ministry recommends that an SPRP review special patients at least every six months following the order for their detention as a special patient. Some special patients can be seen by the SPRP less frequently (eg, every 12 months) where they are sufficiently stable and their stability appears unlikely to change in the near future. It is helpful if the DAMHS provides the Office of the Director with a list of patients who are on such an extended review cycle.

The SPRP reports should be uploaded into the SPMS, including the outcome of the SPRP signed by the DAMHS.

An SPRP should review patients detained under section 45 of the Mental Health Act when they have been subject to a compulsory treatment order for longer than 12 months.

In some cases, the patient's responsible clinician may decide to ask the SPRP to review a patient before that date.

### 3.2.1 Clinical review of certain special patients

In addition to the SPRP process, section 77 of the Mental Health Act requires responsible clinicians to review special patients who are special patients because they have been detained in a hospital pursuant to a court order made under section 24(2)(a) of the CP(MIP) Act no later than three months following the order for detention, and at least every six months thereafter. Where a section 77 clinical review results in the patient's responsible clinician finding that the patient no longer meets the criteria for being held as a special patient, SPRP reports provide valuable information to assist the Office of the Director in making a recommendation to the Minister and/or the Attorney-General.

<sup>3</sup> Historical-Clinical-Risk Management-20. This is a set of structured professional judgement guidelines designed to assist comprehensive, management-oriented evaluations of violence risk.

<sup>4</sup> Short Term Assessment of Risk and Treatability. This is a 20-item clinical guide for the dynamic assessment of seven risk domains (violence to others, suicide, self-harm, self-neglect, unauthorised absence, substance use and victimisation).

<sup>5</sup> Dangerousness, Understanding, Recovery and Urgency Manual. This is a set of structured professional judgement instruments for admission triage, urgency, treatment completion and recovery assessments.



# 4 Leave for special and restricted patients

Leave is an important part of the rehabilitation and recovery process for special patients and should generally occur as part of a comprehensive leave plan supported by the SPRP.

Table 3 sets out the individual steps for leave progression, varied according to a patient's individual plan. A person's first access to the grounds of the hospital or facility is not considered a leave of absence. Ground access should be considered in the person's overall leave plan approved by the DAMHS.

Following ground access within the hospital grounds, the first leave will generally be escorted short leave. Note that each step in the leave progression may not need to be taken consecutively, and that in this context patients may progress at different rates.

**Table 3: Leave progression**

Step	Type of ground access or short leave	Approval required
Step 1	Ground access with staff escort	DAMHS
Step 2	Unescorted ground access	DAMHS
Step 3	Staff-escorted leave outside the hospital grounds	Director
Step 4	Staff-escorted short-term leave, where the patient is left unescorted while at their destination (eg, to attend a community programme, or a home visit)	Director
Step 5	Unescorted short leave, not including overnight leave	Director
Step 6	Overnight leave for 1–3 days ('2+1' leave)	Director
Step 7	Overnight leave for 4–7 days ('6+1' leave)	Director

Prior to the COVID-19 pandemic, procedures for special patients on full section 52 overnight leave for 4–7 days required the patient to return to hospital to stay overnight after being out of hospital for six nights. The patient was assessed the following day and, if they were deemed to be safe, granted another period of leave for a further seven days.

During COVID-19 alert levels, to ensure service continuity and minimise the risk of infection for patients and staff, it was necessary to modify this approach. Under the new approach, patients could return to the hospital (noting that courts have held 'hospital' to include hospital grounds) for a full assessment by the responsible clinician and case manager or another member of the care team, without the need to stay overnight. This approach has remained in place.

Provided the patient is compliant with leave conditions, their mental state is stable and there are no safety issues, they can be granted leave for a further period of seven days

following the assessment. This approach requires the DAMHS and the clinical director of the service to agree on where in the hospital, or on hospital grounds, would be the safest place for the patient to return and assessment to take place. Note that it is not possible to dispense with the return to hospital entirely; that would in effect give the patient a form of ministerial long leave.

## 4.1 Ground access

'Ground access' is defined as permission for a patient to enter the grounds of the RFMHS at which they are detained, either with an escort or unescorted. The grounds of an RFMHS are defined by each individual service. For mixed-purpose hospital facilities, the grounds are likely to include the premises of the wider hospital.

All special patients are eligible for ground access, including patients excluded from section 52 leave under section 50A(3) of the Mental Health Act (that is, patients detained for trial or sentencing, or awaiting the outcome of an appeal following conviction).

Although ground access is not governed by the provisions of section 52 of the Mental Health Act, the Ministry of Health recommends that a patient's responsible clinician should be responsible for seeking permission for ground access, and the DAMHS should provide approval of the requests.

The DAMHS should inform the Director of any request for ground access where the patient is considered to present a significant risk to themselves or to another person, or is likely to attract media attention, prior to granting approval.

## 4.2 Ground access requirements and risk management

Ground access requests for each patient should align with the patient's leave plan and be part of an identifiable pathway set out in the documentation accompanying the request for DAMHS approval. This must include an individualised assessment of risk and consideration of all the relevant circumstances for the patient. The documentation accompanying the request must clearly identify the type of ground access and any restrictions on access. Escort arrangements, including the ratio and gender of escorting staff, should reflect the RFMHS's current policy and the degree of risk the particular patient presents to themselves or others.

Before each period of ground access, staff (in practice, usually be a registered nurse) should conduct a risk assessment. This should include an assessment of the following:

- whether there is the right staff mix to support the person to take the leave
- whether the staff escorts have good rapport with the patient.

The focus should be on making sure that person is well supported to have the optimal experience from the period of leave that helps them achieve their recovery goals, which may include connecting with family/whānau. This experience should be safe for all who are involved.

The request may be deferred if the patient presents with a significant increase in risk. Ground access may be subject to restrictions and conditions imposed by the responsible clinician. Where appropriate, the request for ground access should specify the geographic limits within which the leave can occur.

When considering whether to seek the DAMHS's approval for ground access, the treating team should consider such factors as whether the patient:

- is assessed as posing a low risk to the public, identified people or groups of people
- has the capacity for socially appropriate behaviour
- is able to take responsibility for their wellbeing and recovery
- is assessed as being at low risk of absconding/escaping
- has the capacity to follow directions
- is compliant with medication and directions
- is abstinent from illicit substances and alcohol
- has had liaison with Ara Poutama Aotearoa (Department of Corrections) staff, if the patient is on remand, or awaiting the outcome of a trial or sentencing, where appropriate.

The RFMHS should have a plan in place to enable escorting staff to receive assistance in an emergency. This plan should include a requirement that escorting staff carry a mobile telephone or two-way radio. Any incident during leave should be reported to the DAMHS and, if necessary, to the Director in accordance with the Ministry's requirements on reportable events (see section 13 of these guidelines).

## 4.3 Managing flight risk

As noted in section 2.3, RFMHSs should assess all special patients for flight risk and put steps in place to mitigate any risk.

If the Ministry or the RFMHS considers that a special patient presents a flight risk, they will not approve leave until actions have been taken to minimise this risk.

There are no grounds under which special patients can be restricted in their ability to hold a passport. However, RFMHSs should ask patients assessed as high flight risk to voluntarily surrender their travel documents as a condition of leave. So long as the surrender of documents is done with the special patient's consent and not against their will (and the special patient had capacity to make that decision), there will be no offence under the Passports Act 1992. If a special patient refuses to provide their passport or other travel document, this can be considered as part of the decision on

whether to grant leave (provided safe and secure storage of the passport or travel document was offered to the patient).

If a special patient fails to return from leave (that is, they are AWOL) and there are concerns that they may try to leave the country, the RFMHS should notify immigration authorities immediately.

## **4.4 Border alerts and notifying registered victims**

Overseas border alerts should be in place for all special patients who have unescorted short leave or ministerial long leave. See section 2.3.1 and 6.3.1 for more information on the process of placing overseas border alerts.

Registered victims need to be notified in certain circumstances, including when the special patient has first unescorted leave from hospital, has their first unescorted overnight leave from hospital or is AWOL (including failing to return from leave). See section 12 of these guidelines for a more detailed explanation of the requirements relating to victim notification.

## **4.5 Conditions of ministerial long leave and unescorted community short leave**

Certain conditions apply to all special patients on unescorted short leave and ministerial long leave. Those conditions do not apply to patients on escorted or unescorted ground leave. The RFMHS must inform the patient of all conditions of leave before they leave the hospital grounds, and document conditions in the patient's records.

Any application for ministerial long leave or for unescorted short leave in the community should include the following information:

- confirmation that no overseas travel will be permitted
- a current flight risk assessment
- confirmation that the patient has agreed to surrender their travel documents.

# 5 Transfer of special patients under section 49

Section 49 of the Mental Health Act enables the Director to direct the transfer of any special patient from any hospital in which the patient is detained to any other hospital. Such a transfer can be permanent or temporary, such as for a period of urgent assessment and treatment.

A special patient subject to a direction under this section always remains in custody and is considered to be detained and to be continuing their assessment and treatment as required under the court orders. There needs to be a secure escort during the transfer process (see *Guidelines for the Safe Transport of Special Patients in the Care of Regional Forensic Mental Health Services* (Ministry of Health 2022b)).

This is not a form of leave. Therefore, special patients on remand can be subject to a transfer direction.

It is important to note that DAMHSs for RFMHSs cover regions that often contain more than one hospital. This means that special patients can move from one hospital to another but still be under the oversight (and control) of the same DAMHS. The wording of section 49(3) anticipates this.

The assessment and treatment of special patients should be completed in a holistic manner, and should include all medical treatment and other health care that is appropriate to the patient's condition (under section 66), including physical health investigations and care.

When a special patient is transferred from a forensic mental health ward to a medical or surgical ward, their forensic mental health care (eg, their medication) continues but in addition they will receive the medical treatment they need. For short appointments or admissions for medical treatment, it may not be necessary to transfer DAMHS responsibilities for the special patient from the forensic DAMHS to the general DAMHS.

When a special patient is transferred for extended treatment over a period of weeks, it may be necessary to transfer DAMHS responsibilities. However, it is likely that, in terms of assessment and care under the Mental Health Act, a specific assessment and treatment programme will be needed in this case that includes hospital consultation and liaison staff, forensic staff and general hospital staff (perhaps including security).

The section 49 approval is necessary to transfer the place of care so there is an unbroken chain of custody (which is why the warrant holding the patient needs to be held by the hospital) but the mental health treatment (including compulsory treatment)

continues. In practice, it may still be the same DAMHS administrator who holds the master copy of the warrant.

**Table 4: Information in support of a non-emergency transfer of a special patient under section 49 applications**

Information	<p>A letter from the responsible clinician, including:</p> <ul style="list-style-type: none"> <li>• the patient’s legal status</li> <li>• a current mental state assessment, including compliance with treatment</li> <li>• advice of any critical incidents, including possession of weapons, drugs or other prohibited material, and management of those incidents</li> <li>• the reason for the transfer request, including urgency</li> <li>• escort/supervision details, if relevant</li> <li>• a treatment plan including clinical risk assessment and management and flight risk</li> <li>• the correct section 49 transfer form, signed by the patient’s responsible clinician and the DAMHS</li> <li>• for patients under sections 45 or 46 of the Mental Health Act, advice on the extent of their sentence the patient has served.</li> </ul> <p>A signed transport management plan under the <i>Guidelines for the Safe Transport of Special Patients in the Care of Regional Forensic Mental Health Services</i> (Ministry of Health 2022b) if assistance by another agency is required.</p> <p>In practice, this information will be uploaded into the SPMS.</p>
Timeframe	<p>The DAMHS must submit the application at least three working days prior to the scheduled appointment.</p> <p>The Office of the Director must respond within two working days (unless urgent hospital admission is required). In practice, this information will be uploaded into the SPMS.</p> <p>Incomplete information will result in a delay in approving leave.</p>

## 5.1 Medical emergency transfers

In a medical emergency, meeting the full requirements of a section 53A transport management plan may not be possible, as all of the above information may not be immediately available. In this case, the priority is to ensure the special patient receives life-preserving medical attention. The RFMHS facility should arrange for 111 emergency services if required.

In a medical emergency, the special patient’s responsible clinician or RFMHS staff must notify the DAMHS within the RFMHS as soon as practicable of the situation, and discuss transportation requirements, including the need for restraint or police assistance to support clinical staff to transfer the patient to a general hospital emergency department.

The DAMHS within the RFMHS should contact the Director or Deputy Director of Mental Health as soon as practicable and provide the patient details, a summary of the situation, background information, information on assessments undertaken and recommendations regarding the transportation plan, including whether police assistance is required and whether restraint is deemed necessary. The Director or

Deputy Director can thereafter approve the transfer verbally, so as not to delay treatment.

Due to the urgency of the situation, an exchange of emails between the DAMHS and the Director may be the quickest way to gain confirmation of the transfer and transport approvals. This should be followed up by the more formal documentation being uploaded into the SPMS.

# 6 Leave under section 52: 'short-term leave' requests

Section 52 of the Mental Health Act enables the Director (through the Office of the Director) to approve leave for up to seven days to certain special patients. This is called 'short-term leave' and is subject to conditions the Director sees fit.

Once the Director has approved the category of short-term leave, DAMHSs have delegated authority to approve ongoing short-term leave applications within the category and to cancel or withhold leaves of that category under section 52H.

Exercising the power to grant leave under this section requires consultation with the prison director for patients held under section 45 or section 46.

Under section 52(3), short-term leave cannot be granted to any person who was immediately before their admission to the hospital detained in a prison:

- while awaiting a trial or
- during a trial or
- awaiting sentencing or
- pending the determination of any appeal against conviction or
- subject to a sentence of life imprisonment or preventive detention.

The term 'escorted short-term leave' refers to short-term leave where the Director has imposed a condition requiring the patient to be accompanied by one or more members of RFMHS staff. Where patients present a high risk to themselves or to others, their leave should include a condition that they be accompanied by at least one health professional. Any staff member accompanying a patient should be familiar with the patient and fully briefed on the need for the escort and any particular issues or concerns regarding safety. As in the case of ground access, there should be a plan in place to enable escorting staff to receive assistance in an emergency.

## 6.1 Planned leave

Ongoing planned leave requests should align with a patient's leave plan and be part of an identifiable pathway set out in the documentation accompanying SPRP reports. The approval of the Director is required for each new step in the leave progression, but variations within that step may be approved by the DAMHS (eg, increasing escorted leave from one to two hours does not require approval, but moving leave categories does).



**Table 5: Information in support of planned leave and ground access applications**

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Information	<p>A letter from the responsible clinician, including:</p> <ul style="list-style-type: none"><li>• the patient’s legal status (including the parole or release date)</li><li>• a current mental state assessment, including compliance with treatment</li><li>• advice of any critical incidents, including possession of weapons, drugs or other prohibited material, and management of those incidents</li><li>• the reason for the new leave step request, and its connection to the leave plan</li><li>• escort/supervision details, if relevant</li><li>• a risk assessment and management plan while the patient is on leave, including flight risk</li><li>• the patient’s recovery/wellness plan</li><li>• consideration of the needs of children or other vulnerable people in the household if the patient will be with family while on leave (particularly if the index offence took place within the family)</li><li>• the correct leave form, signed by the patient’s responsible clinician and the DAMHS</li><li>• comment on matters relating to the offending (eg, insight into the offending, relationship with victims)</li><li>• comment on matters relating to the risk presented by the patient, particularly in relation to victims of previous offending, especially when planning unescorted community leaves.</li><li>• for patients under sections 45 or 46 of the Mental Health Act, a copy of the most recent parole board outcome, if available</li><li>• for patients under sections 45 or 46 of the Mental Health Act, advice on where the patient is in terms of their sentence</li><li>• how the leave addresses cultural requirements and whether family/whānau support is part of the management plan</li><li>• a reference to the current SPRP report, if available</li></ul>
Timeframe	<p>The DAMHS must notify and give registered victims 14 days to make a submission on the leave application, if that leave would permit the special patient greater autonomy outside the hospital than previous approved leave.</p> <p>The DAMHS must submit the application to the Director at least five working days prior to the planned leave.</p> <p>The Office of the Director must respond within three working days. In practice, this information will be uploaded into the SPMS.</p> <p>Incomplete information will result in a delay in approving leave.</p>

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## 6.1.1 Recall to hospital and cancelling leave

The Director or the DAMHS (acting with authority delegated by the Director) may, at any time during the period of short-term leave granted under section 52, cancel that period of leave. For example, leave may be cancelled because:

- there are concerns about the patient’s mental state
- the patient has breached their conditions of leave
- there are concerns about the risk the patient presents to others
- the patient has been involved in a serious incident.

The Director or the DAMHS (acting with authority delegated by the Director) does not have to cancel leave if situations listed above occur. However, they do need to consider whether the patient should be recalled to hospital and, if so, whether it is necessary to cancel leave.

If a special patient breaches conditions of leave, section 53 of the Mental Health Act allows the Director, the DAMHS, a duly authorised officer, a constable or any person to whom the patient has been entrusted during the period of leave to return the patient to hospital (see section 6.3 for further information).

If leave is cancelled, the RFMHS should see this as a revocation of that step within the leave progression. The approval of the Director should be sought before recommencing leave, at a step appropriate to the condition of the patient. The reason for cancelling the leave and the safety of the individual and the public should also be considered.

The RFMHS should inform the Director of any decision to recall a patient from leave, the actions taken to address the issues leading to their recall and, if leave is cancelled, the reasons for leave being cancelled. A serious incident resulting in cancellation of leave should trigger the reportable events process described in section 13 of these guidelines.

Where a decision is made to cancel and recall a patient from leave, the Director or DAMHS should inform the patient about the decision and provide the direction and the reasons for the direction to the patient in writing as soon as practicable.

## 6.2 Medical and urgent appointments

One-off short-term leave under section 52 of the Mental Health Act for medical or dental appointments, or compassionate short-term leave (eg, due to bereavement or sudden family illness), may need to be approved within a shorter timeframe than that proposed for 'rehabilitative' short leave. The Office of the Director understands that appointments may be urgent (albeit not life-threatening) and that opportunities for treatment (eg, dental treatment) may arise at short notice.

The Office of the Director will endeavour to respond to requests made at short notice, provided the necessary information is given in support of the request. If possible, the DAMHS should phone the Director or Deputy Director to advise of the pending request for leave and to discuss any relevant issues.

It is particularly important to provide information about the number and mix of people escorting the patient (eg, whether they are nursing staff or other staff, and their gender), with a view to assuring the Director that a patient who may be quite unwell, and who may present a degree of risk where leave would not usually be considered, is able to be managed safely outside the confines of hospital. If the patient would not normally be approved leave outside the hospital, but needs to attend a medical appointment, they should be accompanied by a health professional who can provide

advice and support to the patient prior to (or during) the medical procedure. If the patient presents a high risk, the application needs to include clear reasons why the leave is being sought at this time and cannot be deferred.

**Table 6: Information in support of applications for medical and dental appointments**

Information	<p>A letter from the responsible clinician, including:</p> <ul style="list-style-type: none"> <li>• the patient’s legal status</li> <li>• a current mental state assessment / clinical summary</li> <li>• the reason for the leave request, including why leave cannot be deferred</li> <li>• escort/supervision details</li> <li>• a risk assessment and management plan for the patient while they are on leave, including the potential for media interest in the case of high-profile patients</li> <li>• flight risk assessment</li> <li>• the correct leave form, signed by the patient’s responsible clinician and the DAMHS</li> <li>• comment on matters relating to the offending (eg, insight into the offending, relationship with victims)</li> <li>• a reference to the current SPRP report, if available</li> </ul> <p>A signed transport management plan under the <i>Guidelines for the Safe Transport of Special Patients in the Care of Regional Forensic Mental Health Services</i> (Ministry of Health 2022b) if assistance by another agency is required</p>
Timeframe	<p>The DAMHS must submit the application at least three working days prior to the scheduled appointment.</p> <p>The Office of the Director must respond within two working days (unless urgent hospital admission is required). In practice, this information will be uploaded into the SPMS.</p> <p>Incomplete information will result in a delay in approving leave.</p>

If a patient is admitted to hospital and approval cannot reasonably be sought in advance (eg, due to a life-threatening event or admission to hospital after hours), the DAMHS should ensure that retrospective approval for leave is sought on the next working day.

**Table 7: Information in support of urgent admissions to hospital**

Information	<p>A letter from the responsible clinician, including:</p> <ul style="list-style-type: none"> <li>• the patient’s legal status</li> <li>• a current mental state assessment, including compliance with treatment</li> <li>• the reason for the leave request</li> <li>• escort/supervision details</li> <li>• a risk assessment, including flight risk</li> <li>• a risk and clinical management plan for the patient while they are on leave</li> <li>• comment on matters relating to the offending (eg, insight into the offending, relationship with victims)</li> <li>• a reference to the current SPRP report, if available</li> </ul>
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Timeframe	<p>The DAMHS must submit the application as soon as practicable prior to the scheduled appointment.</p> <p>The Office of the Director must respond within two working days.</p> <p>If approval from the Office of the Director cannot be obtained prior to admission, the DAMHS should seek approval on the next working day. In practice, this information will be uploaded into the SPMS.</p>
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## 6.2.1 Exceptional circumstances

In rare situations, there may be exceptional circumstances in which a special patient needs to travel overseas.

Section 52A of the Mental Health Act prevents special patients from departing, or preparing to or attempting to depart, Aotearoa New Zealand unless:

- they have been granted section 52 or 50A leave
- they have permission from the Minister to be absent from Aotearoa New Zealand during that period of leave, and they agree to comply with terms and conditions specified by the Minister
- their departure from Aotearoa New Zealand is in accordance with those terms and conditions.

Any special patient who attempts to depart, prepares to depart or successfully departs Aotearoa New Zealand without permission from the Minister or in breach of the conditions set by the Minister must be treated as having escaped (see section 6.3 below for further information).

Any application for overseas travel during a period of leave must include information on the details of the proposed overseas travel, the necessity of travel and the processes in place to ensure the safety of the special patient and others while the patient is overseas. In this case, RFMHSs should ring the Director or Deputy Director in the first instance to discuss how to proceed.

## 6.3 Absence without leave

Each RFMHS must implement its own procedures in the event of a special patient who escapes, is AWOL or fails to return on the expiry or cancellation of leave. The Ministry intends that the process described below will build on, rather than contradict, current processes. Appendix 2 provides a flowchart of the special patient AWOL process.

Section 53 of the Mental Health Act provides that:

Any special patient who escapes, or who breaches any condition of leave, or who fails to return on the expiry or cancellation of any period of leave may be retaken at any time by the Director, or by the Director of Area Mental Health Services, or by a duly authorised officer, or by any constable, or by any person to whom the person has been entrusted during the period of leave, and taken to the hospital from which the patient escaped or was on leave or to any other hospital specified by the Director.

If a special patient has escaped or is AWOL, the DAMHS (or their delegated staff member) must immediately take the actions set out below.

A 111 call should always be placed if the special patient has escaped or has become AWOL and there is an immediate concern for the safety of the patient, the public in general or particular people. This call should be made (and subsequently documented) by the staff member responsible for the special patient or anyone with authority in the RFMHS (usually the nurse in charge or the allocated nurse).

Once police have been alerted, the DAMHS should call the Director and/or Deputy Director, and provide the details of the incident, a summary of actions taken and information on whether the special patient is a foreign national and whether there is a potential flight risk.

The initial call to police needs to include information on how best to approach the patient, and information about the risk posed by the patient to themselves or to others. Police also need the following information to help them identify the missing patient:

- the patient's full name and date of birth
- details of the RFMHS's last contact with the patient (in person or by phone, social media, etc)
- a full physical description of the missing patient, including the clothing they wore when they were last seen and any distinguishing features; a recent photograph of the patient should be supplied, if available
- actions already taken to find the patient
- names and contact details of family/whānau, friends and associates
- places the patient is likely to visit
- relevant health information, including medication needed
- details of any people who are, or may be, in the company of the patient.

Police will ask the RFMHS to advise them where members of the public should send information about the patient, if they have it, and for the name of a local contact person at the RFMHS during the patient's absence. Police will provide the RFMHS with an event number that should be referenced in any further communication regarding the incident. Police will also need contact details for the RFMHS (cell phone and landline) and any other person who may be affected by the absence of the patient (eg, family members and registered victims, if relevant (see below)).

A person authorised by section 53 of the Mental Health Act can retake and return a special patient to the hospital from which the patient escaped or was on leave. If the place of return is not easily reached (eg, because the special patient was found in a different region from the hospital in which they are usually detained), the patient should be returned to any other hospital specified by the Director, which will typically be the closest RFMHS. The DAMHS will need to negotiate this with the relevant service. Patients cannot be left in the custody of police, as there may be no lawful ability for the police to detain them. The police only have the power to take or retake the special patient to a hospital.

If a special patient is AWOL, the RFMHS must notify the patient's family/whānau of the event and the actions that it is taking to find and return the patient. If there are concerns that family members may be at risk from the patient, the RFMHS should inform the police of this. The Director-General of Health (in practice, the DAMHS as delegated) must notify any registered victims of the escape or absence without leave in accordance with section 37 of the Victims' Rights Act 2002 (see further discussion on the requirements of the Victims' Rights Act in section 12 below).

### 6.3.1 Emergency border alert

If a special patient is AWOL, the DAMHS must request an emergency overseas border alert. To do this, the DAMHS (or a person acting on their authority) must call Customs' Integrated Targeting and Operations Centre (ITOC) on 0508 ITOC OPS (0508 4862 677). The ITOC will require identifying information about the patient, including their full name, date and place of birth, any aliases and a photograph, where available.

Appendix 1 provides a sample form that sets out the information required to place an emergency overseas border alert.

Once police have been notified of the absence of a special patient, the DAMHS or person acting on the authority of the DAMHS should phone the Director (or the Deputy Director) to give the following information, which should be the same information as that provided to police:

- the police event number
- confirmation that any registered victims have been notified (and their details, first checked with police)
- advice on whether the patient has an up-to-date passport and an assessment of their current level of flight risk.

They should follow up this call with an email giving the same information, and thereafter update the Director (usually by a daily phone call or email), until the patient is retaken or is returned.

The Director or Deputy Director will acknowledge all emails from the DAMHS and inform the DAMHS of any actions they take as a result. Such actions may include:

- checking registered victims' details with police
- informing the Director-General and/or the Minister's office
- checking that the RFMHS has a media strategy in place
- advising the Ministry of Health's media team
- assisting with the emergency overseas border alert if required
- requesting that the Department of Internal Affairs invalidate any passport held for the special patient and asking that the Office of the Director be informed if an application is received from that special patient.

The Director may also arrange for further emergency measures if the special patient is a foreign national by informing the New Zealand Ministry of Foreign Affairs and Trade

(MFAT) and/or the Diplomatic Protection Service's Wellington duty officer and an embassy/consulate.

## 6.4 Return of special patient

When a special patient returns, irrespective of the circumstances, the DAMHS or a delegated staff member needs to take the following actions so that the police can be stood down and the overseas border alert removed. The DAMHS or their delegated staff member should call the main police liaison point and provide the following information:

- the police event number
- the special patient's full name and date of birth
- details of where and when the missing patient was located
- details of the patient's return
- information that may be useful in case there is a future event.

The DAMHS should also inform any registered victims and the patient's family/whānau that the patient has returned to the facility and take steps to remove the emergency overseas border alert by contacting Customs' Integrated Targeting and Operations Centre (ITOC) on 0508 ITOC OPS (0508 4862 677).

The Director will ensure that the Director-General and the Minister's office are advised of the patient's return and remove any emergency passport measures. The Director will also inform the Ministry's media team and MFAT. If a standard overseas border alert is needed to replace an emergency alert, the Office of the Director will place it.

Following the immediate response, the DAMHS should provide the Director with a reportable events form and, in due course, with the findings of any internal or external review.

# 7 Leave under section 50A of the Mental Health Act: 'ministerial long leave'

Section 50A of the Mental Health Act enables the Minister to grant specific periods of 'long leave' to persons detained in a hospital as a special patient:

- acquitted on account of insanity
- pursuant to section 34(1)(a)(i) of the CP(MIP) Act
- pursuant to an order made under section 45 of the Mental Health Act
- pursuant to section 46 of the Mental Health Act.

Some special patients pursuant to section 45 or 46 will not be eligible for ministerial long leave under section 50A of the Mental Health Act. The power to grant leave under this section shall not be exercised in respect of any person who:

- was, immediately before their admission to the hospital, detained in a prison while awaiting or during the course of a trial or hearing before any court or while awaiting sentence by any court or pending the determination of any appeal to any court against conviction
- is subject to a sentence of imprisonment for life or to a sentence of preventive detention.

The Minister may only grant long leave if two medical practitioners have certified that the special patient is fit to be allowed to be absent from the hospital and if the Director supports the proposed leave of absence, taking into account any submission from a victim made in accordance with section 50C or 50D of the Mental Health Act.

The most recent SPRP report should identify the patient's suitability for long leave.

The Minister may grant long leave on such conditions as they consider appropriate, including (at the Minister's discretion) a condition that the person must return to the hospital on the date or within the period that the Minister specifies.

Special patients on remand are not eligible for long leave (section 50A(3) of the Mental Health Act).



The conditions imposed by the Minister on special patients granted ministerial long leave have tended to be somewhat generic. In seeking ministerial long leave, it may be of value to the patient and their responsible clinician if the application for leave suggests specific conditions that are relevant to the individual patient (eg, contact with victims). The responsible clinician should inform the patient about the conditions prior to the patient beginning their leave (ideally in writing).

**Table 8: Information in support of applications for ministerial long leave**

Information	<p>A letter from the responsible clinician, including:</p> <ul style="list-style-type: none"> <li>• the patient’s legal status</li> <li>• a current mental state assessment, including compliance with treatment</li> <li>• justification of the leave request</li> <li>• a risk assessment and management plan for the patient while they are on leave, including in regard to flight risk</li> <li>• an overview of the patient’s recovery plan</li> <li>• advice of any critical incidents, including possession of weapons, drugs or other prohibited material, and management of those incidents</li> <li>• advice on whether the patient has used or is likely to use psychoactive substances</li> <li>• the proposed conditions of leave</li> <li>• a certificate, signed by two medical practitioners, stating that the patient is fit to be allowed to be absent from hospital (section 50A(1)(a) of the Mental Health Act)</li> <li>• a second opinion (or a recent SPRP report) supporting the leave</li> <li>• an indication of support from the DAMHS for the proposed leave</li> <li>• comment on matters concerning the offending (eg, insight into the offending, relationship with victims)</li> <li>• comment on matters relating to the risk presented by the patient, particularly in relation to victims of previous offending</li> <li>• comment on what family/whānau support is available</li> <li>• consideration of the needs of children or other vulnerable people in the household if the patient will be with family while on leave (particularly if the index offence took place within the family).</li> </ul>
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Incomplete information will result in delay in providing a report to the Minister. The DAMHS should inform the Office of the Director of issues arising throughout the period of ministerial long leave, particularly where those issues concern compliance with leave conditions, or the safety of the patient or others.

## 7.1 Extension of leave (re-application)

The first period of ministerial long leave is usually six months; subsequent extension periods are for six or 12 months. Special patients may be granted several consecutive periods of ministerial long leave. The DAMHS should make an application to the Ministry at least six weeks before the current period of leave expires.

**Table 9: Information in support of extension of leave**

Information	<p>A letter from the responsible clinician, including:</p> <ul style="list-style-type: none"> <li>• a current mental state assessment, including compliance with treatment</li> <li>• the justification for extending the leave</li> <li>• a summary of progress while on leave, including any concerns that have arisen during leave (eg, compliance with medication) and how these have been managed</li> <li>• a risk assessment and management plan for the patient while they are on leave, including in regard to flight risk</li> <li>• an overview of the patient’s recovery plan</li> <li>• advice on whether the patient has used or is likely to use psychoactive substances</li> <li>• advice of any critical incidents, including possession of weapons, drugs or other prohibited material, and management of those incidents</li> <li>• any proposed changes to the conditions of leave</li> <li>• a certificate, signed by two medical practitioners, stating that the patient is fit to be allowed to be absent from hospital (section 50A(1)(a) of the Mental Health Act)</li> <li>• a second opinion (or a recent SPRP report) supporting the leave</li> <li>• an indication of support from the DAMHS for the proposed leave</li> <li>• comment on matters concerning the offending (eg, insight into the offending, relationship with victims)</li> <li>• comment on matters relating to the risk presented by the patient, particularly in relation to victims of previous offending</li> <li>• comment on what family/whānau support is available</li> <li>• consideration of the needs of children or other vulnerable people in the household if the patient will be with family while on leave (particularly if the index offence took place within the family)</li> </ul>
Timeframe	<p>The DAMHS must request an extension of ministerial long leave at least six weeks prior to the expiry date. If there are registered victims, DAMHS must allow 14 days for registered victims to make a submission; therefore, the registered victim must be notified eight weeks prior to the expiry date.</p> <p>Incomplete information will result in delay in providing a report to the Minister and may lead to the patient’s section 50A leave expiring.</p>

## 7.2 Recall to hospital and cancelling ministerial long leave

Section 51 permits a DAMHS to direct in writing that a patient on ministerial long leave be admitted or readmitted to hospital if the DAMHS is satisfied that it is necessary 'in the interests of the safety of that patient or the public'. Where such a direction is given, the DAMHS should record in writing the reasons for the direction and give both a copy of the direction and a copy of the reasons for the direction to the patient as soon as practicable.

Where a direction is ordered by the DAMHS under section 51, the patient may be taken to the specified hospital by the Director, the DAMHS, a duly authorised officer, any constable or any person to whom the charge of the patient has been entrusted during the period of leave.

Such an admission can only be for 72 hours, during which time the Minister may be asked to cancel the patient's leave. If leave is not cancelled by the Minister before the expiration of the 72 hours, the patient must be released on leave subject to any conditions imposed by the Minister.

If the patient's leave needs to be cancelled, the Director must prepare a report to the Minister seeking cancellation of leave. This report will need to be prepared at short notice, and sometimes without immediate access to patient records held by the Ministry. Therefore, the following information must be provided.

**Table 10: Information to support cancellation of ministerial long leave**

Information	<p>A letter from the responsible clinician, including:</p> <ul style="list-style-type: none"><li>• a current mental state assessment</li><li>• the reason for cancelling the ministerial long leave</li><li>• current risk assessment and management (including flight risk)</li><li>• if the patient's recall from leave has occurred in the context of a serious incident, advice on the steps that are being taken to review the incident</li><li>• comment on matters relating to the offending (eg, insight into the offending, relationship with victims), particularly if the victim of the index offence has been affected by the decision to cancel leave</li></ul>
Timeframe	<p>The DAMHS must advise the Office of the Director as soon as the patient is recalled to hospital and provide a report to that Office within 12 hours.</p> <p>The Office of the Director must report to the Minister of Health within 24 hours, and the Minister must make a decision within 72 hours.</p> <p>The Office of the Director must send a letter confirming the Minister's decision within 24 hours.</p> <p>If ministerial long leave is cancelled during a weekend or holiday period, the DAMHS must notify the Director by phone.</p>

There may be situations in which a special patient who is on ministerial long leave decompensates in their mental state and behaviours, is assessed by their responsible clinician and agrees to return to hospital for a voluntary admission. Where this occurs, it is important that the patient has the capacity to make that decision. The voluntary admission could be for longer than 72 hours, to investigate the circumstances leading to the deterioration of the patient's mental state.

If cancellation is deemed necessary after investigations into the circumstances and subsequent inpatient admission, a new application for ministerial long leave must be completed identifying the factors leading to the cancellation of leave and indicating how these have been addressed. See section 7.4 for more detail.

## 7.3 Recommencing short-term leave following cancellation

Cancellation of ministerial long leave is not undertaken lightly, and inevitably involves the readmission of the patient to an inpatient ward. If a special patient's ministerial long leave has been cancelled under section 50G of the Mental Health Act, the Director will consider cancelling all short-term leave periods granted under section 52 of the Mental Health Act. The Director's approval or support must be sought for any further periods of leave following cancellation of ministerial long leave.

## 7.4 Applying for ministerial long leave following cancellation

A new application for ministerial long leave following cancellation and subsequent inpatient admission must identify the factors leading to the cancellation of leave and indicate how these have been addressed.

**Table 11: Information in support of a re-application for ministerial long leave following cancellation**

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Information	A letter from the responsible clinician, including: <ul style="list-style-type: none"><li>• a current mental state assessment, including compliance with treatment</li><li>• how the factors resulting in cancellation have been addressed</li><li>• a risk assessment and management plan for the patient while they are on leave, and any concerns held about risk</li><li>• an overview of the patient's recovery plan</li><li>• advice on whether the patient has used or is likely to use psychoactive substances and the steps in place to manage the risk of future use</li><li>• advice of any critical incidents during the patient's time in hospital, including possession of weapons, drugs or other prohibited material, and management of those incidents</li><li>• the proposed conditions of leave</li></ul>
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- a certificate, signed by two medical practitioners, stating that the patient is fit to be allowed to be absent from hospital (section 50A(1)(a) of the Mental Health Act)
  - a second opinion (or a recent SPRP report) supporting the leave
  - an indication of support from the DAMHS for the proposed leave
  - comment on matters concerning the offending (eg, insight into the offending, relationship with victims)
  - comment on matters relating to the risk presented by the patient, particularly in relation to victims of previous offending
  - comment on what family/whānau support is available
  - consideration of the needs of children or other vulnerable people in the household if the patient will be with family while on leave (particularly if the index offence took place within the family)
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Timeframe    The DAMHS must request ministerial long leave as appropriate following cancellation.  
 Incomplete information will result in delay in providing a report to the Minister.

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## 7.5 Voluntary admission to hospital during ministerial long leave

The Mental Health Act is silent on whether special patients can be readmitted on a voluntary basis during a period of ministerial long leave. However, it is reasonable to assume that some people may seek or agree to a brief period of inpatient care. If a voluntary admission is considered, the following factors should form part of that consideration.

- Consent must be documented and reviewed at regular intervals during the admission,<sup>6</sup> including a clinical assessment of capacity to consent (see Appendix 1, which contains a form seeking consent to voluntary admission and treatment while subject to leave under section 50A of the Mental Health Act ('ministerial long leave')).
- Accommodation must be in the least restrictive environment, although the Ministry acknowledges that because of the nature of RFMHS this may be a locked ward. For this reason, consent processes must be rigorous and transparent.
- Voluntary inpatient admissions should generally be for no longer than 14 days.
- The DAMHS must inform the district inspector and the Director.

The patient's responsible clinician should consider whether the circumstances surrounding the admission meet the standard of 'the interests of the safety of that patient or the public' specified in section 51 of the Mental Health Act. If so, the responsible clinician may recommend to the DAMHS that they direct the patient to temporarily return to the RFMHS under section 51 of the Mental Health Act.

<sup>6</sup> See part 6.4 of the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health 2022c).

# 8 Change of legal status

## 8.1 Patients acquitted on the grounds of insanity

Special patients acquitted on account of insanity may have their legal status changed by the Minister and become subject to a compulsory treatment order under the Mental Health Act, or discharged.

If a certificate is given by the responsible clinician under the Mental Health Act to the effect that the patient's detention is no longer necessary to safeguard the patient's own interests and the safety of the public or the safety of a person or class of person, the Minister must:

- consider whether, in the Minister's opinion, the patient's continued detention is no longer necessary to safeguard the patient's own interests and the safety of the public or the safety of a person or class of person; and
- if, in the Minister's opinion, detention is no longer necessary to safeguard those interests, direct that the patient be held as a patient (under a compulsory treatment order under the Mental Health Act), or that the patient be discharged (section 33(3) of the CP(MIP) Act).

Despite section 33 of the CP(MIP) Act, on receiving a copy of the certificate of clinical review under section 77(3)(c), the Minister may, instead of exercising and performing the powers and duties under that section, apply to the review tribunal for a review of the patient's condition, before making a direction.

Please note that under section 33(4A) the Minister is required to have regard to the report provided by the Director of Mental Health. The Director in preparing this report will consider all relevant material (including that supplied by the service and any submission provided by a registered victim). Services are therefore asked to ensure all relevant material is supplied to the Director, including the material set out below.

The information accompanying a certificate of clinical review recommending a change of legal status should address the factors leading to the index offence, how these have been addressed and the measures put in place to reduce the chance of those factors arising in future. It should specifically reference alcohol and drug use, particularly if the responsible clinician considered alcohol and drug use to have had an impact on the index offence.

The information accompanying a certificate of clinical review for this purpose should also address plans for the patient's ongoing management by mental health services once the patient is no longer subject to special patient status. Issues of ongoing

management are particularly important if there are doubts that the patient will continue to meet the criteria for compulsory treatment.

**Table 12: Information to support a request for change of legal status (acquitted on account of insanity)**

Information	<p>A letter from the responsible clinician, including:</p> <ul style="list-style-type: none"> <li>• a current mental state assessment, including compliance with treatment</li> <li>• a section 77 certificate of clinical review</li> <li>• a risk assessment and management plan, including in regard to flight risk.</li> </ul> <p>If not provided in the SPRP report, the following information should be specifically provided in the letter:</p> <ul style="list-style-type: none"> <li>• how the factors leading to the index offence have been addressed and the measures taken to reduce the chance of future offending</li> <li>• comment on matters concerning the offending (eg, insight into the offending, relationship with victims)</li> <li>• comment on matters relating to the risk presented by the patient, particularly in relation to victims of previous offending</li> <li>• specific comment on alcohol and drug use (including the use of psychoactive substances)</li> <li>• advice of any critical incidents, including possession of weapons, drugs or other prohibited material, and management of those incidents</li> <li>• comment on what family/whānau support is available</li> <li>• consideration of the needs of any children of the patient, particularly if the index offence took place within the family</li> <li>• advice on the ways in which the patient meets the criteria of section 33(4) of the CP(MIP) Act</li> <li>• plans for the patient’s ongoing management by mental health services once the patient is no longer subject to special patient status, particularly if the patient may not continue to meet the criteria for compulsory treatment.</li> </ul> <p>A recent SPRP report must be provided with the application. In practice, this information will already be available on the patient’s profile in the SPMS.</p>
Timeframe	<p>If the special patient is subject to registered victim notifications, the Director will notify the registered victim of the application and give them 14 days to make a submission. The Director will then notify the registered victim of the Minister’s decision.</p> <p>The Office of the Director must inform the forensic service of the Minister’s decision within three working days.</p>

## 8.2 Unfit to stand trial: where a patient is now considered fit to stand trial

The Attorney-General makes decisions on whether special patients who were initially considered unfit to stand trial are subsequently fit to do so, on the basis of advice from the Crown Law Office. In formulating that advice, the Crown Law Office is provided with information from the Director.

Under section 30 of the CP(MIP) Act, the maximum period of detention for which a defendant who has been found unfit to stand trial can be detained under section 24 as a special patient is:

- if the defendant was charged with an offence that was punishable by imprisonment for life, 10 years from the date of the making of the order under section 24
- otherwise, a period from the date of the order under section 24 equal to half the maximum term of imprisonment to which the defendant would have been liable if they had been convicted of the offence charged.

If, before or on the expiry of the maximum period of detention, a certificate is given under the Mental Health Act to the effect that the defendant is no longer unfit to stand trial, the Attorney-General must either:

- direct that the defendant be brought before the appropriate court; or
- direct that the defendant be held as a patient (section 31(2) of the CP(MIP) Act).

Despite section 31 of the CP(MIP) Act, on receiving a copy of the certificate of clinical review under section 77(3)(c), the Attorney-General may, instead of exercising and performing the powers and duties under that section, apply to the review tribunal for a review of the patient's condition, before making a direction.

The Attorney-General must direct that the defendant be held as a patient if:

- the defendant is still detained as a special patient when the maximum period of detention specified in section 30 expires; and
- the Attorney-General has not given a direction in respect of the defendant under sections 31(2) or (3); and
- no certificate under the Mental Health Act or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 has been given in respect of the defendant (section 31(4) of the CP(MIP) Act).

A decision about whether a patient should be returned to court may take several months, as the police also need to make recommendations to the Crown Law Office. This process may involve finding witnesses and re-examining prosecution files that are several years old. In forming their advice to the Attorney-General, Crown Law may request additional documentation from the Ministry of Health, who will in turn, request information from the mental health service to ensure the Attorney-General can be satisfied about the grounds for the decision required.

Note that where a responsible clinician believes that a patient is no longer unfit to stand trial in accordance with section 77(3)(c), and/or that the patient no longer needs to be subject to the order of detention as a special patient, their report must be sent directly to all of the following people:

- the Attorney-General
- the Director
- each of the persons specified in section 76(7)(b) of the Mental Health Act (section 78 of that Act).



Clinical reports should be written to explicitly address the grounds for the decision that the Attorney-General is required to make, and should include the below information. The report therefore needs to reflect the key issues in regard to the patient’s progress and management rather than being a detailed clinical summary.

**Table 13: Information to support a request for change of status for a special patient now fit to stand trial**

Information	<p>A report from the responsible clinician, including:</p> <ul style="list-style-type: none"> <li>• a current mental state assessment, including compliance with treatment</li> <li>• a section 77 certificate of clinical review.</li> </ul> <p>If not provided in the SPRP report, the following information should be specifically provided in the letter:</p> <ul style="list-style-type: none"> <li>• comment specifically addressing the patient’s fitness to stand trial</li> <li>• how the factors leading to the index offence have been addressed and the measures taken to reduce the chance of future offending</li> <li>• specific comment on alcohol and drug use</li> <li>• plans for the patient’s ongoing management by mental health services if a decision is reached that they should be detained subject to compulsory treatment status – this is particularly important if the patient may not continue to meet the criteria for compulsory treatment</li> <li>• flight risk assessment and management</li> <li>• consideration of the needs of any children of the patient, particularly if the index offence took place within the family.</li> <li>• comment on matters relating to the offending (eg, insight into the offending, relationship with victims)</li> <li>• comment on matters relating to the risk presented by the patient, particularly in relation to victims of previous offending</li> <li>• if relevant, advice on whether the patient meets the criteria for an insanity plea.</li> </ul> <p>A recent SPRP report must be provided with the application. In practice, this information will already be available on the patient’s profile in the SPMS.</p>
Timeframe	<p>The Office of the Director must send the covering letter and associated material to the Crown Law office within 10 working days of receipt.</p> <p>Note: because of the need to access information from the police, decisions from the Attorney-General can take several months.</p> <p>Incomplete information will result in delays in providing a report to the Crown Law Office.</p>

A patient who is directed to return to court should continue to be treated as a special patient until the court has made a decision about the patient’s future status.

The court may order that a person be detained in a hospital or secure facility for the purpose of an assessment under section 38 of the CP(MIP) Act, in which case they continue to be a special patient.

If, on returning to court, the patient is remanded on bail, the DAMHS, in consultation with the patient’s responsible clinician, should consider whether it is appropriate for an application to be made under the Mental Health Act to ensure ongoing treatment until such time as the court determines the appropriate disposition for the patient.

## 8.3 Unfit to stand trial: end of maximum period of detention

Special patients found unfit to stand trial remain subject to special patient status for the maximum period of detention (see section 8.2 above). Although the patient's legal status automatically changes from 'special patient' to 'patient' at the end of the maximum period of detention, the Attorney-General is still required to provide a direction in relation to the change of status (section 31(4) of the CP(MIP) Act). In effect, this means that the Office of the Director will send a covering letter and accompanying material to the Crown Law Office. The accompanying material will usually consist of the court order, SPRP summary, certificate of clinical review given under section 77(3) of the Mental Health Act, and the clinical report given under this section. Clinical reports should be written to explicitly address the grounds for the decision that the Attorney-General is required to make, and should include the below information.

**Table 14: Information to support a change of status for a special patient at the end of the maximum period of detention**

Information	<p>A letter from the responsible clinician, including:</p> <ul style="list-style-type: none"> <li>• a current mental state assessment, including compliance with treatment</li> <li>• a section 77 certificate of clinical review.</li> </ul> <p>If not provided in the SPRP report, the following information should be specifically provided in the letter:</p> <ul style="list-style-type: none"> <li>• how the factors leading to the index offence have been addressed and the measures taken to reduce the chance of future offending</li> <li>• specific comment on alcohol and drug use</li> <li>• plans for the patient's ongoing management by mental health services if a decision is reached that they should be detained subject to compulsory treatment status – this is particularly important if the patient may not continue to meet the criteria for compulsory treatment</li> <li>• flight risk assessment and management</li> <li>• comment on what family/whānau support is available</li> <li>• consideration of the needs of any children of the patient, particularly if the index offence took place within the family</li> <li>• comment on matters relating to the offending (eg, insight into the offending, relationship with victims).</li> <li>• comment on matters relating to the risk presented by the patient, particularly in relation to victims of previous offending.</li> </ul> <p>A recent SPRP report must be provided with the application. In practice, this information will be uploaded into the SPMS via a change of legal status application.</p>
Timeframe	<p>The Office of the Director will receive a signed direction from the Attorney-General, which will be sent to the DAMHS upon receipt.</p> <p>See table 15 for further information on timeframes.</p>

The status of a special patient following the maximum period of detention, but before receipt of the Attorney-General's direction, is unclear. The Ministry recommends that

the patient continue to be regarded as a special patient until the DAMHS has received the Attorney-General's direction.

**Table 15: Protocol for special patients and special care recipients approaching maximum detention dates**

<b>Task</b>	<b>Timeframe</b>	<b>Agency</b>
1. Detaining authority to conduct clinical review under section 77(3) of the MHCAT Act or section 77 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and provision of certificate of review to the Ministry of Health	Eight to ten weeks prior to maximum detention date	RFMHS, forensic coordination services
2. Provision of certificate of review, special patient or special care recipient court order, accompanying report(s) and covering letter to Crown Law	Seven weeks prior to maximum detention date	Ministry of Health
3. Processing of clinical review and associated documentation from Ministry of Health to Crown Law	Six weeks prior to maximum detention date	Crown Law
4. 'Conditional' direction of Attorney-General made under section 31(4) of the CPMIP Act	Four weeks prior to maximum detention date	Crown Law
5. Transmission of 'conditional' direction from Crown Law to Ministry of Health and detaining authority	Four weeks prior to maximum detention date	Crown Law
6. Communication of change of circumstances to Ministry of Health and Crown Law	Any time prior to maximum detention date, without delay	RFMHS, forensic coordination services

Note: A 'conditional' direction will come into force at the end of the maximum period of detention so long as there is no change of circumstances which might affect that direction. A change of circumstances includes a fresh certificate of clinical review which indicates a person has become fit to stand trial.

If a detaining authority has any doubt as to whether there has been a change of circumstances that might impact upon a conditional direction, it is best practice to raise that issue with Crown Law and the Ministry of Health.

## 8.4 Unfit to stand trial: where the patient no longer needs to be detained as a special patient

Less commonly, a special patient's responsible clinician may consider that, although a patient remains unfit to stand trial, their continued detention is no longer necessary (section 31 of the CP(MIP) Act). In such cases, the Minister makes the decision about a change of legal status with the concurrence of the Attorney-General. Orders made pursuant to section 24(2)(a) of the CP(MIP) Act for the detention of a defendant as a special patient remain unless the Attorney-General (where the defendant is unfit to stand trial) or the Minister (where the defendant is unfit to stand trial but detention as a special patient is no longer necessary) directs a change of legal status under section 31 of the CP(MIP) Act.

**Table 16: Information to support a request for change of status for a patient who is unfit to stand trial but no longer needs to be detained as a special patient**

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Information	<p>A letter from the responsible clinician, including:</p> <ul style="list-style-type: none"><li>• a current mental state assessment</li><li>• a certificate of clinical review.</li></ul> <p>If not provided in the SPRP report, the following information should be specifically provided in the letter:</p> <ul style="list-style-type: none"><li>• how the factors leading to the index offence have been addressed and the measures taken to reduce the chance of future offending (including compliance with treatment)</li><li>• specific comment on alcohol and drug use</li><li>• advice of any critical incidents, including possession of weapons, drugs or other prohibited material, and management of those incidents</li><li>• plans for the patient's ongoing management by mental health services if a decision is reached that they should be detained subject to compulsory treatment status – this is particularly important if the patient may not continue to meet the criteria for compulsory treatment</li><li>• flight risk assessment and proposed management</li><li>• consideration of the needs of any children of the patient, particularly if the index offence took place within the family</li><li>• comment on matters relating to the offending (eg, insight into the offending, relationship with victims)</li><li>• comment on matters relating to the risk presented by the patient, particularly in relation to victims of previous offending</li><li>• comment specifically addressing the patient's continued lack of fitness to stand trial.</li></ul> <p>A recent SPRP report must be provided with the application. In practice, this information will be uploaded into the SPMS.</p>
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Timeframe	<p>The DAMHS must send the report within six weeks of the SPRP meeting.</p> <p>The Office of the Director must send the covering letter and associated material to the Crown Law office within 10 working days and advise the service by email.</p> <p>Because of the need to access information from the police, decisions from the Attorney-General can take several months.</p> <p>If the special patient is subject to registered victim notifications, the Director will notify the registered victim of the application and give them 14 days to make a submission. The Director will then notify the registered victim of the Minister's decision.</p> <p>Incomplete information will result in a delay in providing a report to the Minister.</p>
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## 8.5 Section 77 certificates

The certificate given following a review under section 77 of the Mental Health Act should have one of the following options selected by the responsible clinician.

- The patient is no longer unfit to stand trial (see section 8.2 above).
- The patient is still unfit to stand trial but it is no longer necessary that they should be subject to the order as a special patient (see section 8.4 above).
- The patient is still unfit to stand trial and should continue to be subject to the order of detention as a special patient (see section 8.3 for the process where this option is selected and the special patient is approaching their maximum detention date).

## 8.6 Change of legal status application submission

Provision of supporting documents for any of the processes outlined in sections 8.1–8.4 should be made via the SPMS, using the 'change of legal status' application function.

Change of legal status documents should not be uploaded via the 'Documents' function or 'Patient Review' function, unless they concern a section 77 review that will not trigger a change of legal status application.

## 8.7 Change of legal status application timing

A change of legal status application may take several months to process from the time the application is made. If a special patient is currently on ministerial long leave, and that leave is due to expire within the next three months, RFMHSs need to ensure that an application is put forward to extend this leave, prior to any change of legal status application. The application for an extension of ministerial long leave and a change of legal status application will not be considered as a joint application.

## 8.8 Withdrawal of charges

Section 30(5) of the CP(MIP) Act provides that an order under section 24 for the defendant to be detained as a special patient is to be treated as cancelled if every charge brought against the defendant in the proceedings in which the order was made is withdrawn or dismissed. The person could then be transferred out of medium secure or forensic rehabilitation settings to general mental health services if they are still considered to be mentally disordered or mentally unwell requiring hospitalisation.

Note that in this situation, if the person is not already subject to the provisions of the Mental Health Act, the service will need to commence the assessment process required by the Mental Health Act.

# 9 Application for restricted patient status

Section 54 of the Mental Health Act enables the Director to apply to the court for an order under section 55 declaring a patient to be a restricted patient (restricted patient order). For a restricted patient order to be made under section 55, the court must be satisfied that the patient presents special difficulties because of the danger they pose to others (section 55(3) of the Mental Health Act).

The DAMHS may also refer a case to the Director for consideration if they consider that any patient who is subject to an inpatient order presents special difficulties because of the danger they pose to others and, for that reason, it may be appropriate that an order be made under section 55 declaring the patient to be a restricted patient.

Restricted patient status significantly limits an individual's liberty. Restricted patient orders are rare; few people have been detained in this way since the Mental Health Act came into force.

## 9.1 Key features of restricted patient status

Where a court is considering declaring a person to be a restricted patient, it must be satisfied that the patient presents special difficulties because of the danger they pose to others.

### 9.1.1 Danger

The Mental Health Act does not define danger. In *Re SKN* (1998) 16 FRNZ 559, the court analysed the danger requirement of section 55 of the Mental Health Act, based on earlier restricted patient applications (*Re Tahere* [1995] DCR 545; *Re TAV* [1997] NZFLR 846; *Re RWD* (1994) 12 FRNZ 387). Walsh J found that:

*The words 'the danger he or she poses to others' relate to the second limb of the definition of 'mental disorder' which requires the Court, before making a Compulsory Treatment Order, to be satisfied that the specified clinical symptoms of abnormal state of mind exist to such a degree that it 'poses a serious danger to the health and safety of others'.*

Walsh J applied a commonsense approach to interpreting and applying the danger requirement. He also stated that the danger 'does not have to be imminent or likely to occur immediately because of the effect of current medication on the patient'.

*There can be consideration of the nature of past danger to others in order to look ahead to assess present and future dangerousness. In that context an examination of the ability of a patient to control his or her dangerousness, the degree of insight possessed and the degree of risk of serious harm are relevant considerations.*

In another case, *Applicant 11/040* [2011] NZMHRT 40, the Mental Health Review Tribunal said regarding the definition of 'serious dangerousness':

*The determination of serious dangerousness in terms of the mental disorder definition is ultimately a matter of judgement having regard to a multiplicity of considerations and the unique circumstances of each case. A helpful analysis is to have regard to the following considerations:*

- (i) What is the magnitude or gravity of the behaviour concerned?*
- (ii) What is the likelihood of the behaviour occurring?*
- (iii) What is the proximity or imminence of the behaviour, in other words, how soon or quickly might it occur?*
- (iv) What is the frequency of the behaviour, that is to say how often might it occur?*

*These four considerations are not isolated one from the other but need to be considered collectively. The weighting given to one may reduce the significance of another. For example, if the gravity of a behaviour is particularly high, less weight need be placed on the issues of likelihood, proximity or frequency in order that a finding of serious danger is made. Thus, a risk of say homicide, is likely to constitute serious danger to others in the mental disorder definition despite the likelihood, proximity and frequency being relatively low. On the other hand, low level assaultive behaviour may also be deemed to constitute serious danger to others if its likelihood, proximity and frequency are high. By contrast, the same level of assaultive behaviour may be deemed to not constitute serious danger to others if its likelihood, proximity or frequency are relatively low.*

In relation to the risk of serious danger to others posed by a patient relapsing, the Mental Health Review Tribunal suggested that the following factors may be relevant considerations:

- the degree of causal connection between relapse and dangerousness
- the expected time lapse between release from compulsory status and cessation of treatment
- the estimated time lapse between non-compliance with treatment and relapse
- whether interventions by clinicians or family or friends or others can prevent or lessen a relapse which is in its early stages
- the ability of clinicians to re-initiate the compulsory assessment and treatment provisions of the Mental Health Act.



## 9.1.2 Special difficulties

The Mental Health Act does not define 'special difficulties', but the courts have interpreted 'special' to mean 'peculiar, or exceptional in amount, degree or intensity' (*Re Tahere*). In *Re STN 6/4/00*, NRT766/00, the Tribunal described special difficulties as follows:

*The applicant possesses unusual features out of the ordinary run but not extraordinary or unique. It is the duration, intensity and magnitude of the applicant's antisocial behaviour, which makes his difficulties special.*

In *Re Tahere*, Kendall FCJ held that 'What must be looked at is that "special difficulties" must relate to the degree of danger to others, the nature of it, its causes, and its likely manifestations'. Thus, there must be a causal link between the 'danger' and the 'special difficulties'.

## 9.2 Information in support of an application for restricted patient status

As set out above, under section 54 of the Mental Health Act, the Director may apply to the court for an order declaring a patient to be a restricted patient. In practice, the responsible clinician organises the application, which is then provided to the Director, who in turn applies to the court.

Information in support of an application for restricted patient status should provide a comprehensive overview of the patient's history (including any forensic history), as well as a plan for the patient's proposed management as a restricted patient. In particular, the report on the patient should cover the following matters:

- the relationship between the patient's previous offending and their mental disorder
- whether the responsible clinician considers the patient poses a danger to others, and the reasons for this analysis
- if the patient does pose a danger to others, whether the patient presents special difficulties because of that
- relevant aspects of the patient's cultural background that contribute to the precise diagnosis of their mental disorder.

As far as special difficulties, the information should include:

- the nature and degree of seriousness of the special difficulties presented by the patient because of the danger they pose to others
- an opinion on the ability to manage the special difficulties described, in a clinical and/or community setting.

Information about why the responsible clinician or Director forms the view that the patient presents special difficulties because of the danger they pose to others should also be included, addressing:

- why it would be appropriate that an order be made declaring the patient to be a restricted patient
- why restricted patient status is necessary to provide appropriate clinical supervision
- the reasons for these views.

The application should also discuss the difference that restricted patient status would make in terms of the management of the patient, given that most people for whom such an application is made are already subject to an inpatient compulsory treatment order.

## 9.3 Second opinion

A request for restricted patient status should be accompanied by a second opinion from a forensic psychiatrist, and address the issues set out in section 9.2 above. Accompanying material should be similar to that required for a change in legal status.

**Table 17: Information to support an application for restricted patient status**

Information	<p>A letter from the responsible clinician, including:</p> <ul style="list-style-type: none"> <li>• a current mental state assessment</li> <li>• a certificate of clinical review</li> <li>• a risk assessment and management plan</li> <li>• a recent report from the SPRP, if one is available.</li> </ul> <p>If not provided in the SPRP report, the following information should be specifically provided in the letter:</p> <ul style="list-style-type: none"> <li>• the factors leading to the application for the patient to be made a restricted patient, with a focus on danger and special difficulties</li> <li>• specific comment on alcohol and drug use, including the use of psychoactive substances</li> <li>• advice of any critical incidents that occurred during the patient's time as an inpatient, including possession of weapons, drugs or other prohibited material, and management of those incidents</li> <li>• plans for the patient's ongoing management, including specific comment on the danger the patient presents to others and the special difficulties resulting in the application.</li> <li>• flight risk assessment</li> <li>• consideration of the needs of any children of the patient</li> <li>• comment on matters relating to the risk presented by the patient, particularly in relation to any victims of previous offending</li> <li>• a reference to the current SPRP report, if available</li> </ul>
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Timeframe	<p>The DAMHS must submit a report seeking a change of status within six weeks of the SPRP.</p> <p>The Director must determine to either direct that the patient be released forthwith from compulsory status or apply to the review tribunal for a review of the patient's condition to begin within 21 working days and advise the service by email.</p> <p>Incomplete information will result in delay in receiving a decision from the Director.</p>
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# 10 Change of legal status: restricted patients

A restricted patient can only have their status changed once the matter is referred to the Director. The purpose of a restricted patient order is to ensure that decisions regarding restricted patients regarding long-term leave and discharge from that status are taken at ministerial level, while decisions as to whether patients remain mentally disordered are still to be taken at clinical level, with oversight by the Director or the Mental Health Review Tribunal in any final decision.

In *Re STN 6/4/00*, NRT766/00, the Review Tribunal noted that continuation of restricted patient status is appropriate to ensure the continuation of the ministerial decision-making process. The additional restrictions on the leave and change of status are designed to protect the public where the danger posed by the patient is such that this is necessary.

Section 78 of the Mental Health Act governs clinical reviews and change of status for restricted patients. In the case of a change of legal status, the responsible clinician must conduct a formal review not later than three months after the date of the order and thereafter at intervals not longer than six months. The review may find that:

- the patient is fit to be released from compulsory status
- the patient is not fit to be released from compulsory status, but it is no longer necessary for the patient to be declared to be a restricted patient
- the patient is not fit to be released from compulsory status and should continue to be declared to be a restricted patient.

The responsible clinician must send a copy of the certificate of clinical review to the Director and each of the persons specified in section 76(7)(b) of the Mental Health Act.

## 10.1 Where a restricted patient is fit to be released from compulsory status

Where a responsible clinician is of the opinion that a restricted patient is fit to be released from compulsory status, the Director must either direct that the patient be released from compulsory status or apply to the Mental Health Review Tribunal for a review of the patient's condition. Clinical reports should be written to explicitly address

the grounds for the decision that the Director is required to make and should include the below information.

**Table 18: Information to support a change of status for a restricted patient who is fit to be released from compulsory treatment status**

Information	<p>A letter from the responsible clinician, including:</p> <ul style="list-style-type: none"> <li>• a current mental state assessment</li> <li>• a certificate of clinical review</li> <li>• a risk assessment and management plan, including flight risk.</li> </ul> <p>If not provided in the SPRP report, the following information should be specifically provided in the letter:</p> <ul style="list-style-type: none"> <li>• how the factors leading to the patient being subject to restricted patient status have been addressed (including compliance with treatment)</li> <li>• specific comment on alcohol and drug use, including the use of psychoactive substances</li> <li>• advice of any critical incidents that occurred during the patient’s time as a restricted patient, including possession of weapons, drugs or other prohibited material, and management of those incidents</li> <li>• plans for the patient’s ongoing management by mental health services once the patient is no longer subject to compulsory treatment status (inclusive of recovery plan)</li> <li>• flight risk assessment, particularly if the patient is likely to disengage from services</li> <li>• a cultural assessment</li> <li>• comment on what family/whānau support is available</li> <li>• consideration of the needs of any children of the patient</li> <li>• comment on matters relating to the risk presented by the patient, particularly in relation to victims of previous offending.</li> </ul> <p>A recent SPRP report must be provided with the application. In practice, this information will be uploaded into the SPMS.</p>
Timeframe	<p>The DAMHS must submit the report seeking a change of status within six weeks of the SPRP.</p> <p>The Director must determine to either direct that the patient be released forthwith from compulsory status or apply to the review tribunal for a review of the patient’s condition within 20 working days and advise the service by email.</p> <p>Incomplete information will result in delay in receiving a decision from the Director.</p>

## 10.2 Where a patient is not fit to be released from compulsory status but no longer needs to be a restricted patient

Where a responsible clinician finds that a patient is not fit to be released from compulsory status, but it is no longer necessary that the patient be declared to be a restricted patient:

- the responsible clinician must send a copy of the certificate of clinical review to the Minister
- the Minister must, after consultation with the Attorney-General, either revoke the declaration that the patient shall be a restricted patient or apply to the Mental Health Review Tribunal for a review of the patient's condition.

Clinical reports should be written to explicitly address the grounds for the decision that the Minister and the Attorney-General is required to make, and should include the below information.

**Table 19: Information to support a change of status for a patient who is not fit to be released from compulsory status, but no longer needs to be a restricted patient**

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Information	<p>A letter from the responsible clinician, including:</p> <ul style="list-style-type: none"><li>• a current mental state assessment</li><li>• a certificate of clinical review</li><li>• a risk assessment and management plan.</li></ul> <p>If not provided in the SPRP report, the following information should be specifically provided in the letter:</p> <ul style="list-style-type: none"><li>• how the factors leading to the patient being subject to restricted patient status have been addressed (including compliance with treatment)</li><li>• specific comment on alcohol and drug use, including the use of psychoactive substances</li><li>• advice of any critical incidents that occurred during the patient's time as a restricted patient, including possession of weapons, drugs or other prohibited material, and management of those incidents</li><li>• plans for the patient's ongoing management by mental health services once the patient is no longer subject to restricted patient status (including recovery plan)</li><li>• flight risk assessment and proposed management</li><li>• a cultural assessment</li><li>• comment on what family/whānau support is available</li><li>• consideration of the needs of any children of the patient</li><li>• comment on matters concerning the risk presented by the patient, particularly from victims of previous offending.</li></ul> <p>A recent SPRP report must be provided with the application. In practice, this information will be uploaded into the SPMS.</p>
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NB: Although the Mental Health Act states that the responsible clinician should send the certificate of clinical review to the Minister of Health, in practice they should send it to the Director, who will then prepare a report for the Minister's consideration. The Director may also be asked to provide information for the Attorney-General (via the Crown Law Office).

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Timeframe      The DAMHS must submit the application for change of status within six weeks of the clinical review.

Incomplete information may delay the Director's provision of advice to the Minister of Health.

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# 11 Return to prison

Section 47 of the Mental Health Act provides for a DAMHS, with the consent of the Director, to direct the return of a special patient detained following an application made under section 45(2) of the Mental Health Act to prison. This also applies to people detained under a 'hybrid order'; namely, section 34(1)(a)(i) of the CP(MIP) Act.

The Director may direct the return to prison of a patient detained under section 46 of the Mental Health Act (section 47(2)). If a patient detained under section 46 of the Mental Health Act requests a return to prison, the DAMHS is responsible for 'making the necessary arrangements' as soon as practicable for a return to prison (section 47(4)). These requests are typically made within five working days before the proposed return.

**Table 20: Information to support a request for a patient to be returned to prison**

Information	A letter from the responsible clinician, including: <ul style="list-style-type: none"><li>• a current mental state assessment, including a statement that the patient is fit to be released from compulsory status (including recovery plan)</li><li>• a risk assessment</li><li>• a cultural assessment</li><li>• a plan for the patient's ongoing management following return to prison, including confirmation that this has been discussed with the prison health service</li><li>• a reference to the current SPRP, if available. In practice, this information will be uploaded into the SPMS</li></ul>
Timeframe	The DAMHS must submit the request to the Office of the Director five working days prior to the transfer.  The Office of the Director must respond within three working days prior to transfer.  Incomplete information may result in a delayed response.

## 11.1 Effect of orders under section 24 of the CP(MIP) Act on prison sentences

The situation may arise where someone on an existing sentence, including life imprisonment, is later acquitted on account of insanity following a new offence and placed on a special patient order under section 24(2)(a) of the CP(MIP) Act. This is covered in section 28 of the CP(MIP) Act, which notes that while the offender is subject to that new order, the prison sentence continues to run, unless the offender is absent from the institution without leave. Also, if, while still subject to the prison term, the offender is discharged from the hospital or facility, he or she must be taken to a prison or other appropriate place to serve the remainder of the sentence.



# 12 Registered victim notifications

Certain registered victims of specified offences committed by special patients and other forensic patients may apply to the police to become registered victims. Under section 30A of the Victims' Rights Act 2002, registered victims must be provided with an explanation of the relevant special patient's (or patient's) designation and be given a list of future notifications that they are eligible to receive. They must also be notified and invited to make submissions on certain decisions relating to the treatment of those patients.

Depending on the legal status of the special patient (or patient) a registered victim may be notified of, invited to make a submission on and provided the decision of the application for:

- leave under section 52 of the Mental Health Act that would grant the special patient (or patient) greater autonomy outside the hospital than any other leave of absence previously granted
- leave under section 50A of the Mental Health Act
- a change of legal status under section 31(1) or 33(1) of the CP(MIP) Act
- an application to the Mental Health Review Tribunal.

Registered victims must also be notified of:

- an impending discharge of the special patient (or patient)
- the special patient (or patient) escaping or going AWOL (including failing to return from leave) (see section 6.3 above)
- the special patient's (or patient's) death.

In practice, notifications regarding leave, discharge, absence without leave or death will usually be the responsibility of the forensic DAMHS or victim coordinator for special patients, as delegated by the Director.

All other notifications, including a change of legal status or an application to the Mental Health Review Tribunal, will be made by the Director. More information on these delegations and the timeframes for registered victim notifications and submissions can be found in *Victims' Rights in the Health System: Guidance for Directors of Area Mental Health Services, compulsory care coordinators, care managers, victim coordinators* (Ministry of Health 2023c).

Victims' privacy must be carefully protected; no person (including the Director or a DAMHS) may directly or indirectly disclose to a special patient the current address or contact details of any victim.

To help alleviate a registered victim's concerns, a DAMHS or responsible clinician can discuss with the special patient whether they consent for any additional information to

be provided to the registered victim. In this case, the DAMHS or responsible clinician should consider how potential over-disclosure may affect the rehabilitation or reintegration of the special patient. Any additional disclosures should only be made with the special patient's express consent. Discussions about consent for sharing this information should be recorded in the relevant patient records.

# 13 Incidents and reportable events

Regional forensic mental health services should immediately advise the Director or Deputy Director by phone of adverse events involving special patients. Thereafter, they should upload a completed reportable event form to the documents section of the special patient's profile in the SPMS and notify the Office of the Director via email that this has been uploaded. Adverse events include:

- alleged offending
- attempted or suspected suicide
- absence without leave
- an assault on or by the patient
- possession of prohibited items, including weapons
- significant breach of leave conditions (other than minor breaches, such as returning five minutes late)
- the death of the patient other than suspected suicide.

These reporting requirements do not limit other reporting requirements that may apply (eg, coronial or WorkSafe reporting requirements and the relevant hospital's reporting requirements).

Regional forensic mental health services should report any potential media interest in a special patient to the Office of the Director.

# 14 Contacting the Office of the Director of Mental Health and Addiction

The Office of the Director has a dedicated email address for correspondence regarding special patients: [MentalHealthAdmin@health.govt.nz](mailto:MentalHealthAdmin@health.govt.nz). This is cleared several times each day.

Please phone the Director or Deputy Director to advise of urgent requests for leave or reportable events.

The Office of the Director has implemented a secure SPMS to store clinical details and reports and to process special patient leave and transfer requests.

# References

- Department of Corrections. 2017. *Custodial Practice Manual (CPM)*. Wellington: Department of Corrections.
- 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.
- Ministry of Health. 1988. *Report of the Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients*. Wellington: Ministry of Health.
- Ministry of Health. 2020a. *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.
- Ministry of Health. 2020b. The Mental Health Act – guidelines and resources. URL: [www.health.govt.nz/our-work/mental-health-and-addiction/mental-health-legislation/mental-health-compulsory-assessment-and-treatment-act-1992/mental-health-act-guidelines-and-resources](http://www.health.govt.nz/our-work/mental-health-and-addiction/mental-health-legislation/mental-health-compulsory-assessment-and-treatment-act-1992/mental-health-act-guidelines-and-resources) (accessed 30 May 2022).
- Ministry of Health. 2022a. *Guidelines for the Role and Function of Statutory Officers: Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.
- Ministry of Health. 2022b. *Guidelines for the Safe Transport of Special Patients in the Care of Regional Forensic Mental Health Services*. Wellington: Ministry of Health.
- Ministry of Health. 2022c. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.
- Ministry of Health. 2023a. *Guidelines for Reducing and Eliminating Seclusion and Restraint Under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.
- Ministry of Health. 2023b. *Office of the Director of Mental Health and Addiction Services Regulatory Report 1 July 2021 to 30 June 2022*. Wellington: Ministry of Health.
- Ministry of Health. 2023c. *Victims' Rights in the Health System: Guidance for Directors of Area Mental Health Services, compulsory care coordinators, care managers, victim coordinators*. Wellington: Ministry of Health.

# Appendix 1: Useful resources

## Published documents

The following published documents provide useful information:

- Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2022c)
- Guidelines for the Role and Function of Statutory Officers: Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2022a)
- Office of the Director of Mental Health and Addiction Services Regulatory Report 1 July 2021 to 30 June 2022 (Ministry of Health 2023b)
- NZS 8134:2021 Ngā Paerewa Health and disability services standard
- Guidelines for Reducing and Eliminating Seclusion and Restraint under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2023a)
- Victims' Rights in the Health System: Guidance for Directors of Area Mental Health Services, compulsory care coordinators, care managers, victim coordinators (Ministry of Health 2023c).

## Sample forms and checklists

The following pages comprise sample forms for use in the situations specified.

- a sample summary sheet for SPRP reports
- a form recording consent to voluntary admission and treatment while on ministerial long leave
- a checklist for applications for short leave
- a checklist for applications for ministerial long leave
- a checklist for applications for change of status: patients acquitted on account of insanity
- a checklist for applications for change of status: patients found unfit to stand trial
- a checklist for applications for change of status: restricted patients
- a reportable event notification form
- an emergency border alert form.

# Sample summary sheet for special patient review panel reports

- Notes:
- The summary should stand alone from the accompanying documentation and serve as a quick reference to be compared to future SPRP reports.
  - Please do not include copies of material provided with previous reports.

Patient's first name(s)	Patient's last name
<input type="text"/>	<input type="text"/>
Location/unit	Date of birth <input type="text"/>
<input type="text"/>	NHI number <input type="text"/>
Legal status	Date of SPRP <input type="text"/>
<input type="text"/>	
Responsible clinician	
<input type="text"/>	
Case manager	
<input type="text"/>	

People attending the panel:

- responsible clinician (note if not present)
- clinical team members, including external reviewer
- patient
- cultural advisor(s)
- support person(s)

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

## Discussion

A summary of the panel's discussion, including comments from the patient

Review panel recommendations, including:

- legal status: either the patient should remain subject to their current legal status or the patient's legal status should change
- leave status: note any proposed changes to the patient's leave plan.

## Accompanying documentation

Focusing on current status and progress since the last SPRP:

- Reports from the clinical team, including risk assessment and risk management
- Leave plan / pathway
- A certificate of clinical review if a recommendation is made for a change in legal status
- A medical certificate if leave is being sought under section 50A of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

## Signature

<input type="text"/>	Date <input type="text"/>
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Forensic DAMHS

# Consent to voluntary admission and treatment while on leave under section 50A of the Mental Health (Compulsory Assessment and Treatment) Act 1992 ('ministerial long leave')



Patient's first name(s)

Patient's last name

Address

Date of birth

I have: (delete one)

requested or

agreed to

voluntary inpatient admission and treatment. I understand that I may withdraw my consent at any time.

The following people will be notified of this admission:

Welfare guardian (if applicable)

District inspectors

DAMHS

Director of Mental Health

## Signature

Signed

Date

Witness

Designation



# Checklist for applications for short leave

Section 52 of the Mental Health (Compulsory Assessment and Treatment) Act 1992

This application must include:

- an up-to-date report from the responsible clinician, providing the following information:
  - the patient's legal status
  - a current mental state assessment
  - justification of the leave request
  - a risk assessment and management plan for the patient while they are on leave, including in regard to flight risk
  - the proposed conditions of leave
  - any matters concerning victims, including the likelihood of the patient being in contact with the victim during leave
  
- reference to the most recent SPRP report, if available.

# Checklist for applications for ministerial long leave

Section 50A of the Mental Health  
(Compulsory Assessment and Treatment) Act 1992

This application must include:

- an up-to-date report from the responsible clinician, providing the following information:
  - the patient's legal status
  - a current mental state assessment
  - justification of the leave request
  - a risk assessment and management plan for the patient while they are on leave, including in regard to flight risk
  - the proposed conditions of leave
  - a certificate, signed by two medical practitioners, stating that the patient is fit to be allowed to be absent from hospital (section 50A(1)(a) of the Mental Health Act)
  - comment on issues concerning victims, where the views of victims are known (eg, anticipated opposition to leave), the likelihood of the patient being in contact with victims during leave and measures taken to manage this
  
- reference to the most recent SPRP report.

# Checklist for applications for change of status – patients acquitted on account of insanity

Section 77 of the Mental Health  
(Compulsory Assessment and Treatment) Act 1992

This application must include:

- a certificate of clinical review signed by the responsible clinician, stating their opinion in respect of the special patient
- a letter requesting a change of legal status from the responsible clinician, endorsed by the DAMHS
- an up-to-date report from the responsible clinician, providing the following information:
  - a current mental state assessment
  - a risk assessment and management plan
  - how the factors leading to the index offence have been addressed and the measures taken to reduce the chance of future offending
  - specific comment on alcohol and drug use
  - plans for the patient's ongoing management by mental health services once the patient is no longer subject to special patient status, particularly if the patient may not continue to meet the criteria for compulsory treatment
  - comment on issues concerning victims, where the views of victims are known (eg, anticipated opposition to change of legal status), the likelihood of the patient being in contact with victims and measures taken to manage this
- reference to the most recent SPRP report.

# Checklist for applications of change of status— patients found unfit to stand trial

Section 77 of the Mental Health  
(Compulsory Assessment and Treatment) Act 1992

This application must include:

- a certificate of clinical review signed by the responsible clinician, stating their opinion in respect of the special patient
- a letter requesting a change of legal status from the responsible clinician, endorsed by the DAMHS
- an up-to-date report from the responsible clinician, providing the following information:
  - a current mental state assessment
  - a risk assessment and management plan
  - how the factors leading to the index offence have been addressed and the measures taken to reduce the chance of future offending
  - comment on issues concerning victims, where the views of victims are known (eg, anticipated opposition to change of legal status), the likelihood of the patient being in contact with victims and measures taken to manage this
  - specific comment on alcohol and drug use
  - plans for the patient's ongoing management by mental health services once the patient is no longer subject to special patient status, particularly if the patient may not continue to meet the criteria for compulsory treatment
  - if the patient is likely to return to court, advice on whether they may have an insanity defence
- reference to the most recent SPRP report.

# Checklist for applications for change of status—restricted patients

Section 78 of the Mental Health  
(Compulsory Assessment and Treatment) Act 1992

This application must include:

- a certificate of clinical review signed by the responsible clinician, stating their opinion in respect of the restricted patient
- a letter requesting a change of legal status from the responsible clinician, endorsed by the DAMHS
- an up-to-date report from the responsible clinician, providing the following information:
  - a current mental state assessment
  - a risk assessment and management plan
  - how the factors leading to restricted patient status have been addressed and the measures taken to reduce the danger presented by the patient
  - plans for the patient's ongoing management by mental health services once the patient is no longer subject to restricted patient status, particularly if the patient may not continue to meet the criteria for compulsory treatment
- reference to the most recent SPRP report.

Reason for reporting this event\*:  Section 132 death  Suspected suicide of voluntary inpatient  
 Special patient event  Media attention

Event category:  Death  Suspected suicide  Homicide  Attempted suicide  
 Assault  AWOL  Breach of leave conditions  Other

Te Whatu Ora health service responsible for care:	<input type="text"/>	Legal status – statute: Eg Mental Health Act	<input type="text"/>
Overseeing DAMHS:	<input type="text"/>	Legal status – section: Eg section 30	<input type="text"/>
Date event occurred:	<input type="text"/>	Legal status – leave: Eg section 52	<input type="text"/>
Narrative description of event*:	<input type="text"/>		
Patient's first name:	<input type="text"/>	NHI number:	<input type="text"/>
Middle name(s):	<input type="text"/>	Date of birth:	<input type="text"/>
Last name:	<input type="text"/>	Gender:	<input type="text"/>
Also known as:	<input type="text"/>	Ethnicity:	<input type="text"/>
Diagnoses at time of event:	<input type="text"/>		
Provisional cause of death*:	<input type="text"/>	Inpatient/outpatient:	<input type="text"/>
Provisional mode of death*:	<input type="text"/>	Date of last contact with mental health services*:	<input type="text"/>
Location where event occurred:	<input type="text"/>	Mental health service responsible for care:	<input type="text"/>
Other comments or notes:	<input type="text"/>		

\* Further discussion of this item is on the next page.

This form is the first step of the event process overseen by the Director of Mental Health. It must be completed and sent to the Director within 14 days of an event occurring, for all events that meet the Director's reporting criteria. Depending on the nature of the event, the Director may also require the following documents:

- notification and details of any media coverage and your response
- internal adverse event review report
- external adverse event review report
- coroner's report confirming cause of death
- inquiry/investigation documents (eg, under section 75 or 95 of the Mental Health Act or as required by the Health and Disability Commissioner or a coroner)
- audit documents detailing the implementation of recommendations from the above reports.

#### **Reason for reporting this event**

Since 2013, DAMHSs have been required to advise the Director of four types of events:

- 1) notifications of patient deaths in accordance with section 132 of the Mental Health Act. 'Patients' are further defined as a person required to undergo assessment under section 11 or 13, a person subject to a compulsory treatment order or a special patient
- 2) the death of a voluntary patient in an inpatient unit by suspected suicide
- 3) adverse events involving special patients, including attempted suicide, absence without leave, assault and breach of leave conditions (eg, in terms of alcohol use)
- 4) adverse events likely to draw media attention.

Note that there may be other reporting requirements (such as reporting to the Health Quality & Safety Commission) not connected to the Office of the Director.

#### **Narrative description of the event**

This is a brief description only, outlining what has happened and including any significant points that may not be captured elsewhere in the form.

#### **Date of last contact with mental health services**

This contact may have been face to face or by telephone.

#### **Cause and mode of death**

If the cause and mode of death recorded on this form are provisional, that entry must be followed up with a definitive cause of death according to a coroner's finding or medical certificate.

## Emergency border alert form<sup>7</sup>

<p>To: Customs Integrated Targeting and Operations Centre (ITOC)          0508 ITOC OPS (0508 4862 677)          ITOCOperationsCentre@customs.govt.nz</p> <p>Request to <b>put an emergency alert in place</b> for this special patient, or <b>remove the emergency border alert</b> for this special patient and destroy any identity information solely relating to the planned border alert (including any photograph).</p>	
Status	Mental health special patient
Action required	Place/remove an emergency border alert
Name and number of person who should be called if alert triggered	Director of Mental Health Director of Area Mental Health Services
Patient's name registered at birth or when on first entering the country	
Date of birth	Click or tap to enter a date.
Place of birth (if known)	
Surname	
First name	
Middle name(s)	
Alias(es)	
Gender	
Last known address	
Photograph attached	
Photograph taken on	Click or tap to enter a date.

<sup>7</sup> Black text indicates text to be reproduced in each case, and blue text indicates a guideline for creating or using the form (final versions should not include this text).



# Appendix 2: Special patient escaped or absent without leave: incident process



The DAMHS keeps the Office of the Director informed of progress and places a phone call to the Director or Deputy Director as soon as the special patient is retaken, giving relevant information, including on the special patient's health and welfare



The DAMHS or a delegated staff member calls the police and advises of the special patient's return, and takes off the border alert (by calling 0508 ITOC OPS (0508 4862 677))



The Office of the Director advises the Director-General of Health and Minister, removes passport measures and advises MFAT of the special patient's return, if they are a foreign national



The DAMHS sends a reportable events form to the Office of the Director and completes an internal review and an external review (where one is required)