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Mental Health and Addiction:

Service use 2009/10

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The purpose of this publication is to inform discussion and assist policy development. The opinions expressed in the publication do not necessarily reflect the official views of the Ministry of Health.

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This publication reports information provided to the Programme for the Integration of Mental Health Data (PRIMHD). It has not been possible to verify the accuracy of information in some instances if additional information, such as medical records, would be required to do so. It is important to note that as PRIMHD is a dynamic collection, it was necessary to wait a certain period before publishing a record of the information in it, thereby reducing the chances of amendments to information after publication.

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Key facts

Who received care in 2009/10?

- In 2009/10, 120,293 clients were seen by secondary mental health and addiction services. DHBs saw 116,645 of these clients and NGOs saw 12,256. The total number of clients seen increased by 8.1 percent from 2008/09.
- Just over half (54 percent) of all clients seen were male.
- Clients aged 15–24 years (youth) were most likely to be seen by secondary mental health and addiction services (3987.7 per 100,000 youth population).
- Clients identifying themselves as Māori made up 22.4 percent of all clients seen; 5.5 percent identified as Pacific peoples and 3.2 percent identified themselves as Asian.
- Māori had the highest age-standardised rate for male clients seen (5093.0 per 100,000 Māori males) and for female clients seen (3434.3 per 100,000 Māori females).
- Clients seen by DHBs (compared to NGOs) were, on average, younger. NGOs saw a higher proportion of Māori clients than DHBs.

What services were provided in 2009/10?

- General practitioners were the most common source of all referrals in 2009/10 (26,551 clients or 17.0 percent).
- The most commonly used team types were community teams, who saw 63,284 clients.
- Individual treatment attendances were the most common activity provided, with 1,199,022 contacts, an average of 12 per client.

What outcomes were achieved for clients seen in 2009/10?

- Between admission and discharge (no further care), the average total outcomes score on the HoNOS scale decreased by 57 percent for inpatient settings and 54 percent for community settings.
- Inpatient scores (14.0) were higher than community scores (10.2) at admission.

Introduction

This publication provides information on mental health and addiction service use for the 2009/10 financial year (1 July 2009 to 30 June 2010) and highlights some interesting trends between 2001/02 and 2009/10. A 2009/10 dataset is provided in the accompanying spreadsheet.

This publication includes information on mental health and addiction services provided by secondary organisations that are funded by the New Zealand Government. Mental health and addiction problems often co-exist; therefore, this publication contains information on both. This publication also includes information on mental health and addiction service users (clients) and the outcome of mental health service use. In other words, it describes who receives what services, from whom and to what effect.

This publication does not include information on:

- the provision of primary mental health care, such as care provided by general practitioners
- problem gambling
- people with a mental illness who do not access services.

Data source

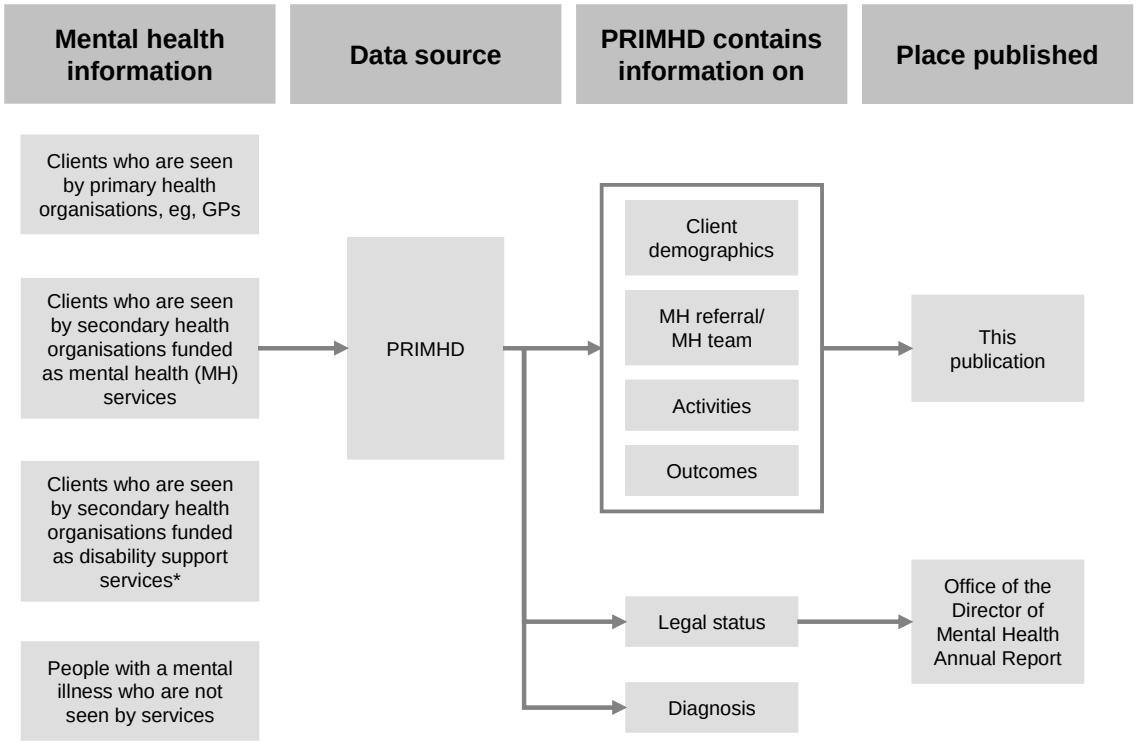
The majority of data used in this publication is sourced from the Programme for the Integration of Mental Health Data (PRIMHD). This is the first publication in this series to present data from PRIMHD. Data from previous publications was sourced from the Mental Health Information Collection (MHINC). PRIMHD superseded MHINC on 1 July 2008.

Additional information is collected in PRIMHD that was not available in MHINC. For example, PRIMHD collects information about the outcome of mental health service use, and more data is provided by non-governmental organisations (NGOs). This information is published in this document.

For more information on PRIMHD, go to www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd.

Information flow

Figure 1: Information flow



* Mental health and addiction services for older people are funded as disability support services in the Southern and Central regions. Most of this data is not collected in PRIMHD.

For the Office of the Director of Mental Health Annual Report please go to:

- http://www.health.govt.nz/publication/office-director-mental-health-annual-report-2010
- http://www.health.govt.nz/publication/office-director-mental-health-annual-report-2009

Abbreviations used in this publication

PRIMHD: (pronounced primed) Programme for the Integration of Mental Health Data

MHINC: Mental Health Information National Collection

WHO: World Health Organization

DHB: District health board

NGO: Non-governmental organisation

For further explanation of terms used, please see the Glossary.

Data quality

This section explains the known data quality issues.

Diagnosis

Investigation into the quality of data collected on diagnoses indicated that it was not of sufficient quality for publication. For example, the default diagnosis codes were used too often to be considered credible.

NGOs

This publication has used combined DHB and NGO data for totals. Please note that NGO coverage was incomplete in 2009/10. Only 118 NGOs (40 percent of all NGOs) reported 2009/10 data to PRIMHD. Of those 118 NGOs, not all teams supplied data, and not all reporting NGOs supplied data for the entire 2009/10 period.

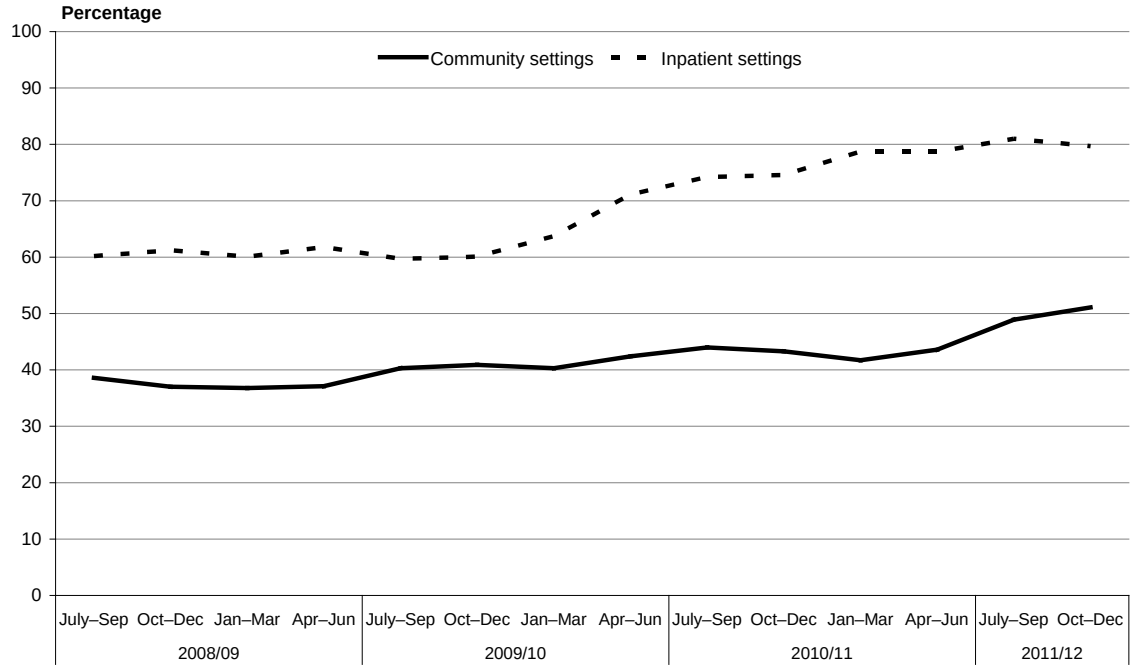
The reporting of NGO data to PRIMHD has been a phased process. The completeness of NGO data has improved since MHINC was disestablished (30 NGOs reported 2007/08 data to MHINC and 118 reported 2009/10 data to PRIMHD) and will continue to improve in future publications in this series.

For these reasons, 'NGO only' totals should be used with caution. In addition, the combined NGO and DHB totals are also likely to be understated and this should be taken into account.

Outcomes

As Figure 2 shows, the percentage of clients with an outcomes data collected has increased across time.

Figure 2: Percentage of face-to-face clients with at least one outcome collection by setting and three-month time period, July 2008 to December 2011



Source: PRIMHD

Note: Face-to-face clients are physically present at a bednight or contact. Care coordination activities, contact with family/whānau, written correspondence, phone calls and text messages are excluded from this data.

Between July 2008 and Dec 2011, the percentage of clients with an outcome collection increased by 12.5 percentage points in community settings and by 19.5 percentage points in inpatient settings.

However, as Table 1 shows, 2009/10 outcomes data was incomplete.

Table 1: Percentage of face-to-face clients seen in 2009/10 with at least one outcome collection by three-month time period

Time period	Community setting	Inpatient setting
July to September 2009	40.3%	59.7%
October to December 2009	40.9%	60.1%
January to March 2010	40.3%	63.7%
April to June 2010	42.4%	71.1%

Notes:

1 Face-to-face clients are physically present at a bednight or contact. Care coordination activities, contact with family/whānau, written correspondence, phone calls and text messages are excluded from this data.

2 The numbers are an update of numbers previously published.

In addition, outcomes data does not represent all mental health and addiction service users. Not all mental health and addiction teams collect outcomes data. The Ministry of Health does not require NGOs, alcohol and drug teams, community skills enhancement teams, and needs assessment and service coordination teams to collect outcomes data. Outcomes data is also incomplete within the team types that are required to collect it.

PRIMHD is a relatively new collection; data quality issues are still being identified and fixed. Data has been released to allow more timely information to be made available to the public, the sector and researchers. However, this publication's outcomes data should be used with caution.

Data on services for older people

Mental health and addiction services for older people are funded as mental health and addiction services in the Northern and Midland regions, but as disability support services in the Southern and Central regions. PRIMHD mainly captures mental health and addiction services and occasionally captures data on disability support services, this means data on clients aged over 65 (including psychogeriatric services) is incomplete.

Data in this publication used from MHINC

Data from before 1 July 2008, used in this publication for trend analysis, has been extracted from MHINC. There are known data quality issues with MHINC data. For information on data quality issues for specific years please consult the data quality sections of *previous publications*.

Also, reporting practices have changed between MHINC and PRIMHD periods. These changes may result in slight changes in totals and rates. Please use caution when comparing MHINC and PRIMHD periods.

Statistical notes

In this publication, numbers are generally rounded to one decimal place. However, calculations are made from the full string (ie, all the numbers after the decimal place), thereby providing more precise reporting.

Crude, age-specific and age-standardised rates

This publication uses age-specific and age-standardised rates. Crude rates are also used twice for the analysis of referral sources.

The age-specific rates of clients seen represent the number of clients seen in relation to the population size of a particular age group. The rate is the number of clients seen divided by the appropriate age-group population and then multiplied by 100,000.

Age-standardised rates account for differences in population structure, and can be used to compare groups with different age structures (eg, males and females, or Māori and non-Māori) and data from different years. In the present publication, the population structure employed is the WHO World Standard Population, and age-standardised rates are per 100,000 population.

Crude rates represent the number of clients seen divided by the appropriate population multiplied by 100,000.

Confidence intervals

When appropriate, confidence intervals have been calculated to aid the interpretation of rates. A confidence interval is a range of values used to illustrate the uncertainty around a single value (such as an age-standardised rate).

Confidence intervals describe how different the estimate could have been if chance had led to a different set of data. Confidence intervals are calculated with a stated probability, typically 95 percent (which would indicate that there is a 95 percent chance that the true value lies within the confidence intervals).

Confidence intervals may assist in comparing rates between different groups. If two confidence intervals do not overlap, then it is reasonable to assume the difference is not due to chance. If they do overlap, it means that the difference is 'not significant' and may be due to chance.

Ethnicity notes

The concept of ethnicity is that of a social construct of group affiliation and identity. The present Ministry of Health statistical standard for ethnicity states that 'ethnicity is the ethnic group or groups that people identify with or feel they belong to'. Thus, ethnicity is self-perceived, complex and multidimensional. This definition is based on the work of Anthony Smith (Smith 1986).

Ethnicity prioritisation

Ethnicity data for the New Zealand population is based on prioritised ethnicity. The prioritised ethnicity classification system is as follows.

Priority order	Ethnic group code description
1	Māori
2	Tokelauan
3	Fijian
4	Niuean
5	Tongan
6	Cook Island Maori
7	Samoan
8	Other Pacific Island
9	Pacific Island NFD (not further defined)
10	South East Asian
11	Indian
12	Chinese
13	Other Asian
14	Asian NFD
15	Latin American / Hispanic
16	African
17	Middle Eastern
18	Other
19	Other European
20	European NFD
21	NZ European

If a client indicates more than one ethnicity, the ethnicity with the highest priority is recorded. For example, if a client indicates: Asian, Māori, Middle Eastern and NZ European, Māori will be recorded. Further information on ethnicity data protocols for the health and disability sector is available at: www.health.govt.nz/publications/ethnicity-data-protocols-health-and-disability-sector.

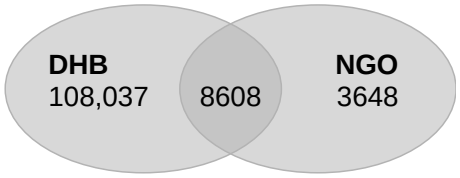
Client demographics

Overview

In 2009/10, 120,293 clients were seen by secondary mental health and addiction services. DHBs saw 116,645 of these clients and NGOs saw 12,256.

Figure 3 breaks down this total into clients that were seen solely by DHBs or NGOs and clients that were seen by both.

Figure 3: Number of clients seen by organisation type, 2009/10



Source: PRIMHD
Note: NGO coverage was incomplete in 2009/10.

Table 2 shows DHB data from July 2001 to June 2010 and a separate column that represents combined NGO and DHB data in 2008/09 and 2009/10. The table shows numbers and the age-standardised rates per 100,000 population.

Table 2: Clients seen: numbers and age-standardised rates, 2001/02 to 2009/10

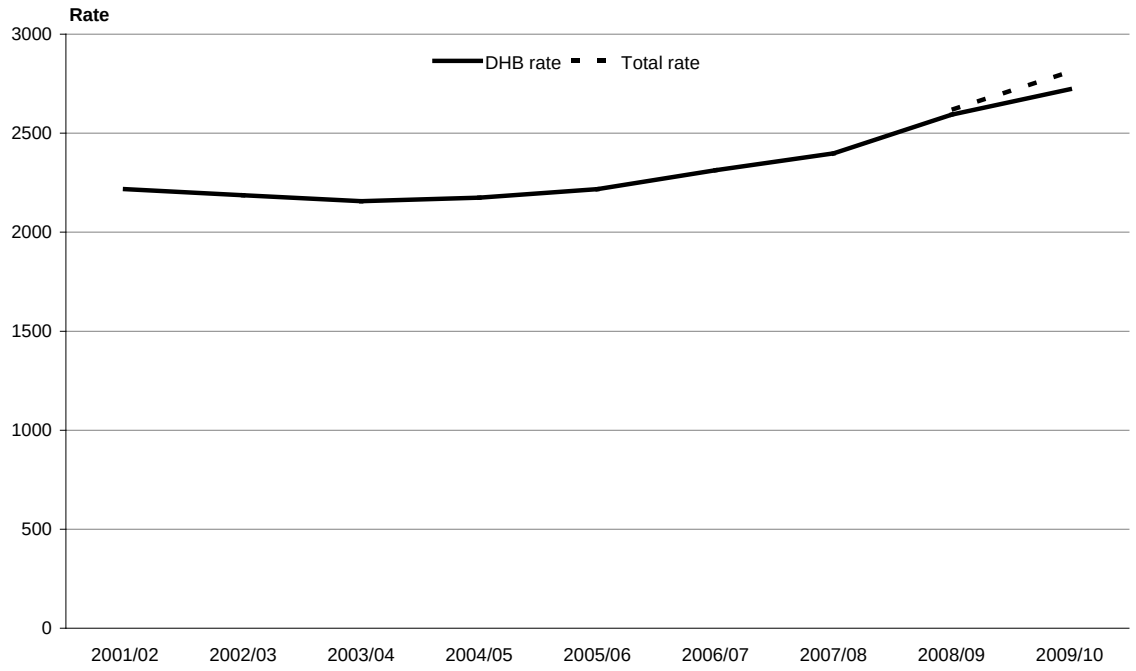
Year	DHB only		Total clients seen	
	No.	Rate	No.	Rate
2001/02	86,796	2217.6		
2002/03	87,434	2186.9		
2003/04	87,823	2156.5		
2004/05	89,469	2174.7		
2005/06	92,054	2217.9		
2006/07	96,662	2312.6		
2007/08	100,571	2398.4		
2008/09	110,266	2593.9	111,313	2617.6
2009/10	116,645	2721.9	120,293	2808.6

Source: MHINC (2001/02–2007/08) and PRIMHD (2008/09–2009/10).

Notes:
1 Clients seen in more than one financial year are counted in each relevant year.
2 Rates are per 100,000 population, age-standardised to the World Health Organization (WHO) world standard population.

Figure 4 shows the age-standardised rate of clients seen across time. The solid black line represents DHB data as only DHB data was complete before 2008/09. The broken line represents the combined NGO and DHB rate.

Figure 4: Age-standardised rates of clients seen, 2001/02 to 2009/10



Source: MHINC (2001/02–2007/08) and PRIMHD (2008/09–2009/10).

Note: Rates are per 100,000 population, age-standardised to the World Health Organization (WHO) world standard population.

The DHB rate was fairly stable between 2001/02 and 2005/06 and then showed a notable increase between 2005/06 and 2009/10. During this time the age-standardised rate increased by 22 percent (from 2217.9 to 2721.9 per 100,000 people).

Sex and age[1]

The following section presents:

- numbers and age-standardised rates of clients seen, by sex.
- numbers and age-specific rates of clients seen, by five-year age group and sex
- age-specific rates of clients seen by DHBs, by life-stage age group, 2001/02 to 2009/10.

Table 3 shows the number and age-standardised rate of male and female clients seen in 2009/10.

In 2009/10, 65,016 males and 55,279 females were seen by secondary mental health and addiction services.

Table 3: Clients seen: numbers and age-standardised rates, by sex, 2009/10

	No.	Rate
Males	65,015	3134.5
Females	55,277	2483.6
Total	120,293	2808.6

Source: PRIMHD

Notes:

1 Rates are per 100,000 population, age-standardised to the WHO world standard population.

2 The sex of one person was coded as undetermined. This person has been included in the grand total.

The male rate (3134.5) was 26 percent higher than the female rate (2483.6, age-standardised, per 100,000 population). This trend is similar to previous years.

[1] As explained in the 'Data quality' section, in this publication data on clients aged 65+ is incomplete.

Table 4 shows numbers and age-specific rates broken down into sex and five-year age groups.

Table 4: Clients seen: numbers and age-specific rates, by five-year age group and sex, 2009/10

	Males		Females		Total	
	No.	Rate	No.	Rate	No.	Rate
0–4	564	352.5	285	187.7	849	272.2
5–9	3519	2395.5	1374	982.0	4893	1705.9
10–14	5595	3691.1	3963	2748.1	9558	3231.5
15–19	7719	4663.8	6746	4300.1	14,465	4486.8
20–24	6814	4222.3	4953	3219.6	11,767	3732.9
25–29	5766	4027.1	4399	3029.0	10,165	3524.5
30–34	5665	4380.3	4748	3391.7	10,413	3866.3
35–39	6349	4439.9	5451	3443.7	11,800	3916.5
40–44	5708	3822.4	4745	2921.8	10,453	3353.2
45–49	4980	3189.4	4358	2616.9	9338	2894.0
50–54	3647	2556.8	3193	2145.1	6840	2346.6
55–59	2348	1902.3	2277	1780.2	4625	1840.1
60–64	1593	1408.6	1772	1511.7	3365	1461.1
65–69	1114	1295.5	1365	1512.8	2479	1406.8
70–74	939	1433.8	1214	1698.9	2153	1572.1
75–79	986	2017.2	1339	2378.3	2325	2210.5
80–84	970	2787.4	1430	3114.8	2400	2973.6
85+	739	3090.8	1665	3605.5	2405	3431.3
Total	65,015		55,277		120,293	

Source: PRIMHD

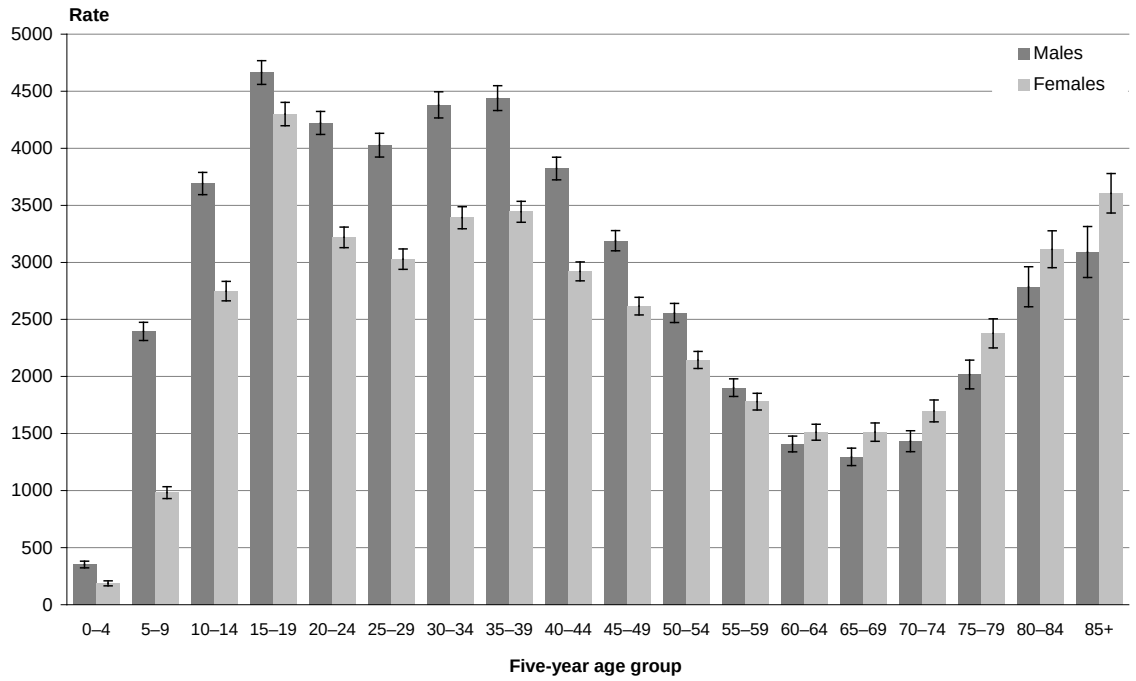
Notes:

1 The sex of one person in the 85+ age group was coded as undetermined. This person has been included in the grand total and the total for the 85+ age group.

2 Rates are age-specific per 100,000 population.

Table 4 and Figure 5 show that the male and female rates both peak at the 15–19 age group. The total age-specific rate of clients in this age group (4486.8) was higher than the rate of other age groups. Figure 5 illustrates the age-specific rate by five year age-group and sex.

Figure 5: Age-specific rates of clients seen, by five-year age group and sex, 2009/10



Source: PRIMHD

Note: Rates are age-specific per 100,000 population.

In the younger age groups (0–54) the male age-specific rate was significantly[2] higher than the female rate. The difference was more marked between the ages of 5 and 44, with the exception of clients aged 15–19. The greatest difference was for males aged 5–9, who were almost 2.5 times more likely to be seen than females (with age-specific rates per 100,000 population of 2395.5 and 982.0 respectively).

For the older age groups (60–85+) the opposite was true: females were more likely to be seen than males. However, the difference was not significant for clients aged 80–84.

Life-stage age group

Clients have been grouped into life-stage age groups in Table 5 and Figure 6. Only DHB data is included.

[2] Rates were found to be statistically significant using 95 percent confidence intervals. For more information see the 'Statistical notes' section.

Table 5: Age-specific rates of clients seen by DHBs by life-stage age group, 2001/02 to 2009/10

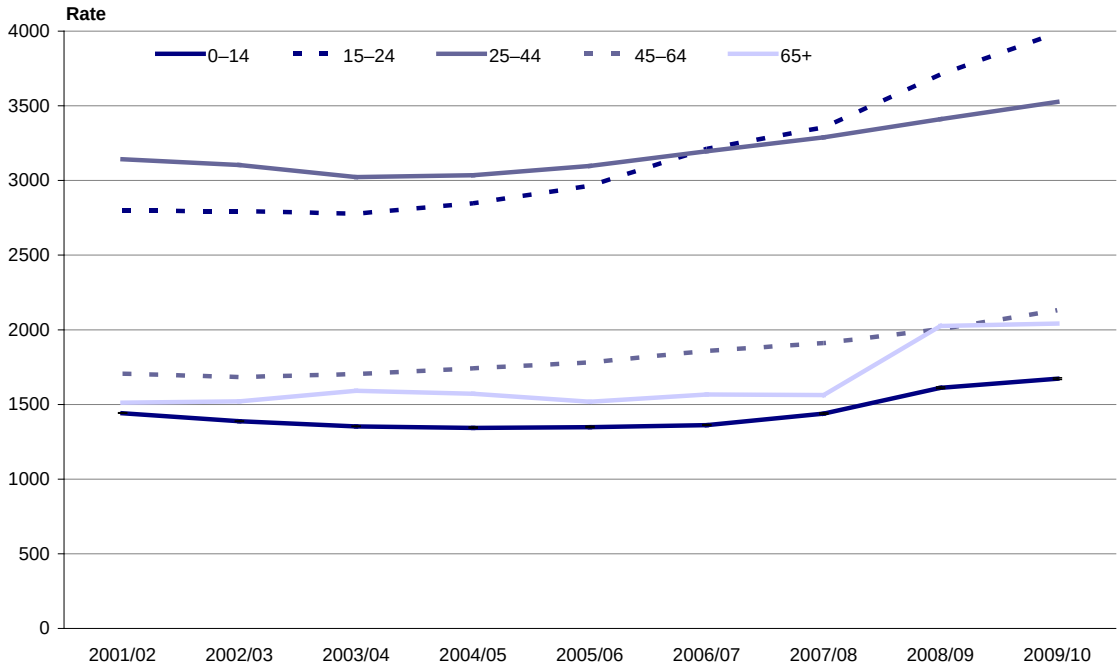
	0–14	15–24	25–44	45–64	65+
2001/02	1441.5	2796.8	3141.8	1705.4	1511.7
2002/03	1387.2	2795.1	3103.2	1683.6	1521.2
2003/04	1353.3	2777.7	3022.8	1703.3	1592.0
2004/05	1343.3	2847.6	3035.5	1741.9	1571.4
2005/06	1347.4	2964.6	3097.4	1782.3	1518.1
2006/07	1361.7	3212.1	3196.0	1858.4	1566.1
2007/08	1438.2	3356.4	3288.4	1910.6	1563.3
2008/09	1611.1	3710.9	3410.6	2004.6	2025.2
2009/10	1672.6	3987.7	3526.2	2131.5	2041.3

Source: PRIMHD

Note: Rates are age-specific per 100,000 population.

Rates for all age groups have increased since 2001/02. For clients aged 65+ the sharp increase seen between 2007/08 and 2008/09 coincides with PRIMHD superseding MHINC and may be due to changes in reporting practices between MHINC and PRIMHD periods.

Figure 6: Age-specific rates of clients seen by district health boards, by life-stage age group, 2001/02 to 2009/10



Source: PRIMHD

Note: Rates are age-specific per 100,000 population.

In 2009/10 the rates of clients seen by DHBs aged 15–24 (3987.7) and 25–44 (3526.2) were higher than other life-stage age groups (age-specific per 100,000 population). As shown in Figure 6 these groups consistently had higher rates across time.

Between 2001/02 and 2005/06, clients aged 25–44 were more likely to be seen than any other life-stage age group. More recently, between 2006/07 and 2009/10, clients aged 15–24 were more likely to be seen. During the same period, the age-specific rate of this group increased by 24 percent (from 3212.1 to 3987.7).

Ethnicity

The following section presents:

- numbers and age-standardised rates of Māori, Pacific, Asian and Other clients
- numbers and age-specific rates of non-Māori and Māori clients
- age-standardised rates of non-Māori and Māori clients seen by DHBs from 2001/02 to 2009/10.

In this publication ethnicity has been prioritised, using the Ministry of Health's prioritised ethnicity classification structure, into Māori, Pacific or Asian. All remaining ethnicities have been combined into a fourth group called 'Other' (see 'Ethnicity notes').

In 2009/10 a total of 26,949 Māori clients, 6670 Pacific, 3890 Asian and 82,784 Other clients were seen by mental health and addiction services.

Table 6: Numbers and age-standardised rates of clients, by ethnicity and sex, 2009/10

Ethnicity	Sex	No.	Rate
Pacific	Males	4286	3161.0
	Females	2384	1742.3
	Total	6670	2445.1
Asian	Males	1850	818.7
	Females	2040	827.5
	Total	3890	823.7
Other	Males	43,101	3132.4
	Females	39,682	2675.2
	Total	82,784	2905.8
Māori	Males	15,778	5093.0
	Females	11,171	3434.3
	Total	26,949	4237.0

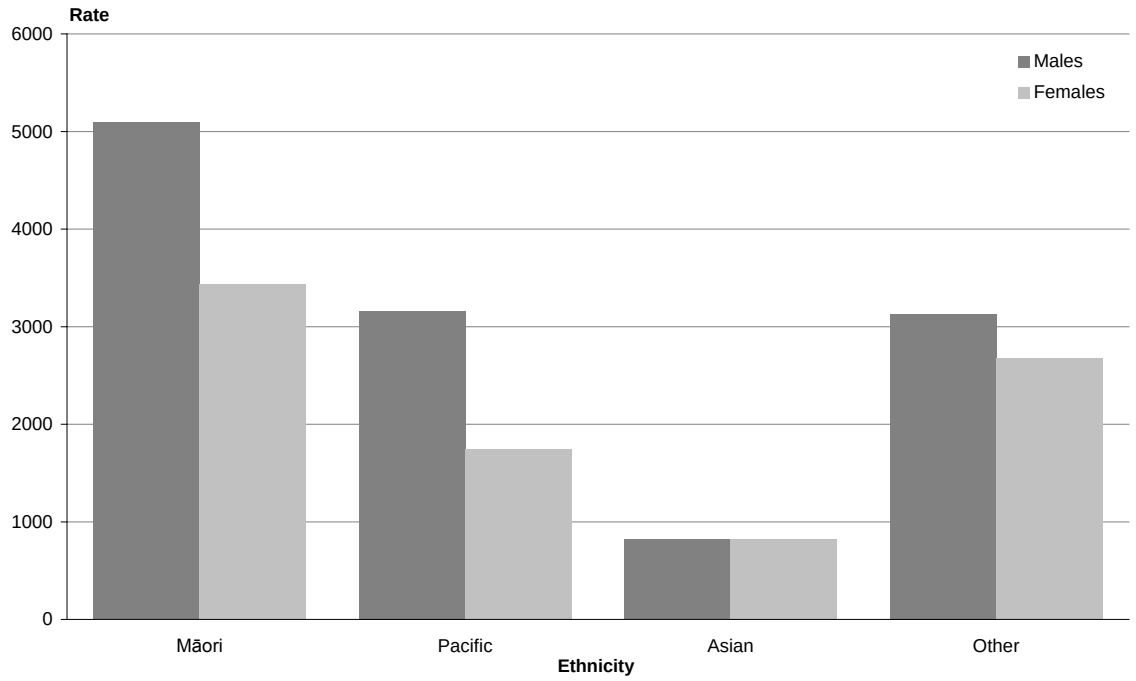
Source: PRIMHD

Note: Rates are per 100,000 population, age-standardised to the WHO World Standard Population.

The total Māori rate (4237.0) was significantly higher than the Pacific, Asian and Other rates (2445.1, 823.7 and 2905.8, respectively, age-standardised per 100,000 population). The Māori rate was 1.7 times higher than the Pacific rate, more than 5 times higher than the Asian, and almost 1.5 times higher than the Other ethnic group.

Figure 7 shows age-standardised rates by ethnic group and sex.

Figure 7: Age-standardised rates of clients, by ethnic group and sex, 2009/10



Source: PRIMHD

Note: Rates are per 100,000 population, age-standardised to the WHO World Standard Population.

In the Māori, Pacific and Other ethnic groups, the male rates were higher than female rates. The difference was most distinct for Māori and Pacific ethnic groups. Male Pacific clients accessed mental health and addiction services at a rate 81 percent higher than female Pacific clients.

Māori and non-Māori

In this section, clients have been grouped into Māori or non-Māori.

Table 7 presents numbers and rates of Māori and non-Māori clients seen by five-year age group and sex. Of the 93,344 non-Māori clients, 53 percent (49,237) were male and 47 percent (44,106) were female. In comparison, 59 percent (15,778) of Māori clients were male and 41 percent (11,171) were female.

Table 7: Numbers and age-specific rates for Māori and non-Māori clients, by five-year age group and sex, 2009/10

Age	Māori						Non-Māori					
	Males		Females		Total		Males		Females		Total	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
0–4	145	315.5	65	150.4	210	235.5	419	367.4	220	202.5	639	287.0
5–9	880	2461.5	260	766.5	1140	1636.1	2639	2374.3	1114	1050.9	3753	1728.4
10–14	1604	4538.8	1053	3145.2	2657	3860.8	3991	3433.4	2910	2628.0	6901	3040.6
15–19	2348	6720.1	1624	4915.3	3972	5842.9	5371	4113.5	5122	4136.0	10,493	4124.4
20–24	2057	7380.7	1336	4658.3	3393	6000.0	4757	3563.0	3617	2889.9	8374	3237.3
25–29	1773	8764.2	1170	5246.6	2943	6918.2	3993	3247.7	3229	2626.7	7222	2937.3
30–34	1620	8307.7	1152	5198.6	2772	6653.9	4045	3683.0	3596	3051.9	7641	3356.2
35–39	1608	8052.1	1233	5344.6	2841	6600.8	4741	3853.5	4218	3119.4	8959	3469.1
40–44	1401	7436.3	1086	5079.5	2487	6183.5	4307	3300.6	3659	2594.7	7966	2934.0
45–49	1060	5773.4	851	4111.1	1911	4892.5	3920	2845.1	3507	2404.9	7427	2618.7
50–54	573	3764.8	538	3183.4	1111	3458.9	3074	2412.5	2655	2012.1	5729	2208.9
55–59	305	2666.1	318	2533.9	623	2596.9	2043	1824.3	1959	1698.2	4002	1760.3
60–64	140	1618.5	174	1839.3	314	1733.8	1453	1391.2	1598	1482.9	3051	1437.8
65–69	91	1566.3	117	1786.3	208	1684.2	1023	1275.9	1248	1491.4	2271	1385.9
70–74	75	1777.3	72	1487.6	147	1622.5	864	1410.2	1142	1714.2	2006	1568.5
75–79	53	2226.9	60	2061.9	113	2132.1	933	2006.5	1279	2395.6	2212	2214.7
80–84	30	2654.9	41	2515.3	71	2572.5	940	2791.8	1389	3136.9	2329	2987.8
85+	15	2777.8	21	2258.1	36	2432.4	724	3098.0	1644	3633.1	2369	3452.8
Total	15,778		11,171		26,949		49,237		44,106		93,344	

Source: PRIMHD

Notes:

1 Rates are age-specific per 100,000 population.

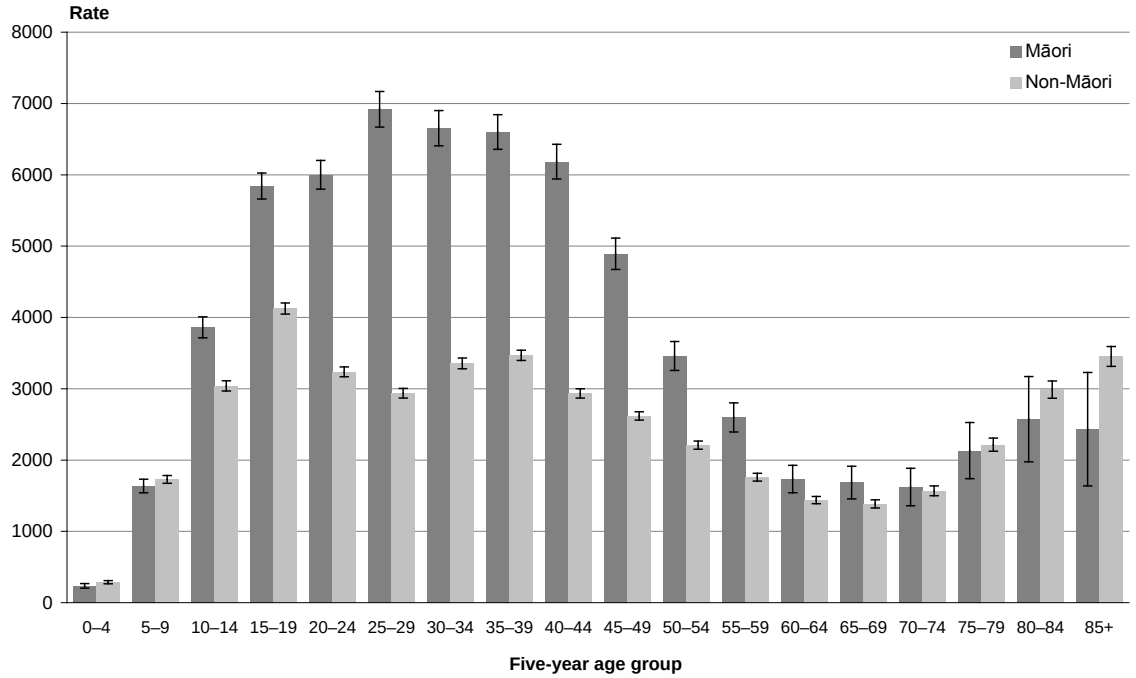
2 The sex of one person in the non-Māori, 85+ age group was coded as undetermined. This person has been included in the grand total and the total for the non-Māori, 85+ age group.

For most age groups the male age-specific rate was higher than the female rate, with the exception of Māori clients aged 60–69 and non-Māori clients aged 15–19 and 60–85+.

Of all groups, the age-specific rate was highest for Māori male clients aged 25–29. This rate (8764.2) was 67 percent higher than the female equivalent (5246.6, age-specific per 100,000 population).

Figure 8 shows the age-specific rates for each age-group by Māori and non-Māori.

Figure 8: Age-specific rates of Māori and non-Māori clients, by five-year age group, 2009/10



Source: PRIMHD

Note: Rates are age-specific per 100,000 population.

Figure 8 shows that the Māori rate was significantly higher than the non-Māori rate for clients aged 10–70. For two age groups, 25–29 and 40–44, the Māori rate was more than double the non-Māori rate.

The non-Māori rate was significantly higher than the Māori rate for clients in the 85+ age group. Although the non-Māori rate was higher for clients aged 0–9 and 75–84, the difference is not significant.

Māori and non-Māori clients seen by DHBs across time

Table 8 shows the number and rate of clients seen by DHBs across time for Māori and non-Māori by sex.

Table 8: Numbers and age-standardised rates for Māori and non-Māori clients seen by DHBs, by sex, 2001/02 to 2009/10

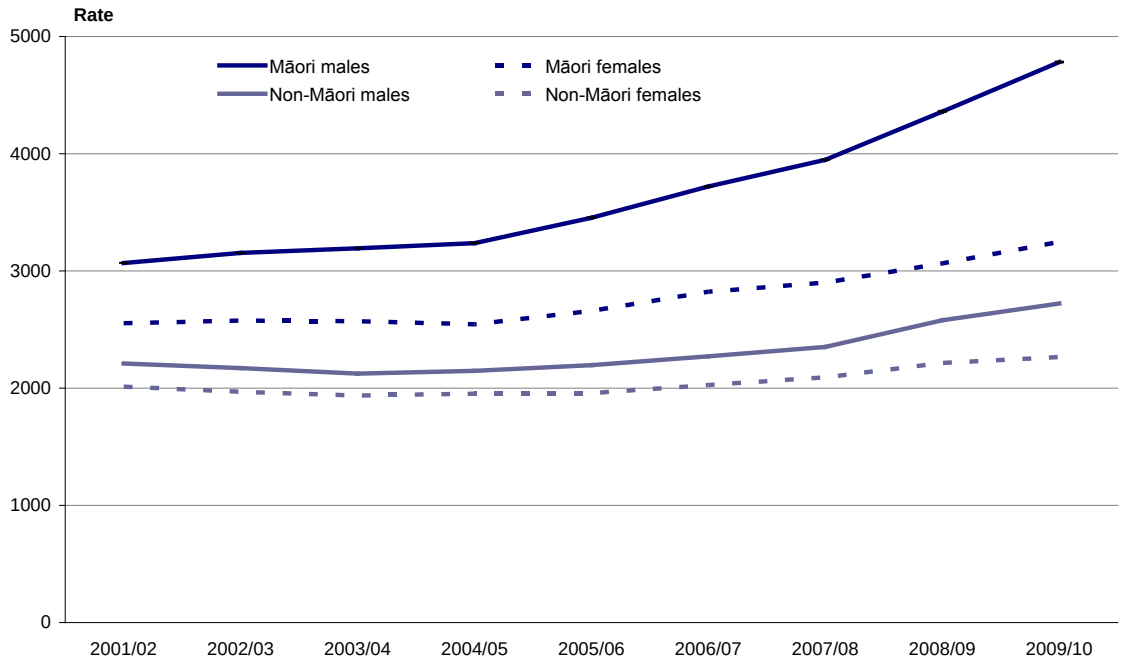
Year	Māori						Non-Māori					
	Males		Females		Total		Males		Females		Total	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
2001/02	8864	3067.2	7554	2554.0	16,419	2806.5	35,495	2210.2	34,882	2013.3	70,377	2114.6
2002/03	9164	3154.0	7659	2576.0	16,823	2860.1	35,715	2171.0	34,894	1968.3	70,611	2072.6
2003/04	9361	3193.2	7767	2571.3	17,130	2876.6	35,605	2124.7	35,086	1937.6	70,693	2033.1
2004/05	9568	3236.5	7849	2545.4	17,418	2882.7	36,342	2148.0	35,708	1952.7	72,051	2051.9
2005/06	10,243	3453.1	8282	2659.5	18,527	3043.4	37,456	2196.7	36,070	1957.5	73,527	2077.8
2006/07	11,117	3720.3	8900	2822.9	20,018	3255.8	39,082	2270.9	37,561	2026.8	76,644	2149.0
2007/08	11,937	3948.2	9220	2901.0	21,158	3408.1	40,680	2352.3	38,733	2092.6	79,413	2222.5
2008/09	13,390	4360.1	9842	3063.7	23,232	3692.8	45,153	2579.0	41,881	2214.8	87,034	2397.5
2009/10	14,786	4782.2	10,617	3247.5	25,403	3988.8	48,082	2721.9	43,159	2264.8	91,242	2494.2

Source: PRIMHD

Note: Rates are per 100,000 population, age-standardised to the WHO World Standard Population.

Table 8 and Figure 9 show that the difference between the Māori rate and non-Māori rate is widening. Between 2001/02 and 2009/10 the Māori male to non-Māori male rate ratio increased from 1.4 to 1.8. This is mainly a result of the notable change in the Māori male rate – an increase of 56 percent over the equivalent 2001/02 rate.

Figure 9: Age-standardised rates of Māori and non-Māori clients, by sex, 2001/02 to 2009/10



Source: MHINC (2001/02–2007/08) and PRIMHD (2008/09–2009/10).

Note: Rates are per 100,000 population, age-standardised to the WHO world standard population.

Deprivation

Table 9 and Figure 10 present the numbers and age-standardised rate of clients seen by deprivation quintile according to the New Zealand Deprivation Index 2006 (NZDep2006) (Salmond et al 2007). This index is a measure of socioeconomic status calculated for small geographic areas, using a range of variables from the 2006 Census of Population and Dwellings.

Table 9: Numbers and age-standardised rates of clients, by deprivation quintile and sex, 2009/10

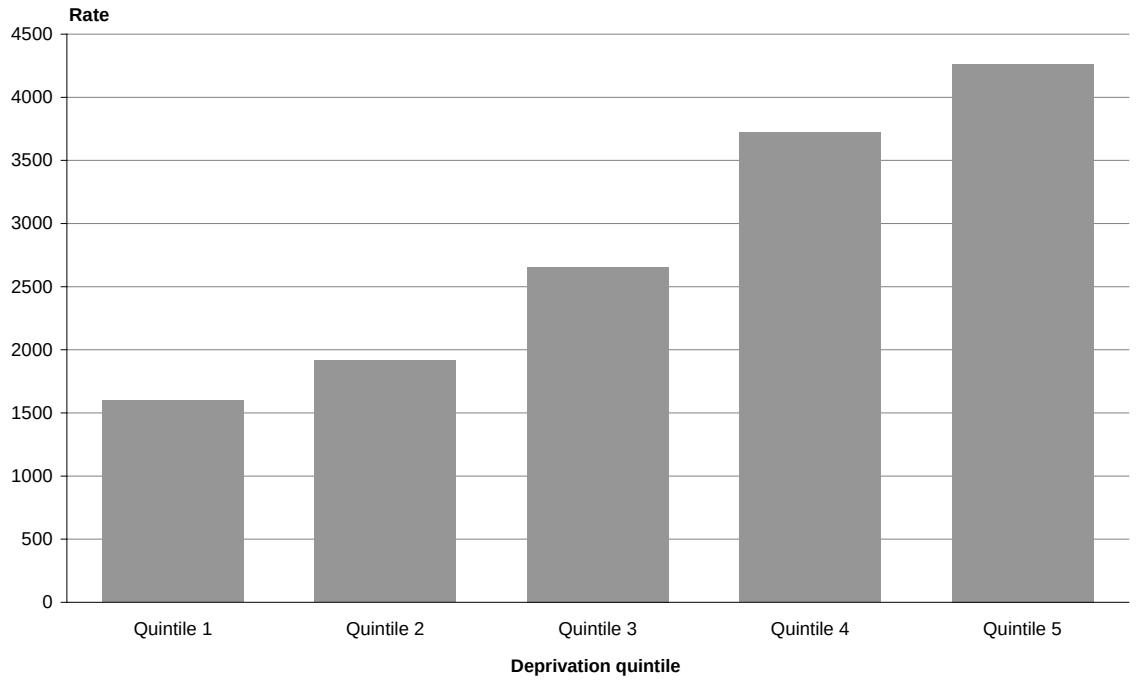
Deprivation quintile	Sex	No.	Rate
1 (least deprived)	Males	6607	1616.2
	Females	6840	1572.2
	Total	13,447	1598.4
2	Males	8397	2007.4
	Females	8103	1814.5
	Total	16,500	1913.6
3	Males	11,982	2887.7
	Females	10,724	2419.6
	Total	22,706	2655.6
4	Males	17,205	4194.2
	Females	14,429	3248.9
	Total	31,635	3721.3
5 (most deprived)	Males	20,695	5121.9
	Females	15,066	3448.0
	Total	35,761	4263.9
Unknown	Total	244	

Source: PRIMHD

Note: Rates are per 100,000 population, age-standardised to the WHO world standard population.

The age-standardised rate for females living in the least deprived areas was not significantly different from the male rate. At all other levels of deprivation, the male rate was significantly higher than the female rate. Of all groups, the highest rate (5121.9) was males living in the most deprived areas (quintile 5, age-standardised per 100,000 population).

Figure 10: Age-standardised rates of clients, by deprivation quintile, 2009/10



Source: PRIMHD

Note: Rates are per 100,000 population, age-standardised to the WHO World Standard Population.

Figure 10 shows that the rate of clients seen increased as deprivation increased. Clients living in the most deprived areas (quintile 5) were 2.7 times more likely to be seen than clients living in the least deprived areas (quintile 1). There is a statistically significant difference between all groups.

Face-to-face clients and DHB region

Table 10 shows the number of face-to-face clients seen and the age-standardised rates by DHB regions. A face-to-face activity involves a client being physically present at a bednight or contact. It does not include care coordination activities, contact with family/whānau, written correspondence, phone calls and text messages (non face-to-face activities).

Administrative practices surrounding the use of non-face-to-face activities vary between district health boards. For this reason clients with no face-to-face activity in 2009/10 have been excluded from Table 10 and Figure 11.

Table 10: Numbers and age-standardised rates of face-to-face clients, by DHB of residence, 2009/10

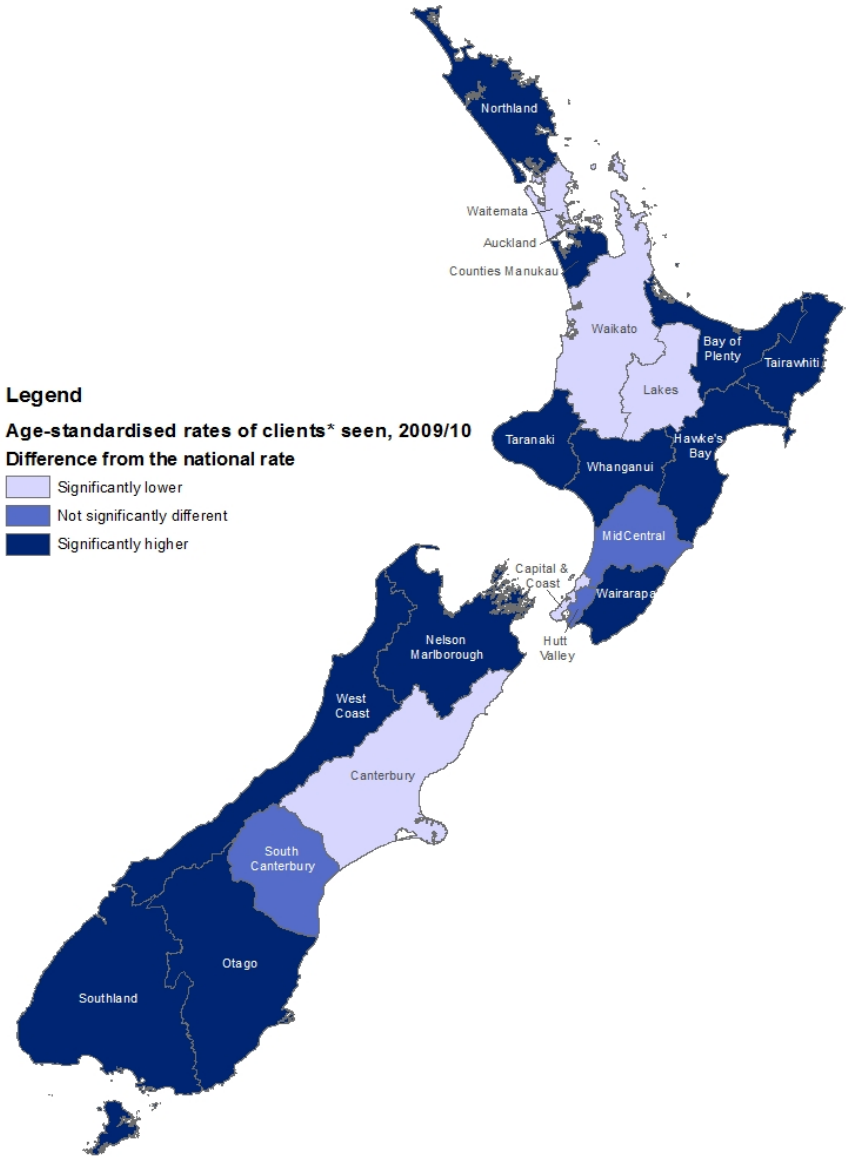
	No.	Rate
Northland	4328	3097.4
Waitemata	12,989	2413.9
Auckland	10,838	2234.2
Counties Manukau	12,959	2691.8
Waikato	7557	2063.9
Lakes	2341	2306.1
Bay of Plenty	5940	3004.3
Tairawhiti	1887	4361.6
Hawke's Bay	4231	3094.8
Taranaki	3496	3340.5
MidCentral	3828	2486.9
Whanganui	2298	4099.8
Capital and Coast	4900	1713.4
Hutt Valley	3562	2577.3
Wairarapa	1016	2996.7
Nelson Marlborough	4090	3385.2
West Coast	1223	4063.8
Canterbury	11,227	2146.3
South Canterbury	1201	2606.3
Otago	5560	3111.7
Southland	2939	2823.4
Unknown	238	
Total	108,648	2528.8

Source: PRIMHD

Note: Rates are per 100,000 population, age-standardised to the WHO world standard population.

In 2009/10, 108,648 face-to-face clients were seen in New Zealand (2528.7 clients per 100,000 people, age-standardised to the WHO world standard population). Figure 11 compares the national rate with the rate of each district health board region.

Figure 11: Age-standardised rates of face-to-face clients, by DHB of residence, 2009/10



Source: PRIMHD

Notes:

1 A face-to-face activity involves a client being physically present at a bednight or contact. Care coordination activities, contact with family/whānau, written correspondence, phone calls and text messages are excluded from this data. *The figure shows face-to-face clients only.

2 The chart illustrates the DHB of residence for clients that were seen in 2009/10. Clients may have been seen in a DHB region different from their place of residence.

3 The rate shown is the age-standardised rate per 100,000 DHB population, standardised to the WHO world standard population; 95 percent confidence intervals.

4 Data should be analysed with caution. Differences between rates may be due to differences in administrative practices.

Waitemata, Auckland, Waikato, Lakes, Capital & Coast and Canterbury had a significantly lower age-standardised rate than the national rate. Three DHB regions, MidCentral, Hutt Valley and South Canterbury, had rates not significantly different from the national rate. The remaining regions had rates significantly higher than the national rate.

Comparison of client demographics, NGOs and DHBs

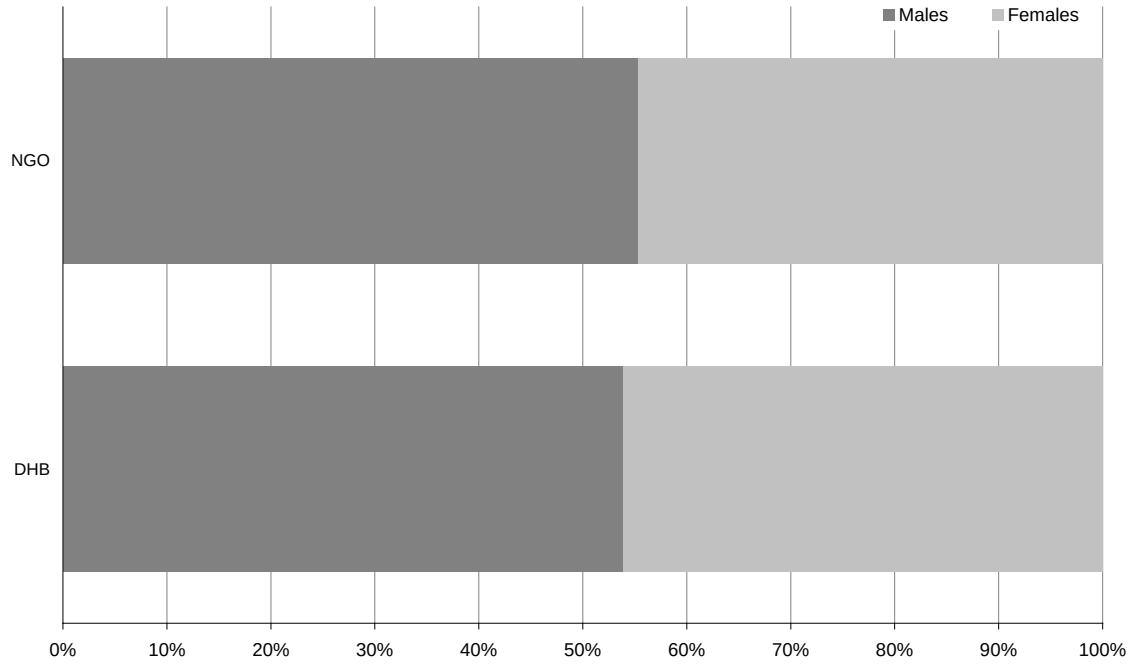
The inclusion of NGO data enables a more comprehensive analysis of mental health and addiction services. NGOs deliver a large proportion of services – in 2009/10 NGOs received almost one-third of all mental health and addiction funding. New NGO data will improve understanding of service use and may influence trends found in future publications in this series.

This section gives some indication of the differences between DHB and NGO demographics and how NGO data may affect trends. Specifically, this section compares the proportion of clients seen by DHBs and NGOs by sex, life-stage age group, and Māori and non-Māori.

Sex

Figure 12 compares the proportion of males and females seen by NGOs and DHBs, and shows that they are similar.

Figure 12: Proportion of clients seen by NGOs and DHBs, by sex, 2009/10

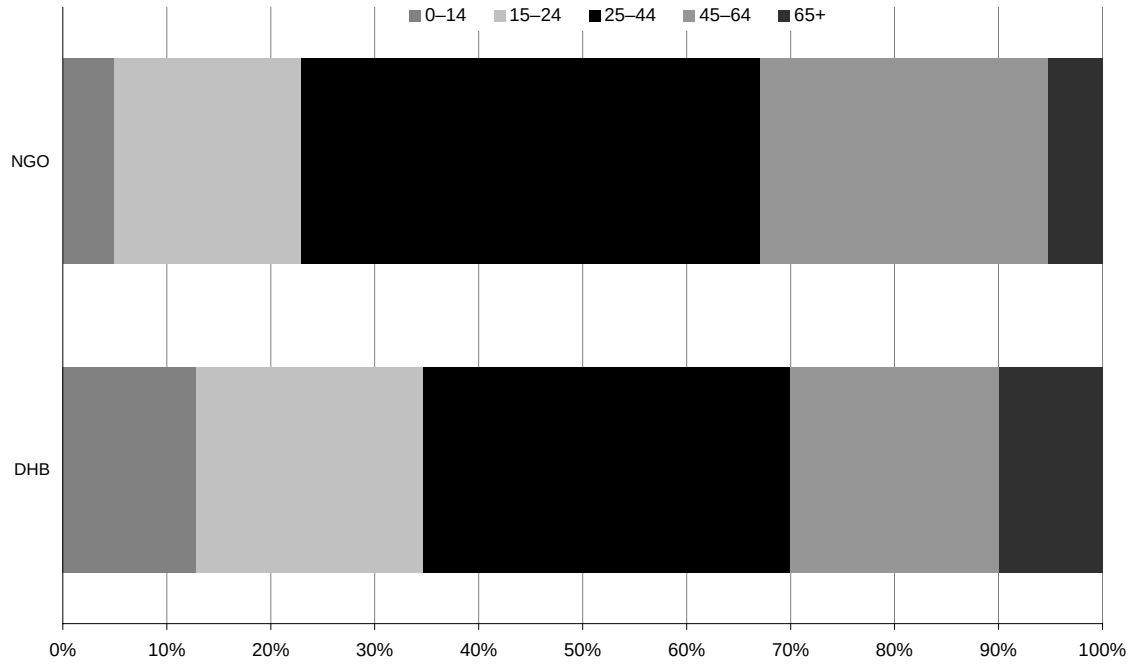


Source: PRIMHD

Age

The average age of clients seen by DHBs (35.9) was lower than the average age of NGO clients (37.8). This is illustrated in Figure 13 – DHBs saw a higher proportion of the younger age groups than NGOs. Thirty-four percent of DHB clients were under the age of 24, compared to 23 percent of NGO clients. Conversely, the proportion of NGO clients in the middle age groups (25–64) was higher than the equivalent DHB proportion.

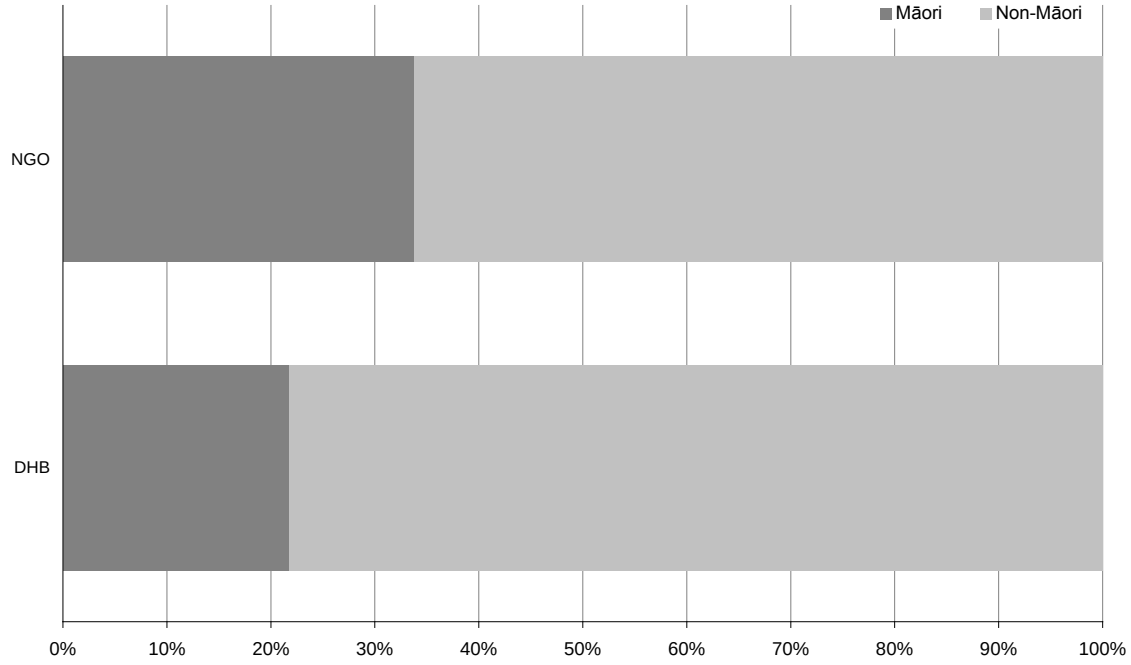
Figure 13: Proportion of clients seen by NGOs and DHBs, by life-stage age group, 2009/10



Source: PRIMHD

Ethnicity

Figure 14: Proportion of Māori and non-Māori clients seen by NGOs and DHBs, 2009/10



Source: PRIMHD.

As Figure 14 shows, the proportion of Māori seen by NGOs was higher than the proportion seen by DHBs. Thirty-four percent (4145) of NGO clients and 22 percent (25,403) of DHB clients were Māori. In addition, the proportion of clients seen by NGOs in a kaupapa Māori setting was also higher than the equivalent DHB proportion. Twenty-three percent (2909) of NGO clients and 4 percent (4842) of DHB clients were seen in a kaupapa Māori setting.

Mental health and addiction services provided

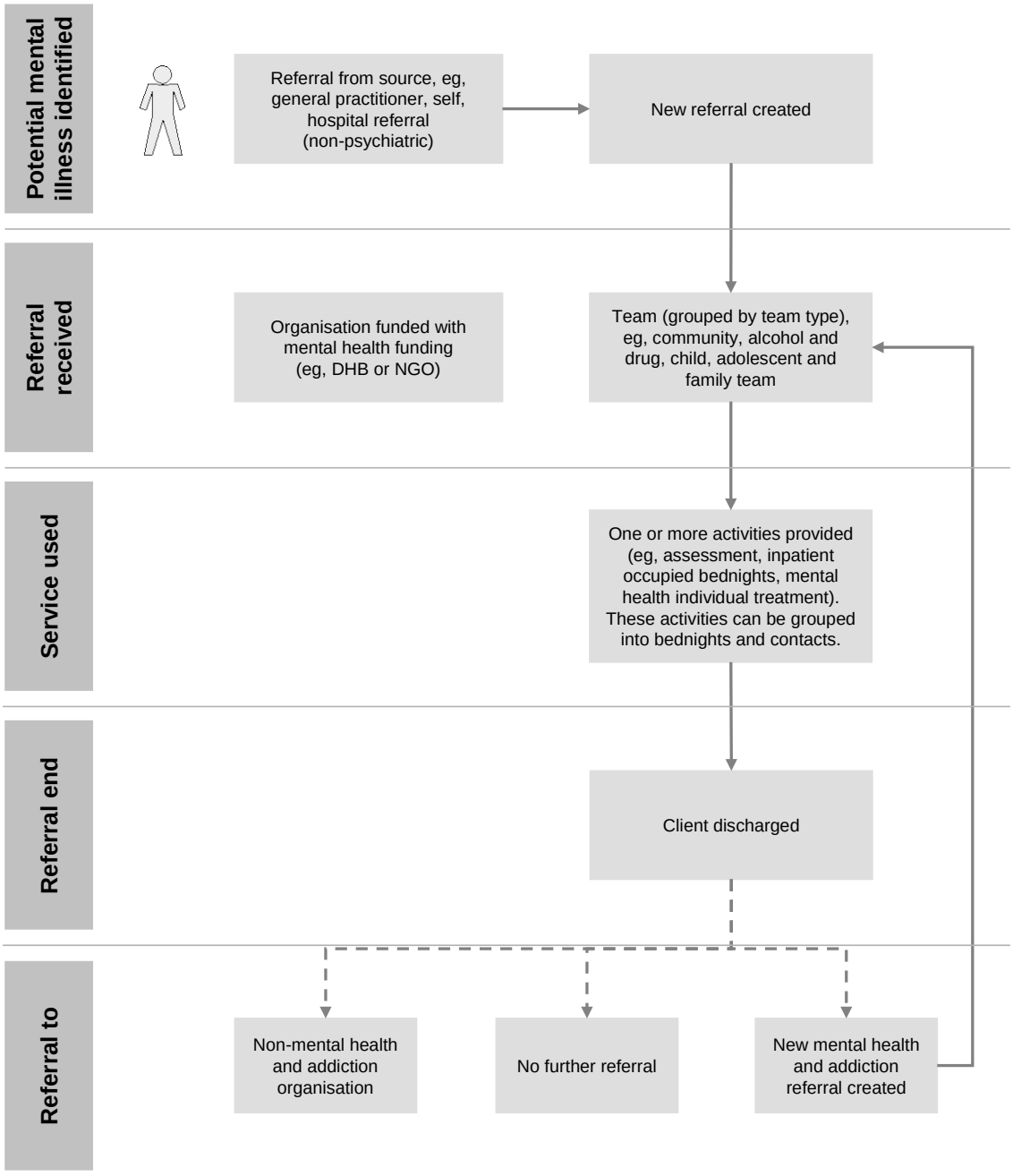
This section gives an overview of services provided in 2009/10, and presents information on:

- the referral source
- the team type
- a comparison of NGO and DHB team types
- the activity type
- the reason for discharge
- the person or place discharged to
- Regular service users (inpatient, residential and community).

Figure 15 illustrates how secondary mental health and addiction clients typically access services.

Overview

Figure 15: Client pathway



Mental health and addiction data is collected at different stages of the pathway. This section provides a summary of information collected at each stage.

Referral source

When a potential mental illness is identified, the client is referred to a mental health and addiction service from a 'referral source'.

A total of 217,668 mental health and addiction referrals were open at some stage in the 2009/10 period. Of these, 156,162 began during the period. The following section provides information on the sources of these referrals.

Table 11: Number and percent of new mental health and addiction referrals, by referral source, 2009/10

Referral source	No.	Percent
General practitioner	26,551	17.0%
Self or relative referral	21,819	14.0%
Adult community mental health services	20,521	13.1%
Hospital referral (non-psychiatric)	9894	6.3%
Police	9572	6.1%
Justice	9178	5.9%
Accident and emergency	7990	5.1%
Psychiatric inpatient	5416	3.5%
Unknown	4243	2.7%
Education sector	2837	1.8%
Additional sources	11,937	7.6%
Other	26,204	16.8%
Total	156,162	100.0%

Source: PRIMHD

Notes:

1 A client can have more than one referral open at once.

2 The least common sources of referrals have been grouped together as 'Additional sources'. Information on these sources is available on request.

3 The Ministry of Health has identified that 16.8 percent (26,204) of referrals have 'Other' as the referral source. This is a known data quality issue and it is likely that 'Other' has been used as a default code. Please use this data with caution.

General practitioners (GPs) were the most common source of all referrals (17 percent). Referrals from GPs, self or a relative, adult community mental health services and hospital (non-psychiatric) made up the majority (more than 50 percent) of all referral sources.

Table 12 and Figure 16 present these four sources broken down into Māori and non-Māori, and sex. The table and figure show crude rates that have been calculated by dividing each group by the relevant population and multiplying by 100,000. The rate represents the number of people referred to mental health and addiction services out of every 100,000 people in the relevant population group.

Table 12: Numbers and crude rate of referrals by referral source for Māori and non-Māori, by sex, 2009/10

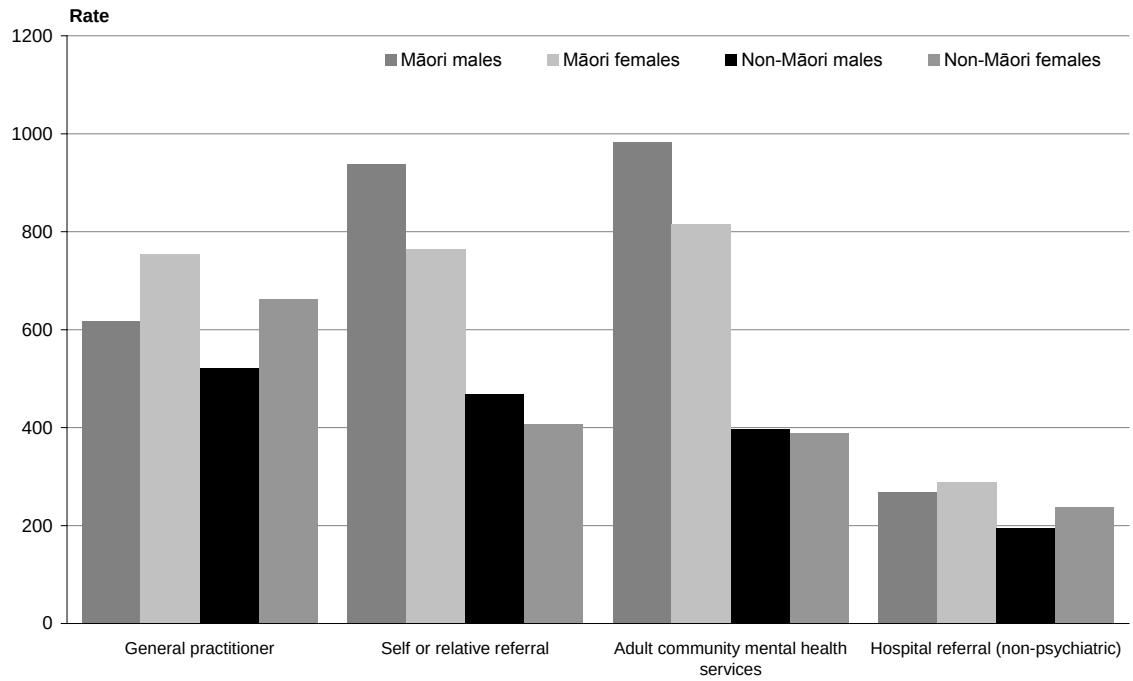
Referral source	Māori males		Māori females		Non-Māori males		Non-Māori females	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate
General practitioner	2014	617.4	2547	754.2	9505	522.7	12,485	662.2
Self or relative	3059	937.8	2579	763.7	8515	468.3	7666	406.6
Adult community mental health services	3205	982.5	2754	815.5	7219	397.0	7342	389.4
Hospital (non-psychiatric)	879	269.5	974	288.4	3536	194.5	4505	238.9

Source: PRIMHD

Note: The rate is a crude rate per 100,000 population and is calculated by dividing the number of referrals in each group by the relevant population total and multiplying by 100,000.

Interestingly, the rate of female referrals from GPs was higher than the male rate for both ethnic groups. The rate of Māori female referrals from GPs (754.2) was 22 percent higher than the Māori male rate (617.4) and the non-Māori female rate (662.2) was 27 percent higher than the non-Māori male rate (522.7, crude rate per 100,000 population).

Figure 16: Crude rate of Māori and non-Māori clients, by sex and referral source, 2009/10



Source: PRIMHD

Note: The rate is a crude rate per 100,000 population and is calculated by dividing the number of referrals by the relevant population total and multiplying by 100,000.

The crude rate (per 100,000 population) of Māori male and Māori female referrals was notably higher than both of the non-Māori equivalents for self or relative referrals and adult community mental health services. The Māori male referral rate was double that of the non-Māori male rate for self or relative referral and 2.5 times higher for adult community mental health service referrals.

The rates of hospital referral (non-psychiatric) were relatively similar for each group.

Team types

After the referral is received the client is referred to a mental health and addiction team.

Teams providing mental health and addiction services are categorised into groups, representing the primary function of the team. Some teams have more than one function. However, only the primary function of the team is recorded in PRIMHD.

This section presents:

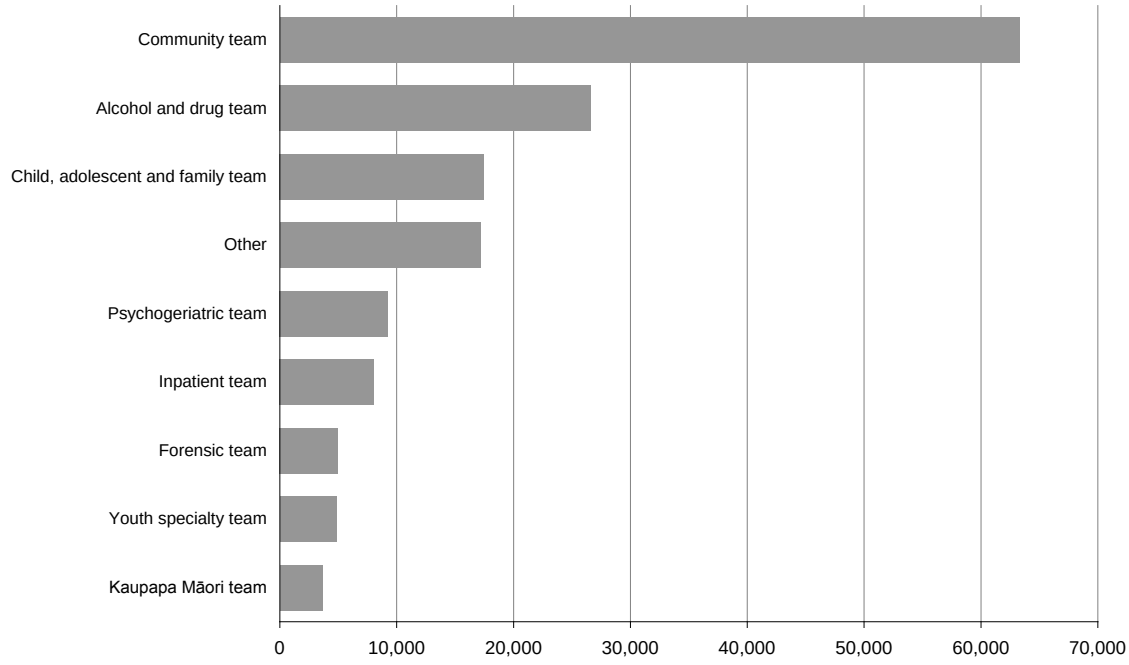
- the number of clients seen[3] by the most common team types
- the number of clients seen, bednights,[4] contacts[5] and face-to-face activities[6] provided by all mental health and addiction team types
- a comparison of the proportion of clients seen by DHB and NGO team types.

Clients seen, bednights, contacts and face-to-face activities, by team type

Figure 17 shows the number of clients seen by the most common team types.

[3] A count of all clients with at least one mental health and addiction activity.
[4] Bednights are nights spent in residential or inpatient settings.
[5] A count of contact with teams in community or outpatient settings.
[6] When a client is physically present at a bednight or contact.

Figure 17: Clients seen, by team type, 2009/10



Source: PRIMHD

Notes:

1 Data on psychogeriatric services is incomplete. Mental health and addiction services for older people are funded as mental health and addiction services in the Northern and Midland regions but as disability support services in the Southern and Central regions.

2 The least common team types have been grouped as Other.

In 2009/10 mental health and addiction teams saw 155,313[7] clients. Community teams saw 41 percent (63,284) of these clients, more than any other team type. Community teams generally provide assessment and treatment services in community or outpatient settings. However, not all teams providing services in these settings are categorised as community teams. Teams aimed at a specific client group or purpose are coded to the specific team type. For example, eating disorder services are coded to eating disorder teams even though clients may be seen in a community setting.

Table 13 presents the number of clients seen, bednights, contacts and face-to-face activities provided by all team types in 2009/10.

[7] This is not a count of unique clients seen – 120,293 unique clients were seen in 2009/10. Clients who were seen by more than one team type have been counted in each relevant team type.

Table 13: Clients seen, bednights, contacts and face-to-face activities, by team type, 2009/10

Team type description	Clients seen	Bednights	Contacts	Face-to-face activities
Alcohol and drug dual diagnosis team	1055	2793	12,492	9139
Alcohol and drug kaupapa Māori team	1607	2600	13,065	8737
Alcohol and drug team	26,624	38,598	284,099	211,060
Child, adolescent and family team	17,467	8435	244,434	106,394
Children and youth, alcohol and drug services	558	17	8228	4812
Community skills enhancement team	2278	7718	78,836	76,068
Community team	63,284	16,376	1,353,453	871,027
Eating disorder team	717	3454	15,130	14,833
Forensic team	4978	85,146	61,422	118,118
Inpatient team	8061	243,530	5188	247,596
Intellectual disability dual diagnosis team	403	3037	4975	6241
Kaupapa Māori dual diagnosis mental health and alcohol and drug services	85	–	966	698
Kaupapa Māori tamariki and rangatahi (child and youth) mental health services	623	–	6082	2556
Kaupapa Māori team	3647	10,677	78,120	57,609
Maternal mental health team	1901	1957	26,673	14,400
Needs assessment and service coordination team	2280	–	11,554	4505
Pacific Island team	2162	2726	52,191	28,542
Psychogeriatric team	9252	29,964	110,561	91,050
Refugee team	72	–	337	229
Residential team	3025	248,504	72,170	309,990
Services for profoundly deaf team	25	–	1511	690
Specialist psychotherapy team	358	–	5784	4753
Youth specialty team	4851	7024	66,960	45,500
Total	155,313	712,556	2,514,231	2,234,547

Source: PRIMHD

Notes:

1 This is not a count of unique clients seen – 120,293 unique clients were seen in 2009/10. Clients seen by more than one team type have been counted in each relevant team type.

2 A face-to-face activity is when a client is physically present at a bednight or contact. Care coordination activities, contact with family/whānau, written correspondence, telephone calls and text messages are excluded from this count.

3 – = not applicable.

4 Data on psychogeriatric services is incomplete. Mental health services for older people are funded as mental health services in the Northern and Midland regions but as disability support services in the Southern and Central regions.

Table 13 presents combined DHB and NGO totals. Previous publications in this series have presented only DHB data for this table. The inclusion of NGO data has resulted in a substantial increase in contact and bednight totals (an increase of 81.4 percent for the bednight total and 14.7 percent for the contact total). This means that totals have also increased for some team types, so caution should be used when comparing this data with previous publications.

Comparison of team types, NGOs and DHBs

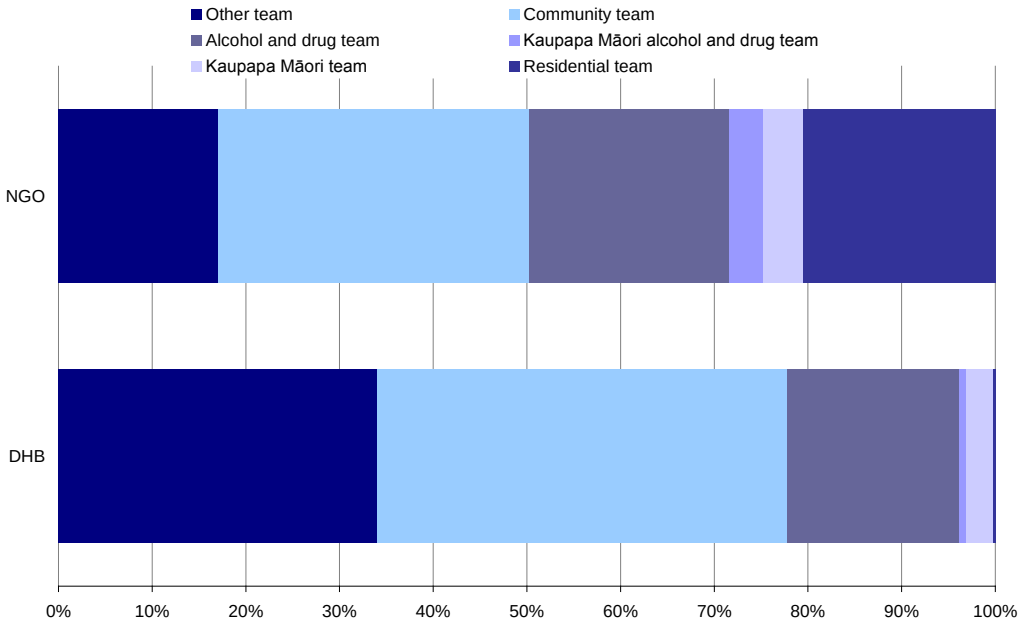
This section presents a comparison of the proportion of clients seen by NGOs and DHBs by team type.

Table 14: Proportion of clients seen by NGOs and DHBs, by team type, 2009/10

Team type	NGO	DHB
Community team	33.2%	43.7%
Alcohol and drug team	21.3%	18.3%
Kaupapa Māori alcohol and drug team	3.7%	0.8%
Kaupapa Māori team	4.3%	2.8%
Residential team	20.5%	0.3%
Other team	17.1%	34.1%
Total	100.0%	100.0%

Source: PRIMHD

Figure 18: Proportion of clients seen by NGOs and DHBs, by team type, 2009/10



Source: PRIMHD.

Note: Clients seen by more than one team type were counted in each relevant team type.

Of all NGO clients, 25 percent were seen by alcohol and drug teams, 8 percent by kaupapa Māori teams and 21 percent by residential teams. Clients seen by kaupapa Māori alcohol and drug teams have been counted in both alcohol and drug and kaupapa Māori percentages mentioned above. The proportion of NGO clients seen by these team types was higher than the proportion of equivalent DHB clients.

Mental health and addiction services used (activities)

Mental health and addiction teams provide various services to clients. These are recorded in PRIMHD as activities.

The following section presents:

- bednights and contacts across time
- face-to-face activities
- the most common activity types.

Bednights and contacts

Table 15 and Figure 19 show the total number of bednights and contacts provided by DHBs across time. Table 15 shows a separate column representing the combined NGO and DHB totals in 2008/09 and 2009/10.

Table 15: Bednights and contacts by organisation type, 2001/02 to 2009/10

Year	DHB		NGO		Total	
	Bednights	Contacts	Bednights	Contacts	Bednights	Contacts
2001/02	439,485	1,425,617				
2002/03	428,820	1,495,957				
2003/04	420,320	1,516,015				
2004/05	407,045	1,603,461				
2005/06	389,877	1,648,369				
2006/07	383,981	1,797,301				
2007/08	382,990	1,792,033				
2008/09	382,178	1,980,227	128,268	100,593	510,446	2,080,820
2009/10	392,846	2,192,270	319,710	321,961	712,556	2,514,231

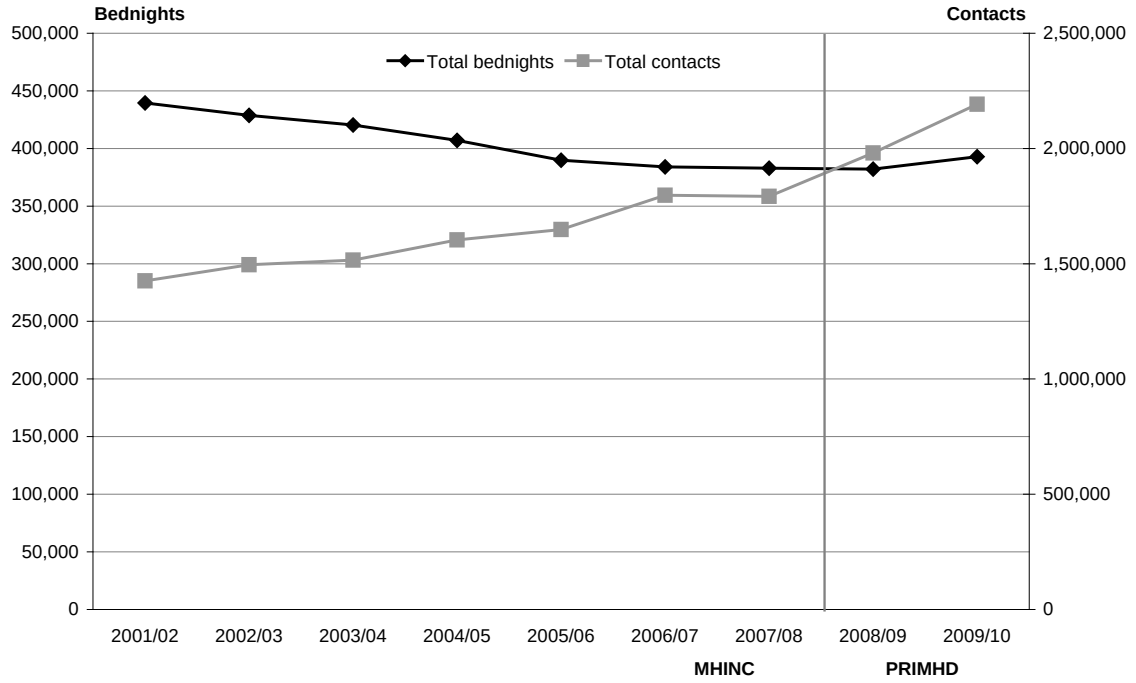
Source: MHINC (2001/02–2007/08) and PRIMHD (2008/09–2009/10).

Note: NGO data is incomplete.

In 2009/10 DHBs provided the majority of contacts recorded in PRIMHD (87 percent of all contacts) and just over half (55 percent) of all bednights.

Figure 19 shows both bednights and contacts provided by DHBs from 2001/02 to 2009/10.

Figure 19: Bednights and contacts provided by DHBs, 2001/02 to 2009/10



Source: MHINC (2001/02–2007/08) and PRIMHD (2008/09–2009/10).

Between 2001/02 and 2009/10 the number of contacts provided by DHBs increased by 54 percent, from 1,425,617 to 2,192,270. The increase in contacts parallels an increase in mental health and addiction service funding from $692.2 million in 2001/02 to $1238.5 million in 2009/10.

The number of bednights in 2009/10 showed an increase from 2008/09, but this may be due to natural fluctuation in the data. Over the entire period (2001/02 to 2009/10) the number of bednights provided by DHBs decreased by 11 percent, from 439,485 to 392,846. During the same period the mental health and addiction sector shifted its focus to recovery, community care and relapse prevention plans, which may have contributed to the decrease in bednights.

Please use caution when comparing MHINC and PRIMHD data.

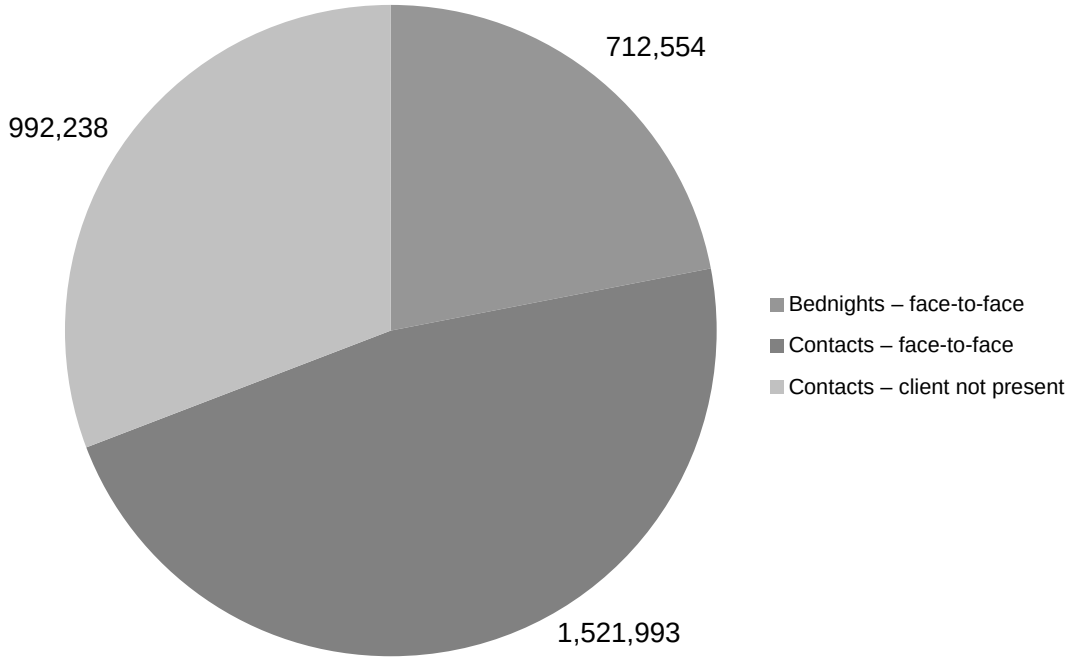
Face-to-face activities

Care of a client may involve activity where a client is not present. For example a health care worker may need to coordinate a client's service or talk to a client on the telephone. In this publication, activities where clients are physically present are called face-to-face activities.

In Figure 20, 2009/10 activities are grouped into:

- bednights – face-to-face
- contacts – face-to-face
- contacts – client not present.

Figure 20: Proportion of clients seen by activity type and client presence, 2009/10



Source: PRIMHD

Notes:

1 A face-to-face activity is when a client is physically present at a bednight or contact. Care coordination activities, contact with family/whānau, written correspondence, telephone calls and text messages are excluded from the face-to-face count.

2 In PRIMHD clients were recorded as not being present at two bednights. It is likely that the bednights are incorrectly coded and have been excluded from figure 20 but are included in the discussion in the text.

In 2009/10 there were a total of 712,556 bednights and 2,514,231 contacts. Sixty-one percent of these contacts were face-to-face (1,521,993) and clients were not present for the remaining 39 percent of contacts (992,238).

Activity type

This section describes the most common activity types – Table 16 presents the five most common.

Table 16: Clients seen, contacts and average number of contacts per client, by the five most common activity types, 2009/10

Activity type	Clients seen	Contacts	Average per client
Mental health individual treatment attendances	96,265	1,199,022	12
Mental health care coordination contacts	65,272	465,536	7
Mental health crisis attendances	30,496	162,807	5
Contact with whānau/family (client present)	20,307	86,503	4
Contact with whānau/family (client not present)	19,142	76,909	4

Source: PRIMHD

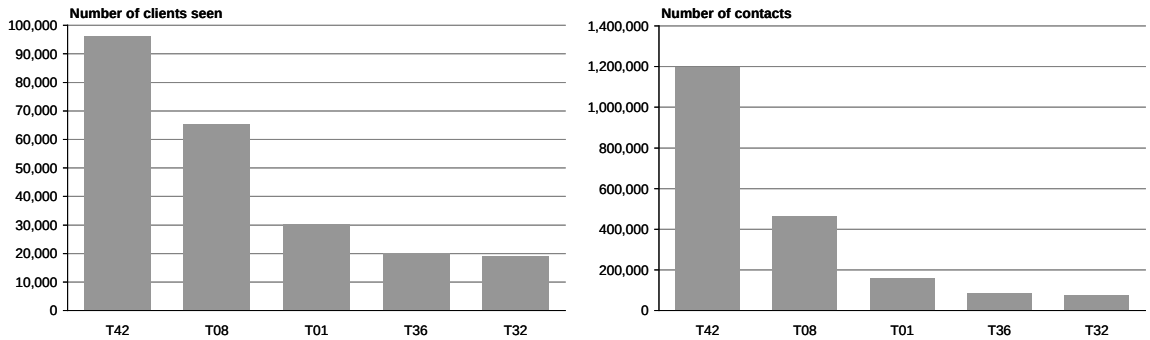
Note: Clients that were seen for more than one activity type have been counted in each relevant activity type.

In 2009/10 individual treatment attendances were the most common activity (with 1,119,022 contacts). This activity was provided to the highest number of clients (96,265) and accounted for 45 percent of all contacts recorded in PRIMHD.

Care coordination contacts were the second most common activity (465,536 contacts, 19 percent), followed by crisis attendances (162,807 contacts, 6 percent) and contact with whānau/family. A total of 163,412 contacts involved whānau/family. These activities accounted for 6.5 percent of all contacts and clients were present for just over half of all whānau/family contact.

Figure 21 illustrates the number of clients seen and number of contacts by activity type.

Figure 21: Number of clients seen and number of contacts, by activity type, 2009/10



T42 Mental health individual treatment attendances
T08 Mental health care coordination contacts
T01 Mental health crisis attendances
T36 Contact with whānau/family (client present)
T32 Contact with whānau/family (client not present)

Source: PRIMHD

Table 17 presents the number of clients seen and bednights by the five most common bednight activity types. In comparison with contacts, bednights are longer in duration and clients requiring inpatient treatment generally have more severe symptoms.

Table 17: Clients seen and bednights, by the five most common bednight activity types, 2009/10

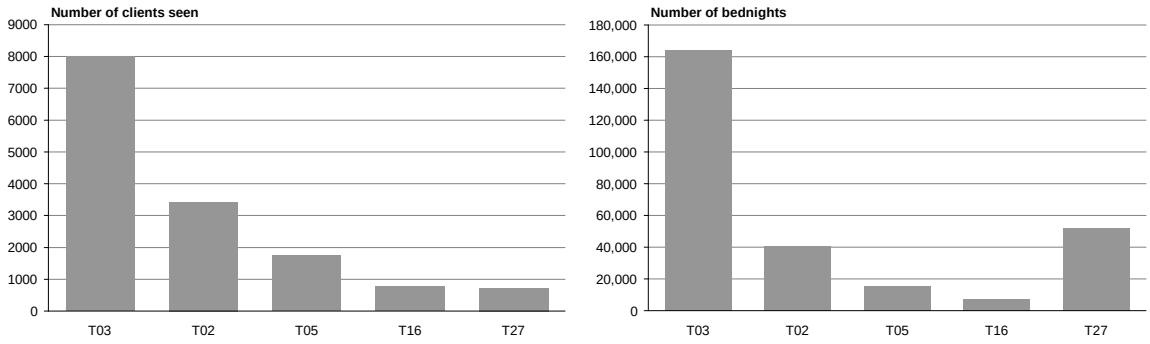
Activity description	Clients seen	Bednights
Mental health acute inpatient occupied bednights	8003	164,159
Mental health intensive care inpatient occupied bednights	3424	40,809
Mental health crisis respite care occupied bednights	1750	15,629
Substance abuse detoxification occupied bednights (medical)	781	7100
Community mental health residential level 3 occupied bednights	727	51,697

Source: PRIMHD

In 2009/10, 8003 clients had at least one acute inpatient bednight - these clients spent a total of 164,159 nights in this setting. A further 3424 clients had at least one inpatient bednight involving intensive care (40,809) and 1750 clients had at least one crisis respite care bednight.

Figure 22 shows the number of clients seen and number of bednights by activity type. Interestingly, community mental health residential bednights accounted for the second highest number of bednights (51,697) but were attended by the fifth highest group of clients (727). This indicates that clients generally stay longer in residential facilities than inpatient facilities.

Figure 22: Number of clients seen and number of bednights, by activity type, 2009/10



T03 Mental health acute inpatient occupied bednights
T02 Mental health intensive care inpatient occupied bednights
T05 Mental health crisis respite care occupied bednights
T16 Substance abuse detoxification occupied bed days (medical)
T27 Community mental health residential level 3 occupied bednights

Source: PRIMHD

Discharge (end of referral)

In 2009/10, 137,914 clients were discharged (that is they had at least one referral closure). PRIMHD recorded the reason for discharge and the person or place that each client was discharged to.

Table 18 presents the reason for discharge for each client.

Table 18: Number of discharges and percent, by reason for discharge, 2009/10

Reason for discharge	No.	Percent
Ended routinely	92,919	67.4%
Discharge to other service within same facility	15,252	11.1%
Gone no address or lost to follow-up	6345	4.6%
Discharge of client to another healthcare facility	5795	4.2%
Referral declined – other services more appropriate	5348	3.9%
Client did not attend following the referral	4779	3.5%
Self-discharge from hospital	3282	2.4%
Referral declined – inability to provide services requested	2103	1.5%
Unknown	1116	0.8%
Died	975	0.7%
Total	137,914	100.0%

Source: PRIMHD

Note: A client can be discharged more than once in a period. These clients have been counted in each relevant category.

As shown in Table 18, the majority of referrals ended routinely (67.4 percent). This indicates that treatment from the mental health and addiction team is complete. However, this does not necessarily mean that the client's overall treatment is complete – they may also be discharged to another mental health and addiction team.

Regular service users

This section presents information on regular service users who were seen in an inpatient, residential or community setting. Regular service users had at least one bednight every quarter (every three months) for a period of one year or longer. At least one of these bednights was in 2009/10.

The definition of a regular service user is similar to the definition of long term clients in the Mental Health, Alcohol and Drug Sector Performance Monitoring and Improvement Report. However, because of slight differences in the criteria used to extract the data the numbers should not be directly compared.

Regular services users seen in an inpatient setting

Table 19 presents data for regular service users who had at least one bednight every quarter (every three months) in an inpatient setting for two periods: one year or longer, and two years or longer. The table shows the number and percent of regular inpatient service users by Māori and non-Māori and sex.

Table 19: Number and percent of regular service users in an inpatient setting: one year or longer and two years or longer, by Māori and non-Māori, and sex

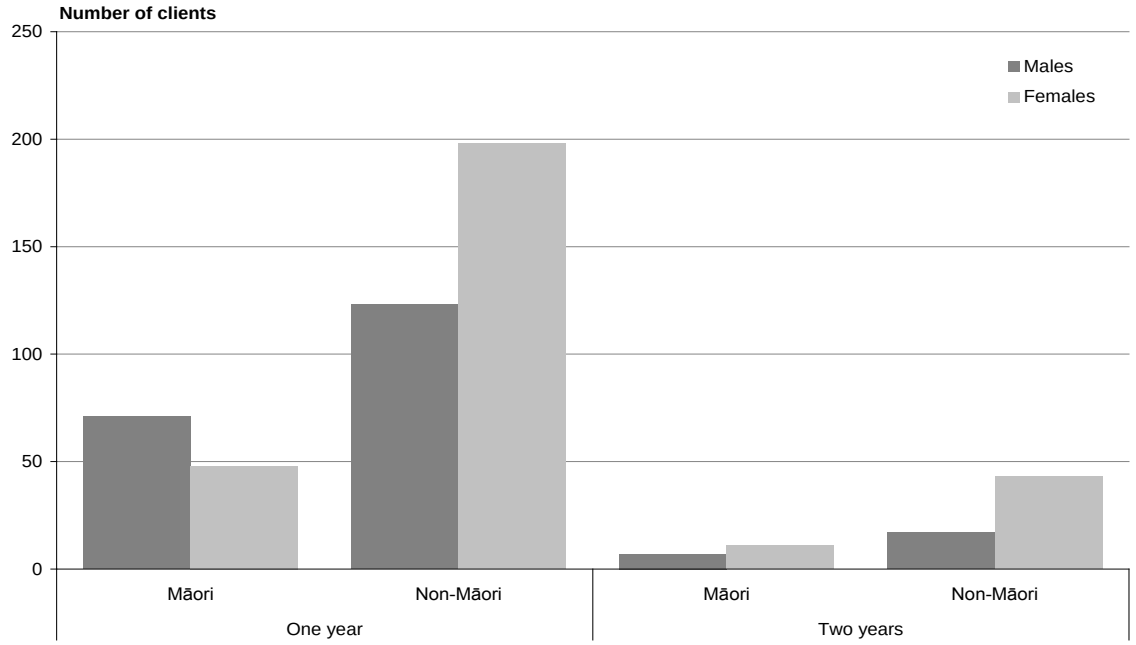
Ethnicity	Sex	One year or more		Two years or more	
		No.	Percent	No.	Percent
Māori	Males	71	16%	7	9%
	Females	48	11%	11	14%
	Total	119	27%	18	23%
Non-Māori	Males	123	28%	17	22%
	Females	198	45%	43	55%
	Total	321	73%	60	77%
Total		440		78	

Source: PRIMHD

A total of 440 people were regular users of inpatient services. Of these, 78 (18 percent) had at least one bednight in eight consecutive quarters (two years). Of the clients that used services for one year or longer 27 percent were Māori and 73 percent were non-Māori. In comparison, a lower proportion (23 percent) of clients that used services for two-years or longer were Māori.

Figure 23 shows the number of Māori and non-Māori regular users of inpatient services by sex.

Figure 23: Regular service users seen in an inpatient setting: one year or longer and two years or longer, by Māori and non-Māori and sex



Source: PRIMHD

The percentages of male and female regular inpatient service users (one year) were relatively similar – 44 percent (194) of clients were males and 56 percent (246) were females.

However, the difference between sexes is highly influenced by ethnicity. The difference between Māori males and females is typical of demographic trends shown in the first section – that is the number of males (71) was higher than the number of females (48). Interestingly, the opposite is true for non-Māori regular service users. The number of non-Māori female clients (198) was 61 percent higher than the male equivalent (123). This group had the highest number of regular service users (for both time periods).

Regular service users seen in a Residential setting

Table 20 presents information on regular service users that attended bednights in a residential setting. Residential bednights include nights spent by a client in a residential home. Figure 24 summarises this information by duration, ethnicity and sex.

Table 20: Number and percent of regular service users seen in a residential setting: one year or longer and two years or longer, by Māori and non-Māori and sex

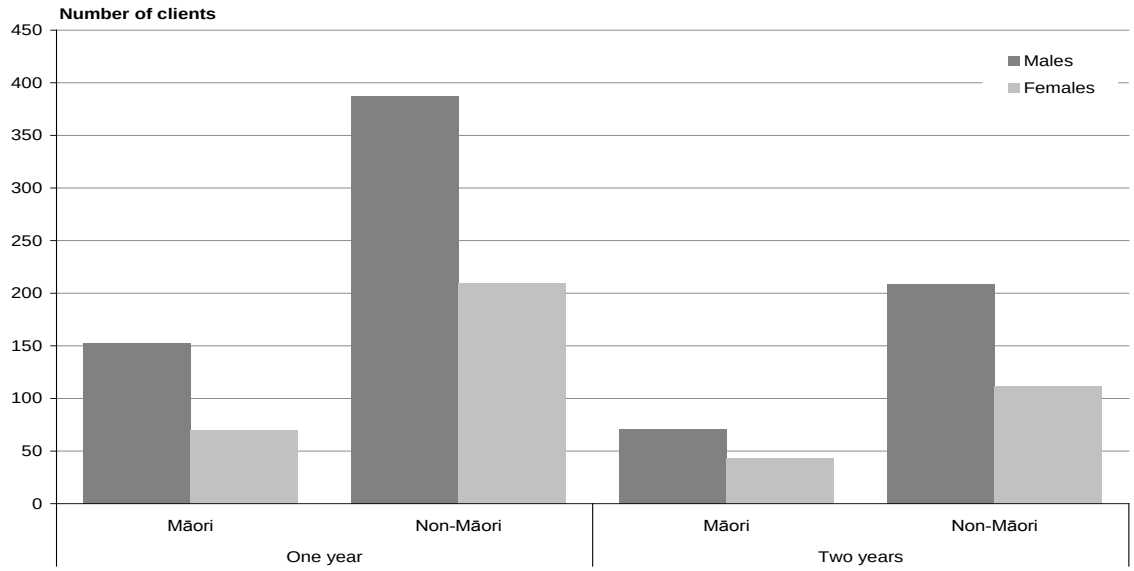
Ethnicity	Sex	One year or more		Two years or more	
		No.	Percent	No.	Percent
Māori	Males	153	19%	71	16%
	Females	70	9%	43	10%
	Total	223	27%	114	26%
Non-Māori	Males	387	47%	209	48%
	Females	210	26%	112	26%
	Total	597	73%	321	74%
Total		820		435	

Source PRIMHD

Note: NGO data from 2009/10 is incomplete. A large proportion of residential services are provided by NGOs, which means the number of regular service users is understated in this table. Please see data quality section for more information.

A total of 820 people were regular residential service users; 74 percent (435) of these clients had residential bednights for two years or longer. The proportion of Māori regular service users was relatively similar for both durations: 27 percent for one-year and 26 percent for two-years.

Figure 24: Regular service users seen in a residential setting: one year or longer and two years or longer, by Māori and non-Māori and sex



Source: PRIMHD

Note: NGO data from 2009/10 is incomplete. A large proportion of residential services are provided by NGOs, which means the number of regular service users is understated in this chart. Please see data quality section for more information.

For both durations and all groups the percentage of males was higher than the percentage of females. The greatest difference was for Māori regular service users (one year), where the number of Māori males (153) was more than twice the number of Māori females (70).

Regular service users seen in community settings

For clients in community settings, the percentage of Māori and non-Māori clients shows a similar pattern to long-term residential clients, as Table 21 shows.

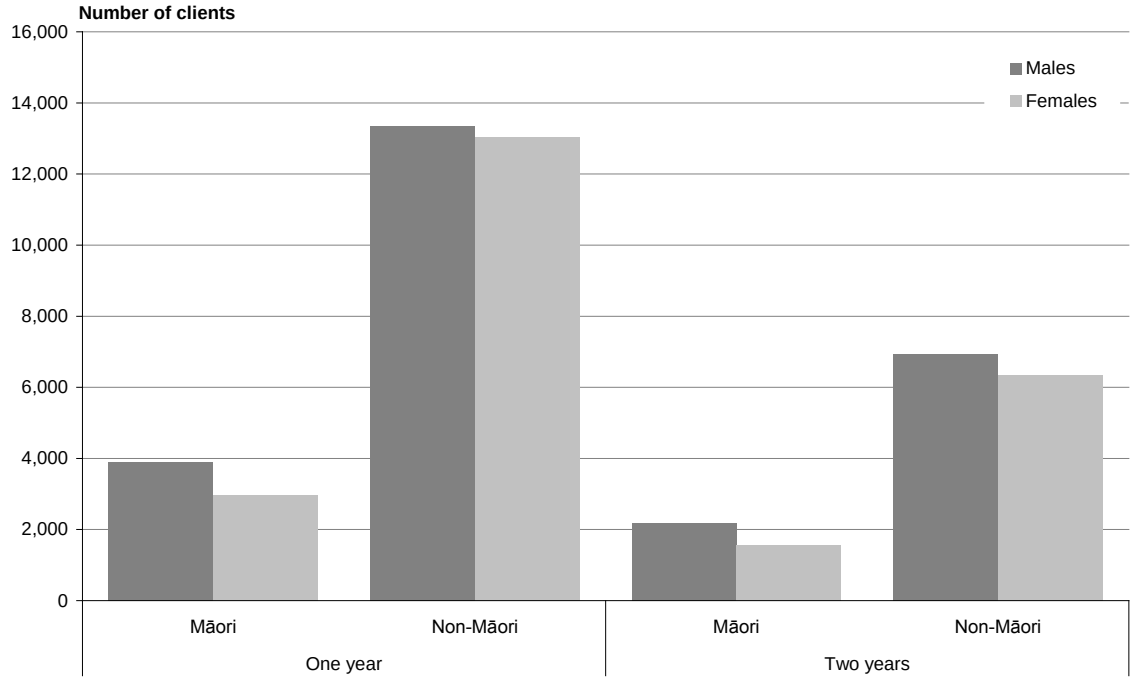
Table 21: Number and percent of regular service users seen in a community setting: one year or longer and two years or longer, by Māori and non-Māori and sex

Ethnicity	Sex	One year or more		Two years or more	
		No.	Percent	No.	Percent
Māori	Males	3904	12%	2171	13%
	Females	2977	9%	1554	9%
	Total	6881	21%	3725	22%
Non-Māori	Males	13,334	40%	6933	41%
	Females	13,032	39%	6350	37%
	Total	26,366	79%	13,283	78%
Total		33,247		17,008	

Source PRIMHD

However, the numbers of male and female clients were more evenly distributed for both periods. This is most noticeable for non-Māori clients, with numbers comparatively equal for both sexes, as illustrated in Figure 25.

Figure 25: Regular service users seen in a community setting: one year or longer and two years or longer, Māori and non-Māori and sex



Source: PRIMHD

Mental health outcomes

This section contains information on the outcomes of secondary mental health services for clients seen in the 2009/10 financial year (July 2009 to June 2010). This includes 2009/10 clients' outcome data from 1 July 2008 to 5 November 2011.

Specifically this section presents:

- background information on both outcomes and the HoNOS suite of measures (the tools used to collect outcomes data).
- aggregated outcome data at a national level – including the average total score. This data provides a measure of clients' overall mental and social health.

Please see the 'Data quality' section for more information on outcomes.

Background information

PRIMHD collects outcomes data in the form of the Health of the Nation Outcome Scale (HoNOS) suite of measures. Below is some background information on both outcomes and the HoNOS suite of measures.

What is an outcome?

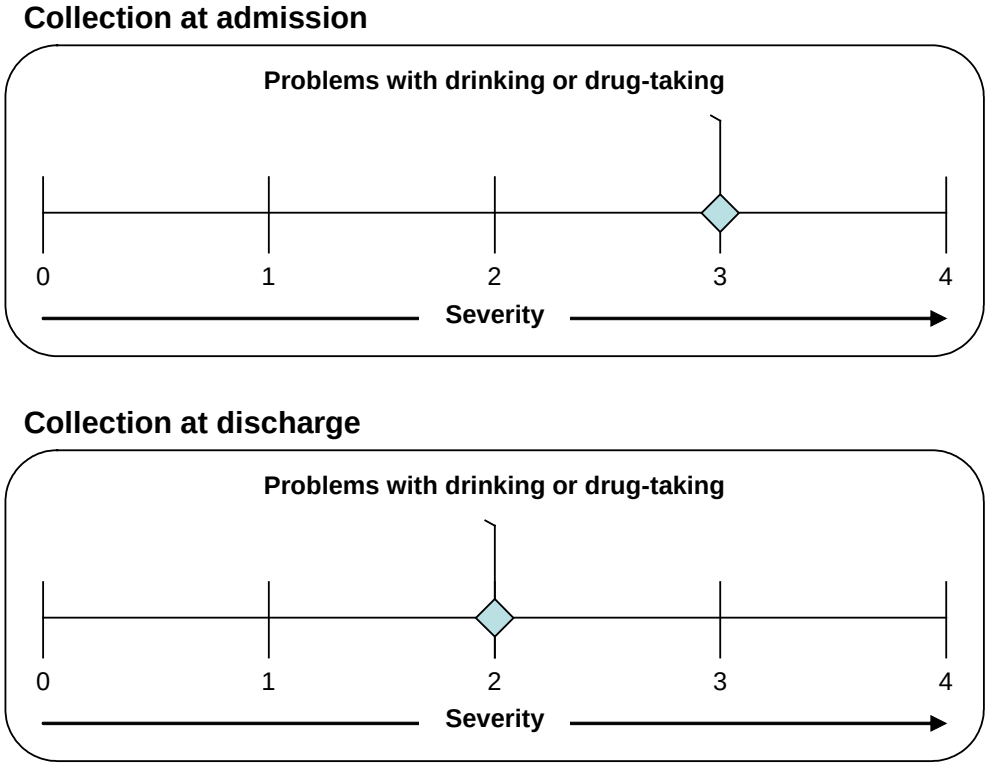
An outcome is a change in health, wellbeing and circumstances over time (Te Pou 2012).

What is HoNOS?

HoNOS is a standard measure of mental health outcomes used across mental health and services.

HoNOS collects information about a person's mental health and social functioning using 12 items (scales). Each item measures one of the following categories: behaviour, impairment, delusions/hallucinations, depression and social problems. A score of 0–4 is assigned to each item according to the severity of symptoms (0 indicating no problem and 4 indicating a severe problem). Figure 26 provides an example of one of the HoNOS items at admission and discharge.

Figure 26: An example of the 'problems with drinking or drug taking' item at admission and discharge



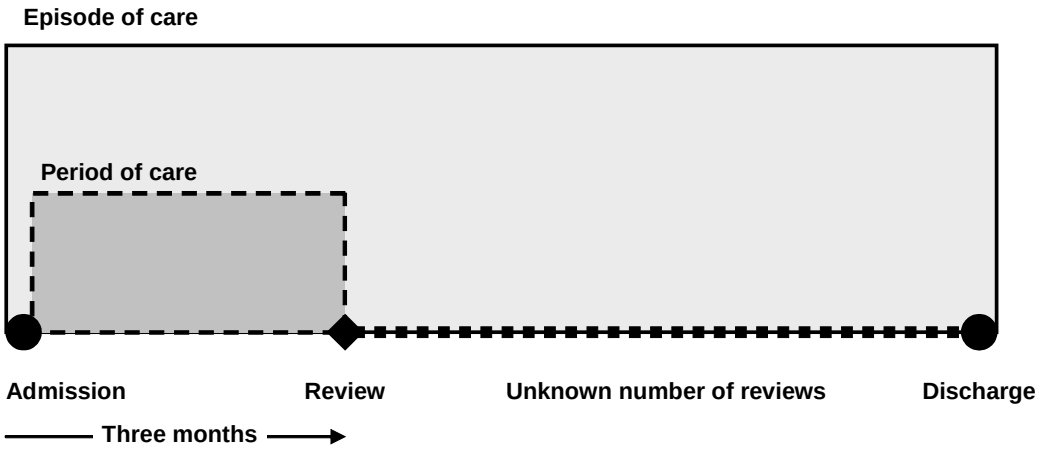
Note: Outcomes data is not continuous.

HoNOS scores can be compared at two points in time; the change is the outcome.

When are HoNOS scores collected?

Figure 27 illustrates when scores are generally collected.

Figure 27: HoNOS collection occasions within a typical episode of care



Source: Adapted from Te Pou 2011

HoNOS scores are initially collected at admission and then during review, after a period of three months. Scores are also collected every three months until discharge. A client is discharged when care is planned in a different setting (for example, the client is transferred from community to inpatient services) or no further care is required from mental health services.

As Figure 27 shows, an 'episode of care' begins at admission and ends at discharge, whereas a 'period of care' is between one HoNOS collection occasion and the next.

HoNOS scores may be collected for different reasons. For example, they may also be collected when a client receives compulsory assessment and treatment.

What different versions of HoNOS are used?

Version	Assessment group
HoNOS	Clients aged 18–64 (this publication only presents outcomes information on clients aged 18–64)
HoNOS65+	Clients aged 65 and above
HoNOSCA	Clients aged 4–17; that is, children and adolescents
HoNOS-LD	Adult clients with a dual diagnosis (ie an intellectual disability)
HoNOS-secure	Adult clients who are supported by forensic services

Why are outcomes useful?

- Outcomes data can be useful to clients, clinicians, service and general managers, planners and funders, and policy analysts. Clients can use their own outcomes data to reflect on their health, wellbeing and circumstances, talk to clinicians about their support needs, and inform their recovery plans.
- Clinicians can use outcomes data to inform therapeutic discussion with clients, support their decision-making in day-to-day practice, monitor change and improve their understanding of client needs, and evaluate the effectiveness of different interventions.
- Service and general managers can use outcomes data to inform service provision, and identify workforce development and community needs.
- Planners and funders can use outcomes data to assess population needs for mental health services and assist with allocation of resources.
- Policy and mental health strategy developers can use outcomes data to develop policy based on nationally aggregated data (Te Pou 2012).

Outcomes data

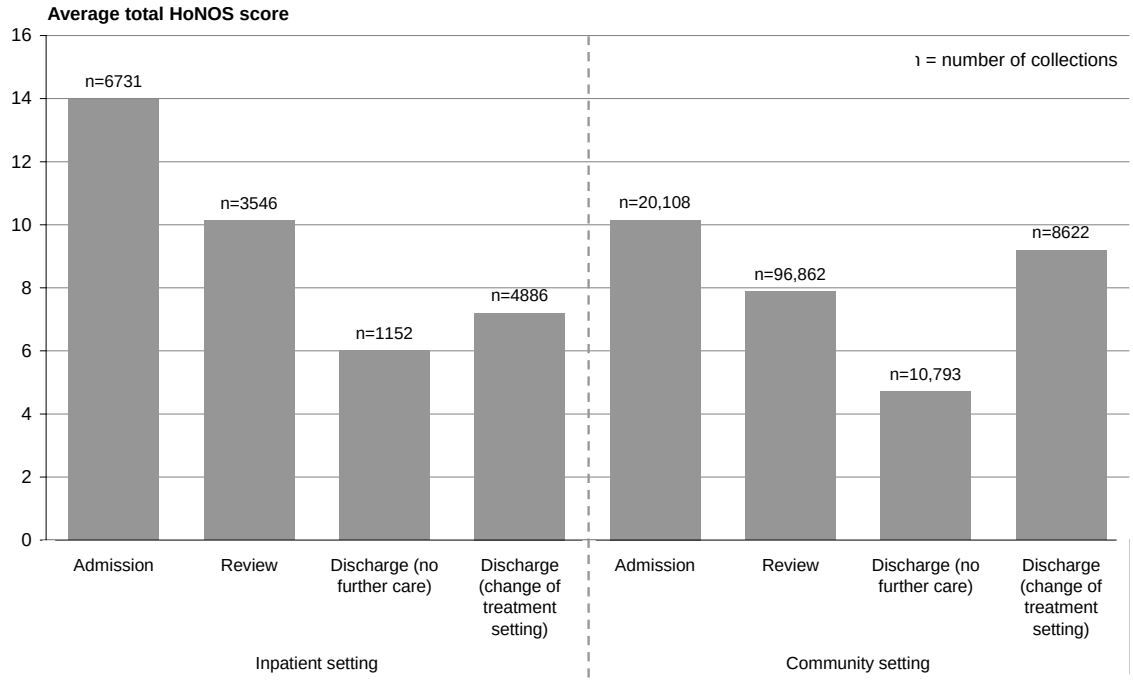
The Ministry of Health would like to acknowledge Te Pou for their contribution to this section. For further information and outcome publications see www.tepou.co.nz/outcomes/measures and www.tepou.co.nz/library/tepou/mental-health-outcomes---information-collection-protocol.

Total HoNOS score

The total HoNOS score is an indication of a person's overall mental and social health. The total score is calculated by summing the rating of each scale. A person with a low total score is healthier than a person with a high score.

Figure 28 presents the average total scores and the number of collections at admission, review and discharge, by setting. Note that this only includes data from DHBs and only for clients aged 18–64.

Figure 28: Average total HoNOS score and number of collections for clients seen in 2009/10, at admission, review and discharge, by setting



Source: PRIMHD

Notes:

1 Discharge (change of treatment setting) is when care is planned in a different setting (for example, a client is transferred from community to inpatient services).

2 Figure 28 only presents data from DHBs, and only for clients aged 18–64. Clients seen by NGOs and clients aged 0–17 and 65+ are not included; nor are clients who were seen solely by alcohol and drug teams.

3 One admission collection and one discharge collection is made per episode of care. There may be multiple review collections during an episode of care.

4 Community applies to all settings apart from inpatient; for example, prison and residential.

5 At admission, 391 collections with a total score of zero were found in 2009/10 data (20 in inpatient settings and 371 in community settings). The validity of these scores is questionable and they have slightly affected the admission average for both settings.

6 In community settings, 5614 clients were seen for assessment only and then received no further care. These collections are not included in Figure 28.

- Between admission and discharge (no further care), the average total score decreased by 57 percent for inpatient settings and 54 percent for community settings.
- In both settings, the average total score was higher for clients who were discharged into a different setting than for clients who received no further care.
- Community clients who were discharged into a different setting had a higher average score (9.2) than both inpatient clients in the same category (7.2) and community clients who received no further care (4.7).
- Inpatient scores were higher than community scores at admission, review and discharge (no further care).
- At admission, the inpatient average (14.0) was 38 percent higher than the community average (10.2).

Limitations of total HoNOS score

As mentioned, total score is an indication of overall mental and social health. However, summing a person's scores will overlook situations where clients had severe symptoms on a few items and no problem on the rest. For example, client A might have a total score of eight (four on the 'non-accidental self-injury' scale and four on the 'problems with depressive mood' scale); client B might have a total score of 24 (two on each of the 12 items). Even though client A has more severe symptoms, client B has a higher total score.

Appendix 1: Further tables

This appendix presents further information on services provided by the six most common mental health and addiction team types:

- community teams
- inpatient teams
- alcohol and drug teams
- child and youth teams
- forensic teams
- kaupapa Māori teams.

Community teams

The majority of community teams provide assessment and treatment services in either community or outpatient settings. The community teams aimed at a specific client group or purpose are coded to the specific team type. For example, eating disorder services are coded to eating disorder teams even though clients may be seen in a community setting.

Table A1: Clients seen, bednights and contacts provided by community teams, by activity type, 2009/10

Activity type	Clients seen	Bednights	Contacts
Mental health individual treatment attendances (family not present)	48,745	–	710,623
Mental health care coordination contacts	32,889	–	209,604
Mental health crisis attendances	27,068	–	148,365
Whānau/family face-to-face	8288	–	26,711
Mental health contact with family/whānau	7518	–	25,193
Community support contacts	5436	–	115,398
Mental health group programme attendances	3602	–	33,327
Support needs assessment attendances	1202	–	3924
Court liaison attendances	1007	–	5,280
Peer support	988	–	8224
Other	6382	16,381	66,804
Total		16,376	1,353,453

Source: PRIMHD

Notes:

1 – = not applicable.

2 In this publication, the least common activities recorded by community teams have been grouped together as Other. Information about these activities is available on request.

3 The Ministry of Health has identified five bednights recorded by community teams while the clients were on leave. Therefore, five bednights have been subtracted from the bednight total.

4 Clients that were seen for more than one activity have been counted in each relevant activity. For a count of total clients seen by this team type please see Table 13.

Inpatient teams

Inpatient teams provide services in a medical environment (such as a hospital) to people who are in need of a period of close observation, intensive investigation or intervention. Inpatient teams aimed at a specific client group or purpose are coded to the specific team type. For example, forensic services are coded to forensic teams even though clients may be seen in an inpatient setting.

Table A2: Clients seen, bednights and contacts provided by inpatient teams, by activity type, 2009/10

Activity type	Clients seen	Bednights	Contacts
Mental health acute inpatient occupied bednights	6898	143,387	–
Mental health intensive care inpatient occupied bednights	3382	51,114	–
Mental health individual treatment attendances (family not present)	541	–	2203
Mental health sub-acute inpatient occupied bednights	361	11,700	–
Psychiatric disability rehabilitation occupied bednights	224	31,805	–
Other	1714	13,046	2985
Total		243,530	5188

Source: PRIMHD

Notes:

1 – = not applicable.

2 The least common activities recorded by inpatient teams have been grouped together as Other. Information about these activities is available on request.

3 The Ministry of Health has identified 7522 bednights recorded by inpatient teams while the clients were on leave. Therefore, 7522 bednights have been subtracted from the bednight total.

4 Clients that were seen for more than one activity have been counted for each relevant activity. For a count of total clients seen by this team type please see Table 13.

Alcohol and drug teams

Alcohol and drug teams provide assessment and treatment services to people with alcohol and drug problems. Teams may be inpatient, residential or community based. The following table summarises data on the five alcohol and drug team types:

- alcohol and drug
- alcohol and drug kaupapa Māori
- alcohol and drug dual diagnosis
- child and youth alcohol and drug services
- kaupapa Māori dual diagnosis mental health and alcohol and drug services.

Table A3: Clients seen, bednights and contacts provided by alcohol and drug teams, by activity type, 2009/10

Activity type	Clients seen	Bednights	Contacts
Mental health individual treatment attendances (family not present)	22,562	–	130,848
Mental health care coordination contacts	11,107	–	50,791
Mental health group programme attendances	6400	–	38,995
Methadone treatment specialist service attendances (clients of specialist services)	4712	–	66,950
Community support contacts	1137	–	11,782
Substance abuse detoxification attendances (social)	1133	–	4577
Methadone treatment specialist service attendances (clients of authorised GPs)	1030	–	3546
Other	4603	44,008	11,361
Total		44,008	318,850

Source: PRIMHD

Notes:

1 – = not applicable.

2 The least common activities recorded by alcohol and drug teams have been grouped together as Other. Information about these activities is available on request.

3 Clients that were seen for more than one activity have been counted for each relevant activity. For a count of total clients seen by this team type please see Table 13.

Child and youth teams

The following tables summarise data for clients aged 0–19 and the four types of child and youth teams:

- child, adolescent and family
- youth specialty, providing services to adolescents aged 15–19
- child and youth alcohol and drug services
- kaupapa Māori tamariki and rangatahi.

Although the majority of clients aged 0–19 are seen by child and youth teams, some clients are also seen by teams that conventionally provide services to adults. This may be because the team provides a specialised service (eg, eating disorder teams). Such teams may provide more appropriate treatment. Furthermore, clients aged 20–79 may be seen by child and youth teams.

Table A4: Clients aged 0–19 and clients seen by child and youth teams, by team type and age group, 2009/10

Team type	0–4	5–9	10–14	15–19	20–24	25–79	Total
Alcohol and drug dual diagnosis team	–	–	3	58	–	–	61
Alcohol and drug kaupapa Māori team	–	–	68	283	–	–	351
Alcohol and drug team	1	24	158	2088	–	–	2271
Child, adolescent and family team	796	4605	7114	4779	42	131	17,467
Children and youth alcohol and drug services	–	8	223	248	40	38	557
Community skills enhancement team	–	–	1	101	–	–	102
Community team	13	167	1013	5908	–	–	7101
Eating disorder team	1	–	76	223	–	–	300
Forensic team	–	1	172	775	–	–	948
Inpatient team	1	2	43	598	–	–	644
Intellectual disability dual diagnosis team	–	–	1	41	–	–	42
Kaupapa Māori tamariki and rangatahi (child and youth) mental health services	8	84	270	165	19	77	623
Kaupapa Māori team	23	101	228	330	–	–	682
Kaupapa Māori dual diagnosis mental health and alcohol and drug services	–	1	6	6	–	–	13
Maternal mental health team	4	–	2	138	–	–	144
Needs assessment and service coordination team	10	91	147	168	–	–	416
Pacific Island team	8	28	180	426	–	–	642
Psychogeriatric team	–	1	1	6	–	–	8
Refugee team	–	2	3	4	–	–	9
Residential team	–	1	30	169	–	–	200
Services for profoundly deaf team	–	–	–	1	–	–	1
Specialist psychotherapy team	–	–	2	14	–	–	16
Youth specialty team	1	38	1633	2914	191	74	4851
Total	866	5154	11,374	19,443	292	320	37,449

Source: PRIMHD

Notes:

1 – = not applicable.

2 One client aged 0–4 has been recorded as seeing an eating disorder team. This is a data quality issue and is incorrect.

Table A5: Clients aged 0–19 and clients seen, bednights and contacts provided by child and youth teams, by activity type, 2009/10

Activity type	Clients seen	Bednights	Contacts
Mental health individual treatment attendances (family not present)	22,420	–	162,193
Mental health care coordination contacts	17,832	–	130,889
Whānau/family face-to-face	9339	–	47,746
Mental health contact with family/whānau	9053	–	43,759
Mental health crisis attendances	5476	–	19,677
Mental health group programme attendances	2665	–	14,532
Community support contacts	1206	–	9822
Other	4245	48,271	26,681
Total		47,353	455,299

Source: PRIMHD

Notes:

1 – = not applicable.

2 In this publication, the least common activities recorded on clients aged 0–19 and by child and youth teams have been grouped together as Other. Information about these activities is available on request.

3 The Ministry of Health has identified 918 bednights recorded by child and youth teams while clients were on leave. Therefore, 918 bednights have been subtracted from the bednight total.

4 Clients that were seen for more than one activity have been counted for each relevant activity. For a count of total clients seen by this team type please see Table 13.

Forensic teams

Forensic teams provide assessment and treatment services to alleged offenders charged with criminal offences who have or are thought to have a mental illness.

Table A6: Clients seen, bednights and contacts provided by forensic teams, by activity type, 2009/10

Activity type	Clients seen	Bednights	Contacts
Mental health individual treatment attendances (family not present)	3866	–	25,233
Mental health care coordination contacts	3163	–	26,178
Court liaison attendances	2301	–	6203
Mental health medium secure inpatient occupied bednights	350	48,835	–
Mental health contact with family/whānau	325	–	578
Integrated Māori and clinical interventions	172	–	1023
Mental health group programme attendances	164	–	1161
Other	555	38,984	1046
Total		85,146	61,422

Source: PRIMHD

Notes:

1 – = not applicable.

2 The least common activities recorded by forensic teams have been grouped together as Other. Information about these activities is available on request.

3 The Ministry of Health has identified 2673 bednights recorded by forensic teams while clients were on leave. Therefore, 2673 bednights have been subtracted from the bednight total.

4 Clients that were seen for more than one activity have been counted in each relevant activity. For a count of total clients seen by this team type please see Table 13.

Kaupapa Māori teams

Kaupapa Māori teams provide assessment and treatment services to clients within a Māori cultural context. Teams may be inpatient, residential or community based. The following table summarises information on the four types of kaupapa Māori teams:

- kaupapa Māori
- alcohol and drug kaupapa Māori
- kaupapa Māori tamariki and rangatahi
- kaupapa Māori dual diagnosis mental health and alcohol and drug.

Table A7: Clients seen, bednights and contacts provided by kaupapa Māori teams, by activity type, 2009/10

Activity type	Clients seen	Bednights	Contacts
Mental health individual treatment attendances (family not present)	4479	–	39,858
Mental health care coordination contacts	3065	–	21,163
Whānau/family face-to-face	1049	–	4245
Integrated Māori and clinical interventions	997	–	8286
Mental health contact with family/whānau	952	–	3941
Other	2570	13,277	20,740
Total		13,277	98,233

Source: PRIMHD

Notes:

1 – = not applicable.

2 The least common activities recorded by kaupapa Māori teams have been grouped together as Other. Information about these activities is available on request.

3 Clients that were seen for more than one activity have been counted for each relevant activity. For a count of total clients seen by this team type please see Table 13.

Appendix 2: Mental health and addiction data available from the Ministry of Health and contact details

Category	Item	Notes
Demographic information	Summarised information including age, sex, client domicile and prioritised ethnicity	See 'Ethnicity notes' on ethnicity prioritisation
Referral	Summarised information about referrals, including where they came from, where clients were referred on to, the start and end dates/times and why referrals ended	
Team	Summarised information about the team, including its name, setting and target population	
Classification/ diagnosis	Summarised information about diagnoses, including start and end dates/times	
Legal status	Summarised information about relevant legal statuses, including start and end dates/times	
Activity	Summarised information about the activity, including type, setting, start and end dates/times	New activity types recorded in PRIMHD: electroconvulsive therapy, did not attend, leave and seclusion
Outcomes	Summarised information about outcomes, including the version of HoNOS used, the stage in treatment (eg, admission and discharge) and the outcome score	

If you need additional information or analyses, or material tabulated in other ways, please contact:

National Collections and Reporting
National Health Board
Ministry of Health
PO Box 5013
Wellington
New Zealand
Phone: (04) 496 2000
Fax: (04) 816 2898
Email: data-enquiries@moh.govt.nz
Website: www.health.govt.nz

Please note that complex queries may incur a cost.

Appendix 3: Feedback

The Ministry of Health would like to know your views on this publication. Please complete our five minute survey at:
https://www.surveymonkey.com/s/MHServiceuse200910FINAL

Results from this survey will be used to improve the quality of Ministry of Health publications.

Glossary

The following definitions are specific to this publication. Note that additional terms in bold are defined elsewhere in the Glossary.

Activity	The type of health care activity provided to the client. Activities can be grouped into bednights, contacts, seclusion and leave.
Activity setting	The type of physical setting or contact channel the activity was provided in; for example, activities can be provided in a court setting.
Addiction, drug or alcohol	Repeated use of a psychoactive substance or substances, to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means. Also known as alcohol and drug dependence (World Health Organization 2012).
Age-specific rate	The number of clients seen in relation to the population size of a particular age group, calculated by dividing the number of clients by the appropriate age-group population and then multiplying by 100,000. See also Clients seen.
Age-standardised rate (ASR)	Age-standardised rates account for differences in population structure, and can be used to compare groups with different age structures (eg, males and females, or Māori and non-Māori) and data from different years. In the present publication, the population structure used is the WHO World Standard Population, and age-standardised rates are per 100,000 population. See also Age-specific rate.
Bednight	A client occupying a bed at midnight. A bednight is assumed to include all care provided to the client occupying the bed. Bednights are provided in inpatient or residential settings.
Clients seen	Users of mental health and addiction services. Note a client does not need to be physically present at an activity to be counted, so clients will be counted if they have telephone contact with a clinician, for example.
Contacts	All mental health and addiction services provided in a community/outpatient setting (as opposed to an inpatient/residential setting). The majority of contacts are less than three hours in duration.
Crude rates	Crude rates are calculated by dividing the number of clients seen by the number of people in a population and then multiplying by 100,000.
Deprivation Index 2006	A measure of socioeconomic status calculated for small geographic areas, using a range of variables from the 2006 Census of Population and Dwellings.
Discharge	Completion of treatment with a particular team. This does not necessarily mean the completion of all treatment, as a client may be discharged to another team.
District health board (DHB)	The body responsible for providing, or funding the provision of health and disability services in a district. In 2009 there were 21 DHBs in New Zealand; they have existed since 1 January 2001. On 1 May 2010 Southland and Otago DHBs were merged into the Southern District Health Board. However, at the time of publication, data from Southland and Otago is still reported separately to PRIMHD.
Domicile code	Residential location, based on Statistics New Zealand's standard area unit code used for the 2006 Census.
Ethnic group	The group in which clients were categorised according to their prioritised ethnicity. See also Prioritised ethnicity.

Face-to-face activity	A client physically present at a mental health and addiction activity. Face-to-face activities exclude care coordination, contact with family/whānau, written correspondence, telephone calls and text messages.
Inpatient setting	Services provided in a medical environment (such as a hospital) to people in need of close observation, intensive investigation or intervention.
Kaupapa Māori service	A mental health and addiction service provided in a Māori cultural context.
Leave	The temporary absence of a client from the health care/support facility to which they were most recently admitted/entered. Leave is reported only when the client is absent at midnight.
Legal status	A code describing a client's legal status under the appropriate section of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Alcoholism and Drug Addiction Act 1966, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, the Criminal Procedure (Mentally Impaired Persons) Act 2003, or the Criminal Justice Act 1985.
Life-stage age group	These are wider than the five-year age groups, and broadly reflect childhood (0–14 years), youth (15–24 years), adult (25–44 and 45–64 years) and older people (65+ years).
Mental health	A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (World Health Organization 2012).
Non-governmental organisation (NGO)	A non-governmental provider of mental health and addiction services that may be contracted to, or provide services independently from, a DHB.
Outcome	A change in health, wellbeing and circumstances over time (Te Pou 2012).
Outpatient	A person who receives care at a hospital but does not stay overnight.
Prioritised ethnicity	The practice of recording a single ethnicity for each client, based on a priority list published by Statistics New Zealand. Up to three ethnic groups can be reported by each client. If more than one ethnicity is reported, the ethnicity with the highest priority is selected (see 'Ethnicity notes').
Programme for the Integration of Mental Health Data (PRIMHD)	PRIMHD collects service activity and outcomes data from across New Zealand's secondary mental health and addiction sector.
Rangatahi	Young people.
Referral	A referral may take several forms, most notably: (a) a request for management of a problem or provision of a service (eg, a request for an investigation, intervention or treatment) (b) notification of a problem with the hope, expectation or imposition of its management. The common factor in all referrals is a communication whose intent is the transfer of care/support, in part or in whole.
Referral end	Details describing the exit of a client from a mental health or addiction service. The most common codes in 2009/10 were ended routinely, discharge to other service within the same organisation, gone no address, lost follow-up.
Referral from	The group of services or people who are sources of mental health and addiction referrals. The most common codes in 2009/10 were general practitioner, other, self or relative referral, adult community mental health services, hospital referral (non-psychiatric).

Referral to	The group of services or people who are destinations of mental health and addiction referrals. The most common codes in 2009/10 data were no further referral, general practitioner, other, adult community mental health services.
Regular service users	Client with at least one bednight in an inpatient, residential or community setting every quarter (every three months) for a period of one year or longer. For this publication, at least one of these bednights was in 2009/10. Please note that as a result of different criteria used to extract the data, the numbers published here are different to those published in ____.
Residential setting	Accommodation, rehabilitation and support provided in a community residence.
Seclusion	The placing of a client, at any time and for any duration, alone in a room or area from which they cannot freely exit.
Service	The type of mental health and addiction care a client receives.
Tamariki	Children.
Team	A person or functionally discrete group of people providing mental health and addiction care to a client or clients.
Team service type setting	A code that categorises whether the team is a designated cultural service health care team; for example, kaupapa Māori service.
Team setting	A code that categorises the activity setting of the health care team; for example, community, general hospital, inpatient, court, mixed, prison and community residential.
Team target population	A code that categorises the age group or target population group that the health care team provides service to; for example, child and youth population.
Team type	A classification according to the primary function of a particular health care team.

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