Office of the Director of Mental Health

Annual Report 2010

Artwork by Arohanoa Chaplow

Citation: Ministry of Health. 2011. *Office of the Director of Mental Health: Annual Report 2010*. Wellington: Ministry of Health.

Published in October 2011 by the
Ministry of Health
PO Box 5013, Wellington 6145, New Zealand

ISBN 978-0-478-37333-2 (Print)

ISBN 978-0-478-37334-9 (Online)

HP 5398

This document is available on the Ministry of Health's website:

http://www.moh.govt.nz

Foreword

Welcome to the sixth edition of the Office of the Director of Mental Health's Annual Report. This report is a summary of the legislative activities of the Mental Health Group and others, as stipulated in the Mental Health (Compulsory Assessment and Treatment) Act 1992. We publish this report annually to demonstrate our commitment to ensuring transparency, accountability and trust in government and its agencies.

When reading the 2010 Annual Report it is important to note that, as in previous years, the report does not attempt to interpret data variations among district health boards, as any such differences could be due to a number of variables, including practice, size, location, population and configuration. For this year's report the Ministry of Health has switched to using data sourced from the Programme for the Integration of Mental Health Data (PRIMHD) instead of manual data. Despite best efforts there have been some technical difficulties with PRIMHD's implementation. These are now largely resolved; however this report, reflecting the change-over period, may contain greater data variability than previous editions. More information on PRIMHD can be found in Appendix 3.

The compilation of the report has required the input of many people. Data collection relies on the willingness of mental health services to collect information meaningfully and forward it to the Ministry. Compiling the data into a form suitable for publication depends on the work of people throughout the Ministry.

My gratitude goes out to all who made this report possible and especially to Dr David Chaplow who, after a decade in the role of Director of Mental Health, retired from this position in June 2011. This Annual Report is a testament to his dedication and commitment to mental health in New Zealand. A tribute to, and commentary on, his work as Director can be found in Appendices 1 and 2 respectively.

Susanna Every-Palmer (Dr)
Director of Mental Health (Acting)
Chief Advisor, Mental Health (Acting)

Contents

List of figures

List of tables

Introduction

Objectives

The objectives of this report are to:

- provide information about specific clinical activities that must be reported to the Director of Mental Health under the Mental Health (Compulsory Assessment and Treatment) Act 1992
- report on some of the activities of District Inspectors
- report on the activities of the Mental Health Review Tribunal
- contribute to the improvement of standards of care and treatment for people with a mental illness
- inform mental health service users, their families and whānau, service providers and members of the public about the role, functions and activities of the Office of the Director of Mental Health (the Office) and the Chief Advisor, Mental Health.

Structure

The report is divided into three main sections. The first section provides an overview of the legislative and service delivery contexts in which the Office operates. The second section describes the work carried out by the Office in 2010. The final section provides statistical information, which covers the use of compulsion, seclusion, reportable deaths and electroconvulsive therapy in the reporting period.

Context

This first section describes the context in which the Office and mental health sector operates, including the roles of the various statutory positions, the strategic environment and the guiding legislation.

The Mental Health (Compulsory Assessment and Treatment) Act 1992

The Mental Health (Compulsory Assessment and Treatment) Act 1992, here referred to as the MH(CAT) Act, provides a framework for balancing public and personal rights and defines the circumstances under which people may be subject to compulsory psychiatric assessment and treatment. The MH(CAT) Act also makes provisions for respecting human rights.

The role of the MH(CAT) Act, as set out in the Act, is to:

> redefine the circumstances in which and the conditions under which persons may be subjected to compulsory psychiatric assessment and treatment, to define the rights of such persons and to provide better protection for those rights, and generally to reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder.

Around 4000 New Zealanders are treated under the MH(CAT) Act at any one time. Treatment for most of these people is managed in the community.

Statutory positions under the Mental Health (Compulsory Assessment and Treatment) Act 1992

The MH(CAT) Act is administered by a number of statutory roles.

- **The Director and Deputy Director of Mental Health**: Section 91 of the MH(CAT) Act provides for the appointment of a Director and Deputy Director of Mental Health. The Director of Mental Health is responsible for the general administration of the MH(CAT) Act under the direction of the Minister of Health and Director-General of Health. The Director is also the Chief Advisor, Mental Health, within the Ministry of Health. Fulfilling these roles requires the Director to undertake a range of statutory and quality-monitoring functions.
- **Directors of Area Mental Health Services**: Under section 92 of the MH(CAT) Act, Directors of Area Mental Health Services are appointed by the Director-General of Health. Directors of Area Mental Health Services are employed by and function within the respective district health boards. They must report to the Director every three months regarding the exercise of their powers, duties and functions.
- **Responsible clinicians**: Under the MH(CAT) Act, the Directors of Area Mental Health Services appoint responsible clinicians to the care of every patient defined in the MH(CAT) Act as a person required to undergo assessment or to be subject to compulsory treatment. Responsible clinicians are accountable to the Directors of Area Mental Health Services for the assessment, treatment and care of patients under their care, both within the inpatient setting and the community.

- **District Inspectors**: Part 6 of the MH(CAT) Act sets out the rights of patients. District Inspectors are essential to the monitoring of these rights. The Minister of Health is responsible for appointing District Inspectors, who operate independently from mental health services. They receive and may inquire into complaints by, or on behalf of, patients. District Inspectors are also required to inspect services regularly. The Director can initiate an inquiry, led by a District Inspector, into a wide range of issues relating to the care and treatment of service users and the management of services.

District Inspectors must report to the Director on the exercise of their powers, duties and functions on a monthly basis. More information about District Inspectors is contained in sections 94 to 99A of the MH(CAT) Act, and in the Guidelines for the Role and Function of District Inspectors Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2011).

Staff of the Office of the Director of Mental Health

This Annual Report is produced by members of the Office of the Director of Mental Health. Its members work closely with, and are heavily reliant on, other sections within the Mental Health Group at the Ministry of Health. During the 2010 calendar year the staff comprised:

- Dr David Chaplow, QSO, MB ChB, FRANZCP; Director of Mental Health and Chief Advisor, Mental Health
- Dr Charles Hornabrook, MB ChB, FRANZCP; Deputy Director of Mental Health and Senior Advisor, Mental Health (until September 2010)
- Dr Susanna Every-Palmer, MB ChB, FRANZCP, Advanced Certificate of Forensic Psychiatry; Deputy Director of Mental Health (from October 2010)
- Dr Frances Hughes, ONZM, RN, PhD, FANZCMHN, Principal Advisor, Mental Health
- Ms Penelope Bailey, Personal Assistant to the Director and Deputy Director of Mental Health (until October 2010)
- Mr Stephen Enright, Team Leader
- Ms Sue Green, Senior Analyst (until December 2010)
- Ms Liza Wilcox (from August 2010)
- Ms Claire Tennent, Policy Analyst (until October 2010)
- Ms Freya Smith, Policy Analyst
- Mr Chris McIlroy, Policy Analyst
- Ms Helen Wong, Support Officer.

The strategic environment

The New Zealand Public Health and Disability Act 2000 provides the overarching legislative framework for mental health and addiction services, as for all other health and disability services.

Strategic directions for mental health and addiction are guided by both the New Zealand Health Strategy (Minister of Health 2000) and the New Zealand Disability Strategy (Minister for Disability Issues 2001). The Health Strategy has a focus on addressing inequalities in health and on improving the health status of people with mental illness. The Disability Strategy covers people with a psychiatric disability and promotes a fully inclusive society.

He Korowai Oranga: Māori Health Strategy (Minister of Health and Associate Minister of Health 2002) is the foundation for Māori health development and informs all other health strategies. It places whānau at the centre of public policy. Through whānau ora, Māori families are supported to achieve their maximum health and wellbeing.

Better, Sooner, More Convenient Primary Health Care is a Government initiative designed to deliver more personalised services, closer to home, through developing integrated family health centres. A priority for mental health and addictions is to build capacity and capability in the primary sector especially for people with mild to moderate mental disorders.

In addition to the Government's initiatives, there are special considerations relevant to secondary mental health services that impact on the strategic environment for mental health. These include the:

- balance of compulsory treatment with statutory rights to a range of protections and safeguards
- consideration of international conventions that require regular monitoring and reporting on compliance
- monitoring role of the Mental Health Commission
- higher prevalence and greater impact of serious mental illness for Māori than for other populations
- diversity of service providers, covering both clinical and support services.

Mental health strategy

Te Tāhuhu – Improving Mental Health 2005–2015 (Minister of Health 2005) is the second national mental health strategy. It describes leading challenges and promotes a range of strategic outcomes for the mental health and addiction sector.

Alongside Te Tāhuhu, the sector is guided by Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015 (Minister of Health 2006) and, more specifically, the Mental Health and Addiction Action Plan 2010 (Ministry of Health 2010) which prioritises the following key actions:

- moving health resources to increase access to mental health and addiction services and improve health outcomes
- lifting system performance to enhance our communities' mental health and wellbeing
- tackling alcohol and drug-related harm
- integrating efforts across government for better mental health outcomes.

Te Puāwaiwhero – The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015 (Ministry of Health 2008) continues to provide direction to the sector in working towards achieving better outcomes for whānau and tāngata whaiora. Acting on the evidence of health inequality is a key principle of this framework.

Agencies

The Ministry of Health is the government health agency concerned with policy, regulation, monitoring, acting as the Government's agent, some direct contracting, and payments. It has a facilitation role and is expected to provide leadership within the sector and advice to the Government.

District health boards (DHBs) were set up under the New Zealand Public Health and Disability Act 2000. They are responsible for funding, planning and the direct or indirect provision of health services for their respective populations. DHBs receive government money on a population-based funding formula. They contract with the Minister of Health in the Crown Funding Agreement for agreed outputs to ensure that health and disability services are provided to their resident populations.

The non-governmental organisation (NGO) sector is a major player in the delivery of mental health and addiction services, with about a third of all funding going to approximately 400 NGOs that provide mental health services. The services range in size from small, consumer-run drop-in centres, to multi-million-dollar providers of residential and home-based support. Eighty percent of these NGOs operate with fewer than 11 full-time positions each. NGOs provide a significant level of service in the areas of alcohol and other drug treatment (especially residential treatment), problem gambling, kaupapa Māori, family support, and residential and home-based support.

Mental health services

Specialist services are still expanding, with a focus on recovery. Mental health has central funding for workforce initiatives, which supplement regional and local initiatives. Contrary to common perceptions, most people who require mental health treatment receive it in the community. Around 90 percent of service users access only community services (including residential care), according to the mental health data collection tool Programme for the Integration of Mental Health Data (PRIMHD). The remaining 10 percent of people receive a mixture of community and inpatient services.

Inpatient care is expensive, accounting for approximately 30 percent of the cost of services, and a large proportion of the cost of acute inpatient care is generated by long or repeat admissions for a small number of service users. Evidence suggests that a number of these admissions could be avoided with better community care, thus reducing costs as well as improving outcomes for service users.

Other legislation

Criminal Procedure (Mentally Impaired Persons) Act 2003

The Criminal Procedure (Mentally Impaired Persons) Act 2003, as stated in section 3, relates to mentally disordered persons who are involved in criminal proceedings, for the purpose of providing:

- the courts with appropriate options for the detention, assessment and care of defendants and offenders with an intellectual disability or mental disorder
- that a defendant may not be found unfit to stand trial for an offence unless the evidence against the defendant is sufficient to establish that the defendant caused the act or omission that forms the basis of the offence
- for a number of related matters, including processes for the treatment, detention and care for defendants who are convicted.

Land Transport Act 1998

The key areas of relevance in the Land Transport Act 1998 are the provisions concerning driver licences for patients under the MH(CAT) Act. Directors of Area Mental Health Services are responsible for retaining the suspended driver licences of special patients and patients subject to compulsory inpatient orders, under section 19 of the Land Transport Act 1998. Directors of Area Mental Health Services are also responsible for returning licences to patients and for forwarding licences to the Director of Land Transport when a patient ceases to be a special patient or subject to a compulsory inpatient order. Licences are returned by Directors of Area Mental Health Services temporarily where patients are certified fit to drive while on leave.

Section 65 of this Act relates to the mandatory penalties for repeat offences involving the use of alcohol or drugs. A person sentenced under section 65 of the Act will be ordered to attend an assessment centre and will be disqualified from holding or obtaining a driver licence until the Director of Land Transport removes that disqualification under section 100 of the Act. The Act defines an 'assessment centre' as an establishment approved for the purposes of the Act by the Chief Executive of the Ministry of Health.

Misuse of Drugs Act 1975

Section 24 of the Misuse of Drugs Act 1975 relates to the treatment of people who are dependent on controlled drugs.

Alcoholism and Drug Addiction Act 1966

The Alcoholism and Drug Addiction Act 1966 provides for the care and treatment of alcoholics and drug addicts.

Victims' Rights Act 2002

Section 37 in the Victims' Rights Act 2002 is concerned with giving notice to registered victims of the discharge, leave, escape or death of an accused or offender who is compulsorily detained in a hospital.

Activities for 2010

This section describes the work of the Office of the Director of Mental Health in fulfilling its statutory and other functions, and reports on the special projects carried out by the Office during the 2010 calendar year. It also reports on the activities of the Mental Health Review Tribunal for the fiscal year ended 30 June 2010.

Relapse prevention plans

The Director-General of Health introduced 10 sector-wide health targets in 2007. The Director of Mental Health, in his Chief Advisor role, was appointed 'target champion' for the mental health target. The target now states that at least 95 percent of people who have been service users of mental health and addiction services for two years or more must have a relapse prevention plan. In 2009 the number of health targets was reduced to six from the previous set of ten. DHB reporting in regard to relapse prevention plans continued as an Indicator of DHB Performance.

A relapse prevention plan identifies the early warning signs of possible relapse for a patient. The plan identifies what the patient can do for themselves and what the service will do to support the patient. Ideally, each plan will be developed with the involvement of the clinician, the patient and their significant others. The plan represents an agreement and ownership between parties. Each plan will vary in its complexity according to the individual involved. Each patient will know of (and ideally have a copy of) their plan.

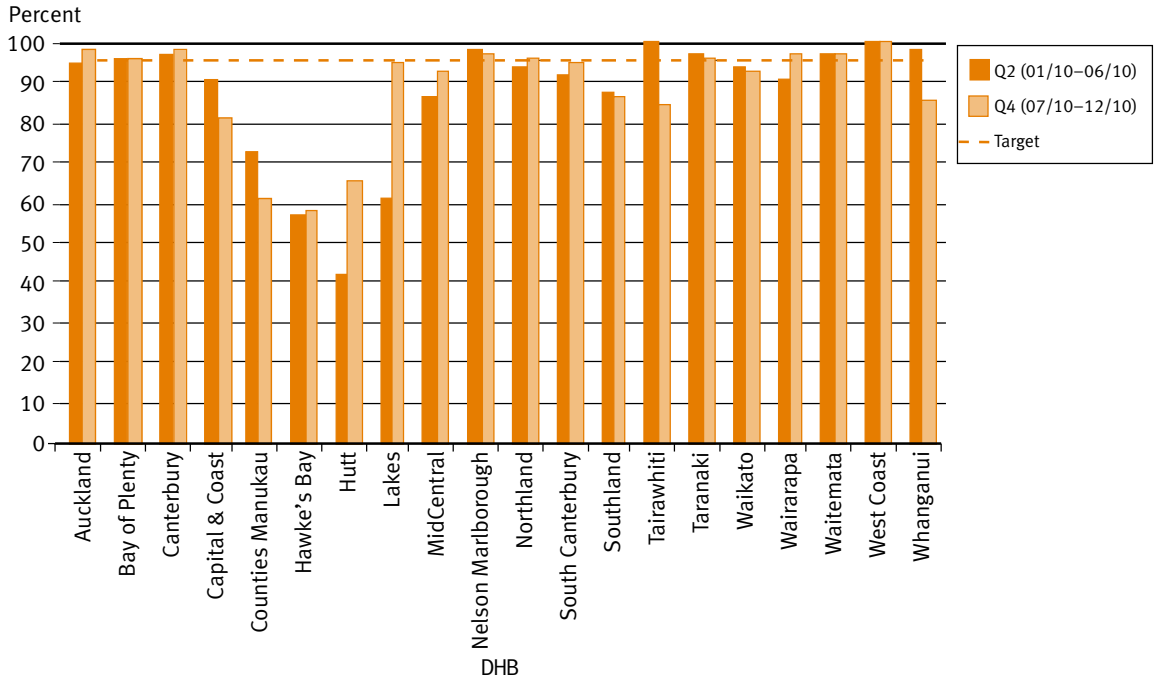
DHBs reported twice during 2010. The first reporting period covered the first and second quarters (1 January 2010 – 30 June 2010) and the second reporting period covered the third and fourth quarters (1 July 2010 – 31 December 2010). Figure 1 shows the results of DHBs' reporting for the 2010 calendar year.

Nationally between 2009 and 2010 the percentage of patients with relapse prevention plans (for adults) decreased from 89 to 87 percent. This decrease is largely attributable to some DHBs changing their methodology for counting and recording relapse prevention plans.

The target rate of relapse prevention plans for adults increased from 90 to 95 percent in 2010. Ten DHBs met the 95 percent target at the end of 2010. On average, 85 percent of long-term adult mental health service users had relapse prevention plans at the end of 2010, representing a 24 percent increase in the proportion of service users with plans since the introduction of the health target in 2007.

It is of interest to note that while the percentage of patients with relapse prevention plans decreased slightly, acute bed use by long-term clients decreased by 8 percent between 2009 and 2010.

Figure 1: Percentage of service users with a relapse prevention plan, by DHB, 1 January to 31 December 2010



Note: Southern DHB was formed on 1 May 2010 through the merger of Southland and Otago DHBs. Reporting of data on relapse prevention plans has come from 'Southern' as the DHB. Elsewhere in this report Southland and Otago DHBs continue to report as separate entities for 2010.

Sector visits (to DHB and NGO mental health services)

During 2010 the Director and Deputy Director of Mental Health made a number of visits to DHBs and NGOs, as shown in Table 1. Each visit was made for one or more of the following reasons:

- promoting mental health target compliance
- communicating and explaining government policy
- assisting in problem solving
- increasing their own awareness of innovation and achievements in the sector
- assisting in planning
- making presentations to groups
- supporting the statutory officers (eg, the Directors of Area Mental Health Services).

Many of the visits were by invitation.

Table 1: Sector visits by the Director and Deputy Director of Mental Health, 1 January to 31 December 2010

DHB	Date of visit
Hutt	19/08
Southland	01/11 07/09
Northland and Auckland	23/04 24/04
Nelson Marlborough	02/07
Whanganui	07/07 21/12
Taranaki	26/08
Canterbury	02/11
Lakes	30/04

Note: Two further sector visits with Auckland DHB were scheduled for the beginning of 2011.

Sector meetings

In 2010 the Director and Deputy Director attended the meetings listed in Table 2. The Director's statutory and advisory roles involve close collaboration with statutory officers. Most of the meetings listed were Ministry-sponsored but sector-led. For practical reasons, most were convened in Wellington.

Table 2: Meetings attended by the Director and Deputy Director of Mental Health, 1 January to 31 December 2010

Meeting	Month of meeting
National Directors of Area Mental Health Services	February May August November
National Directors of Area Mental Health Services, Managers and Clinical Directors	February May August November
Directors of Mental Health Nursing	February May August November
District Inspector National Caucus	March October
National Association of Opioid Treatment Providers	March June
Mental Health Review Tribunal	May November

Pacific Island Mental Health Network Annual Report

The World Health Organization's Pacific Island Mental Health Network (PIMHnet) has been operational since 2005 and has 18 member countries from across the Pacific Island region. From 2005 PIMHnet has been funded by the New Zealand's International Aid and Development Agency (NZAID) and the World Health Organization.

In 2010 the following activities were undertaken to improve outcomes for people with mental illness in Pacific Island countries.

- Placements saw consultants conducting training and clinical supervision; and the Network Facilitator providing support with the completion of mental health policies and plans in 10 PIMHnet countries.
- A journal donation scheme was established, in which members of specific professional organisations donate their journals to 15 member countries.
- A Diploma in Mental Health, Human Rights, and Law was developed in collaboration with the Indian Law Society. To date, four PIMHnet countries have had the opportunity to participate in this course.
- Country summary documents were completed, providing detailed descriptions of each country's health and economic system, and mental health within this context.
- Two articles were published about mental health care in Vanuatu and a conference abstract has been submitted for an international conference in 2011.
- One of PIMHnet's collaborative partners, the Black Dog Institute in Australia, won an AusAID Australia Leadership grant to conduct training in mood disorders during October 2010 in Australia. A total of 10 fellows participated, representing six PIMHnet countries.
- Multicultural Mental Health Australia developed a new resource to help service providers meet the mental health needs of consumers and carers from culturally and linguistically diverse backgrounds.

Pacific Island countries continue to demonstrate that they have the determination and commitment to improve mental health and to collaborate with PIMHnet to ensure evidence-based development. The large majority of countries in the region are implementing changes based on workforce and strategic plans, and substantially advancing national mental health policies, with five now complete and many more in drafting stages. Mental health awareness is increasing and important promotion activities are being undertaken throughout the region.

District Inspectors

The Office of the Director of Mental Health's responsibilities in relation to the District Inspectors include:

- coordinating the appointment and reappointment of District Inspectors by the Minister of Health
- managing District Inspector remuneration
- receiving and responding to monthly reports from the District Inspectors
- organising twice-yearly national meetings of District Inspectors
- facilitating inquiries under section 95 of the MH(CAT) Act
- implementing the findings of section 95 inquiries by District Inspectors.

The role of District Inspectors

District Inspectors are required to report regularly to their Director of Area Mental Health Services after inspecting mental health services. They are also required to report monthly to the Director of Mental Health on the exercise of their powers, duties and functions. These reports provide the Director with support for the approval of invoices for services, as well as an overview of mental health services and any problems arising. In the current reporting year District Inspectors have continued to provide valuable feedback on services.

Section 95 reports completed by 31 December 2010

The Director will occasionally require an inquiry to be undertaken by a District Inspector under section 95 of the MH(CAT) Act. These inquiries typically result in several recommendations being made by the District Inspector. The Director will consider the recommendations and audit the DHB's implementation of relevant recommendations. The Director will also act on any recommendations that have implications for the Ministry of Health and/or the mental health sector generally. The inquiry process is not completed until the Director considers that the recommendations have been satisfactorily implemented by the DHB and, if appropriate, by the Ministry and all DHBs.

In 2010 two section 95 inquiries were completed. Table 3 shows the number of completed section 95 inquiry reports received by the Director over the past nine years.

Table 3: Number of completed section 95 inquiry reports received by the Director of Mental Health, 2002 to 2010

2002	2003	2004	2005	2006	2007	2008	2009	2010
0	1	2	1	4	1	1	3	2

Number of District Inspectors at 31 December 2010

As of 31 December 2010 there were 34 District Inspectors appointed to specific regions throughout New Zealand. One senior advisory District Inspector oversees all of the District Inspectors. A list of current District Inspectors is available on the Ministry of Health website www.moh.govt.nz

Appointment of District Inspectors

In the year from 1 January 2010 to 31 December 2010, five District Inspector positions expired and two District Inspectors resigned. All vacant positions were filled.

Special patients and restricted patients

Special patients and restricted patients are covered by Part 4 of the MH(CAT) Act. Their care is provided in accordance with either the MH(CAT) Act or the Criminal Procedure (Mentally Impaired Persons) Act 2003. Special patients include:

- people charged with, or convicted of, a criminal offence and remanded to a secure hospital for a psychiatric report
- remanded or sentenced prisoners transferred from prison to a secure hospital
- defendants found not guilty by reason of insanity
- defendants unfit to stand trial

- people who have been convicted of a criminal offence and both sentenced to a term of imprisonment and placed under a Compulsory Treatment Order
- people designated as restricted patients because of the special difficulties they present and the danger they pose to others.

The Director of Mental Health has a central role in the management of special patients and restricted patients. The Director may direct their transfer (section 49 of the MH(CAT) Act), or grant leave for any period not exceeding seven days for certain special and restricted patients (section 52). Longer leave requires ministerial assent (section 50), but is not available to special patients unfit to stand trial. The Director provides briefings to the Minister of Health when requests for leave or reclassification are made. The Director must also be notified of the admission, discharge or transfer of special and restricted patients, and certain incidents involving these patients (section 43). The process for reclassifying special and restricted patients differs according to the patient's particular status, but usually requires ministerial involvement.

Table 4 shows the section 50 long-leave applications, revocations and change of status applications that the Office of the Director of Mental Health processed during 2010.

Table 4: Number of long-leave, revocation and reclassification requests for special and restricted patients, 1 January to 31 December 2010

Type of request	Acquitted due to insanity
Initial ministerial s 50 leave applications	7
Ministerial s 50 leave revocations	6
Further ministerial s 50 leave applications	17
Change of legal status applications	7
Change of legal status applications approved	6

Note: No requests were made by restricted patients or special patients unfit to stand trial during the reporting period.

Prisoner transfers to hospital

Once a person has been sentenced to a term of imprisonment, a Compulsory Treatment Order relating to the prisoner ceases to have effect. Remand prisoners may remain on a pre-existing Compulsory Treatment Order, but it is considered ethically inappropriate to enforce compulsory treatment in the prison environment. If compulsory assessment and/or treatment is required, section 45 of the MH(CAT) Act provides for the transfer to hospital of mentally disordered prisoners. Section 46 allows for voluntary admission to hospital with the consent of the prisoner and the approval of the prison superintendent.

Table 5 records the number of prisoners transferred to hospital from 2001 to 2010. All such admissions must be notified to the Director of Mental Health. The average duration of admission was only calculated where both the admission and discharge dates were known (representing approximately 85 percent of cases). If the duration of admission included dates outside of 2010, only dates within the year were included when calculating the average duration.

Table 5: Number of prisoners transferred to hospital, 2001 to 2010

Year	Prisoners transferred to hospital under committal (s 45)	Average duration of s 45 admission (days)	Prisoners transferred to hospital voluntarily (s 46)
2001	134	62	4
2002	96	29	0
2003	113	38	2
2004	121	52	1
2005	117	48	8
2006	128	49	16
2007	98	33	2
2008	80	51	2
2009	120	68	12
2010	105	53	11

Hybrid special patients

The Criminal Procedure (Mentally Impaired Persons) Act 2003 allows the court to sentence a convicted offender to a term of imprisonment while also ordering their detention in hospital as a special patient (if mentally disordered). These orders are referred to as hybrid orders because they combine aspects of compulsory treatment and imprisonment. In 2010 there were eight hybrid orders made under section 34(1)(a)(i) of the Criminal Procedure (Mentally Impaired Persons) Act 2003.

Report of the Mental Health Review Tribunal

The Mental Health Review Tribunal (the Tribunal) is an independent body established under section 101 of the MH(CAT) Act. It comprises three members, one of whom must be a lawyer and one a psychiatrist; by convention the third member is a community member. Although the Tribunal comes under the auspices of the Ministry of Health, it is independent of both the Ministry and the Minister.

Functions of the Tribunal

The principal function of the Tribunal is to review the condition of patients pursuant to sections 79 and 80 of the MH(CAT) Act. Section 79 relates to people who are subject to ordinary Compulsory Treatment Orders, and section 80 relates to the status of special patients.

The Tribunal has a number of other functions under the MH(CAT) Act, including reviewing the condition of restricted patients (section 81), considering complaints (section 75), appointing psychiatrists authorised to carry out certain functions (sections 59–60) and considering brain surgery cases (section 61).

Powers of the Tribunal

Under section 79 of the MH(CAT) Act the Tribunal decides whether or not patients subject to ordinary Compulsory Treatment Orders are fit to be released from compulsory status. If the Tribunal decides they are, the patient is released from compulsory status with immediate effect.

Under section 79 of the MH(CAT) Act, the crucial issue is whether or not the patient is 'mentally disordered' as defined in section 2 of the Act. If the Tribunal finds that the patient is not mentally disordered, then it follows as a matter of law that the patient is fit to be released from compulsory status. Conversely, if the Tribunal finds that the patient is mentally disordered, then as a matter of law the patient is not fit to be released from compulsory status.

Under section 80 of the MH(CAT) Act, the Tribunal makes recommendations relating to special patients to the Minister of Health or the Attorney-General. It is for the Minister or Attorney-General, not the Tribunal, to determine whether there should be a change of status.

The Tribunal also investigates complaints. If the Tribunal decides a complaint has substance, it must report the matter to the relevant Director of Area Mental Health Services, with appropriate recommendations.

Tribunal statistics

During the year ended 30 June 2010 the Tribunal received 146 applications. Table 6 presents the types of applications received for the year ending 30 June 2010. Table 7 shows the outcome of those applications.

Table 6: Number of MH(CAT) Act applications received by the Mental Health Review Tribunal, 1 July 2009 to 30 June 2010

Type of MH(CAT) Act application	Number of cases
Section 79	143
Section 80	1
Section 81	1
Section 75	1
Total cases	**146**

Table 7: Outcome of MH(CAT) Act applications received by the Mental Health Review Tribunal, 1 July 2009 to 30 June 2010

Case outcome	Section 79	Section 80	Section 81	Section 75	Total
Deemed ineligible	7	0	0	1	**8**
Withdrawn	43	0	0	0	**43**
Held over to the next report year	21	0	1	0	**22**
Heard in the report year	72	1	0	0	**73**
Total cases	**143**	**1**	**1**	**1**	**146**

During the year ended 30 June 2010 the Tribunal heard 72 applications received during the reporting year, and four applications held over from the previous reporting year, under section 79 of the MH(CAT) Act (relating to ordinary patients). The results of those cases are reported in Table 8.

Table 8: Results of inquiries under section 79 of the MH(CAT) Act held by the Mental Health Review Tribunal, 1 July 2009 to 30 June 2010

Result of s 79 of MH(CAT) Act inquiry	Number of cases
Not fit to be released from compulsory status	75
Fit to be released from compulsory status	1
Total	**76**

Table 9 shows the ethnicity of the 131 patients for whom ethnicity was identified in making an application to the Tribunal in the year ended 30 June 2010.

Table 9: Ethnicity of patients who identified their ethnicity in Mental Health Review Tribunal applications, 1 July 2009 to 30 June 2010

Ethnicity	Number	Percentage
Caucasian/New Zealand European	89	68
Māori	29	22
Pacific	7	5.0
Asian	2	2.0
Other	4	3.0
Total	**131**	**100**

Of the 146 MH(CAT) Act applications received by the Tribunal during the year ended 30 June 2010, 93 were from male patients and 53 were from female patients. These gender figures are broken down in Table 10.

Table 10: Gender of patients in Mental Health Review Tribunal applications, 1 July 2009 to 30 June 2010

Type of application submitted to the Tribunal	Gender	Number
Applications by patients subject to community treatment orders	Female	32
	Male	50
Applications by patients subject to inpatient treatment orders	Female	21
	Male	41
Applications by patients subject to special treatment orders	Female	0
	Male	1
Applications by patients subject to restricted orders	Female	0
	Male	1

Statistics

Although the Director of Mental Health is not responsible for clinical or committal processes relating to individual patients, the Office of the Director of Mental Health collects consolidated information as a way of monitoring how individual DHBs are functioning in relation to the MH(CAT) Act and to promote best practice. This section provides information that will help to improve service quality and inform public debate.

Compulsory assessment and application for Compulsory Treatment Orders

Information in this subsection and the one following is sourced from data in the quarterly reports from the Directors of Area Mental Health Services and from the PRIMHD data set.

The first assessment period under section 11 of the MH(CAT) Act is for up to five days. It can then be extended for a second period of up to 14 additional days (section 13). If a further extension to the period of assessment is required, an application to the court is made for a Compulsory Treatment Order under section 14(4). Figure 2 and Table 11 show the average number of patients required to undergo assessment under these sections each month, by DHB.

There are a number of factors complicating the interpretation of these data, including that:

- patients are rarely assessed on more than one occasion in a month
- some patients will receive certificates in relation to more than one section of the MH(CAT) Act in a month.

It is also apparent that the data do not allow easy calculation of the duration of compulsory assessment because certificates are often completed before the expiry of the maximum period allowed.

Figure 2: Average number of patients required to undergo assessment under sections 11, 13 and 14(4), per month, per 100,000 population, 1 January to 31 December 2010

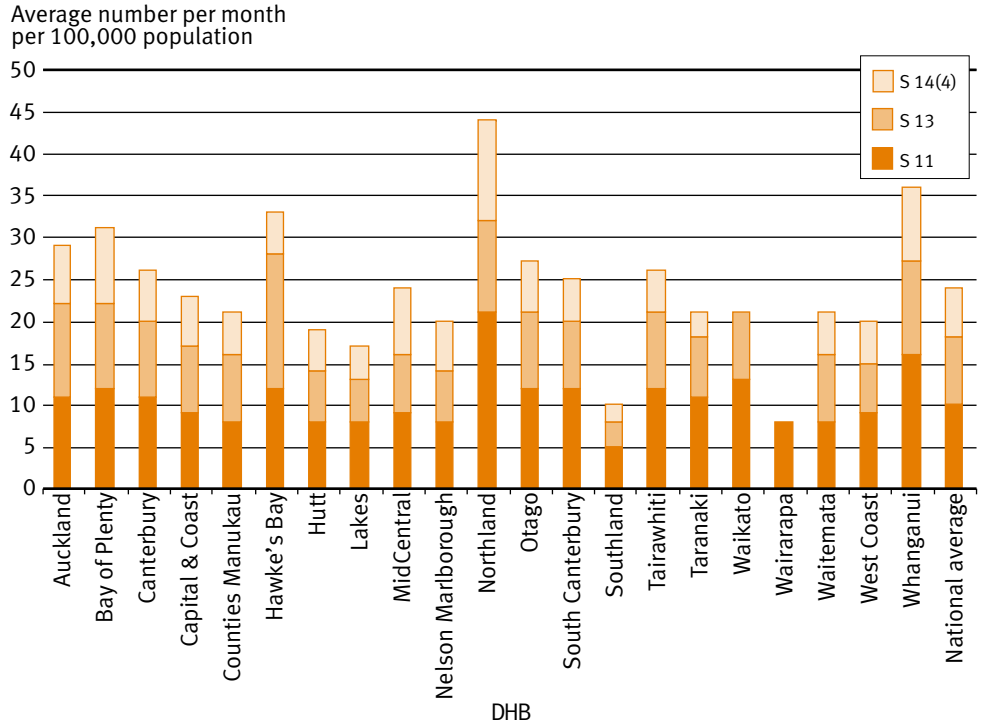


Table 11: Average number of patients required to undergo assessment under sections 11, 13 and 14(4) of the MH(CAT) Act, per month, per 100,000 population, 1 January to 31 December 2010

DHB	S11	S13	S14(4)
Auckland	11	11	7
Bay of Plenty	12	10	9
Canterbury	11	9	6
Capital & Coast	9	8	6
Counties Manukau	8	8	5
Hawke's Bay	12	16	5
Hutt	8	6	5
Lakes	8	5	4
MidCentral	9	7	8
Nelson Marlborough	8	6	6
Northland	21	11	12
Otago	12	9	6
South Canterbury	2	8	5
Southland	5	3	2
Tairawhiti	12	9	5
Taranaki	11	7	3
Waikato	13	8	0
Wairarapa	8	0	0
Waitemata	8	8	5
West Coast	9	6	5
Whanganui	16	11	9
National average	**11**	**8**	**5**

Source: Manual data were used for Capital and Coast, Northland, Waikato and Wairarapa. Data for all other DHBs were sourced from PRIMHD.

Nationally, for every 100,000 people:

- there are approximately 11 committals under the first five-day period of assessment each month
- 80 percent of the initial assessments progress to the second assessment period
- 50 percent of the initial assessments progress beyond the second assessment period.

Patients can have their compulsory status reviewed by a Family Court or District Court judge during the assessment period under section 16 of the MH(CAT) Act. Following application, a judge must examine the patient as soon as practicable, and consult with the responsible clinician and at least one other health professional involved in the case. If the judge is satisfied that the patient is fit to be released from compulsory status, the judge orders that the patient be released from that status immediately.

During 2010 there were approximately 1152 applications made under section 16 of the Act. Of this total, 435 applications were subsequently withdrawn, lapsed or were discontinued for other reasons. The remaining 717 proceeded to hearings. Of these hearings an order for release of the patient from compulsory status was issued in 43 cases (6.4 percent).

Compulsory Treatment Orders

The Ministry of Justice statistics for MH(CAT) Act hearings in respect of Compulsory Treatment Orders are available from 2004 onwards. Table 12 presents data on applications for a Compulsory Treatment Order from 2004 through to 2010. Table 13 shows the types of orders granted over the same period.

Late data entry of Mental Health applications and outcomes has meant that the Compulsory Treatment Order data presented in this Annual Report (received from the Ministry of Justice) differ slightly from the data presented in earlier reports. The Ministry of Justice has taken note of these data entry issues.

Table 12: Applications for Compulsory Treatment Orders (or extensions), 2004 to 2010

Year	Applications for a CTO, or extension to a CTO	Applications granted, or granted with consent	Applications dismissed or struck out	Applications withdrawn, lapsed or discontinued	Applications transferred to the High Court
2004	4391	3855	100	436	
2005	4397	3771	98	528	
2006	4362	3738	116	507	1
2007	4708	4067	96	550	
2008	4736	4137	109	490	
2009	4834	4293	53	488	
2010	5216	4626	71	518	1

Notes: CTO = Compulsory Treatment Order.
Table presents information on applications that had been processed at the time of data extraction (9 March 2011).

Table 13: Types of Compulsory Treatment Order made on granted applications, 2004 to 2010

Year	Granted applications for orders	Compulsory community treatment orders (or extension)	Compulsory inpatient treatment orders (or extension)	Both compulsory community and inpatient treatment orders (or extension)	Type of order not recorded
2004	3855	1868	1528	100	359
2005	3771	1595	1460	85	631
2006	3738	1678	1399	82	579
2007	4062	1810	1360	111	781
2008	4137	1896	1520	130	591
2009	4293	2240	1672	114	303
2010	4626	2472	1881	99	174

Notes: Table presents applications that had been processed at the time of data extraction (9 March 2011).
The year is determined by the date when the order was made (if known) or the final outcome date.

As Table 12 indicates, during the 2010 calendar year 5216 applications for a Compulsory Treatment Order or extension to a Compulsory Treatment Order were made in the Family Court. Of these applications, 4626 were granted, 71 were dismissed and 518 were withdrawn. Table 13 shows that of the 4626 applications granted, a resulting compulsory community treatment order has been recorded for 2472, and a compulsory inpatient treatment order for a further 1881. A combination of compulsory community and compulsory inpatient treatment orders was made for 99 cases. The remaining 174 applications do not have the type of Compulsory Treatment Order recorded in the case management system.

Compulsory Treatment Orders are determined by the court, as noted above. The number of Compulsory Treatment Orders at month's end is recorded and sent to the Office of the Director of Mental Health. In 2010, at any given time, 77 people per 100,000 population were detained under a compulsory community treatment order (section 29), 14 under a compulsory inpatient treatment order (section 30), and 6 under a compulsory inpatient treatment order while the patient was on leave (section 31). Figure 3 and Table 14 show the number of Compulsory Treatment Orders granted for 2010, by DHB. Figures 4 and 5 break down the number of Compulsory Treatment Order applications by the age and gender of the patients.

Figure 3: Average number of Compulsory Treatment Orders (sections 29, 30 and 31), per month, per 100,000 population, 1 January to 31 December 2010

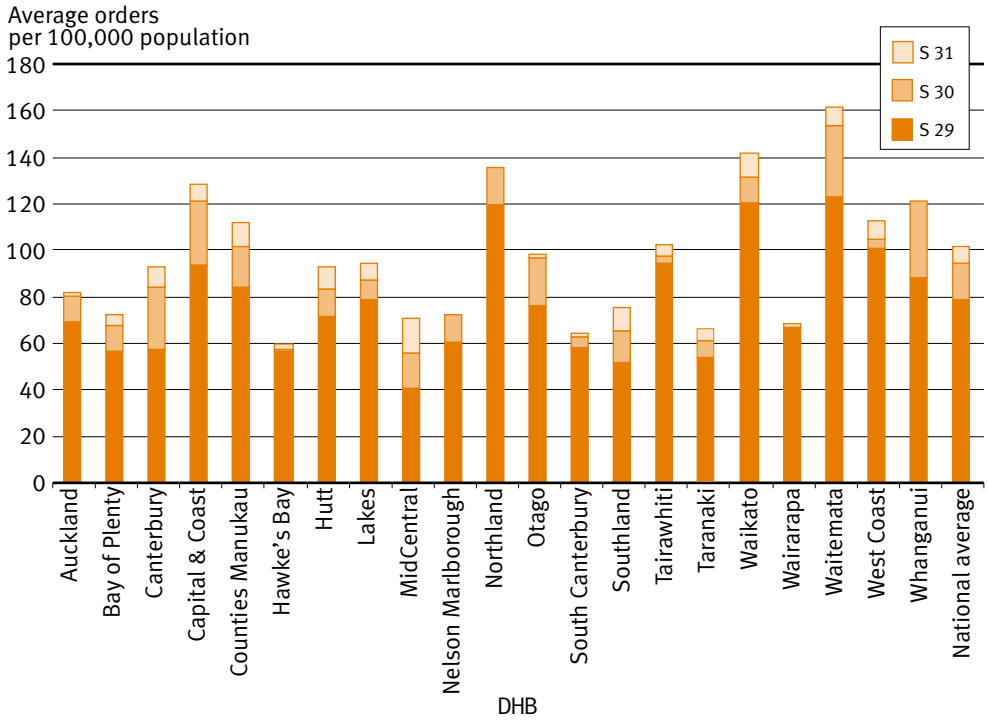


Table 14: Average number of Compulsory Treatment Orders (sections 29, 30 and 31), per month, per 100,000 population, 1 January to 31 December 2010

DHB	S29	S30	S31
Auckland	69	11	1
Bay of Plenty	56	11	5
Canterbury	57	27	8
Capital & Coast	93	28	7
Counties Manukau	84	17	10
Hawke's Bay	56	1	2
Hutt	71	12	9
Lakes	78	9	7
MidCentral	40	15	15
Nelson Marlborough	60	12	0
Northland	119	16	0
Otago	76	20	2
South Canterbury	58	4	2
Southland	51	14	10
Tairawhiti	94	3	5
Taranaki	53	7	5
Waikato	120	11	10
Wairarapa	66	0	2
Waitemata	122	31	8
West Coast	100	4	8
Whanganui	88	33	0
National average	**77**	**14**	**6**

Notes: Data show a continuation of orders (orders in place per month).

Source: PRIMHD: Auckland, Counties Manukau, Hutt, MidCentral, Nelson Marlborough, Northland, Otago, Southland, Taranaki, Waikato, West Coast, Waitemata, Whanganui

Manual data: Bay of Plenty, Canterbury, Capital & Coast, Hawke's Bay, Lakes, South Canterbury, Tairawhiti, Wairarapa

Figure 4: Number of Compulsory Treatment Order applications (including extensions) made, by age group, 2004 to 2010

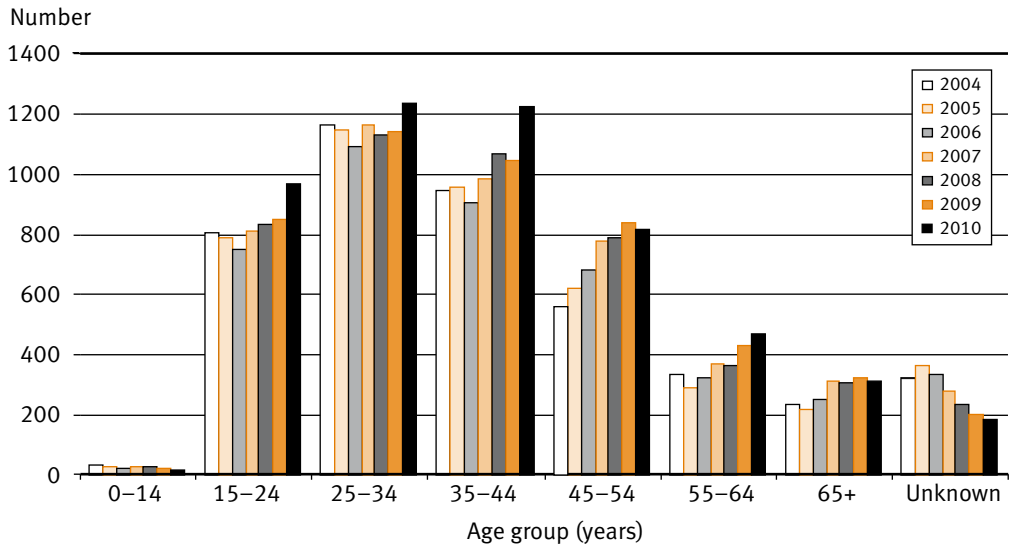
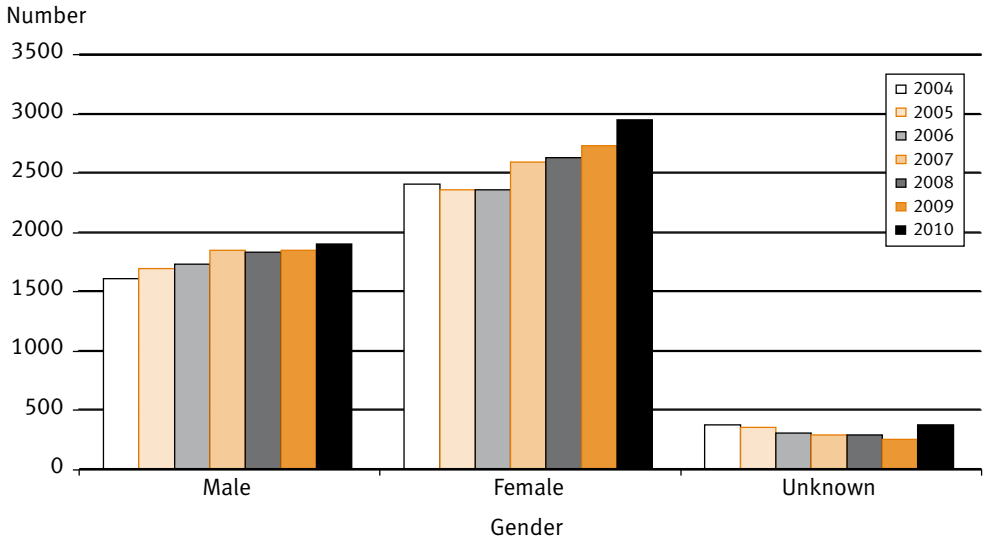


Figure 5: Number of Compulsory Treatment Order applications (including extensions) made, by gender, 2004 to 2010



Seclusion

Seclusion is provided for in section 71 of the MH(CAT) Act. Seclusion can only occur where, and for as long as, it is necessary for the care or treatment of the patient, or for the protection of other patients. Seclusion rooms must be designated for this purpose by the Directors of Area Mental Health Services, and can be used only with the authority of the responsible clinician.

Seclusion should be an uncommon event, and should be used only when there is an imminent risk of danger to the individual or others, and no other safe and effective alternative is possible. Seclusion should never be used for the purposes of discipline, coercion or staff convenience, or as a substitute for adequate levels of staff or active treatment.

The Restraint Minimisation and Safe Practice Standard defines seclusion as 'the placing of a person at any time, and for any duration, alone in an area where he/she cannot freely exit'. The duration and circumstances of each episode of seclusion must be recorded in a register, which must be available for inspection by District Inspectors.

Seclusion in New Zealand mental health services

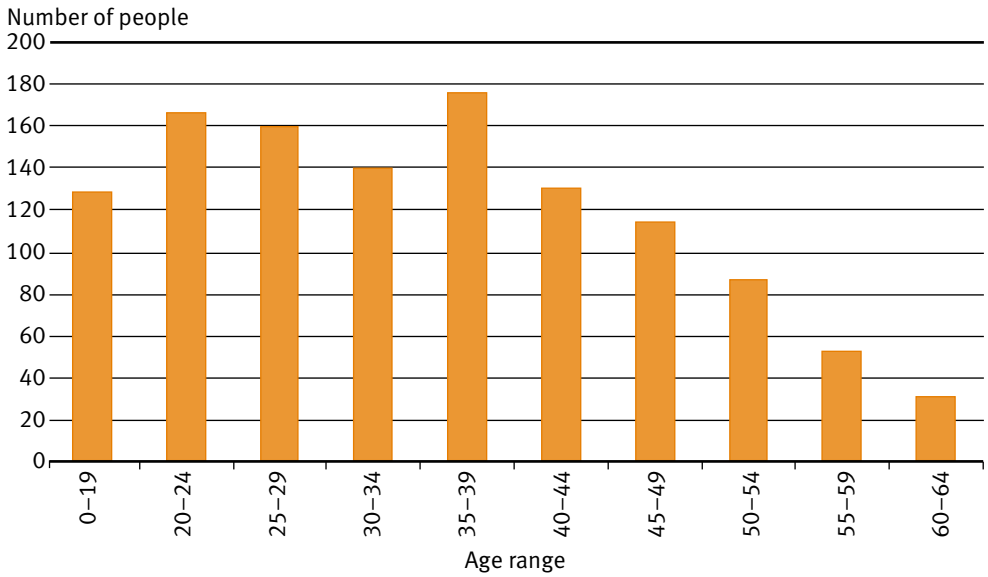
Seclusion data from the 2010 calendar year are presented below. Some data from Tairawhiti DHB have been excluded because they were incomplete. In addition, some DHBs miscoded a number of seclusion records, which may account for a greater variability in the seclusion data compared with previous reports. This issue is being addressed by the DHBs concerned, for future reporting.

There was also a change to the definition of a continuous seclusion event in 2010. Under the new definition there must be less than a one-hour break between episodes for the event to be continuous. This change will explain the increase in seclusion events for some DHBs from previous years.

Between 1 January and 31 December 2010, a total of 6348 patients spent time in New Zealand adult mental health units (excluding forensic and other regional rehabilitation services). This time represented a total of 195,315 bed nights (excluding some data from Bay of Plenty, Hawke's Bay, Hutt Valley and Tairawhiti DHBs due to reporting issues). Of the 6348 patients, 1065 (17 percent) were secluded at some time during the reporting period. As the same people were often secluded more than once (on average 2.27 times), the number of seclusion events in adult services was higher than the number of patients secluded, at 2465 events for adult clients. Across all services, including forensic and youth services, 1191 patients across all age brackets (excluding service users over 65 years of age) experienced at least one seclusion event; 65 percent of secluded patients were male, 34 percent were female and 1 percent were unspecified.

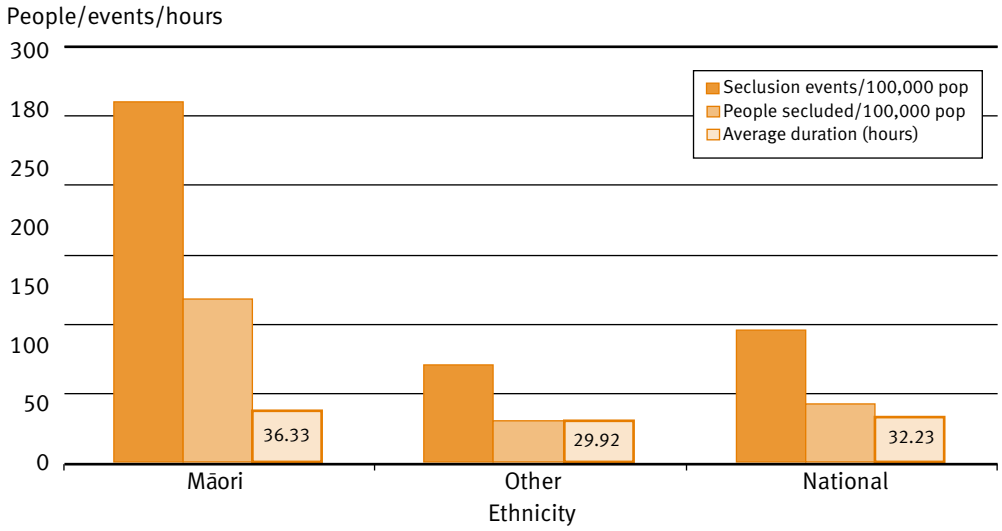
Most patients who were secluded were aged between 20 and 49 years (see Figure 6). In the country's specialist facilities for children and young people (in Christchurch, Auckland and Wellington) a total of 43 young people were secluded, generating 179 seclusion events.

Figure 6: Number of people secluded in all mental health units, by age group, 1 January to 31 December 2010



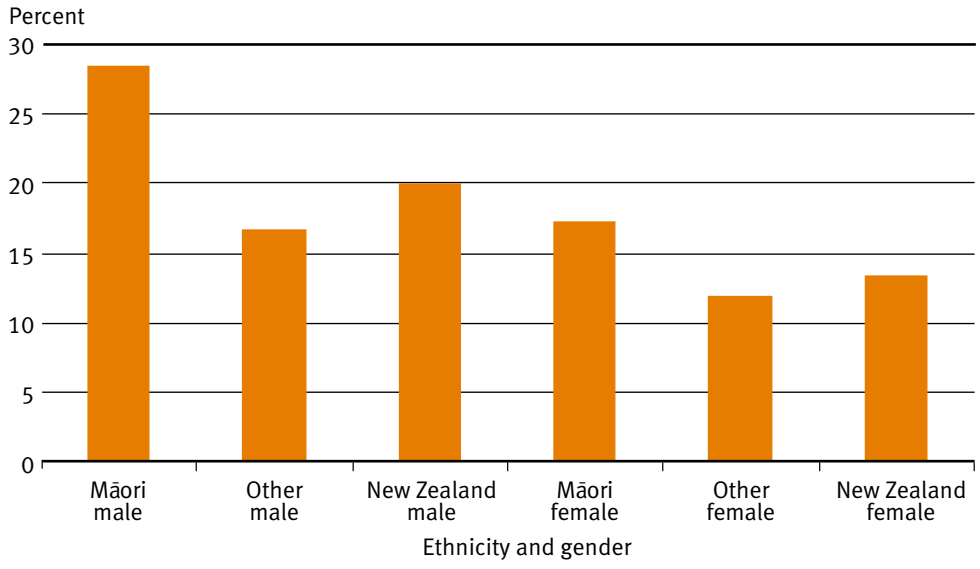
Māori were statistically more likely to be secluded than Pacific peoples or those from other ethnic groups (see Figure 7). Of the 1065 adults (aged 20–64 years) secluded in adult services, 400 were Māori,[1] 54 identified as Pacific peoples and 611 were from other ethnic groups.

Figure 7: Seclusion indicators for adults (aged 20–64 years) in adult mental health units, by ethnicity, 1 January to 31 December 2010



The percentage of inpatients secluded in acute adult services was also calculated for different ethnic groups to control for differences in admission rates between the groups (see Figure 8).

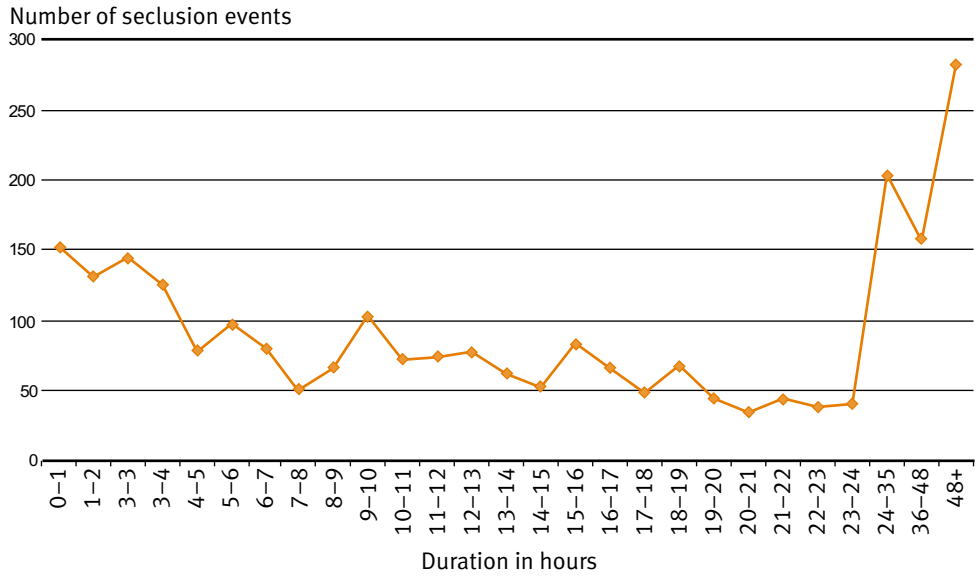
Figure 8: Proportion of adult inpatients (aged 20–64 years) secluded in adult units, by ethnicity, 1 January to 31 December 2010



The length of time spent in seclusion varied considerably. Most seclusion events (73.9 percent) lasted less than 24 hours. Figure 9 shows the way that these seclusion events were distributed among more specific periods within this timeframe.

1 The 2009 Annual Report of the Office of the Director of Mental Health reported that 270 Māori were secluded in the 2009 reporting year. The Office of the Director of Mental Health has since discovered that this figure was a misprint and 374 Māori adults were secluded in 2009.

Figure 9: Distribution of seclusion events, by duration of the event, 1 January to 31 December 2010



Seclusion by DHB

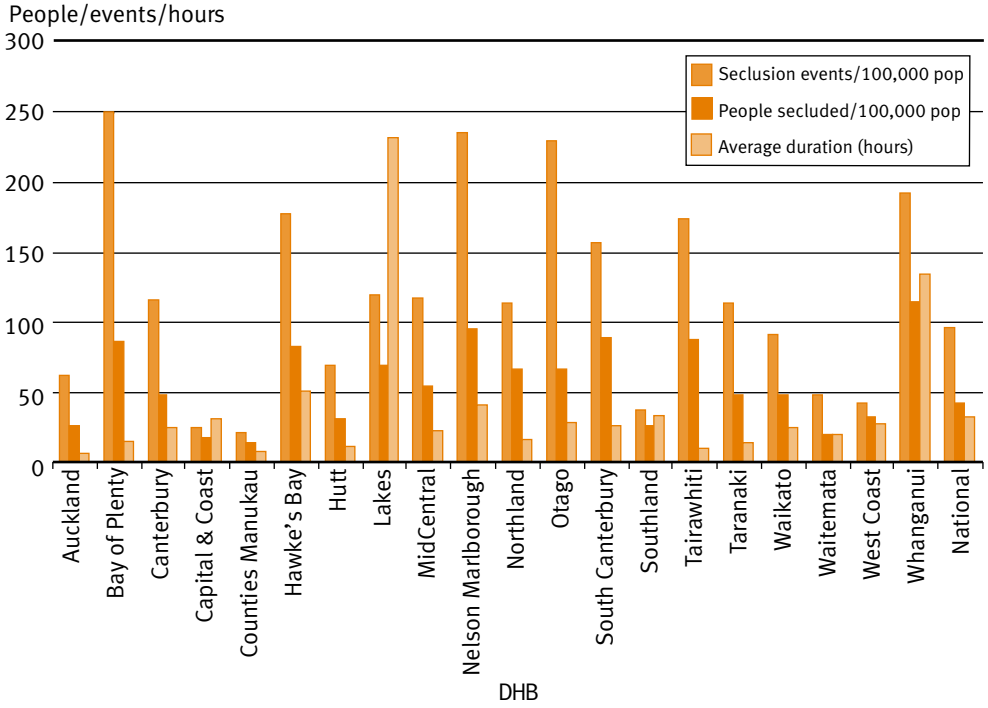
All DHBs except for Wairarapa, which has no mental health inpatient service, use seclusion. If patients in Wairarapa require admission, they are transported to Hutt Valley or MidCentral DHB, and any seclusion statistics in relation to these patients appear on the corresponding DHB's database.

As Figure 10 shows, seclusion data varied widely across DHBs. Such variation is likely to be due to a number of factors, including:

- differences in seclusion practice
- geographical variations in the prevalence and acuity of mental illness
- ward design factors, such as the availability of intensive care and low-stimulus facilities
- staff numbers, experience and training
- use of sedating psychotropic medication
- frequent or prolonged seclusion of one patient, distorting seclusion figures over the 12-month period.

Because it is difficult to measure and adjust for these factors, it can be useful to compare an individual DHB's performance over time, in addition to considering the adjusted comparisons between DHBs made in this Annual Report.

Figure 10: Seclusion indicators, by DHB adult services (for ages 20–64 years), 1 January to 31 December 2010[2]



Note: Population figures are from Statistics New Zealand DHB projections for people aged 20–64 years as at the end of 2010. Data from South Canterbury includes all adult patients from Ashburton (Canterbury population).

Seclusion in forensic units

Specialist inpatient forensic services are provided in five main centres: Northern, Midland, Central, Canterbury and Otago, with a smaller inpatient forensic service in Whanganui. In total, 110 people were secluded in forensic units in the year 2010, contributing to a total of 1109 seclusion events.

Table 15 presents the seclusion indicators for the 2010 calendar year. Although these indicators cannot be compared with adult service indicators because they do not reflect the same client base, it is clear they vary widely. In particular, 13 individuals accounted for 838 out of 1109 seclusion events, and two individuals had over 50 seclusion events each over the reporting period.

Table 15: Seclusion indicators for forensic services, by DHB, 1 January to 31 December 2010

DHB	Clients secluded	Average duration (hours)	Seclusion events/ 100,000 population	People secluded/ 100,000 population
Canterbury	18.00	15.92	105.16	3.54
Capital & Coast	13.00	25.45	8.60	4.47
Otago	21.00	28.22	153.23	11.13
Waikato	18.00	27.36	21.98	4.95
Waitemata	40.00	44.71	33.50	7.40
National	**110.00**	**24.86**	**25.37**	**2.52**

2 Seclusion data were extracted by the Ministry of Health in May 2011. As at August 2011 two DHBs reported changes to their seclusion data which are not reflected in this report. Auckland DHB reported 80 clients secluded (increased from 77) with 190 seclusion events (increased from 182). Lakes DHB reported 45 clients secluded (increased from 40) with 78 seclusion events (increased from 69).

Electroconvulsive therapy

Electroconvulsive therapy (ECT) is a therapeutic procedure in which a brief pulse of electricity is delivered to a patient's brain in order to produce a seizure. ECT is an effective treatment for various types of mental illness, including depressive illness, mania, catatonia and other neuropsychiatric conditions. It is often effective in cases where medication is contraindicated or is not relieving symptoms sufficiently.

ECT is administered under anaesthesia and with muscle relaxants, by medical staff in an operating theatre. The end result is that the patient drifts off to sleep and wakes up a short time later unable to recall the details of the procedure. The most common side-effects of ECT are confusion and memory loss for events surrounding the period of ECT treatment. The confusion and disorientation typically clear within an hour.

Significant advances have been made in improving ECT techniques and reducing side-effects over the last 20 years. Despite these improvements, it remains a controversial treatment. In 2003 the Health Select Committee recommended that a comprehensive review be undertaken, independently of the Ministry of Health, on the safety and efficacy of ECT and the adequacy of regulatory controls on its use in New Zealand. The review concluded that ECT continues to have a place as a treatment option for consumers of mental health services in New Zealand, and that banning its use would deprive some seriously ill patients of a potentially effective and sometimes life-saving means of treatment. The report of the independent review is available on the Ministry of Health website www.moh.govt.nz/publications

In 2009 a consumer resource was created as part of the 2003 Government Response to the Health Committee's report on petition 1999/30 of Anna de Jonge and others regarding ECT. The ECT consumer resource is available on the Ministry of Health website www.moh.govt.nz

Number of patients treated with ECT

Table 16 shows the total number of patients who received ECT from 1 July 2009 to 30 June 2010, by DHB. A total of 235 people received ECT during the year ending 30 June 2010 (5.4 per 100,000 population).

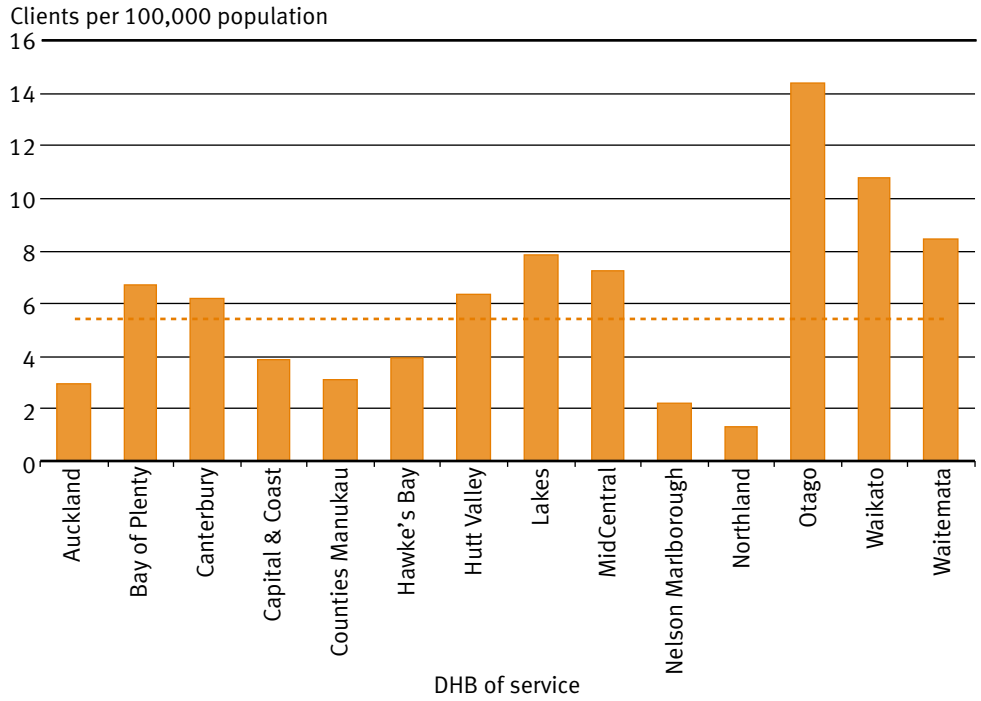
Table 16: Total number of patients treated with ECT, by DHB, 1 July 2009 to 30 June 2010

District health board	Number of patients treated with ECT
Auckland	13
Bay of Plenty	14
Canterbury	31
Capital & Coast	11
Counties Manukau	15
Hawke's Bay	6
Hutt Valley	9
Lakes	8
MidCentral	12
Nelson Marlborough	3
Northland	2
Otago	27
South Canterbury^	–
Southland^	–
Tairawhiti	–
Taranaki	–
Waikato	39
Wairarapa^	–
Waitemata	45
West Coast^	–
Whanganui^	–
Total	**235**

Note: ^ DHB does not perform ECT; patients are sent to other DHBs to receive treatment.

Source: Auckland, Canterbury, Hutt, Lakes, Northland and Taranaki figures are from PRIMHD (extracted on 30 Aug 2011). Data for other DHBs were sourced from manual data. Some patients were seen by more than one DHB. (In August 2011 four DHBs reported changes to their ECT data which are not reflected in this report. Auckland reported 11 clients, Canterbury reported 54 clients, Hutt reported 6 clients and Lakes reported 10 clients treated with ECT during the reporting period).

Figure 11: Number of patients treated with ECT per 100,000 population, by DHB of service, 1 July 2009 to 30 June 2010



As Figure 11 indicates, the number of ECT treatments given varies regionally; across all DHBs of service, an average of 5.4 patients per 100,000 population are treated with ECT. Several factors contribute to such variation. First, regions with smaller populations will be more vulnerable to annual variations (according to the needs of the population at any time). In addition, patients receiving continuous or maintenance treatment will typically receive more treatments in a year than those treated with an acute course. ECT is indicated in older people more often than in younger adults because older people are more likely to have associated medical problems contraindicating medication. Finally, populations in some DHBs have better access to ECT services than others, which is likely to influence the rates of use.

ECT treatments per acute course

A series of ECT treatments, known as an acute course of ECT, is necessary to produce a lasting effect. To sustain the response to ECT, continuation treatment, often in the form of antidepressant and/or mood stabiliser medication, may be prescribed. Some individuals require maintenance ECT, which is delivered on an outpatient basis, usually at a rate of one treatment weekly, tapering off to between fortnightly and monthly for up to one year.

The method used to refine the data to show acute course information involves:

- removing those ECT treatments that are not part of an acute course of treatment (ie, maintenance treatments)
- counting treatments that are more than seven days apart as part of a new treatment course
- excluding acute courses of treatment that occur within five days of the end of one reporting period and five days into a new reporting period, to ensure only full courses are included in the analysis.

Table 17 shows the average number and range of ECT treatments per acute course, by DHB. The national average was 3.62 ECT treatments per acute course of ECT for the year ending 30 June 2010.

Table 17: Number of ECT treatments per acute course, by DHB, 1 July 2009 to 30 June 2010

District health board	Number of courses	Number of treatments	Number of treatments per acute course: mean (range)
Auckland	14	98	7.00 (4–12)
Bay of Plenty	12	65	5.4 (1–10)
Canterbury	80	428	5.35 (1–17)
Capital & Coast	30	94	3.1 (1–9)
Counties Manukau	25	121	4.8 (1–16)
Hawke's Bay	10	34	3.4 (1–8)
Hutt Valley	5	7	1.4 (1–2)
Lakes	13	44	3.38 (1–8)
MidCentral	16	110	6.9 (1–20)
Nelson			
Marlborough	7	19	2.7 (1–7)
Northland	39	71	1.82 (1–10)
Otago	37	135	3.6 (1–12)
South Canterbury^	–	–	–
Southland^	–	–	–
Tairawhiti	0	0	0
Taranaki	0	0	0
Waikato	75	336	4.5 (1–13)
Wairarapa^	–	–	–
Waitemata	49	375	4.5 (1–13)
West Coast^	–	–	–
Whanganui^	–	–	–

Note: ^ DHB does not perform ECT; patients are sent to other DHBs to receive treatment.
Source: Manual data have been used for all DHBs

Several factors can influence the number of individual treatments that a patient may need:

- the severity of the patient's illness and the degree of treatment resistance
- any complicating medical factors
- age (older people may require longer courses)
- the timeliness of maintenance medication being started during the course
- technical factors in how the treatment is given (eg, bilateral versus right unilateral treatment).

Consent to treatment

Section 60 of the MH(CAT) Act describes the process required for obtaining consent for ECT. Either the patient's consent or a second opinion from a psychiatrist appointed by the Mental Health Review Tribunal is required. In the latter case, the treatment must be considered to be in the interests of the patient. This process allows for the treatment of patients too unwell to consent to treatment. Clinicians are advised to make the decision about whether ECT is in the interests of the patient after discussing the options with family/whānau and considering any relevant advance directives made by the patient (refer to section 60 of the Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992, available on the Ministry's website www.health.govt.nz

During the year ended 30 June 2010 no patient was treated with ECT if they retained decision-making capacity and refused consent. Table 18 shows the number of treatments of those patients who were not able to consent to treatment during the 2010 fiscal year.

Table 18: Number of ECT treatments not able to be consented to, 1 July 2009 to 30 June 2010

District health board	Number of administrations not able to be consented to
Auckland	NA
Bay of Plenty	4
Canterbury	1
Capital & Coast	3
Counties Manukau	6
Hawke's Bay	3
Hutt Valley^	NA
Lakes	–
MidCentral	2
Nelson Marlborough	–
Northland	NA
Otago	8
South Canterbury^	–
Southland^	–
Tairawhiti	0
Taranaki	0
Waikato	13
Wairarapa^	–
Waitemata	16
West Coast^	–
Whanganui^	–
Total	**56**

Notes:
^ DHB does not perform ECT; patients are sent to other DHBs to receive treatment.
NA Manual information was not supplied from this DHB. The Ministry of Health is currently unable to provide this figure from PRIMHD.

Age and sex of patients treated with ECT

Table 19 and Figure 12 show the age and sex of people who were treated with ECT during the year ended 30 June 2010. For these data, age group was determined by the individual's age at the beginning of their treatment. Fifty-six percent of people treated with ECT, for whom there was information about age, were aged over 55 years.

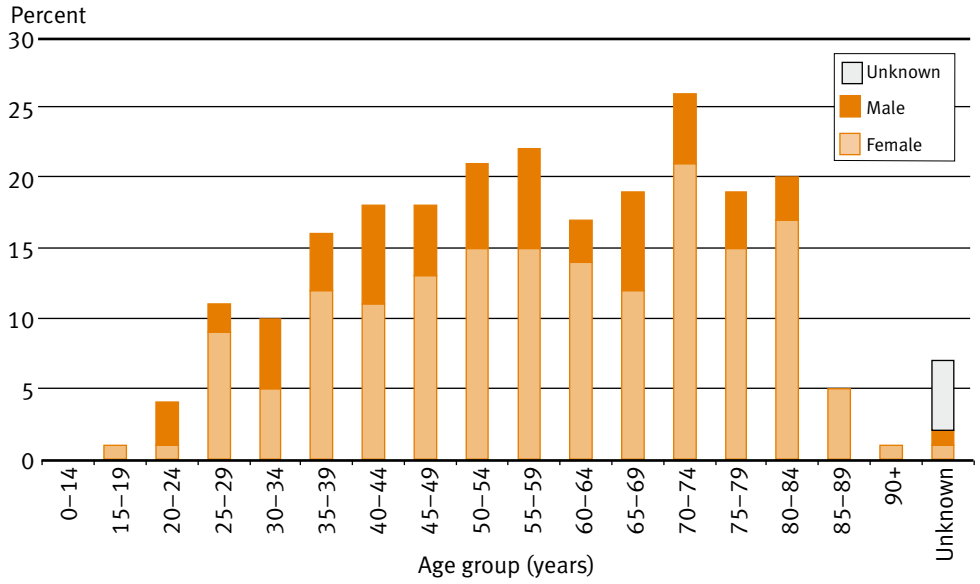
Of the 230 people for whom there is information about age and sex, 168 (73 percent) were women and 62 (27 percent) were men. These percentages are similar to those from the previous year (70 percent women and 30 percent men for the year ending 30 June 2009). The main reason for the gender difference is that more women present to mental health services with depressive disorders. This ratio is similar to that reported in other countries.

Table 19: Number of patients treated with ECT, by age group and gender, 1 July 2009 to 30 June 2010

Age group (years)	Female	Male	Unknown	Total
15–19	1	–	–	1
20–24	1	3	–	4
25–29	9	2	–	11
30–34	5	5	–	10
35–39	12	4	–	16
40–44	11	7	–	18
45–49	13	5	–	18
50–54	15	6	–	21
55–59	15	7	–	22
60–64	14	3	–	17
65–69	12	7	–	19
70–74	21	5	–	26
75–79	15	4	–	19
80–84	17	3	–	20
85–89	5	–	–	5
90+	1	–		1
Unknown	1	1	5	7
Total	**168**	**62**	**5**	**235**

Note: The total is not the sum of the age band data as some patients' birthdays coincided with the treatment day, thereby moving them into the next age band.

Figure 12: Percentage of patients treated with ECT, by age group and gender, 1 July 2009 to 30 June 2010



Ethnicity of patients treated with ECT

The ethnic spread of patients treated with ECT suggests Asian people, Māori and Pacific peoples are under-represented for their population demography (see Table 20). However, the numbers involved are so small that any statistical representation of the percentages of those receiving ECT treatment, relative to the size of each ethnic group as a proportion of the total population, provides no further insight into the situation.

Table 20: Number of people treated with ECT, by ethnicity, 1 July 2009 to 30 June 2010

Ethnicity	Number of patients treated with ECT
Asian	15 (6%)
European	190 (81%)
Māori	14 (6%)
Pacific	5 (2%)
Other	1 (0%)
Unknown	10 (4%)

Reportable deaths

Section 132 of the MH(CAT) Act requires notification to the Director of Mental Health within 14 days of any death of a patient or special patient under the Act, including the apparent cause of death.

If the circumstances surrounding a death cause concern, the DHB may initiate an inquiry. The Director of Mental Health can also initiate an investigation under section 95 of the MH(CAT) Act, and in rare cases the Minister or Director-General of Health can initiate an inquiry under section 72 of the New Zealand Public Health and Disability Act 2000. In these cases, the Ministry of Health also expects details of the proposed inquiry, including timeframes, and it is expected that the inquiry findings will be forwarded to the Ministry of Health when they become available.

The Director is involved to ensure that recommendations flowing from inquiry processes are implemented, and follows up on these issues with Directors of Area Mental Health Services. Recommendations from inquiries of national significance are disseminated through the Office of the Director of Mental Health.

Mental health reportable events (including all serious and sentinel events) are now collected by the Ministry of Health's national incident management system. The Office of the Director of Mental Health only collects information on Serious and Sentinel Reportable Events including reportable deaths. This report only records information about reportable deaths in mental health services, in accordance with the statutory requirement of the Director of Mental Health.

Table 21 records the number of deaths of people receiving care under the MH(CAT) Act. In 2010 the Director of Mental Health received notification of 50 deaths of people who were under the care of the MH(CAT) Act at the time of death. Four people are reported to have died by suicide, and 21 are reported to have died by other means, including natural causes and illness unrelated to the individual's mental health status. Final reports are pending for 8 reported deaths that are suspected suicides and 17 'other deaths', including people who died of natural causes or where the cause of death is unknown.

Table 21: Outcomes of reportable death notifications, 1 January to 31 December 2010

Reportable death outcome	Number of notifications
Suicide reports completed	4
Suicide reports pending	8
Other death reports completed	21
Other death reports pending	17
Total events	**50**

Note: Investigations into reportable deaths can take a significant amount of time for information gathering and reporting. There are 25 pending reports from 2010 (as shown in the table above) at the time of writing this report. This total includes incomplete reports and reports where further information has been requested. The Office of the Director of Mental Health follows up on all reports pending.

Death by suicide or suspected suicide

This subsection provides a brief overview of suicide and intentional self-harm among specialist mental health service users for 2008, as recorded in PRIMHD. Data from 2008 are used because, due to limited capacity in coronial services, it can take up to two years for a coroner's investigation into a suicide to be completed. It is likely that this situation will improve in the future as there are now more full-time coroners.

The focus of this subsection is on people who complete suicide and who have had a history of contact with specialist mental health (including alcohol and other drug) services in the year prior to their death. People with no history of mental health service use in the year prior to death are referred to as 'non-service users', although it is acknowledged that some non-service users may have used mental health or alcohol and other drug services at some point in their lives.

The suicide data in this subsection include deaths by intentional self-harm and self-harm of undetermined intent.[3] The statistics discussed here cover only people aged under 65 years because in 2008 in the Central and Southern regions, older people's mental health treatment was provided by disability services rather than mental health services, and is not recorded in PRIMHD. The data were drawn from information provided to New Zealand Health Information Service databases: the Mortality Database, PRIMHD and the National Minimum Dataset.

Prevalence of suicide in the population

There were 482 suicides recorded in the Mortality Database in 2008. A further 6 deaths of undetermined intent were recorded and are included in this report. Of this initial total of 488 deaths, however, 23 deaths involved people aged 65 years and over and are excluded from this report.

Table 22 shows the remaining 465 suicides, of which 154 (or 33 percent) had been in contact with specialist mental health services in the year prior to the date of death. Service users have about 21 times the rate of suicide compared with non-service users.

Table 22: Number and rates of suicides, by service use, 2008

	Number of suicides	Age-standardised rate
Service users	154	206
Non-service users	311	9
Total	**465**	**13**

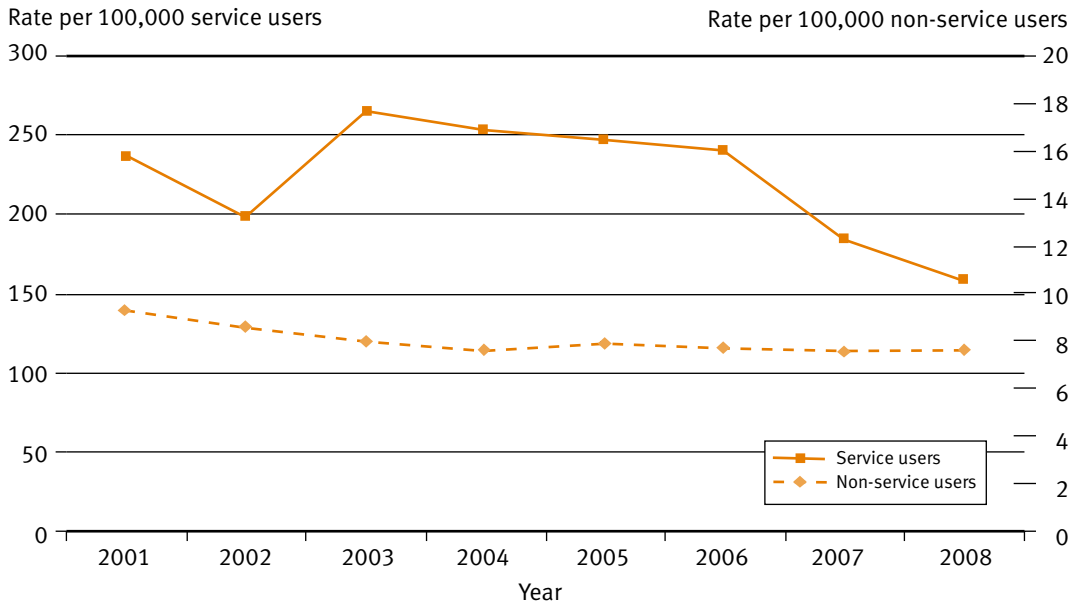
Note: Age-standardised rate is the rate per 100,000 standardised to the World Health Organization standard population; aged under 65 years.

Changes in suicide numbers over time

Between 2001 and 2008, there was a slow but steady decrease of 33 percent in the number of suicides for non-service users. For service users, there was a decrease in the number of suicides since 2003 (Figure 13).

3 These data have been excluded in previous reports so that analysis is comparable with the annual publication of suicide statistics in Suicide Facts (see the statistics section of www.moh.govt.nz/suicideprevention).

Figure 13: Number of suicides, by service use, 2001 to 2008



Sex and age in relation to suicide

There were three times as many male suicides as there were female suicides in 2008. Forty-seven percent of females who committed suicide were users of mental health services, compared with 27 percent of males.

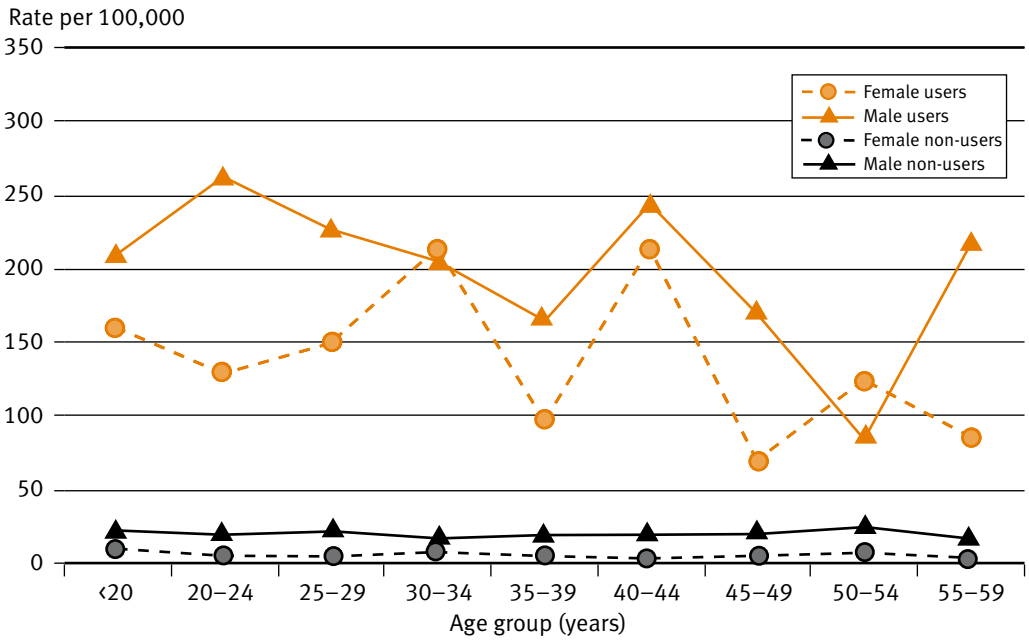
Suicide rates for service users were higher than those of non-service users (see Table 23 and Figure 14).

Table 23: Rates of suicide, by gender and service use, 2008

Gender	Service users		Non-service users		Total	
	Number	Rate	Number	Rate	Number	Rate
Male	96	189	247	17	343	23
Female	58	233	64	6	122	10
Total	**154**	**190**	**311**	**11**	**465**	**16**

Note: Standardised rate is the rate per 100,000 standardised to the World Health Organization standard population aged under 65 years.

Figure 14: Rates of suicide, by age group, gender and service use, 2008



Ethnicity and suicide

As Table 24 indicates, among people receiving mental health services in 2008, the rate of suicide is higher for Pacific peoples (970 per 100,000 service users) compared with Others (341 per 100,000 service users) and Māori (371 per 100,000 Māori service users).[4]

Table 24: Number of suicides, by ethnicity and service use, 2008

Ethnicity	Service users		Non-service users	
	Number of suicides	Age-standardised rate	Number of suicides	Age-standardised rate
Māori	29	174	53	9
Pacific	4	59	25	10
Other	121	204	233	8
Total	**154**	**190**	**311**	**9**

Note: The standardised rate for Pacific peoples is significantly lower than in 2007; this is partly due to a large effect of changes in the number of suicides in small populations, in the World Health Organization formula for age-standardised rates. In addition, in previous Annual Reports the standardised rates have been miscalculated (see footnote below).

Service use

All service users have by definition had a history of contact with specialist mental health (including alcohol and other drug) services in the year prior to their death. In 2008 four mental health service users died by suicide while they were inpatients. Another 150 service users died by suicide while living in the community in 2008. Of these 150 service users, 11 (7 percent) had previously been

4 In past Annual Reports the standardised rates published have been incorrect due to the use of an incorrect formula. The correction to this methodology will partly account for variability in the rates shown in this report compared with previous reports.

admitted to an inpatient unit and had been admitted to mental health acute inpatient units within the 12 months prior to death. Of these, 10 people (91 percent) committed suicide within a week of discharge from a mental health inpatient unit. Of the remaining service users who died by suicide while living in the community, 119 people (77 percent) had contact with community mental health services and 20 people (13 percent) were seen by alcohol and drug services, within the 12 months prior to death.

Detentions and committals under the Alcoholism and Drug Addiction Act 1966

The Alcoholism and Drug Addiction Act 1966 (ADA Act) provides for the compulsory detention and treatment of people with severe substance dependence for up to two years at certified institutions. In October 2009 the Prime Minister announced a review of the ADA Act as part of a range of initiatives to reduce harm from methamphetamine. The Law Commission released its report *Compulsory Treatment for Substance Dependence: A review of the Alcoholism and Drug Addiction Act 1966 (NZLC R118)* in October 2010.

The Ministry of Justice keeps statistics on applications to the Family Court under the ADA Act. Section 8 of the ADA Act allows a person who is dependent on alcohol or another drug to voluntarily apply to the Family Court for detention in a specified institution that is certified under the ADA Act. Section 9 of the Act applies when another person, such as a relative or the Police, makes an application to the Family Court for the person to be committed to a specified institution that is certified under the ADA Act. Section 9 applications must be accompanied by two medical certificates.

Late data entry of mental health applications and outcomes has meant that the figures presented in this Annual Report differ slightly from the data presented in the earlier Annual Reports from the Office of the Director of Mental Health. The Ministry of Justice has taken note of these data entry issues.

As with committal orders under the MH(CAT) Act, Ministry of Justice statistics on the use of the ADA Act are only available from the beginning of 2004. Table 25 details the outcomes of applications under the ADA Act to the Family Court. Table 26 then identifies the number of orders granted for detention under section 8, and for committal under section 9 of the ADA Act.

Table 25: Number and outcomes of applications for detention and committal, 2004 to 2010

Application outcome	2004	2005	2006	2007	2008	2009	2010
Applications granted or granted with consent	72	79	77	71	75	71	68
Applications dismissed or struck out	4	3	4	1	2	3	3
Applications withdrawn, lapsed or discontinued	2	8	2	6	1	4	9
Total applications for s 8 and s 9 orders	78	90	83	78	78	78	80

Note: Table presents applications that were disposed at the time of data extraction (9 March 2011).

Source: Ministry of Justice's Case Management System (CMS). CMS is a live operational database. Figures are subject to minor changes any time hereafter.

Table 26: Outcomes of applications for granted orders for detention and committal, 2004 to 2010

Year	s 8 applications granted for detention	s 9 applications granted for committal	Total applications granted
2004	44 (61.1%)	28 (38.9%)	72
2005	49 (62%)	30 (38%)	79
2006	60 (77.9%)	17 (22.1%)	77
2007	52 (73.2%)	19 (26.8%)	71
2008	63 (84%)	12 (16%)	75
2009	49 (69.%)	22 (31%)	71
2010	54 (79.4%)	14 (20.6 %)	100

Note: Table presents applications that were disposed at the time of data extraction (9 March 2011).

Source: Ministry of Justice's Case Management System. CMS is a live operational database. Figures are subject to minor changes any time hereafter.

Opioid substitution treatment services

The Director of Mental Health is responsible for approvals relating to the prescription, administration or supply of controlled drugs for the purposes of treating people with drug dependence, and for overseeing section 24 of the Misuse of Drugs Act 1975. Opioid substitution treatment is a well-established treatment that involves prescribing opioids such as methadone and Suboxone (buprenorphine) as a substitute for illicit opioids.

The Director of Mental Health undertakes regular site visits to opioid substitution services, meets quarterly with Medsafe, and oversees the evaluation of service compliance with sector standards. In addition, a six-monthly report cycle was initiated in 2007 to provide an overview of key information that informs and affects the provision of opioid substitution treatment services.

There were 16 DHB providers and one NGO provider of opioid substitution services as well as a gazetted primary health organisation providing specialist opioid substitution treatment (OST) services in 2010. Additionally, a number of individual general practitioners (GPs) were authorised to provide OST to clients who are assessed as stabilised.

In 2010 services noticed a significant increase in people seeking to take responsibility for their illicit drug use by enlisting in an OST programme. Specialist providers and individual GPs catered for 5013 clients in the reporting period for July to December 2010. This total represents a 19 percent increase on the number of clients receiving treatment for opioid dependence at the same time in 2009, and the biggest increase in the number of people in OST since reporting to the Office of the Director of Mental Health commenced in 2007.

Although services treated more people than they had previously, the waiting list for opioid substitution treatment increased from 66 to 88 people across five DHBs. However, DHBs in all other parts of the country reported that there were no, or fewer than four, people waiting for treatment.

The number of GPs authorised to treat opioid dependence continued to increase. In 2010 there were 625 authorised GPs compared with 582 in the last reporting period. As a result, 126 more people received treatment in primary care than in the last reporting period. In proportional terms,

however, just over a quarter of clients were receiving treatment in primary care in 2010 compared with a third of clients at the same time in 2009. It is of concern that the rate of people being transferred to primary care treatment for their opioid dependence has not kept pace with the increased demand for treatment.

The number of people receiving treatment for opioid dependency who were transferred to prison has reduced from 99 in the last reporting period to 83 in December 2010. The numbers have continued to be reasonably stable from year to year.

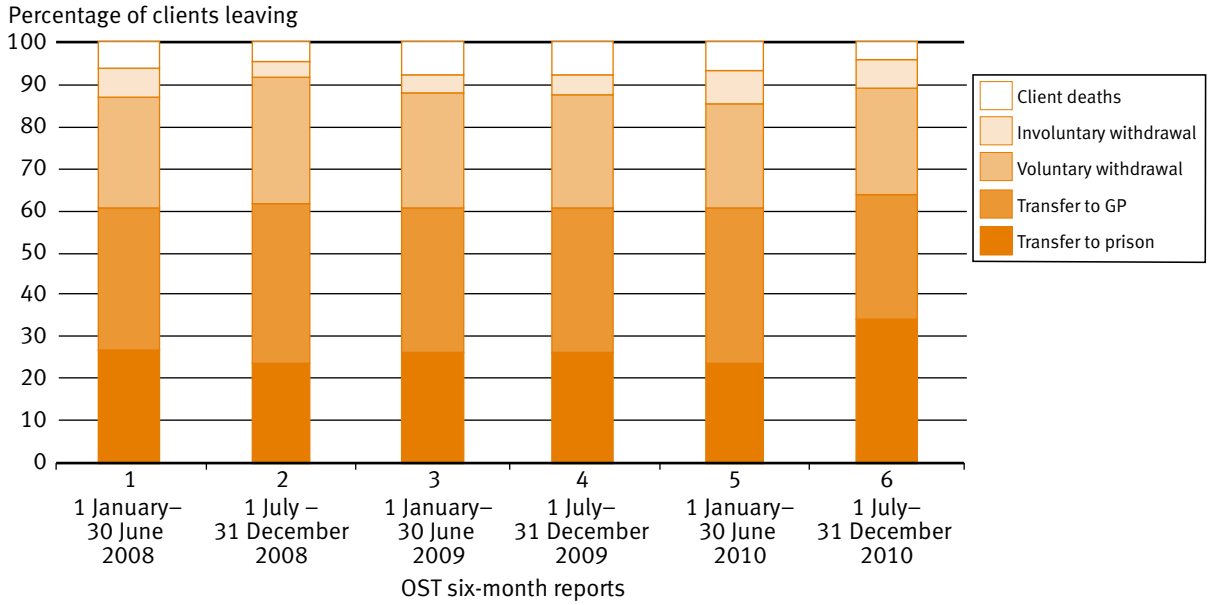
On average, each year approximately 7.5 percent of clients leave OST specialist services for one of the following reasons:

- transfer to GP care
- planned withdrawal from methadone (or other opioid substitution medication)
- involuntary withdrawal from methadone (or other opioid substitution medication)
- transfer to prison
- death.

Approximately 2 percent of clients choose to withdraw from opioid substitution medication via a planned withdrawal; another 0.4 percent of clients are withdrawn from opioid substitution medication against their will in response to behaviour that jeopardises the safety of the individual concerned or others (including staff). Another 0.4 percent of clients die from a range of causes while receiving opioid substitution treatment. The number of clients who die as a consequence of an overdose is very low – under one a year on average.

The highest number of clients, 46 percent, leave opioid specialist services because they actively seek to change their lifestyles. Either they are assessed as sufficiently stabilised to transfer to GP care and receive their treatment in a primary care, community setting or they choose to withdraw voluntarily from opioid substitution medication. Figure 15 shows the reasons for clients leaving OST specialist services at six-month reporting intervals from 2008 to 2010.

Figure 15: Reasons for clients leaving opioid substitution treatment specialist services, 2008 to 2010



Appendix 1: Tribute to Dr David Chaplow

In June 2011, Dr David Chaplow retired as Director of Mental Health and Chief Advisor, Mental Health, to the Minister of Health after an unprecedented 10-year term in office. It is my pleasure to pay a brief tribute to him in light of his achievements in a long and impressive career.

Dr Chaplow has made a remarkable contribution to psychiatry in New Zealand. Before his appointment to the Ministry of Health, he spent almost a decade as founding director of the Mason Clinic, Auckland's forensic psychiatric service. In 2001 he was awarded a Queen's Service Order for his services to forensic psychiatry and the national parole board.

As Director of Mental Health, Dr Chaplow has taken a proactive approach to dealing with systemic issues in mental health services, to the benefit of staff, service users and their families and whānau nationwide. He was integrally involved in the development and implementation of key pieces of strategic mental health policy such as Te Tāhuhu and Te Kōkiri, and the recent Mental Health and Addiction Action Plan 2010. Under Dr Chaplow's leadership, the Office of the Director of Mental Health has maintained rigorous standards for the administration of mental health services, and for the past five years has published this report annually to further promote openness and accessibility to mental health data.

Dr Chaplow has forged strong relationships within the Ministry of Health, other government departments and the mental health sector as a whole. Much of this is due to the level of regard in which Dr Chaplow is held nationwide and throughout the Pacific Island region. He was instrumental in the formation of the Pacific Island Mental Health Network (PIMHnet) to provide mental health assistance and expertise within the region. In recognition of his exemplary performance in the office of Director, Dr Chaplow was recently awarded the prestigious Margaret Tobin Award for services to administrative psychiatry.

Dr Chaplow's success lies not only in his experience and dedication, but also in his personal qualities. He possesses ineffable and unmistakable mana, alongside wisdom, pragmatism, humour, accessibility, compassion and a general passion for people and their wellbeing. He has served as an inspiration to all of us who have had the pleasure of working with him, and he will be sorely missed.

We have invited Dr Chaplow to reflect on his experiences as Director of Mental Health in the following pages. I congratulate him on his success and wish him all the best for the future.

Susanna Every-Palmer
Acting Director of Mental Health

Appendix 2: Reflections of a decade past

Dr David Chaplow (Director of Mental Health and Chief Advisor, Mental Health, to the Minister of Health, Ministry of Health 2001–2011)

The post of Director poses demanding, complex challenges and, at the same time, considerable satisfaction. The job description has two components – statutory and advisory – and is set in an 'office' with a total of eight full-time equivalent staff and supported by other teams within the Ministry.[5]

The statutory functions stem from obligations established under various Acts that govern mental health, disorders of alcohol abuse and drug addiction, land transport and drugs used in the treatment of addiction.[6] One of our primary governing statutes is the Mental Health Act [7] which has serviced New Zealand well for almost 20 years (but needs a 'tweak' in a number of areas). It essentially provides for the assessment, treatment and protection of those under its aegis.

The Mental Health Act governs about 70-statutory officers: Directors of Area Mental Health, District Inspectors and members of the Mental Health Review Tribunal. Receiving, reading and responding to reports, providing advice, conducting sector visits, investigating complaints and convening regular meetings with statutory officers are all important and time-intensive. A detailed summary of these and other functions is provided in this Annual Report of the Office of the Director of Mental Health.

The advisory functions of the Director of Mental Health are more informal, quite diverse and necessitate the Director interfacing with other parts of the Ministry, providing information and/or clarifying events and facilitating cross-agency work.[8] The Office of the Director is thus closely involved in service planning, supporting the Minister of Health, conducting investigations, responding to sentinel/adverse events, and contributing to preventative strategies (eg, suicide prevention). Providing support to the community, through the provider arms of DHBs, and to the NGO sector, is another major aspect of the position, which involves responding to complaints, facilitating consumer demands, education and speaking at 'openings' and conferences in support of the Ministry and/or the Minister

Although it is unstated, the position of Director is essentially a leadership position. I have made the observation that when services are failing, functional leadership is often noticeably absent. Conversely, many disparate, poorly supported, underfunded and over-subscribed services often perform adequately in the presence of identifiable leadership. One is tempted to believe that all leadership attributes belong to the character of the individual. Many do. However people are sometimes set up to fail when task goals are unobtainable and titles fail to align with power and authority; that is, when managers have nothing to manage and directors have nothing to direct.

Notwithstanding the above, the common characteristics of the leader include: clarity of vision (ie, what is to be done), moral rectitude (mapping to a determination to succeed), the respect of peers, intellectual and emotional intelligence, psychodynamic self-awareness, an appreciation of systems

5 For example, policy, workforce, service and programme planning.

6 The Misuse of Drugs Act 1975 and the Alcoholism and Drug Addiction Act 1966 are undergoing review.

7 The Mental Health (Compulsory Assessment and Treatment) Act 1992.

8 With the Police, Corrections, Justice, Welfare, Ombudsman's Office, Law Commission, Mental Health Commission, Ministry of Foreign Affairs and Trade and others.

theory, technical competence and an ability to articulate a vision. The importance of leadership to a district, region and nation is that it can achieve long-term sustainability, continuity, advocacy and public confidence.

Looking back, the obvious question is, 'What has been achieved?' Well . . . after a number of restructures, the Office is in good shape with a clear commitment to excel in the area of statutory obligation. The outputs of these changes are now demonstrated in the Annual Report of the Office of the Director. In addition, and among other accomplishments, we have made valuable contributions to law change (together with the Law Commission)[9] and have participated in the New Zealand–funded, Pacific-led, World Health–managed PIMHnet,[10] a network of services to Pacific Island nation governments fostering a mental health framework, legislation and budgetary progress to and within member countries.[11]

Post restructuring, challenges remain in regard to cohesion, communication, ownership and Ministry mental health leadership in the non-statutory general mental health area. In this area, component parts of mental health (such as policy, mental health services and programmes, contracts and workforce) have been redistributed to other directorates. The reconstitution of a functioning gestalt is currently a 'work in progress'.

Looking forward, I emphasise the importance of information flow and the collection and analysis of Key Performance Indicator (KPI) data. Progress in the future will be a measure of how mental health can adapt to changing realities especially in the fiscal area and how services are relevant to the average 'person in the street'. Currently, the challenge of how the primary and secondary services can be linked more effectively and how people can access services more easily are prime considerations. The current government priorities of 'integrated family health centres' and 'Whānau Ora' sit comfortably within the priorities of mental health.

The theme of mental health has always been embodied in the sayings, 'There is no health without mental health' and 'What is the most important thing in all the world? It is people, people, people.'

9 Amendments to the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Misuse of Drugs Act 1975

10 Pacific Island Mental Health Network.

11 Eighteen within the Pacific basin.

Appendix 3: Programme for the Integration of Mental Health Data

The Programme for the Integration of Mental Health Data (PRIMHD) is a Ministry of Health project to create a single collection of national mental health information, integrating the Mental Health Information National Collection (MHINC) with the Mental Health Standard Measures of Assessment and Recovery (MH-SMART) initiative.

District health boards (DHBs) and non-governmental organisations (NGOs), that provide publicly funded secondary mental health and alcohol and drug services are required to electronically send their data on referrals, activities and any outcomes along with other relevant data to the PRIMHD system at the Ministry of Health, using secure information transfer protocols.

Since 1 July 2008 PRIMHD has captured data provided by compliant DHBs and NGOs. In 2010 all DHBs were reporting to PRIMHD. The PRIMHD information includes:

- Mental Health Information National Collection (MHINC) legacy data from 2000–2008
- details of referrals to and discharges from services provided
- outcome collection information
- all service activity
- provider teams
- legal status
- diagnosis and issues classifications
- demographic information (such as sex, date of birth, ethnicity).

Phase 3 of the PRIMHD project commenced in May 2010. It was focused on the continued role out of DHB and NGO reporting, the development of ad hoc reporting capability and the production of standard reports for the sector.

A total of 15 standard reports were developed with key stakeholders, including clinicians. An ad hoc reporting capability was also developed, and is now being actively utilised by the sector for service improvement. The information collated by PRIMHD will enable better service planning and decision-making by stakeholders, improving transparency and accountability throughout the mental health sector.

The Ministry of Health is using PRIMHD data in place of MHINC information for this 2010 Annual Report. These data, reported by DHBs, inform a significant part of this Annual Report, providing data on compulsion, electroconvulsive therapy, suicide and seclusion. Currently the reliability of the PRIMHD data varies across DHBs; however, it is anticipated that in time PRIMHD data collection will be a more accurate reporting tool than the previous manual data collection.

More information on the PRIMHD programme can be found on the Ministry of Health's website http://www.moh.govt.nz/primhd

References

Minister for Disability Issues. 2001. *New Zealand Disability Strategy: Making a world of difference – Whakanui Oranga*. Wellington: Ministry of Health.

Minister of Health. 2000. *New Zealand Health Strategy*. Wellington: Ministry of Health.

Minister of Health. 2005. *Te Tāhuhu – Improving Mental Health 2005–2015: The second New Zealand Mental Health and Addiction Plan*. Wellington: Ministry of Health.

Minister of Health. 2006. T*e Kōkiri: The Mental Health and Addiction Action Plan 2006–2015*. Wellington: Ministry of Health.

Minister of Health and Associate Minister of Health. 2002. *He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health.

Ministry of Health. 2011. *Guidelines for the Role and Function of District Inspectors Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

Ministry of Health. 2008. *Te Puāwaiwhero – The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015*. Wellington. Ministry of Health.

Ministry of Health. 2010. *Mental Health and Addiction Action Plan 2010*. Wellington: Ministry of Health.

New Zealand Law Commission. 2010. *Compulsory Treatment for Substance Dependence: A review of the Alcoholism and Drug Addiction Act 1966 (NZLC R118)*. Wellington: New Zealand Law Commission.

Further Reading

Mental Health Commission. 1998. *Blueprint for Mental Health Services: How things need to be*. Wellington: Mental Health Commission.

Ministry of Health. 1994. *Looking Forward: Strategic directions for the mental health services*. Wellington: Ministry of Health.

Ministry of Health. 1997. *Moving Forward: The National Mental Health Plan for More and Better Services*. Wellington: Ministry of Health.

Ministry of Health. 2010. *Suicide Facts: Deaths and intentional self-harm hospitalisations 2007*. Wellington: Ministry of Health.