Foreword

I am pleased to present the 2005 Annual Report of the Office of the Director of Mental Health. This is the first time an annual report of the activities of the Office of the Director has been published. I anticipate it will be the first of a series of reports that reflect the increasing importance placed on transparency, accountability and trust in government. Mental health care – compulsory care in particular – is often the subject of public concern. It is my hope that this Annual Report will help explain such issues, as well as the Office’s functions.

It also provides statistical records collected and held by the Office.

In compiling the statistics for this report, it was intended to present trend data to put 2005 in a historical context. Regrettably, data reporting to the Ministry over recent years has not been sufficiently reliable or accurate to allow this. I am pleased that there are now more robust reporting procedures in place and we look forward to seeing trend data emerge in subsequent annual reports.

The Office is a small team, but is ably supported by the Mental Health Directorate. Although this report focuses on the Office's statutory functions, many related reportable aspects are driven by the advisory functions of its office holders. Some of these functions are described in the report and augment the key roles of the Office in the mental health sector, the Mental Health Directorate and the Ministry as a whole.

This first report provides the opportunity for a timely salute to previous office-holders since the 1969 Mental Health Act created a Director of Mental Health: Dr Stan Mirams 1969–78, Dr Robert Dickie (Acting) 1979–81, Dr Basil James 1981–90, Dr Thakshan Fernando 1990–93, and Dr Janice Wilson 1993–2001. Further context is provided by a historical account of the development of mental health legislation included in the appendices.

As the incumbent Director, my commitment is to continue the work of my capable predecessors, and to facilitate the further development of the Office. Underpinning this activity is a commitment to improve the quality of mental health services in New Zealand, thereby improving outcomes for all mental health service users. I hope this report provides a valuable insight into the current operations of the Office.

D G Chaplow
Director of Mental Health and Chief Advisor (Mental Health)
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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 of mental health
- report on the activities of the Mental Health Review Tribunal
- contribute to the improvement of standards of care and treatment for persons with a mental illness
- inform mental health service users, their families/whānau, service providers and members of the public about the role, functions and activities of the Office of the Director of Mental Health and Chief Advisor, Mental Health

Structure
This report is split into three sections.

Section 1 provides an overview of the legislative and service delivery contexts in which the Office of the Director of Mental Health (the Office) operates.

Section 2 describes the work that was carried out by the Office in 2005. This includes ongoing functions, as well as special projects that will not be repeated.

Section 3 provides statistical information, which covers the use of compulsion, seclusion or force by services, as well as electroconvulsive therapy (ECT) treatments and reportable deaths.


1 Context

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

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

Section 91 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHCAT Act) provides for the appointment of a Director and Deputy Director of Mental Health. The Director is responsible for the general administration of the Act under the direction of the Minister and Director-General of Health.

The Director of Mental 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 (DAMHS) are employed by and function within the respective District Health Boards (DHBs). They are appointed by the Director-General of Health and must report to the Director every three months on the exercise of their powers, duties and functions.

Under the MHCAT Act the DAMHS appoint responsible clinicians to the care of each and every ‘patient’ (defined in the Act as a person required to undergo assessment or to be subject to compulsory treatment). Responsible clinicians are accountable to the DAMHS for the assessment, treatment and care of patients under their responsibility, within both the inpatient setting and the community.

Part 6 of the MHCAT Act sets out patients’ rights. Essential to the monitoring of these rights are district inspectors – legally qualified mental health ‘ombudsmen’ (see below). The Minister of Health is responsible for appointing district inspectors, who are independent of services and receive and may inquire into complaints by or on behalf of patients, and who are required to regularly inspect services. The Director can also initiate a district inspector-led inquiry into a wide range of issues relating to the care and treatment of patients 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 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 2003).

Role of the Director and Deputy Director under the Act

In fulfilling the statutory responsibilities described, the Director of Mental Health and staff of the Office:

- facilitate the development of guidelines to the Act, issued by the Director-General, pursuant to section 130 of the Act
- facilitate the development and specification of forms relating to section 133A of the Act
- initiate inquiries relating to section 95 of the Act, when indicated
facilitate the appointment and administration of district inspectors
receive and respond to monthly reports from district inspectors
receive, analyse and respond to quarterly reports from DAMHS
facilitate the appointment and administration of the Mental Health Review Tribunal
approve section 52 leave and section 49 transfer of special and restricted patients
facilitate ministerial approval of section 50 leave and reclassification of special and restricted patients
receive notification of a patient’s death pursuant to section 132 of the Act
facilitate removal from New Zealand of certain patients under section 128 of the Act
manage the interface between the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, and the MHCAT Act 1992
apply to the court for a restricted patient order (section 55)
direct that patients be transferred between services
inspect any aspect of a mental health service.

Related functions of the Director of Mental Health and Chief Advisor, Mental Health
In addition to the broad statutory functions described above, the Director and Chief Advisor has a number of further responsibilities, including:

• receiving notification and reports on all reportable deaths and serious incidents in mental health services
• managing enquiries and correspondence from Ministers, Members of Parliament, mental health services, patients, families/whānau and members of the public
• responding to certain select committee inquiries (including those relating to electroconvulsive therapy)
• providing expert advice and consultation to mental health services and other government departments and agencies, such as the Mental Health Commission, Department of Corrections, Police, Ministry of Foreign Affairs and Trade, the Health and Disability Commissioner, coroners, and medical, nursing and psychiatric colleagues
• participating on working parties and committees related to the welfare of persons receiving treatment or care for a mental illness
• facilitating nationwide meetings (eg, of district inspectors, DAMHS, special project groups)
• taking a national leadership role (eg, by visiting services, providing support on official occasions, attending speaking engagements)
• engaging with the media and representing the mental health sector on issues of national interest
• contributing to policy and service development within the Mental Health Directorate, and more widely across the Ministry of Health
• involvement in the International Initiative of Mental Health Leaders
• involvement in the Pacific Mental Health Network
• carrying out responsibilities in respect to parts of other Acts, namely the:
  – Misuse of Drugs Act 1975 (section 24)
  – Alcoholism and Drug Addictions Act 1966
  – Land Transport Act (section 19).

**Staff of the Office of the Director of Mental Health**

The Office of the Director of Mental Health is a small team, whose members work closely with, and 
are heavily reliant on, other sections within the Mental Health Directorate at the Ministry of Health, 
in particular the Rights and Protection team.

During the 2005 calendar year, the staff comprised:

• Dr David Chaplow QSO, MB ChB, FRANZCP; Director of Mental Health and Chief Advisor, Mental Health

• Dr Jeremy Skipworth MB ChB, MMedSci(HONS), FRANZCP; Deputy Director of Mental Health and Senior Advisor, Mental Health

• Dr Frances Hughes, ONZM, RN, BA, MA, DNurs, FANZCMHN

• Dr Gregory Spencer MB ChB; advanced trainee in administrative psychiatry

• Ms Bernadette Sivapatham; personal assistant to the Director and Deputy Director of Mental Health.

Early in 2006 Ms Bernadette Sivapatham resigned after many years at the Ministry, and several 
years working in the Office of the Director. Her knowledge and valuable contribution are 
acknowledged and missed. Ms Penny Ellison was welcomed to the team in March 2006 to take up 
the role of personal assistant to the Director and Deputy Director of Mental Health.

**Budget**

The office’s personnel expenses for the 2005 year were $404,605 (excluding GST), with overhead 
expenses of $162,063 (excluding GST).

**The strategic environment and policy context for mental health service delivery in New Zealand**

**Strategic environment**

Mental health operates within the same broad legislative, organisational, strategic and funding 
frameworks as the rest of health. Things that make mental health different are:

• compulsory treatment

• the Mental Health Commission

• the cross-directorate responsibilities within the Ministry and the sector

• the number of non-government organisations (NGOs) involved in service delivery

• the Blueprint funding stream\(^1\).

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1 See Mental Health Commission 1998.
Strategic directions for mental health sit within the context of both the New Zealand Health Strategy and the New Zealand Disability Strategy. The New Zealand Health Strategy includes improving the health status of people with severe mental illness as one of 13 priorities areas, along with suicide prevention, alcohol harm minimisation and reduction in violence; while the Disability Strategy covers people with a psychiatric disability. Within He Korowai Oranga, the Māori Health Strategy (Minister of Health and Associate Minister of Health 2002), mental health is one of the identified priority areas for Māori.

Agencies

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

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

The NGO sector is a major player in the delivery of mental health and addiction services, with about a third of all funding going to over 400 NGOs. The services range in size from small consumer-run drop-in centres, to multi-million-dollar providers of residential and home-based support. They 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 services.

Mental Health Strategy

The development of the first national Mental Health Strategy (comprising Looking Forward (Ministry of Health 1994), Moving Forward (Ministry of Health 1997), and the Mental Health Commission’s Blueprint for Mental Health Services: How things needs to be (Mental Health Commission 1998) was fundamental to the growth and quality improvement seen in the decade to 2005. Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan (Minister of Health 2005) now joins Looking Forward and Moving Forward, and together with its action plan, Te Kōkiri, will provide the vision and actions needed for growth and quality improvements in mental health for the next decade.

The agenda for action over the next 10 years is set out in the 10 leading challenges contained in Te Tāhuhu, which cover:

- promotion and prevention
- building mental health services
- responsiveness
- workforce and a culture for recovery
- Māori mental health
- primary care
- addiction
- funding mechanisms for recovery
- transparency and trust
- working together.
Te Tāhuhu acknowledges that detailing the actions necessary to tackle these challenges is an exacting task. DHBs and the Ministry of Health have jointly taken responsibility for this in producing Te Kōkiri, an action plan. Progress on the action plan will be reported to Cabinet on a regular basis.

**Funding**

Overall, funding for specialist mental health services has increased from around 7.6 percent to over 10 percent of Vote Health funding (excluding capital contributions) between 1994/95 and 2004/05. Mental health expenditure for 2004/05 was $863 million (excluding GST), including additional funding of $8 million for problem gambling. Funding levels for 2005/06 are estimated at approximately $938 million.

Funding is becoming more equitable around the country, but there are still significant variations in the range, type and quantity of services that are available at the individual DHB level.

**Measuring mental health**

There is a strong focus on improving information use in mental health to achieve better-quality services with improved outcomes, as well as being better able to demonstrate the value of services.

It is difficult to measure mental health objectively, and until recently our rates of mental illness had not been comprehensively measured. New Zealand has recently published an extensive epidemiological survey, *Te Rau Hinengaro* (Oakley Browne et al 2006), as part of a wider World Health Organization initiative. This survey provides internationally comparable information on the rates and severity of illness (including substance disorder) and treatment received among those aged 16 and over living in the community.

Suicide is also sometimes used as an indicator of the mental health of a population. Research shows that mood disorders, which include depression, are a key risk factor for suicide. Although international comparisons are problematic, for the latest data available New Zealand’s all-age suicide rates were sixth highest among OECD countries with comparable data, third highest for 15–24-year-old males and fourth highest for 25–34-year-old males. For the period 1996–2002 Māori rates were higher than non-Māori rates of suicide.

**Service use**

Specialist services are still expanding, with a focus on recovery. This requires increased numbers of people as well as different skill bases within the workforce. Mental health has central funding for workforce initiatives, which supplement regional and local initiatives.

Contrary to common perceptions, most people receive mental health treatment in the community. Around 90 percent of service users access only community services (including residential care) according to the Mental Health Information National Collection (MHINC). The remaining 10 percent of people receive a mixture of community and inpatient services.

Inpatient care is expensive, accounting for 30 percent of the cost of services. A large proportion of the cost of acute inpatient care goes on a small proportion of service users with repeat admissions. Evidence suggests that a number of these admissions could be avoided with better community care, thus reducing cost as well as improving outcomes for service users.
Quality
Since 2001, providers of hospital services and residential services for five or more people have needed to comply with a set of standards in order to gain certification under the Health and Disability Services (Safety) Act 2001. Currently there are four standards approved under the Act:

- Health and Disability Sector Standards (NZS 8134:2001)
- Infection Control Standard (NZS 8142:2001)
- Restraint Minimisation and Safe Practice Standard (NZS 8141:2001)

In July 1995 Standards New Zealand was contracted to undertake a review of these four standards. Early feedback indicated that providers sought the removal of duplication, both within and between standards. It was also felt there needs to be a clearer distinction between standards that relate to all services, such as the National Mental Health Sector Standard, and those more applicable to acute and hospital services, such as the Restraint Minimisation and Safe Practice Standard.

More generally, the strategic focus on improved mental health services is aimed at improving recovery through:

- earlier presentation to services
- more intensive therapies and support
- implementation of guidelines and standards
- regular review and audit of service quality (against standards)
- effective use of the MHCAT Act 1992
- better understanding of and prediction of dangerousness
- improved collaboration between mental health service users, their families and clinicians.

The Mental Health (Compulsory Assessment and Treatment) Act 1992
The Office is responsible for administering the MHCAT Act 1992. Over the years, New Zealand mental health legislation has undergone significant change. Appendix 1 provides a history of legislation from the 1880s to the present, and Appendix 2 discusses the main issues that led to the development of the present Act, and issues that arose following its enactment.

The Act is defined as:

an Act 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.

A guide to the Act (a chapter from the book Mental Health and the Law published by the Wellington Community Law Centre and the Legal Services Agency) is available for reference under Mental Health Guidelines on the Ministry of Health’s website (www.moh.govt.nz).
Other related legislation

Other key legislation of relevance to this report is briefly described below.

Criminal Procedure (Mentally Impaired Persons) Act 2003

The purpose of this Act is to ‘restate the law formerly set out in Part 7 of the Criminal Justice Act 1985 relating to mentally disordered persons who are involved in criminal proceedings, and to make a number of changes to that law’, including changes to:

(a) provide the courts with appropriate options for the detention, assessment, and care of defendants and offenders with an intellectual disability

(b) provide 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

(c) provide for a number of related matters.

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

The purposes of this Act are:

(a) to provide courts with appropriate compulsory care and rehabilitation options for persons who have an intellectual disability and who are charged with, or convicted of, an offence; and

(b) to recognise and safeguard the special rights of individuals subject to this Act; and

(c) to provide for the appropriate use of different levels of care for individuals who, while no longer subject to the criminal justice system, remain subject to this Act.

Land Transport Act 1998

The key areas of relevance from this Act are the provisions concerning drivers’ licences for patients under the MHCAT Act 1992. DAMHS 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. DAMHS 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 DAMHS temporarily where patients are certified fit to drive on leave.

Crimes Act 1961

Section 23 of this Act sets out the conditions that apply to a defence of insanity.

Misuse of Drugs Act 1975

Section 24 of this Act relates to the treatment of people dependent on controlled drugs.

Alcoholism and Drug Addiction Act 1966

The aim of this Act is to consolidate and amend the Reformatory Institutions Act 1909 and to make better provision for the care and treatment of alcoholics and drug addicts.

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2 In the case of Classes 1 and 6 and/or D, F, R, T or W licence endorsements.
3 In the case of Classes 2, 3, 4, 5 and/or P, V, I, or O licence endorsements.
Victims’ Rights Act 2002
Section 37 of this Act concerns notice to be given to registered victims of the discharge, leave or escape, or death of an accused or offender who is compulsorily detained in a hospital.

Legislative context for service delivery

New Zealand Public Health and Disability Act 2000
The aim of this Act is to provide for the public funding and provision of personal health services, public health services and disability support services, and to establish new publicly owned health and disability organisations, in order to pursue the following objectives:

(a) to achieve for New Zealanders—
   (i) the improvement, promotion, and protection of their health
   (ii) the promotion of the inclusion and participation in society and independence of people with disabilities
   (iii) the best care or support for those in need of services

(b) to reduce health disparities by improving the health outcomes of Māori and other population groups

(c) to provide a community voice in matters relating to personal health services, public health services, and disability support services
   (i) by providing for elected board members of DHBs
   (ii) by providing for board meetings and certain committee meetings to be open to the public
   (iii) by providing for consultation on strategic planning

(d) to facilitate access to, and the dissemination of information to deliver, appropriate, effective, and timely health services, public health services and programmes, both for the protection and the promotion of public health, and disability support services.

Health and Disability Services (Safety) Act 2001
The purpose of this Act is to:

(a) promote the safe provision of health and disability services to the public

(b) enable the establishment of consistent and reasonable standards for providing health and disability services to the public safely

(c) encourage providers of health and disability services to take responsibility for providing those services to the public safely

(d) encourage providers of health and disability services to the public to improve continuously the quality of those services.
2 Activities for 2005

This section describes the work of the Office in fulfilling its statutory and other functions, and reports on the special projects carried out by the Office during the year. The Office is assisted by other staff members of the Mental Health Directorate, in particular the Rights and Protection team, in carrying out this work.

Bedding in new legislation

The introduction of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the ID(CCR) Act) and the Criminal Procedure (Mentally Impaired Persons) Act 2003 (the CM(MIP) Act) in September 2004 led to significant procedural and service changes for both intellectually disabled and mentally ill persons who are charged with, or convicted of, offending.

The Disability Services Directorate of the Ministry of Health is responsible for administering the ID(CCR) Act 2003, including establishing the systems and framework for the operation of the Act. However, the close relationship between forensic mental health services and the new services for intellectually disabled persons have required frequent cross-directorate consultation on the many issues of common interest. An example of this work includes Office of the Director membership on the ID(CCR) Act Moderation Panel, to assist in the resolution of some difficult cases and issues.

The interrelationship between the ID(CCR) Act 2003 and the CP(MIP) Act 2003, and the pathways followed after arrest, are depicted in Figure A.2 (see Appendix 3). Further information and relevant publications can be accessed on the Ministry of Health website at: www.moh.govt.nz/disability.

Best practice guidelines for judicial review under section 16

Section 16 of the MHCAT Act allows a patient to apply for a judicial review of their condition prior to the determination of a compulsory treatment order. The hearing is conducted in an inquisitorial fashion. As Judge Adams stated in *L v Director of Mental Health Services* [1999] NZFLR 949, at p954:

> The procedure provided under s 16 is a safety valve to ensure that the right of the patient to liberty is not curtailed for medical or other reasons which would not meet the criteria and scheme in the Act.

The patient must satisfy the Judge that he or she is fit to be discharged.

Following the tragic death of Paul Ellis in 2001, the Ministry initiated a section 95 inquiry into the adequacy and timeliness of services provided to him and his family by the South Auckland Mental Health Services. The inquiry included an investigation into the scheduling of, involvement of family members in, and information required for the section 16 review hearing, and the presentation of opinion and evidence at that hearing.

The inquiry was conducted by Helen Cull QC, and the findings were released in October 2003. During 2004 the Office of the Director facilitated a forum to review section 16 hearings, and in early 2005 promulgated best practice guidelines prepared by Principal Family Court Judge Boshier (attached in Appendix 4). The review also highlighted the importance of the role of the second health professional, which led to the development of a clinical report form for this purpose.
Electroconvulsive therapy

Section 60 of the MHCAT Act provides for electroconvulsive therapy (ECT). No patient can be required to accept ECT for mental disorder unless they consent to it, or the treatment is considered to be in the interests of the patient by a psychiatrist (not being the responsible clinician) who has been appointed for these purposes by the Mental Health Review Tribunal (see below).

In 2003 the Government responded to a Health Committee report on a petition to ban ECT. The Committee called for a major review of the safety, efficacy and regulatory controls of ECT. This review was undertaken by a team led by Professor Craig Anderson, whose report is available on the Ministry of Health website. In summary, the review found ECT to be an effective short-term treatment for severe depressive illness, and certain other forms of serious and potentially life-threatening mental illnesses. The review team rejected the notion that ECT should be banned in New Zealand, but recommended changes to the law and guidelines relating to ECT to ensure greater emphasis on obtaining informed consent (Ministry of Health, 2004).

The recommendation for changes to mental health legislation has a number of wider implications, which are the subject of ongoing consideration and research. In the meantime, the Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health, 2000) have been amended to clarify the importance of considering competence when assessing whether ECT is in the interests of the patient. The amendment to the guideline was issued by the Director-General of Health on 17 February 2006.

A further recommendation was that the Ministry of Health produce an annual report showing the total number of patients who receive ECT and the number of patients who are treated with ECT under compulsion. The Ministry of Health published the first annual report of ECT statistics in 2006. This report covers both the 2003/04 reporting period and the 2004/05 reporting period (Ministry of Health 2006). A summary of these statistics is provided in section 3 of this report.

Directors of area mental health services

Under section 92 of the MHCAT Act, DAMHS are required to report quarterly to the Director. In 2005 the Office instituted standardised reporting formats. These reports now include the provision of statistical information that was previously provided to the Office independently, as well as some new statistical information on the use of seclusion.

The Office follows up on issues raised by these reports, and during the year directed special effort to ensure that the statistics were complete and accurate.

The Office also facilitates quarterly meetings of the DAMHS, which provide a forum for addressing current issues.

District inspectors

The Office’s responsibilities include:

• co-ordinating the appointment and reappointment of district inspectors by the Minister of Health
• managing their remuneration
• receiving and, where appropriate, responding to monthly reports
• facilitating twice yearly meetings of district inspectors
• setting up section 95 inquiries
• implementing the results of section 95 inquiries.

Reporting by district inspectors
District inspectors (and deputies) are required to report regularly to DAMHS on their visits to mental health services. They are also required to report monthly to the Director on the exercise of their powers, duties and functions. These reports provide the Director with support for the approval of invoices for service, and an overview of mental health services and problems with services. In the current reporting year, district inspectors have continued to provide valuable feedback on services.

Section 95 reports completed by 31 December 2005
The Director will occasionally (under section 95 of the Act) require an inquiry to be undertaken by a district inspector. These inquiries typically involve an audit process for implementing the recommendations that flow from the inquiry.

During 2005 there were two section 95 inquiries in progress, both of which were completed in 2006. An important finding resulting from one of these inquiries was that of Judge Hansen, in Walsh v Shortland and Chaplow (unreported, High Court Hamilton, CIV 2003-419-861), which clarified the proper extent of the jurisdiction of section 95 inquiries, such that, in certain circumstances, they may extend to periods of time when the person was not under the Act.

Number of district inspectors at 31 December 2005
There are 28 district inspectors appointed to regions throughout New Zealand, and one senior advisory district inspector, whose appointment spans these regions. There are also six deputy district inspectors, whose duties are essentially the same as those of the district inspectors, but they are assigned their work via district inspectors in their region, or via the Director of Mental Health. A list of current district inspectors and deputy district inspectors is available on the Ministry of Health website: www.moh.govt.nz.

Appointment round
The main appointment round for district inspectors took place during 2005. District inspectors are appointed for a three-year term. Deputy district inspectors can be appointed for any time period up to three years. The ministerial appointments of district inspectors follow a comprehensive advertising programme, interviews in several parts of the country, reference checking, and briefing recommendations to the Minister.

In the year from 1 January 2005 to 31 December 2005, 23 district inspectors (including the senior advisory position) were appointed. Twenty of these had previously been appointed as district inspectors, and three were new appointees. Three deputy district inspectors were also appointed; all were new appointees. Another district inspector and a deputy district inspector were reappointed.

Budget
The total cost of district inspectors for the 2005 year was $1,181,911 (excluding GST).
New forms for committal processes

The requirement for a variety of new forms to record findings in relation to the MHCAT Act came from several sources, including:

- an awareness of inconsistency in clinical report forms following the section 7A review (see ‘Special projects’, below)
- the introduction of the ID(CCR) Act, and the CP(MIP) Act in late 2004
- issues raised in relation to the role of second health professionals in mental health hearings.

These forms have now all been drafted, reviewed, and promulgated.

Reportable deaths

Section 132 of the MHCAT Act requires notification to the Director within 14 days of any death of a patient or special patient under the Act, and the apparent cause of death. Section 31(5)(c) of the Health and Disability Services (Safety) Act 2001 requires that:

... a person certified to provide health care services of any kind must promptly give the Director-General written notice of any death of a person to whom the person was providing the services, or occurring in any premises in which they were provided, that is required to be reported to a coroner under the Coroners Act 1988.

This means that deaths of other patients resident in certified facilities in receipt of mental health services must be reported to the Director-General if a coronial inquiry is undertaken. On receipt of notification, the Director reviews the information and may seek further clarification from the service.

There is considerable variation in the reliability of reporting among services. Starting in 2005, the Office has attempted to clarify reporting obligations to enhance compliance and the reliability of the data collected. The Office has also distributed guidelines clarifying the reporting requirements to all area mental health services. The Director has asked for the following information relating to reportable deaths:

- name
- gender
- ethnicity
- date of birth
- National Health Index (NHI) number
- incident date
- incident category, including legal status
- date of last contact with the service
- diagnoses
- a description of the issues raised by the incident.

If the circumstances surrounding a death cause concern, DHBs may initiate an inquiry. The Director can also initiate an investigation under section 95 of the 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 enquiry, including timeframes, and, when available, it is expected that the enquiry findings will be forwarded to the Ministry of Health.
The Director is concerned to ensure that recommendations flowing from inquiry processes are implemented, and follows up on these issues with DAMHS. Recommendations from inquiries of national significance are disseminated through the Office of the Director.

See section 3 for statistics on reportable deaths.

Special patients and restricted patients

Special patients and restricted patients are covered by part IV of the MHCAT Act. They include several distinct categories:

- persons charged with, or convicted of, a criminal offence and remanded to a secure hospital for a psychiatric report, usually involving relatively brief admissions (sections 23, 35, 38, 44 CP(MIP)Act)
- remanded or sentenced prisoners transferred from prison to a secure hospital, either as informal admissions (section 46 of the Act) or as compulsory admissions (section 45 of the Act)
- defendants found not guilty by reason of insanity (section 24(2)(a) CP(MIP)Act)
- defendants unfit to stand trial (section 24(2)(a) CP(MIP)Act)
- persons who have been convicted of a criminal offence and both sentenced to a term of imprisonment and placed under a compulsory treatment order (section 34(1)(a)(i) CP(MIP)Act)
- people designated as restricted patients, because of special difficulties they present as a result of the danger they pose to others (section 55 of the Act). These patients are civilly committed, but are managed in a similar fashion to special patients.

The Director has a central role in the management of special patients and restricted patients. The Director may direct transfer (section 49), 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 when requests for leave or reclassification are made. The Director must also be notified of the admission, discharge, transfer and certain incidents involving special and restricted patients (section 43).

The process for reclassifying special and restricted patients differs depending on the patient’s particular status, but usually requires ministerial involvement.

The following section 50 long leave applications, revocations or change of status applications were processed by the Office of the Director during the year 2005 (see Table 1). All section 50 leave applications were approved by the Minister. Ten of the eleven applications for a change of legal status for special patients acquitted due to insanity were granted; four of the five applications for a change of legal status for special patients unfit to stand trial resulted in a change of status.
Table 1: Long leave and reclassification requests for special and restricted patients, 2005

<table>
<thead>
<tr>
<th>Type of request</th>
<th>Acquitted due to insanity</th>
<th>Unfit to stand trial</th>
<th>Restricted patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial ministerial s. 50 leave applications</td>
<td>9</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Ministerial s. 50 leave revocations</td>
<td>0</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Ministerial s. 50 leave applications (following prior revocation)</td>
<td>2</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Ministerial s. 50 leave extensions</td>
<td>23</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Change of legal status applications</td>
<td>11</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Change of legal status applications approved</td>
<td>10</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

See section 3 for the numbers of special patients and restricted patients.

**Mental Health Review Tribunal**

The Tribunal comprises three persons appointed by the Minister:

- a barrister or solicitor, who is traditionally the convener
- a psychiatrist
- a community member.

A number of deputy members are also appointed because of the volume of work involved.

The Office’s responsibilities include:

- co-ordinating the appointment and reappointment of members of the Tribunal by the Minister of Health and Cabinet
- managing their remuneration
- providing advice on psychiatrists’ suitability to provide second opinions
- processing recommendations requiring ministerial approval
- contracting with a provider of secretariat services to the Tribunal
- facilitating twice yearly meetings of members.

The principal function of the Tribunal is to consider the condition of a patient who has applied for a review, or in respect of whom an application for a review has been made, under sections 79, 80 and 81.

The Tribunal also appoints psychiatrists who determine (by way of a second opinion) whether treatment is in the interests of patients who are either not capable of consenting to treatment or who refuse to consent to that treatment (sections 59 and 60). Although almost never used, the Tribunal is also responsible for considering consent issues relating to brain surgery (section 61), and appoints psychiatrists to give opinions in that regard. The MHCAT Act also confers a number of rights on patients, and complaints regarding breaches of these rights can be referred to the Tribunal for investigation.

In discharging its principal function, the Tribunal considers whether or not a committed patient under the Act is fit to be released from compulsory status. Every person subject to the Act must have his or her condition reviewed at least every six months (sections 76, 77 and 78). If a patient...
disagrees with their responsible clinician’s decision that they are not fit to be released from compulsory status, the patient may apply to the Tribunal for a review of his or her condition. The patient may withdraw this application at any point of the proceedings.

The determination of whether a patient is fit to be released from compulsory status basically involves deciding whether the patient remains mentally disordered. So, if the patient remains mentally disordered, he or she is thereby not fit to be released. If the patient is no longer mentally disordered, he or she is thereby fit to be released. In the case of patients and restricted patients, the Tribunal's decision is determinative. In the case of special patients, the Tribunal's decision is a recommendation, with the final determination resting with the Minister.

In 2005 133 section 79 applications were received by the Tribunal, and 55 of these were withdrawn. Of the remaining 78 applications determined by the Tribunal, the Tribunal certified five (6.4 percent) were fit to be released from compulsory status and 73 (93.6 percent) were not fit to be released from compulsory status.

Of the two special patients whose cases were reviewed in the reporting period, one recommendation for a change in status was made. One restricted patient whose application was determined in the reporting period was not released.

Members, retirements and appointments
The current convener of the Tribunal is Mr Nigel Dunlop, a Christchurch barrister. The psychiatrist member is Dr Nick Judson, and the community member is Ms Helen Walch. There are currently 11 deputy members of the Tribunal.

Secretariat
The Ministry of Health has contracted with the Wellington law firm of D'Ath Partners to be the Tribunal's secretariat. The secretariat processes applications and sets up the hearings. The latter involves liaising with Tribunal members, hospitals, doctors and lawyers, and making the travel arrangements for Tribunal members. The Tribunal's Secretary is Mrs Susan D'Ath.

Budget
The Mental Health Review Tribunal total cost for the 2005 year was $410,831 (excluding GST).

Approvals for the supply of controlled drugs
Under section 24(7)(a) of the Misuse of Drugs Act 1975, the Minister of Health may, by publication of a notice in the Gazette, specify any medical practitioner as being able to prescribe, administer, or supply controlled drugs for the treatment of dependence. The Minister also has the power to specify, in the Gazette, a hospital care institution, clinic or other place where a specified medical practitioner works, as a place at which controlled drugs may be prescribed, administered or supplied, under section 24(7)(b). These powers have been delegated by the Minister to the Director of Mental Health.

During 2005 the following gazette notices were processed under the Misuse of Drugs Act: medical practitioners (six), services (one), declined applications (one), and revocation of medical practitioners (two).
Approval of assessment centres under the Land Transport Act 1999

Sections 56 to 62 of the Land Transport Act set out the offences that may be committed by persons driving, or attempting to drive, motor vehicles while under the influence of alcohol or drugs. If a Court convicts a person of one of these offences, and that person has been similarly convicted twice within the preceding five years, the Court must make an order under section 65 of the Land Transport Act. The Court can also make an order in relation to persons twice convicted of certain offences. A Court order issued under section 65 of the Act must disqualify a person from holding or obtaining a driver's licence, and must require him or her to attend an assessment centre.

The Director of Land Transport may make an order removing the disqualification imposed after the mandatory disqualification period, under section 100 of the Land Transport Act, if Land Transport New Zealand receives a favourable assessment from an assessment centre. The Act defines ‘assessment centre’ as an establishment approved for the purposes of the Act by the Chief Executive of the Ministry of Health. The Office is responsible for administering the process by which assessment centres are approved by the Chief Executive.

During the period 1 January 2005 to 1 January 2006, the following approvals were determined under section 65 of the Land Transport Act: assessors (13), medical practitioners (12), services (six), and revocations (one, an assessor).

Special projects

In addition to the work relating to its statutory and other functions, the Office undertook a number of special projects in 2005.

Consultation with family/whānau

Before the 1999 amendment to the MHCAT Act, clinicians were required at certain stages of the compulsory assessment and treatment process to send a patient's principal caregivers and guardians copies of certain documents (eg, the section 10 certificate of preliminary assessment and section 14(4) application for compulsory treatment order), but they were not required to 'consult' with caregivers and guardians.

The 1999 amendment introduced section 7A and made consultation with family/whānau compulsory during both the assessment and treatment of patients (or proposed patients) under the Act, in addition to the pre-existing requirements. Section 7A states that consultation with a patient's (or proposed patient's) family/whānau must take place during the patient's assessment and treatment unless it is not reasonably practicable to do so, or it is not in the patient's best interests.

The lack of consultation with families/whānau or principal caregivers featured as a perennial issue in inquiries in the mental health sector before the 1999 amendment (eg, Mason et al 1996). This concern has continued to be raised since the amendment.

In 2002 a parliamentary petition (2002/17) requested that the Act be amended to extend the circumstances where indefinite orders apply. In 2003 a private member's Bill was proposed: the Mental Health (Compulsory Assessment and Treatment – Family Involvement in Assessment and Release) Amendment Bill. The Health Select Committee, which considered the parliamentary petition, recommended that the Ministry of Health review the application of section 7A to
determine whether it had increased consultation with family/whānau. The review that resulted from this recommendation included:

- a review of the literature and legislation from comparable jurisdictions
- an audit of clinical files
- a survey of responsible clinicians
- a description of the experiences and views of interested groups and individuals
- a review of section 7A’s application, particularly in relation to consultation with principal caregivers
- a review of the Ministry-published guidelines to ensure they included adequate information about the principal caregiver’s role and the information to be provided to caregivers.

The broad consensus was that section 7A allows for adequate consultation. The involvement of family/whānau extends beyond any legislative demands, being a part of best clinical practice. Therefore, the Ministry of Health’s recommendations, rather than concentrating on legislative change, focused on developing a wider culture of family/whānau consultation that takes into account the circumstances of the clinical situation and an individual’s rights.

As a result, section 7A of the Act was not amended. However, the guidelines were revised to:

- further define ‘consultation’, ‘reasonably practicable’ and ‘best interests’
- provide practical examples of the defined terms
- address consultation for assessments late at night or after hours
- address consultation by people other than the responsible clinician
- clarify when consultation should occur, including consultation at the section 12 stage
- discuss the different mechanisms for consultation (eg, in person or by phone)
- discuss family/whānau attendance at court hearings
- include the principal caregiver as a family/whānau member
- address guardianship and principal caregiver issues.

Other resources (eg, guidance notes, see RANZCP 2000) were made available to responsible clinicians, and the opportunity to attend a Mental Health Workforce Development Programme workshop on involving family/whānau in Mental Health Act processes was facilitated. Ways of giving clinicians more training and better access to resources about the Act (particularly clinicians arriving from overseas) and being appointed as responsible clinicians are being promoted. A new clinical report form developed during this process is now used consistently throughout the country, and should facilitate consistency of practice.


Pacific Island Mental Health Network

The Director and staff have a key role in the Pacific Island Mental Health Network (PIMHnet). This network currently involves 12 Pacific Island countries, including Australia and New Zealand, with a view to eventually incorporating 21 countries. The Office was instrumental in establishing this network through presentations to key New Zealand agencies and also through a WHO meeting in Tonga with eight other countries in August 2005. The network is led by the WHO office in Manila.
The overall objectives of this network are to improve the treatment and care of mental health service users in the Pacific Islands by:

- the promotion and improvement of mental health through advocacy activities
- promoting comprehensive mental health policy and legislation
- enhancing the care and services available
- building sustainability, capacity and capability, both within a country and within the region
- establishing regional co-operation.

The priority areas identified by countries within the network are:

- advocacy for mental health within the region and within Pacific Island countries
- human resources and training
- strategy, policy, legislation, planning and service development
- research and information
- access to drug and alcohol assessment and treatment.

This network enables Pacific Island countries to work together and with strategic partners in a co-operative and co-ordinated fashion on a range of initiatives centred on mental health. In broad terms, PIMHNet brings together countries that share geographic, social, cultural and/or other relationships and are experiencing similar difficulties or issues. By coming together, network countries are able to draw on their collective experiences, knowledge, resources and efforts. Existing relationships, arrangements and proximity make countries located in the southern Pacific area ideally suited to such a process.

The Office of the Director of Mental Health gained a successful bid from the Official Development Assistance Vote of the New Zealand Agency for International Development for $1.5 million to support the establishment and ongoing operation of the network for three years.

**Review of outcomes for special patients**

The Law Commission has indicated its intention to review section 23 of the Crimes Act 1961, which relates to insanity. Given the potential for legislative reform, the Office undertook to examine the outcomes for special patients found not guilty by reason of insanity over the last three decades.

In New Zealand, defendants found not guilty by reason of insanity may be disposed of by the court as special patients, whereby they are treated, rehabilitated and monitored by forensic mental health services. Special patients have a high degree of administrative structure overseeing their care, and can not be discharged or reclassified without ministerial assent. Leave from hospital requires approval from the Director of Mental Health.

All the records of insanity acquittees disposed of by the courts as special patients after 1976 and released before 2004 were analysed. Their duration of inpatient care, and rates of reconviction and rehospitalisation following release, were examined. The high resolution rate for violent crime reported to police suggests that reconviction rates are a reasonable proxy for violent reoffending. Factors predicting the duration of inpatient care and reoffending were also analysed.

Of note, the severity of the index offence was the only variable predicting duration of inpatient care of the 135 special patients examined. Offenders of more serious offences were securely detained for longer periods, averaging six years in the case of those charged with murder.
Figure 1 shows that most patients were readmitted over the decade following discharge.

**Figure 1: Cumulative non-readmission rate of insanity acquittees following release**

Only 6 percent had violently reoffended two years after release into the community, although many more patients were convicted of other offences (see Figure 2). Reoffending was predicted by prior offending, age at release, ethnicity and gender, but not by diagnosis or duration of inpatient admission.

**Figure 2: Cumulative non-reconviction rate of insanity acquittees following release**

It can be seen that following discharge into the community, insanity acquittees are reconvicted of violent crimes at a very low rate, although readmission to hospital is common. It may be that insanity acquittees are initially detained in hospital longer than is clinically indicated, and that safe forensic community treatment can occur at an earlier stage of recovery without compromising public safety. This study will be published in the *Australian and New Zealand Journal of Psychiatry* (in press).
3 Statistics

Introduction

Although the Director is not responsible for clinical or committal processes relating to individual patients, the Office collects consolidated information as a way to monitor how individual DHBs are functioning in relation to the Act and to promote best practice. There are also a number of areas that attract public debate, including seclusion and ECT.

The aim of this section of the report is to provide information that will help to both improve service quality and inform public debate. Statistics are provided, or are intended to be provided in future, for the following areas:

- compulsory assessment and treatment under the Act
- special patients
- reportable deaths
- use of seclusion
- use of force
- use of ECT.

Data sources

Data on these areas is collected in a variety of ways (see Appendix 5 for a fuller description of the various data sources). However, there have been problems with the quality of data and/or the ability to extract information from the data with many of these collections. Each section specifies the source of data used, and any actions being taken to improve the data collection.

Compulsory assessment and application for compulsory treatment orders

Information in the following two subsections is sourced from data in the quarterly reports from DAHMS. Although data has been collected for a number of years, the Office has concerns about the quality or completeness of past years’ data. For this reason, data is shown only for 2005. Trend information will be available in future reports.

The information is presented by DHB, using populations for individual DHBs. Note that differences between DHBs can arise for a variety of reasons, such as differences in the nature of the populations, service coverage or clinical practice.

The first assessment period under section 11 of the Mental Health Act is for up to five days. It can then be extended during the second period (section 13) for up to a further 14 days. If a further extension to the period of assessment is required, an application to the court is made for a compulsory treatment order (section 14(4)). The number of these in each region is recorded and sent to the Office of the Director on a monthly basis.

Rarely, patients will be assessed on more than one occasion in a month. More commonly, some patients will receive certificates in relation to more than one section of the Act in a month. Both these factors complicate analysis. It is also apparent that the data does not easily allow calculation of the duration of compulsory assessment, because certificates are often completed before the expiry of the maximum period allowed.
Figure 3: Average rate of compulsory assessment and treatment per month, per 100,000 population, by MHCAT Act section and DHB, 2005

Table 2: Average rate of compulsory assessment and treatment per month, per 100,000 population, by MHCAT Act section and DHB, 2005

<table>
<thead>
<tr>
<th>DHB</th>
<th>S11</th>
<th>S13</th>
<th>S14(4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>11</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>10</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Canterbury</td>
<td>11</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Capital and Coast</td>
<td>11</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>10</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>12</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Hutt</td>
<td>10</td>
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<td>5</td>
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<td>Lakes</td>
<td>8</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>MidCentral</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Nelson Marlborough</td>
<td>9</td>
<td>7</td>
<td>4</td>
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<tr>
<td>Northland</td>
<td>11</td>
<td>10</td>
<td>6</td>
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<tr>
<td>Otago</td>
<td>14</td>
<td>10</td>
<td>7</td>
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<tr>
<td>South Canterbury</td>
<td>12</td>
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<td>Southland</td>
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<td>Tairawhiti</td>
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<td>Taranaki</td>
<td>19</td>
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</tr>
<tr>
<td>Waikato</td>
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<td>12</td>
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<td>Wairarapa</td>
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<td>2</td>
<td>1</td>
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<td>8</td>
<td>7</td>
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</tr>
<tr>
<td>West Coast</td>
<td>13</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Whanganui</td>
<td>15</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>National Average</td>
<td>11</td>
<td>9</td>
<td>5</td>
</tr>
</tbody>
</table>
Nationally, for every 100,000 people there are 11 committals under the first five-day period of assessment each month; 82 percent of the initial assessments progress to the second assessment period, but only 45 percent of the initial assessments progress beyond the second assessment period.

Patients can have their compulsory status reviewed by a Family or District Court judge during the assessment period under section 16 of the Act. Following application, a judge must examine the patient as soon as practicable, consult with the responsible clinician and at least one other health professional involved in the case, and may consult with such other persons as the judge thinks fit concerning the patient’s condition. The examination typically occurs within a week of application. 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 the 2005 year there were approximately 950 section 16 applications, 310 of which were subsequently withdrawn. The remaining 640 hearings resulted in an order for release of the patient from compulsory status in approximately 44 cases (6.9 percent).

**Compulsory treatment orders**

Ministry of Justice statistics for MHCAT Act hearings in respect of compulsory treatment order hearings are available from 2004 onwards. Previous years are not available because of a change in systems in 2003. Table 3 presents data for 2004 and 2005 regarding applications for a compulsory treatment order. Table 4 depicts the types of orders granted over the same time period.

**Table 3:** Numbers and outcomes of applications for compulsory treatment orders 2004–2005

<table>
<thead>
<tr>
<th>Year</th>
<th>Applications for a CTO, or extension to a CTO</th>
<th>Applications granted</th>
<th>Applications dismissed</th>
<th>Applications withdrawn</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>4404</td>
<td>3848 (87.4%)</td>
<td>97 (2.2%)</td>
<td>459 (10.4%)</td>
</tr>
<tr>
<td>2005</td>
<td>4231</td>
<td>3635 (85.9%)</td>
<td>97 (2.3%)</td>
<td>499 (11.8%)</td>
</tr>
</tbody>
</table>

**Table 4:** Outcomes of applications for granted compulsory treatment orders 2004–2005

<table>
<thead>
<tr>
<th>Year</th>
<th>Applications granted</th>
<th>Compulsory community treatment order</th>
<th>Compulsory inpatient treatment order</th>
<th>Type of order not recorded in system</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>3848</td>
<td>1855 (48.2%)</td>
<td>1611 (41.9%)</td>
<td>382 (9.9%)</td>
</tr>
<tr>
<td>2005</td>
<td>3635</td>
<td>1606 (44.2%)</td>
<td>1472 (40.5%)</td>
<td>557 (15.3%)</td>
</tr>
</tbody>
</table>

As can be seen in tables 3 and 4, during the 2005 calendar year, 4231 applications for a compulsory treatment order or extension to a compulsory treatment order were resolved in the Family Court: 3635 of these applications were granted, 97 were dismissed and 499 were withdrawn. Of the 3635 applications granted, a resulting compulsory community treatment order has been recorded on 1606 of these, and a compulsory inpatient treatment order on a further 1472 applications. The remaining 557 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 (see sections 27 and 28). The number of compulsory treatment orders at month’s end is recorded and sent to the office of the Director. In 2005, at any given time, 60 persons per 100,000 population were detained under a compulsory community treatment order (section 29), 17 under a compulsory inpatient treatment order (section 30), and five under a compulsory inpatient treatment order but on leave (section 31).
Figure 4: Average rate of compulsory treatment orders, per month, per 100,000 population, by MHCAT Act section and DHB, 2005

Table 5: Average rate of compulsory treatment orders, per month, per 100,000 population, by MHCAT section and DHB, 2005

<table>
<thead>
<tr>
<th>DHB</th>
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<td>3</td>
</tr>
<tr>
<td>West Coast</td>
<td>46</td>
<td>20</td>
<td>14</td>
</tr>
<tr>
<td>Whanganui</td>
<td>108</td>
<td>59</td>
<td>7</td>
</tr>
<tr>
<td>National Average</td>
<td>60</td>
<td>17</td>
<td>5</td>
</tr>
</tbody>
</table>
Special and restricted patients

Table 6 was compiled from a census of special and restricted patients carried out in 2005.

Table 6: Census of special and restricted patients, whether inpatient or outpatient, as at October 2005

<table>
<thead>
<tr>
<th>Special patient category</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unfit to stand trial</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Insanity acquittees</td>
<td>48</td>
<td>29</td>
<td>77</td>
</tr>
<tr>
<td>s. 34(1)(a)(i): those convicted to a term of imprisonment concurrent with a compulsory treatment order</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>s. 45 prison transfers</td>
<td>17</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>s. 46 informal prison transfers</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Court ordered remandees</td>
<td>13</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>s. 55 restricted patients</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>87</td>
<td>33</td>
<td>120</td>
</tr>
</tbody>
</table>

As at October 2005, of the 90 special and restricted patients entitled to leave (excluding the 17 prison transfers and 13 remandees), 33 (or just over a third) were being managed largely in the community, either on section 50 leave or section 52 leave, with relatively brief admissions to hospital each week. During 2005 there were three new special patients acquitted by reason of insanity, and five new special patients unfit to stand trial. Over the same time period, 10 special patients in these categories were reclassified (see section 2 for reclassification statistics).

Total number of people under compulsory assessment and treatment

The number of patients under compulsory treatment at any time – whether in the assessment process, under a court order or as special or restricted patients – cannot be determined from these statistics. Because the assessment and treatment statistics are aggregated figures for the period of a month, and individuals may be counted more than once, it is not possible to derive a precise figure for the numbers of people under assessment at any point in time. The Office estimates that in New Zealand, at any point in time in 2005, around 4000 people were subject to compulsory assessment and/or treatment, of whom one-third were detained in hospital, and two-thirds were in the community. This represents approximately 10 percent of all adult mental health service users.

Seclusion

Seclusion is provided for in section 71 of the 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 DAMHS, and can be used only with the authority of the responsible clinician. The duration and circumstances of each episode of seclusion must be recorded in a register, which must be available for inspection by district inspectors. Further guidance is provided in the Restraint Minimisation and Safe Practice Standard (2001).
Because of its intrusive nature, and the potential for misuse, there is an increasing focus on the use of seclusion both nationally and internationally. The Ministry has committed to reducing the use of seclusion in mental health services, and to having facilitated workshops with the Mental Health Commission on developing skills that enable alternative approaches to be utilised. More attention is also being given to the collection and analysis of seclusion data. A new recording template has been developed, and will start to be utilised in 2006. This will facilitate annual reporting of seclusion data in this report.

**Use of force**

Section 122B of the Act prescribes the circumstances under which reasonable force may be used in the exercise of certain powers under the Act. If force has been used under this section, the circumstances must be recorded and the record provided to the DAMHS. The Office is intending to publish statistics in the future.

**Electroconvulsive therapy**

Electroconvulsive therapy (ECT) is a valuable and sometimes life-saving treatment procedure, despite the sometimes negative depictions of it in popular culture and the media. ECT is most commonly administered for the treatment of severe depression, but can also be used for other types of serious mental illness, such as mania, schizophrenia, catatonia and other neuropsychiatric conditions. It is most often prescribed as part of a treatment plan in combination with other therapies. It can be administered as an acute course (a number of consecutive treatments) or as a continuation or maintenance treatment after the acute phase of an illness.

Government’s response to the Health Select Committee report included agreement to produce annual reports on the provision of ECT. The first report covered the 2003/04 financial year.

In the 2004/05 financial year 307 patients received ECT, of whom 84 (22 percent) were under the MHCAT Act at some point during the course of their treatment. Overall, 77 percent of the treatments given were consented to, and the remaining 23 percent of treatments were given to patients who were either incapable of consenting or refused to consent. No patients were treated against their competent wishes. This information is sourced from annual census data collected from DHBs.

Full details can be found in the report *Electroconvulsive Therapy Annual Statistics: For the period 1 July 2003 to 30 June 2005* (Ministry of Health 2006).

**Reportable deaths**

During 2005, there were 23 deaths recorded for people under the MHCAT Act, of which six were suspected suicides.

Between 1 January 2005 and 31 December 2005, the deaths of 100 individuals (65 percent male, 35 percent female) were reported to the Director, of whom 66 percent were suspected to be suicide. This includes the deaths of the 23 patients under the Act noted above.
Appendix 1: Historical perspectives on compulsory treatment in New Zealand

From the earliest days of mental health legislation in New Zealand (around 1880), there has been a view that there are occasions when people with mental disorder (however that might be defined) will need treatment without their consent. However, the proper extent of the use of detention and compulsory treatment remains controversial. The central dilemma posed in drafting the 1992 Act encapsulates the issue well: ‘In what circumstances should a civilised society insist on treating a mentally disordered citizen who is incapable of giving consent, or worse still, is capable of giving consent but refuses to do so?’

New Zealand’s early mental health policy was built on three foundational policies:
- institutional care
- state provision
- functional and administrative separatism (Dalley and Tennant 2004).

To a large extent, those policies have shaped the development of mental health policy until relatively recently. However, mental health legislation operates within a broader social, cultural and political environment. It is influenced by a wide range of factors, such as international trends, domestic legislation, human rights, cultural considerations, and the prevailing medical understanding of diagnostic and treatability issues.

It is often said that it is impossible to legislate for good practice. However, new legislation can set minimum standards for good practice, and can establish key principles such as:
- the provision of treatment in the best interests of the patient and in the least restrictive environment
- ensuring services maximise patient autonomy while minimising the risk of harm to the patient and/or others
- wherever patient liberty is restricted, legislation can provide appropriate protections and safeguards for the patient.

Social and political factors form an important part of the complex environment in which mental health legislation is developed and implemented. The experience and interests of people with mental illness must not be lost in the debate, though these are not the only relevant interests. Members of Parliament have the interests of their constituencies to consider, health professionals may be wary of the influence of new legislation on their practice, and family members of people with mental illness need to safeguard their wellbeing and interests. All parties are influenced by their personal experiences and role in the system, and have a legitimate place in the debate. At any point in time, mental health legislation represents the balance of these issues and reflects contemporary societal attitudes toward mentally ill people, hence the need for continual review.

The 1846 Lunatics Ordinance provided the first basis for compulsory detention in New Zealand prisons. No distinction was made between mental illness, disability and offending. Some hospitals were built and were managed by lay superintendents, but they were beset by widespread allegations of abuse and neglect.
The Lunatics Act 1882 was the first statute that permitted the detention of people with mental illness in New Zealand. This allowed for the detention of those defined as ‘lunatics’, including ‘idiots and imbeciles’ in asylums rather than prisons, and for the management of their affairs by the state. The 1882 Act also included provisions for the protection of patients, including appointed inspectors and requirements that annual reports be provided to Parliament. Lunatic asylums run by medical superintendents proliferated, but quickly became plagued by overcrowding.

The Mental Defectives Act 1911 retained a broad definition of mental illness that encompassed people with disabilities, including those with dementia. Over-crowding remained a problem, particularly in relation to ‘inebriates’. With regard to the protection of detained patients, the 1911 Act retained the role of the Inspector-General, who was responsible for inspecting and reporting to the Minister on the administration of hospitals and the welfare of patients.

The title of the 1911 Act was changed by the Mental Health Amendment Act 1954, which introduced the concept of ‘voluntary boarders’ and the use of the villa system by mental hospitals, particularly in relation to those regarded as ‘curable’. The 1954 amendment also focused on people with intellectual disability (‘mentally defective’) and commenced the development of separate institutions for people with such disabilities, as well as a new profession of ‘psychopaedic’ nursing.

The Mental Health Act 1969 replaced the Mental Health Act 1911. It was primarily focused on detention, but also introduced review and appeal mechanisms. The Act differed significantly from its predecessors in that it endeavoured to provide a definition of mental disorder based on diagnostic features, and differentiated between people with mental illness, people with intellectual disability, and those who were infirm. The ‘mentally infirm’ was a category into which people with a number of conditions could be included. Those whose infirmity had arisen from advancing age (eg, suffering from dementia) were less likely to be committed under the 1969 Act than those who were severely disturbed as a result of head injury or long-term alcohol abuse. It dealt with both ‘committed’ and ‘voluntary’ patients, and was based on the premise that treatment for mental illness needed to be (at least initially) delivered in a hospital environment. Services delivered in the community to patients on leave and to outpatients were provided from a hospital base. General practitioners were rarely involved in the delivery of mental health services, particularly to committed patients.

Over time, the factors outlined above, together with pressures on inpatient mental health services, resulted in the 1969 Act largely being applied to those with mental illness and in a reducing number of cases to the ‘mentally infirm’ and ‘mentally subnormal’, who, it was increasingly recognised, required a different type of care.

The process of deinstitutionalisation was largely effected during the life of the 1969 Act, with a movement towards treatment in less restrictive environments in the community. While some early providers of mental health services had endeavoured to provide a more humane environment,
the lack of effective treatment options nevertheless resulted in detention rather than treatment. It was not until the introduction of electroconvulsive therapy (ECT) in the 1940s and anti-psychotic medication in the 1950s that options other than detention were seriously considered, particularly for those with more severe illnesses. This new therapeutic optimism enabled increasing numbers of patients to be cared for in the community. The fact that hospitals still remained available as back-up made it easier to place some patients in the community on ‘trial leave’. The number of patients in psychiatric hospitals peaked in the late 1940s, when about 500 people per 100,000 population were in mental hospitals. This number steadily fell until the late 1990s when the rate dropped to about 50 people per 100,000 population in mental health units.

**Figure A.1: Rate of residency in mental health inpatient units, 1970–2000**

The rates of compulsory admission to hospital have reflected this trend, reaching their peak in the 1950s. In 1954, 87.9 people per 100,000 population were committed patients. By 1969, the rate of committal had dropped to 70.1 per 100,000 population, although the introduction of compulsory treatment in the community may have again increased the rate of committal, albeit predominantly in the community.

The myth that deinstitutionalisation has increased the risk of harm to the community in New Zealand has been comprehensively dispelled by recent research into homicide and mental illness in New Zealand. There is no evidence that services have become less safe since deinstitutionalisation – quite the opposite. Services are safer, rates of homicide by mentally ill people are unchanged, and the public are at relatively lower risk from those with serious mental illness than they were in 1970 (Simpson et al 2003).
Appendix 2: The Mental Health (Compulsory Assessment and Treatment) Act 1992

The development of the Mental Health (Compulsory Assessment and Treatment) Act 1992 involved:

- a new definition of mental disorder
- a move from a custodial approach to an assessment and treatment focus
- the introduction of concepts of community care
- philosophies of treatment in the least restrictive environment
- greater emphasis on patients’ rights
- strengthening processes to appeal and review the legitimacy of detention and/or treatment
- the formal recognition of the importance of cultural factors in diagnosis and treatment.

The new definition of mental disorder was more restrictive than its predecessor, excluding certain categories of people from the Act (including criminal delinquents, the intellectually disabled and substance abusers). This resulted in some individuals being released from compulsory treatment, a small number of whom went on to commit serious sexual offences. As a result of media and public concern, the then Minister of Health (Hon Jenny Shipley) introduced a bill to amend the MHCAT Act, designed to enable the compulsory detention and care of people who were not mentally disordered but who were considered dangerous because of their impairment. There was substantial opposition to the bill and it did not proceed. However, what this did emphasise was the lack of available services for some individuals, and a series of ‘gaps’ in legislation and service provision. The introduction of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 closed the identified gaps in relation to the intellectually disabled.

Perhaps the most significant change with the introduction of the 1992 Act was that mentally disordered patients could be compulsorily assessed and treated in the community. Deinstitutionalisation had already resulted in fewer people being detained in hospital and for shorter periods, while community services were becoming more widely available.

At the time of the introduction of the MHCAT Act, the number of compulsory admissions had been declining for at least 20 years. People with intellectual disability, alcohol or drug disorders and age-related illnesses were increasingly unlikely to be committed under the 1969 Act, even though it was permitted under that legislation. Available data suggests that the introduction of the MHCAT 1992 Act was not associated with a dramatic increase in the rate of use of compulsion. Inpatients on leave were increasingly discharged under the community treatment order provisions of the Act.

6 Mental disorder, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—
(a) Poses a serious danger to the health or safety of that person or of others; or
(b) Seriously diminishes the capacity of that person to take care of himself or herself...

7 54 General rules relating to liability to assessment or treatment
The procedures prescribed by Parts 1 and 2 of this Act shall not be invoked in respect of any person by reason only of—
(a) That person’s political, religious, or cultural beliefs; or
(b) That person’s sexual preferences; or
(c) That person’s criminal or delinquent behaviour; or
(d) Substance abuse; or
(e) Intellectual disability.
However, the use of compulsory community treatment orders remains a controversial issue, allowing as they do greater liberty than was previously possible during compulsory assessment and treatment, while at the same time allowing the duration of compulsion to be extended in the community for much longer periods of time than was previously possible under inpatient leave provisions of the 1969 Act.

A recently published comprehensive report by John Dawson (Professor of Law, University of Otago) examines the use of community treatment orders in New Zealand, Victoria, New South Wales, Switzerland, the UK and Canada (Dawson 2005). He concludes that:

... the structure of the NZ legal regime is satisfactory, and that NZ should continue to encourage the use of community treatment orders, under civil mental health legislation, particularly to avoid the unnecessary criminalisation of the mentally ill and to prevent the over-use of forensic mental health care.

Although the 1969 Act referred to ‘treatment’ of both committed and voluntary patients, it did not deal with issues of ‘consent to treatment’. The 1992 Act is the first piece of mental health legislation in New Zealand which acknowledges that many patients are capable of making decisions about their treatment and (more generally) their affairs. The 1992 Act allows treatment without consent during the initial assessment period, and the first month of a compulsory treatment order, but thereafter only if it is deemed to be in the interests of the patient. It has been suggested that the area of capacity to consent to treatment requires further refinement when the 1992 Act is next reviewed (Dawson 2005), and in particular it has been recommended in the independent review that a patient should never be able to be treated with ECT over their competent refusal, as is currently possible.

The other major area of change with the 1992 Act related to the increase in emphasis on patients’ rights, with the introduction of much greater ability to challenge the legitimacy of detention expeditiously at all stages of the committal process, either via the Family or District Court prior to a compulsory treatment order being made, or by the Mental Health Review Tribunal thereafter. District inspectors of mental health, who are lawyers functioning as ombudsmen for the Act, were retained to investigate complaints of breaches of patients’ rights. The provisions of the Act regarding reviews and appeals have resulted in a significant increase in activity by district inspectors and the Tribunal.

The only major amendment since 1992 came with the Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999, which refined and extended the protections offered by the Act to mental health service users, professionals, and those who come in contact with them in the course of administering the Act. It also introduced section 7A, mandating consultation with family/whānau. The review of section 7A is discussed in ‘Special projects’ (see section 2 of this report).

A minor amendment was made in 2003 in respect of section 122B(3). The effect of this amendment was to extend the circumstances in which reasonable force could be used to cover those patients undergoing assessment, as well as patients subject to a compulsory treatment order.

Significant consequential amendments were required with the passing of the ID(CCR) Act 2003 and the CP(MIP) Act 2003.
Figure A.2: Criminal Procedure (Mentally Impaired Persons) Act / Mental Health (Compulsory Assessment and Treatment) Act 1992 and Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 interface flow diagram

Person is arrested

Appears in court

Questions of mental illness, ID, insanity or fitness to stand trial raised

Believed unfit to stand trial

Remanded for s38 CPMIP report

Pre-trial detention is available under s44(1) CPMIP and s171(2) Summary Proceedings Act

Not Responsible

Responsible

Opinion from two Health Assessors?

Found unfit to stand trial

Found fit to stand trial

Hearing (believed fit to stand trial)

Convicted

Acquitted

s35 CPMIP Inquiry (question of mental impairment raised)

Disposition options include CPMIP:

- Hybrid orders
- Committed patient

Suspicious mental illness/disorder

Process interchange if either a Health Assessor identifies possible ID or a Specialist Assessor identifies possible mental disorder

Health Assessor’s assessment of mental illness/disorder and treatment needs

Reports back to s23 CPMIP hearing

Disposition options include:

- s12(2)(a) Special patient MHCAT, or
- s25(1)(a) Committed patient MHAT, or
- s25(1)(b) Care recipient IDCRR or
- s25(1)(c) no order or
- s25(1)(d) released under CPMIP

Suspected mental illness/disorder

Process interchange if either a Health Assessor identifies possible ID or a Specialist Assessor identifies possible mental disorder

Health Assessor’s assessment of mental illness/disorder and treatment needs

Reports back to s23 CPMIP hearing

ID identified

ID not identified

Needs assessment commenced. Care Manager appointed. Specialist Assessor designated

Reports back to s23 CPMIP hearing

No ID identified

No ID identified

Disposition options include:

- s12(2)(b) Special care recipient IDCRR, or
- s25(1)(b) Care recipient IDCRR or
- s25(1)(c) no order or
- s25(1)(d) released under CPMIP

Disposition options include CPMIP:

- Hybrid orders
- Committed patient

Alternative disposition under Sentencing Act

No mental disorder

Mentally disordered

No ID

ID identified

Needs Assessment commenced. Care Manager appointed. Specialist Assessor designated

Reports back to s23 CPMIP hearing

Alternative disposition under Sentencing Act

Disposition options include CPMIP:

- Hybrid orders
- Committed patient

Alternative disposition under Sentencing Act

Disposition options include CPMIP:

- Hybrid orders
- Committed patient

1. Upon the filing of an application for review, the hospital receiving the application shall communicate immediately with the appropriate Court and discuss with the Registrar the earliest practicable scheduling of the application.

2. When the s16 application is received by the Court, it must be acted upon within three days unless there are exceptional circumstances. A visit as required by s16 should occur within this time, and preferably within the period of assessment when it was made.

3. The Judge's visit should occur at the hospital or place where the patient is being assessed. If that is not practicable in time, arrangements can be made to have the patient brought to the nearest court where a judge is available. (Video conferencing may be considered if consented to by the patient.)

4. Once the date for review has been set, the hospital should advise the applicant for the s8 assessment and the other persons listed in s10(4)(a) of the fact of the filing of the s16 application and of the date and place of the intended review.

5. When the s.16 application is referred to the Court, the hospital should also provide for the Judge and for any lawyer representing the patient, copies of the following documents:
   (i) Application for assessment: s8A
   (ii) Certificate of medical practitioner: s8B
   (iii) Notice to attend an assessment examination: s9
   (iv) Certificate of preliminary assessment: s10
   (v) Clinical report to DAMHS required by s10(2)(b)
   (vi) Notice requiring patient to undergo 5 day assessment s11.

   All these documents are to be provided to the Judge prior to the review.

6. Where the review occurs beyond the initial five day assessment period, there shall also be supplied:
   (i) Certificate of further assessment s12
   (ii) Further clinical report to DAMHS required by s12(2)(b).

7. It will be the responsibility of the hospital to arrange for the attendance of the Responsible Clinician and at least one other health professional familiar with the patient's assessment and treatment. If the Responsible Clinician has not yet assessed the patient, then the medical practitioner who completed the s10 certificate of preliminary assessment should be in attendance.

8. The Court should expect a report in writing from the Responsible Clinician, and a written clinical report from the second health professional according to the form approved by the Director of Mental Health (Dr Skipworth's form).

9. The review shall take the form of an inquiry. The presiding Judge will lead the inquiry with those matters required to be covered by s16(3) and by then consulting and inviting such questions or contributions as will, in the Judge's opinion, facilitate the inquiry.
10. Information received at the inquiry will not be on oath but all proceedings shall be recorded. The Judge’s decision is to be recorded on a standardised form (of distinctive colour readily noticeable on the file) and, where appropriate formal reasons are to be given in writing. A copy of the Judge’s decision shall be made available to those who attended, as soon as practicable after the review.

11. The Judge may adopt such procedure as best facilitates the conduct of the inquiry. This may mean that not all participants who require input, need be present at the same time.

12. The test to be applied under s16(5) as defined by the Waitemata Health case, is a single one – whether the patient is no longer mentally disordered and thereby fit to be released from compulsory status.

13. If the Judge is of the opinion that it cannot be ascertained, having regard to the state of the evidence, that the patient is no longer mentally disordered and thereby fit to be released from compulsory status, the review may be adjourned to enable the Judge to consult further and more fully.

14. A Judge who is not satisfied that the patient is fit to be released on a first application, may bear in mind the opportunity for the patient to make a second or subsequent application under s16(1C). If a second or subsequent application is made, it will be for the hospital to provide any evidence that the patient’s condition has not changed since the last review.
Appendix 5: Sources of Data

There are a number of data collections from service providers, with different coverage, data elements or definitions, and methods of collection. These are useful for different purposes. They are briefly described below.

Reports from directors of area mental health services (DAMHS)

Data is provided via DAMHS, who must report to the Director every three months on the exercise of their powers, duties and functions. This includes aggregated monthly statistics on the use of compulsion. It represents the most reliable source of data on compulsion in New Zealand currently, but this is aggregated data, which means it is not possible to report on the demographics of patients. There have also been gaps in reporting from some DHB's in recent years, which limited the ability to present trend data in this annual report to put 2005 in a historical context.

This reporting also includes data on the use of seclusion for those detained under the Act in both child and youth and adult services.

Mental Health Information National Collection (MHINC)

The MHINC is a national database providing information (including legal status) at an individual level on the use of both inpatient and community mental health services from 2002 onwards. However, there are a number of problems with the accuracy of legal status data, and statistics are not reported. These problems are being addressed.

The diagnosis data within the collection includes ECT procedures. However, this data is not provided by all DHBs. In addition, the procedure codes do not identify individual ECT sessions.

Coverage of the MHINC does not yet extend to all NGOs. A number of key NGO providers of alcohol and drug treatment are not yet included within the coverage. For this reason the MHINC is not a good source of data on compulsion under the Alcoholism and Drug Addiction Act.

National Minimum Dataset (NMDS)

The NMDS provides information (including legal status) on individual inpatient episodes. This series covers 1988 to the present day, although there are data quality issues with recent years in this series. As with the MHINC, the collection includes ECT procedure codes. Although the coverage is wider, the same quality issues arise in relation to the procedure codes.

Mental health data

Aggregated statistics (including legal status) from returns from psychiatric institutions were published by the Ministry of Health for the period 1955 to 1994.

ECT collection

DHBs provide data to the Ministry annually, from records in their ECT registers.

Special patient database

This is a Ministry database, held by the Office, which has run for a number of years. Processes for validating the data will be introduced in 2006 and it is expected that in future statistics will be produced from this database.
References


