Te Kāwanatanga o Aotearoa
New Zealand Government

MANATŪ HAUORA
MINISTRY OF HEALTH

Office of the Director of Mental Health and Addiction Services

Regulatory Report
1 July 2021 to 30 June 2022

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Foreword

Welcome to our regulatory report for the financial year from 1 July 2021 to 30 June 2022. This report presents data about the use of compulsory assessment and treatment legislation in Aotearoa New Zealand, including the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the Intellectual Disability Care Act).

To get a full picture of mental health and addiction services in Aotearoa New Zealand, I recommend you read this report in conjunction with updates on the Te Whatu Ora Health New Zealand (Te Whatu Ora) webpage, in particular the **Mental Health and Addiction monitoring, reporting and data** page. The data and information were previously published by Manatū Hauora; however, they are now the responsibility of Te Whatu Ora following the July 2022 health and disability system reforms. Because this report covers the 2021/2022 financial year, reference is still made to district health boards (DHBs).

I'd like to take this opportunity to thank the mental health, intellectual disability and addiction workforce in Aotearoa New Zealand. This dedicated group continues to provide a critical service to some of our most vulnerable tāngata whaiora no matter what. We know that there is a high demand for services, which are provided by an increasingly stretched workforce. There is always more to do, to grow, strengthen and support our workforce, and we are working hard to ensure that the programmes underway are successful in providing sustainable solutions. I would like to share my appreciation for all those involved in the development of this report.

As the Director of Mental Health and Addiction, I am responsible for the general administration of the relevant legislation under the direction of the Minister of Health and Director-General of Health. My functions and powers under the Acts listed above, as well as the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Substance Addiction Act), allow Manatū Hauora to provide guidance and oversight to mental health, addiction and intellectual disability services. It is my role to make sure that under compulsory care or treatment in Aotearoa New Zealand, people are well cared for, their rights are upheld, and all legislative requirements are followed. I am able to intervene when required to ensure this is the case.

Since 2005, the Office of the Director of Mental Health and Addiction Services has been reporting annually on the activities we undertake. The main purpose of the report is to present information and statistics that serve as barometers of quality for our mental health, intellectual disability and addiction services in the context of providing compulsory care. We monitor these services to assure ourselves and the public that people receiving compulsory assessment and treatment under the relevant legislation are receiving quality care.

In this year's report, we set out to solely use data submitted by services through the Programme for the Integration of Mental Health Data (PRIMHD). In previous years, we have had to contact services and receive manually submitted data to supplement the

PRIMHD records. This process leads to delays in developing the report. Due to known data issues, we have had to use some manually reported data this year. This relates to Waikato DHB's seclusion use, and Northland DHB's electroconvulsive therapy (ECT) use. It is unfortunate that we have had to do so, as reliable and timely data is an important factor in monitoring the quality of our services. We encourage all Te Whatu Ora services to improve their adherence to the PRIMHD standards so the data can be used to better inform services and practice.

The use of compulsory assessment and treatment remains steady with previous years, in line with population and service use increases. We have seen a decrease in the number of people who have been secluded, which is positive to observe. However, we have seen an increase in the total hours spent in seclusion. We are committed to working with Te Whatu Ora, Te Aka Whai Ora Māori Health Authority (Te Aka Whai Ora) and Te Tāhū Hauora Health Quality & Safety Commission (HQSC) on the reduction and elimination of seclusion, in line with their ***Zero Seclusion: Safety and dignity for all*** project. In April 2023, my office published ***Guidelines for reducing and eliminating seclusion and restraint under the Mental Health Act***. These guidelines include a stronger emphasis on person-centred and culturally appropriate approaches to safely reduce and eventually eliminate the use of seclusion and restraint in mental health services.

Wider work to strengthen Aotearoa New Zealand's mental health and addiction system continues, for example through the publication of ***Oranga Hinengaro System and Service Framework*** by Manatū Hauora. This identifies the core components of a contemporary mental health and addiction system with a 10-year view, and sets out the services that should be available for different population groups to guide those responsible for publicly funded health system policy, design, service commissioning and delivery. It is the next step towards the vision outlined in *Kia Manawanui* of an equitable and thriving Aotearoa New Zealand where mental wellbeing is promoted and protected, people are supported to stay well, and people can get the support they need when and where they need it.

Work has also continued on repealing and replacing the current Mental Health Act, as recommended in *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Updates on this work are provided on the **Manatū Hauora website**. My office has been working closely with our policy and strategy team to ensure the rights of tāngata whaiora are at the centre of any policy development.

My office has close working relationships with Te Whatu Ora, Te Aka Whai Ora, and Whaikaha Ministry of Disabled People to ensure there is a consistent and high-quality level of care being provided to tāngata whaiora and tāngata whaikaha. While this report highlights areas where improvements have been made, sustained focus and efforts are needed to continue to improve the experiences of tāngata whaiora, tāngata whaikaha and their whānau.

Noho ora mai

Dr John Crawshaw
Director of Mental Health and Addiction

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Use of the Mental Health Act

The following summarises the use of the Mental Health Act in the year 1 July 2021 to 30 June 2022.[1]

- 11,299 people (6.4% of specialist mental health and addiction service users) were subject to the Mental Health Act.[2]
- About 5,975 people were subject to either compulsory assessment or compulsory treatment under the Mental Health Act on the last day of that year.
- Males were more likely to be subject to the Mental Health Act than females.
- People aged 25–34 were the most likely age group to be subject to compulsory treatment, and people aged 65 and over were the least likely.
- Māori were more likely to be assessed or treated under the Mental Health Act than Pacific peoples and other ethnicities.[3]

[1] Source: Programme for the Integration of Mental Health Data (PRIMHD) data (extracted 20 June 2023).

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

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

The Mental Health Act process

Court applications in 2021/22

Clinicians made 6,097 applications for compulsory treatment orders (CTOs) or extensions under the Mental Health Act. Of these applications, the courts granted 5,377 (88%). Appendix 1 shows a diagram of the Mental Health Act process and Appendix 2 presents a timeseries of CTO application data.

Approximately 1,360 applications were filed for a judge's review of the patient's condition, in line with section 16 of the Mental Health Act. Of these applications, judges issued an order to release a person from their CTO in 38 cases (2.8%) and confirmed the continuance of the order in 744 applications (55%). The remaining applications were withdrawn. [4]

Compulsory assessment and treatment in 2021/22

On the last day of the 2021/22 financial year, a total of 5,975 people were subject to either compulsory assessment or compulsory treatment under the Mental Health Act.[5]

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

Section 11	645 people were subject to an initial assessment	13 people per 100,000 population
Section 13	678 people were subject to a second period of assessment	13 people per 100,000 population
Section 14(4)	487 people were subject to an application for a CTO	10 people per 100,000 population

Note: Section 14(4) data may also include PRIMHD records for section 15(1) and 15(2). These section 15 provisions describe similar circumstances in which a patient is waiting for a court decision on compulsory treatment.

Source: PRIMHD data (extracted 20 June 2023).

This data shows a slight increase from the previous financial year, with 2020/21 rates being 12, 13 and 9 per 100,000 population for sections 11, 13, and 14(4) respectively.

[4] Source: Ministry of Justice's case management system (CMS) data (extracted 16 May 2023).

[5] Source: PRIMHD data (extracted 20 June 2023).

In Aotearoa New Zealand, on an average day in the 2021/22 financial year, the treatment provisions of the Mental Health Act were applied as follows.

Section 29	4,900 people were subject to a community treatment order	96 people per 100,000 population
Section 30	763 people were subject to an inpatient treatment order	15 people per 100,000 population
Section 31	176 people were on temporary leave from an inpatient unit	3 people per 100,000 population

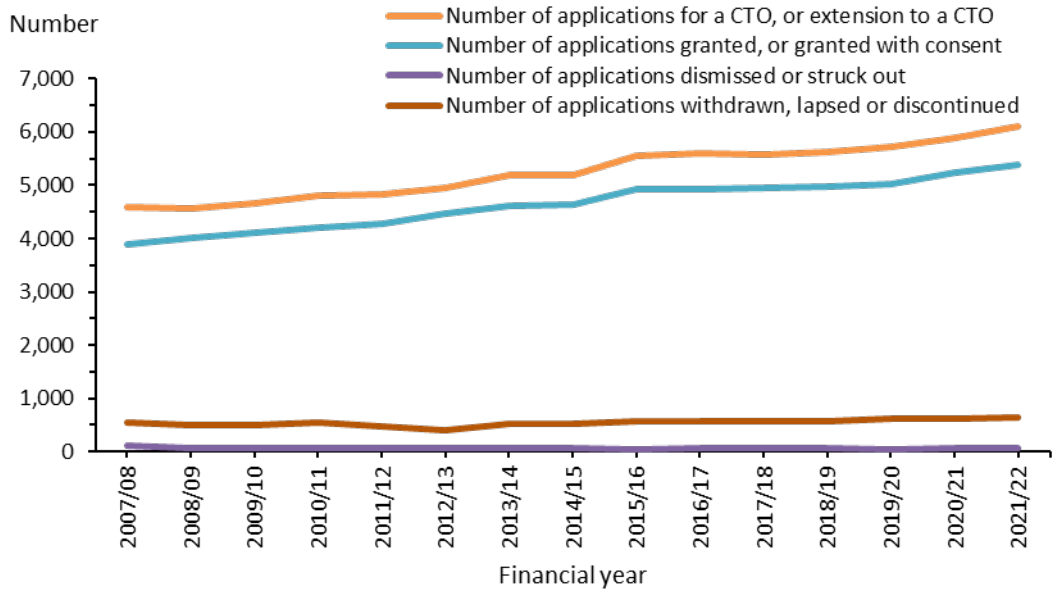
Note: 'On an average day' is the average of the last day of each month.

Sources: PRIMHD data (extracted 20 June 2023).

Similar to the assessment sections, there has been an increase from the previous financial year for the treatment provisions of the Mental Health Act. In 2020/21, these were 90, 13 and 3 per 100,000 population for sections 29, 30 and 31 respectively.

Figure 1 shows that the number of CTOs and extensions that clinicians have applied for and courts have granted since 2007/08. It also shows the number of applications dismissed or withdrawn.

Figure 1: Applications and outcomes for CTOs and extensions, 2007/08–2021/22

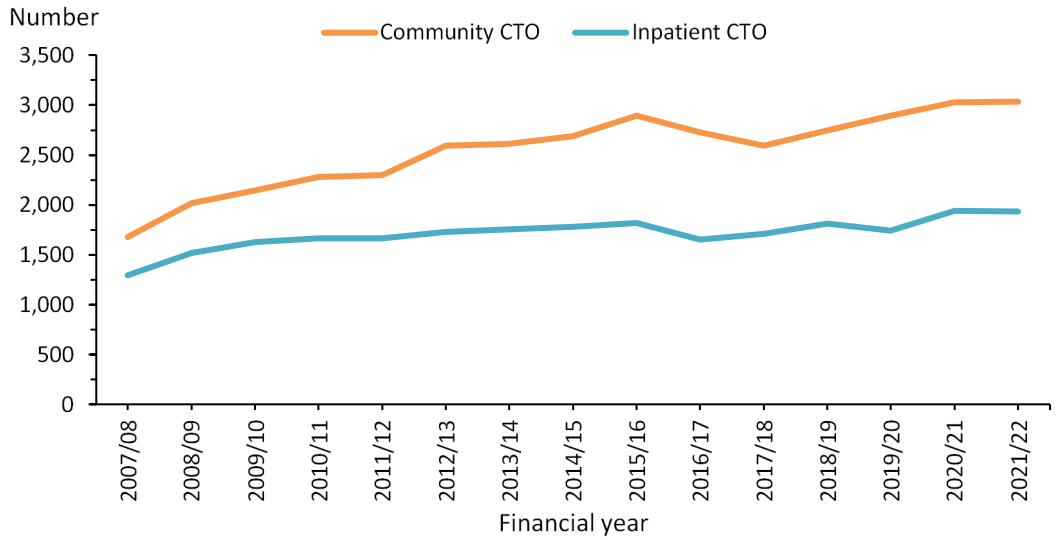


Notes: This figure is based on data entered into the CMS, which is a live operational database. Figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System data (extracted 16 May 2023).

Figure 2 shows the number of applications for community and inpatient CTOs that courts have granted since 2007/08.

Figure 2: Number of granted CTOs and extensions, community and inpatient, 2007/08 to 2021/22



Notes: This figure is based on data entered into the CMS, which is a live operational database. Figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System data (extracted 16 May 2023).

Comparing compulsory assessment and treatment among DHBs

Table 1 shows the average number of people per month from 1 July 2021 to 30 June 2022 who were required to undergo assessment under the Mental Health Act in each DHB. Table 2 shows the average number of people subject to a compulsory treatment order on a given day in the same period in each DHB. Figures 3 and 4 present the average number of people subject to a CTO on a given day, focusing specifically on either community treatment orders (Figure 3) or inpatient treatment orders (Figure 4).

Table 1: Average number of people each month required to undergo assessment under section 11, 13 or 14(4) of the Mental Health Act per 100,000 population, by DHB, 1 July 2021 to 30 June 2022

DHB	s 11	s 13	s 14(4)
Auckland	17	18	14
Bay of Plenty	15	13	6
Canterbury	12	13	9
Capital & Coast	13	15	11
Counties Manukau	10	12	9
Hawke's Bay	14	9	5
Hutt Valley	16	16	9
Lakes	12	10	7
MidCentral	10	9	8
Nelson Marlborough	10	10	11

DHB	s 11	s 13	s 14(4)
Northland	15	17	13
South Canterbury	7	6	3
Southern	11	11	8
Tairāwhiti	17	12	4
Taranaki	14	12	6
Waikato	20	20	14
Wairarapa	10	5	6
Waitematā	11	14	10
West Coast	8	5	3
Whanganui	15	13	10
National average	**13**	**13**	**10**

Notes: Section 14(4) data may also include PRIMHD records for section 15(1) and 15(2). These section 15 provisions describe similar circumstances in which a patient is waiting for a court decision on compulsory treatment. Volumes of section 14(4) may be higher in some DHBs due to reporting extension and indefinite order applications under section 14(4) in addition to original CTO applications. This occurs because of local differences in the approach to reporting. As these figures are averages, some services may have higher section 13 volumes than section 11.

Source: PRIMHD data (extracted 20 June 2023).

Table 2: Average number of people on a given day subject to section 29, 30 or 31 of the Mental Health Act per 100,000 population, by DHB, 1 July 2021 to 30 June 2022

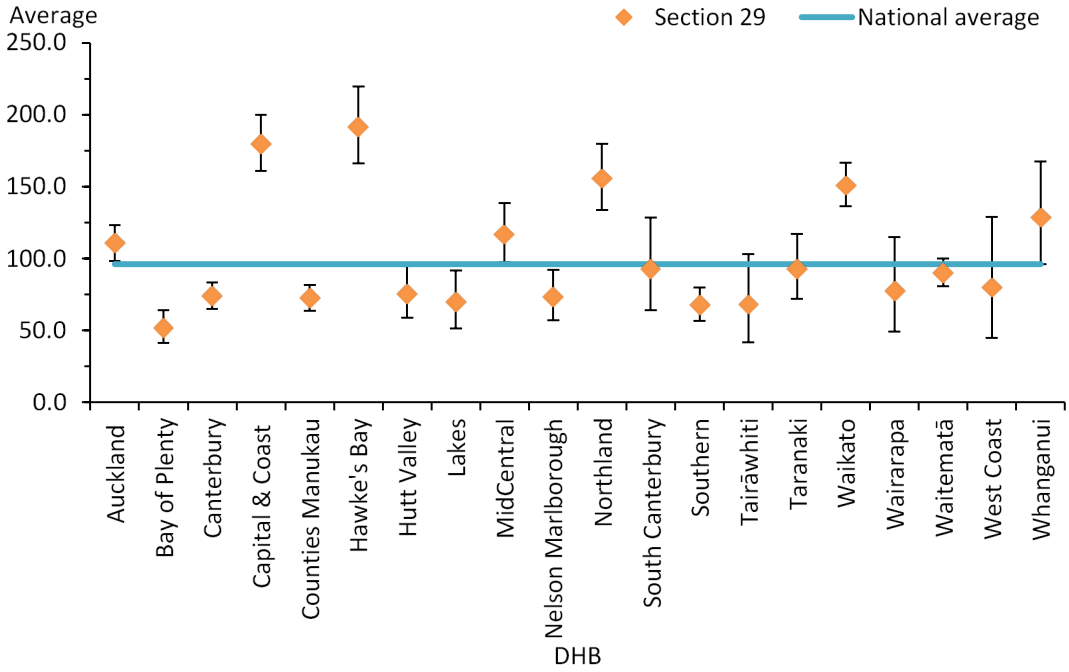
DHB	s 29	s 30	s 31
Auckland	110	16	1
Bay of Plenty	52	14	4
Canterbury	74	18	6
Capital & Coast	180	43	6
Counties Manukau	72	12	1
Hawke's Bay	192	24	17
Hutt Valley	75	10	2
Lakes	70	7	3
MidCentral	117	10	3
Nelson Marlborough	73	8	-

DHB	s 29	s 30	s 31
Northland	155	12	3
South Canterbury	92	4	3
Southern	67	11	3
Tairāwhiti	68	6	6
Taranaki	92	5	3
Waikato	151	21	4
Wairarapa	78	3	0
Waitematā	90	12	1
West Coast	80	3	1
Whanganui	128	25	5
National average	**96**	**15**	**3**

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

Source: PRIMHD data (extracted 20 June 2023).

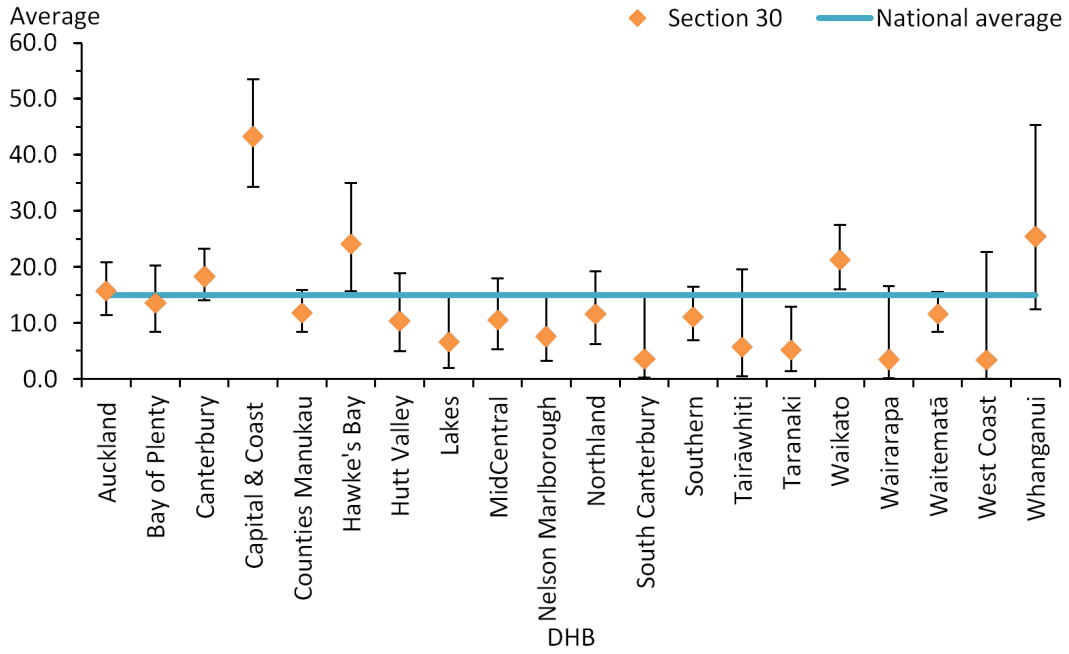
Figure 3: Average number of people on a given day subject to a community treatment order (section 29) per 100,000 population, by DHB, 1 July 2021 to 30 June 2022



Notes: 'On a given day' is the average of the last day of each month. This graph shows confidence intervals (for 99% confidence) to help in interpreting the data. A DHB confidence interval crossing the national average means its rate was not statistically different from the average.

Source: PRIMHD data (extracted 20 June 2023).

Figure 4: Average number of people on a given day subject to an inpatient treatment order (section 30) per 100,000 population, by DHB, 1 July 2021 to 30 June 2022



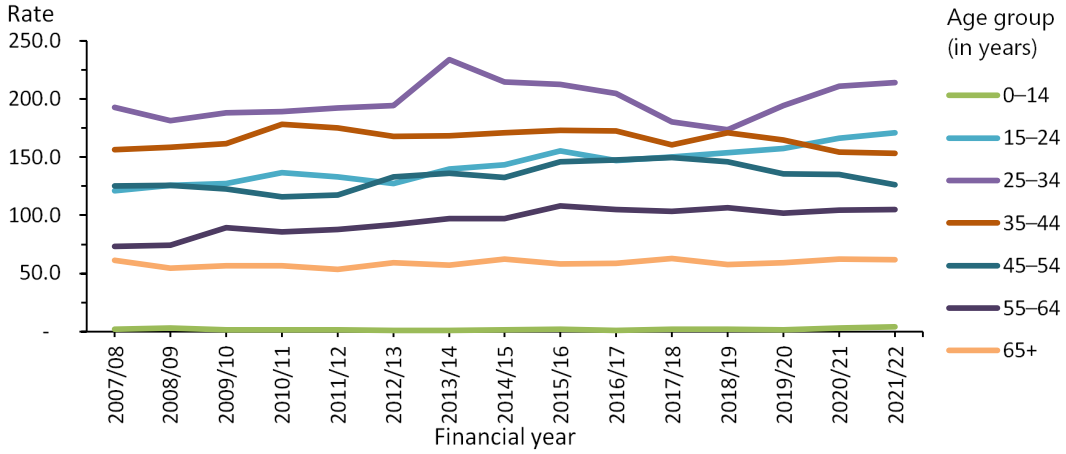
Notes: 'On a given day' is the average of the last day of each month. This graph shows confidence intervals (for 99% confidence) to help in interpreting the data. A DHB confidence interval crossing the national average means its rate was not statistically different from the average.

Source: PRIMHD data (extracted 20 June 2023).

Compulsory treatment by age and gender

Of people aged 15 and over, those aged 25–34 were the age group most likely to be subject to a CTO (324 people per 100,000 population), while people aged 65 or over were the least likely (127 per 100,000).[6] Figure 5 shows the rate of people subject to CTO applications per 100,000 population by age group, using Ministry of Justice data.

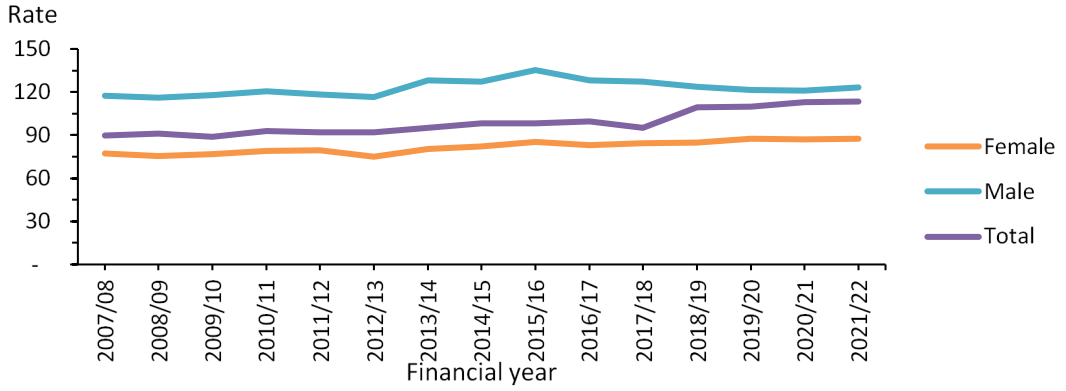
Figure 5: Rate of people subject to CTO applications (including extensions) per 100,000 population, by age group, 2007/08 to 2021/22



Notes: This figure is based on data entered into the CMS, which is a live operational database. Figures are subject to minor changes at any time.
Source: Ministry of Justice Integrated Sector Intelligence System data (extracted 16 May 2023).

Males were more likely to be subject to a CTO application (123 per 100,000 population) than females (87 per 100,000), as shown in Figure 6.[7]

Figure 6: Rate of people subject to CTO applications (including extensions) per 100,000 population, by gender, 2007/08 to 2021/22



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

Source: Ministry of Justice Integrated Sector Intelligence System data (extracted 16 May 2023).

6 Source: PRIMHD data (extracted 20 June 2023).
7 Source: Ministry of Justice Integrated Sector Intelligence System data (extracted 16 May 2023).

Tāngata whai ora

This section presents statistics on tāngata whai ora (people seeking wellness) under the Mental Health Act. This information underlines the need for mental health services to take meaningful actions to address the disparity in outcomes for Māori and Pacific peoples in Aotearoa.

The following summarises tāngata whai ora data from 1 July 2021 to 30 June 2022.[8]

- 5.6% of Māori accessed mental health and addiction services, compared with 3.0% of non-Māori.[9]
- Māori were 1.8 times more likely than Pacific peoples and 4.0 times more likely than other ethnicities to be subject to a community treatment order.[10]
- Māori were 1.9 times more likely than Pacific peoples to be subject to an inpatient treatment order and 3.6 times more likely than other ethnicities.
- Of all population groups, Māori men were the most likely to be subject to community and inpatient treatment orders.
- DHBs varied in their ratio of Māori, Pacific peoples and other ethnicities subject to community and inpatient treatment orders.
- On average, Māori, Pacific peoples and other ethnicities remained on community and inpatient treatment orders for similar lengths of time.
- Māori were 2.9 times more likely to be subject to indefinite community treatment orders than non-Māori, and 4.1 times more likely to be subject to indefinite inpatient treatment orders than non-Māori.
- Māori made up about 17% of Aotearoa New Zealand's population, yet they accounted for 28.4% of all mental health service users.
- Pacific peoples made up about 7% of Aotearoa New Zealand's population and accounted for 5.8% of all mental health service users.
- Among service users, 28.9% of Māori, 26.7% of Pacific peoples and 27.4% of other ethnicities were aged under 20.
- Among service users under a community treatment order, 46% of Māori and 45% of Pacific peoples were living in the most deprived areas (quintile 5), compared with 27% of non-Māori and non-Pacific peoples.[11]

[8] Source: PRIMHD data (extracted 20 June 2023).

[9] Source: PRIMHD data (extracted 24 May 2023).

[10] These ratios are based on the age-standardised rates of the Māori, Pacific peoples and other populations. Source: PRIMHD data (extracted 20 June 2023).

[11] Deprivation quintiles are ranked 1 to 5, where 1 represents areas with the least-deprived scores and 5 the areas with the most-deprived scores.

Compulsory assessment

From 1 July 2021 to 30 June 2022, Māori were more likely to undergo compulsory assessment than other ethnicities. Table 3 shows the number of people subject to compulsory mental health assessment on a national level by ethnicity and the rate per 100,000 population.

Table 3: Number and rate of people required to undergo assessment under section 11, 13 or 14(4) of the Mental Health Act, by ethnicity, 1 July 2021 to 30 June 2022

	Section 11		Section 13		Section 14(4)	
Ethnicity	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**
Māori	2,129	241.7	1,876	213.0	1,327	150.6
Pacific peoples	417	114.6	418	114.9	322	88.5
Other	3,419	88.3	2,965	76.6	1,964	50.7
National total	**5,965**	**–**	**5,259**	**–**	**3,613**	**–**

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

Source: PRIMHD data (extracted 20 June 2023).

Compulsory treatment orders

Table 4 shows that Māori were more likely to be subject to community and inpatient treatment orders than Pacific peoples and other ethnicities. These figures represent people who were subject to a CTO during the 2021/22 financial year, rather than the number of CTOs issued for the year.

Table 4: Number and rate of people subject to a CTO under section 29 or 30 of the Mental Health Act, by ethnicity, 1 July 2021 to 30 June 2022

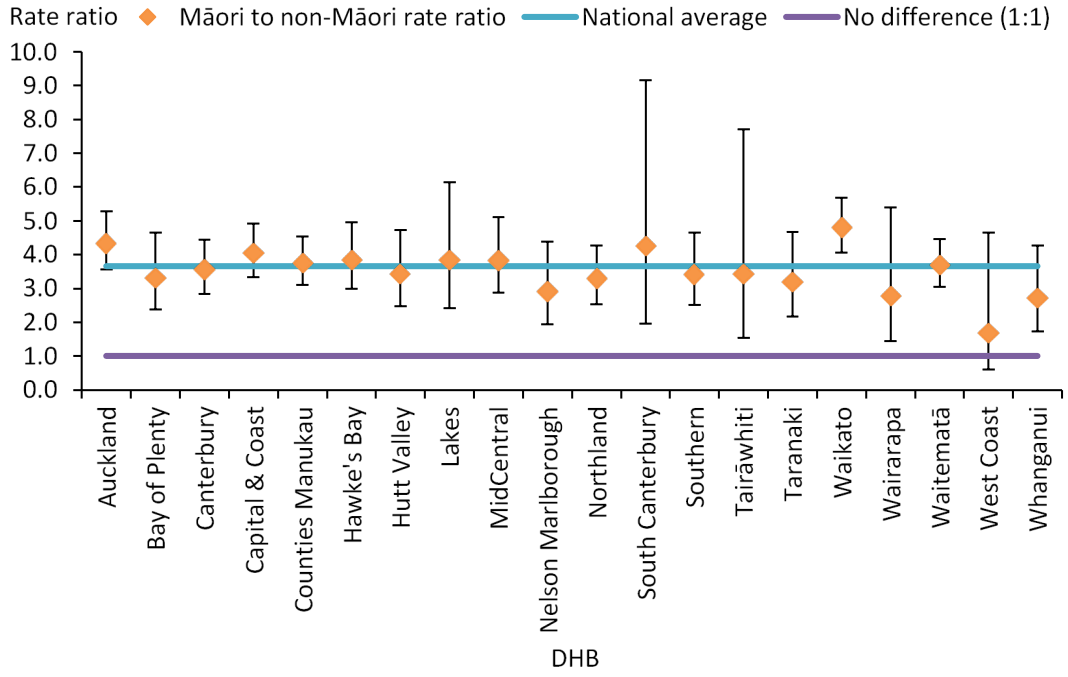
	Section 29		Section 30	
Ethnicity	**Number**	**Rate**	**Number**	**Rate**
Māori	2,777	314.0	885	100.1
Pacific peoples	651	183.5	201	56.7
Other	3,581	91.7	1,262	32.3
National total	**7,009**	**–**	**2,348**	**–**

Source: PRIMHD data (extracted 20 June 2023).

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

It is difficult to interpret the range of rates because the proportions of different ethnic groups within a population vary greatly across DHBs, so it is hard to define a standard rate ratio for a given population or DHB. However, to aid in comparison, each figure includes a line of 'no difference' to indicate where Māori and non-Māori would be subject to CTOs at the same rate (ie, a 1:1 ratio). The figures emphasise the need for in-depth, area-specific knowledge to understand why differences occur in each DHB region and how to address them at a local level.

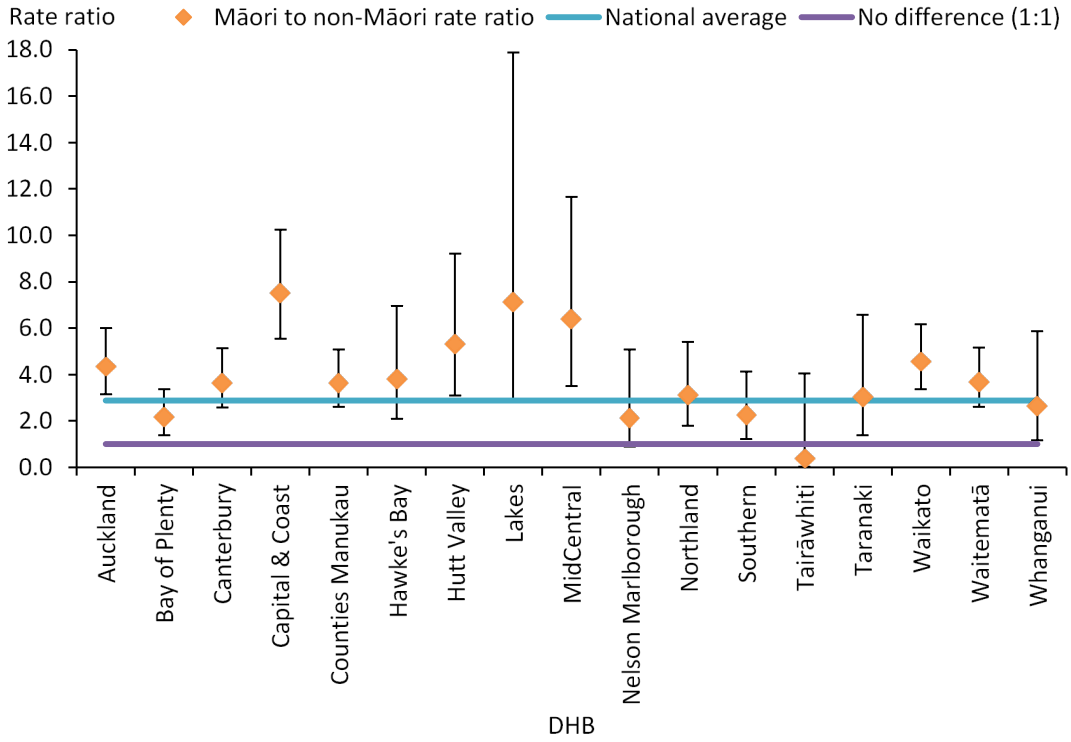
Figure 7: Rate ratio of Māori to non-Māori subject to a community treatment order (section 29) under the Mental Health Act per 100,000 population, by DHB, 1 July 2021 to 30 June 2022



Notes: Confidence intervals (for 99% confidence) have been used to help with interpretation. A DHB confidence interval crossing the national average means its rate per 100,000 is not statistically different to the average. These are age-standardised rates.

Source: PRIMHD data (extracted 20 June 2023).

Figure 8: Rate ratio of Māori to non-Māori subject to an inpatient treatment order (section 30) under the Mental Health Act per 100,000 population, by DHB, 1 July 2021 to 30 June 2022



Notes: Confidence intervals (for 99% confidence) have been used to help with interpretation. A DHB confidence interval crossing the national average means its rate per 100,000 is not statistically different to the average. These are age-standardised rates. Because South Canterbury and West Coast DHBs had a small population, their rates were very volatile and error bars of the resulting calculations were large. Wairarapa DHB has no inpatient service. This figure does not include the data for South Canterbury, Wairarapa and West Coast DHBs, to avoid skewing the overall results.

Source: PRIMHD data (extracted 20 June 2023).

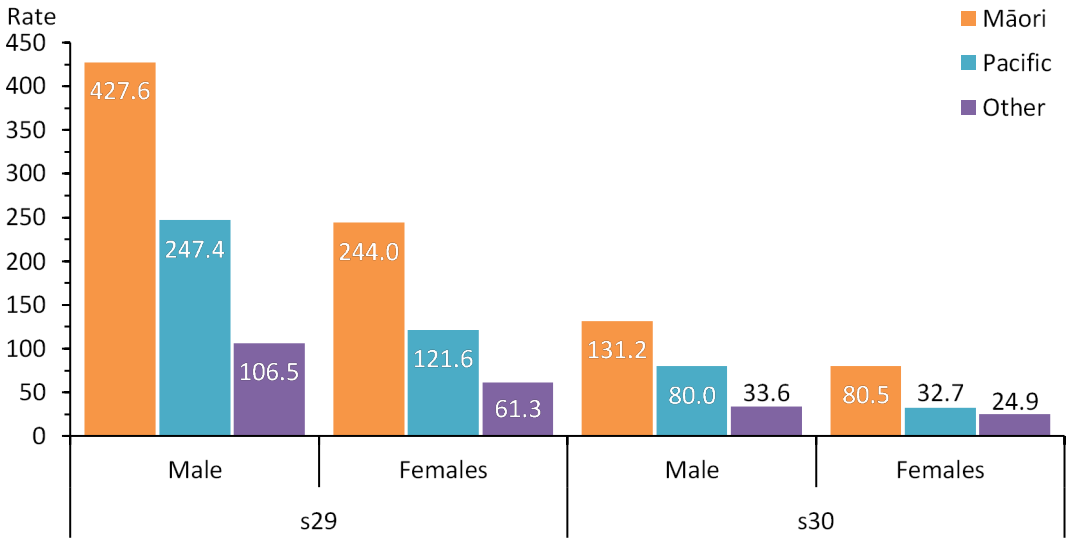
Table 5: Age-standardised rates of people subject to community (section 29) and inpatient (section 30) treatment orders under the Mental Health Act, by gender and ethnicity, 1 July 2021 to 30 June 2022

	Community treatment orders		Inpatient treatment orders	
	Male	**Female**	**Male**	**Female**
Māori per 100,000 population	427.6	244.0	131.2	80.5
Pacific peoples per 100,000 population	247.4	121.6	80.0	32.7
Other ethnicities per 100,000 population	106.5	61.3	33.6	24.9
Māori to Pacific peoples rate ratio	1.7:1.0	2.0:1.0	1.6:1.0	2.5:1.0
Pacific peoples to other ethnicities rate ratio	2.3:1.0	2.0:1.0	2.4:1.0	1.3:1.0
Māori to other ethnicities rate ratio	4.0:1.0	4.0:1.0	3.9:1.0	3.2:1.0

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

Source: PRIMHD data (extracted 20 June 2023).

Figure 9: Age-standardised rates of people subject to community (section 29) and inpatient (section 30) treatment orders under the Mental Health Act, by gender and ethnicity, 1 July 2021 to 30 June 2022



Note: Rates per 100,000 are age standardised.

Source: PRIMHD data (extracted 20 June 2023).

Length of time people are subject to CTOs

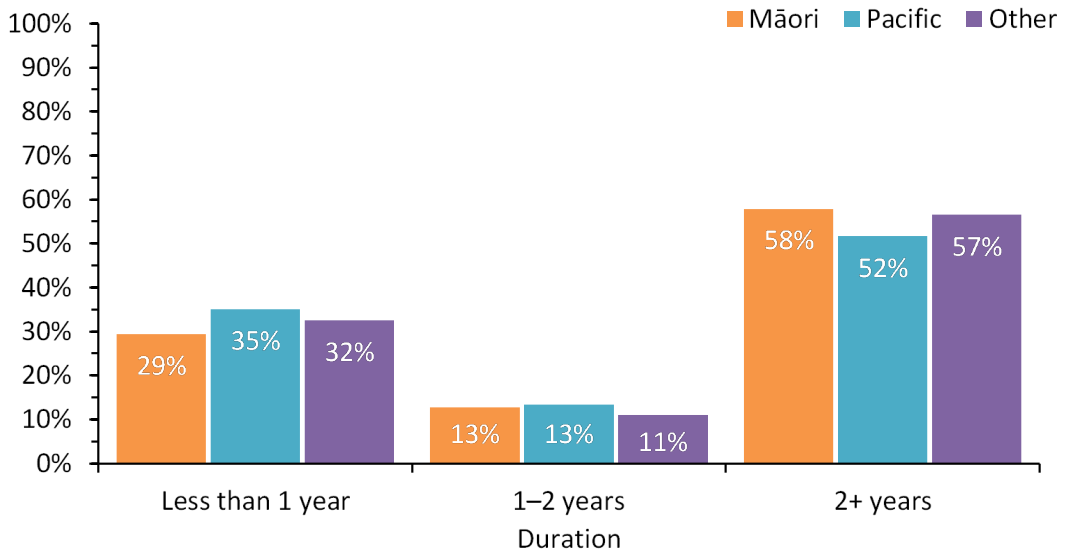
We have been reporting the duration of CTOs since 2014. However, in February 2023 a review found that there was an issue in how duration had been calculated in some cases. Therefore, we have revised the methodology used for the data presented in this section. Further details, including a revised version of the data for previous years, are presented in Appendix 3: Duration of CTOs.

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

For people with community treatment orders current at any time in the 2021/22 year, 29.3% of Māori, 35.0% of Pacific peoples and 32.5% of other ethnicities were subject to the order for less than a year (Figure 10).

For people with inpatient treatment orders current at any time 2021/22 year, 71.8% of Māori, 71.1% of Pacific peoples and 77.1% of other ethnicities were subject to the order for less than a year (Figure 11).

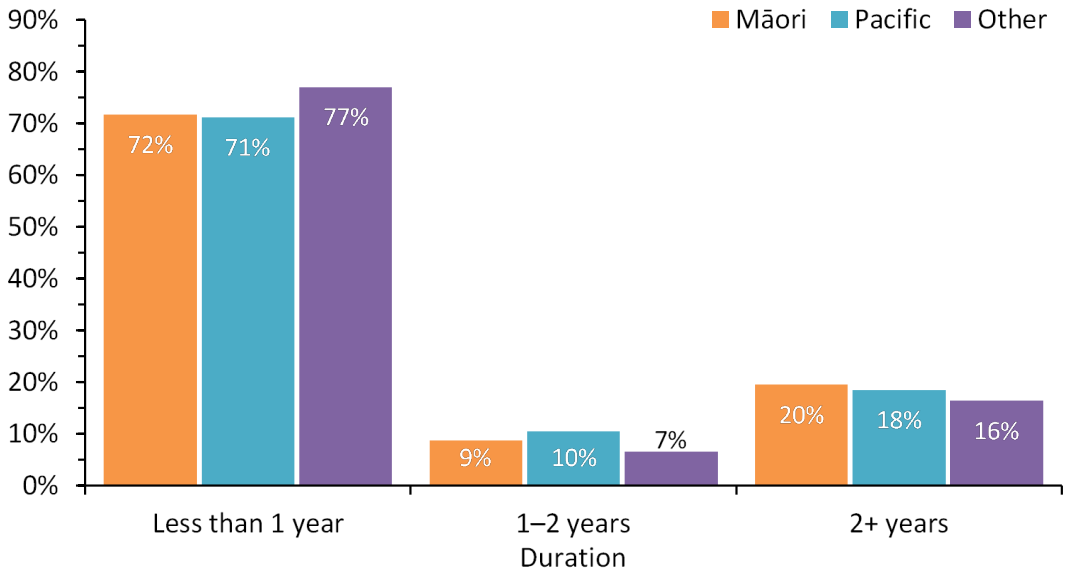
Figure 10: Total duration subject to a community treatment order (section 29) under the Mental Health Act in the last 3 years, by ethnicity, for those with a current order in the year 1 July 2021 to 30 June 2022



Notes: The data refers to people with treatment orders that were current at any point in 2021/22 and shows their total duration subject to the order in the period from 1 July 2019 to 30 June 2022. Some orders current in this period will have started before 1 July 2019. The total duration for some people with orders starting in the most recent 2 years is not yet known as the orders are still current.

Source: PRIMHD data (extracted 2 June 2023).

Figure 11: Total duration spent subject to an inpatient treatment order (section 30) under the Mental Health Act in the last 3 years, by ethnicity, for those with a current order in the year 1 July 2021 to 30 June 2022



Notes: The data refers to people with treatment orders that were current at any point in 2021/22 and shows their total duration subject to the order in the period from 1 July 2019 to 30 June 2022. Some orders current in this period will have started before 1 July 2019. The total duration for some people with orders starting in the most recent 2 years is not yet known as the orders are still current.

Source: PRIMHD data (extracted 2 June 2023).

Family and whānau consultation under the Mental Health Act

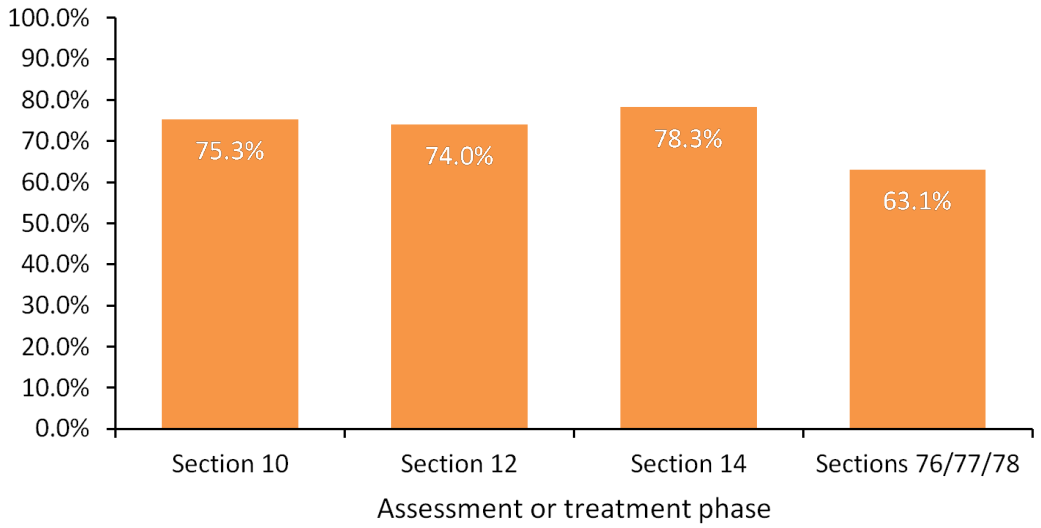
Section 7A of the Mental Health Act requires clinicians to consult family and whānau, unless service providers and clinicians consider it is not reasonably practicable or not in the interests of the person being assessed or receiving the treatment. Clinicians are encouraged to consider that the term 'whānau' could include any set of relationships a patient or proposed patient recognises as their closest connections, with no limitation to blood ties.

The following summarises the consultation data from 1 July 2021 to 30 June 2022.

- On average nationally, clinicians consulted families and whānau about Mental Health Act assessment or treatment events 71.6% of the time.
- Of all the steps in the Mental Health Act treatment process, clinicians were most likely to consult family and whānau at section 14, when a person is issued with a certificate of final assessment.
- DHBs varied in the extent to which their clinicians consulted with families and whānau.
- The most common reason families and whānau were not consulted was that service providers and clinicians considered consultation was not reasonably practicable in the particular circumstance.

Figure 12 shows the percentage of cases in which consultation with families and whānau occurred at 4 points in the assessment and treatment process.

Figure 12: Average national percentage of family and whānau consultation for particular assessment or treatment events, sections 10, 12, 14, and 76, 77 and 78, 1 July 2021 to 30 June 2022



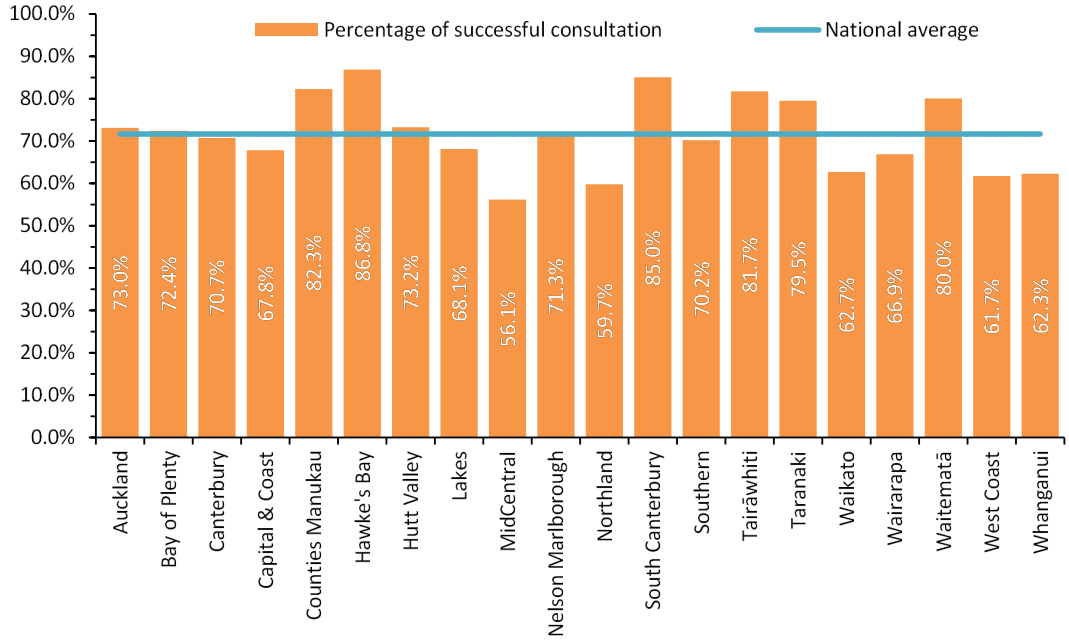
Note: Previous reports described 'sections 76/77/78' as 'section 76' but included the data for all three sections. Section 76 relates to clinical reviews of people subject to CTOs, whereas clinical review for special patients and restricted patients is covered in sections 77 and 78 respectively.

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

On average nationally during this 12-month period, 71.6% of cases included consultation with family and whānau across the assessment and treatment events. Hawke's Bay had the highest rate of consultation at 86.8% and Northland had the lowest at 56.1% (Figure 13).

As Figure 14 shows, by far the most common reason (in 83.2% of cases) for not consulting families and whānau was that service providers and clinicians considered consultation was not reasonably practicable in the particular circumstance.

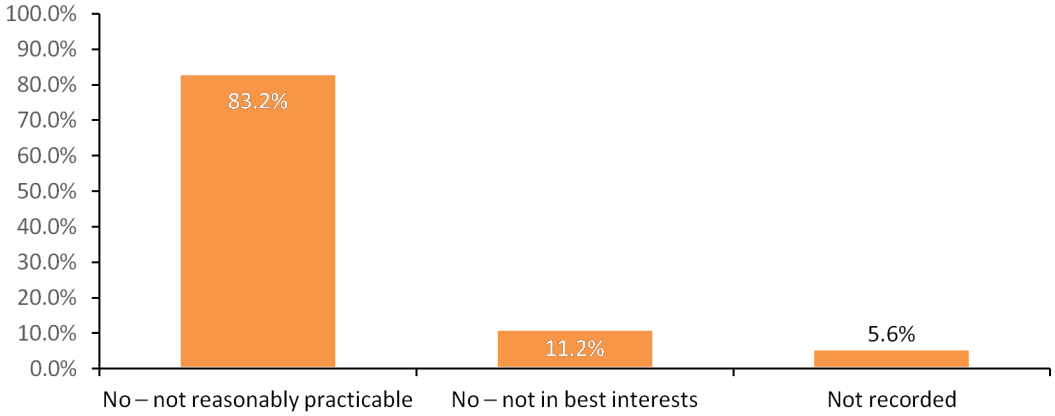
Figure 13: Average percentage of family and whānau consultation across all assessment and treatment events, by DHB, 1 July 2021 to 30 June 2022



Note: Data for the period 1 July 2021 to 31 December 2021 for Nelson Marlborough DHB was not available, therefore their average is for the 6 months from 1 January 2022 to 30 June 2022.

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

Figure 14: Reasons for not consulting families and whānau, 1 July 2021 to 30 June 2022



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

Indefinite CTOs

CTOs last for an initial period of up to 6 months. They can be ended earlier by a patient's responsible clinician or the Mental Health Review Tribunal, or the responsible clinician can apply to the courts to have it extended for a further 6 months. After that extension, an order can be extended 'indefinitely'. People who are subject to an indefinite CTO are reviewed every 6 months by their responsible clinician to determine whether compulsory treatment is still necessary.

From 29 October 2023, indefinite CTOs will no longer exist as a result of the Mental Health (Compulsory Assessment and Treatment) Amendment Act 2021 and will be replaced by 12-month extensions. This change means that responsible clinicians will need to reapply to the courts annually if they believe that a person still requires compulsory treatment.

These statistics summarise indefinite CTOs at 30 June 2022.[12]

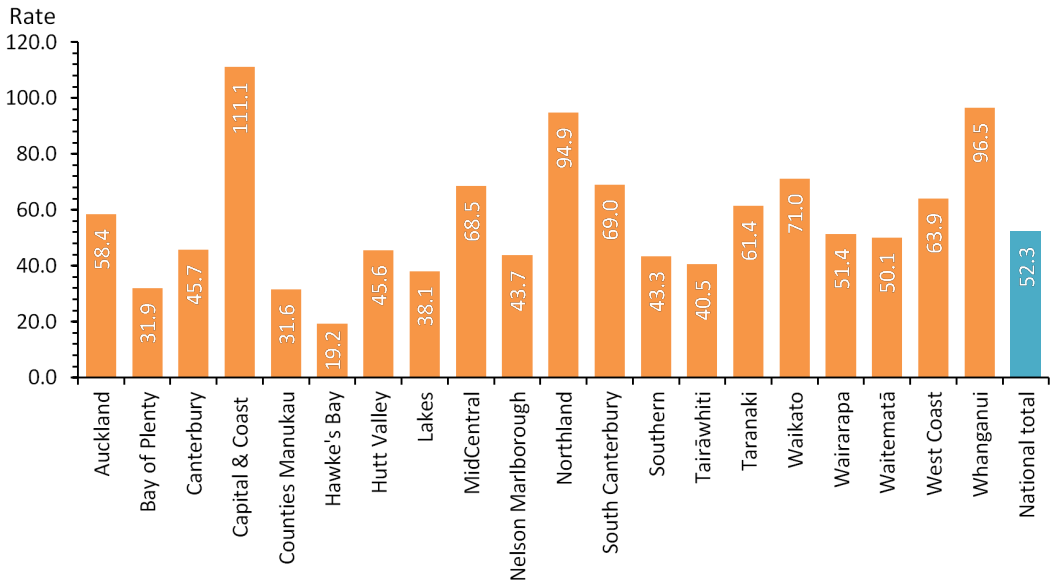
- 2,841 people were subject to indefinite CTOs.
- 2,675 people were subject to indefinite community treatment orders, which is 54% of all individuals on these orders.
- 194 people were subject to indefinite inpatient treatment orders, which represents 24% of all individuals on these orders.
- The average period for which a person was subject to an indefinite community treatment order was 1,659 days (approximately 4 and a half years), and the maximum period was 10,585 days (about 29 years).
- The average period for which a person was subject to an indefinite inpatient treatment order was 1,526 days (nearly 4 and a quarter years) and the maximum period was 8,227 days (approximately 22 and a half years).

Indefinite community treatment orders

On 30 June 2022, 52.3 people per 100,000 population across Aotearoa New Zealand were subject to indefinite community treatment orders. Figure 15 shows the rates of indefinite community treatment orders in each DHB, per 100,000 of the general population.

[12] Source: PRIMHD data (extracted 16 May 2023).

Figure 15: Number of people subject to indefinite community treatment orders per 100,000 population, by DHB, at 30 June 2022



Source: PRIMHD data (extracted 16 May 2023).

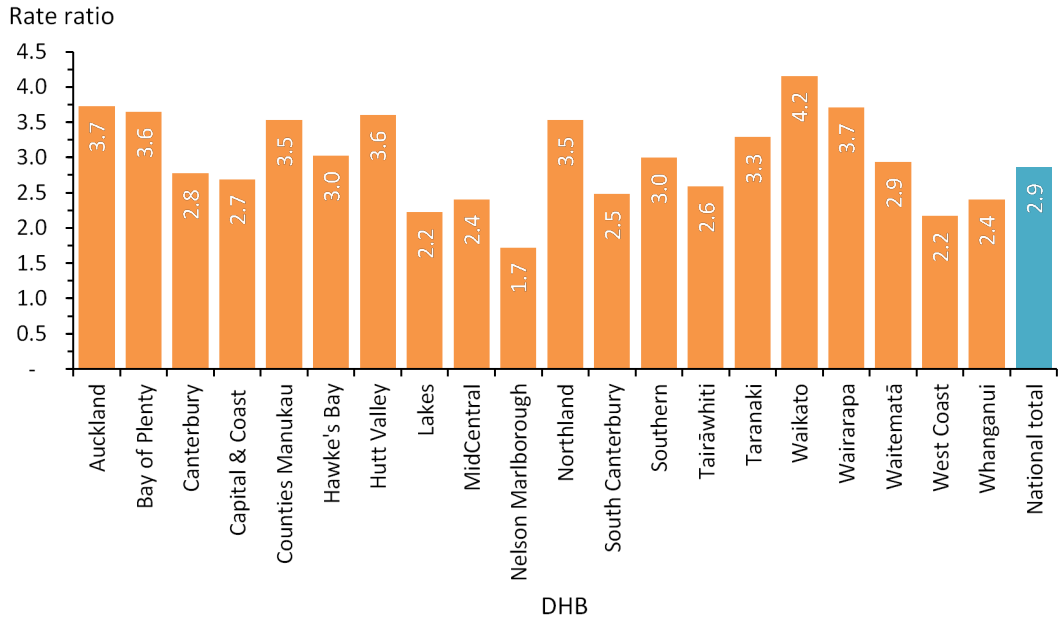
Nationwide, Māori were 2.9 times more likely to be subject to an indefinite community treatment order than non-Māori. Table 6 and Figure 16 show the rate ratio of Māori to non-Māori in each DHB, per 100,000 people in the general population.

Table 6: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, by DHB, at 30 June 2022

DHB	Māori	Non-Māori	Rate ratio Māori : non-Māori
Auckland	178	48	3.7
Bay of Plenty	69	19	3.6
Canterbury	107	39	2.8
Capital & Coast	248	92	2.7
Counties Manukau	79	22	3.5
Hawke's Bay	37	12	3.0
Hutt Valley	111	31	3.6
Lakes	58	26	2.2
MidCentral	126	53	2.4
Nelson Marlborough	70	40	1.7
Northland	175	49	3.5
South Canterbury	150	60	2.5
Southern	106	35	3.0
Tairāwhiti	56	22	2.6
Taranaki	135	41	3.3
Waikato	166	40	4.2
Wairarapa	126	34	3.7
Waitematā	122	42	2.9
West Coast	121	56	2.2
Whanganui	165	69	2.4
National total	**113**	**40**	**2.9**

Source: PRIMHD data (extracted 16 May 2023).

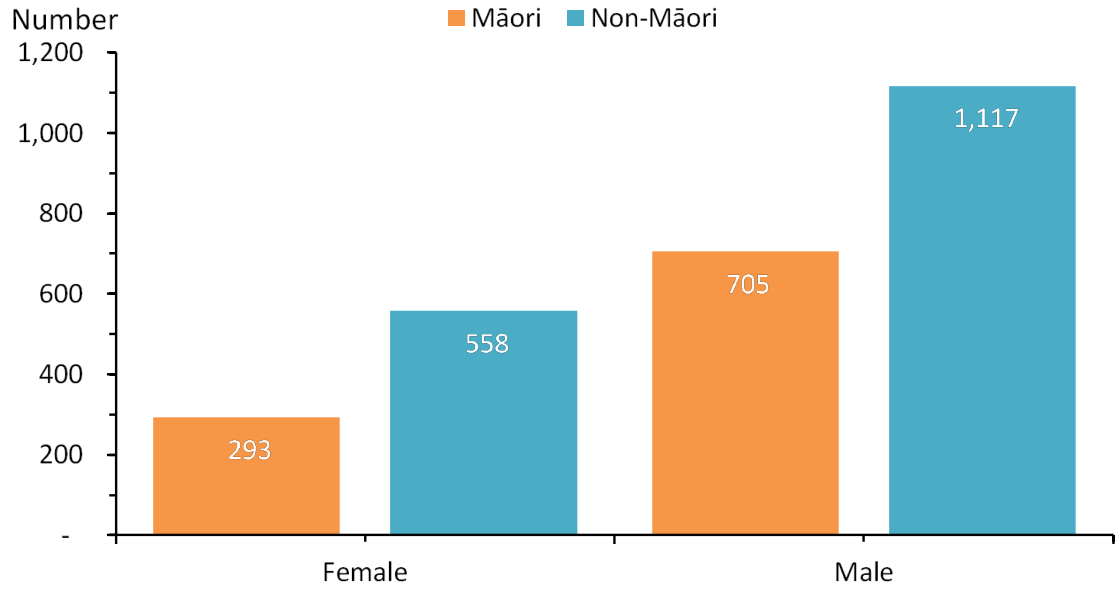
Figure 16: Rate ratio of Māori to non-Māori subject to indefinite community treatment orders per 100,000 population, by DHB, at 30 June 2022



Source: PRIMHD data (extracted 16 May 2023).

On 30 June 2022, 68.1% of people subject to indefinite community treatment orders were male (Figure 17). This trend is consistent with the higher rate of males subject to CTO applications.

Figure 17: Number of people subject to indefinite community treatment orders, by gender and ethnicity, at 30 June 2022



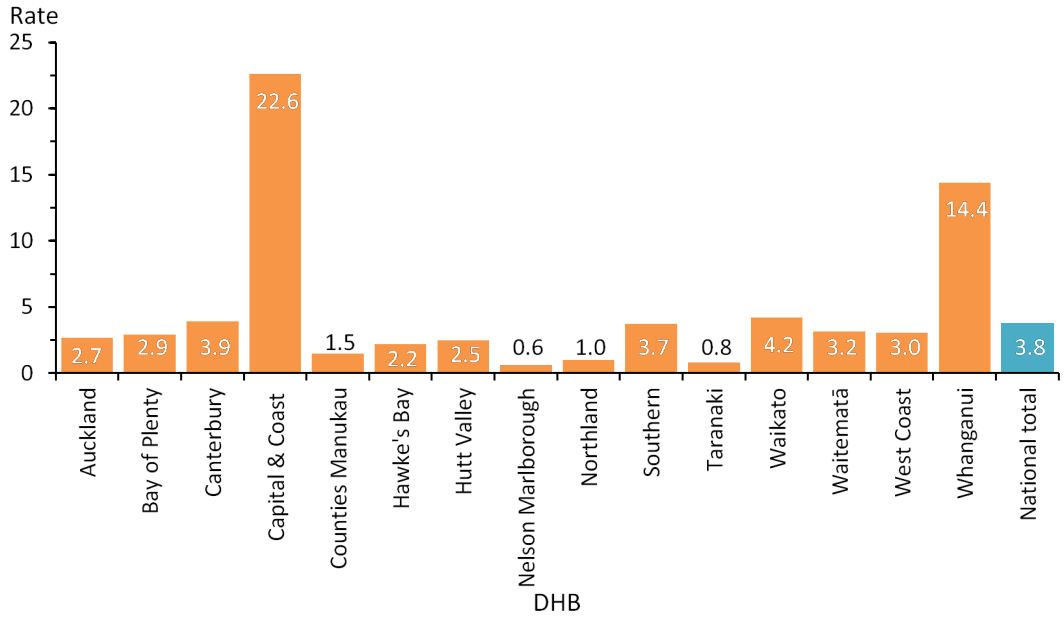
Source: PRIMHD data (extracted 16 May 2023).

Indefinite inpatient treatment orders

Across Aotearoa, 3.8 people per 100,000 of the general population were subject to indefinite inpatient treatment orders. Figure 18 shows the rates of indefinite inpatient treatment orders in each DHB, per 100,000 of the general population on 30 June 2022.

Some services may have higher rates of inpatient indefinite orders because they care for more patients with forensic and intellectual disability needs but whose presentation means a Mental Health Act order is appropriate for them. Smaller services may be less likely to offer long-term inpatient care for people with complex needs. In 2021/22, Lakes, MidCentral, South Canterbury, Tairāwhiti, and Wairarapa DHBs had no individuals on indefinite inpatient treatment orders.

Figure 18: Number of people subject to indefinite inpatient treatment orders per 100,000 population, by DHB, at 30 June 2022



Note: Wairarapa DHB did not have an inpatient service, and Lakes, MidCentral, South Canterbury and Tairāwhiti DHBs had no indefinite inpatient treatment orders so these DHBs are not shown in this figure.

Sources: PRIMHD data (extracted 16 May 2023).

Nationwide during this time, Māori were 4.1 times more likely to be subject to an indefinite inpatient treatment order than non-Māori. Table 7 and Figure 19 show the rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders in each DHB per 100,000 people in the general population.

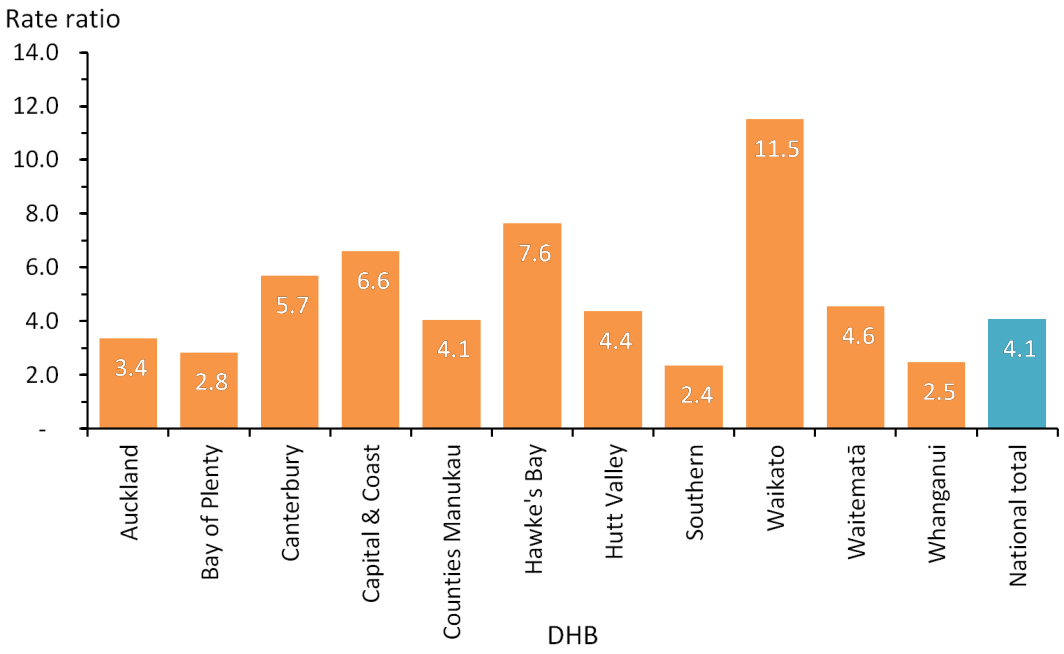
Table 7: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, by DHB, at 30 June 2022

DHB	Māori	Non-Māori	Rate ratio Māori : non-Māori
Auckland	8	2	3.4
Bay of Plenty	6	2	2.8
Canterbury	15	3	5.7
Capital & Coast	88	13	6.6
Counties Manukau	4	1	4.1
Hawke's Bay	6	1	7.6
Hutt Valley	7	2	4.4
Nelson Marlborough	–	1	–
Northland	3	–	–
Southern	8	3	2.4
Taranaki	–	1	–
Waikato	14	1	11.5
Waitematā	10	2	4.6
West Coast	–	3	–
Whanganui	25	10	2.5
National total	**10**	**2**	**4.1**

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

Source: PRIMHD data (extracted 16 May 2023).

Figure 19: Rate ratio of Māori to non-Māori subject to indefinite inpatient treatment orders per 100,000 population, by DHB, at 30 June 2022

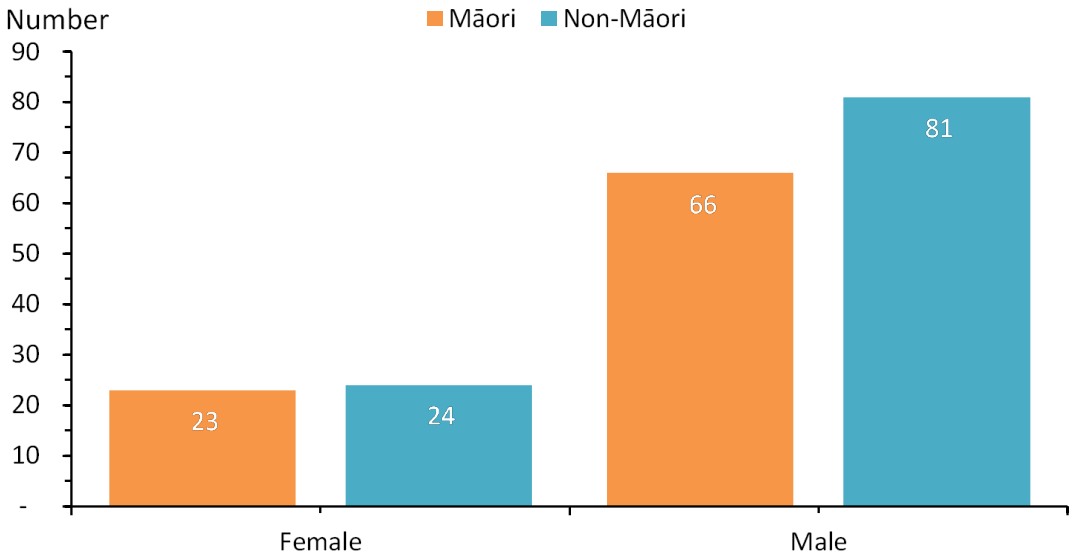


Notes: Wairarapa DHB did not have an inpatient service, and Lakes, MidCentral, South Canterbury and Tairāwhiti DHBs had no indefinite inpatient treatment orders, so these DHBs are not shown in this figure. Nelson Marlborough, Northland, Taranaki and West Coast DHBs had a rate ratio of zero so are also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

Source: PRIMHD data (extracted 16 May 2023).

Overall, 147 males were subject to indefinite inpatient treatment orders, making up 75.8% of all people under these orders (Figure 20). Similar to the findings for indefinite community treatment orders, this trend is consistent with the higher rate of males subject to CTOs.

Figure 20: Number of Māori and non-Māori subject to indefinite inpatient treatment orders, by gender, on 30 June 2022



Source: PRIMHD data (extracted 16 May 2023).

Seclusion

This section focuses on people under the Mental Health Act in adult inpatient wards who have been secluded. It also covers people who have been secluded in intellectual disability facilities, either under the Mental Health Act or the Intellectual Disability Care Act. Standards New Zealand defines 'seclusion' as a situation where a service user is 'placed alone in a room or area, at any time and for any duration, from which they cannot freely exit'.[13]

For the 2021/22 financial year, we have left out data from an outlier, where a high proportion of recorded seclusion hours from Southern Regional Forensic Mental Health Service relates to a single patient.

The following summarises adult inpatient services data[14] from 1 July 2021 to 30 June 2022.[15]

- The total number of people who experienced seclusion while receiving mental health treatment in an adult inpatient service decreased by 26.9% since 2009[16] (Figure 21). However, the number of Māori who have been secluded has increased by 47% over the same period.
- Since 2009, the total number of hours spent in seclusion decreased by 57.5% (Figure 22). However, the total number of hours spent in seclusion has increased by 6.1% compared with 2020/21.
- The number of people secluded decreased by 4% compared with 2020/21.
- 67.2% of all seclusion events lasted for less than 24 hours, and 14.8% lasted for longer than 48 hours.
- Males were more than twice as likely as females to spend time in seclusion.
- People aged 20–29 were more likely to spend time in seclusion than any other age group.
- Māori were more likely than non-Māori to have been secluded, have more seclusion events (as a rate per 100,000 population) and have longer periods of seclusion on average.
- Inpatients had an average of 6.6 seclusion events for every 1,000 bed nights they spent in adult inpatient units.
- Of the 10,330 admissions to adult inpatient units, 876 (8.5%) had seclusion recorded at some point during the stay.

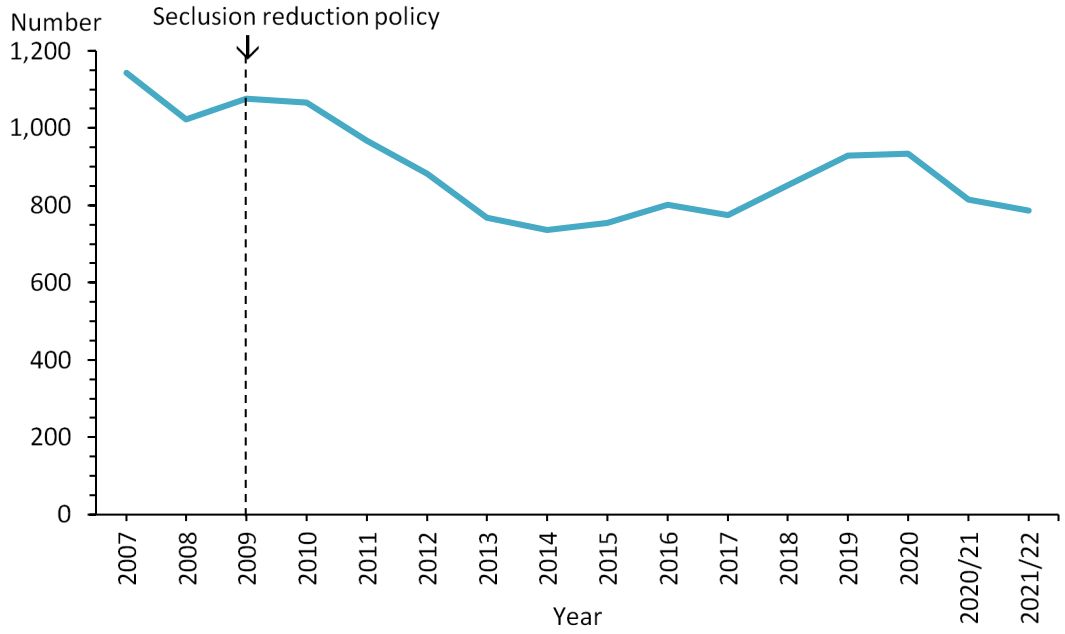
[13] Standards New Zealand. 2021. *Ngā Paerewa Health and Disability Services Standard*. Wellington: Standards New Zealand.

[14] 'Adult inpatient service' means an inpatient mental health service for those 18 and older. It does not include those in older persons mental health services.

[15] Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

[16] We compare with 2009 because in that year seclusion reduction policies were introduced in Aotearoa New Zealand.

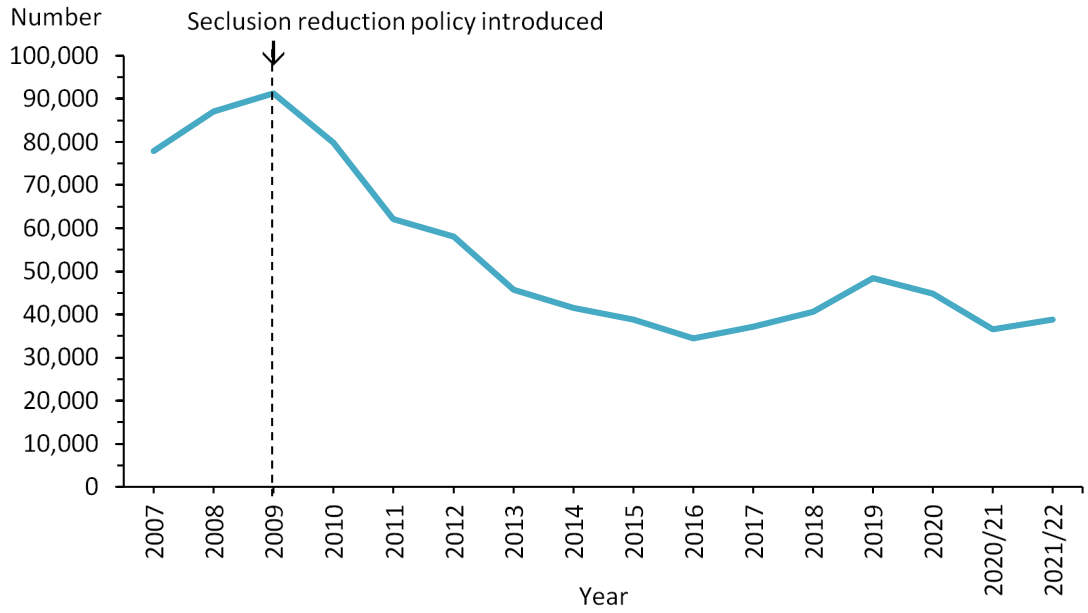
Figure 21: Number of people secluded in adult inpatient services nationally, 2007 to 2021/22



Notes: The data excludes forensic inpatient services and regional intellectual disability secure services. All years before 2020/21 are calendar years.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

Figure 22: Number of seclusion hours in adult inpatient services nationally, 2007 to 2021/22



Notes: The data excludes forensic inpatient services and regional intellectual disability secure services. All years before 2020/21 are calendar years.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

Seclusion in Aotearoa mental health services

Between 1 July 2021 and 30 June 2022, Aotearoa New Zealand adult mental health services (excluding forensic and other regional rehabilitation services) accommodated 7,977 people for a total of 220,996 bed nights. Of these, 786 (9.9%) were secluded at some stage during the reporting period.

Many were secluded more than once (on average 1.9 times). For this reason, the number of seclusion events in adult inpatient services (1,459) was higher than the number of people secluded. Services are encouraged to support patients in exiting seclusion as opposed to them being secluded for a longer single session. If the period outside of seclusion is not yet successful, they may be secluded again, meaning a patient could have several seclusion events.

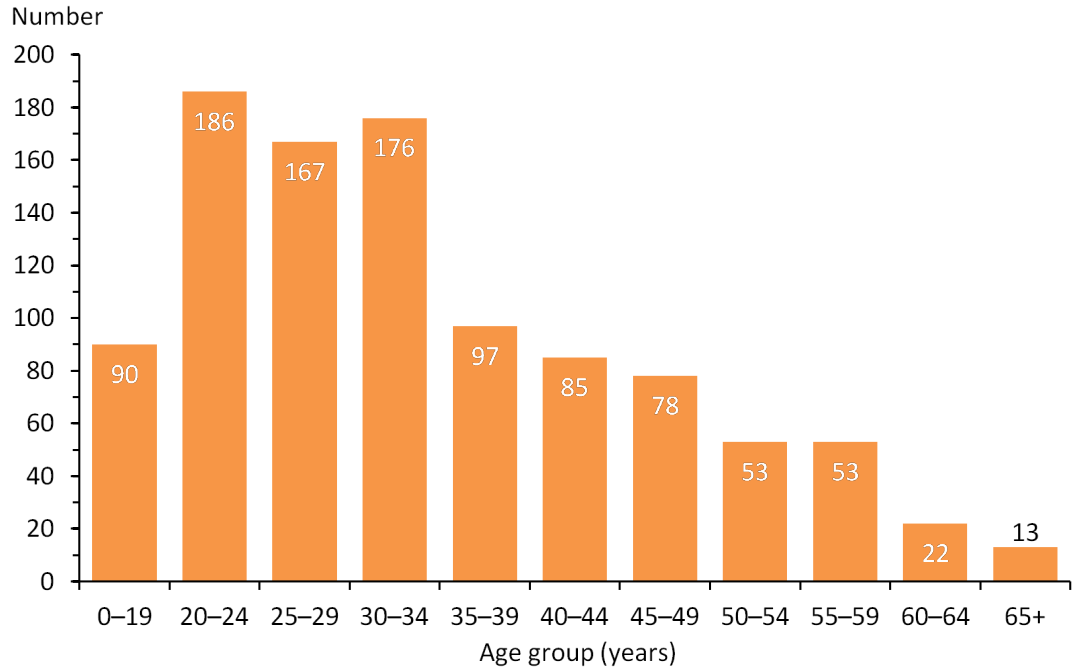
There were 6.6 seclusion events per 1,000 bed nights in adult inpatient units. This means that nationally and on average, for every 1,000 bed nights a person spent in an inpatient unit, they would have 6.6 seclusion events.

Across all inpatient services, including forensic, intellectual disability and youth services, 1,020 people experienced at least 1 seclusion event, with 72% male and 28% female.

The most common age group for those secluded was 20–29. A total of 90 young people (aged 19 and under) experienced 184 seclusion events during the year (Figure 23). This year, we have included the rate per 100,000 population of each age group to better demonstrate the differences between them (Figure 24). [17]

[17] Data in this section excludes forensic, intellectual disability, and youth services unless specified otherwise. Bed nights are measured by team types that use seclusion. This may differ from denominator figures used in other entities' seclusion reporting. This data cannot be compared with years before 2017, when bed nights were measured by acute and sub-acute bed nights. Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB. Waikato DHB has incomplete bed night data in PRIMHD.

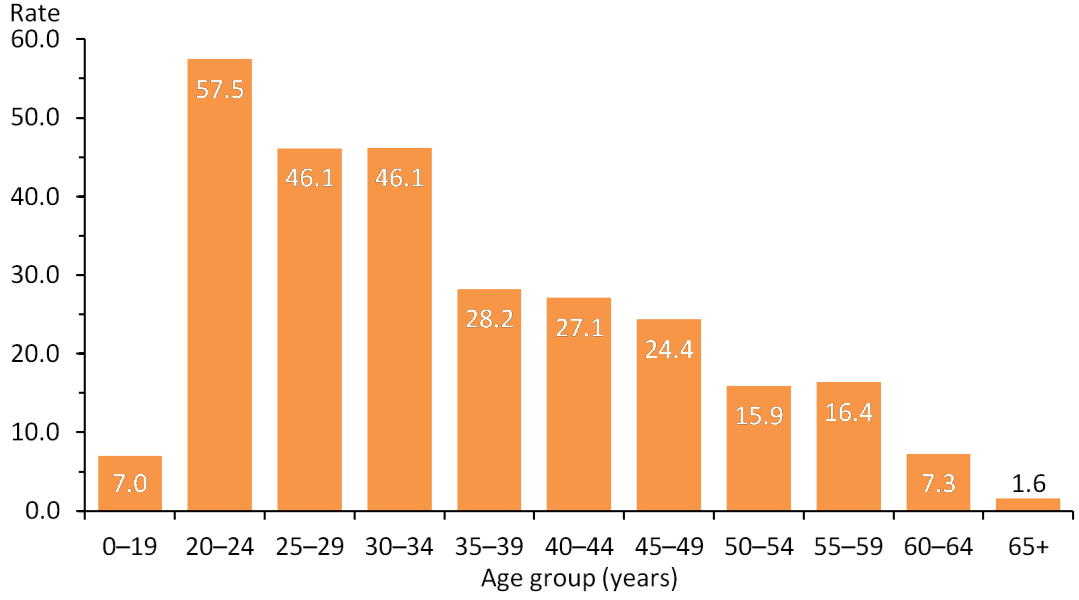
Figure 23: Number of people secluded across all inpatient services (adult, forensic, intellectual disability and youth), by age group, 1 July 2021 to 30 June 2022



Note: The data includes patients treated in regional intellectual disability secure services.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

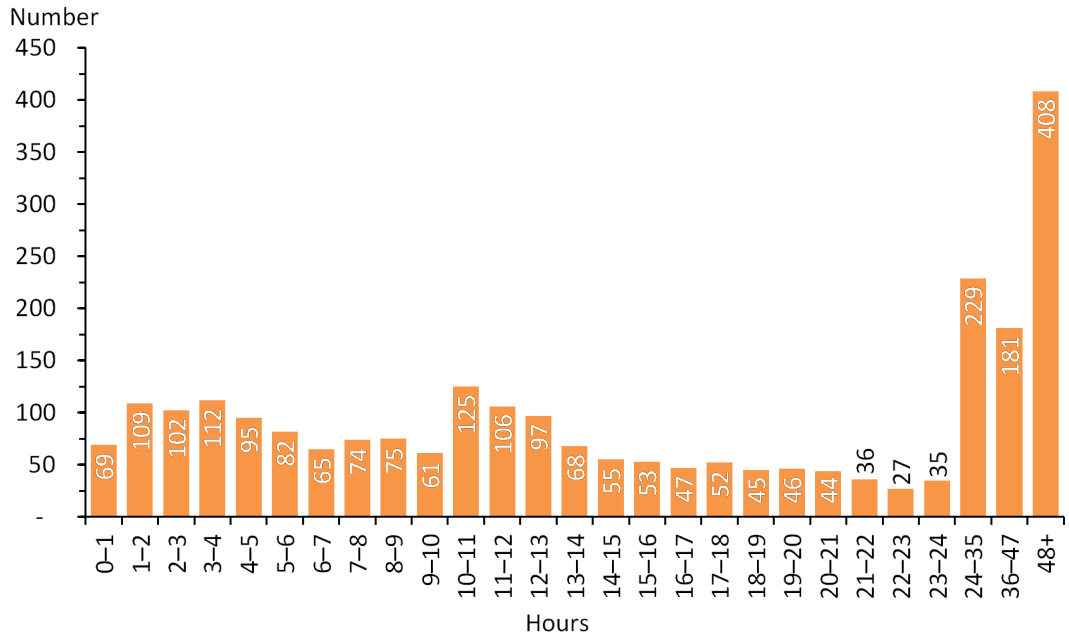
Figure 24: Rate of people secluded across all inpatient services (adult, forensic, intellectual disability and youth) per 100,000 population, by age group, 1 July 2021 to 30 June 2022



Note: The data includes patients treated in regional intellectual disability secure services.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

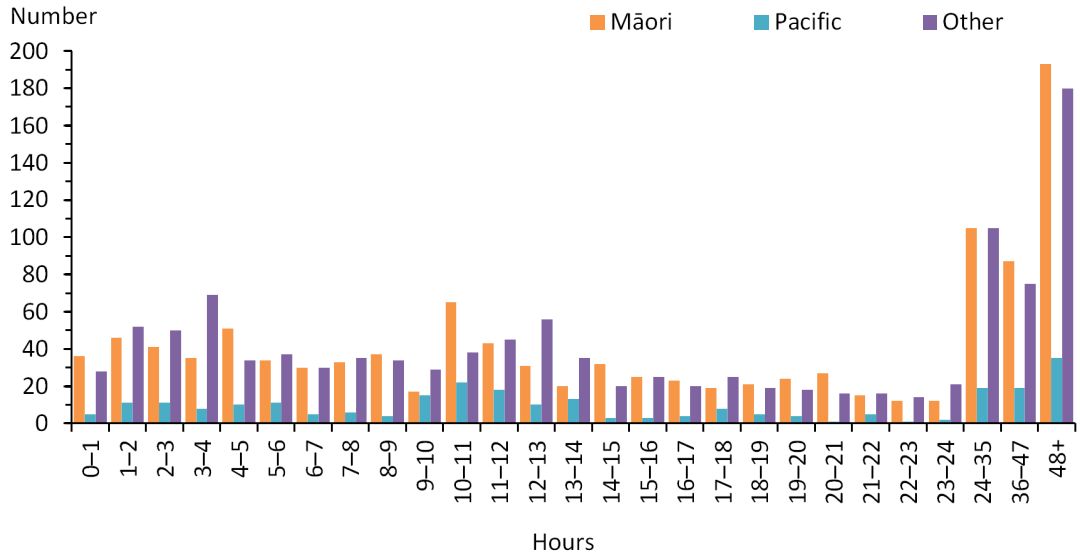
Figure 25: Number of seclusion events across all inpatient services (adult, forensic, intellectual disability and youth), by length of event, 1 July 2021 to 30 June 2022



Notes: The data includes patients treated in regional intellectual disability secure services. The lower limit is the shortest included time, for example 0–1 hours includes any time up to 59 minutes.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

Figure 26: Number of seclusion events across all inpatient services (adult, forensic, intellectual disability and youth), by ethnicity and length of event, 1 July 2021 to 30 June 2022



Notes: The data includes patients treated in regional intellectual disability secure services. The lower limit is the shortest included time. For example, 0–1 hours includes any time up to 59 minutes.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

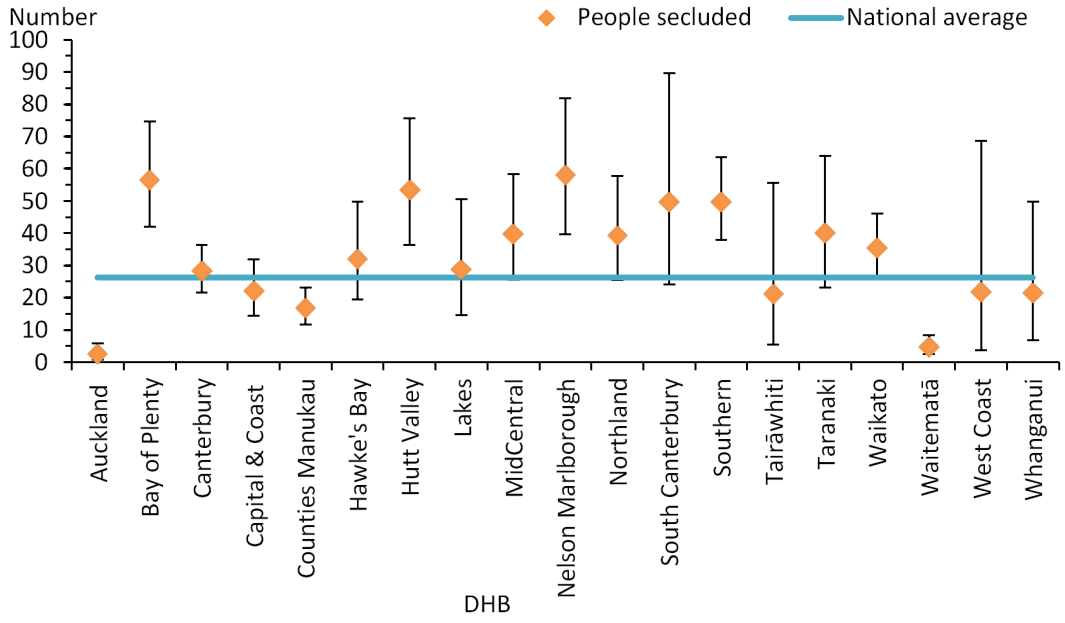
Use of seclusion by DHBs

All DHBs except for Wairarapa DHB (which had no mental health inpatient service) used seclusion.[18]

At the national level from 1 July 2021 to 30 June 2022, the average number of people secluded in adult inpatient services was 26.2 per 100,000 population. Figure 27 shows how individual DHBs compare with this national average. Table 8 shows the seclusion rate for each DHB as a percentage of patients admitted to adult inpatient services who experienced seclusion during their admission.

Nationally, the average number of seclusion events was 48.6 per 100,000 population, down from 59.6 in the 2020/21 financial year. Figure 28 breaks this rate down by DHB. The average duration of a seclusion event was 26.6 hours, an increase from 20.3 hours in the previous year.

Figure 27: Number of people secluded in adult inpatient services per 100,000 population, by DHB, 1 July 2021 to 30 June 2022

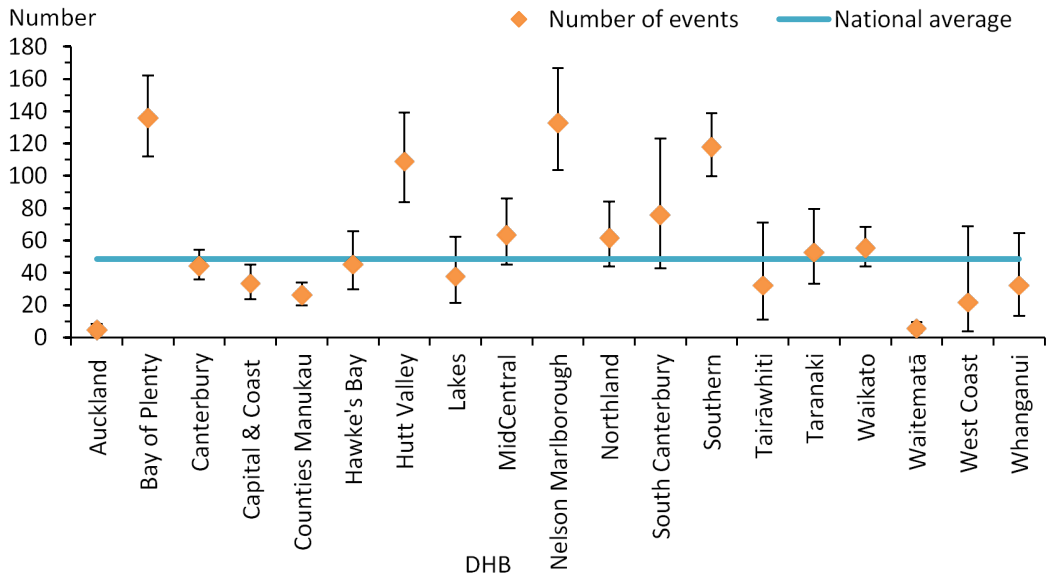


Notes: The graph uses confidence intervals (for 99% confidence) to help in interpreting the data. A DHB confidence interval crossing the national average means its rate was not statistically significantly different from the average. The data excludes forensic inpatient services and regional intellectual disability secure services. Wairarapa DHB did not have an inpatient unit, so is not shown in this figure.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

[18] If people in Wairarapa DHB required admission to mental health inpatient services, they were transported to either Hutt Valley DHB or MidCentral DHB. Any seclusion statistics for them are included in the DHB where they received treatment.

Figure 28: Number of seclusion events in adult inpatient services per 100,000 population, by DHB, 1 July 2021 to 30 June 2022



Notes: The graph uses confidence intervals (for 99% confidence) to help in interpreting the data. A DHB confidence interval crossing the national average means its rate was not statistically significantly different from the average. The data excludes forensic inpatient services and regional intellectual disability secure services. Wairarapa DHB did not have an inpatient unit, so is not shown in this figure.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

Table 8: Percentage of admissions to adult inpatient services with seclusion recorded during admission, by DHB, 1 July 2021 to 30 June 2022

DHB	Percentage	DHB	Percentage
Auckland	1.2%	Northland	5.3%
Bay of Plenty	12.6%	South Canterbury	12.4%
Canterbury	8.4%	Southern	11.7%
Capital & Coast	8.1%	Tairāwhiti	4.7%
Counties Manukau	7.9%	Taranaki	6.9%
Hawke's Bay	12.4%	Waikato	12.5%
Hutt Valley	11.3%	Waitematā	2.0%
Lakes	10.5%	West Coast	7.0%
MidCentral	10.7%	Whanganui	3.8%
Nelson Marlborough	22.6%	**National average**	**8.5%**

Notes: The data excludes forensic inpatient services, regional intellectual disability secure services, and Wairarapa DHB as they have no inpatient service.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

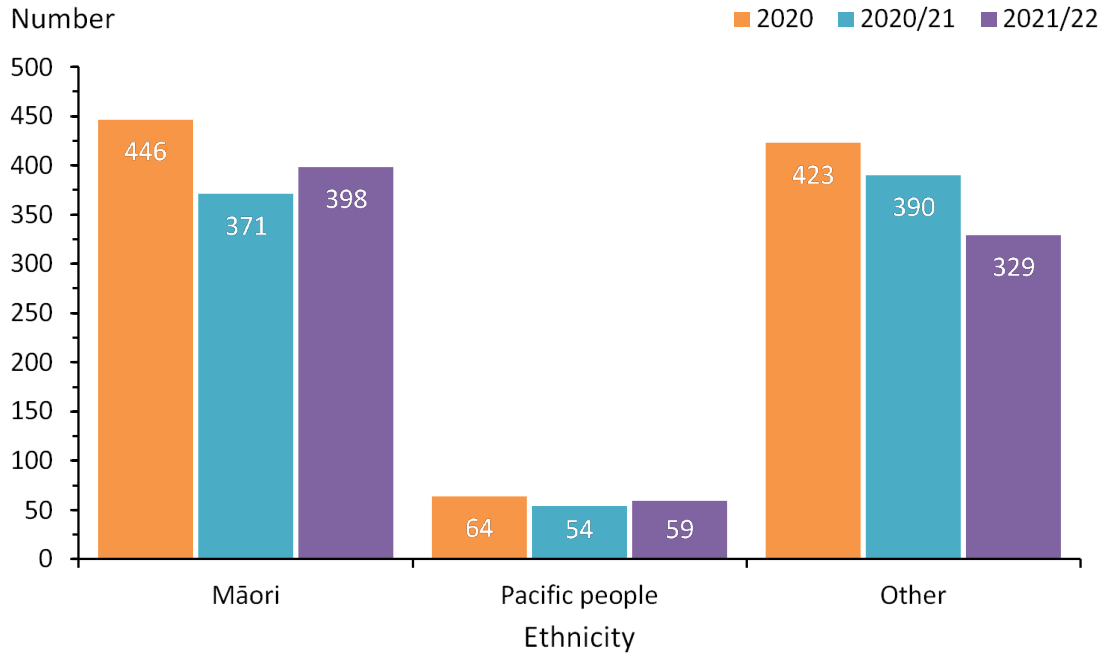
Seclusion and ethnicity

The rate of seclusion for Māori in adult inpatient services was 84 people per 100,000 population. They were 5.5 times more likely to be secluded than non-Māori, who had a rate of 15.3 people per 100,000.

This is an increase in the rate for Māori and a decrease for non-Māori, widening the inequity gap between the populations.

Pacific peoples were secluded at similar rates to non-Pacific peoples, at 28.0 and 26.0 per 100,000 (Figure 30) respectively. Figure 29 shows the number of people secluded by ethnicity over three periods: the 2020 calendar year, and 2020/21 and 2021/22 financial years.

Figure 29: Number of people secluded in adult inpatient services, by ethnicity, and year from 1 January 2020 to 30 June 2022

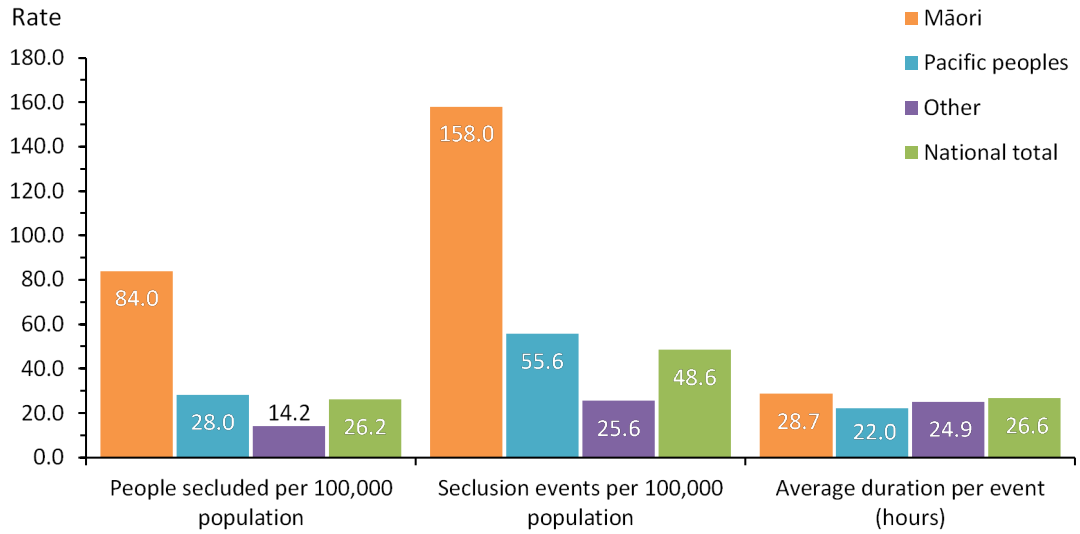


Notes: The data excludes forensic services and regional intellectual disability secure services.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

Figure 32 shows seclusion indicators for Māori, Pacific peoples and other ethnicities from 1 July 2021 to 30 June 2022. Māori were secluded at a rate of 84 people per 100,000 population, Pacific peoples at 28 people per 100,000 population and other ethnicities at a rate of 14.2 people per 100,000 population.

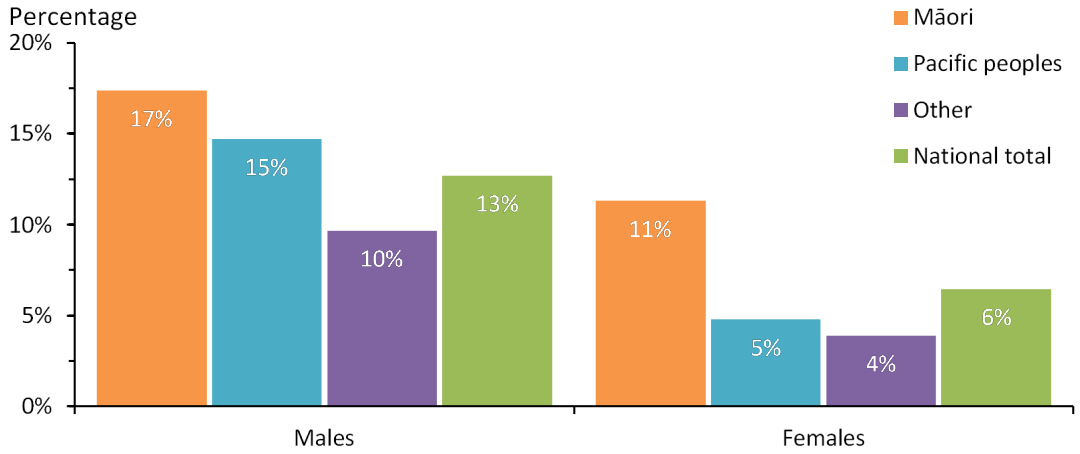
Figure 30: Seclusion indicators for adult inpatient services, by ethnicity, 1 July 2021 to 30 June 2022



Notes: The data excludes forensic services and regional intellectual disability secure services.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

Figure 31: Percentage of people with inpatient admissions who spent time in seclusion in adult inpatient services, by ethnicity and gender, 1 July 2021 to 30 June 2022

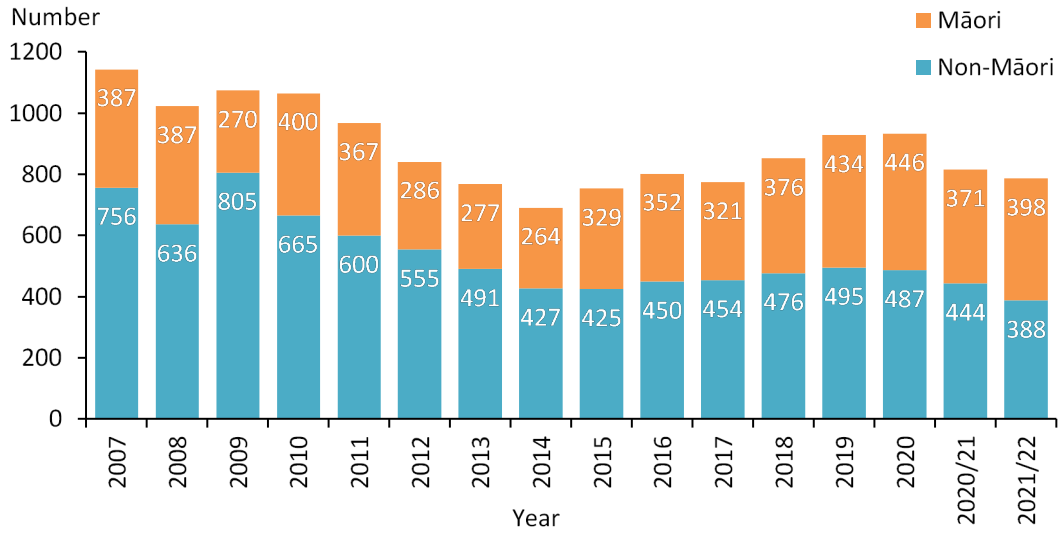


Notes: The data excludes forensic services and regional intellectual disability secure services.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

Figure 32 shows the number of Māori and non-Māori aged 20–64 secluded in adult inpatient services from the 2007 calendar year to the 2021/22 financial year. Nationally over this time, the number of people secluded decreased by 31.2%. The number of people secluded who identified as Māori has increased by 2.8% over the same period.

Figure 32: Number of Māori and non-Māori secluded in adult inpatient services, 2007 to 2021/22



Notes: The data excludes forensic services and regional intellectual disability secure services. All years before 2020/21 are calendar years.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

Seclusion in forensic units

Specialist inpatient forensic care is provided by 5 regional forensic mental health services.

- Auckland Regional Forensic Psychiatry Service operates from Waitematā DHB and covers Auckland, Counties Manukau, Northland and Waitematā DHBs.
- Midland Regional Forensic Psychiatric Service operates from Waikato DHB and covers Bay of Plenty, Lakes, Tairāwhiti, Taranaki and Waikato DHBs.
- Central Regional Forensic Mental Health Service operates from Capital & Coast DHB and covers Capital & Coast, Hawke's Bay, Hutt Valley, MidCentral, Wairarapa and Whanganui DHBs.
- Canterbury Regional Forensic Mental Health Service operates from Canterbury DHB and covers Canterbury, Nelson Marlborough, South Canterbury, and West Coast DHBs.
- Southern Regional Forensic Mental Health Service operates from and covers Southern DHB.

These services provide mental health treatment in a secure setting for prisoners with mental disorders and for people defined as a special or restricted patient.

In previous annual reports, the forensic services were reported under the name of their operating DHB. In this report they are split into the regional forensic mental health services listed above.

Table 9 presents seclusion indicators for the regional forensic mental health services. Figure 33 gives a breakdown of the number of people secluded and number of events by ethnicity on a national level. These indicators cannot be compared with adult inpatient service indicators because they have a different client base.

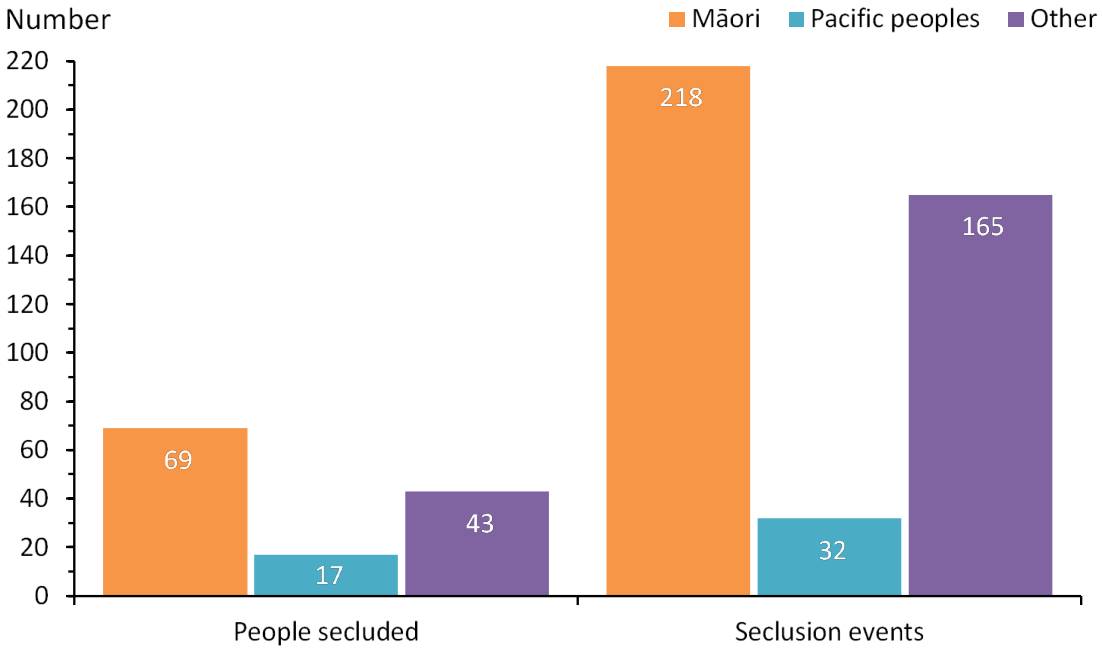
Table 9: Seclusion indicators for forensic mental health services, by DHB, 1 July 2021 to 30 June 2022

Regional service	Number of people secluded	Number of events	Total hours	Average duration per event (hours)
Auckland	54	193	5,925	30.7
Canterbury	32	118	9,499	80.5
Central	5	5	109	21.8
Midland	33	86	5,790	67.3
Southern	5	13	959	73.8
National total	**129**	**415**	**22,282**	**53.7**

Notes: This data is for mental health service users aged 20–64. It excludes 1 outlier.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

Figure 33: Seclusion indicators for forensic mental health services nationally, by ethnicity, 1 July 2021 to 30 June 2022



Notes: This data is for mental health service users aged 20–64. It excludes 1 outlier.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

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

The 5 regional forensic mental health services listed above also provide forensic intellectual disability services for people with an intellectual disability under the Intellectual Disability Care Act, as care recipients or special care recipients. Individuals become subject to the Intellectual Disability Care Act when convicted of criminal offending and compulsory care is ordered rather than a prison sentence. A small number of individuals in forensic intellectual disability services are under the Mental Health Act.

The seclusion data presented for people with intellectual disabilities is for individuals with a legal status under the Intellectual Disability Care Act or the Mental Health Act. People receiving care under these Acts can be secluded only in hospital-level secure services that meet specific requirements.

Table 10: Seclusion indicators for people with intellectual disabilities, by regional service, 1 July 2021 to 30 June 2022

Act	Regional service	Number of people secluded	Number of events	Median number of events	Average number of events per person
Intellectual Disability Care Act	Auckland	8	137	7	17
	Canterbury	0	0	0	0
	Central	6	9	1	2
	Midland	0	0	0	0
	Southern	2	26	13	13
	National total	**16**	**172**	**2**	**10.8**
Mental Health Act	Auckland	1	151	151	151
	Canterbury	1	5	5	5
	Central	1	6	6	6
	Midland	0	0	0	0
	Southern	2	101	51	51
	National total	**5**	**263**	**6**	**52.6**

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

Table 11: Length of seclusion for people with intellectual disabilities, by regional service, 1 July 2021 to 30 June 2022

Act	Regional service	Total seclusion hours	Median length of seclusion events (hours: minutes)	Average length of seclusion events (hours: minutes)
Intellectual Disability Care Act	Auckland	1,906.6	10:45	13:55
	Canterbury	0	0:00	0:00
	Central	63.0	6:12	7:00
	Midland	0	0:00	0:00
	Southern	2,790.7	15:47	107:20
	National total	**4,760.3**	**11:00**	**27:41**
Mental Health Act	Auckland	5,279.5	23:35	34:58
	Canterbury	99.7	15:00	19:57
	Central	23.0	2:10	3:50
	Midland	0	0:00	0:00
	Southern	2,096.3	12:55	20:45
	National total	**7,498.6**	**13:40**	**28:31**

Note: The totals for the Auckland and Canterbury services are driven by very high seclusion hours for two clients in each of these services.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

Table 12: Seclusion indicators for Māori and non-Māori with intellectual disabilities, 1 July 2021 to 30 June 2022

Act	Ethnicity	Number of people secluded	Number of seclusion events	Median number of events	Average number of events per person
Intellectual Disability Care Act	Māori	8	36	1	4.5
	Non-Māori	8	136	7	17
Mental Health Act	Māori	1	5	5	5
	Non-Māori	4	258	53	64.5

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Waikato DHB.

Special and restricted patients

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

Special patients include:

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

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

Special and restricted patients can be detained in the 5 regional forensic mental health services.

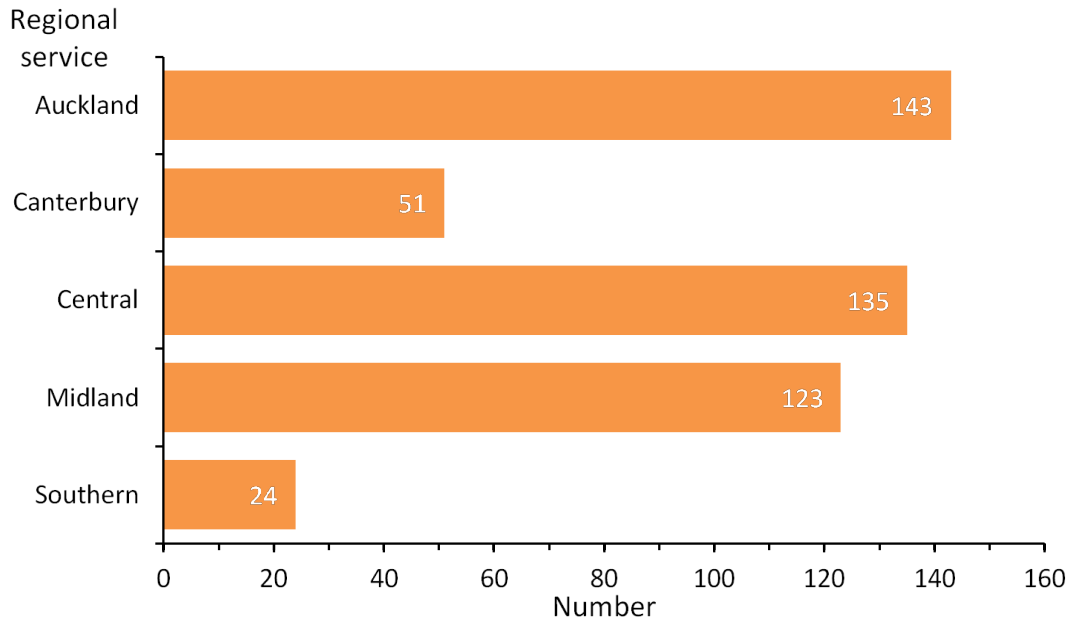
- Auckland Regional Forensic Psychiatry Service operates from Waitematā DHB and covers Auckland, Counties Manukau, Northland and Waitematā DHBs.
- Midland Regional Forensic Psychiatric Service operates from Waikato DHB and covers Bay of Plenty, Lakes, Tairāwhiti, Taranaki and Waikato DHBs.
- Central Regional Forensic Mental Health Service operates from Capital & Coast DHB and covers Capital & Coast, Hawke's Bay, Hutt Valley, MidCentral, Wairarapa and Whanganui DHBs.
- Canterbury Regional Forensic Mental Health Service operates from Canterbury DHB and covers Canterbury, Nelson Marlborough, South Canterbury and West Coast DHBs.
- Southern Regional Forensic Mental Health Service operates from and covers Southern DHB.

In previous annual reports, the forensic services were reported under the name of their operating DHB. In this report they are split into the regional forensic mental health services listed above.

The number of special patients nationally, 465 in total, is lower than the sum of special patients by regional service. This is because some may have transferred across services during the year.

Figure 34 presents the total number of special patients in the care of each regional forensic mental health service.

Figure 34: Total number of special patients, by regional service, 1 July 2021 to 30 June 2022



Source: PRIMHD data (extracted 16 May 2023).

Special and restricted patients may be detained for extended or short-term care.

Extended forensic care special patients

Extended forensic care (EFC) patients include special patients who have been found not guilty by reason of insanity or unfit to stand trial under section 24(2)(a) of the Criminal Procedure (Mentally Impaired Persons) Act 2003. Restricted patients under section 55 of the Mental Health Act are also supported in extended forensic care facilities.

From 1 July 2021 to 30 June 2022, Aotearoa New Zealand had 172 EFC special patients.

Table 13 shows the number of these patients in the care of regional forensic mental health services.

Short-term forensic care special patients

Short-term forensic care (SFC) patients include people transferred from prison to a forensic mental health service. When a person has been sentenced to a term of imprisonment, any Mental Health Act status no longer applies. Remand prisoners may remain on a current CTO, but it is unlawful to enforce compulsory treatment in the prison environment. However, a court may make a 'hybrid order' under section 34(1)(a)(i) of the Criminal Procedure (Mentally Impaired Persons) Act 2003, sentencing an offender to a term of imprisonment while also ordering their detention in hospital as a special patient.

From 1 July 2021 to 30 June 2022, Aotearoa New Zealand had a total of 311 SFC special patients.

Table 13 shows the number of these patients in the care of each regional forensic mental health service. Figure 35 shows the percentage of court orders given for SFC and EFC legal status in each of these services.

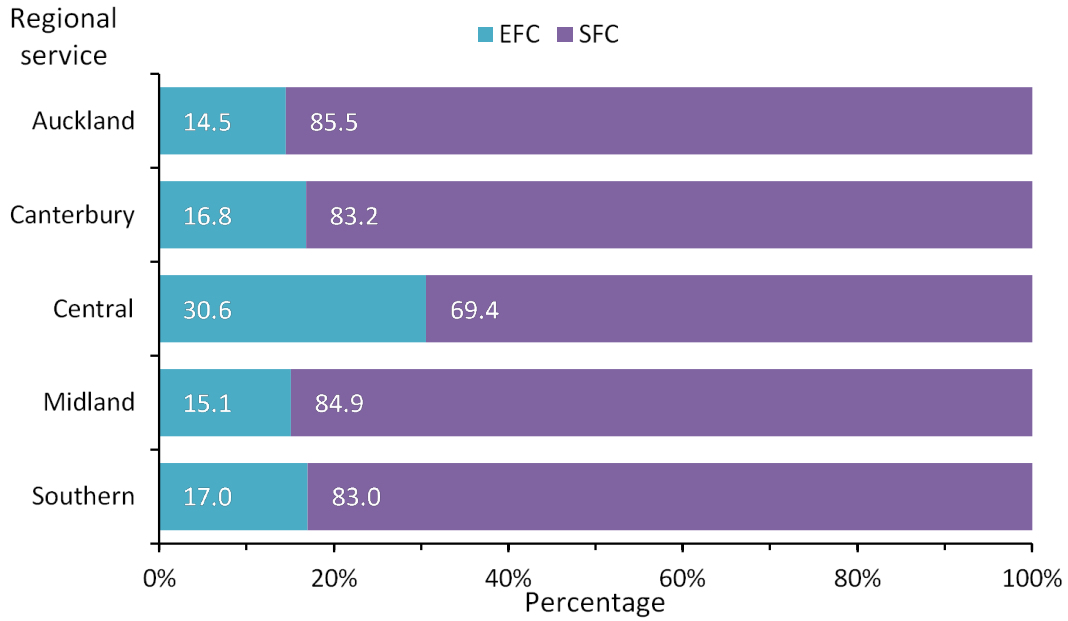
Table 13: Total number of special patients, by type and service, 1 July 2021 to 30 June 2022

Regional service	EFC special patients	SFC special patients	Total special patients
Auckland	47	100	143
Canterbury	19	36	51
Central	64	78	135
Midland	38	88	123
Southern	9	15	24
National total	**172**	**311**	**465**

Notes: Special patients who receive treatment with more than 1 service are counted in each, which is why the sum of patients in the 5 services is higher than the national total. A patient may be represented under both the EFC and SFC categories in this table. Court orders for a few special patients directed them to receive treatment outside a regional forensic service. This data is excluded to protect patient confidentiality.

Source: PRIMHD data (extracted 16 May 2023).

Figure 35: Percentage of court orders given for EFC and SFC, by regional service, 1 July 2021 to 30 June 2022



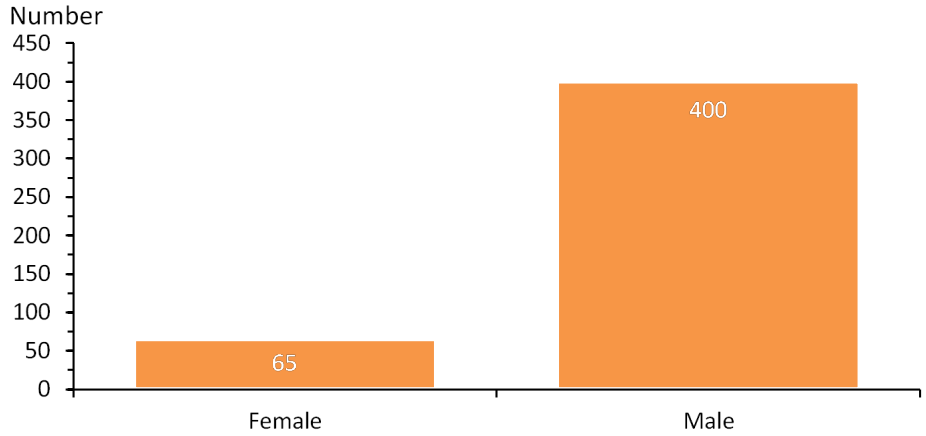
Notes: Unlike previous data in this section, this figure is based on a count of court orders rather than the number of special patients. A single special patient may have many court orders in the year, which could include both EFC and SFC, but each special patient's legal status is counted in only 1 category at any 1 time. Please use caution when comparing the counts of court orders for legal status with the counts of people with either EFC or SFC legal status.

Source: PRIMHD data (extracted 16 May 2023).

Gender, age and ethnicity of special patients

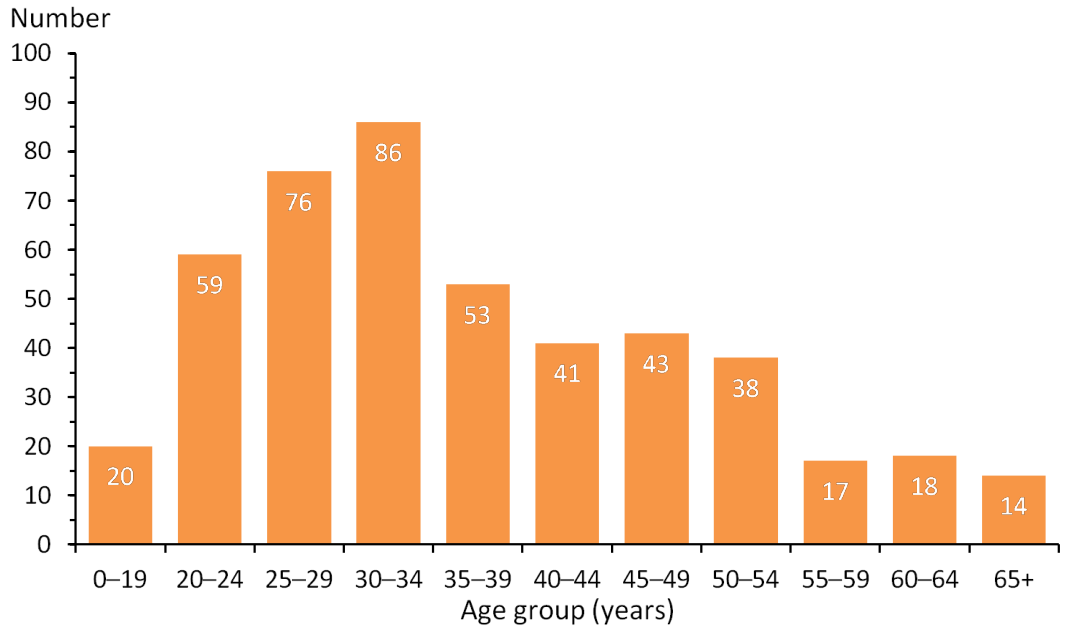
Special patients were over 6 times more likely to be male (86.0%) than female (14.0%) (Figure 36). The most common age group for special patients from 1 July 2021 to 30 June 2022 was 30–34 (Figure 37).

Figure 36: Number of special patients, by gender, 1 July 2021 to 30 June 2022



Source: PRIMHD data (extracted 16 May 2023).

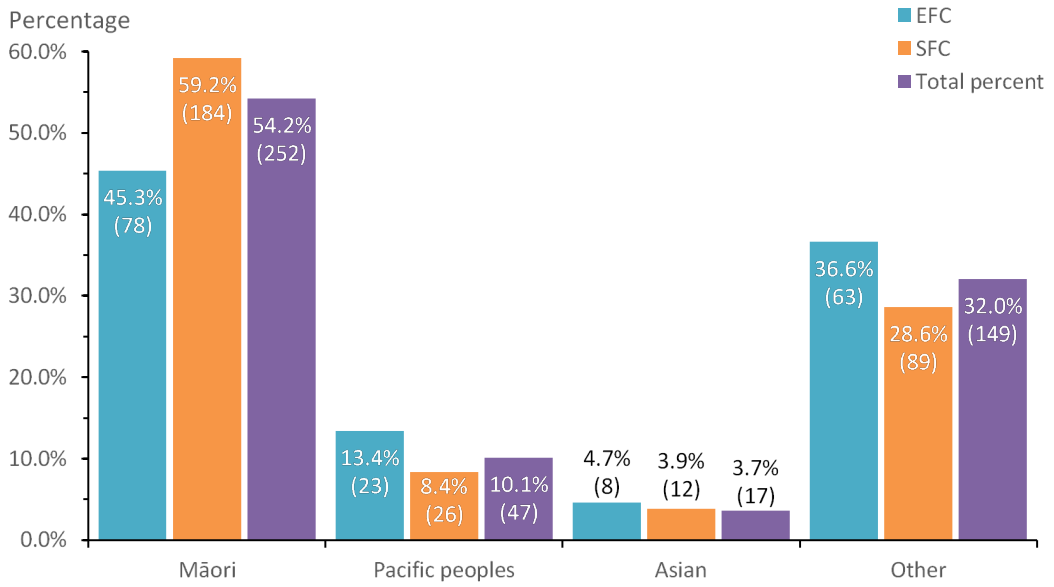
Figure 37: Total number of special patients, by age group, 1 July 2021 to 30 June 2022



Source: PRIMHD data (extracted 16 May 2023).

Among people subject to a special patient order, most (54.2%) were Māori (Figure 38). Māori represented the highest proportion of both EFC (45.3%) and SFC care (59.2%) special patients.

Figure 38: Percentage and number of special patients, by ethnicity and special patient type, 1 July 2021 to 30 June 2022



Note: A single patient may be represented under both the EFC and SFC categories in this figure. Numbers in brackets are the number of special patients.

Source: PRIMHD data (extracted 16 May 2023).

Decisions about leave and change of legal status for special and restricted patients

The Director of Mental Health (the Director) has a central role in managing special patients and restricted patients through the continuum of care. The Director must be notified when special and restricted patients are admitted, discharged or transferred, and when certain incidents involving these people occur (section 43 of the Mental Health Act). The Director may authorise the transfer of patients between DHBs under section 49 of the Mental Health Act or grant leave for any period no longer than 7 days for certain special and restricted patients (section 52).

Under section 50 of the Mental Health Act, the Minister of Health can grant periods of leave for longer than 7 days to certain categories of special patients. The Director briefs the Minister of Health when requests for leave are made. The first period of ministerial section 50 leave is usually granted for a period of 6 months, with the possibility of further applications for ministerial leave for a period of 12 months.

A special patient found not guilty by reason of insanity, or if the act is proven but they are not criminally responsible on account of insanity,[19] may be considered for a change of legal status if it is determined that their detention as a special patient is no longer necessary to safeguard their own or the public's interests. This will usually occur after the person has been living successfully in the community on ministerial long leave for several years. Services apply to the Director for such changes in legal status. After careful consideration, the Director makes a recommendation for the Minister of Health's decision about a person's legal status.

Table 14 shows the number of applications for section 50 long leave, revocation of leave and reclassification the Office of the Director of Mental Health and Addiction Services processed through to the Minister of Health from 1 July 2021 to 30 June 2022.

[19] 'Act proven but not criminally responsible on account of insanity' is a new finding that was introduced by the Rights for Victims of Insane Offenders Act 2021 to replace 'not guilty by reason of insanity'.

Table 14: Number of section 50 long leave, revocation and reclassification applications received by the Minister of Health for special and restricted patients, 1 July 2021 to 30 June 2022

Type of request	Number completed
Initial ministerial section 50 leave applications approved	5
Initial ministerial section 50 leave applications not approved	0
Ministerial section 50 leave revocations (initial and further)	2
Further ministerial section 50 leave applications approved	17
Further ministerial section 50 applications not approved	0
Change of legal status applications approved	10
Change of legal status applications not approved	1
Total applications completed	**35**

Note: Applications that were withdrawn before the Minister of Health received them and applications for adjustments to be made to section 50 leave conditions for a special patient are not included.

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

Mental health and addiction adverse event reporting

Aotearoa New Zealand has 2 major national reporting mechanisms for adverse events relating to mental health.[20]

1. DHBs notify the Director of Mental Health of the death of any person or special patient under the Mental Health Act.
2. DHBs report all adverse events rated Severity Assessment Code[21] 1 or 2 to Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora) in line with the National Adverse Events Reporting Policy.[22] When this data was collected mental health services not funded by DHBs were encouraged but not required to report adverse events to Te Tāhū Hauora. On 28 February 2022 the Ngā Paerewa Health and Disability Services Standard came into effect, with all residential mental health and addiction services now required to report to Te Tāhū Hauora.

Adverse events have been reported publicly since 2006. From then, the number of adverse events has increased each year. This is not necessarily because adverse events are more frequent; at least part of the explanation may be that DHBs have improved their reporting systems and created a stronger culture of transparency and commitment to learning.

To provide timely access to adverse event data, Te Tāhū Hauora publish mental health and addiction data quarterly: **https://reports.hqsc.govt.nz/AdverseEventsQuarterly/**

Te Tāhū Hauora publishes events in the year that providers reported them to Te Tāhū Hauora, as a way of making harm visible and transparent. Event totals fluctuate because some events are reclassified more accurately after reviews which may change the severity assessment code (SAC) rating and therefore the obligation to report or not. This may result in the data displayed in the dashboards changing as events are reclassified.

Te Tāhū Hauora welcome increases in reporting rates, because rather than representing worsening rates of adverse events, they believe they represent more thorough and consistent reporting of the events that have always been a part of the system. This stronger reporting culture creates real opportunities for improvement across the system.

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

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

[22] See the National Adverse Events Reporting Policy on the website for Te Tāhū Hauora at: **www.hqsc.govt.nz/our-programmes/adverse-events/national-adverse-events-policy/**.

Deaths reported to the Director of Mental Health

Section 132 of the Mental Health Act requires services to notify the Director within 14 days of the death of any person or special patient under the Mental Health Act, identifying the apparent cause of death.

In Aotearoa New Zealand, a coroner determines a cause of death after completing their inquiry. Only deaths that the coroner decides are 'intentionally self-inflicted' will receive a final verdict of suicide. The coronial inquiry is unlikely to occur within a year of a death. So when a death appears to be self-inflicted but the coroner has not yet made a ruling it is called a 'suspected suicide'. For more information and data, search for 'suicide statistics' on the Manatū Hauora website (**health.govt.nz**).

Between 1 July 2021 and 30 June 2022, the Director received 55 death notifications relating to people under the Mental Health Act (Table 15). Of these, 21 related to people who were reported to have died by suspected suicide. The remaining 34 reportedly died by other means, including natural causes and illnesses unrelated to their mental health status.

Table 15: Outcomes of reportable death notifications under section 132 of the Mental Health Act, 1 July 2021 to 30 June 2022

Reportable death outcome	Number of deaths
Suspected suicide	21
Other deaths	34
National total	**55**

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

Section 95 inquiries and section 99 inspections

The Director will occasionally require a district inspector to carry out an inquiry under section 95 of the Mental Health Act or undertake an inspection under section 99. Inquiries and inspections generally focus on systemic issues across 1 or more mental health services. They typically result in the district inspector or Director making specific recommendations about the mental health services and/or their system.

The Director considers the recommendations and acts on any that have implications for the Ministry or the mental health sector. The Director later audits the DHB's implementation of the recommendations.

The inquiry process is complete when the Director considers that the DHB concerned and, if appropriate, the Ministry and all other DHBs have satisfactorily implemented the recommendations.

No section 95 inquiries or section 99 inspections were completed from 1 July 2021 to 30 June 2022. Table 16 shows the number of completed section 95 inquiry reports the Director received, and the number of section 99 reports the Director received or completed between 1 July 2011 and 30 June 2022.

A section 99 inspection was initiated on 6 July 2022, following a serious incident in late June 2022 and in the context of concerns regarding the Canterbury adult inpatient and associated mental health services. This will be included in next year's reporting. More information on this, including the Terms of Reference, is on the Manatū Hauora website: **https://www.health.govt.nz/our-work/mental-health-and-addiction/mental-health-legislation/section-99-inspection-canterbury-mental-health-services**

Table 16: Number of completed section 95 inquiries and section 99 inspections reports received or completed by the Director, 2011/12 to 2021/22

2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
1	0	0	1	2	0	0	0	0	0	0

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

Electroconvulsive therapy

Electroconvulsive therapy (ECT) is a therapeutic procedure that delivers a brief pulse of electricity to a person's brain to generate a seizure. ECT can be an effective treatment for depression, mania, catatonia and other serious neuropsychiatric conditions. It can only happen if the person receiving it consents or in carefully defined circumstances.

In last year's report, there was an error in calculating the mean number of ECT treatments, and a higher figure was reported. Appendix 4 has the corrected data.

The following summarises ECT data from 1 July 2021 to 30 June 2022.[23]

- 256 people received ECT (5.0 people per 100,000 population).
- Services administered a total of 3,002 treatments of ECT.
- ECT patients received an average of 11.7 treatments each over the year.
- Females were more likely than males to receive ECT (63.7% compared to 36.3%).
- Older people were more likely to receive ECT, with those over 50 making up 62.5% of ECT patients.

Number of people receiving ECT

Around 200 to 300 people receive the treatment each year, and this has remained relatively stable since 2006. (Figure 39).

Figure 39: Number of ECT patients per 100,000 population, 2005 to 2021/22

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Northland DHB. All years before 2020/21 are calendar years.

[23] Sources: PRIMHD data (extracted 16 May 2023) and manual data from Northland DHB.

ECT by region

The number and rate of ECT treatments vary regionally (Table 17 and Figures 40, 41 and 42). Several factors help to explain these variations.

- Regions with smaller populations are more vulnerable to annual variations (according to the needs of the population at any given time).
- People receiving continuous or maintenance treatment will typically receive more treatments in a year than those treated with an acute course.
- Populations in some DHB areas have fewer barriers to accessing ECT services than those in other DHB areas. Some DHB areas have no ECT facilities.

It is important to consider these factors when interpreting the following information.

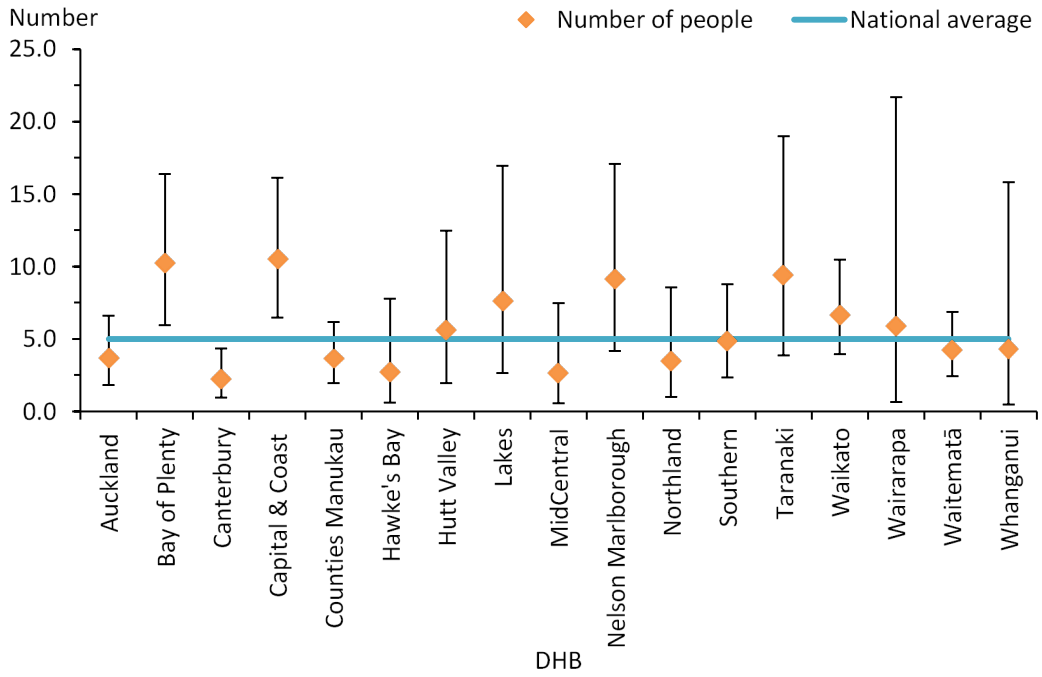
Table 17: ECT indicators, by DHB of domicile, 1 July 2021 to 30 June 2022

DHB of domicile	Number of people treated with ECT	Number of treatments	Mean number of treatments per person (range)
Auckland	18	151	8 (1–18)
Bay of Plenty	28	343	12 (2–57)
Canterbury	13	97	7 (2–23)
Capital & Coast	34	411	12 (2–28)
Counties Manukau	22	366	17 (1–53)
Hawke's Bay	5	98	20 (4–36)
Hutt Valley	9	70	8 (2–11)
Lakes	9	55	6 (1–12)
MidCentral	5	67	13 (1–25)
Nelson Marlborough	15	163	11 (2–33)
Northland	7	108	15 (1–35)
South Canterbury	0	0	–
Southern	17	163	9 (1–29)
Tairāwhiti	0	0	–
Taranaki	12	178	15 (6–34)
Waikato	30	347	12 (1–63)
Wairarapa	3	31	10 (7–12)
Waitematā	27	329	12 (1–38)
West Coast	0	0	–
Whanganui	3	25	8 (2–21)
National total	**256**	**3,002**	**12 (1–63)**

Note: In 2021/22, 18 people were treated out of area: Auckland DHB saw 1 person from Waitematā; Bay of Plenty DHB saw 1 person from Lakes; Capital & Coast DHB saw 2 people from Hutt Valley, 1 from MidCentral, 1 from Wairarapa and 2 people from Whanganui; Counties Manukau DHB saw 1 person from Auckland; Hutt Valley DHB saw 1 person from Capital & Coast and 2 people from Wairarapa; Lakes DHB saw 1 person from Waikato; MidCentral DHB saw 1 person from Whanganui; Waikato DHB saw 1 person from Bay of Plenty; Waitematā saw 2 people from Auckland and 1 person from Bay of Plenty.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Northland DHB.

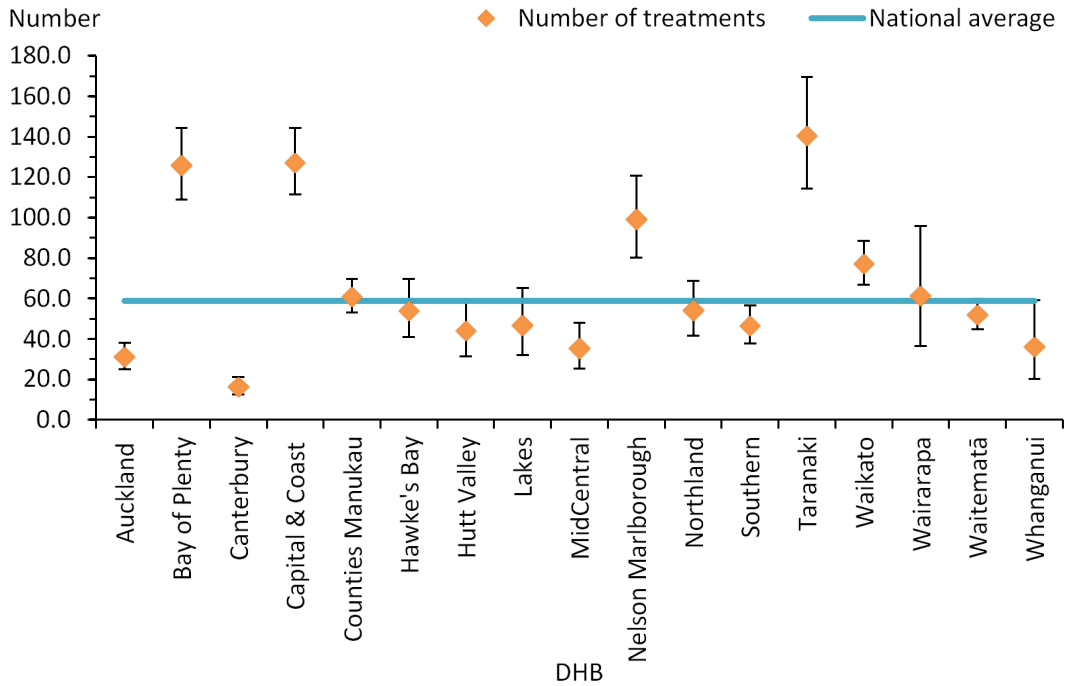
Figure 40: Number of people per 100,000 population treated with ECT, by DHB of domicile, 1 July 2021 to 30 June 2022



Note: No one living in South Canterbury, Tairāwhiti or West Coast DHBs received ECT treatment in the period, so these DHBs are not included in the figure.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Northland DHB.

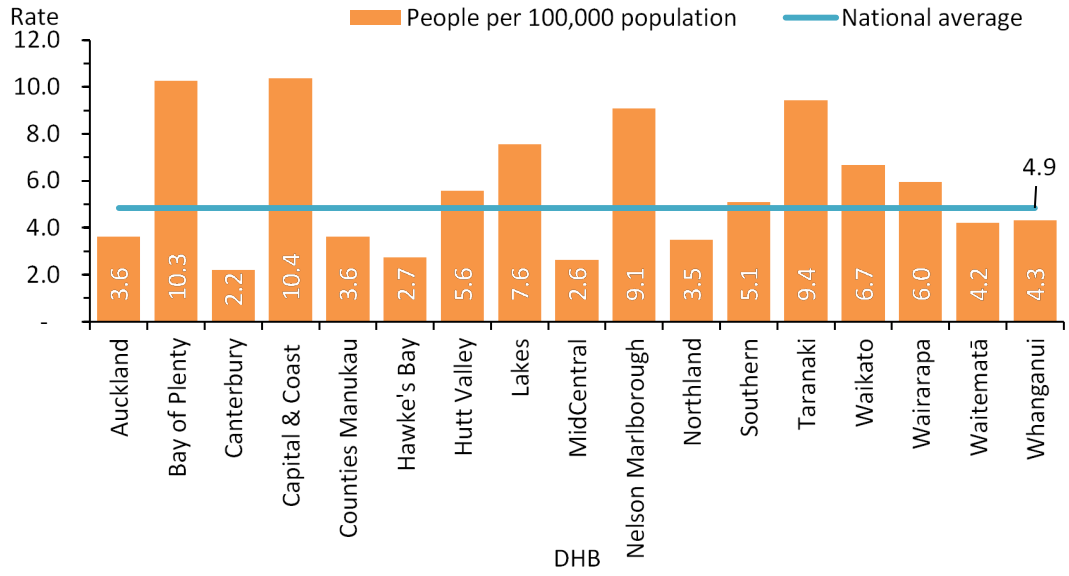
Figure 41: Number of ECT treatments per 100,000 population, by DHB of domicile, 1 July 2021 to 30 June 2022



Note: No one living in South Canterbury, Tairāwhiti or West Coast DHBs received ECT treatment in the period, so these DHBs are not included in this figure.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Northland DHB.

Figure 42: Rate of people treated with ECT per 100,000 population, by DHB of domicile, 1 July 2021 to 30 June 2022



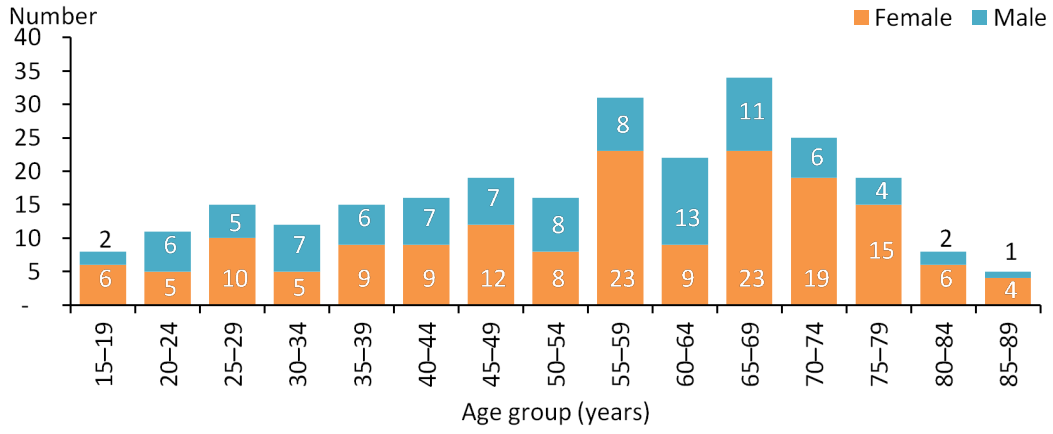
Note: No one living in South Canterbury, Tairāwhiti or West Coast DHBs received ECT treatment in the period, so these DHBs are not included in this figure.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Northland DHB.

Age and gender of people receiving ECT

Between 1 July 2021 and 30 June 2022, women were more likely to receive ECT than men. Older people were more likely to receive ECT, with those over 50 making up 62.5% of ECT patients. Figure 43 presents the numbers broken down by age group and gender.

Figure 43: Number of people treated with ECT, by age group and gender, 1 July 2021 to 30 June 2022



Note: No one aged under 15 or over 89 received ECT, so these age groups are not included in this figure.

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Northland DHB.

Ethnicity of people treated with ECT

Table 18 indicates that Asian, Māori and Pacific peoples were less likely to receive ECT than other ethnicities, such as New Zealand Europeans. However, the numbers involved are so small that it is not statistically appropriate to compare the percentages of people receiving ECT in each ethnic group with its proportion of the total population.

Table 18: Number and rate per 100,000 population of people treated with ECT, by ethnicity, 1 July 2021 to 30 June 2022

Ethnicity	Number	Rate per 100,000
Asian	18	2.2
Māori	39	4.4
Pacific peoples	6	1.6
Other	193	6.3
National total	**256**	**5.0**

Sources: PRIMHD data (extracted 16 May 2023) and manual data from Northland DHB.

Consent to ECT treatment

Under the Mental Health Act, a person can be treated with ECT if they consent in writing or if an independent psychiatrist appointed by the Mental Health Review Tribunal[24] considers this treatment to be in the person's interests. An independent psychiatrist cannot be the patient's responsible clinician or part of the patient's clinical team.

Between 1 July 2021 and 30 June 2022, a total of 986 ECT treatments were administered to 102 people who did not have capacity to consent. We have removed data relating to one individual who had capacity to consent but did not consent to protect their privacy, as they were the only individual to have this. We have not identified the DHB in which this occurred. In all of these cases, the DHBs gained a second opinion from an independent psychiatrist.

Table 19 shows the number of treatments administered without consent during this period.

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

Table 19: ECT administered under second opinion without consent, by DHB of service, 1 July 2021 to 30 June 2022

DHB of service	Second opinion where patient did not have the capacity to consent		Second opinion where patient had the capacity but refused to consent	
	Number of people given ECT	Number of treatments administered	Number of people given ECT	Number of treatments administered
Auckland	7	63	0	0
Bay of Plenty	4	22	0	0
Canterbury	7	59	0	0
Capital & Coast	8	75	0	0
Counties Manukau	14	90	0	0
Hawke's Bay	1	6	0	0
Hutt Valley	–	–	–	–
Lakes	4	28	0	0
MidCentral	1	11	0	0
Nelson Marlborough	1	12	0	0
Northland	2	36	0	0
South Canterbury	–	–	–	–
Southern	12	151	0	0
Tairāwhiti	–	–	–	–
Taranaki	4	51	0	0
Waikato	15	150	0	0
Wairarapa	–	–	–	–
Waitematā	21	232	0	0
West Coast	–	–	–	–
Whanganui	–	–	–	–
National total	**102**	**986**	**0**	**0**

Notes: The data in this table cannot be reliably compared with the data in Table 19 because it relates to DHB of service rather than DHB of domicile. Data relating to one individual who had capacity but did not consent has been removed to protect their privacy. DHBs that did not perform ECT (–) may have sent people to other DHBs for treatment.

Source: Manual data from DHBs.

Substance use treatment

Opioid substitution treatment

The Director, acting under delegated authority from the Minister of Health, designates specialist services and lead clinicians to provide treatment with controlled drugs to people who are dependent on them, under section 24A(7)(b) of the Misuse of Drugs Act 1975. These services are also subject to a Ministry audit every 3 years, through the *Specialist Opioid Substitution Treatment (OST) Service Audit and Review Tool*.[25]

Opioid dependence is a complex, relapsing condition requiring a model of treatment and care much like any other chronic health problem. Opioid substitution treatment (OST) helps people who have an opioid dependence to access treatment, including substitution therapy, which provides them with the opportunity to recover their health and wellbeing.

Specialist OST services are specified by the Minister of Health under section 24A of the Misuse of Drugs Act 1975 and notified in the *New Zealand Gazette*.[26] OST services in Aotearoa New Zealand are expected to provide a standardised approach that puts the person, family and whānau at the heart of treatment, recovery, wellbeing and citizenship. To help services take this approach, the *New Zealand Practice Guidelines for Opioid Substitution Treatment*[27] provides clinical and procedural guidance for specialist services and primary health care providers who deliver OST.

The following summarises OST data from 1 July 2021 to 30 June 2022.[28]

- 5,367 people received OST.
- 77.7% of these people were New Zealand European, 17.0% were Māori, 1.8% were Pacific peoples and 3.5% were of other ethnicities.
- 68.3% of clients receiving OST were over 45.
- 26.3% of people receiving OST were being treated by a general practitioner in a shared-care arrangement.

[25] For more information, see Ministry of Health. 2014. *Specialist Opioid Substitution Treatment (OST) Service Audit and Review Tool*. Wellington: Ministry of Health. URL: **www.health.govt.nz/publication/specialist-opioid-substitution-treatment-ost-service-audit-and-review-tool** (accessed 17 June 2022).

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

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

[28] Source: Data provided by OST services in 6-monthly reports. These 6-monthly reports do not collect data by National Health Index numbers. The national total is a sum of the DHB figures, so it may double count people who received services from more than 1 DHB.

Service providers

There are three types of OST service providers.

Specialist services: Specialist OST services are the entry point for nearly all people requiring treatment with controlled drugs. They comprehensively assess the needs of clients, provide specialist interventions and stabilise clients. This creates a pathway for recovery planning, referrals for co-existing health needs and social support, and eventually the transfer of treatment to a primary health provider or withdrawal from treatment altogether.

Between 1 July 2021 and 30 June 2022, 73.0% of OST clients received treatment from specialist services.

Primary health: Specialist addiction services work alongside primary health care. This approach allows specialist services to focus on clients who have the highest need, and normalises the treatment process.

Between 1 July 2021 and 30 June 2022, 26.3% of OST clients received this treatment from their general practitioner (GP).

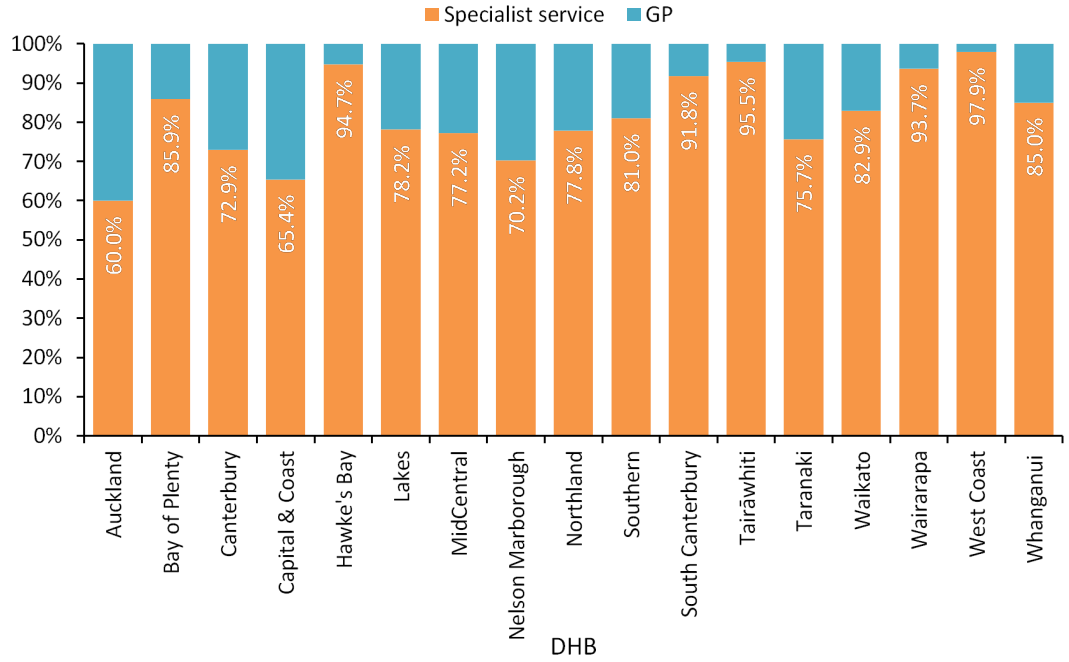
The Ministry's target for service provision is 50:50 between primary and specialist health care services.

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

Between 1 July 2021 and 30 June 2022, less than 1% of OST clients received this treatment from Ara Poutama. Service providers and Ara Poutama work together to initiate OST as appropriate for people who are imprisoned.

Figure 44 presents the percentage of people receiving OST from specialist services and GPs in each DHB in 2021/22. Figure 45 shows the number of people receiving OST from these providers from 2008/09 to 2021/22, based on January to June 6-monthly reports from OST providers.

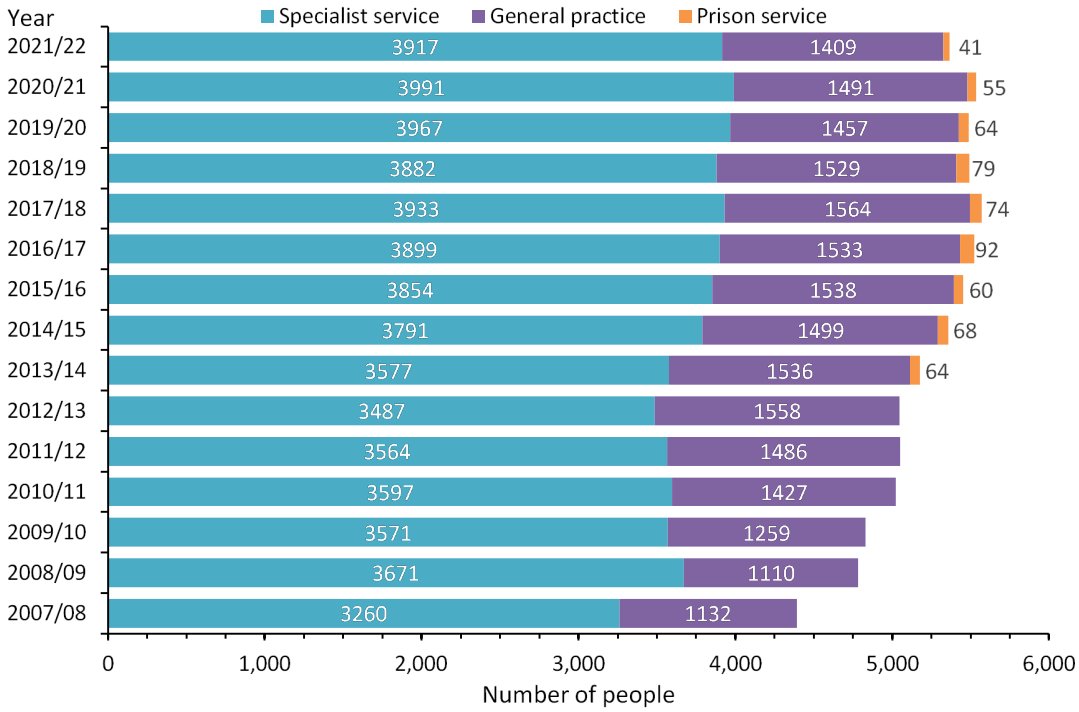
Figure 44: Percentage of people receiving OST from specialist services and GPs, by DHB, 1 July 2021 to 30 June 2022



Notes: 'Auckland' includes Auckland, Counties Manukau and Waitematā DHBs. 'Capital & Coast' includes Capital & Coast and Hutt Valley DHBs. 'Canterbury' includes 1 GP service operating in Christchurch.

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

Figure 45: Number of people receiving OST from a specialist service, GP or prison service, 2008/09 to 2021/22



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

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

Prescribing opioid treatments

Replacing addictive substances like opioids with prescribed drugs is called pharmacotherapy. The purpose of this treatment is to stabilise the opioid user's life and reduce harms related to drug use, such as the risk of overdose, blood-borne virus transmission and substance-related criminal activity.

The 2 types of pharmacotherapy are:

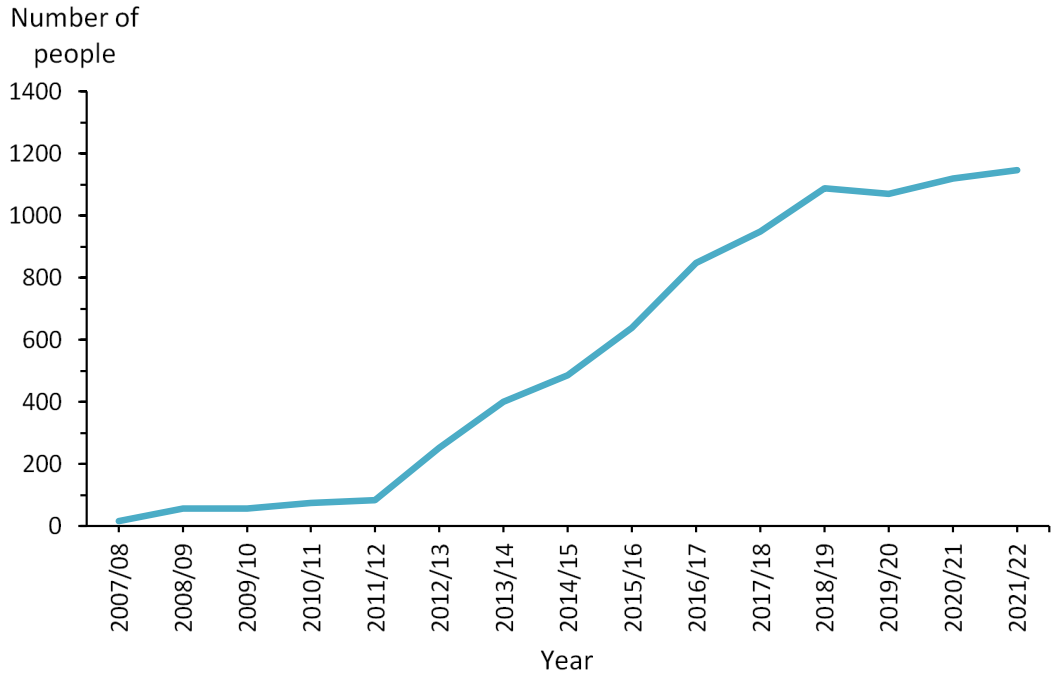
- maintenance therapy — using opioid substitutes to remain on a stable dose
- detox — using opioid substitutes to gradually withdraw from the substitute so the client can be free of all opioid substances.

Methadone has historically been the main OST available. Clients need a daily dose, which in turn makes it necessary to place limits on prescribing and dispensing.

In 2012, the Pharmaceutical Management Agency Ltd (Pharmac) began funding a buprenorphine-naloxone (suboxone) combination. Suboxone can be administered in cumulative doses that last several days, which reduces the risk of drug diversion and offers clients more normality in their lives. Figure 46 presents the number of people prescribed suboxone from 2008/09 to 2021/22.

In the period 1 July 2021 to 30 June 2022, 21.4% of OST clients were prescribed suboxone.

Figure 46: Number of people prescribed suboxone, 2008/09 to 2021/22



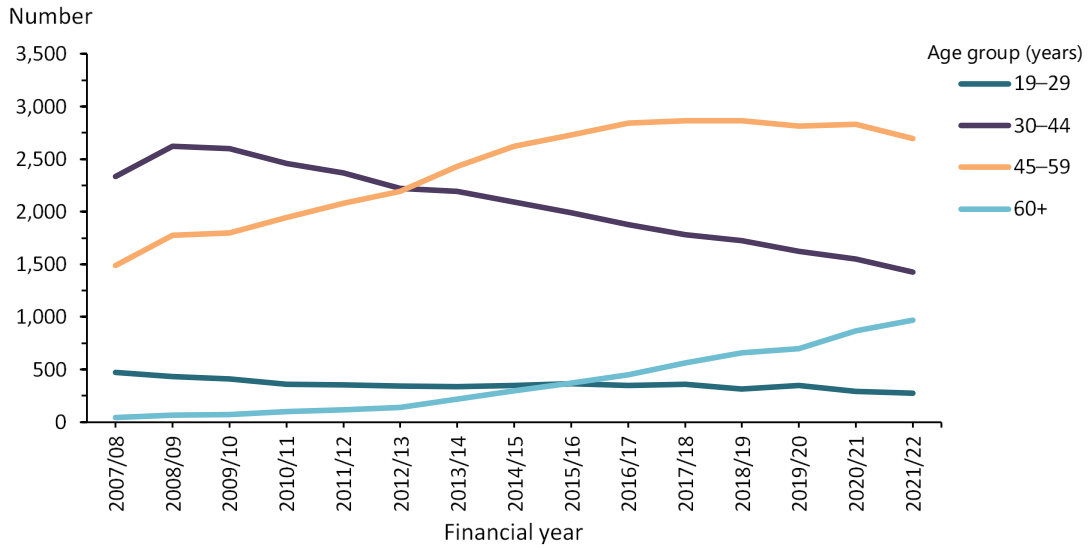
Source: Data provided by OST services in January to June 6-monthly reports.

The ageing population of OST clients

OST clients are an ageing population. Figure 47 shows how clients in older groups have been increasing in number from 2008/09 to 2021/22 to the point that those over 45 are now the most likely age group to be receiving OST.

Between 1 July 2021 and 30 June 2022, the majority of clients (68.3%) were over 45. Treating an ageing population brings with it more health complications.

Figure 47: Number of OST clients, by age group, 2007/08 to 2021/22



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

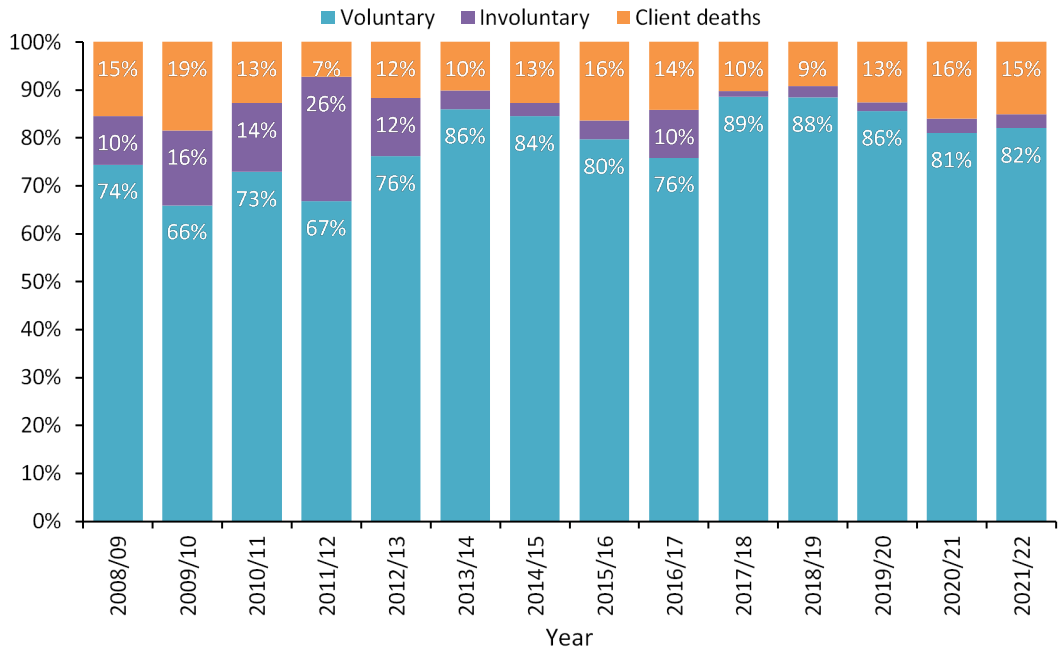
Exit from OST

The following summarises OST exit data from 1 July 2021 to 30 June 2022.

- Of those who exited OST, 369 (82%) voluntarily withdrew.
- There were 13 involuntary withdrawals (3% of all exits), which can result from behavioural risks that jeopardise the safety of the client or others.
- 68 people who had been receiving OST died. A small proportion of these people died of a suspected overdose. In these cases, the Ministry requires services to conduct an incident review and report it to the medical officer of health. The remaining deaths had a range of other causes, such as cancer and cardiovascular disease.

Figure 48 gives an overview of the reasons for exit from treatment (voluntary, involuntary or death) from 2008/09 to 2021/22.

Figure 48: Percentage of exits from opioid substitution treatment programmes, by reason (voluntary, involuntary or death), 2008/09 to 2021/22



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

Substance Addiction Act

In February 2018, the Substance Addiction Act came into force, replacing the Alcoholism and Drug Addiction Act 1996. The Substance Addiction Act is designed to help people who have a severe substance addiction and impaired capacity to make decisions about engaging in treatment. This legislation is better equipped than the earlier Act to protect the human rights and cultural needs of patients and their families and whānau, and it places greater emphasis on enhancing mana and following a health-based approach.

Section 119 of the Substance Addiction Act requires the Ministry to publish certain information in its annual report, such as the number of people who received compulsory treatment. The latest annual report, covering the 2021/22 financial year, is available on the Ministry's website, **health.govt.nz**.

Land Transport Act 1998

In 2021/22, the Office of the Director of Mental Health and Addiction Services continued to work with Waka Kotahi New Zealand Transport Agency (Waka Kotahi), the Ministry of Transport, and the Drug and Alcohol Practitioners' Association Aotearoa New Zealand to monitor the reinstatement of drivers disqualified for offences involving alcohol or drugs, and to approve assessment centres under section 65A of the Land Transport Act 1998.

This section requires indefinite disqualification of driver licences and assessment for repeat driving offenders involving drugs or alcohol. To determine if a licence can be reinstated, an approved assessment centre considers the person's ability to manage their substance use or addictive behaviours. The assessment centres send copies of their reports to Waka Kotahi, which decides whether to reinstate the person's licence.

The Director-General of Health approves assessment centres. Establishments and individuals applying to be an approved assessment centre must demonstrate that they are competent in assessing alcohol and other drug problems, and are a registered and experienced alcohol and drug practitioner.

Drug Checking Licensing Scheme

In December 2020, the Misuse of Drugs Act 1975 was amended to allow the Director-General of Health to appoint drug checking service providers by way of notice in the *New Zealand Gazette*. These appointment provisions were temporary and were intended to allow drug checking to take place with legal certainty while a licensing scheme was developed.

In December 2021, the temporary legislation was replaced by permanent regulations under the Misuse of Drugs Act 1975. Licensing for drug checking service providers began in May 2022, under the Misuse of Drugs (Drug and Substance Checking Service Providers) Regulations 2022.

Drug checking services aim to reduce drug harm and risk by helping people make informed decisions about drug use. It does not promote illicit drug use or claim that illicit drug use is safe. Licensed drug checking providers conduct scientific tests on substances in order to indicate their likely identity and composition. Licensed providers test unknown substances (which may be illicit drugs), interpret results, and provide harm reduction information to a person who provides a sample. Drug testing results inform New Zealand's early warning system, Drug Information Alert New Zealand.

Since July 2022, the team responsible for the drug checking licensing scheme operates from the Office of the Director of Mental Health and Addiction Services. The team are responsible for:

- licensing activities (including new providers, amendments, renewals, suspensions and cancellations)
- licensing scheme maintenance activities such as reporting, approval of service models, and testing methodology and technology
- regulatory monitoring activities of licensed providers, including audit to ensure compliance with the Misuse of Drugs Act 1975, its regulations and the provider's licence conditions
- compliance and enforcement activities, including complaint management, investigations of potential breaches of the Misuse of Drugs Act 1975, its regulations and provider's licence conditions.

During 2021/22, changes to the Misuse of Drugs Act 1975 resulted in four providers being appointed under the temporary legislation to provide drug checking services, resulting in greater access to people receiving drug harm reduction information.

A transition clause in the Misuse of Drugs Act 1975 enabled these four appointed providers to continue to deliver drug checking services until a licensing decision was made by the Director-General of Health. As the licensing scheme grows, service delivery will expand, from summer festivals to wider access via events, drop-off services, and permanent and pop-up clinics across the country.

In future reports, the Ministry's drug checking licensing team will publish data on the implementation and outcomes of the drug checking licensing scheme including:

- number of events/clinics
- number of substances tested
- number of clients given harm reduction information
- number of high alert notifications resulting from licensed drug checking services.

Appendix 1: The Mental Health Act process

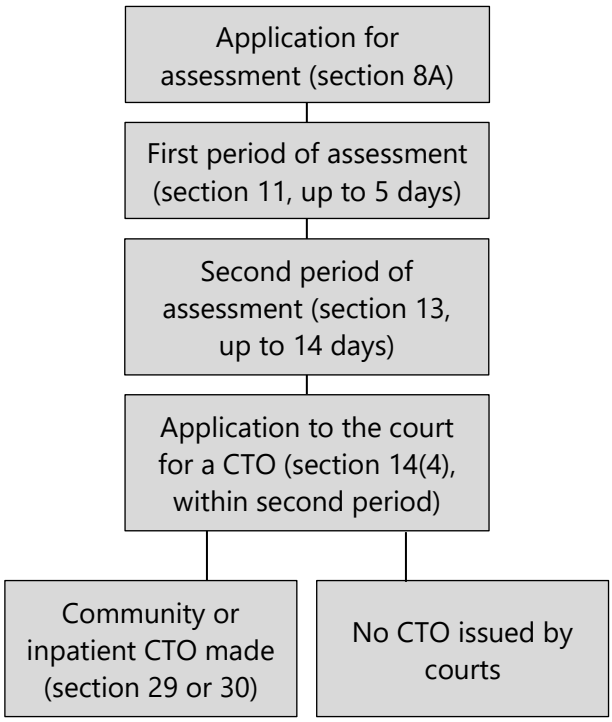
The compulsory assessment and treatment process begins with a referral and an initial assessment. If the health assessor believes a person fits the Mental Health Act's criteria, the person will become subject to the Mental Health Act and receive further assessment accordingly.

Compulsory assessment

Compulsory assessment can take place in either a community or a hospital setting. There are two periods of compulsory assessment, during which a person's clinician may release them from assessment at any time.

During the assessment period, a person is obliged to receive treatment as prescribed by their responsible clinician. The first period (section 11 of the Mental Health Act) is for up to 5 days. The second period (section 13 of the Mental Health Act) can last up to 14 days.

Following the first 2 assessment periods, a person's responsible clinician can make an application to the courts under section 14(4) of the Mental Health Act to place the person under a compulsory treatment order (CTO).



At any time during the compulsory assessment process, the person (or someone on their behalf) can request a review of their condition by the courts to determine whether it is appropriate that they continue to be assessed. Based on information presented to them, a judge will decide whether the assessment should continue or not.

Compulsory treatment

There are two types of CTOs: community (section 29 of the Mental Health Act) and inpatient (section 30 of the Mental Health Act). A person's responsible clinician can convert an inpatient CTO to a community CTO at any time. A responsible clinician can also grant a person who is under an inpatient CTO leave in the community for up to 3 months (section 31 of the Mental Health Act).

Appendix 2: Additional statistics – Ministry of Justice

Table A1 presents data on applications for a CTO from 2007/08 to 2021/22. Table A2 shows the types of orders granted over the same period.

Table A1: Applications for CTOs or extensions, 2007/08 to 2021/22

Financial year	Number of applications for a CTO, or extension to a CTO	Number of applications granted or granted with consent	Number of applications dismissed or struck out	Number of applications withdrawn, lapsed or discontinued	Number of applications transferred to the High Court
2007/08	4,579	3,899	105	540	0
2008/09	4,570	4,003	76	496	0
2009/10	4,661	4,101	72	507	0
2010/11	4,807	4,198	63	542	1
2011/12	4,838	4,272	69	475	0
2012/13	4,950	4,480	75	397	0
2013/14	5,181	4,610	53	522	0
2014/15	5,184	4,629	55	526	0
2015/16	5,564	4,918	51	560	0
2016/17	5,607	4,927	73	563	0
2017/18	5,570	4,959	74	566	0
2018/19	5,619	4,972	64	571	0
2019/20	5,711	5,021	52	622	0
2020/21	5,899	5,244	62	626	0
2021/22	6,097	5,377	75	631	0

Notes: The table presents applications that had been processed at the time of data extraction on 16 May 2023. The year is determined by the final outcome date. The CMS is a live operational database, which means figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System, which uses data entered into the CMS (extracted 16 May 2023).

Table A2: Types of CTOs made on granted applications, 2007/08 to 2021/22

Financial year	Number of granted applications for orders	Number of community CTOs (or extension)	Number of inpatient CTOs (or extension)	Number of orders recorded as both community and inpatient CTOs (or extension)	Number of applications where type of order was not recorded
2007/08	3,899	1,676	1,293	127	781
2008/09	4,003	2,020	1,520	99	349
2009/10	4,101	2,148	1,628	116	203
2010/11	4,198	2,283	1,668	95	142
2011/12	4,272	2,297	1,664	97	206
2012/13	4,480	2,591	1,731	62	96
2013/14	4,610	2,616	1,756	88	148
2014/15	4,629	2,688	1,782	84	75
2015/16	4,918	2,897	1,822	59	136
2016/17	4,927	2,727	1,654	75	469
2017/18	4,959	2,594	1,709	49	603
2018/19	4,972	2,747	1,814	47	363
2019/20	5,021	2,897	1,745	67	312
2020/21	5,244	3,031	1,939	48	223
2021/22	5,377	3,032	1,936	87	320

Notes: The table presents applications that had been processed at the time of data extraction on 16 May 2023. The year is determined by the date the application was granted. When more than 1 type of order is shown, it is likely to be because new orders are linked to a previous application in the CMS. The CMS is a live operational database, which means figures are subject to minor changes at any time.

Source: Ministry of Justice Integrated Sector Intelligence System, which uses data entered into the CMS (extracted 16 May 2023).

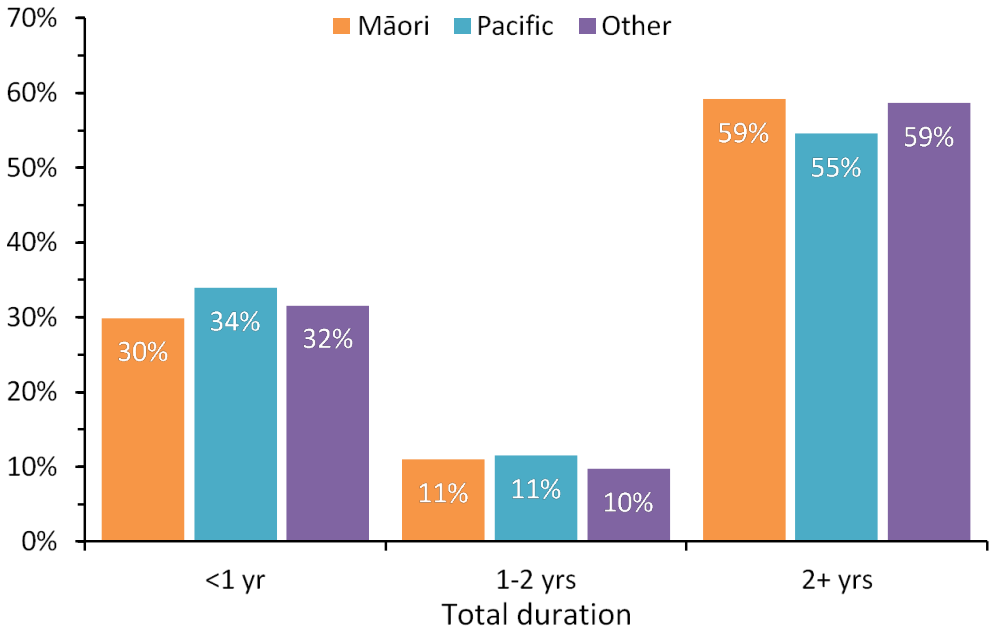
Appendix 3: Duration of CTOs

We have been reporting the duration of CTOs since 2014. However, a review in February 2023 found an issue in calculating the length of time people had spent subject to a CTO in some cases.

Previously, each CTO code submitted to PRIMHD was counted multiple times. For example, an individual subject to a CTO for 3 years, was counted under all duration groups (less than 1 year, 1–2 years, 2+ years). The number of orders were being counted, as opposed to person-level measures. We have now revised the methodology used to ensure each person is only counted in only 1 duration group.

Figures A1 through A16 show the revised version of the data for previous years, recalculated using the new methodology. The revised figures cover financial years rather than the calendar year originally published.

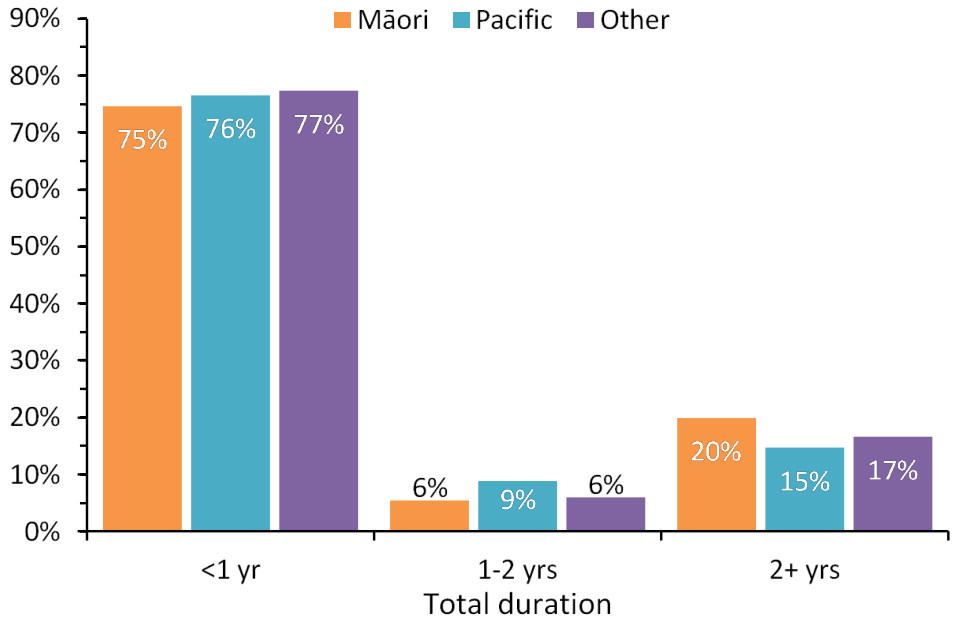
Figure A1: Revised total length of time spent in the last 3 years subject to a community CTO for those with a current order in 2020/21



Note: The previously published data is on page 14 of:
https://www.health.govt.nz/system/files/documents/publications/odmhas-regulatory-report-sep22.pdf

Source: PRIMHD data (extracted 2 June 2023).

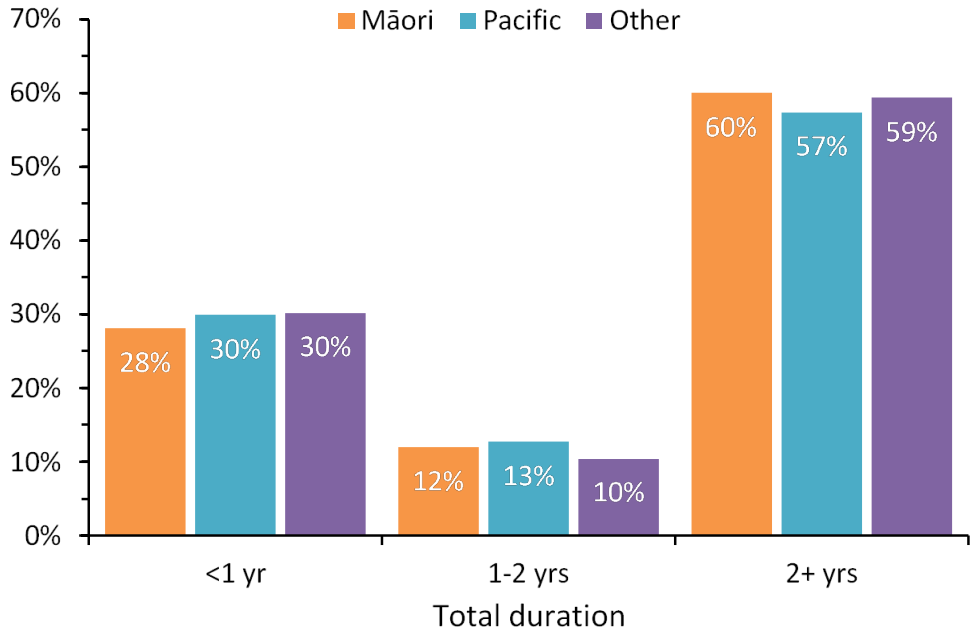
Figure A2: Revised total length of time spent in the last 3 years subject to an inpatient CTO for those with a current order in 2020/21



Note: The previously published data is on page 14 of:
https://www.health.govt.nz/system/files/documents/publications/odmhas-regulatory-report-sep22.pdf

Source: PRIMHD data (extracted 2 June 2023).

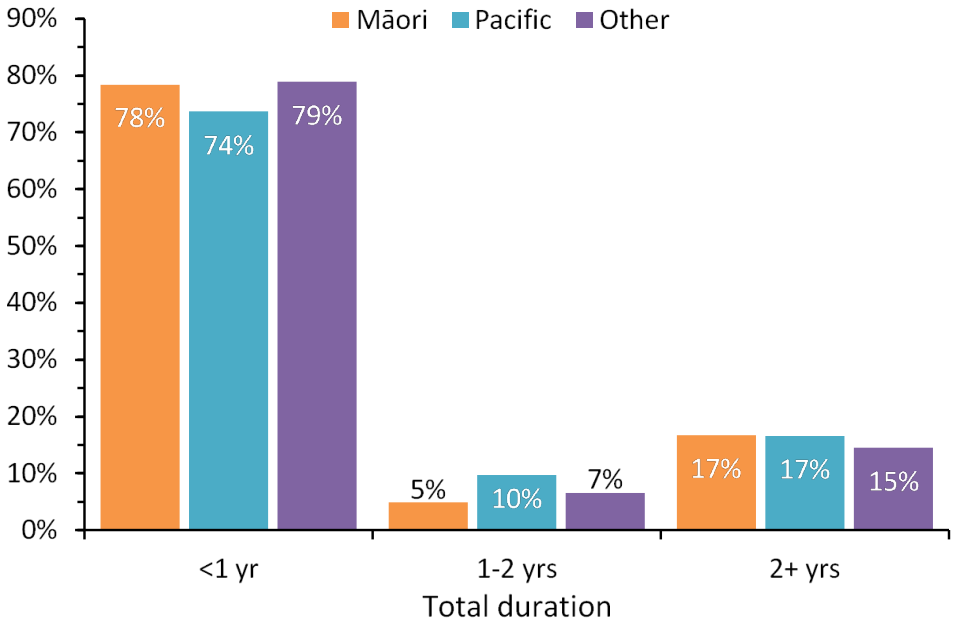
Figure A3: Revised total length of time spent in the last 3 years subject to a community CTO for those with a current order in 2019/20



Note: The previously published data is on page 14 of:
https://www.health.govt.nz/system/files/documents/publications/office_of_the_director_of_mental_health_and_addiction_services_-_2020_regulatory_report_final_v2.pdf.

Source: PRIMHD data (extracted 2 June 2023).

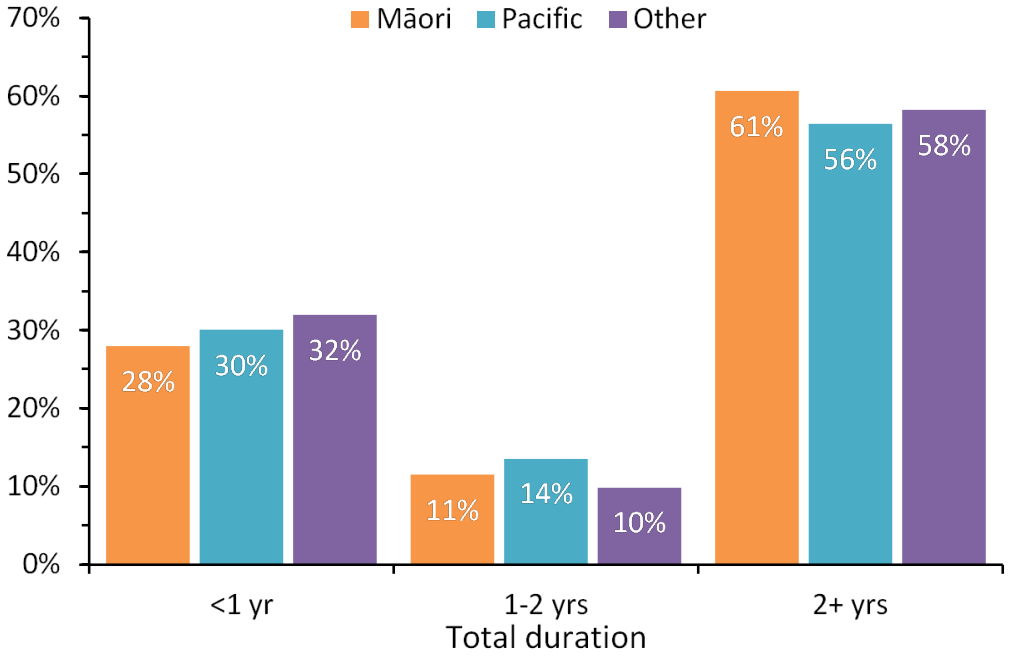
Figure A4: Revised total length of time spent in the last 3 years subject to an inpatient CTO for those with a current order in 2019/20



Note: The previously published data is on page 14 of:
https://www.health.govt.nz/system/files/documents/publications/office_of_the_director_of_mental_health_and_addiction_services_-_2020_regulatory_report_final_v2.pdf.

Source: PRIMHD data (extracted 2 June 2023).

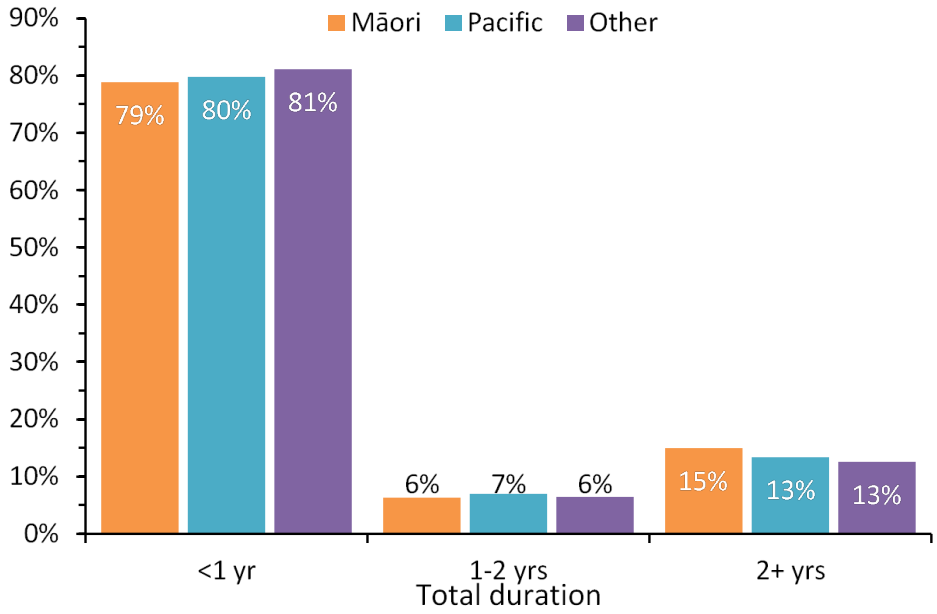
Figure A5: Revised total length of time spent in the last 3 years subject to a community CTO for those with a current order in 2018/19



Note: The previously published data is on page 26 of:
https://www.health.govt.nz/system/files/documents/publications/office-director-mental-health-addiction-services-annual-report-2018-2019-apr21.pdf.

Source: PRIMHD data (extracted 2 June 2023).

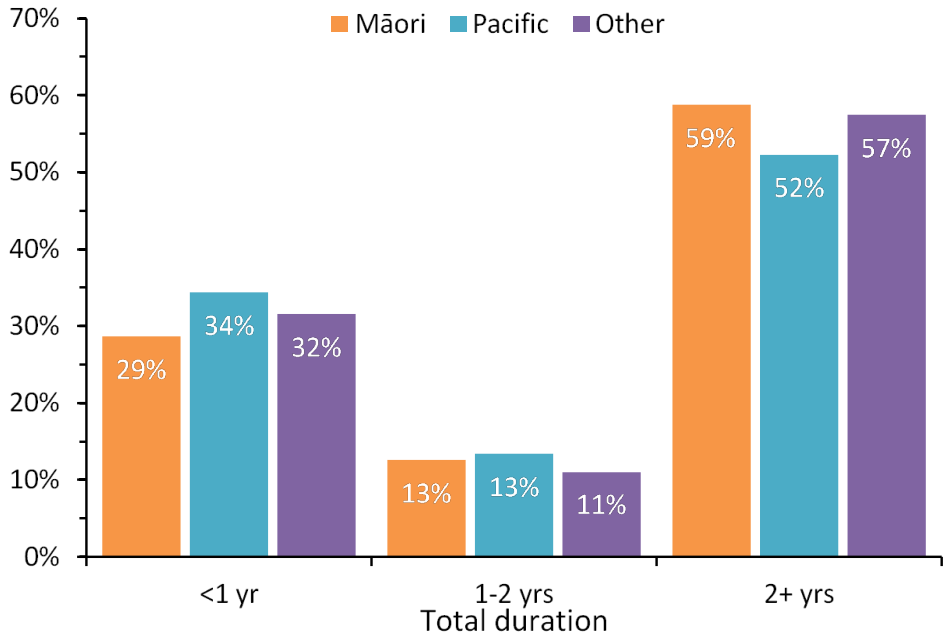
Figure A6: Revised total length of time spent in the last 3 years subject to an inpatient CTO for those with a current order in 2018/19



Note: The previously published data is on page 26 of:
https://www.health.govt.nz/system/files/documents/publications/office-director-mental-health-addiction-services-annual-report-2018-2019-apr21.pdf.

Source: PRIMHD data (extracted 2 June 2023).

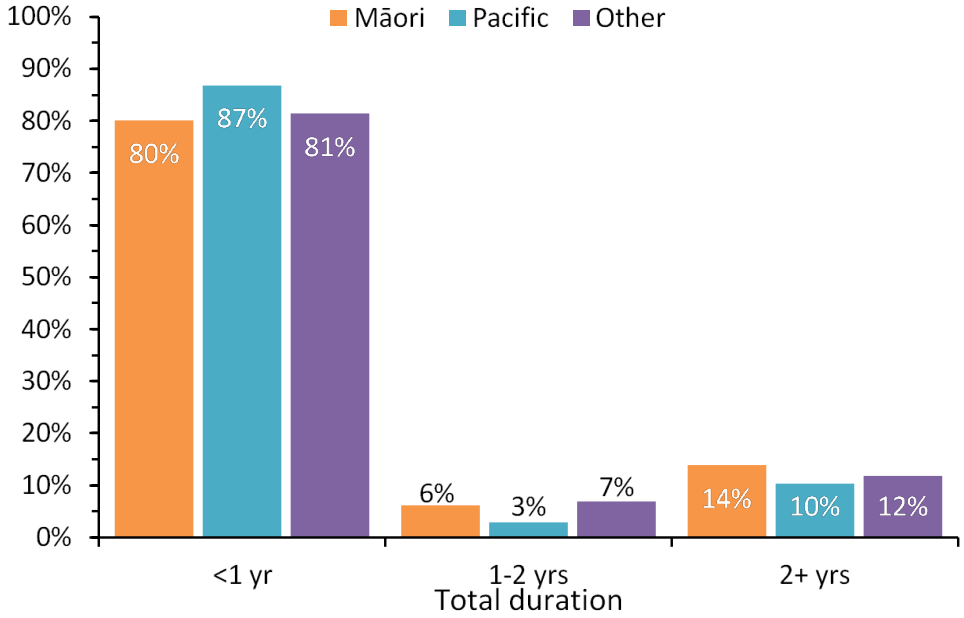
Figure A7: Revised total length of time spent in the last 3 years subject to a community CTO for those with a current order in 2017/18



Note: The previously published data is on page 26 of:
https://www.health.govt.nz/system/files/documents/publications/office-director-mental-health-addiction-services-annual-report-2018-2019-apr21.pdf.

Source: PRIMHD data (extracted 2 June 2023).

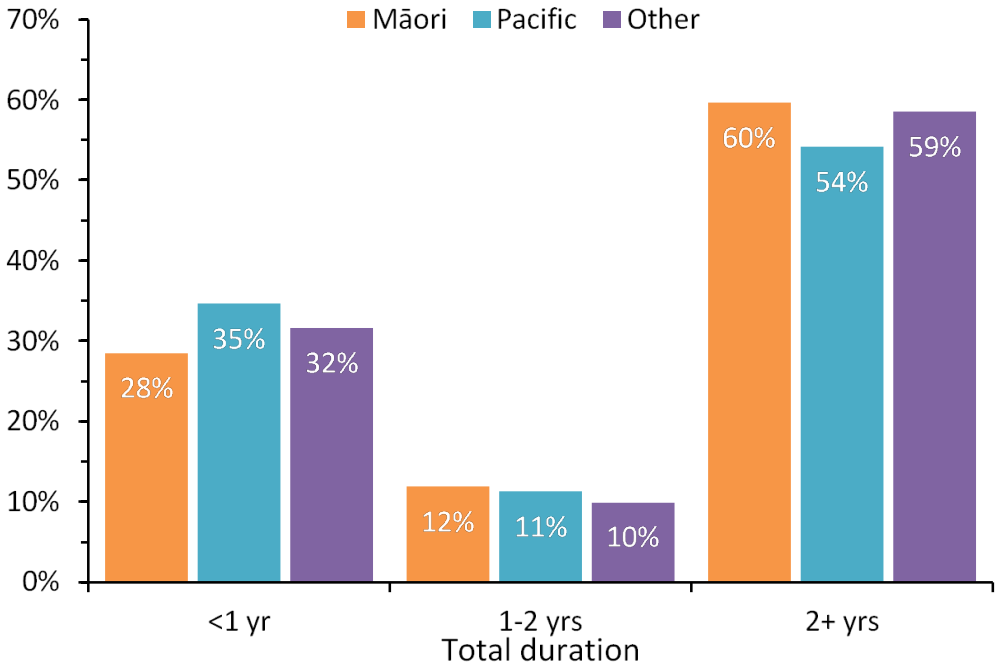
Figure A8: Revised total length of time spent in the last 3 years subject to an inpatient CTO for those with a current order in 2017/18



Note: The previously published data is on page 26 of: **https://www.health.govt.nz/system/files/documents/publications/office-director-mental-health-addiction-services-annual-report-2018-2019-apr21.pdf**.

Source: PRIMHD data (extracted 2 June 2023).

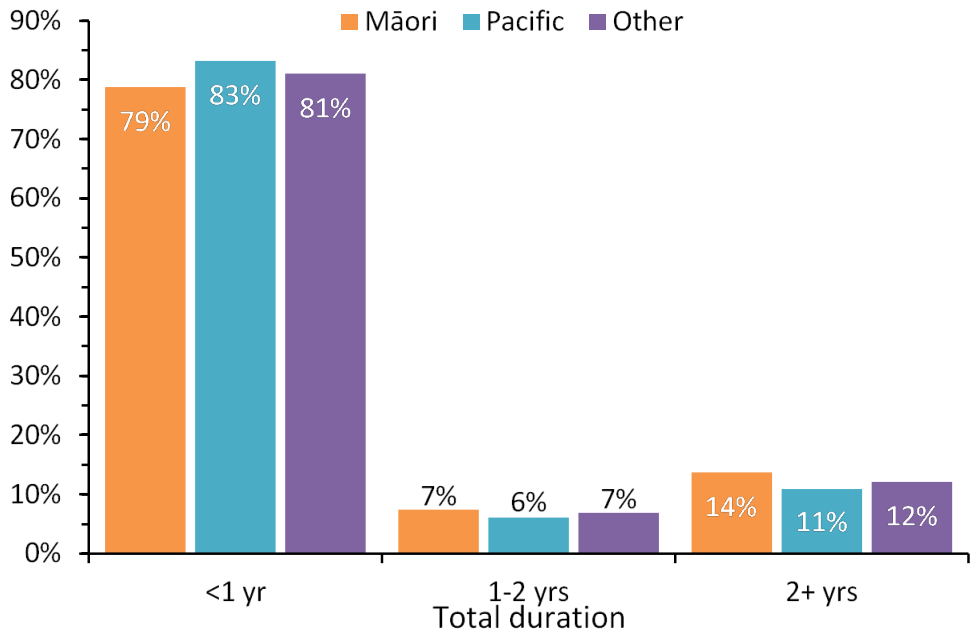
Figure A9: Revised total length of time spent in the last 3 years subject to a community CTO for those with a current order in 2016/17



Note: The previously published data is on page 39 of: **https://www.health.govt.nz/system/files/documents/publications/office-of-the-director-of-mental-health-and-addiction-services-annual-report-2017-v2.pdf**.

Source: PRIMHD data (extracted 2 June 2023).

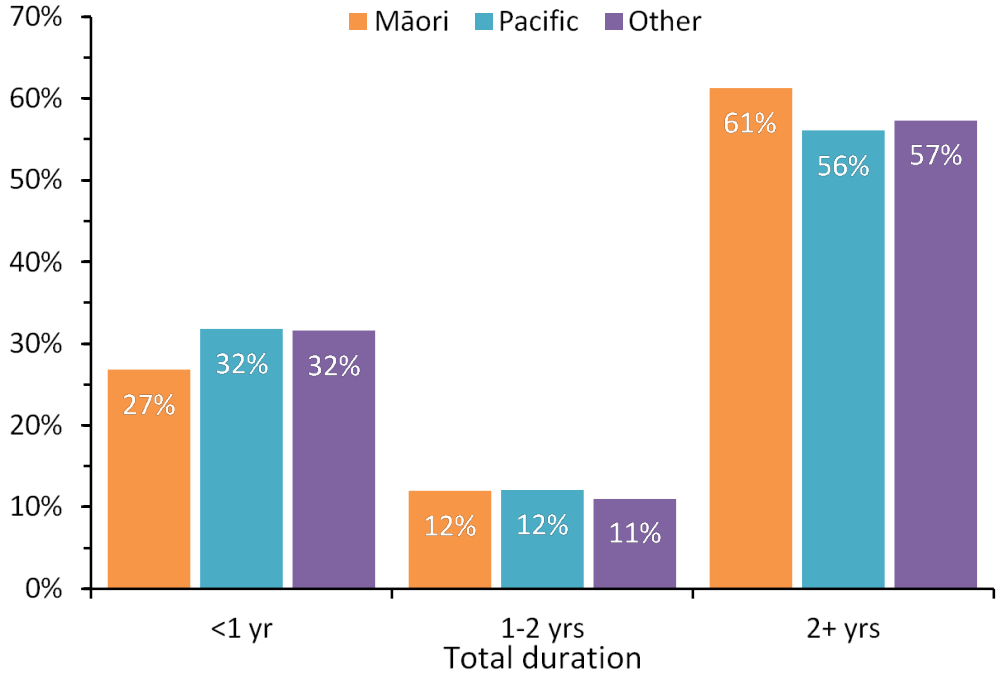
Figure A10: Revised total length of time spent in the last 3 years subject to an inpatient CTO for those with a current order in 2016/17



Note: The previously published data is on page 39 of:
https://www.health.govt.nz/system/files/documents/publications/office-of-the-director-of-mental-health-and-addiction-services-annual-report-2017-v2.pdf.

Source: PRIMHD data (extracted 2 June 2023).

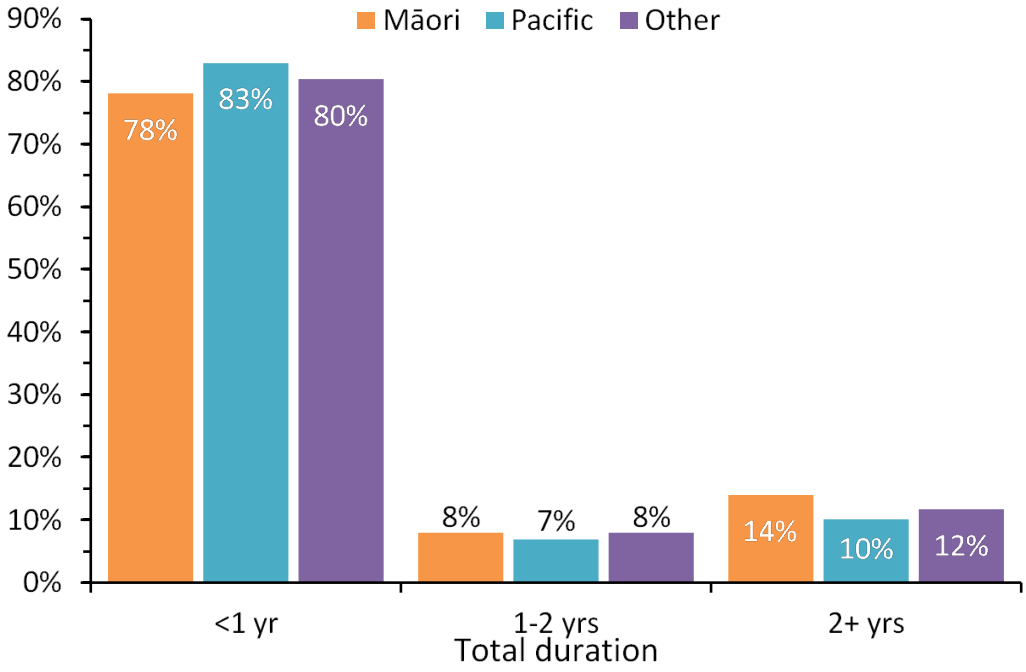
Figure A11: Revised total length of time spent in the last 3 years subject to a community CTO for those with a current order in 2015/16



Note: The previously published data is on page 29 of:
https://www.health.govt.nz/system/files/documents/publications/office-of-the-director-of-mental-health-annual-report-2016-dec17-v2.pdf.

Source: PRIMHD data (extracted 2 June 2023).

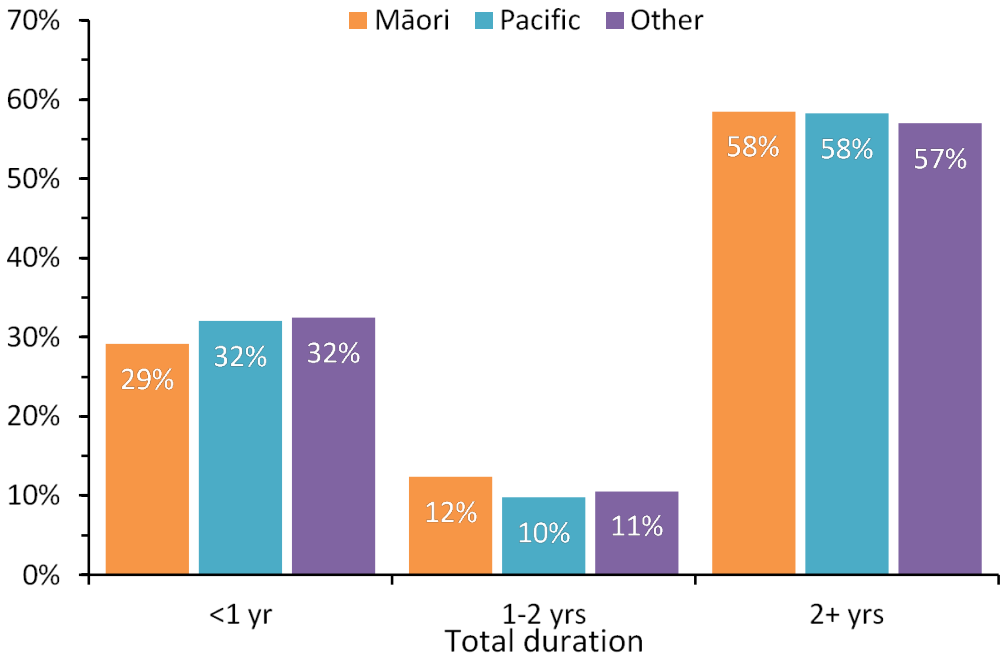
Figure A12: Revised total length of time spent in the last 3 years subject to an inpatient CTO for those with a current order in 2015/16



Note: The previously published data is on page 29 of: **https://www.health.govt.nz/system/files/documents/publications/office-of-the-director-of-mental-health-annual-report-2016-dec17-v2.pdf**.

Source: PRIMHD data (extracted 2 June 2023).

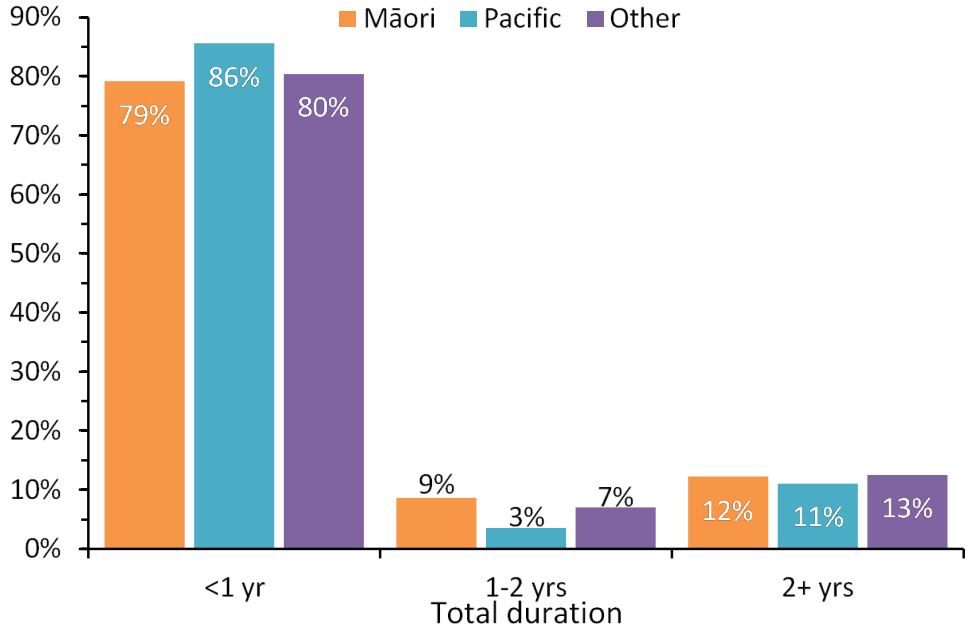
Figure A13: Revised total length of time spent in the last 3 years subject to a community CTO for those with a current order in 2014/15



Note: The previously published data is on page 25 of: **https://www.health.govt.nz/system/files/documents/publications/office-director-mental-health-annual-report-2015-nov16.pdf**.

Source: PRIMHD data (extracted 2 June 2023).

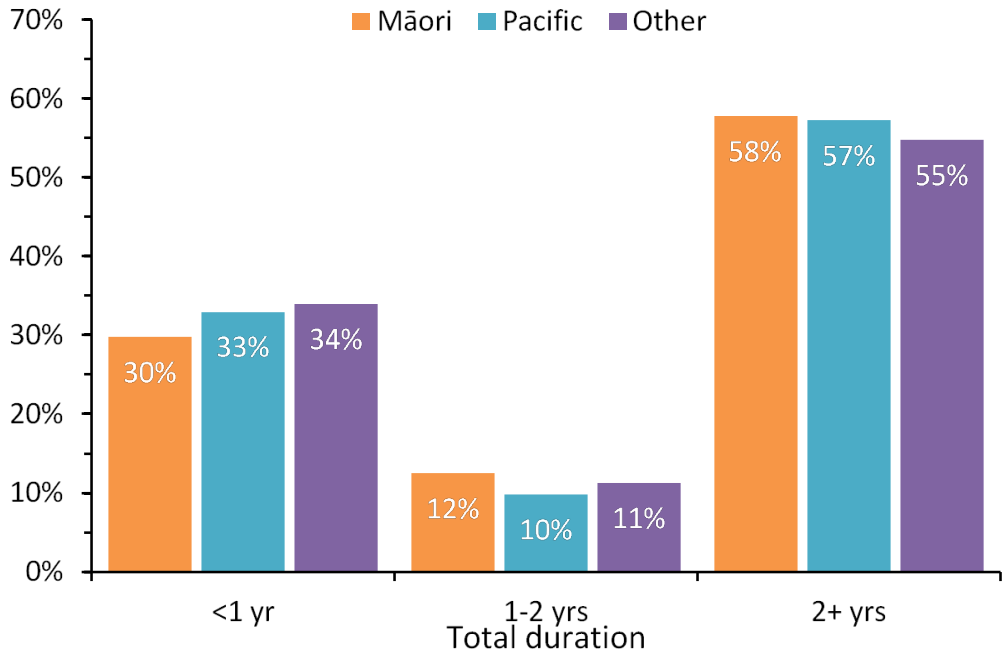
Figure A14: Revised total length of time spent in the last 3 years subject to an inpatient CTO for those with a current order in 2014/15



Note: The previously published data is on page 25 of: **https://www.health.govt.nz/system/files/documents/publications/office-director-mental-health-annual-report-2015-nov16.pdf**.

Source: PRIMHD data (extracted 2 June 2023).

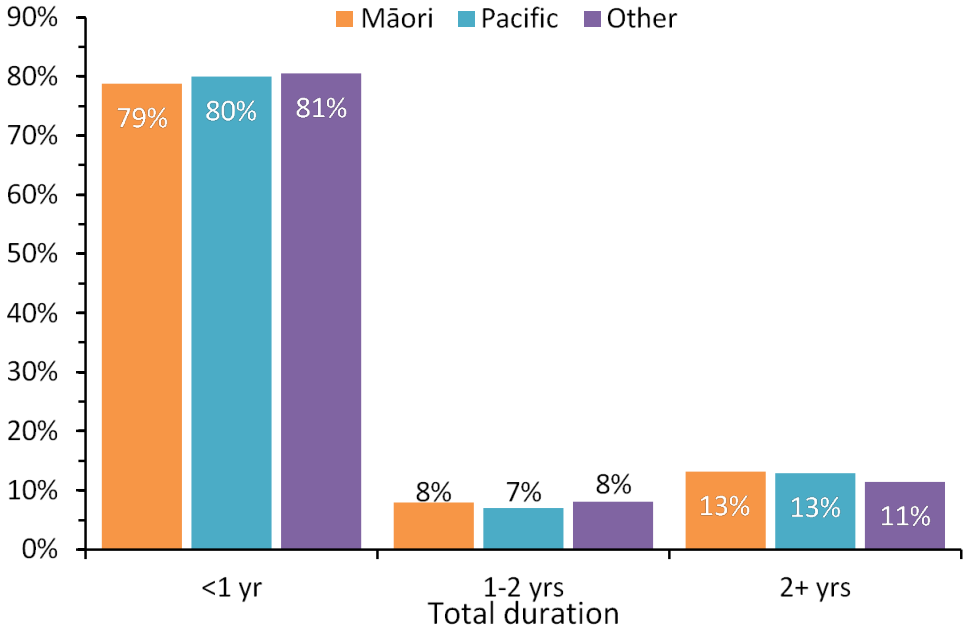
Figure A15: Revised total length of time spent in the last 3 years subject to a community CTO for those with a current order in 2013/14



Note: The previously published data is on page 33 of: **https://www.health.govt.nz/system/files/documents/publications/director-of-mental-health-annual-report-2014-dec15.pdf**.

Source: PRIMHD data (extracted 2 June 2023).

Figure A16: Revised total length of time spent in the last 3 years subject to an inpatient CTO for those with a current order in 2013/14



Note: Inpatient CTO duration data was not previously published; this figure is included for completeness.

Source: PRIMHD data (extracted 2 June 2023).

Appendix 4: Corrected ECT data from 2020/21

A review in May 2023 discovered that the mean, maximum and minimum ECT treatments for the national total and several DHBs was incorrect for 2020/21. The ODMHAS Regulatory Report stated that people received an average of 23.4 treatments each over the year. This should have been an average of 12 treatments.

Table A3 shows the difference between the corrected and previously published data.

Table A3: Corrected ECT indicators, by DHB of domicile, 1 July 2020 to 30 June 2021

DHB of domicile	Number of people treated with ECT	Number of treatments	Correct mean number of treatments per person (range)	Previous mean number of treatments per person (range)
Auckland	16	195	12 (1–48)	No difference
Bay of Plenty	21	306	15 (1–60)	No difference
Canterbury	21	145	7 (1–19)	No difference
Capital & Coast	28	331	12 (2–31)	No difference
Counties Manukau	22	179	8 (1–32)	9 (1–32)
Hawke's Bay	6	70	12 (3–31)	8 (3–15)
Hutt Valley	12	123	10 (3–16)	No difference
Lakes	11	106	10 (4–16)	No difference
MidCentral	6	67	11 (1–18)	No difference
Nelson Marlborough	12	134	11 (1–23)	No difference
Northland	7	55	8 (3–12)	14 (3–52)
South Canterbury	0	0	–	No difference
Southern	30	481	16 (1–68)	14 (1–68)
Tairāwhiti	0	0	–	No difference
Taranaki	6	70	12 (2–34)	No difference
Waikato	40	436	11 (1–48)	No difference
Wairarapa	2	30	15 (15–15)	12 (9–15)
Waitematā	22	285	13 (1–39)	14 (1–39)
West Coast	0	0	–	No difference
Whanganui	1	30	30 (30–30)	No difference
National total	**259**	**3043**	**12 (1–68)**	**23 (1–68)**

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