Office of the Director of Mental Health Annual Report 2012

Disclaimer

The purpose of this publication is to inform discussion about mental health services and outcomes in New Zealand, and to assist in policy development.

This publication reports information provided to the Programme for the Integration of Mental Health Data (PRIMHD)(see Appendix 2) by district health boards and non-governmental organisations. It is important to note that PRIMHD is a dynamic collection, and so it was necessary to wait a certain period before publishing a record of the information in it, thereby reducing the chances of amendments to information after publication.

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MINISTRY OF HEALTH
MANATŪ HAUORA

Foreword

Tena koutou,

Nau mai ki tēnei te tuawaru o ngā Rīpoata ā Tau a te Āpiha Kaitohu Tari Hauora Hinengaro mō te Manatū Hauora. Kei tēnei tūnga te mana whakaruruhau kia tika ai te tiaki i te hunga e whai nei i te oranga hinengaro. Ia tau ka pānuitia tēnei ripoata kia mārama ai te kaitiakitanga me te takohanga o te apiha nei ki te katoa.

Welcome to the eighth edition of the *Office of the Director of Mental Health Annual Report*. This report is a summary of the legislative activities of the Office, the Mental Health Protection Team and others, as stipulated in the Mental Health (Compulsory Assessment and Treatment) Act 1992, referred to here as the MH(CAT) Act. We publish this report annually to demonstrate our commitment to ensuring transparency, accountability and trust in government and its agencies.

2012 was a busy year for our Office. During the year, we published statuatory guidelines for the MH(CAT) Act, and revised guidelines for the role and function of directors of area mental health services. Both publications will help to better define best practice in mental health services with regard to the assessment and treatment of those under the MH(CAT) Act. I would like to thank those who lent their time and talents to the completion of these papers.

In 2012 I was pleased to establish the Mental Health Governance Group. This group consists of senior Ministry of Health managers and clinical leaders, who work together to provide strategic leadership, oversight and coordination of the Ministry's work programme. The opportunity to collaborate closely with colleagues from across the Ministry has proved invaluable, allowing different business units to work effectively together to reach mental health objectives.

In 2012 I was fortunate to welcome Dr Arran Culver on board as Deputy Director of Mental Health. Arran brings valuable clinical leadership and experience to the role of the Deputy Director, especially in the area of child and youth mental health. I look forward to our continued work together.

In addition to these achievements an important success story can be found in the pages of this Annual Report. The use of seclusion in New Zealand is declining. This national decline speaks to an ongoing effort by DHBs to engage with best practice and find alternative ways to work with high needs individuals.

Since taking up the position of Director of Mental Health in November 2011 I have been consistently impressed with the dedication and spirit that people in the mental health sector bring to their work. I see my role as an opportunity to provide leadership that supports this commitment and builds on the good work that has already taken place.

Looking to the future, our Office will continue to review and improve the processes and guidance related to the administration of the MH(CAT) Act, always with the aim of making a meaningful contribution to the mental health conversation in New Zealand.

Noho ora mai.

Dr John Crawshaw
Director of Mental Health
Chief Advisor, Mental Health

‘There is no health without mental health.’

World Health Organization

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Introduction

Objectives

The objectives of this report are to:

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

Structure

The report is divided into three main sections. The first section (following this introduction) provides an overview of the legislative and service delivery contexts in which the Office operates. The second section describes the work carried out by the Office in 2012. The final section provides statistical information, which covers the use of compulsion, seclusion, reportable deaths and electroconvulsive therapy during the reporting period.

Context

The Ministry of Health

The Ministry improves, promotes and protects the mental health of New Zealanders through:

- whole-of-sector leadership of the New Zealand health and disability system
- advising the Minister of Health, and government as a whole, on mental health issues
- directly purchasing a range of important national mental health services
- providing health sector information and payment services.

Ministry groups play a number of roles in leading and supporting mental health services. The Clinical Leadership, Protection and Regulation business unit monitors the quality of mental health and addiction services and the safety of compulsory mental health treatment, through the Office of the Director of Mental Health and provider regulation groups. The Sector, Capability and Implementation business unit supports the implementation of mental health policy through the Mental Health Service Improvement and Māori Health Service Improvement groups. Clinical and policy leaders from these groups collaborate with the Policy business unit to advise the Government on mental health policy and to implement policy.

Rising to the challenge

Over the last 50 years New Zealand mental health services have moved from an institutional model to a recovery model which emphasises community treatment. Compulsory inpatient treatment has largely given way to voluntary engagement in a community setting.

In 2012 the Ministry published *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* (Ministry of Health 2012f). This document builds on improvements to this model of mental health care by providing a strategic direction for mental health service improvement over the next five years. *Rising to the Challenge* outlines key actions to build on and enhance mental health service delivery, with the aim of improving wellbeing and resilience, expanding access and decreasing waiting times.

Rising to the Challenge also targets disparities in mental health outcomes for certain groups, including Māori, Pacific peoples, refugees, and people with disabilities. Implementation of *Rising to the Challenge* is the responsibility of the Ministry, district health boards (DHBs), other government agencies, and non-governmental organisations (NGOs) contracted to provide mental health and addiction services.

One of the goals discussed in *Rising to the Challenge* is reducing and eliminating the use of seclusion and restraint in DHB inpatient mental health services.[1] This goal is discussed in greater depth in the 'Activities for 2012' section and in Appendix 1 of this report.

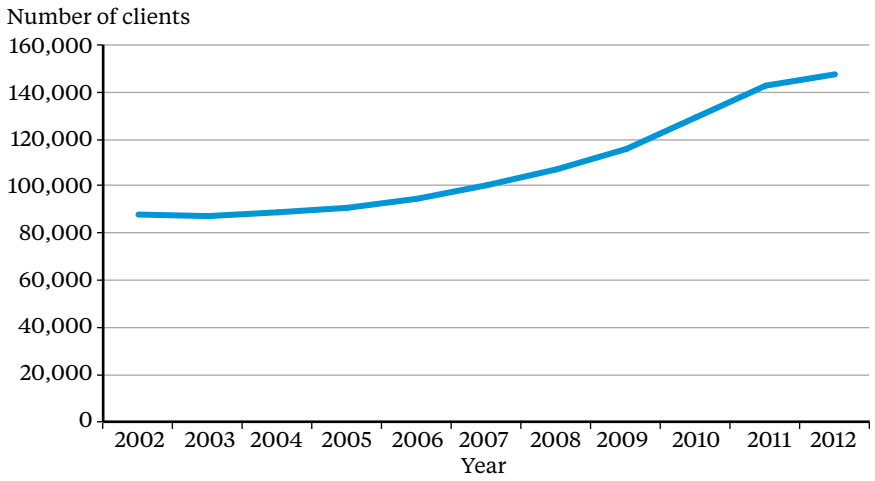
Rising to the Challenge also contributes to the Prime Minister's Youth Mental Health Project, which aims to reduce the incidence of mental health problems in youth, and to improve access to specialist treatment for youth experiencing mental health problems.

1 *Rising to the Challenge: Mental Health and Addiction Service Development Plan 2012–2017*, section 3.3.

Specialist mental health services

Many people experiencing mental illness are supported by their general practitioner (GP) or another primary health care provider. Specialist mental health services provide support to people whose needs cannot be met by a primary care provider. In 2012, there were 147,598[2] people engaged with a specialist mental health or addiction service.

Figure 1: Number of people engaging with specialist services each year, 2002 to 2012



Note: The data in PRIMHD was incomplete for Southern DHB, which did not report for the period July to December 2012.

Source: RIMHD data, extracted on 2 September 2013

Figure 1 shows that the number of people engaging with specialist services steadily increased from 2002 to 2012. The rise in specialist service users could be due to a range of factors, including better data capture, increased NGO reporting, a growing New Zealand population,[3] improved visibility of and access to services, and stronger referral relationships between providers.

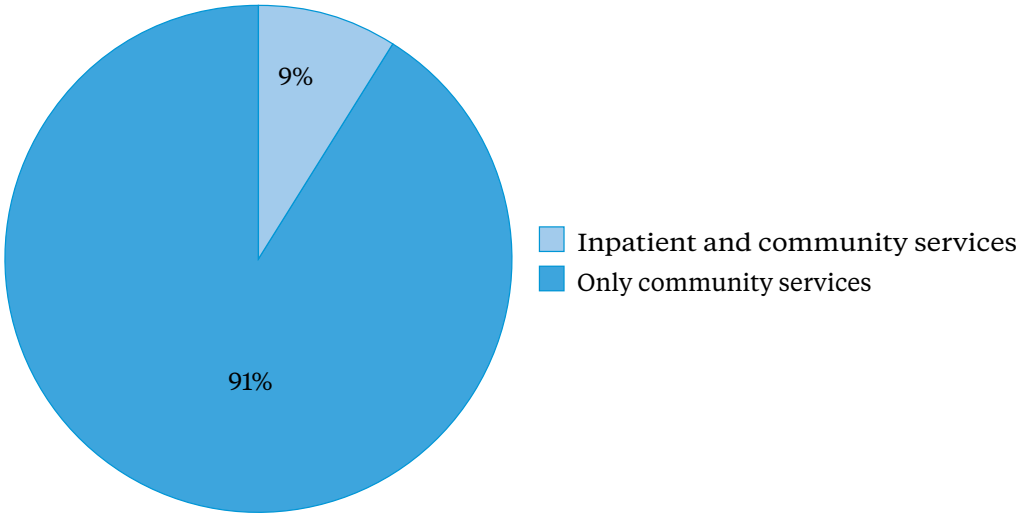
DHBs are responsible for funding, planning and providing specialist mental health services for their respective populations. Mental health services are provided directly by DHBs, or indirectly by contracting between DHBs and NGOs. In most DHB areas, directly provided specialist mental health services include hospital mental health care and community mental health services. NGOs provide a range of significant mental health services in each area, which can include alcohol and other drug treatment, kaupapa Māori services, family support, supported accommodation and home-based support.

Most people accept mental health services in the community. In 2012 about 91 percent of specialist service users only accessed community mental health services. The remaining 9 percent accessed a mixture of inpatient and community services. The proportion of people who receive treatment in the community increased from 86 percent in 2002 to 91 percent in 2012.

2 Includes NGOs. Source: PRIMHD data extracted on 2 September 2013. Please note: the data reported from Southern DHB was incomplete and does not include data from July to December of 2012.

3 Between 2002 and 2012 the total New Zealand population increased by approximately 13 percent (Statistics New Zealand 2013).

Figure 2: Percentage of service users accepting only community services, 1 January to 31 December 2012



Note: Includes NGOs.

Source: PRIMHD data, extracted on 2 September 2013. This does not include data from Southern DHB for the period July to December 2012

The Mental Health (Compulsory Assessment and Treatment) Act 1992

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MH[CAT] Act) defines the circumstances under which people may be subject to compulsory mental health assessment and treatment. The Act provides a framework for balancing personal rights and the public interest when a person poses a serious danger to themselves or others due to mental illness. The purpose of the Act is to:

> redefine the circumstances in which and the conditions under which persons may be subjected to compulsory psychiatric assessment and treatment, to define the rights of such persons and to provide better protection for those rights, and generally to reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder.[4]

The 'Statistics' section of this report provides data on the use of the MH(CAT) Act.

Administration of the MH(CAT) Act

The chief statutory officer under the MH(CAT) Act is the Director of Mental Health, appointed under section 91. The Director is responsible for the general administration of the Act under the direction of the Minister of Health and Director-General of Health. The Director is also the Chief Advisor, Mental Health, and is responsible for advising the Minister of Health on mental health issues. The Act also allows for the appointment of a Deputy Director of Mental Health. The Director's functions and powers under the MH(CAT) Act allow the Ministry to provide guidance to mental health services, supporting the strategic direction provided in *Rising to the Challenge* and a recovery-based approach to mental health.

In each DHB the Director-General of Health appoints a director of area mental health services (DAMHS) under section 92 of the MH(CAT) Act. The DAMHS is a senior mental health clinician, responsible for administering the compulsory treatment regime within their DHB area. They must

4 Mental Health (Compulsory Assessment and Treatment) Act 1992, long title.

report to the Director every three months regarding the exercise of their powers, duties and functions under the Act (Ministry of Health 2012b).

In each area the DAMHS will appoint responsible clinicians and assign them to lead the treatment of every patient subject to compulsory assessment or treatment (Ministry of Health 2012a). The DAMHS will also appoint competent health practitioners as duly authorised officers to respond to people experiencing mental illness in the community who are in need of intervention. Duly authorised officers are required to provide general advice and assistance in response to requests from members of the public and police. If a duly authorised officer believes that a person may be mentally disordered and may benefit from a compulsory assessment, the MH(CAT) Act grants them powers to arrange a medical examination (Ministry of Health 2012c).

Monitoring and protecting the rights of compulsory patients

Although each DAMHS is expected to protect the rights of compulsory patients in their area, the MH(CAT) Act also provides for independent monitoring mechanisms. The Minister of Health appoints district inspectors under section 94 of the MH(CAT) Act to monitor compliance with the compulsory assessment and treatment process, and to protect the rights of patients and investigate alleged breaches of those rights. District inspectors are required to inspect services regularly and report on their activities monthly to the Director of Mental Health. From time to time the Director can initiate an investigation under section 95 of the MH(CAT) Act, in which case a district inspector is granted powers to conduct an inquiry into a suspected failing in a patient's treatment or in the management of services (Ministry of Health 2012b).

The MH(CAT) Act also provides for the appointment of the Mental Health Review Tribunal, a specialist independent tribunal comprising a lawyer, a psychiatrist and a community member. If a compulsory patient disagrees with the findings of their responsible clinician's clinical review, they can apply to the Tribunal for an examination of their condition and the necessity of continuing compulsory treatment.

Activities for 2012

Mental health sector relationships

The Director of Mental Health visited each DHB mental health service at least once during the reporting year. The Director made multiple visits to some areas to support services to address particular concerns, such as earthquake recovery in Canterbury and youth mental health issues in several other areas.

The Office of the Director of Mental Health maintains relationships with many parts of the mental health sector through attending and presenting at a large number of mental health sector meetings.

Cross-government relationships

The Office of the Director of Mental Health maintains relationships with a number of government departments, particularly where mental health concerns have an impact on the work of those departments, or where those departments can enhance the Director's clinical leadership role in the mental health sector.

Relationship with the Department of Corrections

The Ministry works closely with the Department of Corrections to improve the health services provided to people detained in prisons. Many remanded people and offenders have complex mental health needs, which may require more intensive support than Corrections health services can provide as a provider of primary health care. Regional Forensic Psychiatry Services support Corrections to access and treat prisoners with complex mental health needs. Prisoners may be transferred to a hospital for treatment in a therapeutic environment where necessary.

In late 2011 a memorandum of understanding was signed, governing the transport of prisoners with complex mental health needs between prison and hospital. This agreement was successfully implemented during 2012. A general memorandum of understanding was signed by the Director-General of Health and the Chief Executive of Corrections in December 2012, which provides a formal framework for the continuing relationship between the two departments.

Relationship with New Zealand Police

People detained in police custody often have complex mental health needs. In addition, although DHB mental health services operate emergency intervention teams, police are often required to be the initial response to people whose mental illness appears to contribute to the person being a danger to themselves or to others. It is therefore important for police and DHB mental health services to maintain collaborative relationships. In December 2012 the Director of Mental Health signed a new high-level agreement with the New Zealand Police underpinning the relationship between these services. It is expected that DHBs and police districts will review their local agreements during 2013.

District inspectors

As noted above, the Minister of Health appoints district inspectors under section 94 of the MH(CAT) Act to monitor compliance with the compulsory assessment and treatment process. District inspectors work to protect the rights of patients, address concerns of whānau and investigate alleged breaches of patient rights, as set out in the Act.

The Office of the Director of Mental Health's responsibilities in relation to district inspectors include:

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

The role of district inspectors

District inspectors are required to report to the DAMHS within 14 days of inspecting mental health services. They are also required to report monthly to the Director of Mental Health on the exercise of their powers, duties and functions. These reports provide the Director with support for the approval of invoices for services, as well as an overview of mental health services and any problems arising from them. In 2012 district inspectors continued to provide valuable feedback on services.

Section 95 reports completed by 31 December 2012

The Director will occasionally require an inquiry to be undertaken by a district inspector under section 95 of the MH(CAT) Act. Such inquiries are generally focused on systemic issues across one or more mental health services. These inquiries typically result in recommendations being made by the district inspector. The Director will consider the recommendations and audit the DHB's implementation of relevant recommendations.

The Director will also act on any recommendations that have implications for the Ministry of Health and/or the mental health sector generally. The inquiry process is not completed until the Director considers that the recommendations have been satisfactorily implemented by the DHB and, if appropriate, by the Ministry and all DHBs.

In 2012 one section 95 inquiry was completed and another was under way. Table 1 shows the number of completed section 95 inquiry reports received by the Director of Mental Health between 2003 and 2012.

Table 1: Number of completed section 95 inquiry reports received by the Director of Mental Health, 2003 to 2012

2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
1	2	1	4	1	1	3	2	1	1

The section 95 inquiry completed in 2012 was commissioned in 2010 by the former Director of Mental Health after allegations were raised concerning Hutt Valley DHB. The inquiry led to a number of recommendations being made to the DHB by the Director of Mental Health. The Director of Mental Health continues to work closely with the DHB to monitor progress and ensure the recommended changes have been implemented. More information about this section 95 inquiry can be found on the Ministry of Health's website (www.health.govt.nz).

Number of district inspectors

As at 31 December 2012 there were 35 district inspectors appointed to specific regions throughout New Zealand. One senior advisory district inspector is appointed to provide leadership and advice to the other district inspectors. A list of current district inspectors is available on the Ministry of Health website (www.health.govt.nz).

In the year from 1 January to 31 December 2012 three district inspector positions expired and were subsequently filled, including one vacant position outstanding from 2011. During 2012 one additional district inspector was appointed to the Auckland region, raising the total number of district inspectors from 34 to 35.

Special patients and restricted patients

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

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

People designated as restricted patients are civil patients detained by a court under similar conditions to special patients because of the special difficulties they present and the danger they pose to others.

The Director of Mental Health has a central role in the management of special patients and restricted patients. The Director may direct their transfer under section 49 of the MH(CAT) Act, or grant leave for any period not exceeding seven days for certain special and restricted patients (section 52). Longer periods of leave are granted by the Minister of Health (section 50) and are available to certain categories of special patients. The Director briefs the Minister of Health when requests for leave are made.

The Director must also be notified of the admission, discharge or transfer of special and restricted patients, and certain incidents involving these patients (section 43). The process for reclassifying special and restricted patients differs according to the patient's particular status but always requires ministerial involvement.

Special patients found not guilty by reason of insanity may be considered for a change of legal status if it is determined that their detention is no longer necessary to safeguard the interests of the patient or the public. Applications for changes of legal status are sent to the Director of Mental Health. After careful consideration, the Director will make a recommendation to the Minister about a person's legal status.

Table 2 shows the section 50 long-leave applications, revocations and change of status applications processed by the Office of the Director of Mental Health during 2012.

Table 2: Number of long-leave applications, and revocation and reclassification requests for special and restricted patients, 1 January to 31 December 2012

Type of request	Acquitted due to insanity	Unfit to stand trial	Restricted patients
Initial ministerial section 50 leave applications	9	0	0
Ministerial section 50 leave revocations	1	0	0
Further ministerial section 50 leave applications	25	0	1
Change of legal status applications approved	8	0	0
Change of legal status applications not approved	1	0	0

Source: Office of the Director of Mental Health records

Prisoner transfers to hospital

Once a person has been sentenced to a term of imprisonment, a compulsory treatment order relating to the prisoner ceases to have effect. Remand prisoners may remain on a pre-existing compulsory treatment order, but it is unlawful to enforce compulsory treatment in the prison environment. If compulsory assessment and/or treatment is required, section 45 of the MH(CAT) Act provides for the transfer to hospital of mentally disordered prisoners. Section 46 allows for voluntary admission to hospital with the approval of the prison superintendent. The Director of Mental Health is notified of all such admissions.

Table 3: Number of patients transferred to hospital from prison under sections 45 and 46 of the MH(CAT) Act, 2001 to 2012

Year	Prisoners transferred to hospital for compulsory treatment (s45)	Prisoners transferred to hospital voluntarily (s46)
2001	134	4
2002	96	0
2003	113	2
2004	121	1
2005	117	8
2006	128	16
2007	98	2
2008	80	2
2009	120	12
2010	105	11
2011	85	4
2012	84	3

Source: Manual data provided by DHBs

Hybrid special patients

The Criminal Procedure (Mentally Impaired Persons) Act 2003 allows the court to sentence a convicted offender to a term of imprisonment while also ordering their detention in hospital as a special patient (if mentally disordered). These orders are referred to as hybrid orders because they combine aspects of compulsory treatment and imprisonment. In 2012 there was one hybrid order made under section 34(1)(a)(i) of the Act.

Report of the Mental Health Review Tribunal

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

Functions of the Tribunal

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

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

Powers of the Tribunal

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

Under section 80 of the Act the Tribunal makes recommendations relating to special patients to the Minister of Health or the Attorney-General. It is for the Minister or Attorney-General to determine whether there should be a change to a special patient's status under the Act.

The Tribunal may also investigate complaints if a complainant is dissatisfied with a district inspector's investigation. If the Tribunal decides a complaint has substance, it must report the matter to the relevant DAMHS, with appropriate recommendations.

Tribunal statistics

During the year ended 30 June 2012 the Tribunal received 174 applications. Table 4 presents both the types of applications received and the outcomes of these applications.

Table 4: Outcome of MH(CAT) Act applications received by the Mental Health Review Tribunal, 1 July 2011 to 30 June 2012

Case outcome	Section 79	Section 80	Section 81	Section 75	Total
Deemed ineligible	6	0	0	0	6
Withdrawn	72	0	0	0	72
Held over to the next report year	19	0	0	0	19
Heard in the report year	71	5	1	0	77
Total cases	**168**	**5**	**1**	**0**	**174**

Source: Annual Report of Mental Health Review Tribunal, 1 July 2011 to 30 June 2012

During the year ended 30 June 2012 the Tribunal heard 71 applications that had been received during the reporting year, and eight applications held over from the previous reporting year, under section 79 of the MH(CAT) Act (relating to ordinary patients). The results of those cases are reported in Table 5.

Table 5: Results of inquiries under section 79 of the MH(CAT) Act held by the Mental Health Review Tribunal, 1 July 2011 to 30 June 2012

Result of MH(CAT) Act section 79 inquiry	Number of cases
Not fit to be released from compulsory status	76
Fit to be released from compulsory status	4
Total	**80**

Source: Annual Report of Mental Health Review Tribunal, 1 July 2011 to 30 June 2012

Table 6 shows the ethnicity of the 159 patients for whom ethnicity was identified in an application to the Tribunal in the year ended 30 June 2012.

Table 6: Ethnicity of patients who identified their ethnicity in Mental Health Review Tribunal applications, 1 July 2011 to 30 June 2012

Ethnicity	Number	Percentage
New Zealand European	122	77
Māori	30	19
Pacific Island	2	1
Asian	5	3
Other	0	0
Total	**159**	**100**

Source: Annual Report of Mental Health Review Tribunal, 1 July 2011 to 30 June 2012

Of the 174 MH(CAT) Act applications received by the Tribunal during the year ended 30 June 2012, 117 were from male patients and 57 from female patients. These gender figures are broken down in Table 7.

Table 7: Gender of patients in Mental Health Review Tribunal applications, 1 July 2011 to 30 June 2012

Type of application submitted to the Tribunal	Sex	Number
Applications by patients subject to community treatment orders	Female	48
	Male	82
Applications by patients subject to inpatient treatment orders	Female	9
	Male	29
Applications by patients subject to special patient orders	Female	0
	Male	1
Applications by patients subject to restricted patient orders	Female	0
	Male	1

Source: Annual Report of Mental Health Review Tribunal, 1 July 2011 to 30 June 2012

Statistics

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

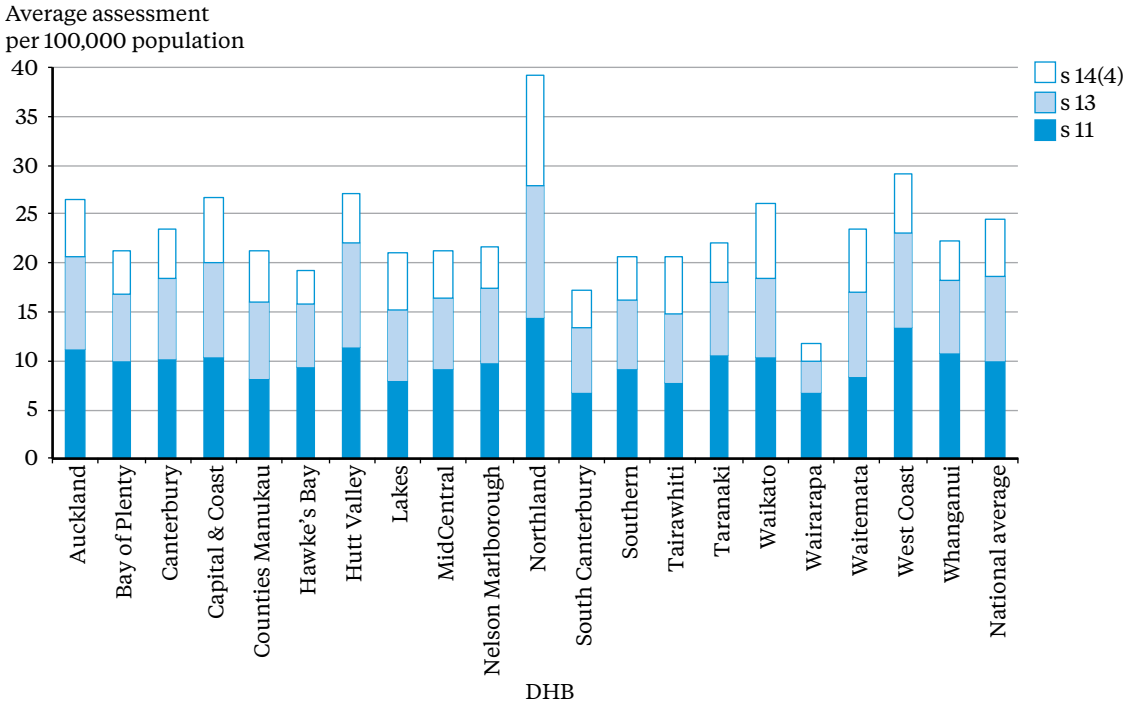
Compulsory assessment and application for compulsory treatment orders

Information in this subsection and the one following is sourced from data in the quarterly reports from the DAMHS, from the PRIMHD data set and from data collected by the Ministry of Justice.

The first assessment period under section 11 of the MH(CAT) Act is for up to five days. It can then be extended for a second period of up to 14 additional days (section 13). If a further extension to the period of assessment is required, an application to the court is made for a compulsory treatment order under section 14(4). Figure 3 and Table 8 show the average number of patients required to undergo assessment under these sections each month, by DHB.

In 2012 the national average rate of assessments per 100,000 per month was 10 under section 11 and 9 under section 13. The average rate per month of applications for compulsory treatment orders under section 14(4) was 6.

Figure 3: Average number of patients per month required to undergo assessment under sections 11, 13 and 14(4), per 100,000 population, by DHB of service, 1 January to 31 December 2012



Note: For the 2012 annual report, manual data supplied by DHBs has been used for reporting compulsory assessment and treatment under the MH(CAT) Act. This decision was made after issues with 2012 PRIMHD data were identified. These issues will be addressed, with the intention of returning to PRIMHD for future annual reports.

Source: Manual data provided by DHBs

Table 8: Average number of patients per month required to undergo assessment under sections 11, 13 and 14(4) of the MH(CAT) Act, per 100,000 population, by DHB of service, 1 January to 31 December 2012

DHB	s 11	s 13	s 14(4)
Auckland	11	9	6
Bay of Plenty	10	7	4
Canterbury	10	8	5
Capital & Coast	10	9	7
Counties Manukau	8	8	5
Hawke's Bay	9	6	4
Hutt Valley	11	11	5
Lakes	8	7	6
MidCentral	9	7	5
Nelson Marlborough	10	8	4
Northland	14	13	11
South Canterbury	7	7	4
Southern	9	7	4
Tairawhiti	8	7	6
Taranaki	11	7	4
Waikato	10	8	8
Wairarapa	7	3	2
Waitemata	8	9	7
West Coast	13	10	6
Whanganui	11	7	4
National average	**10**	**9**	**6**

Notes: The New Zealand total is a unique client count and not an average of the DHB information (as clients can be seen by more than one DHB).

For the 2012 annual report, manual data supplied by DHBs has been used for reporting compulsory assessment and treatment under the MH(CAT) Act. This decision was made after issues with 2012 PRIMHD data were identified. These issues will be addressed, with the intention of returning to PRIMHD for future annual reports.

Source: Manual data provided by DHBs

Compulsory treatment orders

The Ministry of Justice statistics for MH(CAT) Act hearings in relation to compulsory treatment orders are available from 2004 onwards. Table 9 presents data on applications for a compulsory treatment order from 2004 through to 2012. Table 10 shows the types of orders granted over the same period.

Table 9: Applications for compulsory treatment orders (or extensions), 2004 to 2012

Year	Applications for a CTO, or extension to a CTO	Applications granted, or granted with consent	Applications dismissed or struck out	Applications withdrawn, lapsed or discontinued	Applications transferred to the High Court
2004	4423	3863	100	460	0
2005	4302	3682	100	520	0
2006	4268	3643	109	515	1
2007	4557	3916	99	542	0
2008	4557	3969	103	485	0
2009	4586	4038	54	494	0
2010	4751	4156	74	520	1
2011	4801	4215	70	516	0
2012	4838	4328	72	438	0

Notes: The table presents applications that had been processed at the time of data extraction (12 June 2013).

The year is determined by the final outcome date.

CTO = compulsory treatment order.

Source: Ministry of Justice's Integrated Sector Intelligence System, which uses data entered into the Case Management System (CMS). The CMS is a live operational database, and figures are subject to minor changes at any time

Table 10: Types of compulsory treatment orders made on granted applications, 2004 to 2012

Year	Granted applications for orders	Compulsory community treatment orders (or extension)	Compulsory inpatient treatment orders (or extension)	Orders recorded as both compulsory community and inpatient treatment orders (or extension)	Type of order not recorded
2004	3863	1831	1540	112	380
2005	3682	1575	1440	91	576
2006	3643	1614	1388	87	554
2007	3916	1713	1335	114	754
2008	3969	1842	1429	118	580
2009	4038	2087	1565	101	285
2010	4156	2241	1615	102	198
2011	4215	2258	1680	83	194
2012	4328	2428	1687	65	148

Notes: The table presents applications that had been processed at the time of data extraction on 12 June 2013. The year is determined by the final outcome date.

Source: Ministry of Justice's Integrated Sector Intelligence System, which uses data entered into the Case Management System (CMS). The CMS is a live operational database, and figures are subject to minor changes at any time

In 2012, 4838 applications for a compulsory treatment order or extension to a compulsory treatment order were dealt with in the Family Court. Of these applications, 4328 were granted, 72 were dismissed and 438 were withdrawn.

Of the 4328 applications granted, 2428 resulted in compulsory community treatment orders and 1687 in compulsory inpatient treatment orders. A combination of compulsory community and compulsory inpatient treatment orders were made for an additional 65 applications. The remaining 148 applications do not have the type of compulsory treatment order recorded in the Case Management System.

In 2012, at any given time an average of 77 people per month per 100,000 population were subject to a compulsory community treatment order (section 29), an average of 13 people per month per 100,000 were under a compulsory inpatient treatment order (section 30), and an average of 4 people per month per 100,000 were under a compulsory inpatient treatment order while on leave (section 31).

Figure 4 and Table 11 show the number of compulsory treatment orders granted for 2012, by DHB. Figures 5 and 6 break down the number of compulsory treatment order applications by age and gender.

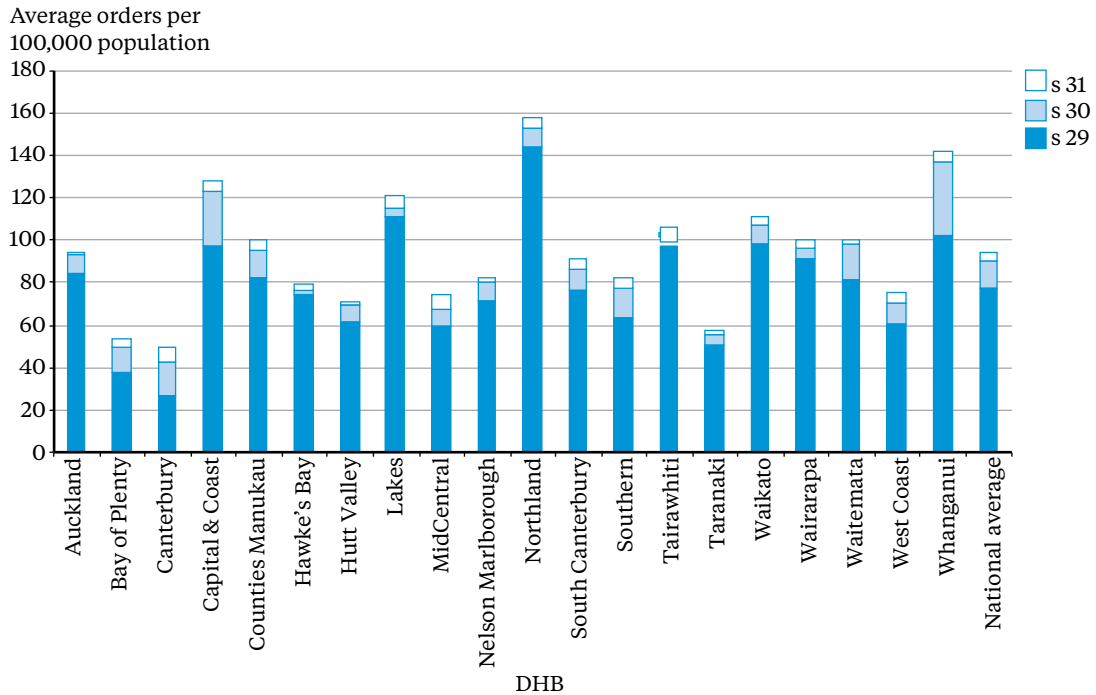
Table 11: Average number of compulsory treatment orders at month's end under sections 29, 30 and 31 of the MH(CAT) Act, per 100,000 population, by DHB of service, 1 January to 31 December 2012

DHB	s 29	s 30	s 31
Auckland	85	9	0.31
Bay of Plenty	38	12	4
Canterbury	27	16	7
Capital & Coast	98	25	5
Counties Manukau	82	14	4
Hawke's Bay	74	2	3
Hutt Valley	61	8	1
Lakes	111	4	7
MidCentral	59	8	7
Nelson Marlborough	71	9	2
Northland	144	9	5
South Canterbury	76	10	5
Southern	64	14	4
Tairawhiti	97	3	6
Taranaki	51	6	1
Waikato	98	9	4
Wairarapa	92	4	5
Waitemata	81	18	1
West Coast	60	11	5
Whanganui	102	35	4
National average	**77**	**13**	**4**

Note: For the 2012 annual report, manual data supplied by DHBs has been used for reporting compulsory assessment and treatment under the MH(CAT) Act. This decision was made after issues with 2012 PRIMHD data were identified. These issues will be addressed, with the intention of returning to PRIMHD for the future annual reports.

Source: Manual data provided by DHBs

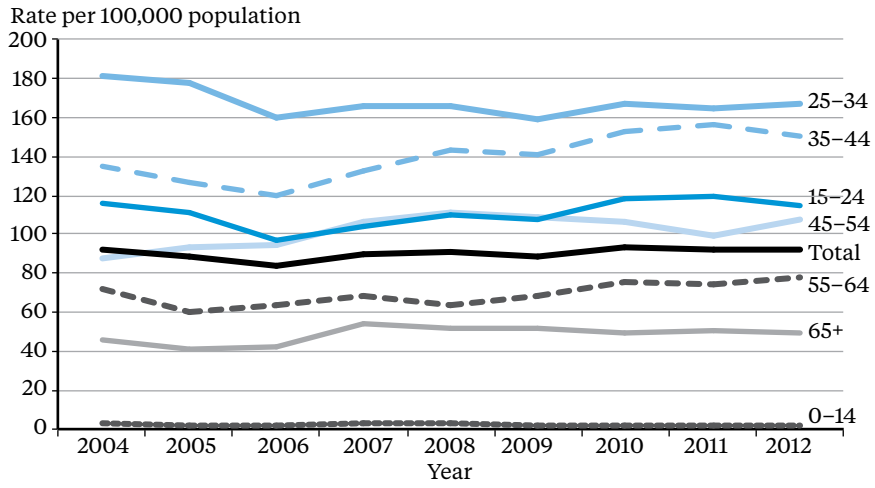
Figure 4: Average number of compulsory treatment orders at month's end under sections 29, 30 and 31 of the MH(CAT) Act, per 100,000 population, by DHB of service, 1 January to 31 December 2012



Note: For the 2012 annual report, manual data supplied by DHBs has been used for reporting compulsory assessment and treatment under the MH(CAT) Act. This decision was made after issues with 2012 PRIMHD data were identified. These issues will be addressed, with the intention of returning to PRIMHD for future annual reports.

Source: Manual data provided by DHBs

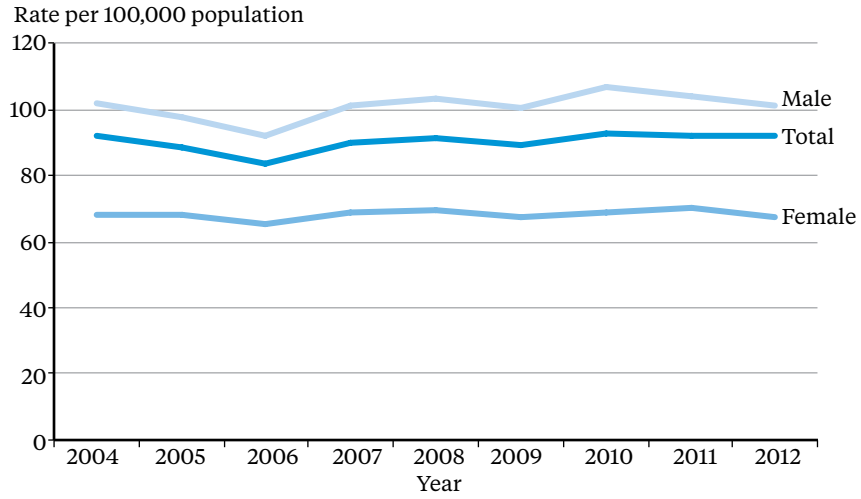
Figure 5: Rate of compulsory treatment order applications (including extensions), by age group, 2004 to 2012



Note: The figure presents applications that had been filed at the time of data extraction on 12 June 2013. The year is determined by the filing date of the application. Each person is counted once for every year an application is filed. Since patients can be associated with more than one application, the number of patients is less than the number of applications.

Source: Ministry of Justice's Integrated Sector Intelligence System, which uses data entered into the Case Management System (CMS). The CMS is a live operational database, and figures are subject to minor changes at any time

Figure 6: Rate of compulsory treatment order applications (including extensions), by gender, 2004 to 2012



Note: The figure presents applications that had been processed at the time of data extraction on 12 June 2013. The year is determined by the filing date of the application. Each person is counted once for every year an application is filed. Since patients can be associated with more than one application, the number of patients is less than the number of applications.

Source: Ministry of Justice's Integrated Sector Intelligence System, which uses data entered into the Case Management System (CMS). The CMS is a live operational database, and figures are subject to minor changes at any time

Section 16 reviews

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

During 2012 there were approximately 1175 applications considered under section 16 of the Act. Of this total, 477 applications were subsequently withdrawn, lapsed or were discontinued for other reasons. A further 698 proceeded to hearings. An order for release of the patient from compulsory status was issued in 47 cases (6.7 percent of the applications that proceeded to hearings).[5]

Relapse prevention plans

The Director-General of Health introduced 10 sector-wide health targets in 2007 (reduced to six in 2009). The Director of Mental Health, in his Chief Advisor role, was appointed 'target champion' for the mental health target. The target stated that at least 95 percent of people who have been service users of mental health and addiction services for two years or more must have a relapse prevention plan. DHB reporting on relapse prevention plans continued as an indicator of DHB performance.

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

Since the health target was introduced in 2007, the national percentage of service users with a relapse prevention plan has increased from 59 percent in 2007 to 92 percent in 2012 (Figure 7).

DHBs reported twice during 2012. The first reporting period covered 1 January 2012 to 30 June 2012 and the second reporting period covered 1 July 2012 to 31 December 2012. Figure 8 shows the results of DHBs' reporting for the 2012 calendar year. During 2012 eight of the 20 DHBs achieved the 95 percent target for both reporting periods (January to June and July to December) for the proportion of long-term service users with a relapse prevention plan. This is an increase from six DHBs for both reporting periods in 2011.

5 Source: Ministry of Justice

Figure 7: Percentage of long-term service users with a relapse prevention plan, 2007 to 2012

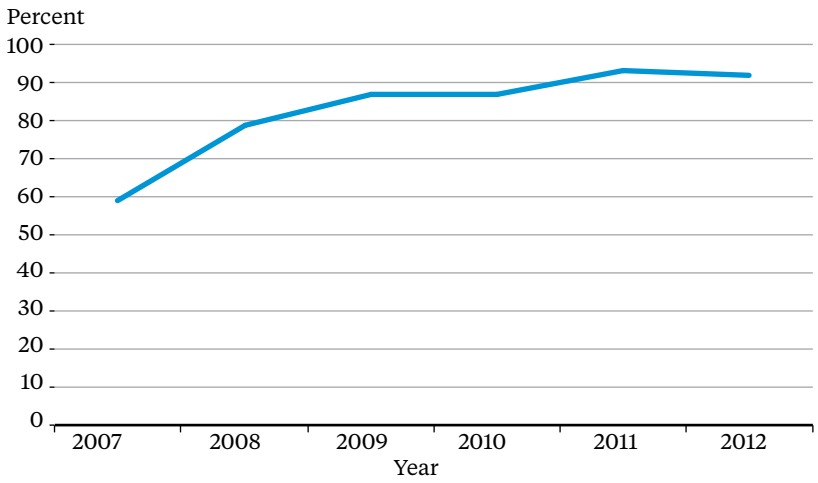
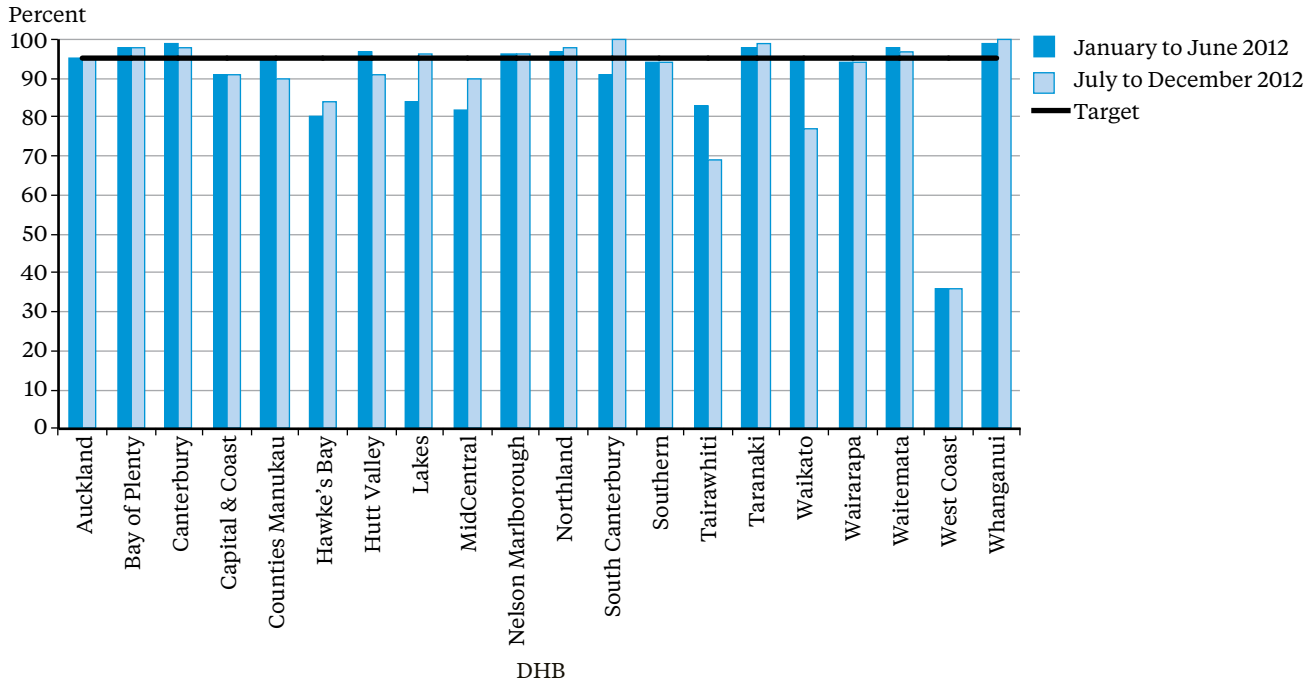


Figure 8: Percentage of service users with a relapse prevention plan, by DHB, 1 January to 31 December 2012



Seclusion

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

The *Health and Disability Services (General) Standard* (Standards New Zealand 2008a) defines seclusion as 'where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit'. The duration and circumstances of each episode of seclusion must be recorded in a register, which must be available for review by district inspectors.

The *Health and Disability Services (Restraint Minimisation and Safe Practices) Standards* (Standards New Zealand 2008b) note that the intent of the standards is to 'reduce the use of restraint in all its forms and to encourage the use of least restrictive practices'. The standards came into effect on 1 June 2009.

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

In February 2010 the Ministry of Health published revised guidelines for the use of seclusion in mental health services: *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health 2010b). The guidelines identify best practice methods for using seclusion in mental health acute patient units, in alignment with the specifications set out in the Health and Disability Services Standards. The intent of the revised guidelines is to progressively decrease and limit the use of seclusion and restraint for mental health patients.

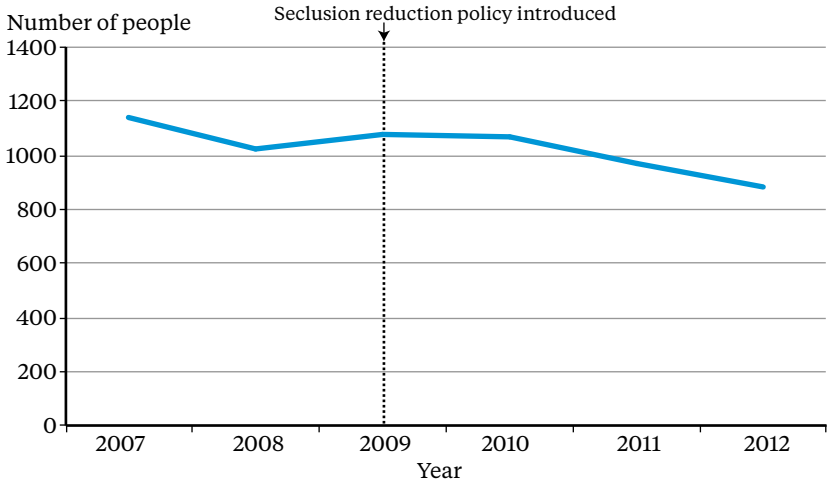
Te Pou o Te Whakaaro Nui (National Workforce Centre for Mental Health, Addiction and Disability) supports the national direction set by the Ministry of Health for seclusion and restraint reduction by using evidence-based information, such as the '6 Core Strategies' of the National Technical Assistance Centre (Huckshorn et al 2005). Te Pou works with DHBs to support their local initiatives. Further information and stories of emerging good practice can be found on their website www.tepou.co.nz

Changes in the use of seclusion over time

Figures 9 and 10 show a decrease in the number of people secluded in adult services (ages 20 to 64) and in the total number of seclusion hours since 2007. Since 2009, when the seclusion reduction policy was introduced, the total number of patients secluded in adult services nationally decreased by 18 percent, with a 9 percent decrease between 2011 and 2012. The total number of seclusion hours for patients in adult services nationally has decreased by 36 percent since 2009, with a decrease of 6 percent between 2011 and 2012.

The declining trend for both the number of patients and the total number of hours spent in seclusion is in line with the goals of *Rising to the Challenge* (Ministry of Health 2012f) to reduce and eliminate the use of seclusion and restraint in New Zealand.

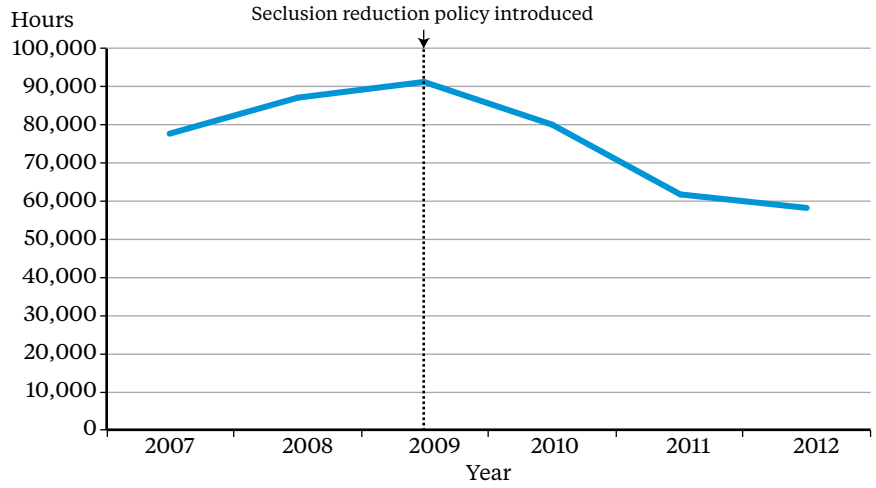
Figure 9: Number of people secluded in adult services nationally, 2007 to 2012



Note: Seclusion data provided by Tairawhiti DHB was incomplete for 2012.

Source: For 2007 to 2009, manual data provided by DHBs was used. For 2010, PRIMHD data was used, except for Capital & Coast, which provided manual data. PRIMHD data was used for 2011, except for Hawke's Bay and Canterbury DHBs, which provided manual data. For 2012, PRIMHD data was used, extracted on 14 August 2013, except for Southern and Hawke's Bay DHBs, which provided manual data

Figure 10: Number of hours of seclusion in adult services nationally, 2007 to 2012



Note: Seclusion data provided by Tairawhiti DHB was incomplete for 2012.

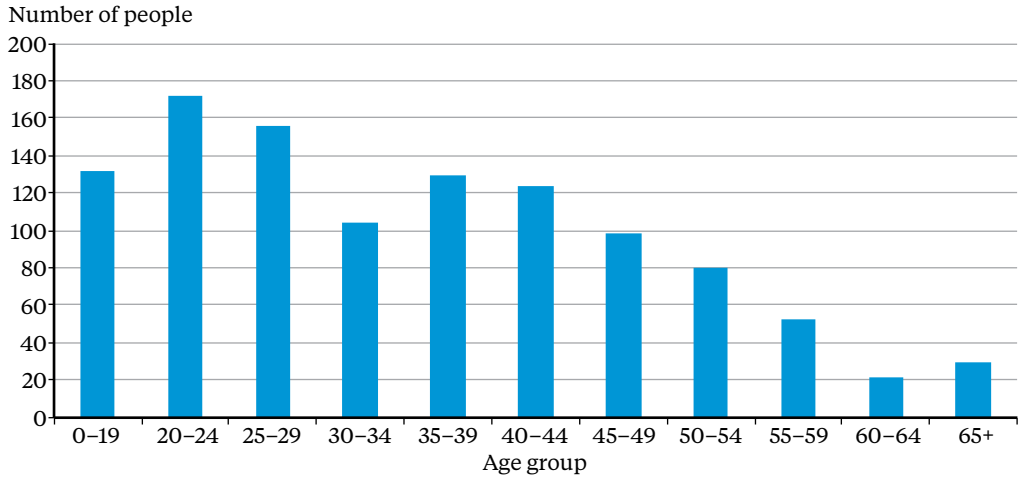
Source: For 2007 to 2009, manual data provided by DHBs was used. For 2010, PRIMHD data was used, except for Capital & Coast, which provided manual data. PRIMHD data was used for 2011, except for Hawke's Bay and Canterbury DHBs, which provided manual data. For 2012, PRIMHD data was used, extracted on 14 August 2013, except for Southern and Hawke's Bay DHBs, which provided manual data

Seclusion in New Zealand mental health services

Between 1 January and 31 December 2012, 6823 patients spent time in New Zealand adult mental health units (excluding forensic and other regional rehabilitation services). This represents 192,766 bed nights. Of these 6823 patients, 882 (13 percent) were secluded at some time during the reporting period. As the same people were often secluded more than once (on average 2.6 times), the number of seclusion events in adult services was higher than the number of patients secluded (2259 events for adult clients).

Across all services, including forensic and youth services, 1101 patients across all age groups experienced at least one seclusion event. Sixty-six percent of secluded patients were male and 34 percent were female. Most patients who were secluded were aged between 0 and 54 years (see Figure 11). A total of 60 young people were secluded in the country's specialist facilities for children and young people (in Christchurch, Auckland and Wellington). There were 193 seclusion events reported for this group of young people.

Figure 11: Number of people secluded in all mental health units, by age group, 1 January to 31 December 2012



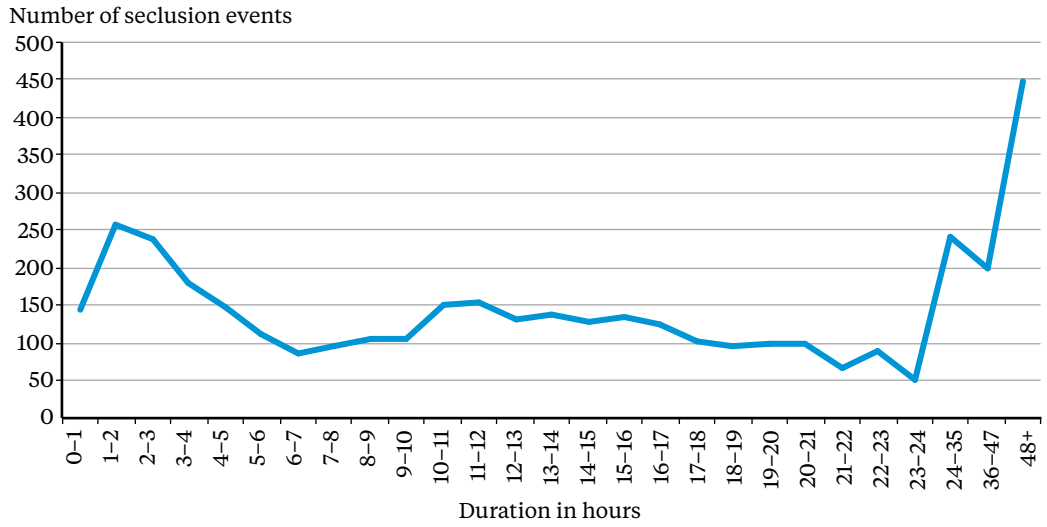
Notes: Shortly before publication of this report, Hawke's Bay DHB provided revised seclusion figures for 2012. The revised figures were not provided in time to amend this figure.

Seclusion data provided by Tairawhiti DHB was incomplete for 2012.

Source: PRIMHD data, extracted on 14 August 2013, except for Southern DHB, which provided manual data

The length of time spent in seclusion varied considerably. Most seclusion events (77 percent) lasted for less than 24 hours. Figure 12 shows the number of seclusion events by duration of the event.

Figure 12: Distribution of seclusion events in all mental health units, by duration of the event, 1 January to 31 December 2012



Notes: Shortly before publication of this report, Hawke's Bay DHB provided revised seclusion figures for 2012. The revised figures were not provided in time to amend this figure.

Seclusion data provided by Tairawhiti DHB was incomplete for 2012.

Source: PRIMHD data extracted on 14 August 2013, except for Southern DHB, which provided manual data

Seclusion by DHB

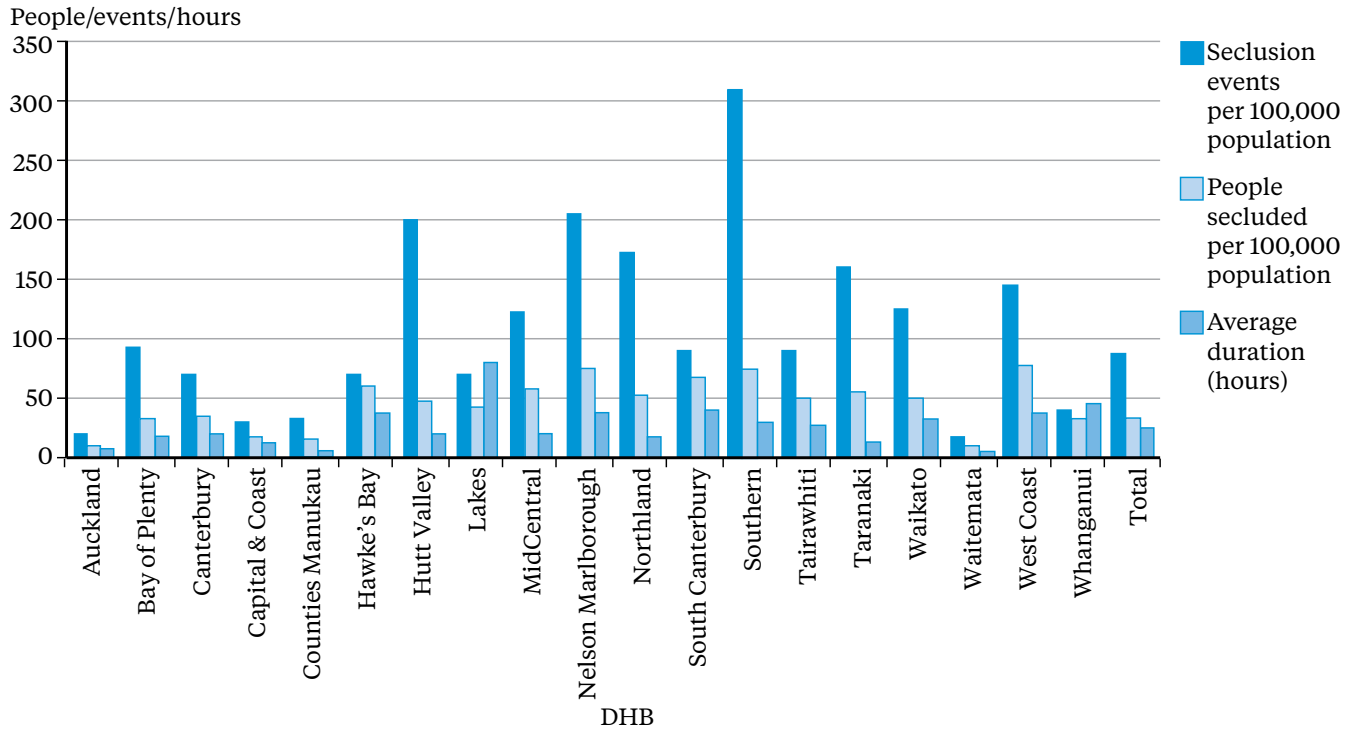
All DHBs except for Wairarapa, which has no mental health inpatient service, use seclusion. If a person in Wairarapa requires admission, they are transported to Hutt Valley or MidCentral DHB, and any seclusion statistics in relation to these patients appear on the corresponding DHB's database.

As Figure 13 shows, seclusion data varied widely across DHBs. Such variation is likely to be due to a number of factors, including:

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

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

Figure 13: Seclusion indicators for adult services (aged 20 to 64 years), by DHB, 1 January to 31 December 2012



Notes: Wairarapa DHB is not included in this figure as they do not have a mental health inpatient service.
Average duration is per event.
Seclusion data provided by Tairawhiti DHB was incomplete for 2012.

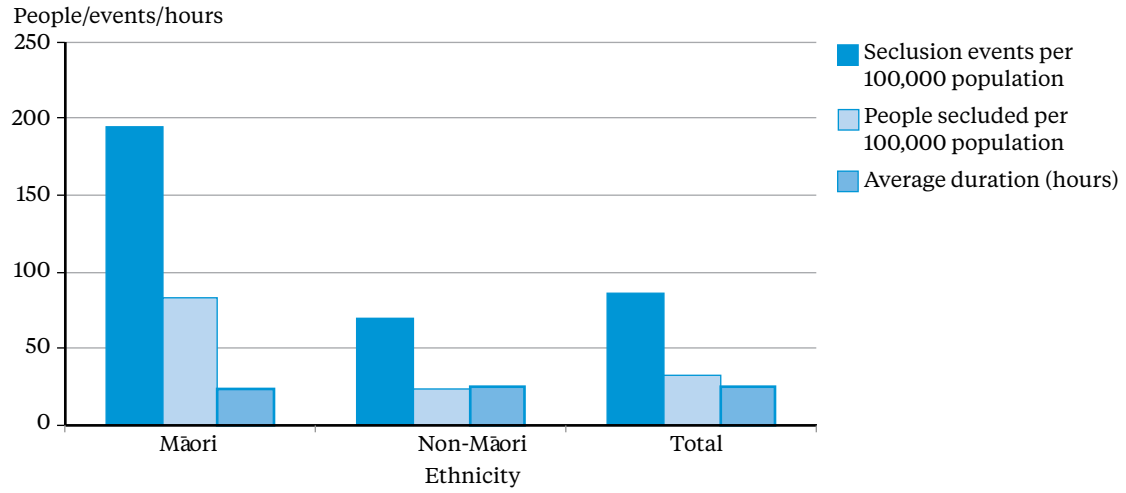
Source: PRIMHD data, extracted on 14 August 2013, except for Southern and Hawke's Bay DHBs, which provided manual data

Seclusion and ethnicity

As a population group, Māori experience the greatest burden due to mental health issues in New Zealand. Māori are more likely to be secluded than people from other ethnic groups. Figure 14 shows that in 2012 of the 882 people (aged 20 to 64) secluded in adult services, 32 percent were Māori.

Reducing and eliminating the use of seclusion for Māori is a priority action in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017* (Ministry of Health, 2012f). Te Pou supports the Ministry initiative outlined in *Rising to the Challenge.* Information on initiatives and strategies for reducing the use of seclusion with Māori can be accessed on Te Pou's website (www.tepou.co.nz).

Figure 14: Seclusion indicators for adults (aged 20 to 64 years) in adult mental health units, by ethnicity, 1 January to 31 December 2012



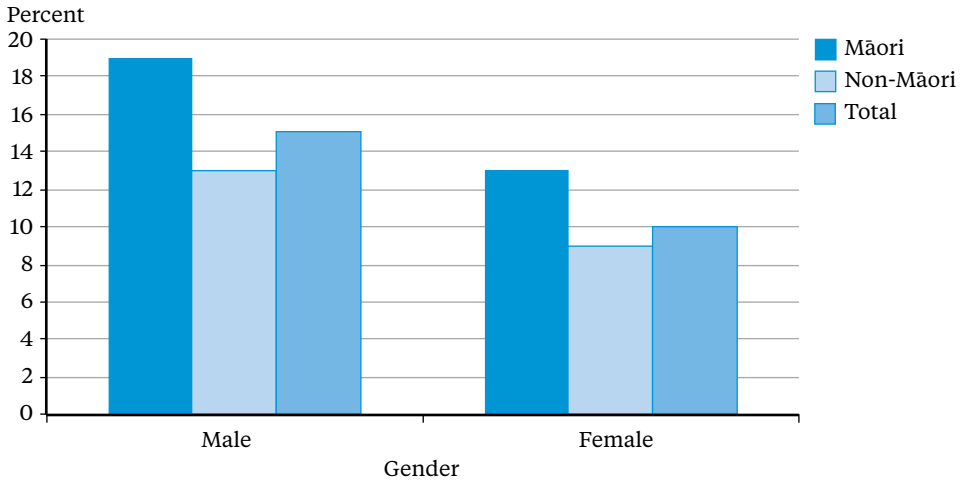
Notes: Shortly before publication of this report, Hawke's Bay DHB provided revised seclusion figures for 2012. The revised figures were not provided in time to amend this figure.

Seclusion data provided by Tairawhiti DHB was incomplete for 2012.

Source: PRIMHD data, extracted on 14 August 2013, except for Southern DHB, which provided manual data

Figure 15 shows the percentage of inpatients secluded in acute adult services, by ethnicity and gender in 2012. This figure indicates that a greater proportion of Māori patients were secluded than non-Māori, and that across all ethnicities men were more likely to be secluded (15 percent) than women (10 percent).

Figure 15: Proportion of adult inpatients (aged 20 to 64 years) who experienced seclusion in adult units, by ethnicity and gender, 1 January to 31 December 2012



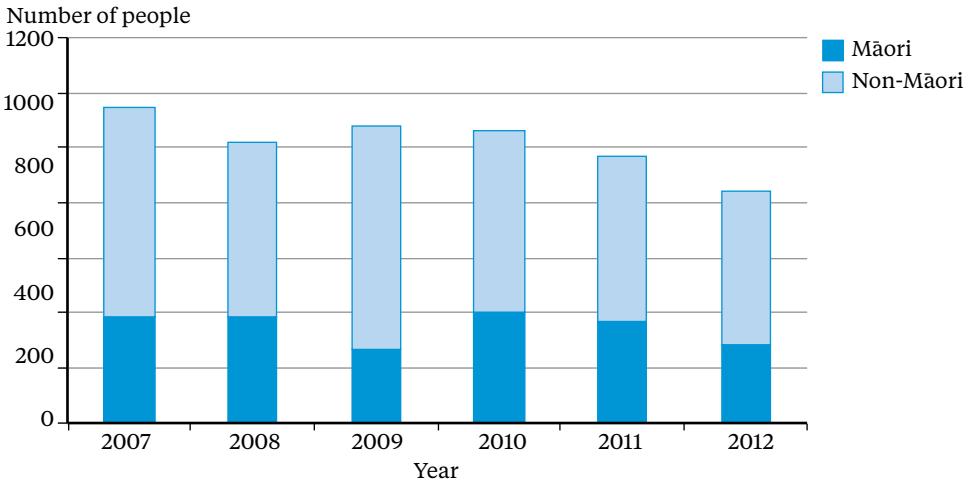
Notes: Shortly before publication of this report, Hawke's Bay DHB provided revised seclusion figures for 2012. The revised figures were not provided in time to amend this figure.

Seclusion data provided by Tairawhiti DHB was incomplete for 2012.

Source: PRIMHD data extracted on 14 August 2013, except for Southern DHB, which provided manual data

Figure 16 shows the proportion of Māori secluded in general adult mental health services (for ages 20 to 64 years) from 2007 to 2012. Nationally since 2009 the number of people secluded has decreased by 22 percent. Consistent with the declining national rate, the number of people secluded who identify as Māori has decreased by 24 percent between 2009 and 2012, while the proportion of service users who identify as Māori has remained the same since 2009 at 34 percent.

Figure 16: Proportion of Māori aged 20 to 64 secluded in general adult mental health units nationally, 2007 to 2012



Notes: Shortly before publication of this report, Hawke's Bay DHB provided revised seclusion figures for 2012. The revised figures were not provided in time to amend this figure.

Seclusion data provided by Tairawhiti DHB was incomplete for 2012.

Source: PRIMHD data, extracted 14 August 2013, except for Southern DHB, which provided manual data

Seclusion in forensic units

Specialist inpatient forensic services are provided in five regions: Northern, Midland, Central, Canterbury and Otago, with a smaller inpatient forensic service in Whanganui.[6] Forensic services provide mental health treatment in a secure environment for prisoners with a mental disorder, and for people defined as special or restricted patients under the MH(CAT) Act.

In 2012, 118 people were secluded in forensic units (comparable with 119 in 2011), contributing to a total of 1240 seclusion events. The average duration of a seclusion event in a forensic service decreased by 28 percent, from 39.4 hours in 2011 to 28.3 hours in 2012.

Table 12 presents the seclusion indicators for the 2012 calendar year. Although these indicators cannot be compared with adult service indicators because they do not reflect the same client base, it is clear they vary widely. The rates of seclusion of the relatively small group of patients in the care of forensic services can be affected by individual patients who were secluded significantly more often than other patients. In particular, four individuals accounted for 632 of the 1240 seclusion events. Of these, there was one individual who had 376 seclusion events, and another who had 126 events over the reporting period.

6 The Whanganui inpatient unit comes under the Central region's forensic services.

Table 12: Seclusion indicators for forensic services, by DHB, 1 January to 31 December 2012

DHB	Clients secluded	Average duration (hours)
Canterbury	20	21.5
Capital & Coast	8	36.9
Southern	12	23.3
Waikato	21	39.2
Waitemata	55	40.3
Whanganui	2	53.8
Total	118	28.3

Note: For the 2011 annual report, this table included a column of rates per 100,000. This column has been excluded from this report as the numbers are too small and variable to be usefully represented by a rate.

DHB refers to DHB of service.

Source: PRIMHD data extracted on 14 August 2013, except for Southern DHB, which provided manual data

Electroconvulsive therapy

Electroconvulsive therapy (ECT) is a therapeutic procedure in which a brief pulse of electricity is delivered to a patient's brain in order to produce a seizure. ECT can be an effective treatment for various types of mental illness, including depressive illness, mania, catatonia, and other serious neuropsychiatric conditions. It is often effective as a last resort in cases where medication is contraindicated or is not relieving symptoms sufficiently. ECT can only be given with the consent of the patient, other than in certain carefully defined circumstances.

ECT is administered under anaesthesia and with muscle relaxants by medical staff in an operating theatre. The patient goes to sleep under anaesthesia and wakes unable to recall the details of the procedure. The most common side-effects of ECT are confusion and memory loss. Confusion and disorientation typically clear within an hour, but memory loss can be persistent and in some cases even permanent (Ministry of Health 2004; American Psychiatric Association 2001).

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

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

Number of patients treated with ECT

The number of patients treated with ECT in 2012 is presented in Table 13 by DHB for the area where the patient lives (DHB of domicile). The reason for this is that some DHBs do not perform ECT, and patients in that area are referred to other DHBs for ECT treatment. Presenting the figures by DHB of domicile therefore gives a better picture of the rates of ECT treatment by DHB. Other ECT statistics are by DHB of service.

Table 13 shows the total number of patients who received ECT from 1 January to 31 December 2012, by DHB of domicile. A total of 265 people received ECT during the year ending 31 December 2012. The total number of treatments administered over this period was 2670, with the mean number of treatments per person being 10.08.

Table 13: Number of patients treated with ECT, by DHB of domicile, 1 January to 31 December 2012

DHB of domicile	Number of patients treated with ECT	Total number of treatments	Mean number of treatments per person (range)
Auckland	14	114	8.14 (1–16)
Bay of Plenty	10	102	10.2 (1–28)
Canterbury	45	457	10.16 (2–27)
Capital & Coast	23	223	9.7 (1–37)
Counties Manukau	24	210	8.75 (1–22)
Hawke's Bay	10	114	11.4 (7–27)
Hutt Valley	2	11	5.5 (5–6)
Lakes	17	167	9.82 (1–34)
MidCentral	7	89	12.71 (5–22)
Nelson Marlborough	2	18	9 (5–13)
Northland	15	140	9.33 (2–21)
South Canterbury	2	18	9 (9–9)
Southern	36	342	9.5*
Tairawhiti	2	14	7 (4–10)
Taranaki	11	128	11.64 (6–22)
Waikato	31	345	11.13 (1–31)
Wairarapa	1	9	9 (9–9)
Waitemata	14	155	11.07 (4–33)
West Coast	1	12	12 (12–12)
Whanganui	2	2	1 (1–1)
New Zealand	**265**	**2670**	**10.08**

Notes: This table does not include ECT figures for clients receiving treatment with health services for older people in the Central and Southern regions. Health Services for Older People in these regions do not report to PRIMHD.

In 2012, 12 clients were seen out of area:

- Auckland DHB saw one client from Northland
- Bay of Plenty saw one client from Whanganui
- Canterbury DHB saw one client from Counties Manukau, two from South Canterbury and one from West Coast.
- Counties Manukau DHB saw two clients from Auckland
- Lakes DHB saw one client from Waikato
- MidCentral DHB saw one client from Taranaki, one from Wairarapa and one from Whanganui.

The 2011 annual report presented data on the number of acute courses of ECT by DHB. This year the Ministry has attempted to improve and simplify ECT reporting by replacing acute courses with the total and mean number of treatments per person.

If a client was seen while living in two DHB areas, they were counted twice. The New Zealand total of 265 is a unique count and not a sum of this table column as the New Zealand total excludes individuals who were counted by more than one DHB.

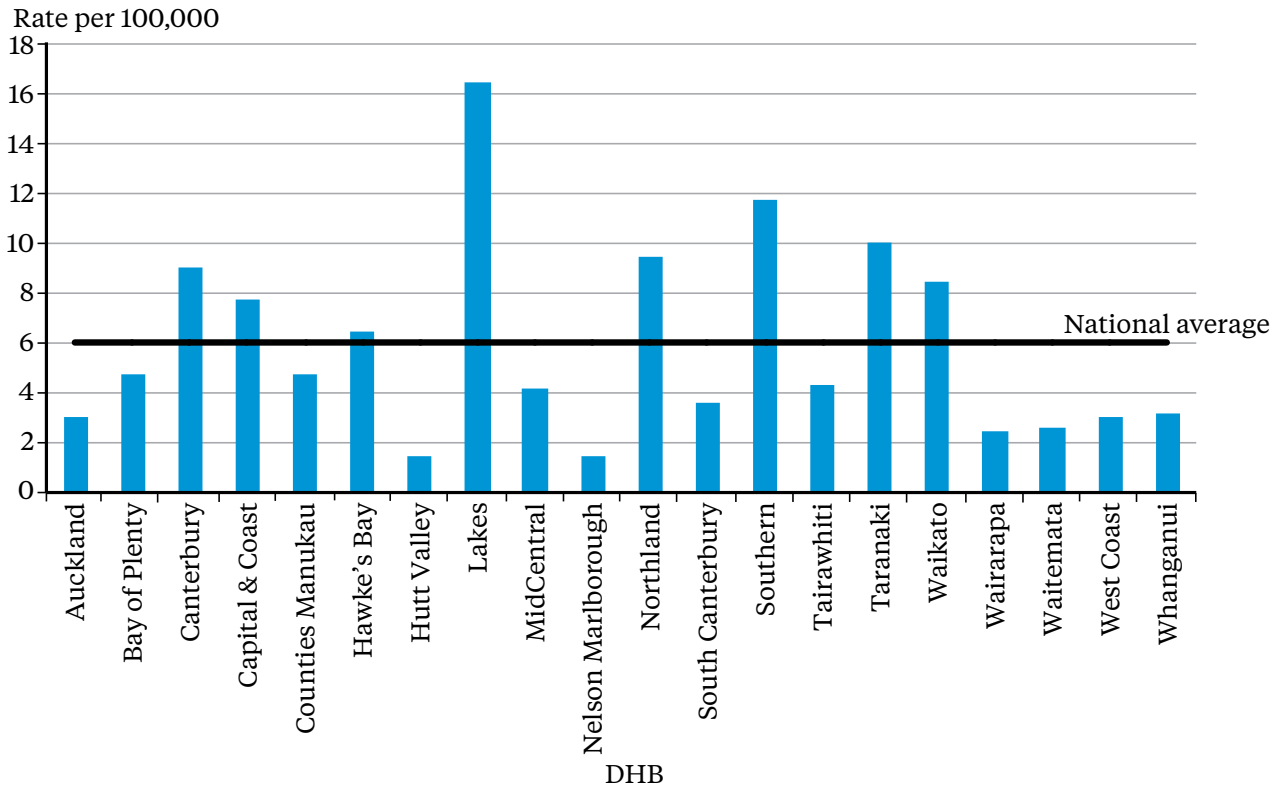
* The manual data provided by Southern DHB did not include a range.

Source: PRIMHD, extracted on 14 August 2013, except for Southern, Lakes and Hawke's Bay DHBs, which provided manual data. Lakes DHB manual data was for DHB of service and not DHB of domicile

The rate of people treated with ECT by DHB of domicile is presented in Figure 17. The national rate of people receiving ECT treatment was 6 per 100,000 in 2012, compared with 6.5 in 2011 and 5.4 in 2009/10.

As Figure 17 shows, the rate of ECT treatments given varies regionally. Several factors contribute to such variation. First, regions with smaller populations will be more vulnerable to annual variations (according to the needs of the population at any time). In addition, patients receiving continuous or maintenance treatment will typically receive more treatments in a year than those treated with an acute course. ECT is indicated in older people more often than in younger adults, because older people are more likely to have associated medical problems contraindicating medication. Finally, populations in some DHBs have better access to ECT services than others, which is likely to influence the rates of use.

Figure 17: Rate of people treated with ECT, by DHB of domicile, 1 January to 31 December 2012



Source: PRIMHD data, extracted on 14 August 2013, except for Southern, Hawke's Bay and Lakes DHBs, which provided manual data

Consent to treatment

Section 60 of the MH(CAT) Act describes the process required for obtaining consent for ECT. Either the patient's consent or a second opinion from a psychiatrist appointed by the Mental Health Review Tribunal is required. In the latter case, the treatment must be considered to be in the interests of the patient.

This process allows for the treatment of patients too unwell to consent to treatment. Clinicians are advised to make the decision about whether ECT is in the interests of the patient after discussing the options with family/whānau and considering any relevant advance directives made by the patient. (Refer to the *Guidelines to the Mental Health [Compulsory Assessment and Treatment] Act 1992*, Ministry of Health 2012d, available on the Ministry's website: www.health.govt.nz).

During 2012 no patient was treated with ECT if they retained decision-making capacity and refused consent. Table 14 shows the number of treatments administered to those patients who were not able to consent to treatment during 2012.

Table 14: Number of ECT administrations not able to be consented to, by DHB of service, 1 January to 31 December 2012

DHB of service	Number of administrations not able to be consented to	DHB of service	Number of administrations not able to be consented to
Auckland	0	Northland	102 (44%)
Bay of Plenty	43 (33%)	South Canterbury	–
Canterbury	NA	Southern	101 (30%)
Capital & Coast	212 (50%)	Tairawhiti	0
Counties Manukau	103 (42%)	Taranaki	0
Hawke's Bay	0	Waikato	100 (30%)
Hutt Valley	0	Wairarapa	–
Lakes	0	Waitemata	NA
MidCentral	29 (33%)	West Coast	–
Nelson Marlborough	0	Whanganui	–
		New Zealand	**690 (30%)**

Notes: The percentages relate to the proportion of total ECT administrations for each DHB.

The total number of ECT treatments not able to be consented to increased from 495 treatments in 2011 to 690 treatments in 2012. One factor explaining this increase is the inclusion of data from Northland (102 treatments) in 2012. Northland DHB did not supply this information for the 2011 annual report.

This table includes figures from health services for older people in the Southern and Central regions. The data reported manually and including figures from health services for older people will report a higher number of patients receiving ECT, and a higher number of total administrations, especially since the majority of service users treated with ECT tend to be over the age of 55.

Waitemata DHB was unable to confirm whether six treatments were consented to or not.

Canterbury DHB did not collect this data for the 2012 reporting period.

A dash (–) indicates the DHB does not perform ECT: patients are sent to other DHBs for treatment.

Source: The Ministry of Health is currently unable to provide this figure from PRIMHD. DHBs supplied manual data

Age and gender of patients treated with ECT

Information on the age and gender of people who were treated with ECT in 2012 is presented in Table 15 and Figure 18. For this data, age group was determined by the individual's age at the beginning of their treatment. The majority of people (54 percent) treated with ECT were aged over 55 years in 2012.[7]

Of the 265 people who received ECT treatment in 2012, 172 (65 percent) were women, 79 (30 percent) were men, and for the remaining 10 (5 percent) the gender was unknown.[8] The main reason for the gender difference is that more women present to mental health services with depressive disorders. This ratio is similar to that reported in other countries.

7 This figure excludes Hawke's Bay DHB, which did not include age information in the data provided (the DHB treated 10 clients). It also excludes four clients from Lakes DHB.

8 Hawke's Bay DHB did not provide gender information. The DHB treated a total of 10 clients.

Table 15: Number of people treated with ECT, by age group and gender, 1 January to 31 December 2012

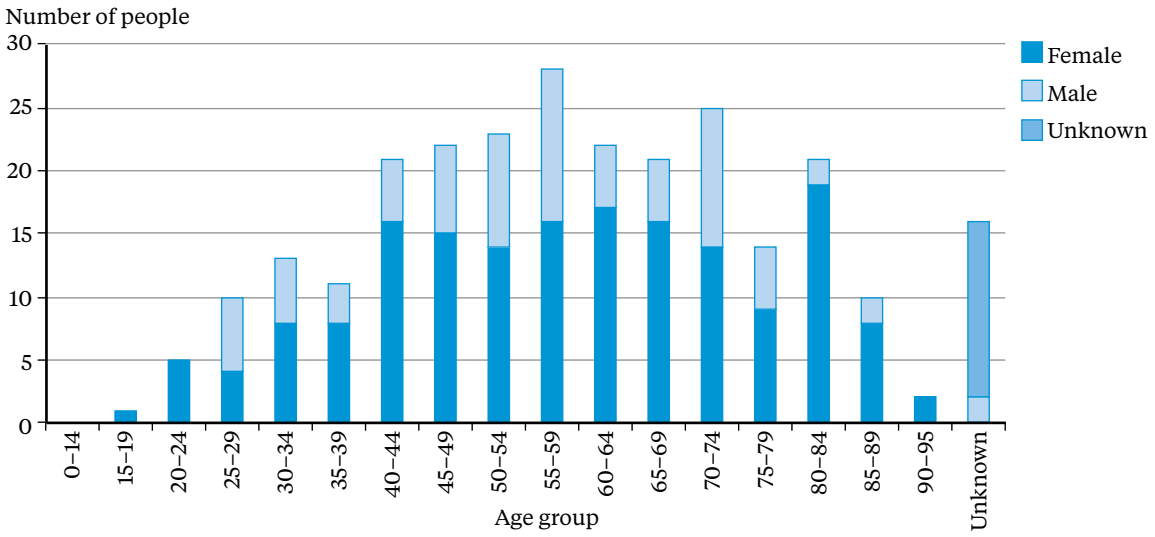
Age group (years)	Female	Male	Total
0–14	0	0	0
15–19	1	0	1
20–24	5	0	5
25–29	4	6	10
30–34	8	5	13
35–39	8	3	11
40–44	16	5	21
45–49	15	7	22
50–54	14	9	23
55–59	16	12	28
60–64	17	5	22
65–69	16	5	21
70–74	14	11	25
75–79	9	5	14
80–84	19	2	21
85–89	8	2	10
90–95	2	0	2
Unknown	0	2	16
Total	**172**	**79**	**265**

Notes: Hawke's Bay DHB provided manual data, which did not include age or gender information. These 10 clients are represented here as 'unknown'. Similarly, Lakes DHB provided data for four clients without age or gender information and Capital & Coast provided data for two clients without age information. These clients are also represented here as 'unknown.'

This table does not include ECT figures for clients receiving treatment with health services for older people in the Central and Southern regions. Services for older people in these regions do not report to PRIMHD.

Source: PRIMHD data extracted on 14 August 2013, except for Southern, Lakes and Hawke's Bay DHBs, which provided manual data

Figure 18: Number of people treated with ECT, by age group and gender, 1 January to 31 December 2012



Notes: The manual data Hawke's Bay DHB provided did not include age or gender information. Lakes DHB provided data for four clients without age or gender information and Capital & Coast provided manual data for two clients without age information. These 16 clients are represented here as 'unknown'.

In last year's report, this figure was presented as the percentage of clients treated with ECT by gender and age.

This figure does not include ECT figures for clients receiving treatment with health services for older people in the Central and Southern regions. Services for older people in these regions do not report to PRIMHD.

Source: PRIMHD data extracted on 14 August 2013, except for Southern, Lakes and Hawke's Bay DHBs, which provided manual data

Ethnicity of patients treated with ECT

The numbers presented in Table 16 suggest that Asian, Māori and Pacific people are less likely to receive ECT than those of European ethnicity. However, the numbers involved are so small that it is not statistically appropriate to compare the percentages to the proportion of each ethnic group in the total population of New Zealand.

Table 16: Number of people treated with ECT, by ethnicity, 1 January to 31 December 2012

Ethnicity	Number (and percent) of people treated with ECT
Asian	6 (2%)
European	217 (82%)
Māori	15 (6%)
Pacific	4 (2%)
Other	9 (3%)
Unknown	14 (5%)

Note: Hawke's Bay DHB provided manual data, which did not include age or gender information. These 10 clients are represented here as 'unknown'. Similarly, Lakes DHB provided data for four clients without age or gender information. These clients are also represented here as 'unknown.'

Source: PRIMHD 14 August 2013, except Southern DHB, which provided manual data

Reportable deaths

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

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

Recommendations from inquiries of national significance are disseminated through the Office of the Director of Mental Health. The Director of Mental Health is involved to ensure that recommendations resulting from the inquiry processes are implemented, and follows up on these issues with directors of area mental health services.

Serious adverse events relating to clients of DHB mental health services are reported to the Health Quality and Safety Commission. The Office of the Director of Mental Health collects information on serious and sentinel reportable events involving people under the MH(CAT) Act, including reportable deaths. The Office of the Director's Annual Report only presents information about reportable deaths in mental health services, in accordance with the statutory requirement to report such deaths to the Director of Mental Health.

Table 17 records the number of deaths of people receiving treatment under the MH(CAT) Act. In 2012 the Director of Mental Health received notification of 61 deaths of people who were under the care of the MH(CAT) Act at the time of death; 20 people are reported to have died by suicide or suspected suicide, and four of these deaths have been confirmed as a suicide by the coroner at the time of writing this report. The Ministry is yet to receive coroners' reports for the other 16 people who are suspected to have died by suicide.

In 2012, 41 people are reported to have died by other means while receiving treatment under the MH(CAT) Act, including natural causes and illness unrelated to the individual's mental health status.

Table 17: Outcomes of reportable death notifications under section 132 of the MH(CAT) Act, 1 January to 31 December 2012

Reportable death outcome	Number of notifications
Suicide	4
Suspected suicide	16
Other deaths	41
Total events	**61**

Note: A person is recorded as having died by suicide when the coroner has made a finding of suicide.

Death by suicide or suspected suicide

This section provides a brief overview of suicide and deaths of undetermined intent among specialist mental health service users for 2010. Data from 2010 is used because it can take up to two years for a coroner's investigation into a suicide to be completed. It is likely that this situation will improve in the future as there are now more full-time coroners.

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

The suicide data in this subsection includes deaths by intentional self-harm and deaths of undetermined intent. The statistics discussed here cover only people aged under 65 years, because in 2010, in the Central and Southern regions, older people's mental health treatment was provided by health services for older people rather than mental health services and is not necessarily recorded in PRIMHD. Deaths of children under 10 have also been excluded because they are unlikely to be caused by suicide.[9] The data was drawn from information provided to the Ministry's national Mortality Database and PRIMHD.

Prevalence of suicide in the population

At the time the data was extracted there were 536 suicides recorded in the Mortality Database in 2010[10]. A further 15 deaths of undetermined intent were recorded and are included in this report. Of this initial total of 551 deaths, 59 involved people aged 65 years and over. These deaths are excluded from the following discussion.

Table 18 shows the remaining 492 deaths by suicide or deaths of undetermined intent, of which 163 (33 percent) had contact with specialist mental health services in the year prior to the date of death. Mental disorders (in particular, mood disorders, substance-use disorders and antisocial behaviours) are a significant risk factor for suicidal behaviour (Beautrais et al 2005).

9 There were only two reported deaths due to suicide for children under the age of 10 between 1948 and 2010.

10 These numbers are subject to change. The Mortality Database is a dynamic collection, and changes can be made even after the data is considered nominally final.

Table 18: Number and age-standardised rate of suicides, by service use, ages 10 to 64, 1 January to 31 December 2010[a]

	Number	Age-standardised rate[b]
Deaths due to intentional self-harm		
Service users	159	183.8[c]
Non-service users	320	8.3
Total	**479**	**12.6**
Deaths of undetermined intent		
Service users	4	4.8
Non-service users	9	0.2
Total	**13**	**0.3**

	Number	Age-standardised rate[b]
Total deaths		
Service users	163	188.7
Non-service users	329	8.5
Total	**492**	**12.3**

Notes: The definition of 'service user' has changed this year to include only face-to-face contacts. (In previous years telephone contacts were included in this definition.) Equivalent figures for 2009: intentional self-harm: service users 155 (ASR 189.6), non-service users 304 (ASR 7.9), total 459 (ASR 12.3); undetermined intent: service users 6 (ASR 7.6), non-service users 10 (ASR 0.2), total 16 (ASR 0.4). Total: service users 161 (ASR 197.2), non-service users 314 (ASR 8.1), total 475 (ASR 11.9).

[a] Service user denominator excludes service users with unknown age. Extracted on 4 July 2013.

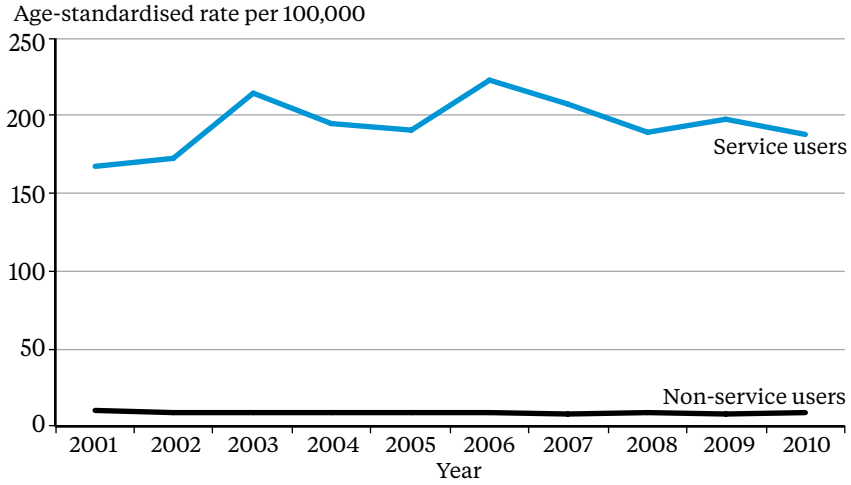
[b] Age-standardised rate is per 100,000, standardised to the WHO population aged 0–64 years.

[c] Please note that the 2010 ASR of service user suicides is higher (159= 183.8 ASR) than that reported in the 2011 annual report (166= 137.6 ASR) (This 2009 figure has been subsequently revised, please see above footnote.) This change in ratio is due to the change in methodology between the 2011 and 2012 publications as described above.

Changes in number of suicides over time

Figure 19 shows the changes in the rates of suicide by service users and non-service users between 2001 and 2010.

Figure 19: Age-standardised rate of suicides, by service users and non-service users, ages 10 to 64, 2001 to 2010



Notes: Age-standardised rate is per 100,000, standardised to the WHO standard population aged under 65 years.

The service-user population is much smaller than the total population of non-service users and will therefore produce rates more prone to fluctuation from year to year.

Sex and age in relation to suicide[11]

As shown in Table 19 and Figure 20, approximately 2.5 times as many males as females died by suicide in 2010. Forty-four percent of females who committed suicide in 2010 were service users, compared with 29 percent of males. Of those service users who died by suicide in 2010, 38 percent were female and 62 percent were male.

Table 19: Number and age-standardised rate of suicide, by service use and sex, ages 10 to 64, 1 January to 31 December 2010[a]

Sex	Service users[b]		Non-service users		Total	
	Number	ASR	Number[c]	ASR	Number[d]	ASR
Male	101	226.8	250	13.0	351	17.7
Female	62	149.8	79	4.2	141	7.1
Total	**163**	**188.7**	**329**	**8.5**	**492**	**12.3**

Notes: ASR= age-standardised rate.

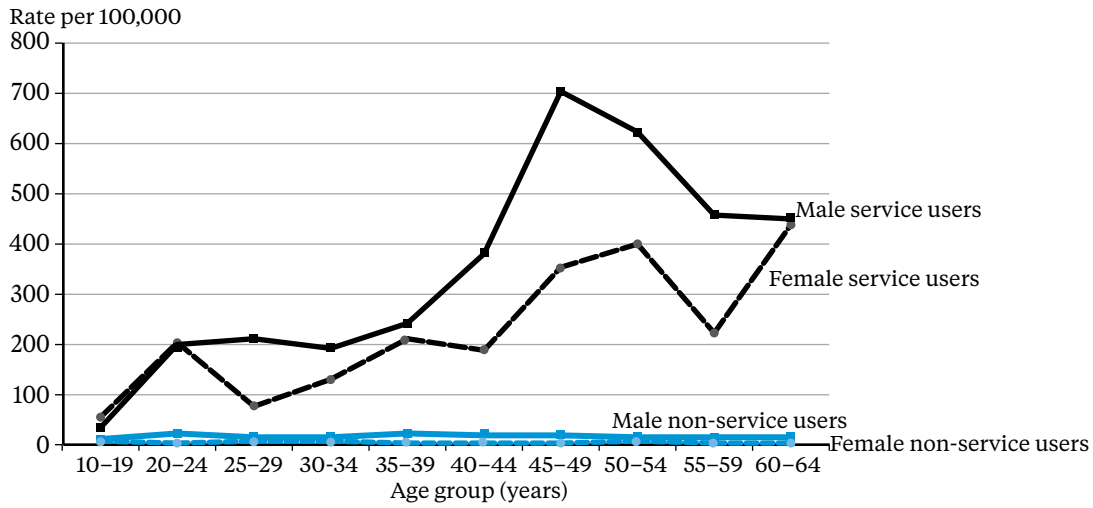
[a] Suicide includes deaths of undetermined intent. Data extracted on 4 July 2013. The age-standardised rate is per 100,000, standardised to the WHO population 0–64 years. Service-user denominator excludes service users of unknown age.

[b] The definition of 'service user' has changed from previous years to include only face-to-face contacts. Revised 2009 figures under this new definition are: males 109 (ASR 252.9), females 52 (ASR 137.1), total 161 (ASR 197.2).

[c] Revised 2009 figures: males 258 (ASR 13.5), females 56 (ASR 2.9), total 314 (ASR 8.1).

[d] Revised 2009 figures: males 367 (ASR 18.8), females 108 (ASR 5.3), total 475 (ASR 11.9).

Figure 20: Age-standardised rate of suicide, by age group, sex and service use, ages 10 to 64, 1 January to 31 December 2010



Note: The age-standardised rate is the rate per 100,000 standardised to the WHO standard population aged under 65 years.

As shown in Table 20 and Figure 20, the age-standardised rate of suicide among female service users in 2010 was highest for the 60 to 64 years age group, at 435.9 per 100,000 ASR. For male service users the 45 to 49 years age group had the highest rate of suicide at 701.6 per 100,000 (ASR).

For female non-service users the rate of suicide was highest in the 25 to 29 years age group, at 7.8 per 100,000 (ASR), and the 20 to 24 years age group had the highest age-standardised rate for male non-service users, at 23 per 100,000.

11 The term 'gender' has been used for all other reporting measures in this report. However, the Mortality Database uses 'sex' in relation to suicide statistics, and this section follows that convention.

When considering these numbers it is important to note that because these age-standardised rates are derived from a small service-user population, they are highly variable over time.

Table 20: Number and age-standardised rate of suicides, by sex and service use, aged 10 to 64 years, 1 January to 31 December 2010

	Service users				Non-service users			
	Female		Male		Female		Male	
Age group	Number	ASR	Number	ASR	Number	ASR	Number	ASR
10–19	5	54.8	4	32.3	21	7.2	34	11.2
20–24	9	202.2	11	199.2	5	3.3	36	23.0
25–29	4	75.5	13	210.2	11	7.8	21	15.3
30–34	6	130.4	11	193.0	9	6.6	20	16.2
35–39	9	211.8	12	243.1	5	3.3	29	21.0
40–44	6	185.9	14	381.6	4	2.5	26	17.8
45–49	8	352.9	17	701.6	8	4.9	27	17.6
50–54	7	400.9	10	621.9	8	5.4	22	15.6
55–59	3	222.6	5	457.5	6	4.7	20	16.3
60–64	5	435.9	4	449.9	2	1.7	15	13.4

Notes: Includes deaths of undetermined intent.
ASR= Age-standardised rate.

Ethnicity and suicide

As Table 21 indicates, among people receiving mental health services in 2010, the age-standardised rate of suicide was higher for Māori (234 per 100,000 service users) compared with Pacific people (47 per 100,000 service users). The age-standardised rate of suicide for those in the category of other ethnicities was 197 per 100,000 service users.

Table 21: Number and age-standardised rate of suicides and deaths of undetermined intent, by ethnicity and service use, ages 10 to 64, 1 January to 31 December 2010

Ethnicity	Service users		Non-service users		Total	
	Number of deaths	ASR	Number of deaths	ASR	Number of deaths	ASR
Māori	30	234.3	79	13.4	109	21.4
Pacific	1	47.2	22	8.8	23	10.3
Other	132	196.7	228	7.1	360	11.3
Total	163	188.7	329	8.5	492	12.3

Note: ASR = age-standardised rate.

An overview of service users dying of suicide, 2001 to 2010[12]

Over the period 2001 to 2010, 1607 service users died by suicide.[13] Of this total, 19 service users died while an inpatient,[14] 104[15] died within a week of being discharged, and 422 service users died within 12 months of discharge.[16]

Of the 1607 service user suicides from 2001 to 2010, 1364 service users were receiving treatment from a specialist service community team in the 12 months before death, and 333 patients were receiving treatment from a specialist alcohol and drug team in the 12 months before death.

Detentions and committals under the Alcoholism and Drug Addiction Act 1966

The Alcoholism and Drug Addiction Act 1966 (ADA Act) provides for the compulsory detention and treatment of people with severe substance dependence for up to two years at certified institutions. In October 2009 the Prime Minister announced a review of the ADA Act as part of a range of initiatives to reduce harm from methamphetamine.

The Law Commission released its report *Compulsory Treatment for Substance Dependence: A review of the Alcoholism and Drug Addiction Act 1966* in October 2012 (New Zealand Law Commission 2012). In 2012 a bill to repeal and replace the ADA Act was being developed.

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

Late data entry of mental health applications and outcomes has meant that the figures presented in this Annual Report differ slightly from the data presented in the 2011 Annual Report of the Office of the Director of Mental Health (Ministry of Health 2012e).

Ministry of Justice statistics on the use of the ADA Act are only available from the beginning of 2004. Table 22 details the outcomes of applications under the ADA Act to the Family Court. Table 23 shows the number of orders granted for detention under section 8, and for committal under section 9 of the ADA Act.

12 Data in this section has previously been reported for a year's breadth. For the 2012 annual report, a nine-year overview has been presented to provide greater context to figures, which tend to vary widely from year to year.

13 Includes deaths of undetermined intent.

14 The actual classification for this in the data concerns the number of people who died on the same day they had an inpatient activity. This has been taken to mean here that they were still in the context of an inpatient unit on the day of death.

15 Excluding those who received treatment on the day of death.

16 Excluding those who received treatment on the day of death, and those who died within a week of being discharged from an inpatient service.

Table 22: Number and outcomes of applications for detention and committal, 2004 to 2012

Application outcome	2004	2005	2006	2007	2008	2009	2010	2011	2012
Applications granted or granted with consent	72	79	77	71	75	71	68	74	72
Applications dismissed or struck out	5	3	4	1	2	3	3	1	2
Applications withdrawn, lapsed or discontinued	3	9	2	6	1	4	9	5	9
Total applications for s 8 and s 9 orders	**80**	**91**	**83**	**78**	**78**	**78**	**80**	**80**	**83**

Note: The table presents applications that were disposed at the time of data extraction (24 June 2013).

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

Table 23: Outcomes of applications for granted orders for detention and committal, 2004 to 2012

Year	Section 8 applications granted for detention	Section 9 applications granted for committal	Total applications granted
2004	44 (61.1%)	28 (38.9%)	72
2005	49 (62.0%)	30 (37.9%)	79
2006	60 (77.9%)	17 (22.1%)	77
2007	52 (73.2%)	19 (26.8%)	71
2008	63 (84.0%)	12 (16.0%)	75
2009	49 (69.0%)	22 (31.0%)	71
2010	54 (79.4%)	14 (20.6%)	68
2011	59 (79.7%)	15 (20.3%)	74
2012	61 (84.7%)	11 (15.3%)	72

Note: The table presents applications that were disposed at the time of data extraction (24 June 2013).

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

Opioid substitution treatment services

Opioid substitution treatment (OST) is a well-established treatment that involves prescribing opioids such as methadone and buprenorphine as a substitute for illicit opioids. The Director of Mental Health is responsible for approvals relating to the prescription, administration or supply of controlled drugs for the purposes of treating people with drug dependence, and for overseeing section 24 of the Misuse of Drugs Act 1975. In 2012 the Office of the Director of Mental Health began a review of the process and criteria for granting approvals under section 24.

The Director of Mental Health undertakes regular site visits to opioid substitution services. The Director's role in OST service safety and quality is supported by regular meetings with the National Association of Opioid Treatment Providers and other Ministry of Health groups with an interest in OST. In addition, a six-monthly report cycle was initiated in 2007 to provide an overview of key information that informs and affects the provision of OST services.

In 2012, 18 DHBs, one primary health organisation and one general practice provided specialist OST services to provide national coverage. In addition, a number of individual general practitioners (GPs) are authorised to provide OST to clients who are assessed as stabilised in treatment.

Between 2007, when reporting to the Director of Mental Health started, and December 2010 the number of clients receiving substitution treatment for opioid dependence increased by 19 percent. Over 2011 and 2012 the number of clients being treated by an OST programme remained stable. At the end of December 2012 there were 4996 people receiving OST in specialist services and with individual GPs.

The waiting list for OST has decreased from 80 people in 2011 to 60 in 2012. However, it is worth noting that the number of people on a waiting list is not a good measure of unmet demand, because people tend not to seek treatment if they perceive there is little chance of accessing it in the foreseeable future.

The number of GPs authorised to treat opioid dependence has remained stable. In 2012 there were 646 authorised GPs, compared with 647 in 2011, 625 in 2010 and 582 in 2009. In 2012, nationally, 30 percent of people were able to access OST in a community setting, compared to 29 percent in 2011 and 27 percent in 2010.

The number of people receiving treatment for opioid dependency in prison has reduced from 83 in December 2010 to 76 in December 2011, and 73 in December 2012.

On average, each year approximately 18 per cent of clients leave OST specialist services for one of the following reasons:

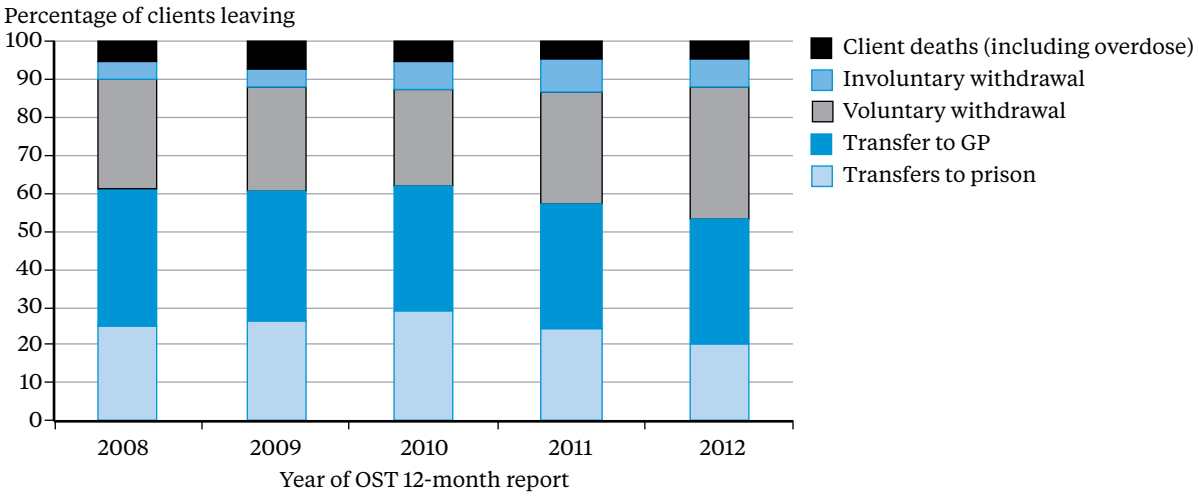
- transfer to GP care
- voluntary withdrawal from OST
- involuntary withdrawal from OST
- transfer to prison
- death.

In 2012 approximately 6.9 percent of clients of OST services chose to withdraw from opioid substitution medication via a planned voluntary withdrawal; another 1.6 percent of clients were withdrawn from opioid substitution medication against their will in response to behaviour that jeopardised the safety of the individual concerned or others (including staff).

Another 0.9 percent of clients died from a range of causes while receiving OST. The number of clients who die as a consequence of an overdose is very low – less than one a year on average. In 2012 one client of OST services died as a consequence of overdose.

Many clients leaving opioid specialist services leave because they actively seek to change their lifestyles. The majority of clients who leave OST programmes are either assessed as sufficiently stabilised to transfer to GP care, or they choose to withdraw voluntarily from opioid substitution medication. Figure 21 shows the reasons for clients leaving OST specialist services from 2008 to 2012.

Figure 21: Reasons for clients leaving opioid substitution treatment specialist services, 2008 to 2012



Source: Office of the Director of Mental Health opioid substitution treatment six-month reports

The use of buprenorphine for OST

In 2012 PHARMAC began funding sub-lingual buprenorphine with naloxone for both detoxification and maintenance of OST. Prior to 1 July 2012 this treatment was only available at a considerable cost to OST consumers.

Buprenorphine with naloxone has a reduced potential for diversion and misuse compared to methadone, is safer in overdose, and can be given in cumulative doses lasting several days rather than the daily dosing regimen required for methadone. The Office of the Director of Mental Health expects to report on the use of buprenorphine with naloxone in future annual reports.

The *New Zealand Clinical Guidelines for the Use of Buprenorphine (with or without Naloxone) in the Treatment of Opioid Dependence* (Ministry of Health 2010a) are available on the Ministry of Health website.

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Appendix 1: Rising to the Challenge

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017, approved by Cabinet in 2012, is the Government's five-year vision for ongoing improvements in the delivery of mental health and addiction services in New Zealand. It reflects how far New Zealand mental health services have come and provides further impetus for improvements in the delivery of mental health and addiction services in New Zealand.

The vision for this work is that 'all New Zealanders will have the tools to weather adversity, actively support each other's wellbeing, and attain their potential within their family and whānau and communities'(Ministry of Health 2012f, p. vi). *Rising to the Challenge* had input from a wide range of people in the mental health and addiction sector, including families and whānau, stakeholders and other agencies. It recognises the contribution the health sector makes to other key initiatives such as The Prime Minister's Youth Mental Health Project, Drivers of Crime, Whānau Ora, Vulnerable Children and welfare reforms. *Rising to the Challenge* will set the direction for service development, and will increase national consistency in access, service quality and outcomes for people who use mental health and addiction services.

The Ministry is taking a leadership role to foster effective partnerships at all levels of the mental health and addiction sector and community to deliver the 100 actions outlined in *Rising to the Challenge*. Many of the actions are under way, and some have been completed, such as the development of an interagency suicide prevention action plan.

The overarching goals of *Rising to the Challenge* are given in Table A1.

Table A1: The ABCD overarching goals and desired results

Overarching goal		Results we wish to see
A	**A**ctively using our current resources more effectively	Increased value for money
B	**B**uilding infrastructure for integration between primary and specialist services	Enhanced integration
C	**C**ementing and building on gains in resilience and recovery for: i. people with low-prevalence conditions and/or high needs (psychotic disorders and severe personality disorders, anxiety disorders, depression, alcohol and drug issues or co-existing conditions ii. (a) Māori (b) Pacific people, refugees, people with disabilities and other groups	i. improved mental health and wellbeing, physical health and social inclusion ii. disparities in health outcomes addressed
D	**D**elivering increased access for: i. infants, children and youth ii. adults with high-prevalence conditions (mild to moderate anxiety, depression, alcohol and drug issues or co-existing conditions, and medically unexplained symptoms iii. our growing older population	Expanded access and decreased waiting times in order to: i. avert future adverse outcomes ii. improve outcomes iii. support their positive contribution in the home and community of their choice

Note: Table A1 is sourced from *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* (Ministry of Health 2012f).

National forensic framework

One of the actions in *Rising to the Challenge* is the development of a national forensic framework. In particular, the plan requires the Ministry to 'ensure robust planning for adult forensic mental health services'. The objective of the project is to develop a national framework for forensic mental health services and to guide the development and delivery of forensic mental health services throughout New Zealand over the next five years. The project will require close collaboration with a range of mental health services and other stakeholders.

Appendix 2: Caveats relating to PRIMHD data

The Programme for the Integration of Mental Health Data, or PRIMHD (pronounced 'primed'), is the Ministry of Health's national collection for mental health and addiction service activity and outcome data for mental health consumers. PRIMHD data is used to report on what services are being provided, who is providing the services, and what outcomes are being achieved for health consumers across New Zealand's mental health sector. These reports enable better-quality service planning and decision-making by mental health and addiction service providers, at the local, regional and national levels (Ministry of Health 2013). PRIMHD reports are invaluable for facilitating important conversations and debates about mental health issues in New Zealand.

In 2008 reporting to PRIMHD became mandatory for DHBs. In addition, from this date an increasing number of NGOs began reporting to the PRIMHD database. As of December 2012, 228 NGOs were reporting to PRIMHD, representing 90 percent of all NGO funding (Platform Charitable Trust 2013).

Both because of its recent introduction and the enormous complexities of creating and maintaining a national data collection, the following caveats need to be kept in mind when reviewing the statistics generated using PRIMHD data.

- Shifts or patterns in the data after 2008 may reflect the gradual adaptation of service providers to the PRIMHD system, in addition to, or instead of, any trend in mental health service use or consumer outcomes.
- PRIMHD is a living data collection, which continues to be revised and updated as data reporting processes are improved. Because of this, previously published data may be liable to amendments.
- Statistical variance between services may reflect different models of practice and different consumer populations. However, inter-service variance may also result from differences in data entry processes and information management.
- To function as a national collection, PRIMHD requires integration with a wide range of patient management systems across hundreds of unique service providers. As the services adjust to PRIMHD, it is expected that the quality of the data will improve.
- For the 2012 annual report, manual data supplied by DHBs has been used for reporting compulsory assessment and treatment under the MH(CAT) Act. This decision was made after issues with 2012 PRIMHD data were identified. These issues will be addressed, with the intention of returning to PRIMHD for future annual reports.
- Mental health and addiction services for older people are funded as mental health and addiction services in the Northern and Midland regions but as health services for older people in the Southern and Central regions. PRIMHD mainly captures mental health and addiction services and occasionally captures data on health services for older people, which means that data on clients aged over 65 years (including services for older people) is incomplete.

- The quality and accuracy of statistical reporting relies on consistent, correct, and timely data entry by the services that report to PRIMHD.
- The Ministry of Health is actively engaged in a continuing project to review and improve the data quality of PRIMHD. This project is considered a priority given the importance of mental health data in providing information about mental health consumption and outcomes, and generating conversations and public debate about how to improve mental health care for New Zealanders.

Appendix 3: Introducing Arran Culver

In December 2012, Dr John Crawshaw, the Director of Mental Health, announced the appointment of Dr Arran Culver to the role of Deputy Director of Mental Health.

Prior to his appointment, Arran held the roles of Clinical Director and Executive Officer at Hauora Waikato Kaupapa Māori Mental Health Service. Arran spent nine years with Hauora Waikato, specialising in child and adolescent mental health, early intervention and youth and adult forensic mental health.

Arran is a consultant child and adolescent psychiatrist and maintains a clinical role one day per week at Capital & Coast DHB with the Youth Forensic Mental Health Team. His main clinical interests include early intervention in severe mental illness, youth forensic mental health, primary and secondary mental health care integration, and clinical quality improvement / health innovation.

Arran trained as a psychiatrist in Wellington. He is a Fellow of the Royal Australian and New Zealand College of Psychiatrists and a member of the College's Faculty of Child and Adolescent Psychiatry. He is currently on the New Zealand National Committee of the College and the New Zealand Committee of the Faculty of Child and Adolescent Psychiatry.