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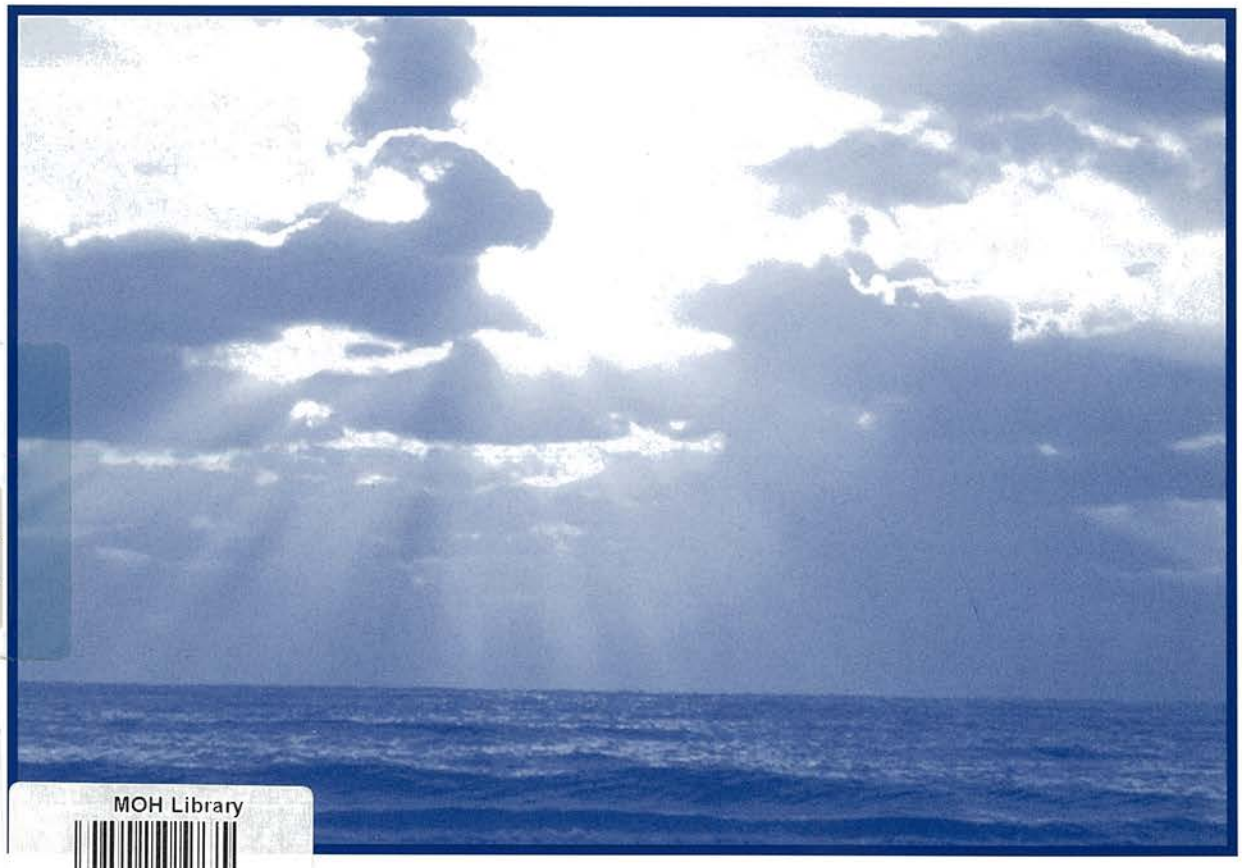
Services for People with Mental Illness in the Justice System

Framework for Forensic Mental Health Services



Services for People with Mental Illness in the Justice System

Framework for Forensic Mental Health Services

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Foreword

Forensic mental health services in New Zealand form a specialist component of a comprehensive continuum of mental health services covering assessment, treatment and rehabilitation.

Forensic services arose as a consequence of the first *Mason report (Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admissions, Discharge or Release on Leave of Certain Classes of Patients 1989)*. Since then a national network of comprehensive mental health services have developed to people in prisons and courts, including a range of secure inpatient services and community follow-up.

In the 10 years following the first Mason report, there have been a significant number of changes in delivery of mental health services. These have included the closure of psychiatric hospitals and the implementation of the Mental Health Strategy, embodied in *Moving Forward 1997* and *Looking Forward 1994,* and the Mental Health Commission's *Blueprint for Mental Health Services in New Zealand 1998*, a community-based focus of treatment and care including inpatient units (acute and rehabilitation).

In 1999 the Department of Corrections published the *National Study of Psychiatric Morbidity in New Zealand Prisons*, which established the number of people in prison with a mental illness. A projected increase in inmate numbers is expected to impact on forensic services.

It was considered timely for a review to be undertaken by the Ministry of Health to determine the optimum treatment for all people in the population requiring forensic services. This report provides the future framework for forensic services.

Overall, there is a strong consensus from the forensic providers and service clients that the Mason model provides an effective service delivery framework.

This report outlines a comprehensive, integrated community approach building on and enhancing the community care principle at the heart of modern mental health service delivery. Features of the model of service are:

- additional services to prisons
- an increased number of secure beds for appropriate assessment and treatment for people referred from the courts, prisons and other mental health services
- Adult Mental Health Services (AMHS) community teams being the hub of community service provision assisted by forensic community teams
- enhanced court forensic services
- an increased focus on partnerships between forensic services and AMHS
- strong working relationships between the Ministry of Health and the Department of Corrections at national and regional levels.

Participation of Māori and Pacific peoples in decision-making, service delivery, and service provision are addressed in the report with recommendations for mainstream, kaupapa Māori and Pacific services.

Together these changes should mean that people receive responsive, quality services in the least restrictive and least stigmatising environment.

A Ministry of Health-led forensic implementation group will be charged with developing an implementation plan. The changes will be implemented in a careful and considered fashion. The Ministry of Health, District Health Boards (DHBs), Department of Corrections, Department for Courts, and NZ Police all have a role in planning for the implementation of the changes. The plan will take into account the current changes in the health sector and address issues such as building workforce capacity.

The costs of the service enhancements will be met from within the funding provided in the 2000 Budget for implementing the Mental Health Commission's *Blueprint for Mental Health Services in New Zealand.*

New Zealand has some of the best forensic mental health services in the world. We have a good base and with the implementation of this framework we are moving to make services better. I would like to thank all those agencies and people that participated in providing information and reviewing the documents.

Janice Wilson
Deputy Director-General
Mental Health Directorate

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Whakatauki

Hutia te rito o te harakeke
Kei hea te komako e ko
Ki te ui koe ki au
He aha te mea nui ki tenei ao
Maku e ki Atu
He tangata! He tangata! He tangata!

If you were to uproot the flax bush, where would the bellbird sing
and if I were to ask you
what is the greatest treasure in the world?
I could reply
It is people! It is people! It is people!

Mihi

Nei te ngakau ka tangi ki te hunga kua whakawhiti atu ki tua o te arai, ki te kapunipunitanga ote wairua, ki nga ringa o Hinenuitepo.

Nei te ngakau ka mihi ki te hunga ora kua puta ki te wheiao, ki te ao marama.

Tihei Mauriora.

E nga mana, e nga reo, e nga matawaka huri noa I te motu, tena koutou katoa.

I pay heartfelt tribute to those who have passed on to the gathering place of the spirits, to rest in the hands of Hinenuitepo.

I pay heartfelt tribute to those of us who remain in this world of light. Behold there is light.

Executive Summary

The 1988 Mason report established the model around which forensic services are structured and delivered today. Since then, community-based services for all mental health patients have developed considerably, driven largely by the national mental health strategy (*Looking Forward* 1994) and increased funding for mental health development. Although the Mason report proposed their development, it did not anticipate the present configuration of community services.

This review is intended to enhance provision of both corrections and forensic services, including services to prisons and courts. It was conducted in the wider context of health services.

The terms of reference for this review are to:

1. establish benchmarks for levels of service to forensic clients
2. clarify responsibilities of forensic services by identifying and resolving interface issues between health and criminal justice sectors
3. identify current and future resource requirements
4. develop a comprehensive 'best possible' model for forensic services.

The resulting proposals clarify the purpose and target population of forensic services, and emphasise community mental health over specialist services. They aim to improve services as much as possible for the consumer, with as little disruption as possible for service providers and clients.

Review findings

The review used a census and qualitative surveys to gather up-to-date data. The *Review Findings* companion document presents results in full.

The census shows:

- forensic services treat only a few people overall (189 inpatients and 256 outpatients)
- court and prison liaison staff of regional forensic services assess about 2500 people at court and 4500 prison inmates per annum
- the vast majority of inpatients and outpatients are male
- a disproportionately high number of Māori are forensic service consumers
- many forensic service consumers are diagnosed with schizophrenia or another serious mental illness, most of whom are required to receive care under legislation
- for most inpatients and outpatients, index offences are 'serious' (ie, violent or sexual) offences.

From qualitative feedback, overall consensus was that the current model of forensic services is appropriate. Predominant themes among responses were liaison and integration of forensic services and adult mental health services (AMHS). Concern was expressed about:

- inadequacy of forensic facilities for women and long-term patients
- inappropriateness of forensic care for people with an intellectual disability, with behaviour problems associated with head injuries, or with challenging high-risk behaviours
- workforce and resources, in view of increasing demand and shortages of Māori and Pacific staff
- screening for mental illness in prisons
- the lack of step-down or community-based residential facilities for forensic clients.

The Māori review highlighted:

- lack of effective Māori participation at all forensic service levels
- lack of Māori frameworks and infrastructures to integrate Māori into mainstream services in many regions
- issues for Māori mental health professionals and traditional practitioners
- the high proportion of Māori in the forensic population, including high rates diagnosed with schizophrenia.

Issues

The lack of clarity about the target population could create more forensic consumers than necessary. Possible consequences are more forensic institutions, service delivery inefficiencies and, for many people, inappropriate care as well as unnecessary criminalisation and stigmatisation.

Blurred boundaries between forensic service providers and associated services illustrate a need for more integrated services and greater continuity for the consumer.

The need to gather information for the review, and consequent difficulties, indicate major problems in data collection and information systems.

Model of service

A comprehensive, integrated community approach is proposed. It builds on the community care principle at the heart of modern mental health services, aiming for the least restrictive level of care in the most 'normal' environment possible. It also enhances the current model of corrections and forensic services.

Under the model the forensic services will continue to be a specialist service, but greater focus is given to their role of working with AMHS in a supportive partnership. AMHS will have an enhanced (and supported) role in providing community services to people who are discharged from prisons or forensic inpatient services.

Specialist forensic teams in the community and inpatient service will support AMHS and provide a consultation liaison service, as well as provide (direct) ongoing oversight of a small number of individuals. Expanded forensic court liaison and prison teams will enhance services to people referred by court or a prison.

Reallocation of funding as well as increased funding may be considered, so that AMHS can strengthen their capacity for both community and inpatient care.

There should be greater Māori participation at all forensic service levels. This result may be achieved through additional Māori staff or kaupapa Māori services in the mainstream environment, or by establishing separate kaupapa Māori services.

Services have clear responsibilities under the new arrangements. Part of the implementation process is to ensure there are appropriate incentives (eg, a review process) to meet those responsibilities.

National benchmarks have been developed for forensic services under this model. These benchmarks are intended to *guide* rather than determine resource allocation.

Resource requirements under the proposed model include:

- more resources for forensic inpatient beds and court liaison services
- new or enhanced services for prison, assertive treatment and community mental health teams
- quality improvements in AMHS community teams, acute inpatient wards, and services for Māori in all areas
- skilled, competent staff – with further work needed to determine training and education needs, and ways to meet them effectively
- information services to support community teams and, more generally, the proposed model.

Together these changes should lead to responsive, quality services delivered in the least restrictive and least stigmatising environment.

Implementation

Implementation will be planned in the context of current changes in the health sector. It is envisaged that establishing the enhanced role for AMHS is a medium- to long-term goal, probably taking four to five years.

Future work

Further study is needed on the needs of children and youth, which this review did not address.

It is proposed that people in prison receive services on the same basis as people in the community. Within the prison setting it is not possible to provide compulsory treatment. There is a need for extensive debate over the suggestion to change this situation.

In 1998 the Mental Health Commission released the *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission 1998). It details the needs of forensic clients and service components, including essential components for Māori. While identifying provisional resource guidelines, it also indicated a greater need to identify and treat prisoners with severe mental illness.

To address the *Moving Forward* and *Blueprint* objectives, the Department of Corrections and Ministries of Justice and Health sought more information on mental illness in the criminal justice population. The *National Study of Psychiatric Morbidity in New Zealand Prisons* (Department of Corrections 1999) found that for several mental illnesses, a disproportionately high number of prisoners were diagnosed with the disorder compared with the community as a whole (see Background for additional findings).

Parallel to this study and directly linked to *Moving Forward*, the Ministry of Health together with the Health Funding Authority (HFA) and criminal justice agencies commenced this review of forensic mental health services. It does not cover services to children through Child, Youth and Family Services and youth court.

The terms of reference for this review of the forensic service framework are to:

1. establish benchmarks for levels of service to forensic clients
2. clarify responsibilities of forensic services by identifying and resolving interface issues between health and criminal justice sectors
3. identify current and future resource requirements
4. develop a comprehensive 'best possible' model for forensic services.

This review is intended to enhance provision of both corrections and forensic services, including services to courts. It has been informed by background research to gain up-to-date quantitative and qualitative data on current forensic services, including their perceived effectiveness.

These services vary in their security level. When the 1999 review began, Good Health Wanganui provided a national secure service for people needing observation, intensive treatment or secure care at higher levels than regional secure units could provide. This National Security Unit, or Wai O Hine, was based at Lake Alice hospital.

After the NSU closed in October 1999, extended secure beds were established in Auckland, Wanganui and Christchurch. These beds are seen as a 'national' resource. In addition, regional secure beds were made available in Wellington.

Each regional forensic service (except Auckland) has a *community forensic team*. This team consults and liaises with AMHS community teams. In addition, it follows up outpatients who are perceived as needing its particular focus and skills.

Specialist forensic services to prisons include mental health clinics (within prison), assessments, transfer of mentally ill prisoners to medium secure hospital facilities, and consultation/liaison and support services for prison staff. These services are additional to primary care by Corrections health staff and psychologists.

The *court liaison services* include attendance in court, liaison (with court, counsel, police, Corrections, AMHS), informal assessments, referral for formal assessments, and reports and advice to the judiciary. In some cases prison and court liaison service staff are shared across both services.

Forensic services complement AMHS and kaupapa Māori mental health services, with specialist forensic services for people with severe and often complex mental illness. A range of AMHS services are available to:

- people who are no longer perceived to be a serious, persistent danger to others, without complex forensic psychiatric needs (eg, assessments, parole board reports), but who need other levels of care
- people who are forensic service consumers but who have needs (eg, substance abuse needs) that the service alone cannot meet.

Forensic services for Māori

The Government recognises the Treaty of Waitangi as New Zealand's founding document. It acknowledges the special relationship between tangata whenua and the Crown under the Treaty.

To date, the Māori–Crown relationship in the health sector has been based on three key principles:

- participation at all levels
- partnership in service delivery
- culturally appropriate practices.

Forensic services to Māori should be culturally meaningful and meet actual needs. One of the best-known models of health reflecting a Māori world view is Whare Tapa Wha. Its four cornerstones of Māori health are:

- te taha wairua (spiritual aspects)
- te taha hinengaro (mental and emotional aspects)
- te taha whānau (family and community aspects)
- te taha tinana (physical aspects) (Durie 1994).

All these interrelated dimensions must be considered for effective and appropriate services for Māori.

A sense of spiritual, mental and physical wellbeing depends on the security of one's self in relation to family and community, as well as knowledge of and comfort from one's cultural background. It involves living in harmony with the environment and being able to participate in society with a sense of belonging and dignity.

Important principles in providing culturally appropriate services to Māori are:

- *choice* from a range of services
- *relevant* services that are culturally meaningful and address actual needs
- *integration* of mental health with other health services, with connections strengthened in line with a holistic approach to Māori development
- *quality* of care and treatment, as reflected in outcomes
- *cost effective* services, taking advantage of economies of scale (Durie et al 1995).

Forensic population overview

It has been estimated that in any six-month period, approximately 3 percent (Ministry of Health 1997) of the overall population need access to specialist mental health services. Some of this group belong to the criminal justice population and require some form of forensic service.

The 1999 *National Study of Psychiatric Morbidity in New Zealand Prisons* (prison study) found substance abuse and psychotic illness – including schizophrenia, major depression, bipolar disorder, obsessive compulsive disorder and post traumatic stress disorder – among a disproportionately high number of the prison population compared with the community as a whole.

According to the prison study, prisoners have a greater need for specialist forensic services than previously envisaged. Although some with a major mental illness received treatment in prison, a significant number had not been diagnosed with their mental illness and therefore had not received treatment. For example, an estimated 135 prisoners with schizophrenia or another serious mental illness, in addition to those currently under care in forensic units, were likely to need hospital (forensic unit) admission.

Although there has been no official study among community-based offenders, the Department of Corrections asked a sample of probation officers to identify how many people on parole or serving a community sentence had or may have a mental illness. The reported level of perceived mental illness was about 10 percent (900 nationally) of community-based offenders, with about one-third (360) requiring hospitalisation.

As community-based offenders, these people are part of the AMHS rather than forensic population, so are expected to access mental health services in the same way as other community members. Some, however, are assessed by the court liaison service on the request of the judiciary.

An individual's status as part of the criminal justice population should neither diminish nor heighten his or her right to mental health care, relative to the general population. While the Department of Corrections provides primary care to prisoners, it has been agreed that the health sector is responsible for their specialist service needs.

Legislative environment

Both the Criminal Justice Act 1985 (CJA) and the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) provide for the care and treatment of people with a mental illness.

The Criminal Justice Act 1985

Part VII of the Criminal Justice Act 1985 (CJA) concerns people who have or may have committed an offence but are 'under disability'. That is, because of the extent of mental illness, the person is:

- unable to plead
- unable to understand the nature or purpose of court/justice proceedings
- unable to communicate adequately with counsel for defence purposes.

In addition a person may plead 'insanity' if charged with an offence punishable by death[1] or imprisonment. As defined in the Crimes Act 1961, 'insanity' is based on the McNaughton Rule 1843.

The following CJA provisions are most commonly used for access to forensic services.

- *Section 115.* If a person is found to be under disability (thus unable to stand trial) or is acquitted because of insanity, the court may order his or her detention in hospital as a special patient under the MHA. (In practice a person under section 115 almost invariably goes to a forensic unit.)

[1] Crimes Act 1961.

- *Section 118.* If a person is convicted, two medical practitioners may certify that the person is mentally ill to the extent that he or she should be detained in hospital for the safety of the person or public. If the court is satisfied with this assessment, it may choose not to pass sentence and instead order the person's detention in hospital as an ordinary patient. (In practice a person under section 118 usually goes to either an acute mental health inpatient unit or a forensic unit, depending on the offence and clinical circumstances.)
- *Section 121(1).* If a person is charged with or convicted of an offence punishable by imprisonment, the court may request a psychiatric examination and report to help determine:
  - whether that person is under disability [section 121(1)(a)]
  - whether that person is 'insane' as defined by the Crimes Act [section 121(1)(b)]
  - what type and length of sentence to impose, including appropriate conditions.
- *Section 121(2).* The court may set a psychiatric report as a condition of bail or commit the person to a penal institution or hospital [section 121(2)(b)(ii)] for psychiatric examination.

The Mental Health Act 1992

The Mental Health Act 1992 (MHA) applies to people who are mentally disordered according to the following definition:

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

Section 5 of the MHA determines exclusions to the Act's powers. It also requires all MHA powers to be exercised with proper respect for cultural identity and personal beliefs, recognising the importance of a person's family, whānau, hapū and iwi, and respecting their cultural and ethnic identity, language, and religious or ethical beliefs.

In relation to forensic services, compulsory treatment orders are the most commonly used MHA provisions.

- *Section 29.* This community treatment order requires a person to attend a certain place for treatment and accept that treatment.
- *Section 30.* This inpatient order requires a person to be detained in or go to a specified hospital for treatment and to accept that treatment.

Other MHA sections used in relation to forensic services are:

- *section 45*, enabling transfer from prison to a forensic unit for assessment and treatment
- *section 46*, enabling a person in prison to accept voluntary care in a forensic unit
- *section 55*, enabling the court to declare a patient to be a restricted patient usually because he or she poses a danger to others.

Summary of 1999 Review

This section summarises the methodology and main findings of the 1999 forensic services review. More detail is included in the *Review Findings* companion document.

Methodology

The following methods of data collection were used.

- A *census of forensic inpatient and outpatient services* was originally taken on 1 September 1999. The outpatient census was taken again on 1 April 2000, following differing interpretations of the original questionnaire.
- A *Māori review* made a specifically Māori analysis. With an audit tool, it assessed Maori participation in all significant aspects of forensic services.
- Staff in forensic units and AMHS received separate *qualitative questionnaires* on forensic service provision and possible improvements. The Department of Corrections, Department for Courts and New Zealand Police each undertook a short survey to gather 'client' feedback on services, interface with forensic services and their respective activities.
- *Additional information* for benchmarking comes from the Department of Corrections (projections for the prison population and siting of prisons) and Department for Courts (court volumes).

Census results

Forensic services treat relatively few people overall. The census counted 189 forensic inpatients and 256 forensic outpatients. The vast majority of both groups are male.

In addition, RFS court and prison liaison staff assess about 2500 people at court and 4500 prisoners per annum.

Although a disproportionately high number of Māori are forensic service consumers compared with their representation in the general population (15%), it is relatively consistent with their representation in the criminal justice sector.

Despite the low number of women inpatients, it is disproportionately high relative to the prison population. The proportion of women in inpatient facilities (8.2%) is almost twice that of women prisoners overall (4.3%).

Many forensic patients are diagnosed with schizophrenia or other serious mental illness. As expected, most of these people receive care and treatment under legislation.

For most inpatient and outpatients, index offences are 'serious' (violent or sexual) offences.

Inpatients

Of the 189 inpatients, 92 percent are male and 8 percent female; 50 percent are identified as Māori and 7.5 percent as Pacific peoples.

Diagnoses

The most common diagnosis for forensic inpatients is schizophrenia (72%), especially for Māori (86%).

Seven forensic inpatients have an intellectual disability, organic brain damage or neurological degenerative illness. While some of their behaviours may be difficult to manage, a forensic unit is probably not the most appropriate environment for them.

Legal status

As expected, all inpatients (except one) are under legislation. The majority (61%) are under the CJA, usually section 115(1)(b) – acquitted because of insanity but detained in hospital as a special patient. The second largest group are under MHA section 30.

Referral source

Courts make most referrals (37%) to forensic inpatient services, followed by prison (24%). Given the combined court and prison rates (61%), and the relatively high first admission rate, a considerable percentage of people may be diagnosed with a mental illness for the first time when they reach the criminal justice system.

Contact and admission history

The census shows that 44 percent of those studied have no previous admissions to a forensic unit, while a similar percentage has one or two admissions. However, 70 percent of all inpatients have one or more previous admissions to AMHS; often this contact extends over 10 years.

Length of admission ranges from less than a year for 51 percent, to over five years for 14 percent.

Types of offence

For about 70 percent of inpatients, violence or threat of violence is their precipitating (index) offence. Next most prevalent is wilful damage/trespass (including arson) at 13 percent, followed by sexual offences (8%) and unlawful taking of property (4%).

Cultural assessments

Māori specialist staff generally conduct cultural assessments for Māori. They consider the relevance of culture to the client's mental illness, along the four dimensions of wairua, hinengaro, tinana and whānau (see Background above).

The census found about 76 percent of Māori and 36 percent of Pacific inpatients have received cultural assessments. However, the Māori review noted that there is no way of knowing whether these services were appropriate to the needs of these people.

Unmet demand

While Auckland and Christchurch had waiting lists for admission to forensic beds, inpatient facilities were not at capacity overall. The pending closure of the NSU at the time of the census probably affected these data.

Outpatients

On 1 April 2000, RFS were providing follow-up care to 256 outpatients: 89 percent male and 10 percent female (with missing data for another three people). The proportion of Māori (28.5%) is higher than that in the overall population (approximately 15%), but lower than that in forensic inpatient services (50%).

Diagnoses

The most common primary diagnosis for both men and women is schizophrenia (64%). Twenty-two percent of women have personality disorder, compared with 11 percent for men. Eleven percent of women have bipolar affective disorder compared with 12 percent for men.

Residence

Most outpatients (65%) are living in their own homes or rented accommodation. Next most common is Level 3 accommodation (10%) and Level 3+ (9%). However, it is uncertain whether all respondents based their answers on the same definitions of accommodation type.

Legal status

Forty-one percent are informal or voluntary patients, but many may previously have been inpatients under the CJA or MHA. The next largest group (19.5%) are under section 29 of the MHA.

Referral source

As expected, forensic inpatient units refer the majority (53.5%) of outpatients. Another 21.5 percent come from general mental health services (inpatient units and unspecified) and AMHS (including alcohol and drug services). Together with courts and prisons, these avenues account for 90 percent of referrals.

Contact and admission history

Most (68%) have been outpatients for less than two years (49 percent for less than one year). Another 30 percent have been outpatients for two to five years, but only 2 percent for more than five years.

Only 7 percent have had no previous admission to either forensic services or AMHS.

Types of offence

Violence and threat of violence are the main offences (51.5 percent overall, 70 percent for women) bringing people to community forensic service. Next are wilful damage/trespass (12%) and sexual offences (9%). For Māori, the statistics are similar.

Of concern is that 14.6 percent of outpatients have never been charged with an offence.

Cultural assessments

Of the 73 outpatients identified as Māori, 57.5 percent nationally received a cultural assessment. Regions vary widely from 89 percent in Auckland to 29 percent in Christchurch.

Nationally, four of the 12 outpatients identified as Pacific peoples received a cultural assessment.

Reasons for being a forensic outpatient

Respondents explained qualitatively (subjectively) why each outpatient is in the forensic service. Nearly 50 percent are there because they are considered 'dangerous'.

A concerning observation from the forensic outpatients service, consistent with questionnaire feedback, is that many (37.5%) are outpatients because of 'inability of AMHS to provide service'. It may mean that the AMHS cannot manage these clients, highlighting resourcing and training issues, or that interface issues between AMHS and forensic services are affecting service delivery.

A few are outpatients because they have a long-standing relationship with a particular clinician.

Court liaison service

The forensic court liaison service provides advice, assessments, reports and recommendations to the judiciary. It also consults and liaises with AMHS, prisons, community probation and police.

In six months, approximately 1514 referrals for assessment are made to forensic services (about 57 per week) and forensic staff write 511 reports for courts (about 20 a week). Both activities are relatively time-consuming.

People in Auckland, Hamilton, and Christchurch were waiting for assessments at the time of the census, possibly indicating unmet demand.

In Auckland, Hamilton, Wellington, Christchurch and Dunedin, the vast majority of people are assessed under the CJA sections 121(2)(a) and (2)(b)(i). In Wanganui, most are assessed under section 121(2)(b)(ii).

The highest proportion of women are assessed in Wellington (39%), Auckland (30%) and Christchurch (20%), possibly related to the location of women's prisons. The other regions assess around 10 percent.

The highest percentage of Māori are assessed in Wanganui (70%), followed by Auckland (37%).

Prison liaison service

Specialist forensic services to prisons include outpatient mental health clinics (within prison), assessments, transfer of mentally ill prisoners to medium secure hospital facilities, and consultation/liaison and support services for prison staff.

These services are additional to the primary care by Department of Corrections health staff and psychologists.

According to census data, forensic services assess about 87 prisoners each week. Auckland, Hamilton and Christchurch had waiting lists for assessment, while prisoners were awaiting admission in Auckland and Christchurch.

In discussions before and after the review, the Department of Corrections has confirmed there is some evidence that forensic assessment services to prisoners may be at lower levels than demand requires. The prison study supports this view.

Māori review

The review team made the following observations of Māori services in forensic inpatient units.

- *Mason Clinic*, Auckland. Three FTE staff provide cultural assessments to all clients in the Clinic, local prisons and courts. Māori rarely participate at a strategic/ operational level.
- *Henry Bennett Centre*, Hamilton. In addition to one FTE, the Centre draws support from the Mental Health Māori Service. Māori do not participate at a strategic level.
- *Purehurehu*, Capital Coast Health, Wellington. Forensic services have recently agreed with Te Whare Marie to develop three FTE positions (additional to their one FTE). Through Te Whare Marie some Māori participate at a strategic level.

- *Te Whare Manaaki*, Sunnyside Hospital, Christchurch. One FTE position is linked to Te Korowai Atawhai, a strategic approach to Māori development throughout the mental health service. Māori participate at a strategic level.
- *Ward 9*, Wakari Hospital, Dunedin. One FTE is linked to Māori mental health development overall and has recently been placed with the Māori service.

The Ministry of Health has been informed that Stanford House, Wanganui (which Māori review team did not visit) has two FTE Māori mental health workers, and Māori participate at a strategic level.

The Māori review highlights:

- lack of effective Māori participation at all forensic service levels
- lack of Māori frameworks and infrastructures (except in Christchurch, Wellington and, partially, Dunedin) to integrate Māori into mainstream services
- workforce issues for both mental health professionals and Māori traditional practitioners working alongside clinical teams
- the high proportion of Māori in the forensic population
- high rates of diagnosed schizophrenia among Māori. Further research is required to determine whether this finding legitimately reflects illness.

Qualitative survey results

The Ministry surveyed the following health services or their overseeing department, with results as summarised below.

Forensic services

Overall consensus was that the current forensic service model is appropriate, although it was suggested that the current model may be suited to urban more than rural areas.

Predominant themes among responses were liaison and integration of forensic services and AMHS. Respondents identified the need to:

- improve integration and liaison among forensic services while maintaining the integrity of the service roles
- better integrate forensic services and AMHS to improve community services
- clarify management and gatekeeping roles in the whole range of services, with the option of 'mainstreaming' forensic clients when clinically appropriate
- change AMHS focus from a person's criminality to the person with a disorder, so AMHS is more accessible to 'forensic' patients
- improve AMHS resourcing, skills, expertise and understanding of the forensic service role

- better integrate AMHS and alcohol and drug services, dual diagnosis services, and other welfare, housing and income support agencies
- overcome difficulties in discharging people from forensic services to AMHS.

Concerns were expressed for specific groups.

- Given the low numbers of *women*, forensic facilities are not ideal for their care.
- People with an *intellectual disability* and people with behaviour problems associated with *head injuries* are inappropriately placed in forensic services.
- It is inappropriate for forensic services to care for people with *challenging behaviours*, posing significant risk to others, yet they are not managed by AMHS.
- Better facilities are needed for *long-term patients* so they have access to secure sport and recreational areas and occupations.

Other concerns relate to:

- workforce and resources, particularly as demand for prison liaison appears to be increasing
- the lack of trained, experienced Māori and Pacific peoples in forensic services
- the need for improved screening for mental illness in prisons
- lack of step-down or community-based residential facilities for forensic clients.

Adult and kaupapa Māori mental health services

Overall respondents give the impression that relationships between AMHS and forensic services are reasonably good. However, they are uneven, with a lack of clarity about role boundaries and lack of understanding of respective client needs. Many AMHS respondents asked for better communication (including sharing expert knowledge) and more resources (physical and staff) to meet the needs of some clients.

Nationally AMHS expressed needs for:

- clear protocols and data exchange between services, and joint case management requirements
- more AMHS training especially to manage clients with violent behaviour
- forensic services to be proactive in training, such as for managing challenging behaviours
- forensic teams to work more with community-based clients
- better rehabilitation and living facilities in the community for people with mental illness who have challenging behaviour and pose significant risk to others
- improved forensic service access for people under the MHA
- dealing with distance logistics in rural areas.

Department of Corrections

The Department of Corrections investigated the provision of health services, particularly mental health screening procedures and psychological services, in prisons. It also provided information on inmate numbers in each prison facility.

The Department of Corrections does not have an explicit model for mental health care in prisons. In its view the prison population is a high-risk subgroup of the overall population for whom the health sector has explicit responsibilities under legislation.

Nurses and doctors give primary care to prisoners on a basis similar to general practice in the community. On reception into prison all offenders receive a health assessment, including a mental health assessment, according to the *New Zealand Prison Service Policy and Procedure Manual*.

At the time of the survey, the Department of Corrections employed 48 registered psychologists and eight assistant psychologists; 22 nurses were registered psychiatric nurses.

Corrections psychologists help reduce reoffending by:

- providing specialist psychological counselling, assessment and treatment
- running three special focus units for long-term treatment in small groups
- preparing psychological reports on offenders for parole boards, district prison boards, courts, Community Probation Services and Public Prisons Service
- undertaking research.

New Zealand Police

The New Zealand Police asked their prosecutions staff for their perceptions of forensic services. Overall responses were extremely positive. However, respondents mentioned a need to improve the interface between forensic and AMHS.

Most prosecutions staff have extensive contact (one to three times a week) with court liaison services, to seek advice or refer people in police custody who may have a mental illness.

Considerable concern was expressed about mental health services in general, including their perceived failure to meet the needs of:

- people with a mental illness, who come before the court as a 'last resort'
- acutely ill people in police custody.

Department for Courts

The Department for Courts surveyed court managers about the courts–forensic services interface. Overall court managers throughout the country praised the court liaison forensic service highly, focusing on quality and timeliness of reports, staff availability, assistance to judiciary and quality of relationships within court 'teams'.

Some identified needs for:

- better liaison among forensic services, AMHS and judiciary, especially over assessments
- some type of forensic liaison service for youth court.

Census Update

This section outlines significant changes mooted or undertaken in the criminal justice and health sectors since the census.

Developments within the health sector

The health sector is undergoing major structural change. The Health Funding Authority has amalgamated with the Ministry of Health and 21 District Health Boards (DHBs) were created late in 2000. DHBs will plan and fund most health and disability support services, which will be devolved to them. The Ministry of Health will directly fund some services, temporarily or indefinitely.

Through the transition process, it will be decided which services (eg, forensic services) meet the criteria for devolution, and over what timeframe. Until then, the way of funding forensic services will remain unchanged.

Budget 2000

The recent Budget allocated mental health services an extra $257.4 million over four years: $27.4 million for 2000/01, $50 million for 2001/02, $80 million for 2002/03, and $100 million for 2003/04.

Ministry of Health initiatives

The Mental Health Information project and the Mental Health Information National Collection (MHINC) system (adopted from 1 July 2000) will allow consistent data collection, stronger analysis, and thus enhanced management of service delivery and planning. The new database is designed to provide complete, accurate and timely information (without identifying individual patients) on the utilisation of secondary mental health services.

Concurrent to this review, the Ministry of Health and Department of Corrections are examining the impact of substance abuse and dependency on criminal offending, and treatment programmes for those with dependencies within the corrections system. A report on the size of service gaps and options to address them is with Government.

National criteria for entry into forensic inpatient services is being developed. This project, involving the Ministry of Health and interfacing with alcohol and drug services, will consider the provision of mental health care in prisons.

In a review of residential community support services, a move is being considered towards a 'supported accommodation' approach, whereby people with appropriate needs are supported in their own homes or other settings. Specialist services would provide certain stages of clinical care, such as acute intensive care.

Interface between health and criminal justice sectors

Since 1992 a Memorandum of Understanding between the then Departments of Justice and Health has outlined their respective responsibilities in providing specialist mental health services to those with mental illness in the criminal justice system.

The Ministry of Health and Department of Corrections have agreed a new Memorandum of Understanding, effective from 22 May 2000. Its purpose is to:

- clarify roles and responsibilities
- provide mechanisms to improve co-operation among agencies.

The agreement defines differing levels of services, and mental illness. It states responsibilities of the main agencies, funding arrangements and guiding principles. It covers hospital admissions, use of the MHA, and forensic service assessment and advice on management of prisoners. From this basis, prisons and local forensic services can develop and implement protocols.

Developments within the criminal justice sector

Ministry of Justice

The Ministry of Justice is undertaking a review of the Criminal Justice Act 1985 and the Minister of Justice will introduce a Sentencing Parole and Reform Bill in early 2001. The aim of the review is to provide for greater transparency and consistency, more clarity in sentencing legislation, and an emphasis on the severity of punishment matching the seriousness of the crime. The review will address general sentencing guidance, the range of sentences imposed by the courts, sentencing for murder and high-risk serious offenders, and parole/release of offenders from prisons.

Department of Corrections

The Department of Corrections proposes to develop a Corrections Bill (probably after the Sentencing Reform Bill) to replace the Penal Institutions Act 1954 and CJA provisions on community-based sentences. The Bill will provide a modern, more appropriate framework for managing offenders. It will cover the administration of prisons and community-based sentences and orders.

Integrated Offender Management

The Department of Corrections is developing and implementing Integrated Offender Management (IOM). These more consistent, integrated procedures for offender management are designed to reduce reoffending and improve compliance with sentence requirements. The emphasis on more thorough assessment of need and sentence management/planning processes, in particular, is likely to constitute significant change.

Home detention

Over the next few years the home detention scheme will probably see more offenders confined to their own homes (under Department of Corrections supervision). This trend is likely to affect AMHS, which these offenders are expected to access, rather than RFS.

Courts

Since this review began, the courts scoping study (Peters et al 2000) has been completed. With a policy and operational focus, it found that RFS generally serve the criminal and high courts well. The assessment system works relatively well for consumers and the judiciary.

Some issues from the study are similar to those discussed in this review, such as:

- interface between police and AMHS (especially crisis services), and AMHS and RFS (including court liaison teams)
- access to inpatient beds (especially in Auckland) and court liaison services, consumer access to mental health care through the criminal justice system
- appropriateness of legislation and services for people with intellectual disabilities.

Other issues were:

- the need among judges, lawyers and court staff for more information on mental illness, service facilities, cultural issues
- legal concerns over the wording and lack of graduation in CJA section 115, and court reluctance to use section 118 when sentencing (with the result that offenders go to prison and then are transferred to hospital).

In interviews, generally consumers said that RFS supported them well. They needed to be respected, informed and heard, and to have family support. Some consumers said they could only access help by 'acting out' or getting charged.

Developments in forensic services

Additional funding 1999/2000

In 1998/99 mental health funding of forensic services was $48 million, rising 4 percent from the previous year. In 1999/2000 the Health Funding Authority purchased more forensic services with additional funding estimated at $1.2 million, divided as follows:

- youth forensic service, Auckland $0.250 million
- kaupapa Māori forensic liaison step-down, Hamilton $0.735 million
- more community forensic services, Wellington $0.240 million

The kaupapa step-down service is one of several contracts held by Hauora Waikato, established to provide mental health services to the Hamilton Māori community.

National Security Unit relocation

After the NSU closed on 31 October 1999, additional extended secure beds were funded in Waitemata (20 for Auckland and five for Midland), Wanganui (10 plus five step-down) and Christchurch (seven). Ten regional secure beds were also transferred to the Wellington region, bringing its total to 25.

Other regional changes

With the extended secure beds, *Auckland* has gained more staff. As at 30 May 2000, it has 5.21 medical FTEs and 132.62 nursing FTEs for inpatient units (89 beds). Average occupancy for forensic units in the region is 99 percent.

As *Waikato* has contracted Hauora Waikato for five forensic subacute beds, access to step-down facilities and discharge into the community will probably improve. By expanding capacity for flow-through, this arrangement is also likely to reduce demand for inpatient services.

The HFA, Lakeland, Pacific Health and Hauora Waikato have discussed improvements to their interface, communication and support. The relationship between Health Waikato and Hauora Waikato has also been enhanced through a new Memorandum of Understanding.

In the *Central* region, services have been significantly reconfigured and reorganised, with relocation of beds and more community forensic services. Central now services Gisborne, Wanganui (reducing the forensic regions from six to five) and the lower half of the North Island.

Issues

This section identifies issues arising from the review and in the global context. It sets the scene for the changes proposed in the next section.

The 1988 Mason report led to the establishment of forensic services in their present form. Five (initially six) forensic regions provide inpatient, court and prison liaison, and community services.

The comprehensive Mason model is respected internationally and within New Zealand. It centres on consumer and client needs, and on continuity of care. Consistent with principles inherent in mental health services, forensic services treat people on the basis of clinical presentation, in the least restrictive environment possible. However, the features of mental illness and dangerousness often require a treatment programme incorporating security and safety, for legal reasons (treating transferred prisoners) and more importantly for therapeutic reasons.

Since the Mason report, community-based services for all people needing mental health services have developed considerably, driven largely by the national mental health strategy (Ministry of Health 1994b) and increased funding for mental health development. Although the Mason report proposed their development, it did not anticipate the present configuration of community services.

Despite methodological limitations and probable inaccuracies, the census provides a useful snapshot of forensic service delivery, a basis for analysis and a baseline for future reviews. The absence of existing data, and difficulties encountered in data collection, illustrate major shortfalls in information systems (see below).

Overall, forensic service providers and clients agree the Mason model is an effective framework for service delivery. Analysis of the review data, however, highlights areas where changes may improve services to consumers and clients, and increase efficiencies at the interfaces between service providers and clients.

The Māori review identified that progress in achieving the Mason recommendations for Māori has been slow, except in Wellington and Christchurch regions.

Service provision

The following issues applied to provision of forensic services at the time of the review. Many apply equally to other areas of health services. Some are more specific to AMHS than RFS, and some have been addressed or are being managed through projects and processes. Each issue is significant to Māori.

Underlying philosophy

Although overarching principles (including those of particular relevance to Māori) apply across all health services, some apply specifically to forensic services. There is some uncertainty over what philosophy should drive forensic service provision. In turn, there is confusion over their purpose and consequently their functions. Many interface issues probably stem from this lack of clearly defined principles.

This review raises many of the ongoing questions related to principles underpinning forensic services, as outlined below.

Comprehensive service and alignment with mental health strategy parameters

- Is there a sufficient range of services from secure inpatient beds to community facilities and services (including step-down beds) for forensic use?
- Should the main responsibility for community care lie with forensic services or community mental health services?
- Are community mental health services the hub of service delivery, while forensic services specialise?

Cultural appropriateness and models of care

- How appropriate are forensic services to people of differing cultures?
- Do current services meet the needs of Māori?
- Do we involve whānau and treat the person holistically?
- How should medical and Māori models be integrated?
- How is best practice from both medical and Māori worlds ensured?

Treating in the least restrictive circumstances possible

- How is the principle of least restrictive circumstances applied to people detained because of a serious offence, who also need a sense of safety and 'security'?
- How are individual needs of patients balanced with the public right to protection?
- How do we meet demand and need without building a large 'institutionalised' forensic population?

Avoiding stigmatising and criminalising where possible

- How do we minimise negative public perception of people with a mental illness, particularly of those who use forensic services?
- Does the current forensic model perpetuate stigma rather than reduce it?
- What can be done to prevent people with mental illness from getting into circumstances that lead to criminal charges and records?

Sector responsibilities and cultures

- Given the health sector is responsible for providing services to mentally ill people, how should it provide those services in prison?
- Who can AMHS treat safely?
- How do we balance the service cultures of corrections (custodial) and forensic (treatment and rehabilitation albeit in a secure setting) to the advantage of individuals in forensic services?

Identifying those needing forensic psychiatric services

- Are people with personality/psychopathic disorders treatable?
- Are forensic services appropriate for people who are dangerous when unwell, are intellectually disabled or have head injuries?
- Who should provide what type of service, and where?

Target population

As discussed above (see Background), forensic services are part of a continuum of mental health services for a specific population. The census showed, however, that some people may be placed inappropriately in forensic services – either by default when other services are not readily available, or 'via the back door' through the courts to ensure they receive a mental health assessment. It is also arguable whether forensic services are appropriate for:

- people with severe intellectual impairment – although the census indicates proportionately fewer forensic consumers in this group in New Zealand[2] compared with some overseas jurisdictions, from a clinical perspective a psychiatric facility is unlikely to be appropriate for anyone in this group
- people diagnosed with a serious personality disorder – there is ongoing clinical debate around whether people with this disorder are treatable and what sort of care, if any, they should receive from psychiatric services
- people referred by AMHS because they are perceived to be dangerous and difficult to manage when unwell – many may not require a specialist forensic service nor its restrictive, potentially 'stigmatising' environment.

The lack of clarity about target population, as identified in the qualitative research, could create more forensic consumers than necessary. Possible consequences are more forensic institutions, service delivery inefficiencies and, for many people, inappropriate care as well as unnecessary criminalisation and stigmatisation.

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[2] Categorised by primary diagnosis, four inpatients have intellectual disability and three have brain injury; four outpatients have intellectual disability and six have brain injury.

Once people have been under forensic care and gain additional stigma through their association with the criminal justice system, it is often difficult to discharge them to the care of other health professionals. These consequences underline the importance of accepting into forensic services only those people who genuinely need their expertise.

An additional reason to target entry to forensic inpatient services is that they are intensive and therefore costly.

Interface issues

The review identified blurred boundaries between forensic service providers and service clients (ie, courts, prisons), despite the existence of memoranda of understanding, service contracting and purchasing specifications, protocols between providers, and other procedural documents.

As the Māori review and qualitative research indicated, service providers and clients differ in their understanding of their roles and how they perform them. While in some areas services are reasonably aligned, misunderstandings and misconceptions about responsibilities are apparent in others. Communication and liaison are also variable.

Interface with AMHS

AMHS interfaces with police and courts seem especially problematic. It appears that, because of the nature of the police–AMHS interface, police refer people to forensic services for want of access to other mental health services. Some of these people have come to police attention by committing relatively minor crimes or behaving 'unacceptably'. They may have a mental illness and require mental health care; they do not necessarily require specialist forensic care.

Issues at the AMHS–RFS interface relate mainly to the target population and core business of each service. These two separate but parallel systems have grey areas concerning who should provide inpatient services to whom. In addition, there are disincentives and difficulties over transferring patients between AMHS and forensic services, outpatient follow-up, and access to community facilities and services for forensic service consumers. These issues illustrate a need for more integrated services and greater continuity for the consumer.

Interface with iwi and Māori providers of mental health services

AMHS and RFS relationships with iwi can also be problematic. Providers should establish appropriate, consistent links with iwi and Māori provider groups, particularly in cities where the Māori population contains a significant proportion of Mataawaka (Māori who come from other places). Positive relationships with iwi also strengthen Māori participation in developing and delivering appropriate services to Māori.

Corrections and Health

At a strategic level, the Department of Corrections, Ministry of Health and HFA have defined their respective roles in the care of offenders, through the April 2000 Memorandum of Understanding (see Update above). Negotiation produced two as yet unresolved issues relating to:

- transporting unwell offenders to hospital
- caring for offenders assessed as requiring hospital admission and waiting for a bed.

Putting policy into practice has its problems. The review showed that service providers (Public Prison Service and forensic prison liaison) sometimes have different interpretations of what services they provide to whom and where. In some prisons, prison health staff provide comprehensive primary care including primary mental health care; in others, any mental health care is left to the forensic prison liaison team. A direct influence on service levels, especially for assessment, early diagnosis and referral, is often whether appropriately trained nurses are on the prison health staff. A clarification of responsibilities within the prison environment needs to occur.

A contentious question is whether prisoners should receive treatment under compulsory treatment orders, which would require change to both the CJA and MHA. The possibility raises concerns over differences in the purpose and culture of criminal justice and mental health systems, and the potential for misuse or abuse of treatment by custodial officers. We recommend this issue be debated separately in future.

Consumer needs, including appropriateness to Māori

Consumer feedback indicates strong support for forensic services, primarily due to the quality of care provided, compared with their previous experiences in AMHS. The review identified groups of consumers who have specific and differing needs because of their ethnicity, gender, location and diagnosis: Māori, Pacific peoples, women, people in rural and remote areas, people in long-term forensic care, people with violent or dangerous behaviour, and people with severe personality disorders.

RFS inpatient services and prisons are configured regionally. Thus some people are isolated from their families and support systems. Regionalisation may have a particularly negative impact on Māori, as witnessed by the Māori review team. It is desirable that Māori are treated as close as possible to their home (wakainga), whānau and hapū, to assist the healing process (from a Māori perspective).

Issues specific to Māori

Some of the issues raised by the census are:

- uneven access to cultural advisors and assessments
- high rate of schizophrenia among Māori (86 percent compared with 72 percent overall)
- high proportion of Māori in forensic inpatient (50.5%) and prison (52%) populations.

Respondents to the forensic services questionnaire expressed the need for more trained and experienced Māori staff as well as for better services to Māori clients especially those in crisis.

The Māori review raised issues of:

- lack of Māori participation in service development
- lack of policy for including Māori health in forensic service development
- lack of clarity around the role and functions of Māori health teams
- lack of resources for Māori mental health in forensic services
- difficulties for consumers in accessing programmes and Māori healing strategies.

Unmet need

The census indicated, probably due to its timing, that inpatient facilities were not at capacity. However, the wider review established that the need for services may be greater than their availability in some regions (eg, Auckland and Waikato). Together with the prison study, the review identified areas of 'unmet need', particularly among prisoners with a mental illness.

The Department of Corrections reports that often it must continue to house prisoners who are diagnosed as requiring inpatient treatment because no bed is available in forensic services. This situation presents significant risks for both the prisoner and prison staff. Corrections also reports on evidence that forensic assessment services to prisoners are less than demand requires, with waiting lists necessary.

Projected growth in the prison population

Recently the Department of Corrections projected a rise in the number of prison beds required from 5935 in 2000, to 6978 in 2003. Together with the location of new facilities, this projected population growth will affect forensic services, especially in the northern region. Likely flow-on effects are increased needs for prison liaison clinics and assessments, and inpatient referrals and services. Where to deliver these services will also need consideration.

Community services

Moreover, it appears community rehabilitation services and facilities are insufficient to enable forensic patients to return to the community when they no longer need specialist inpatient services. Consequent problems arise in providing community-based residential facilities, community follow-up, and transfer to AMHS.

Workforce requirements

Review information on staffing levels across forensic services was problematic. The data were not consistently collected or reported. It was difficult to make comparisons because of the way staff were utilised (ie, dedicated or shared), and particularly difficult to assess resources against volumes. Resource analysis was further complicated by regional differences in geographical size, demographics, recruitment difficulties, and changes in service delivery during or since the census.

Overall, however, it appears that resourcing is extremely variable, some areas have serious workforce shortages, and some regions may be better served than others.

The review raised workforce issues such as training, resource/skill sharing, recruitment and retention of staff (particularly Māori and Pacific peoples), and the quantity and quality of prison health staff. It is anticipated that the review proposals will help address both quantity and quality of staff (see Way Forward and Benchmarking sections).

This review's brief assessment of forensic training and education, along with the qualitative research, indicates that a variety of training is available at differing levels and through different providers. Equally, however, it appears timely to review the curricula for their appropriateness and comprehensiveness, as well as for the accessibility and availability of the training to the workforce.

As this review proposes to extend the AMHS role (see the Way Forward), it is important that community mental health teams, assertive treatment teams and AMHS acute services teams have sufficient competence and capability to treat and support people previously treated by RFS. This training should be more 'operational', and available locally. It may also be useful to consider the training needs of prison health staff and their access to current courses.

With regard to Māori, workforce issues are significant. The shortage of Māori health professionals (Ministry of Health 1997) was again apparent. It was also difficult to identify and quantify Māori working at other levels in forensic services. In addition to general workforce issues, the following questions concern Māori practice and Māori-specific services within AMHS and forensic services.

- What is traditional Māori practice?
- How do Māori practitioners function differently from other health professionals providing a Māori service?
- What are the roles and responsibilities of Māori specialists (eg, tohunga, kaumatua)?
- How are Māori specialists valued alongside health professionals?
- How is Māori practice validated?

Information

The review highlights the lack of a national data collection framework. The need to gather information for this review itself indicates major problems in information systems. Data were inconsistently defined, gathered, recorded and stored. The validity of some data is questionable, constraining the quality of the review.

The review did not canvass forensic services for their ability to monitor and follow up people receiving care. However, recent reviews of high profile incidents have shown problems with monitoring. It is clear that effective monitoring of consumers across provider boundaries is severely compromised by the inadequacy of information systems within and across services.

Other significant factors

Over the last five years, other factors that have affected and continue to affect forensic services include:

- changes in delivery of mental health services, with a continuing emphasis on developing community rather than institutional services
- a significant increase in prison populations, with further increases projected
- population growth especially among Māori and Pacific peoples – particularly concerning because of the high proportion of Māori among forensic consumers
- more significant co-morbidity
- significant increases in violent crime.

Many of these factors require changes to the way services are organised and provided.

The Way Forward

In the further development of forensic mental health services, the foundation and framework of the Mason report (1988) remain universally accepted as appropriate parameters. However, over the last 10 years, general adult mental health services have been inadvertently deskilled in the assessment and treatment of people with mental illness and violent or potentially violent behaviours. In addition, the interface between forensic ('specialist') services and (more 'generic') AMHS must be developed to optimise care for targeted consumers.

The ability of forensic mental health services to meet the expectation of a responsive and appropriate service is influenced by the whole mental health sector environment as well as the services able to be provided by the Department of Corrections.

This section makes proposals to address forensic service development. Specifically it addresses interface issues, service demand, and capacity- and capability-building in AMHS. These proposals are consistent with the review's terms of reference.

The fundamental principle of modern mental health services (Ministry of Health 1994b; 1997; Mental Health Commission 1998) is that the hub of service is the community mental health team. Specialising within mental health, forensic services focus on a target population, supporting and augmenting community services. The way forward is to build on this principle. Therefore these proposals aim to enhance both forensic services and community AMHS.

These proposals are designed to clarify the parameters of forensic services and their targeted population, and to emphasise community mental health. They aim to improve services as much as possible, while reducing the associated stigma and discrimination.

Principles of care

The following principles are proposed to guide provision of forensic services. They are a subset of the principles for mental health services overall. Their fundamental premise is that people in forensic services, including prisoners, are entitled to the same level of health services, including continuity of treatment, as people in any other situation. This premise embraces the recovery approach outlined in the *Blueprint*.

The principles for forensic services are as follows (not in any ranked order).

- Consumers' need for mental health care should govern their access to services.
- Consumers should be accommodated in facilities that match their need.
- Consumers should be treated in the least restrictive environment that their circumstances allow.
- Services should be client focused, enhancing wellbeing and preserving dignity.
- Services must balance individual rights against any need to protect the public.

- Services should be culturally appropriate, treating the whole person and involving whānau and families.
- The approach to care should be holistic, integrated, open-minded and non-judgemental.
- Service provision should minimise negative public perceptions of people with mental illness, including those who have both a mental illness and contact with the criminal justice system.

With regard to Māori, these principles are additional to the five principles for culturally effective services – namely, choice, relevance, integration, quality and cost effectiveness (see Background).

The parameters of forensic services

Forensic services have skills in diagnosing, assessing and treating mental illness. However, these skills are no greater than other mental health services, and other services may have more expertise with specific disorders (eg, depression, schizophrenia). The core of forensic expertise is an in-depth understanding of the law and the way the criminal justice and mental health sectors interact, particularly through the Criminal Justice Act and Mental Health Act.

Forensic services work predominantly at the court–Corrections interface. They can guide people through both systems, knowing which mechanics of law and mental health may be applied to whom and when. That involves understanding the CJA and MHA frameworks, people and their illness within the terms of the law, and the interface between organisations.

Thus although forensic services are not necessarily more skilled in dealing with people who pose significant risk, they have a thorough knowledge of the principles of risk assessment and management. With this expertise, they can assist other services in developing and implementing effective plans for risk assessment management.

In addition, forensic services have expertise in managing offenders with certain types of mental illnesses, such as disorders leading to sexual offending, morbid jealousy, or stalking. Other services may also manage such people.

Target population

Forensic services assess or treat people with:

- a suspected mental illness
- a severe mental illness
- a severe personality disorder, if the person fits the MHA definition of mental illness, is a pervasive risk to others or himself or herself, and cannot be managed in either the prison or AMHS environment.

Legally, people are referred either under the Criminal Justice Act (sections 115, 118, 121) or Mental Health Act (sections 29, 30, 34, 45, 46). Referrals may come from prisons or courts. AMHS may also make referrals when specialist forensic services are needed to treat people with severe mental illness and persistently dangerous behaviour.

People with severe intellectual impairment

Forensic services care for a very few people who have significant intellectual impairment, either from an organic cause or a major head injury, and exhibit consistently violent behaviour. In the near future, with the advent of compulsory care legislation currently before Parliament and new funding for services to high-need individuals, this group will have access to their own specialist services. Forensic services may still have consultation/ liaison role.

People with severe personality disorders

Like the general population, people with severe personality disorders gain access to forensic services based on need and legislation. AMHS manages most of these people, using forensic inpatient services only if the person meets the MHA definition of mental illness and clinically requires such treatment.

In their consultation/liaison role, forensic services can also support other services or Corrections in managing individuals with self-harming or risk-taking behaviours in prison or elsewhere.

High-risk people referred by AMHS

This review found that highly skilled staff from AMHS moved to forensic services as they were established in the early 1990s. Thus to some extent AMHS have lost skills in managing people with a mental illness and high-risk behaviour. These people are frequently referred to forensic services for assessment and treatment.

Care and treatment in forensic services will remain the best option for some people with mental illness and associated violent behaviour, usually due to the ongoing need for a safe and secure therapeutic environment. However, forensic services should have a much-expanded role of providing expertise, training and support to AMHS. This approach allows more people to stay within AMHS parameters, provided they have not been referred from the criminal justice system, and do not have a significant forensic history.

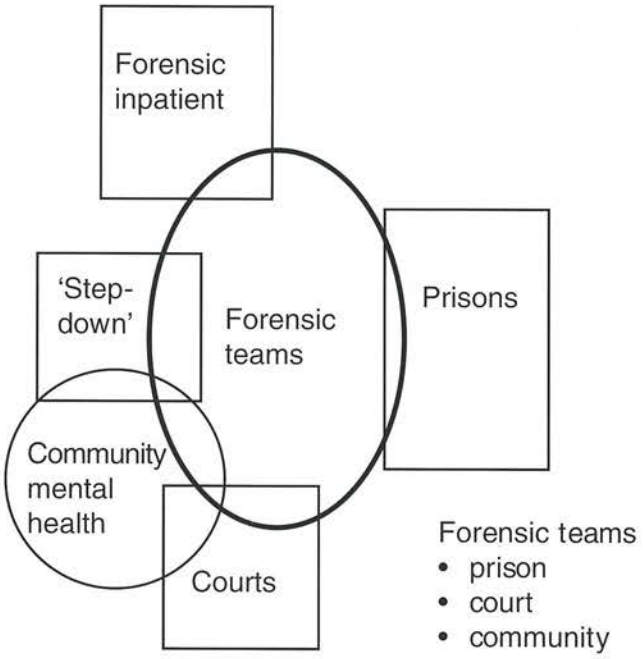
To implement this proposal, additional resources are needed for both AMHS and forensic services.

Components of service

The settings for forensic service assessment and treatment are:

- secure inpatient facilities (beds)
- forensic teams in prisons
- court liaison service
- community forensic service
- step-down hostel beds or community residential services.

Figure 1: Components of forensic services



Secure inpatient facilities

All inpatient beds offer a secure and safe environment to assess and treat individuals whose mental illness poses significant risk. Referrals may come from courts, prisons or community mental health services.

The following service levels are required. Each level includes Māori staff participation and support.

- *Acute services* assess and treat acutely ill people. Courts may refer people under CJA section 121(2)(b)(ii). Such people are not necessarily mentally ill nor needing acute care, but require observation and assessment to establish the relationship, if any, between mental illness and the offence. Their stay is generally brief, although some may become secure inpatients after sentencing.

- *Structured rehabilitation* may follow acute treatment, where people with a mental illness and risk of dangerousness require ongoing treatment and rehabilitation in a secure environment before returning to prison or moving to community residence. Such rehabilitation is considered medium term, taking up to two years.
- *Extended rehabilitation* involves long-term care and rehabilitation in a secure environment for some people who have an ongoing severe mental illness and associated risk. In a very few cases, care may continue for the rest of a person's life, but usually people eventually are referred to step-down beds or intensive community residential services.

In some regional forensic services, AMHS supervises intensive rehabilitation beds in partnership with forensic services. This model enables effective transition to AMHS.

Forensic teams in prisons

Forensic services aim to provide the specialist mental health services to the prison population at a level similar to that provided by any general AMHS. Referrals come either from the prison medical or primary health staff, or from AMHS community teams when people under their care become prisoners.

A multi-disciplinary forensic team assesses and treats people who are acutely ill, as well as those not acutely ill. In some areas and circumstances the forensic team may respond to mental health crises in prisons, but from 4.30 pm to 8.30 am it is usually the general adult community crisis intervention team who responds.

The forensic team assesses whether an individual should be transferred to a forensic inpatient unit for ongoing assessment and treatment, or can be assessed and treated in the prison environment. This decision is based on the individual's clinical needs. Generally the threshold for admission should be similar to that for acute inpatient admission in the community mental health system. However, the prison environment itself may contribute to a person's illness or deter some individuals from responding appropriately to mental health assessment and treatment, and thus in reality the threshold may often be much lower. The effect of the environment in prisons as an aggravating and perhaps causative factor in presentations of mental illness needs further exploration and research.

In addition, the forensic prison team provides a consultation/liaison service to prison primary health staff and Department of Corrections staff. This role involves assessments, advice, teaching and training sessions, assistance in developing screening processes for mental illness, and support.

Because there is no provision to apply the MHA to someone in a prison setting, the culture of detention and punishment sometimes limits the range of medical and psychosocial treatments. Within a policy framework, there is need for further exploration of and debate over the contentious issue of applying for compulsory treatment orders for prisoners (ie, community orders).

In extreme circumstances and where a hospital bed is not available, the forensic team must provide 24-hour care and supervision in a prison and assist Department of Corrections staff in transporting people to and from hospital. When a prisoner is admitted to hospital, the forensic team is involved in planning the discharge from the inpatient unit and is responsible for follow-up care and management when the individual returns to prison.

The forensic team is also responsible for ensuring ongoing care and follow-up in the community. The community forensic team may provide that care, sometimes in partnership with community AMHS, which could include a community mental health or assertive treatment team.

Primary mental health care in prisons

The Department of Corrections prison health service will continue to be responsible for primary mental health care of prisoners including appropriate treatment and care for those who abuse alcohol and other drugs. Through consultation and liaison, forensic teams will support the primary health role of assessment to enable diagnosis, referrals and intervention. To effectively fulfil the primary care role, the Department of Corrections may consider a policy change and review of its primary health capacity. Further work needs to be undertaken with Department of Corrections on analysing the training needs and skill development of the staff in the prison, and the primary health care staff to ensure the primary health care needs of inmates are met.

Court liaison service

Within the courts, the principal role of forensic services is to provide triage and advice. They assess individuals in the court system to identify those who have mental illness and who should be assessed and treated within the mental health system. It is important that those individuals who have an identified mental illness are not remanded to prison, where the environment there may further undermine their mental health.

Forensic court liaison staff also act as gatekeepers to ensure that court referrals to mental health services are appropriate – that is, those referred have or may have a mental illness and require mental health services. Thus staff ensure access to treatment and assist fair representation through the justice system. Their roles include liaison, referral, advocacy, initial assessment and court reports, referrals for psychiatric assessment and court reports.

It is important for forensic court liaison staff to maintain effective contact with the individual's existing caregiver, if there is one and subject to the individual's approval.

In addition to informal advice, forensic court liaison staff provide the court with formal reports under CJA section 121 and the Children and Young Persons Act section 333, and with oral evidence when the court calls for it. When staff make an assessment, it does not necessarily mean the person will become a formal forensic 'patient' at this time.

Forensic staff also act as 'interpreters'. They help court staff and lawyers to understand mental health concepts and to interpret the judicial system for assessed individuals.

This work is at an important public interface. Thus it is important that forensic staff give authoritative and accurate advice to the court.

Community forensic service

The community forensic team has two main roles:

(a) to ensure appropriate hand over of individuals to the AMHS community assertive teams, to support AMHS in the ongoing management of these people, and to provide consultation and liaison services as appropriate regarding any of the consumers of AMHS

(b) to provide direct clinical management for a small group of individuals, mainly those designated as special and restricted patients under the Mental Health Act.

Facilitating transfer of patients to AMHS

A key role of the community forensic team is to facilitate the transfer of individuals from forensic services to AMHS – either the community mental health or community intensive treatment team. This transfer requires a working partnership based on consultation and liaison. That is, community forensic and AMHS teams form a partnership around each individual, with a shared understanding of the management plan for that individual, to ensure continuity of care through the transfer period (which varies according to the individual's needs).

In an acute inpatient setting, the community forensic team can provide consultation and liaison to assist with care and management planning for individuals whose behaviour poses a risk to themselves or others. By supporting AMHS staff in the community and inpatient setting, the transfer of people to a secure forensic inpatient facility may not be required.

Consultation and liaison with AMHS are at the core of the community forensic team's work, incorporating teaching, training and expert knowledge.

Specific follow-up and management of specific patients

It is appropriate for the community forensic team to manage certain individuals in the community. These individuals may be 'special patients' or 'restricted patients' under the MHA, or their specific characteristics may mean it is the forensic team who has the necessary expertise to manage them over a short or long term. However, it is envisaged that the community forensic team will directly manage only a few people in the community. Most of its work will be in partnership with AMHS.

Step-down beds and community residential services

Individuals may be referred from inpatient settings to intensively supervised step-down beds, in a hostel or supervised residence. In this way, they gain ongoing care and rehabilitation, and are gradually integrated back into their own community and live as normally as possible.

The level of supervision depends on an individual's needs, and the assessment of risk. Where RFS manage a few step-down beds associated with their inpatient services, the census classifies them as 'inpatient beds'. However, where the community AMHS manages such beds, the census classifies them within community residential services.

If at all possible, AMHS – particularly the intensive community treatment team initially – should have clinical responsibility for the individuals leaving forensic inpatient services. However, they will act in partnership with the community forensic team, within an individual plan that both teams have developed. In some circumstances (outlined above) an individual may remain directly with the community forensic team.

Some RFS may consider it appropriate for forensic services to continue to manage step-down beds, counting them as inpatient beds. Where possible, however, step-down beds should be community based, under the clinical oversight of AMHS in partnership with forensic services (as already occurs in Wellington and Christchurch).

The following conditions are important to the success of AMHS community teams with enhanced responsibility for individuals who have either been in forensic services or may be significantly dangerous.

- A strong allegiance and partnership must be formed with the expert community forensic team. Each individual consumer should have a care and treatment plan, including times for review, over which there is joint agreement.
- The capability and capacity in the AMHS community teams must match the requirements for ongoing assessment and treatment. Necessary qualities include:
  - the ability to engage with the consumer and be highly vigilant for signs of recurring illness
  - familiarity with local community and iwi resources
  - good networks and cultural linkages
  - good contacts and partnerships with other teams such as the homeless team, crisis intervention team and particularly the community forensic team
  - strong, effective relationships with community residential providers
- Case loads must allow time for clinicians to maintain close contact with and assertively follow-up the consumer.

It is acknowledged that both resources and skills must be enhanced before these proposals can be implemented.

Police will continue to use community mental health teams, particularly crisis intervention teams, as their first point of contact regarding people who they think may be mentally unwell. With enhanced formal relationships between AMHS and the community forensic team, people arrested and taken into police custody should gain access to services as soon as possible. If they do not, and consequently are unnecessarily charged, this failure will be reported as an 'incident' and subject to review. This approach will focus on early intervention and thus, in some cases, prevent a criminal charge or court appearance.

Services for Māori

It is unlikely that needs of Māori consumers will be met without Māori participation in decision-making, service delivery and service provision.

Essential components

The following components should be applied to all Māori in all forensic settings – namely, in prisons, courts, secure inpatient units and the community (including all AMHS). For effective implementation, services will have formal and informal relationships with Māori/iwi to ensure participation at all forensic service levels, as the Mason report indicated. Good relationships will foster supportive networks with other agencies, thus helping the consumer's integration into the community and/or including whānau/hapū more fully in assessment, treatment and discharge planning.

Whānau participation

Standard 10 of the National Mental Health Standards clearly defines participation of family and whānau. Services need protocols for this participation, particularly to cover situations where the consumer may not participate in discussions in the presence of family/whānau or where their involvement is not in the consumer's best interests.

Te reo Māori

Using a language other than the consumer's mother tongue can limit assessment and treatment significantly. Where English is a second language, Māori should have the option of a Māori interpreter, just as other non-English speakers might. Equally, it should not be assumed that because a client is Māori, he or she speaks Māori.

Tikanga Māori

Tikanga Māori involves adapting Māori protocol for use in treatment settings, making the environment appropriate for the intervention. It ensures family/whānau are appropriately greeted and received, and pakeke/kaumatua are included at appropriate treatment stages. Tikanga Māori often allows family/whānau to feel more comfortable and able to talk even in mainstream settings.

Karakia

Openness to spirituality is an integral part of the journey towards wellbeing. To use karakia appropriately in mainstream settings, it is necessary to develop appropriate policies on their use, train staff and establish a safe environment for practitioners.

Rongoa

Rongoa Māori encompasses the range of traditional (often unique) Māori healing services, including herbal remedies, physical therapies such as manipulation and massage, and spiritual healing. Where practicable, rongoa should be adjuncts to treatment. Combining rongoa with psychotropic medication is generally seen as unproblematic.

Involvement of tohunga/traditional healers

The belief that mental health and illness occur in a cultural context underpins the need for cultural understanding and treatment in a cultural context. Most Māori are of two cultures. From logical and clinical viewpoints, this status contributes to illness; hence integrating western clinical and Māori healing will help them return to health.

Services should develop good ways of assessing when the input of tohunga or traditional healers is appropriate; mechanisms to ensure that they are available when needed; and give consideration to how these services are integrated within overall treatment plans.

Kaupapa Māori

For some Māori, a kaupapa Māori service managed by a Māori/iwi provider is the most appropriate forensic service. Based in Māori philosophy and spirituality, this service treats consumers in the context of their total life span, with Māori clinicians using a Māori model. It is expected that Māori is available as a language choice for Māori clients. The use of karakia is also integral.

Over the next 5–10 years, most separate kaupapa Māori forensic services will be developed in step-down facilities, residential services and community (AMHS) services. With increasing skill development in Māori mental health, in the longer term there may well be concomitant development of kaupapa Māori forensic services in all settings (eg, prison, courts, inpatient settings). Such kaupapa Māori services must have a partnership relationship reflected in working protocols with the mainstream forensic services.

Some Māori choose not to be assessed and treated in a kaupapa Māori setting. Moreover, sometimes it may be impossible to provide kaupapa Māori services due to a shortage of Māori staff with the necessary clinical skills. To meet Māori consumer needs in these situations, mainstream forensic services must employ Māori staff or have a direct relationship with a Māori/iwi provider.

Secure inpatient services

In the near future, it is envisaged that secure inpatient services will continue to be mainstream. However, these services will develop a stronger kaupapa Māori approach, as well as establishing partnerships with Māori at all forensic service levels. Where bed numbers reach a critical mass (ie, two or more wards), it is recommended that services consider developing at least one ward into a separate kaupapa Māori environment. The mainstream provider could manage this ward, or subcontract it to a kaupapa Māori provider.

In the longer term (when there is significant expertise in Māori mental health), kaupapa Māori secure units may be established in regions with a large population or critical mass of consumers, such as Auckland or Hamilton.

Prison and court services

The relationship between forensic services and corrections and courts sectors is critical to delivering effective service in these sectors. The most effective approach involves one skilled team that liaises with other parts of forensic services and AMHS. For appropriate services, active Māori participation in these teams is essential.

Where expertise exists, separate kaupapa Māori team(section) will give choice to Māori in prisons and courts. However, such teams must have a partnership agreement with mainstream forensic services to ensure efficient, effective and safe service delivery.

Kaupapa Māori services and mainstream forensic services

Kaupapa Māori services have expectations similar to those of mainstream services. That is, they have high standards for clinical performance and treatment, as well as for consultation/liaison services with other agencies involved with Māori.

As outlined above, kaupapa Māori services – in the community or for inpatients – could provide some or all components of forensic care. These services may be separate from or within the mainstream environment.

Pacific peoples

Although only a few Pacific peoples are in forensic services, anecdotal evidence suggests that numbers are increasing. Every Pacific person must have access to a culturally appropriate service. Establishing that service involves building strong relationships with regional Pacific mental health services (where they exist), recruiting Pacific staff at all levels, including decision making, service delivery and provision, and building partnerships with Pacific communities.

When expertise exists, separate Pacific services will develop in step-down facilities, residential services and community mental health services. The role of forensic services is to assist such development and to work in partnership with separate Pacific mental health services, based on the principles of consultation and liaison.

Women

Women inpatients have specific needs, relating to gender, dislocation from family, and their status as a minority in a predominantly male environment.

Separate areas in regional secure inpatient units should be developed, to ensure women are safely and appropriately assessed and have good access to family and whānau. Special consideration should be given to this development in view of the expected increase in women prisoners over the next 10 years. If numbers increase by more than predicted, services may also need to consider developing separate secure forensic facilities (within existing forensic units) near women's prisons.

Likewise, in developing step-down beds and residential services, the needs of women require careful attention.

The prison study showed high rates of mental illness among women in prison. Forensic prison services must be developed to give separate, special attention to the needs of women prisoners.

Unmet need

To overcome unmet need and service gaps, identified especially through the prison study as well as through the census, it is planned to develop services further in prisons, inpatient settings, courts and the community. In particular, once skills are enhanced among community AMHS (including appropriate residential services) in partnership with community forensic teams, consumers will receive more effective care in the community, alleviating pressure on inpatient beds. Moreover, enhanced service in prisons, from both forensic prison teams and prison health services, should alleviate waiting lists for assessment and transfer.

Given the identified shortage of forensic beds for prisoners and the projected rise in prison numbers, it appears that demand for forensic beds may well be outstripping current resources. Addressing this shortfall means increasing all service components, including AMHS, because all components are interdependent.

The proposed benchmarks (see next section) indicate the likely prevalence of forensic consumers, service needs and resource levels. They should *guide* resource allocation to all current 'forensic' services, such as the number of inpatient beds required for acutely ill and other offenders.

Although positive effects are expected from closer integration of RFS and AMHS, additional community facilities will probably be required to give good service to forensic inpatients in terms of rehabilitation, discharge and reintegration back into society. Initiatives from the HFA are addressing some shortages of step-down and community facilities in 2000/01, such as by funding additional step-down beds and reviewing residential community support services. Together with the focus on community services, these initiatives should extend opportunities for community care and increase the flow back into the community.

Workforce issues

The benchmarks (next section) indicate required staff numbers and their caseloads. Purchase specifications and provider workforce planning should address recruitment, training and retention of staff including Māori and Pacific peoples.

In addition, all staff working in forensic services should have appropriate postgraduate qualifications that encompass the required areas of expertise.

Māori should participate in all teams providing services to Māori in hospitals, the community, courts or prisons. Such participation may come from Māori staff as team members, or from kaumatua and other support people. Close links must also be established and maintained with iwi/Māori social service groups.

Certain workforce conditions are prerequisites to the success of the community approach and change in the target population. To expand their services to include those previously provided by RFS staff, AMHS staff must gain appropriate training to treat and manage risks associated with consumers and their complex needs. Training should cover techniques of de-escalation, calming and restraint.

A comprehensive review of all forensic programmes is proposed. It will examine:

- course content for its appropriateness, its match with the proposed changes, and its consistency with the intent of Mason recommendations for the workforce
- training and education at all levels, including postgraduate education for health professionals and programmes for health support workers
- policy associated with reorganising the health sector.

To foster ongoing learning, it is vital to develop centres of excellence where research and academic teaching can occur alongside service provision.

Workforce and provider development is also required in supported accommodation services. Skills and knowledge will be developed, with ongoing support and training from both community mental health teams and forensic consultation/liaison teams.

Possible workforce issues for the Department of Corrections include:

- recruiting more nurses with psychiatric experience
- training prison medical staff to provide more comprehensive primary mental health care, including assessments
- additional training for prison custodial and health staff on managing prisoners who have personality disorders and do not require mental health treatment.

Information systems

A nationally consistent framework for data collection is required to enhance patient management, follow-up and monitoring. Its development should be integrated and consistent with the overall Health Information Strategy and Mental Health Information National Collection (MHINC). The implementation of MHINC will be built on to ensure specific information on forensic services utilisation is available for ongoing analysis at regional and national levels.

In addition to utilisation information, the review highlighted the need for better flows of clinical information between various providers and/or teams supporting an individual. These issues are quality issues and apply generally to the whole mental health sector, and therefore no specific solution is proposed for forensic clients. Providers need to ensure that these issues are being addressed, in particular in their implementation of Standard 7 of the National Mental Health Standards.

Benchmarks

This section responds to the first and third objectives of the terms of reference, by establishing benchmarks for service levels for forensic clients, and identifying current and future resource requirements. This approach helps target forensic services to a defined population, based on a community services model involving enhanced forensic prison teams, forensic inpatient services, community forensic and AMHS teams, and community residential services (see The Way Forward, page 30).

Why benchmark?

National benchmarks have been established for general (Ministry of Health 1997), and child and adolescent mental health services (Ministry of Health 1998). Interim benchmarks for forensic services were given in the *Blueprint* awaiting this forensic review.

Like benchmarks for other mental health services, benchmarks for forensic services indicate how many consumers are likely to need their services, based on information about mental illness prevalence. By indicating the capacity of services required to meet forensic consumer needs, this information guides decisions about national resource allocation, which in turn guide regional and local requirements. Thus there are benchmarks for population access and benchmarks for service resource or capacity.

Caution is needed because benchmarking is an inexact process, with no single internationally recognised method. Moreover, it is reiterated that benchmarks are intended to guide rather than determine national resource allocation. The proposed benchmarks assume all service components work together. Benchmarks also should not inhibit flexibility and innovation. Service planning must include consideration of the local population, with the ultimate aim of providing the best possible care in response to consumer needs.

Approach to benchmarking

These national benchmarks for forensic service levels apply to the target population and are predicated on the integrated community approach proposed above (see The Way Forward, page 30). They have been developed with reference to:

- review data – the snapshot of the forensic population's size and location, and data from which to extrapolate current use
- prison study information on the prevalence of mental illness in prisons
- volume projections from prisons and courts
- international prevalence data
- methodology used to develop benchmarks for general mental health services.

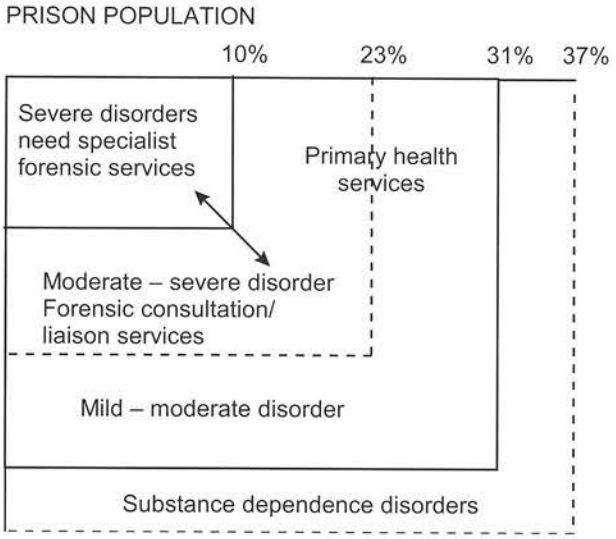
As noted above, the purpose of these benchmarks is to *guide* national resource allocation and service delivery. These benchmarks update those given in the *Blueprint*.

Population approach

Prison population

From the prison study, it is estimated that at any one time 10 percent of prisoners require access to specialist mental health services. This benchmark is over three times higher than the benchmark for the equivalent consumer group in the general population (3%).[3] Unlike the general population benchmark, this prison benchmark excludes those with substance dependence disorders (see Appendix 1 for details).[4]

Figure 2: Estimated need for mental health services in the prison population



General population

The 3 percent benchmark for the general population indicates the extent of the need for specialist mental health services, including forensic services, among people presenting in court or with special needs in AMHS.

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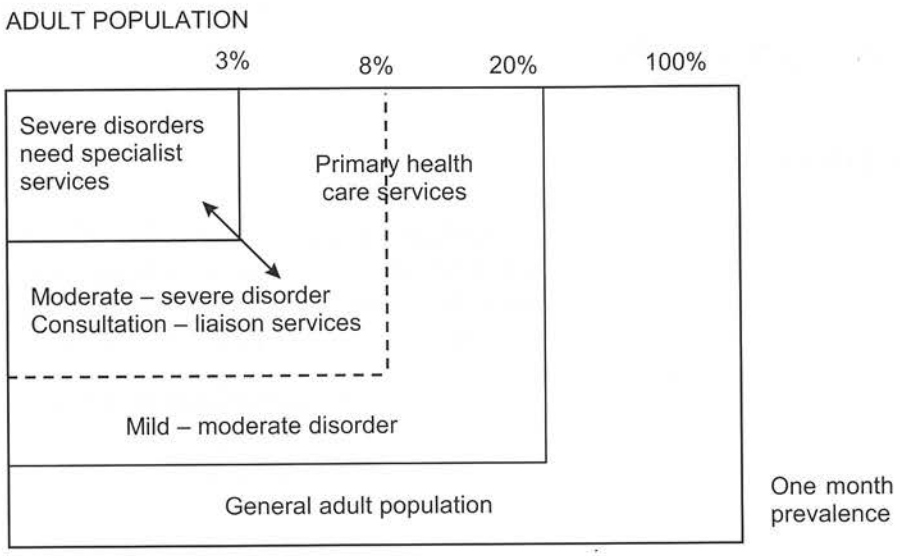
[3] As given in *Looking Forward, Moving Forward* and the *Blueprint*.

[4] Only a few prisoners with severe substance abuse disorders have no co-existing mental illness; this group should have access to specialist alcohol and drug services.

Figure 3: Estimated need for mental health services in general population



Services approach

Prison forensic teams

Although many areas combine the roles of prison and community forensic teams due to operational realities and low numbers of consumers, other areas may require two or more teams to perform these roles. Estimated staff numbers reflect the different population groups. They have been developed on the assumption that:

- 10 percent of prisoners need to access specialist mental health services
- current and planned prison musters to 2003 are accurate
- the staff:consumer ratio is 1:15.[5]

The exact mix of skills in the multidisciplinary teams required (eg, psychiatrists, psychologists, nurses, social workers, Māori and Pacific health workers) will be calculated in each regional implementation plan.

Based on current prison numbers (5935) and the above assumptions, it is estimated that 39.5 (40) FTEs are required nationally to fulfil the proposed functions of forensic teams. In 2003, the need rises to 46.5 (47) FTEs predominantly in the Auckland region, if prisons in Northland and South Auckland open as planned.

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[5] This ratio is halfway between the 1:25 ratio of general community mental health teams and that of 1:8 of assertive treatment teams. It allows for the greater need among people with severe mental illness in prisons, and for the expected rise in referral to forensic services from prisons. It also allows for the strong consultation liaison role of the forensic prison team. This national figure applies to national resource calculation. Higher ratios are relevant in Auckland and Christchurch, where the majority of maximum secure prison beds are located; regional figures will be calculated more accurately in regional implementation plans.

Overall it is projected that prison numbers will rise by approximately 18 percent over three years. If the prison plans are implemented, the largest growth – by about 83 percent – will be in Auckland (see appendix 3 for detailed estimates).

Community services

As census data indicate, use of community services varies across the country due to factors such as socio-demographic influences, proximity to prison and/or local service delivery. Nonetheless, these national data are the best available to estimate the number and complexity of people discharged from a forensic inpatient unit or prison and requiring community follow-up. These data have been used for both community forensic teams and AMHS assertive treatment teams. As RFS did not provide community services in the northern regions, separate data on service requirements for the region were factored into the calculations.

In April 2000 there were 385[6] people receiving ongoing care in community forensic services or AMHS assertive treatment teams. A 1:8 staff to consumer ratio is assumed and recommended for both community forensic teams, given their consultation/liaison role and 'special' caseload, and for AMHS assertive treatment teams.

In total, approximately 48 FTEs are needed nationwide. It is assumed that this total is split by a ratio of 30:70 between:

- community forensic teams, with 14.4 FTEs
- AMHS assertive treatment teams, with 33.6 FTEs.

In practice not all staff in AMHS assertive treatment teams will have the overall competencies to care and treat individuals who have a forensic history. This number of staff required refers to those additional people who will need such competencies.

However, the precise split is to be decided through consultation/liaison and partnership arrangements between local community forensic teams and AMHS services (see Appendix 3 for regional estimates).

The exact FTEs and skill mix will be calculated in each regional implementation plan. As in most parts of the country, the forensic community teams are small, practically they may be combined with the prison or court liaison staff.

It should be noted that the data upon which the benchmark figures are derived is probably inaccurate. What is important is the assumption of a 1:8 staff to consumer ratio, and the principle of consumers moving to AMHS with the ongoing support of the forensic community teams.

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[6] This figure is approximate only, due to inaccuracies in data collection. It should be refined when there is accurate information from MHINC. There will probably be a corresponding increase in outpatient numbers, when more people are referred and treated in prisons. The resource allocation to these community services may need regular review, although the population size should already be reflected as community numbers in the *Blueprint*.

Given the predicted 18 percent rise in prison populations in 2003, with a consequently greater need for forensic services and, implicitly, for criminal justice system activities, it is assumed that people in ongoing care in community forensic services and AMHS will similarly increase to 454 by 2003.[7] Thus there is a need for:

- 17.0 FTEs in community forensic teams
- 40.0 FTEs in AMHS assertive treatment teams.

Court liaison teams

Benchmarks for court liaison teams are based on:

- current use and staffing, in a context of general satisfaction with their service
- the number of criminal summary cases brought.

From these data, a ratio of 'dedicated' court liaison nurses to summary cases brought has been calculated and then a regional breakdown suggested. These benchmarks exclude psychiatrists' input to CJA section 121 reports, which courts purchase separately.[8]

On this basis, 19.2 FTEs are required nationwide. Further to regional analysis, ongoing evaluations are required to establish future need, which cannot be predicted from current information (see Appendix 3 for regional estimates).

Forensic inpatient beds

Given the lack of information from which to estimate benchmarks for forensic inpatient services, resource guidelines for this service component are the most difficult to determine. Benchmarks have been developed with reference to:

- census data on current utilisation by referral and legal status. Note, however, the census provides a snapshot, while a critical determinant of required bed numbers is the flow of patients in and out of the facility
- prison study data on prevalence and unmet need. Note, however, it is difficult to assess how much of this treatment requires admission to an inpatient facility
- data on the projected growth in the prison population (to 2003), changes to the target population and assumptions about the impact of proposed service changes, to estimate the number of beds required now and in future.

The method of calculating benchmarks varied for each of the three primary client groups. The results for each group are summarised below (see Appendix 2 for detailed calculations.)

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[7] The precautions discussed in note 6 also apply to this figure.

[8] It is acknowledged that the basis of 'summary cases brought' may not be the most appropriate parameter to use, and that 'days of court sitting', along with some rural adjuster may give better guidance to resource requirements. This can be further explored in the implementation plan(s).

Group I

Group I comprises inpatients admitted under CJA sections 115 and 121. The courts generate most of the demand for beds for this group.

The Ministry of Health monitors inpatients under section 115 closely. Given the number in this category has been relatively stable, if not declining, over the past 10 years, it is assumed the population size will remain static. Five people under section 115 currently have a diagnosis of intellectual disability or head injury; it is assumed these people may relocate to a different service developed from the forthcoming compulsory care legislation.

Different sentencing practices may slightly increase numbers requiring admission to a forensic inpatient facility under section 121 to be assessed for court processes. Because there is limited access to forensic beds in some regions, currently people are remanded to prison and then transferred under MHA section 45 to an inpatient bed. Improved access to forensic beds will increase court referrals under section 121, but this should be matched approximately by a fall in referrals under section 45. It is unclear what changes of sentencing practise may result from legislation currently before the House.

Group II

Group II covers people sentenced under:

- CJA sections 117/118 (excluding those referred from prison), where court sentencing generates demand for beds. Usually people with this status are admitted to AMHS. A very few who need the expertise of forensic services are referred
- the MHA, when AMHS refer inpatients beyond the capacity of AMHS.

In both cases, it is assumed that as AMHS develop in capacity and capability, demand for beds will fall somewhat. However, this trend will probably be offset by growth in referrals to the service. Thus numbers will remain static.

Group III

Group III comprises inpatients under MHA sections 45/46 and CJA sections 117/118 who have been referred from prison – that is, the group covered by the prison study. Because the study did not cover people in hospital, it is assumed the census reflects the additional numbers. The prison study also reflected a level of 'unmet need'.

The proportion of beds required to meet prisoner needs at the time of the prison study is estimated as 26.2 times more than that of the general population, assuming:

- use of prison study prevalence rates, relative to Australian community rates (Australian Bureau of Statistics 1999)
- there is twice the rate of treatment in an inpatient setting (ie, twice the acute admission rate), given that the prison environment is considered more 'toxic' to treatment than the general community environment, so probably has a lower threshold to admission

- people in prison requiring acute treatment in an inpatient setting will on average stay at least 2.0 times as long as that expected in an acute AMHS inpatient unit
- the result is related to numbers of acute beds required to meet the general population needs as specified in the *Blueprint*.

Based on these estimates, 31 beds are currently required to meet group III needs (see Appendix 2). If the Corrections forecasts of larger prison musters are added to this information, it is predicted that 36 beds will be required by 2003.

Capacity

The system must have some capacity to respond to variations in demand. Because most of the population appears relatively stable, it is assumed that units can operate at 95 percent capacity. In this case, a further 10 beds are required currently and 11 in 2003 nationwide to meet fluctuations in demand.

Summary

The census recorded national bed capacity as 192.[9] Since then the HFA purchased seven more extended secure beds in Christchurch, taking current capacity to 199. From the above benchmarks, it appears 18 more beds are needed now and six more by 2003.

Table 1: Forensic inpatient beds required

Groups	Occupation at census date	People requiring beds currently	People requiring beds in 2003
I (CJA sections 115, 121)	76	76	76
II (mainly MHA)	67	67	67
III (from prisons)	33	33	33
Unmet demand		31	36
Total people requiring beds	**176**	**207**	**212**
Capacity allowance		10	11
Total number beds required		**217**	**223**

These figures reflect all inpatient beds – for acute assessment and treatment, medium-term rehabilitation and long-term inpatient care. As discussed above (The Way Forward, page 30), step-down beds in some regions have been counted as inpatient beds, and have been recategorised as community residential.

These benchmarks for bed numbers required are built on assumptions that are open to challenge. From these national figures, regional needs must be assessed and reflected in implementation plans, to guide individual purchase decisions.

[9] NB. Census data included 14 'hostel beds' in Auckland. As these are not inpatient secure beds, they have been excluded.

Community residential services

An identified barrier to discharge is the general unwillingness among community residential services to accept patients after discharge from forensic inpatient services. Rather than providing specialist community residential services, it is proposed that these people continue to access general residential services after discharge. The barrier will begin to break down as more assertive community models of care are adopted, alongside a stronger partnership between AMHS and forensic services.

Only a few people are in this situation. No attempt has been made to change existing national benchmarks for provision of community residential services to the general population. As indicated above, local purchase should reflect local needs.

The range of residential services including highly supported services (as outlined in the *Blueprint*) will eventually support the appropriate discharge of people from forensic inpatient services, as long as there is a strong working relationship between the forensic teams and the AMHS community teams. Ongoing development of skilled community providers with the support of AMHS assertive treatment teams and, where appropriate, the forensic team will lead to a flow from forensic inpatient care to supported community care.

Existing 'step-down' and 'hostel' beds have been recategorised as community residential. Since the census, the Ministry of Health has purchased five more step-down beds in Waikato and are in the process of funding 15 more in Auckland. The combined benchmarks (*Blueprint*) of residential intensive long-term and forensic community residential are supported.

Summary and Implementation

This review has developed a comprehensive best possible model for forensic mental health services, addressed interface issues (largely in relation to AMHS), determined national benchmarks for service to forensic service consumers and identified current and future resource requirements. This section summarises each of these areas, before touching on how the proposals might be implemented.

Model of service

The proposal for a comprehensive, integrated community approach builds on the community care principle at the heart of modern mental health services.

AMHS community teams are already at the hub of community mental health services. Specialist forensic services provide support and expertise to these teams, through a consultation/liaison model. They also provide direct consumer care and treatment to prisons and courts, in secure inpatient settings, and to a few people in the community.

Under the proposed model:

- the consultation/liaison role of specialist forensic teams will expand and assertive treatment teams will be enhanced, with the result that AMHS can treat people in the least restrictive environment possible, facilitating the recovery process
- improved and expanded forensic court and prison liaison teams will enhance services to people referred by court or in prison
- specialist secure inpatient services will be enhanced.

More resources are required so AMHS can strengthen their capacity to provide community care. Funding may be for additional training and staff. More resources are also required to expand specialist forensic services.

The 'best possible' model adds to the current model of forensic services, with:

- enhanced assessment of people in court
- improved and expanded assessment of people in prison
- more emphasis on comprehensive mental health treatment in prisons
- secure specialist inpatient services for people in prison and offenders with mental illness requiring acute care and rehabilitation in a secure hospital setting
- greater involvement of Māori staff, and emphasis on developing kaupapa Māori services.

It is also proposed that both RFS and AMHS actively extend Māori participation at all forensic service levels. This result may be achieved through additional Māori staff or kaupapa Māori services in the mainstream environment, or by establishing separate kaupapa Māori services.

Inpatient services with sufficient population and/or need should consider establishing a distinct wing within an existing facility, as a 'separate' kaupapa Māori inpatient service.

A separate wing should also be considered for women inpatients to cater for their special needs.

Together these changes should mean that people receive responsive, quality services in the least restrictive and least stigmatising environment.

Interface issues

In general, the review found positive views of the interface between criminal justice agencies and forensic services.

The key issues relate to interfaces within the health sector (between AMHS and RFS) and between AMHS and the criminal justice sector. Predominantly, these issues arose from perceptions of delivery failures and lack of clarity around responsibilities.

The Way Forward proposals clearly identify service responsibilities under the new arrangements. Part of the implementation process is to ensure there are appropriate incentives to meet those responsibilities. One such incentive might be a review process to address service delivery problems that arise for any agency.

Benchmarks

The national benchmarks are intended to guide rather than determine resource allocation under the proposed model.

For the prison population, benchmarks assume approximately 10 percent of all prisoners will need specialist treatment for mental illness (excluding substance abuse) at any one time. A further 13 percent are likely to need treatment by prison primary health services in consultation/liaison with specialist forensic teams. Because the population is very small, these benchmarks are susceptible to change.

Resource requirements

This review details high-level resource requirements for each service element in the proposed service model. Expansion and quality improvements are required for:

- forensic inpatient beds
- court liaison services
- prison teams
- assertive treatment teams
- community forensic teams
- adult community mental health teams

- acute inpatient wards
- services for Māori in all areas.

Workforce

The proposed model requires skilled, competent staff. To implement it, training and education needs, and ways to meet them effectively, must be determined.

Information

Improved patient information is vital to support community teams and the proposed model. A separate implementation plan should establish a system of nationally consistent, accessible information on individual patients for service providers. The non-identifiable utilisation data from MHINC fill a different need.

Implementation

Outlined here are the broad timeframe and planning for implementing the proposed model. No further details are given largely because, before AMHS can assume their greater responsibilities, current services must be expanded and upgraded significantly.

Timeframe

It is likely that a two-year lead-in or transition will be needed, with progress formally reviewed at the end of this period. This progress review may need to take into account proposed changes resulting from changes to the Criminal Justice Act.

Planning

Implementation will be planned in the context of current health sector changes. The roles of the various agencies in planning for change are summarised below.

The Ministry of Health, working closely with the Department of Corrections, will lead the implementation of this review with both national and regional plans, and advised by a national reference group.

Ministry of Health:

- has overall responsibility for implementing health services and developing the national implementation plan
- promulgates changes and ensures developments are reflected in funding agreements with DHBs

- has overall responsibility for interfaces between agencies – eg, developing national protocols with Corrections to cover the responsibilities of the two organisations
- designs and implements review processes in consultation with the Department of Corrections.

Ministry of Health with DHB/regional networks:

- develop regional implementation plans
- translate national resource guidelines into regional resource requirements reflecting regional need
- agree detailed service specifications
- review pricing and funding for services
- agree service provision plans with providers.

Ministry of Health with Clinical Training Agency and workforce project of DHBNZ (the national association of DHBs):

- develop a strategic plan for the workforce
- review existing training and education
- analyse training needs
- facilitate workforce development (eg, training, recruitment) for providers to deliver the new services.

Providers:

- ensure the necessary culture shift and skill development.

Adult mental health services:

- recruit appropriate staff
- train existing and new staff in community mental health and inpatient services
- develop assertive treatment teams
- increase Māori involvement in service delivery.

Forensic services:

- expand services where required
- increase Māori involvement in service delivery
- address the needs of specific groups (eg, women) in inpatient facilities
- develop the roles of prison teams
- develop the consultation/liaison function
- develop new working arrangements with Corrections at the local level.

The Department of Corrections also has a role in improving health assessments and primary mental health care, and establishing interfaces with the enhanced prison teams.

To make the proposed model a reality, it is vital that Māori, Pacific peoples, consumers and family/whānau participate fully in planning and implementation.

Future work

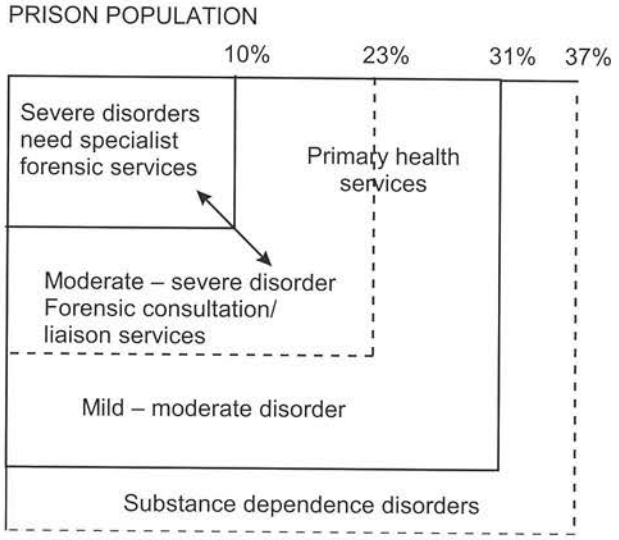
This review does not address the needs of children and youth. Although data showed several court services produced reports for the family courts, the census indicated only two inpatients and no outpatients under 20 years in forensic services. The needs of this group should be the subject of further study.

Many forensic service consumers are diagnosed with both a mental illness and substance abuse. A separate study on the need for alcohol and drug treatment services in prisons is before Government.

Underlying this review is the principle that people in prison should receive services on a similar basis as people in the community. In other words, prison is the 'community' setting for prisoners. However, in treating mental illness, there is one important difference between the community and prison. Namely, in prisons it is not possible to provide compulsory treatment. It has been suggested it may be desirable to change this situation – a suggestion needing extensive debate.

Appendix 1: Benchmarks for Forensic Services in Prisons

Figure 1.1: Estimated one-month prevalence of mental illness among prisoners, relative to service boundaries



These benchmarks are based on information from the 1999 *National Study of Psychiatric Morbidity in New Zealand Prisons*. Benchmarks identify the capacity of specialist mental health services required to assess and treat prisoners with a serious mental illness. In essence they indicate access to service.

Assumptions

1. For many disorders, prevalence differs for women prisoners, remand men and sentenced men. These benchmarks were developed with a national average that accounts for these differences. However, regional implementation plans should address these three populations so that service development reflects the different mix of the prison population in each area.

2. The overall one-monthly (or point) prevalence of mental illness is 34 percent of the prison population. This prevalence rises to 51.2 percent if the lifetime prevalence of phobic disorder is added – an important consideration, as it includes social phobia, a significant anxiety disorder. Unfortunately, the prison study did not assess social phobia separately; however, it may be estimated at the 2.7 percent monthly prevalence found in Australian community studies.

3. Personality disorders have been excluded from the estimated prevalence of mental illness, as 59.6 percent of prisoners meet criteria for at least one personality disorder.

Overview of mental illness

Unless otherwise stated, the following rates measure prevalence over one month.

Schizophrenia-related disorders	2.4 percent	
Bipolar	1.0 percent	
Major depression	8.1 percent	
Dysthymia	1.1 percent	lifetime prevalence
Obsessive compulsive disorder	4.0 percent	
Panic disorder	0.7 percent	
General anxiety disorder	0.5 percent	
Agoraphobia	0.3 percent	
*(Phobic disorder)	17.2 percent	lifetime prevalence
Post traumatic stress disorder	9.9 percent	
Alcohol dependence	2.1 percent	
Cannabis dependence	0.0 percent	
Other substance abuse and dependence	3.6 percent	
Total	**51.0 percent**	

Note:

1. Excluding phobic disorder (lifetime)	33.8 percent
but adding social phobia (Australian community)	36.5 percent
2. Excluding substance dependence	30.8 percent

Severe illness

An estimated 10 percent have severe illness and require access to specialist mental health services, broken down as follows.

Schizophrenia-related disorder, bipolar disorder	3.4 percent
Major depression	3.2 percent
Other disorders	2.3 percent
Total 'severe' disorders	**9.9 percent**

Assumptions

1. According to other studies (Gunn et al 1991), approximately 80 percent of people with schizophrenia-related disorders in prison require admission at some time. Therefore this estimate assumes 100 percent of prisoners with schizophrenia-related and bipolar disorders should have access at any time to specialist mental health services.

2. According to other studies (Bushnell et al; Andrews 1991; Andrews 1994), in any month specialist intervention is needed for approximately 20 percent of those in the community with a major mental illness. This estimate has been doubled to 40 percent of prisoners with a major depression because people in prison are likely to have greater disability and needs (eg, about 7 percent of prisoners attempt or plan suicide).

3. For prisoners with other disorders (eg, dysthymia, post traumatic stress disorder, all anxiety disorders), it is estimated that approximately 20 percent in a month will require specialist intervention due to the severity of illness.

Moderate–severe illness

According to other studies (Bushnell et al and Andrews et al), in one month approximately 60 percent of those with major depression and approximately 50 percent of those with other disorders have a moderate disorder and need health service intervention. Most of this intervention can comprise care from primary practitioners in consultation with specialist services.

Based on these assumptions, a further 13 percent of prisoners have a diagnosable disorder of moderate severity and require some intervention.

Mild–moderate illness

At any one time, the remaining 9 percent of prisoners with a diagnosable mental illness are likely to have mild to moderate symptoms and may need to access primary mental health services (see Figure 1.1).

Alcohol and drug dependence and abuse

If prisoners with alcohol dependence (2.1%) and other substance abuse and dependence (3.6%) are included in the estimate of people with mild to moderate illness, the estimate rises to about 15 percent. This is probably an overstatement, as it is likely that only a small proportion of those misusing other substances (eg, opiates) have a serious dependence disorder.

As noted in the Census update, a report on options for services for this group is before Government.

Those identified with abuse rather than dependence disorders should have access to education, promotion and prevention programmes to avoid progression to dependence.

Appendix 2: Use of Forensic Inpatient Services

Current service use

Table 2.1: Service use by the three primary client groups

Group I CJA sections 115/121		Group II MHA and CJA sections 117/118		Group III Referred from prison	
Section 115	58	MHA referred from AMHS	15	Sections 45/46	13
Section 121	18	MHA referred from other services	25	Other MHA**	15
		CJA sections 117/118	23	Section 118***	5
		Other*	4		
Total	**76**	**Total**	**67**	**Total**	**33**

Note:
* Includes CJA, voluntary patients and missing data.
** Includes sections 11, 15, 34, 55.
*** It is assumed these patients were remanded to prison before sentencing and recorded as 'referrals from prison'. People on remand were included in the remand population of the study so for benchmarking purposes are included in prison referrals.

Future requirements

Group I (CJA sections 115, 121)

It is assumed:

- demand will remain relatively constant, given that numbers under section 115 have been relatively constant over the last 10 years
- numbers under section 121 may grow slightly with population growth, offset by improved treatment in AMHS
- the five inpatients in group I who have a head injury or intellectual disability will move to alternative facilities under the forthcoming compulsory care legislation.

Thus forensic service use among this group is estimated as:

- current 76
- future 76

Group II (MHA and CJA sections 117/118 excluding prison referrals)

The following assumptions are made.

- Demand for inpatient care is influenced by:
  - adequacy of mental health services before admission, and their ability to prevent relapse or intervene early to avoid admission
  - availability of crisis services and hospitalisation options
  - philosophies, beliefs and clinical practices of 'community' clinicians
  - accommodation, support and treatment options for people leaving inpatient services.
- Currently:
  - prisoners have access to only limited mental health services for treatment and to prevent admissions, which influences courts in sentencing
  - AMHS inpatient services (as alternatives to forensic hospitalisation for some) have limited capacity to manage people who are violent when unwell for prolonged periods
  - discharge from forensic units is difficult because acute inpatient services, many residential providers and community services are reluctant to assume responsibility for this group of people.
- As proposed in this review:
  - assertive treatment teams will be strengthened
  - enhanced teams will encourage community residential service providers to accept discharged forensic inpatients
  - an increase in AMHS capacity and capability to address specific needs in inpatient units (eg, by establishing teams competent in calming and restraint within acute inpatient services)
  - AMHS capacity will increase in community mental health and assertive treatment teams.
- Although these strategies should decrease AMHS demand for forensic inpatient services, it is conservatively assumed (because other social changes, eg, levels of offending, are unpredictable) that demand will remain constant.

Thus forensic service use among this group is estimated as:

- current 67
- future 67

Group III (MHA sections 45/46 and CJA sections 117/118 referred from the prison)

Benchmarking here is isolated from other planned changes in the mental health sector.

It is assumed that:

- prison growth will proceed as planned
- group III requires hospitalisation for acute mental illness and is then returned to prison unless their sentence is completed
- the number requiring hospitalisation is related primarily to rates of psychotic disorders (schizophrenia-related and bipolar disorders), reflecting the diagnosis of 85 percent of all people currently in forensic units
- the one-month prevalence of 3.44 percent from prison is accurate and can be related to the point prevalence of 0.4 percent for the general community[10] (ie, prison rate is 8.6 times higher)
- 30 acute beds per 100,000 is appropriate for the prison community (c/f 15/100,000 acute beds for the general community)
- non-treatment rates are twice those in the community
- need for hospitalisation is therefore twice that in the community
- 516 beds per 100,000 is appropriate for the prison population (17.2 times 30).

Based on these assumptions:

- current provision (from census) 33
- unmet need from current prison muster 31
- **Total** **64**

Prison growth is assumed from Corrections prison musters, therefore:

- unmet need from projected prison muster 36
- total future need 69 people in three years

Key limitations to these estimates are as follows.

- The prison prevalence is based on symptoms over one month rather than the point prevalence in the population against which this figure has been compared. Thus the figure is likely to be a slight overestimate (some people experience symptoms during the month but not currently).
- Thirty beds per 100,000 may not be the appropriate level. It is, however, based on the assumption that people from prisons stay at least twice as long in an inpatient setting as people from the general community.

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[10] Australian National Survey of Mental Health and Wellbeing, *Report 4*, gives prevalence rates of between 4 to 7 per 1000 for psychotic illness, with 60 percent due to schizophrenia or schizoaffective disorders.

- Non-treatment rates in the community are unknown, so the adjustment for non-treatment is not based on data and may not be accurate.
- Treatment in prisons is not currently at the community level, so demand in the interim may be underestimated.

Summary

Table 2.2: Inpatient beds required

Group	People currently requiring beds	People requiring beds in future (2003)
I (CJA sections 115, 121)	76	76
II (mainly MHA)	67	67
III (from prisons)	64	69
Total people requiring beds	207	212
At about 95 percent occupancy, total number beds required	217	223

It is uncertain how planned changes will affect demand for forensic inpatient care and the movement of consumers from forensic inpatient services. Therefore, it is recommended that inpatient service benchmarking is regarded as provisional at this stage, and is reviewed either when all of the proposed changes are in place and fully operational or, at the latest, after two years.

Appendix 3: Regional Staffing Requirements

The following tables set out the regional requirements for staff for individual teams based on the national benchmarks. These are indicative only. The regional levels will need to be adjusted, as part of the implementation process, to reflect the differences in composition of the prison population in each area, and other local variations.

Table 3.1: FTEs required for prison forensic teams 2000–2003

	Prison muster		FTEs	
	2000	**2003 (projected)**	**2000**	**2003**
Total	**5935**	**6978**	**39.5 (40)**	**46.5 (47)**
Regional estimates				
Auckland (including Northland)	1120	2055	7.5	13.7
Hamilton	1579	1614	10.5	10.8
Wellington	1926	1957	12.8	13.0
Christchurch	1079	1121	7.2	7.5
Dunedin/Invercargill	231	231	1.5	1.5

Table 3.2: FTEs required for community forensic teams

	Number of consumers	Staff FTE
Total	**116**	**14.5**
Regional estimates		
Auckland	45	5.6
Hamilton	23	2.9
Wellington	25	3.0
Christchurch	15	2.0
Dunedin	8	1.0

Table 3.3: FTEs required for AMHS assertive treatment teams

	Number of consumers	Staff FTE
Total	**269**	**33.6**
Regional estimates		
Auckland	104	13.0
Hamilton	54	6.6
Wellington	57	7.0
Christchurch	34	4.5
Dunedin	20	2.5

Table 3.4: FTEs required for court liaison teams

	Staff FTE
Total	**19.2**
Regional estimates	
Auckland	7.4
Hamilton	3.9
Wellington	4.1
Christchurch/Dunedin	3.8

The indicative staff numbers required for different teams are very low in a number of places. These numbers reflect the function proposed, and services may need to combine the functions within a single team to achieve practically sized units.

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