



Department of Health
Government of Western Australia

North Metropolitan Area Health Service

To all staff

This review was undertaken to inform deliberative processes for the State Forensic Mental Health Service as an internal process and is not to be circulated, copied or reprinted without permission from the Area Executive Director.

Yours sincerely

Dr A Hodge
Area Executive Director, Mental Health
North Metropolitan Area Health Service

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Forensicare

WESTERN AUSTRALIA
STATE FORENSIC MENTAL HEALTH
SERVICE

REVIEW - 2008

TERMS OF REFERENCE

Objective

To review the management structure and operational functioning of the inpatient and community programs within the State Forensic Mental Health Service (SFMHS).

The review should be conducted in line with the proposed National Statement of Principles for Forensic Mental Health 2002.

Scope

Examine practices and procedures relating to the operational functioning and relationships of the prison service, inpatient program, community programs and overarching management of SFMHS.

Make recommendations based on service delivery, clinical performance, clinical risk management, education and training and organizational structure.

Key areas:

1. Risk assessment and management
2. Nursing hierarchy
3. Prison service
4. Court liaison service
5. Clinical reviews- initial and follow up.
6. Security
7. Relationship between programs
8. Program's relationship with executive.
9. Discharge planning
10. Academic relationships/ research potential

Methodology

A range of methodological approaches can be employed to collect and review the relevant information including:

- Documentation reviews
- Semi structured interviews
- Observations

Information provision prior to arrival will include annual report, minutes of meetings, organisational structure and overview of service.

No limitation will be made to access any area within SFMHS.

Documentation Reviews

- A random sample of clinical records selected by reviewers
- Policy and procedure manuals
- Data such as monthly and annual reports, strategic plans, minutes of key meetings

Semi Structured Interviews

Semi structured interviews can be conducted with:

- SFMHS managers, key clinical staff and SFMHS personnel
- Other key service providers or agencies that have a relationship with the SFMHS such as prison services.

Observations

Observation can be used to assess three main aspects of SFMHS:

- Professional to professional interaction
- Risk Management
- Facilities

Review Personnel

It is proposed that the Review team would be led by Prof Paul Mullen, supported by additional senior-level executive and nursing professionals.

Executive Contacts

Dr Ann Hodge- A/Area Executive Director, NMAHS Mental Health

Dr Viki Pasco- A/Director SFMHS

Sylvia Meier- Deputy Area Executive Director

Time frame

Five days on site, two days for travel.

Costing

The service has allocated approximately \$20,000 for the review. Specific details to be negotiated with Sylvia Meier.

Records

A written report to be provided, with recommendations, at the completion of the review

Confidentiality

All discussions, findings and final report will be confidential and distributed by authority of Dr Ann Hodge, A/Area Executive Director.

All participants in the review are obliged to maintain the confidentiality of any discussion arising from the proceedings of the review

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EXECUTIVE SUMMARY

1. The Western Australian forensic mental health services start with a number of advantages. They have a number of excellent mental health professionals across the whole range, with the quality of their younger nursing staff being worthy of note. The current budget is more than adequate to the tasks being undertaken and should even allow a modest expansion of roles. The inpatient unit will allow redevelopment and potentially expansion in the future. There is a genuine desire for improvement and a willingness to change at every level of the service.
2. The physical environment of the Frankland Centre has a number of positive elements but it is not currently configured in a way that will maximize therapeutic programs for patients or efficient resource utilization.

Reconfiguring and refurbishing the Frankland Centre will result in resource efficiencies that could be used to enhance and expand the range of services and programs currently provided by the State Forensic Mental Health Service.

3. To support the role and functioning of the Frankland Centre the patients on seven day assessment Hospital Orders from the Magistrates' Courts must be relocated, or at second best reduced and capped. This could be achieved through establishing a 7-10 bed unit from within the Graylands Hospital specifically for this purpose, potentially staffed largely from within the Frankland Centre existing staff compliment.
4. In the longer term the number of beds available at the Frankland Centre and the range of vocational, recreational, educational and therapeutic programs able to be provided within the current 'footprint' will be inadequate. A large amount of work has already been undertaken in developing plans for a redevelopment of WA Forensic Mental Health Services- Business Case for Improved Mental Health Services for Offenders February 2006. We understand that more recently this

business case has been modified to provide a more realistic proposal. This document should be further reviewed and modified to focus on what we would consider to be the key areas of: future bed expansion (including purpose designed acute, sub acute, rehabilitation and recovery units); community forensic mental health service expansion; legislative reform and governance.

5. No change will be effective or sustainable unless there is strong and skilled leadership. The leadership required is both clinical and operational. The focus for the service has been on the recruitment of a Clinical Director. We would encourage these efforts to continue but there should be equal emphasis on ensuring that there is appropriate operational leadership. The current organisational structure does not provide for this and we have suggested this be reviewed.
6. The governance structure of any organisation must promote cohesion and efficient and effective service provision. Currently SFMHS are encumbered with a lack of autonomy, a management structure that is ineffective, instability and uncertainty of leadership and a lack of cohesion between the inpatient and community programs. We have outlined a range of short and longer term actions that could be taken to assist in providing a governance structure that will build on the positive attributes of SFMHS.
7. The workforce is one of SFMHS's strengths. They have a dedicated and well qualified staff. Multidisciplinary team functioning however is impeded by the dominance, in numbers and culture, of the medical and nursing staff. An increase in the numbers of allied health staff will not only promote more effective team functioning but will also provide opportunities for patient programs that support rehabilitation and recovery.
8. Risk assessment broadly speaking is appropriate. Utilisation of a wider range of risk assessment tools within the inpatient service will support longer term risk

management. Adopting the CFMHS risk assessment and management practices will begin to create more cohesion between this and the inpatient program.

9. To some extent legislative reform is outside of the control of SFMHS, however North Metro Mental Health Service should have the capacity to influence the finalization of a review of the Crimes Act.
10. SFMHS need to clarify their target patient population. Currently they appear to have accepted their inpatient role as predominantly an assessment unit for the Magistrates Court. This has resulted in SFMHS losing focus on mentally ill prisoners and Mentally Impaired Defendants. These are patients who we believe should be a priority for a forensic mental health service.
11. Serious mental illness, and in particular the schizophrenias contribute disproportionately to violent crime and homicide (8-12% of homicides are committed by 0.7% of population with a schizophrenic syndrome). Those with serious mental illness who go through the prison system have an even higher rate of reoffending than non disordered ex-prisoners. Managing effectively the mentally abnormal offender, particularly those with psychotic disorders, can make a major contribution to public safety.
12. There are high rates of mental disorders and substance abuse among prisoners. Psychotic illness is present in between 5 and 8%. The identification and management at least of this seriously mentally ill group of prisoners should be a high priority. Currently it has a low, or even absent, priority. This requires urgent reform. We would suggest a comprehensive mental health care system be developed for the WA prisons based around an Assessment and Treatment Unit, but also including appropriate reception screening, a responsive assessment service for all prisons and programs of management both in mainstream and the Assessment and Treatment Unit and finally a process to ensure ongoing treatment on release. This service ideally should be administered and funded by the health department.

Irrespective of the department responsible it must have close and effective liaison with the Frankland Centre and the Community Forensic Mental Health Service ideally with staff from these services providing the bulk of the prison based services for psychotic prisoners.

13. The WA forensic mental health service lacks a sense of identity and common purpose. This reflects in part the lack of a coherent and cohesive management structure. The long period with an 'acting' medical director, and various other non substantive appointments in key roles has not helped. The paucity of professionals with specific forensic training (as opposed to on the job experience) compounds the problem. The first solution is creation of a strong unified management structure. The second is to develop a 'forensic identity' through specialist training, the development of academic links, and becoming a genuine centre of expertise and training for the rest of the mental health service.
14. The lack of a 'forensic identity' links to a confusion over the roles and priorities for the service. The most serious outcome of the addled priorities is that the Frankland Centre expends more effort servicing the needs of magistrates courts for accommodating minor offenders, who may or may not be mentally ill, than in addressing the core priorities of assessing and managing mentally ill offenders who are either on governors pleasure orders or serving prison sentences. In short the service currently determines its activities by reactions to immediate pressures rather than by any coherent set of priorities.

1. INTRODUCTION

1.1 The Functions of a Forensic Mental Health Service

The functions of a forensic mental health service vary with local conditions but can be located within the broad framework of the assessment and management of the mentally abnormal offender.

The breadth of the category of mentally abnormal is usually limited according to the legal framework, the resources available, and the political contingencies. The scope of 'mentally disordered' is the major limiting factor for the breadth of forensic mental health services. In Australia the general mental health services focus primarily, though not exclusively, on serious low incidence disorders (the schizophrenias, manic disorders, serious depressive illness, and other psychotic conditions). It is proper for forensic mental health service to have a similar focus. The implications for wider, or tighter limits on mental disorder becomes clear when you consider the prevalence of such disorders among prisoners and offenders appearing before the courts. These are broadly as follows (with the community prevalence noted in brackets):-

The schizophrenias	(0.7%)	5 – 8%
Other psychotic disorders	(0.4%)	2 – 3%
Major depression	(8-10%)	20%+
Severe personality disorders	(5-10%)	20%+
Substance Abuse	(10-30%)	80%+

Restricting the ambit of forensic mental health services to that of general mental health services still leaves forensic services facing a burden of morbidity some 10 times higher than in the general population. Unfortunately the nature of serious mental disorders among offenders differs in a number of ways from those in the general population. Offender patients compared to general mental health service patients with, for example, a schizophrenic syndrome have:-

1. Significantly higher rates, and more severe forms, of substance abuse.
2. Far higher rates of coexisting personality vulnerabilities such as callousness, impulsiveness, lack of awareness of consequences, interpersonal exploitiveness, and a mixture of traits which result in poor compliance and antagonism to service providers.
3. They are less likely to have the low motivation and social withdrawal of their non offending peers – destructive features which nevertheless make general management easier.
4. More frequent histories of conduct disorders as children, and delinquency in early adolescence.
5. They are a significantly younger population with an even higher proportion of males.

Thus not only are major mental disorders found more frequently among offenders but when they occur they usually present as more complex and challenging clinical problems. On the positive side many of those with schizophrenic syndromes coming into the criminal justice system are either new to the mental health system or have only had fleeting contact. This is an advantage because if they can be brought into an effective treatment environment the degree of progress and functional recovery can be considerable. They also more often retain drive and desire, though not always directed in positive directions.

The other side of the scope of forensic mental health services is which of the potential functions they are funded to provide. The potential roles for a forensic mental health service include:-

1. Provision of assessments for courts and tribunals.

2. The care, containment and rehabilitation of those found unfit to plead or insane/mentally impaired and placed on an order by the courts.
3. The care and treatment of prisoners with mental disorders.
4. The management in the community of mentally disordered offenders who have either:-
 - a) Been placed on a community corrections order with a recommendation for psychiatric treatment.
 - b) Been discharged from forensic mental health service inpatient units.
 - c) Been released from prison on parole or at the end of their sentence.
5. Providing consultation and support and general mental health services in the assessment and management of patients who raise issues of the risk of criminal behaviours, usually violent. This may include the admission of civilly detained patients unmanageable by general mental health services.
6. Historically forensic mental health services have played a major role in the assessment and management of sex offenders, in particular child molesters. In our own service we also include other problem behaviours namely; stalking, threatening, arson, and querulous complaining.
7. Some forensic mental health services take an active role in the assessment and management of victims of criminal violence or potentially compensable injury. In Victoria we developed a service for victims of stalking but once established this service moved into the private sector. The interest in victims reflects both the important role of forensic psychiatry and psychology in assessment in the civil courts, and the role of victimisation in the histories of so many mentally abnormal offenders.

In developing a forensic mental health service choices have to be made about prioritising these roles and matching resources to the service areas chosen.

1.2 Correctional Services and Forensic Mental Health Services

Inevitably there are overlapping interests and responsibilities between aspects of the correctional services and a forensic mental health service. Correctional services are responsible for mentally disordered prisoners. The extent to which they devolve, or share, that responsibility with a forensic mental health service is essentially a decision for government.

The prisons contain such large numbers of people with major psychiatric problems that transferring all of them to mental health facilities is not practical. One model of care is for those prisoners with for example schizophrenic illnesses to be managed in the prison except when in a clinical state where they would have been admitted to hospital had they been in the community. At that point the prisoner would be transferred out of prison to a forensic psychiatric hospital for acute management. The problem with this model of equivalence between management in prison and management in the community is that the environment of a prison is not the equivalent of that in the community. The stresses on prisoners are different but generally greater and the supports from family and friends are negligible. For example even the most robust of characters tends to acquire 'prison paranoia' marked by distrust of fellow prisoners and fears of authority. The more vulnerable are often overwhelmed by such suspicions and fears. The simple aspects of managing serious mental illness, such as administering the right medication at the right time of day, in practice all too often are disputed by the rigidity of prison regimes. The end result is that the level of disturbance found in those with an ongoing illness such as schizophrenia in the prisons is greater than in the general community. When this group totally breakdown it takes a far longer period of hospitalization to restore them to a level of function compatible with surviving in prison than it would with community patients. The end result is prisoners with serious mental illnesses breakdown more frequently, take longer to recover and need to be brought to a high level of function than would be

required for a discharge into the community. The number of psychiatric beds required to adequately serve the needs of such prisoners is more than most mental health services can provide. The alternative is to treat those acutely psychotic prisoners who will accept treatment voluntarily in prison and only transfer out to hospitals those unable to be managed voluntarily in a prison mental health unit. A warning needs to be inserted. If the mental health needs of psychotic and psychiatrically disabled prisoners are ignored they simply fade from notice. The price of ignoring mentally ill prisoners is born largely by the prisoner and the community when they are released from prison even more disturbed and lawless than when they entered. Providing adequate services in prison will bring the previously unregarded mentally ill prisoners to notice and place an increased burden on prison health services. It may not be regarded by some parts of the correctional service as doing anything but making their task more difficult. The presence of a mental health facility in the prison system and of mental health professionals in all prisons does, however, over time increase awareness and acceptance of the need to treat the mentally ill prisoners. On balance therefore we favour the use of prison mental health units backed up by beds in secure forensic mental health units as the solution.

In our view the optimal division of labour is that forensic mental health services provide the care and rehabilitation for prisoners with serious mental illnesses, such as schizophrenia, through both in reach services and having psychiatric units in prison. Corrections through their psychology services are best placed to manage self damaging behaviours, personality disorders and uncomplicated substance abuse. So called dual diagnosis disorders or morbidity which combine psychosis and serious substance abuse (almost always accompanied by significant personality disorder) are definitely the business of the mental health services. In an ideal world correctional and mental health staff should be able to serve their target populations in a cooperative and integrated system. In practice there are often clashes between potentially antagonistic cultures, and over the issues of control of resources. In our experience clear demarcation of roles and the unambiguous linkage of responsibility to control best serve the interests of prisoner patients and the mental health of service managers. Ultimately the health department should, we believe, be responsible for the health needs of prisoners just like any other

citizens. They need, however, to deliver services in a manner which recognises Corrections' requirements for containment, order, and the safety and control of those in their custody.

The psychotic prisoner who is refusing to cooperate with treatment presents a particular challenge. This group are often a risk to themselves and others because of their behaviour, and always at risk of further deterioration in mental and physical function. This group of psychotic prisoners need transfer to a mental health facility outside of the prison for acute management and stabilisation. In practice in Australia (though not in some other jurisdictions) this implies transfer to a secure forensic psychiatric hospital. In Australia the practice is to return such patients to prison once stable enough to manage within the prison. In some jurisdictions (e.g. Scotland) they usually remain in mental health facilities for the remainder of their sentence. The speed and effectiveness with which such mentally ill prisoners can be returned to prison is greatly enhanced by the presence of a mental health unit within the prison through which they can transition back into the mainstream prison population.

1.3 Why Spend Money on Specialist Forensic Mental Health Services?

The strongest argument is, in our view, that of the improved community protection which emerges from the effective care and rehabilitation of mentally disordered individuals with increased propensities to violent and other criminal behaviours. Secondly the reputation of general mental health services and the survival of community based systems of care for the seriously mentally ill depends on continuing public confidence in such services to protect them from harm. Nothing damages services and augments stigma more than high profile crimes of violence perpetrated by psychotic patients. There is even less sympathy for services when mentally disordered offenders reoffend due to perceived service failures. Finally there is the need to ensure that all citizens receive an acceptable level of mental health care given current community standards.

In our view the primary mission of a forensic mental health service is to reduce reoffending among mentally disordered offenders and, where possible, to contribute to reducing the chances of offending even occurring among high risk patients.

Somewhere between 8 and 12% of all homicides are perpetrated by those with a schizophrenic disorder although they make up only some 0.7% of the population. The majority of those who kill were known previously to their mental health service. With the benefit of hindsight most were obviously at high risk of some form of interpersonal violence, though nobody could have predicted the seriousness of the violence in advance. In addition at least 6% of all other serious crimes of violence are perpetrated by those with a schizophrenic disorder. Offenders with schizophrenic disorders have significantly higher rates of criminal recidivism even than other offenders, and they go on offending until later in life. Even if the forensic mental health services are limited to their scope to the management of schizophrenic and other psychotic disorders in the prison population, then they can make a significant impact on future offending, reoffending, and community safety.

2. FORENSIC MENTAL HEALTH SERVICES IN THE WESTERN AUSTRALIAN CONTEXT

Western Australia faces very particular problems in responding to the needs of mentally disordered offenders. Western Australia has a similar prison muster to Victoria but on the base of a lower population. It also has a greater number and far wider geographical spread of correctional facilities and courts. In the region of a third of all prisoners are from the indigenous population, and many of these grew up in rural and remote areas. The defence of mental impairment/insanity appears to be raised less frequently in WA than in the Eastern States and certainly succeeds less frequently. The diminished responsibility defence is not available. This tends to increase the number of serious offenders (particularly homicide) with serious mental illness in the prison system. To further complicate this situation those that are found not guilty because of being mentally impaired currently are far more likely to be found in the prison system than in the forensic mental health service. The exact whereabouts of most of these mental impairment **acquittees** was not known either by the forensic mental health clinicians or the director of the correctional health service. Certainly they were not in any designated mental health unit or program. The WA forensic mental health service is set up as a statewide service but administratively it sits with North Metro. The service has its own budget which has remained effectively unchanged for the last seven years.

Western Australia was a pioneer state in the development of forensic mental health services in Australia. The Frankland Centre predates every other modern purpose built forensic facility in Australia, with only the arguable exception of South Australia. A contemporary forensic mental health service existed in WA before those developed in Victoria, NSW, Queensland and Tasmania. In recent years however the state's forensic mental health service has stagnated and even in some areas receded in the scope of provided services. In part the service is paying the price of being an early leader. In part,

its effectiveness has shielded government from some of the more obvious scandals which have attracted funds to services interstate. In part it may have lost its way.

The existing forensic mental health service has become increasingly marginalised. Currently the service is playing little, if any role in the assessment and management of seriously mentally ill prisoners. They do not play the lead role even in what many would regard as the prime responsibility of a forensic mental health service, the care, containment, and rehabilitation of those acquitted, or found unfit to plead, on the grounds of being mentally impaired. We did not meet with the Mentally Impaired Offenders Review Board so are unaware of their stance on this situation. The Frankland Centre does admit severely psychotic prisoners for treatment but the admissions are often curtailed by bed pressure and their ability to follow up and manage these prisoner/patients once they return to prison is severely limited. As a result readmissions are commonplace. The forensic mental health service plays a marginal role at best in the prisons in reception screening, case identification, risk assessment or management of seriously mentally ill offenders or the care of those chronically or acutely psychotic.

The forensic mental health service in WA is a major player in providing reports to the courts and tribunals. The highest volume of demand is for reports to magistrates courts, which is mirrored in all other Australia forensic mental health services. What is unique is the use by magistrates of 7 day assessment orders. The use of these orders currently results in the admission of a wide range of potentially mentally disordered offenders directly into the Frankland Centre.

There is an active clinically integrated community forensic mental health service. The service is, however, also marginalised. Its role in the management of mentally ill prisoners released from prison is not structured or consistent. Its services to the wider mental health service appears somewhat adhoc. It does not contribute to the management of serious sex offenders particularly child molesters which may be depriving the State of the single most effective intervention to this group, the use of anti-libidinal medications.

The WA forensic mental health service is blessed with excellent staff and a budgeting and facility base from which it can grow and develop. To attain its former status as a contemporary centre for excellence will require major organizational changes and increased funding over time, but in our view that journey back to excellence can begin with the existing constraints set by the current budgeting and facility realities.

2.1 WA State Forensic Mental Health Service Context

Western Australia is the countries largest State geographically and Perth is the most distant State capital city. Western Australia's total population is 2.1 million, with 80% of the population living in Perth and the surrounding area. The location of Perth can lead to a perception that WA is quite isolated from the rest of the Country. The vast distances and remote locations of several communities, particularly indigenous communities, provide specific challenges to the provision of services. Recently a decision was made to build a mental health unit in Broome as mentally ill patients from this area have been required to be flown by the Royal Flying Doctor Service to Perth to receive inpatient treatment and care.

The WA prison population is just under 4,000. This rate of incarceration is the highest of any Australian state or territory. There are 15 prisons, 2 Juvenile Justice Centres and 4 Work Camps. Each prison has their own health service which is managed by Corrections Health. The main prison locations for prisoners with mental health issues are Hakia Prison and Casuarina Prison. Haikia is the main reception prison for the State and whilst there are no dedicated mental health units within the prison system, Hakia Prison does have a 20 bed Crisis Care Unit for vulnerable and disturbed prisoners. Indigenous prisoners comprised 45% of the total prison population, which is over representative. (Indigenous population comprises less than 5% of the state population). It was also reported to us that a large number of new prison receptions to Hakia Prison are individuals under the influence of illicit substances, particularly 'ice'.

The State Forensic Mental Health Service (SFMHS) comprises the 30 bed Frankland Centre and a Community Forensic Mental Health Service. The Frankland Centre is the States only forensic mental health facility and in 2007 received 356 admissions, with an average length of stay of 21 days. This is a very high number of admissions for a 30 bed specialist forensic service and the average length of stay is closer to a general mental health service than a forensic service (where average length of stay is 3 or 4 times this length).

SFMHS is a Statewide service, however it reports to the North Metropolitan Mental Health Service (NMMHS) which is a program under the North Metropolitan Health Service. NMHS is a large comprehensive health service network comprising a wide range of primary and tertiary health services, for example women's and children's services. Therefore SFMHS is only a very small component of NMHS operations. It is noteworthy that it was only recently that SFMHS was offered membership of the NMMHS Executive.

2.2 Services to Mentally Ill Prisoners

The links in Western Australia between the services provided to mentally ill prisoners by the correctional health services and the forensic mental health service appear to have become increasingly tenuous over recent years. The director of health services for the correctional service, informed us he is in the process of recruiting his own psychiatrist and medical officer to provide such services within his vision of "a co morbidity service not a mental health service".

The increasing divorce between the services for the mentally ill in prisons and the forensic mental health services is illustrated by the changing financial links. The correctional services used to finance both 50% of the costs of the Professor/Director, a position last held by David Greenberg, and the full costs of a consultant psychiatrist, a position last held by Dr Pullela. They also used to pay for services delivered by the forensic mental health services' consultant's to the prisons. These financial links are all

in abeyance. Any plans for extending the role in prison of the forensic mental health service seem to have been abandoned.

The priority, in our view, is to re-establish the working relationships essential for the care of severely mentally ill prisoners, both for these prisoners' sakes and for the sake of the community's future safety. This can only be attained through a restructuring of the current system of care for mentally ill prisoners which ensures both partners, corrections health and forensic mental health services, play their proper roles and discharge their responsibilities to a needy, disturbed, and disadvantaged group of mentally ill people.

We could obtain no coherent account of the service model currently operating for prisoners with serious mental illness. There is a reception process which involves a mental health assessment but we are unclear how cases are identified and how once identified they are assigned to any particular management pathway. We were informed of an "offender mental health pathway" but this appeared to have a broad focus not just on serious mental illness but encompassing substance abuse, personality disorder and post traumatic stress disorders.

There are over 100 receptions a week into Haikia prison and further receptions into regional prisons, notably the East Goldfields facility. There is a Crisis Care Unit but this does not have any input from a psychiatrist and few of the 20 beds are occupied by the mentally ill. Apparently mentally ill prisoners are usually managed from their cells. Some are transferred to the Frankland Centre, though on what basis other than coming to notice somehow by becoming seriously disruptive and refusing medication was not clear to us. There may well be a coherent system for making such decisions and clear protocols in place, but we did not encounter any evidence for this. There are no effective links with the mental health service ensuring the continuing care of mentally ill prisoners on release from prison. The forensic mental health service community program does not play a major, if any, role in this all important aspect of care and risk management.

In our view this is an unsatisfactory situation. Quite apart from losing an opportunity to treat and rehabilitate mentally ill prisoners, and thus reduce their re-offending, there are real questions of breaches of human rights for the Governors Pleasure patients arising from their detention in prison.

2.3 Potential Solutions and Ways Forward

In the short to medium term the forensic mental health service's opportunities for contributing to improving services in the prisons may already be lost. Dr Chapman clearly believes what he regards as their past derelictions has led to him developing plans in which forensic mental health services have no part. As Dr Chapman has the budget and authority to determine the pattern of mental health services within WA's prisons, unless something changes there will be no role for the forensic mental health service other than managing prisoners transferred to the Frankland Centre.

If, however, we proceed on the assumption that bridges may yet be built and a cooperative approach to the care and treatment of mentally ill prisoners may re-emerge then some potential solutions recommend themselves.

There is a wide range of mental health needs among prisoners. Those with severe and psychotic mental illnesses are not the most numerous and arguably not the highest priority. (For example the actively suicidal and self damaging might well be considered the highest priority, a group which only partly overlaps with the seriously mentally ill). A service for mentally ill prisoners should have the following elements:

1. Reception screening to identify cases.
2. An assessment service to provide rapid responses to concerns raised by staff or prisoners about a prisoner's mental health.
3. Clinics at all major prisons providing more advanced assessment and active treatment.

4. A service to follow up, support, and supervise mentally ill prisoners treated within the general prison.
5. An assessment and treatment unit where mentally ill prisoners who are seriously disturbed can be sent for stabilisation and treatment.
6. A link to an external secure hospital facility for prisoners whose mental illness cannot be managed within the prison service.
7. Close links with the services providing management of substance abuse as this complicates the majority of cases of psychosis among offenders.
8. A transition service which establishes contact with local mental health services, or the forensic mental health service, to try to ensure continuity of care on release.

The reception screening can be performed by a mental health nurse. Attempts to use a 2 stage procedure with a custodial officer performing the initial screen are usually time and resource wasting. Over 70% of prisoners usually score high enough on screening instruments which detect serious substance abuse and/or mental health problems to require a more advanced professional screening (lower rates of ascertainment simply indicate a faulty screening process). Those identified as probably requiring ongoing psychiatric treatment should be referred to a psychiatrist and/or clinical psychologist. Typically this is some 20-30% of whom about 10% are commenced on an 'outpatient treatment program'. A variable number (usually less than 2%) are identified as needing immediate inpatient treatment.

There needs to be a mental health nursing service to rapidly screen self referred and staff referred prisoners who could be mentally ill. This, like the reception screening, requires psychiatric/clinical psychology back up for further assessment and treatment. Again occasional prisoners will require rapid transfer to an 'inpatient' program either in a prison

or in a secure hospital. The majority of prisoners identified with serious mental illness will only require ongoing supervision and treatment whilst remaining in mainstream units. This requires regular visits by the mental health nurse and regular, but less frequent, appointments with the treating psychiatrist, or in stable cases, the treating general practitioner.

An assessment and treatment unit within the prison service performs the functions of:-

- a) An initial placement for all acutely psychotic prisoners unmanageable safely in the main prison environment.
- b) A unit to decide whether it is necessary to transfer the prisoner out to a secure hospital unit.
- c) An appropriate treatment environment for cooperative, adequately compliant prisoner/patients.
- d) A step down unit for those returning from the forensic secure hospital where they can finish their stabilisation before returning to mainstream prison.

Currently WA has the basics of a reception screening and a follow up service. It lacks an appropriate assessment and management unit, and has poorly structured services for transition back to the community.

We would propose:-

1. The establishment of a 20 bed 'Assessment and Treatment Unit' (ATU) for mentally ill prisoners. This could well be placed within the Haikia prison possibly where the current CCU is located. These units require clinical and custodial staff. The clinical staff required to provide a 7 day a week, 24 hour service would be:

- 1 Consultant Psychiatrist FTE or 0.5 of a consultant psychiatrist and
- 1 FTE of a registrar or medical officer
- 7 nursing FTE's
- 0.5 clinical psychologist
- 1 social worker
- 1 occupational therapist

The clinical staffing could potentially be derived largely from the reconfiguring of existing clinical services at the Frankland Centre (see Section 7.1). Some additional funding might be required for the psychologist, social worker and OT positions.

This would provide a hub for a re-energised prison mental health service.

2. The development of a properly structured assessment and management service for mentally ill prisoners in all major prison sites. The centre of such services would be the mental health nurses, many of whom are already in post. In place of the adhoc and fluctuating services from private and medical staff the Frankland Centre would be responsible for all such services. This would presuppose they would be willing to give this service absolute priority in the demands on their medical staff.

The transition of prisoners to the community requires the efforts of an experienced mental health nurse and a social worker backed up by a psychiatrist or clinical psychologist for risk assessments where indicated.

The introduction of this integrated service model would provide a quality mental health service. Mentally ill prisoners would be known to the forensic mental health service throughout their period of incarceration and in some cases beyond. The movement from being serviced in mainstream to the ATU to the Frankland Centre and back would be, if not seamless, certainly smoother and more informed. The psychiatric and other staff at the Frankland Centre would acquire knowledge and ownership of the seriously mentally

ill prisoners in the WA prison system. This could not but benefit the mentally ill prisoners, the correctional services, and ultimately the community.

3. THE SERVICE IDENTITY

Forensic mental health services have only two stable positions in a mental health service hierarchy; they are either at the bottom, or at the top. This is quite simply because of the nature of their patient group and the realities of managing them. Mentally abnormal offenders are doubly stigmatised as bad and mad. The history of secure hospitals has been one of scandal and exclusion. The reality of care and containment in a forensic mental health service is of clinical challenge, of risks both personal and political, of having your decisions publicly scrutinised in courts and tribunals, and of being hemmed in by legal and administrative imperatives. To make this an attractive area for mental health professionals to work the service must be regarded as a centre of excellence. Once it loses that status it will lose key staff with the abilities to manage the challenges of forensic mental health.

When forensic mental health services begin to fail they do so publicly, and at the price of patient and staff safety. They rapidly lose first their good staff, then eventually any staff member capable of finding employment elsewhere. All too soon they are left with the dregs leavened by the occasional dedicated missionary. This process affects nursing staff first, and it is the nursing staff who carry and create the culture of the service.

When forensic mental health services begin to succeed they do so invisibly. Scandals cease, political anxieties lessen, administrators attention turn elsewhere, the judges and magistrates relax, and the media lose all interest. But to succeed and to continue to succeed they need a profile among mental health professionals in general and nurses in particular which will attract the very best staff. This requires they are seen as a, if not the, premier mental health service. They need better training opportunities, better chances for further qualifications, a more professional and collegial culture, and above all a profile which stimulates envy and emulation from other services. This requires a better training budget, being prominent in providing education and training to other services, and an academic profile not just in psychiatry but in psychology, social work, occupational therapy, and above all nursing.

The WA forensic mental health service is a service going through a crisis of identity. It is unsure of its own position and status, and equally dubious about how it is viewed by many of its stakeholders. In part it reflects the combination of stagnation and erosion in its service roles. Above all, in our view, it reflects the lack of a clear management structure able to infuse the service's senior figures with a sense of corporate identity and the confidence to aspire to excellence. Frankly the service is on the brink of beginning to descend down the mental health hierarchy. Once commenced such descents are difficult to stop.

The service has a range of excellent mental health professionals. What it lacks are professionals who have been trained in forensic mental health, particularly at centres of excellence in the field. A well trained general mental health professional can acquire the specialist experience by working in a forensic service. This however requires a core of properly trained staff to guide the novice and a structured program of continuing education on forensic issues. Attending external training programs also assists. The lack of a cadre of properly trained forensic mental health professionals is contributing to the lack of a 'forensic' identity.

Currently there is a culture of fragmentation and mutual antagonism, in which those who should be leading are seeking solace, not among other senior figures but among those with whom they work. There is a suggestion of doctors, nurses, and sometimes whole clinical teams, forming self defensive groups which experience themselves as alienated, if not actively persecuted. Problems and anxieties are not contained and managed within the senior management teams but diffused through the whole organisation to feed uncertainty and division. As a corollary decisions made by the management team become matters for debate and usually rejection by the wider staff, rather than being regarded as directions.

A number of staff commented on the absence of any vision for the service, either long or short term. There was a sense of “nobody being at the wheel” to which we would add, nor anybody on the brake. The usual solution advanced was the appointment of a medical director. Listening repeatedly to staff expressing their desire for a “strong” medical leadership that could “inspire confidence” and “respect”, combined naturally with “much greater resources” conjured up a vision of a psychiatric messiah carrying a pot of gold. Though we understand the frustrations of a service left for over six years without the permanent appointment of a medical director, we do not share their confidence that this is THE problem and THE solution. A high profile medical director is part of any long term solution but only a part. Increased resources are similarly part of any long term strategy for development, but are not essential for the initial stages of forging a coherent service out of what one staff member described as a “rudderless organisation” that has “come to a grinding halt and is in danger of sinking”. To be frank no responsible administrator should commit greater resources to a service so visibly failing to make full use of those with which they have already been entrusted.

The core of the problem, as we see it, is the lack of an effective management team with the authority, not just the responsibility, to direct the service. The management structure is discussed elsewhere but it is worth reiterating our surprise at a structure where the senior manager has nobody except their P.A directly reporting or responsible to them. It has precious little administrative or managerial autonomy. It is often used as a reservoir of beds to back up the needs of the general mental health service. It seems to be regarded with little respect as a specialist service constituting what is a scarce and valuable resource. It is apparently regarded with no respect, or even interest, by correctional health. Even the magistrates feel free to treat it as a stop gap measure for the sad, homeless and disordered in need of admission for whom general mental health services have no place. This parlous state may have been contributed to by the lack of boundaries and overly accommodating response of the forensic mental health service in past. WA’s forensic mental health service has to assert its clinical and administrative identity. Equally its stakeholders have to stop regarding it as their creature, or of no account.

The chances of attracting a medical director with any knowledge of service organisation and function is remote until the fundamental problems are addressed. An academic appointment for the medical director is essential. Hopefully the service will attract a figure who can claim associate or full professorial status on merit. There needs to be visible academic links, most particularly for the nursing work force, but also for allied health professionals. The department of psychiatry at the University of WA has conducted research in the field of forensic mental health but it did not involve the states forensic mental health services, and nobody in the service has access to the results of this research. The data from this research should be informing service planning in the state.

3.1 Potential solutions to an identify crisis

1. Create a strong unified management structure. This should be empowered to determine the services' external relationships as well as the internal service structure and priorities. The management structure should be headed by a medical director working alongside, and in concert with, the service's senior manager.
2. The academic links so essential to the service becoming a centre of excellence need to be reforged. Efforts need to be made not only to encourage greater involvement by the staff in further training and improving their qualifications but also in their becoming a training resource for the rest of the mental health service. This is one area where the immediate expenditure of greater resources could in our view be justified. The best way to maintain a high and positive profile locally is to become the recognised provider of training for the state in risk assessment and management. They should also be providing training and advice on the management of threats and violence, and on those conditions and problems in which forensic services have specialist knowledge [e.g. stalking, arson, preparing reports and giving evidence, managing complaints and workforce safety].
3. Once the forensic mental health service is functioning it should actively solicit visits from magistrates, judges, other mental health service chiefs, politicians and senior

correctional department officials. It is important that stakeholders understand what the service can offer, what it cannot now provide, and what it could provide should new resources be made available to develop.

4. The lack of an adequate number of nurses, psychologists and above all psychiatrists who have had formal training in forensic mental health is contributing to the lack of identity in the service. There are too few professionals with the knowledge and experience to train and mentor their colleagues in the basics of forensic mental health. It is difficult to acquire an identity as a specialist service, if those in the service are somewhat uncertain about the core aspects of the speciality.

4. THE ROLE OF THE SERVICE

The roles that a forensic mental health service can perform were outlined in the introduction. The priority given to any particular role can vary with the local context but certain functions fall inevitably to a forensic service. In situations of inadequate, or inappropriate resourcing, choices have to be made with competing roles in the knowledge that failure to deliver on either one, or the other, will result in a lack of service, or totally inappropriate servicing, for one group.

The priorities for a forensic mental health service are usually regarded as –

1. The provision of assessments and reports to courts and tribunals. The extent of these obligations is usually defined either in statute or by agreement with bodies such as the Department of Public Prosecutions.
2. Containment, treatment and rehabilitation and community management of offenders found unfit to plead or not guilty by virtue of mental impairment [old insanity] who are detained ‘at the governor’s pleasure’.
3. The containment, acute treatment and stabilisation of seriously mentally ill prisoners unmanageable in the correctional services. Ideally the service should also be providing follow up of the more difficult mentally abnormal offenders following release from prison.
4. The role of a forensic mental health service in providing care to the seriously mentally ill in prison is contested but in our view should be provided by a forensic mental health service [See section on prison services].
5. The admission for acute care and stabilisation of patients on civil orders from the general mental health services who are unmanageable because of the risk of violence they present to the community, their fellow patients, or staff.

6. The provision of community services to mentally abnormal offenders, high risk psychiatric patients, and severe problem behaviour patients [e.g. child molesters].

The WA forensic mental health service has effectively opted out of providing inpatient services for the governor's pleasure patients. The service seemed unsure where most of these people were currently placed or even their number. The Director of the corrections health service was equally in the dark about numbers and the location of these people currently in the prison service, and even if they were under treatment. In all fairness it should not be the role of a correctional health service to provide care and treatment for those found not guilty because of being mentally impaired. In short there has been a disintegration of services to this group. This is a concerning situation legally, morally and medically.

We were led to understand that the absence of governor's pleasure patients from the Frankland Centre was the consequence of the lack of appropriate facilities for the long term care and rehabilitation. We were informed at least two governor's pleasure patients had requested they be returned to prison where they would have access to more activities and space (and could smoke!).

The current configuration of the Frankland Centre and the choices made over staff mix do render the unit a poor place for long term care and rehabilitation. This could be rectified, in our view, without great difficulty [See section 7.2 of report]. In part the lack of staff able to provide a rehabilitation stream for the Frankland Centre is a product of the choices of who to employ, and who not to employ, with the existing budget.

The withdrawal of services from governor's pleasure patients does not appear to have been a positive management decision based on an examination of competing priorities for the service. On the contrary it seems to have happened without consideration of the implications, or even much active involvement in setting up alternative services in the prison system. Presumably the Mentally Impaired Review Board who carry the legal

responsibility for the care and containment of these patients was party to the decision, but even here we are not entirely sure.

One factor emphasised by several members of the medical staff as responsible for the disappearance from the service for governor's pleasure patients was bed pressure created by the magistrates placing defendants on seven day orders into the Frankland Centre. This suggests a somewhat passive acquiescence to immediate pressures rather than a clear commitment to one of the service's primary roles. In effect minor offenders who may or may not have a serious mental illness have been placed by magistrates for assessment in the scarce and expensive forensic beds. These defendants could under the legislation have been placed in other psychiatric or correctional facilities. As a result seven day assessment order patients have displaced serious offenders placed by the superior courts, following a finding of not guilty by virtue of impairment, in the care of the forensic mental health services for treatment and rehabilitation.

To be fair this probably reflects less pusillanimity on the part of forensic management and medical staff and more the lack of effective autonomy. This situation reflects once more the Frankland Unit's weakness in asserting their forensic identity and specialist roles against the pressures from Northern Metro administration who are understandably concerned with the needs of the whole mental health service. The community arm of the forensic mental health service does play a role in managing 'governor's pleasure' patients in the community. We were unsure if all such patients were currently cared for in this service and their total number. This aspect of the service appears to be functioning well once a patient is accepted into the community program. The failures are earlier in the process and concern an appropriate place of containment, care, and rehabilitation, as well as the structured return to the community so essential if reoffending is to be minimised.

The other major role of a forensic mental health service, at least in the Australian context, has been the provision of services to seriously mentally ill prisoners. In all Australian jurisdictions some tensions exist between correctional and health departments over the

distribution of responsibility, and more importantly financial liability, for such services. In NSW a unified service is provided by a service located within the health department. In Victoria there exists a fragmented service model with the health department funding via Forensicare inpatient and some community services for mentally abnormal offender, whilst corrections contracts out some, but not all, services within prisons to Forensicare.

The conflicts between health and corrections, which so far have only been successfully resolved in NSW, reflect real difficulties with the model of funding currently operating for prisoner health services. As soon as a person enters prison they lose all rights to funding under Medicare. This absurd situation is justified by federal funding to state correctional services supposedly including an unspecified aliquot to provide health services for prisoners [or some may be in federal funding to health depending on who you ask]. Given the resources are in one department and the facilities to provide the services in another department only a 'whole of government' approach can solve the problem. Either that or restoring Medicare funding to prisoners and providing the funding to health departments to service the 'hospital based' or specialist services to prisoners as for any other member of the community. In the meantime WA like all other states and territories has to develop services within the existing flawed funding model.

Currently the role of WA's forensic mental health service in caring for seriously mentally ill prisoners appears to have become restricted to the provision of a varying number of inpatient beds at the Frankland Unit. This is the rump of a service which given the current disconnect with services within prisons is difficult to view as anything but ad hoc and inadequate. We were unsure what the role if any the community arm of the service played in managing released prisoners with serious mental illness.

The Frankland Centre admits far more patients on civil orders than would be expected for a specialist forensic service. Unfortunately this does not reflect the results of an active consultation and liaison service to the state's general mental health service which is resulting in the admission of carefully selected high risk patients for stabilisation. The situation reflects largely the use of the Frankland Centre as a short term lodgment for

patients under civil orders urgently requiring a bed in the *general* mental health service. To be fair to the general services in a time of constant bed pressures any empty bed is a temptation impossible to pass up. This raises the question why the Frankland Centre is managing its precious beds in a manner which results in less than 99% occupancy. The answer apparently is the need, as they perceive it, to have empty beds available should a magistrate make a seven day assessment order in favour of the Frankland Centre.

The reality appears to be that the first priority for bed allocation on the Frankland Centre is for the magistrates' seven day assessment orders. This is currently given such a high priority that beds are left empty in expectation, prisoners are returned half treated to prison, and governors pleasure patients are left potentially untreated and without rehabilitation somewhere, who knows where, in the corrections system. As noted previously those on seven day orders are almost exclusively minor offenders, often current or past patients of the general mental health services, who magistrates place on orders as much to try and find accommodation and/or psychiatric treatment as for any medico-legal purpose.

Not surprising the Chief Magistrate, Mr. Heath expressed considerable satisfaction with the services provided by the forensic mental health service. He acknowledged that the seven day orders were being used to find psychiatric beds for disordered offenders and to obtain quicker reports than are currently provided by remand to prison. Mr. Heath indicated even if the prison service was able to match the speed of the Frankland Centre in providing reports, magistrates would not use that option for those they considered mentally ill. From the magistrates' point of view the current system is a win-win situation in which they are able to discharge their responsibilities to the mentally disordered offenders who appear before them. The price of this Rolls Royce service in one area is multiple service failures in other areas.

The court liaison service provided by the community arm of the forensic mental health service is greatly appreciated by the magistrates. This aspect of the service is functioning at a high level. Our only caveat would be that it does not seem able to dissuade

magistrates from using seven day orders, in fact we gained the impression that some at least in the community might actually be encouraging their use. Hopefully we were mistaken.

In our opinion the needs of the magistrates and the power of their seven day assessment orders (which often turn into 14, 21,28, and so on, day orders) should not be allowed to continue to hijack WA's forensic mental health service inpatient services. There are a number of potential solutions –

1. The least responsible solution would be to keep the beds at the Frankland Centre full with those patients who should have priority and simply refer those on seven day assessment orders back to the North Metro administration to find a bed. This would almost certainly provoke magistrates into making the kind of public fuss which upsets politicians. It would create a crisis for general services who would have to place these people wherever they could. It would put a wide range of consultants in a position of having to carry out assessments with which they are not familiar, prepare reports they are not experienced in preparing, and occasionally appearing in court which many dread.
2. An alternative would be to limit admissions to the Frankland Centre to three beds for assessment and when they are full no more orders could be accepted [the courts currently average about three orders a week]. In reality this would produce the same situation as the last solution because of the wide variation in the number of orders made and the frequency with which they are extended.
3. A change in clinical practice could in theory solve the problem. The seven day assessment orders are intended to provide the magistrate with a psychiatric assessment which clarifies the defendants fitness to plead (if unfit they are simply discharged), or if a hospital order is appropriate. Setting up a rota of forensic medical staff to go to court to assess the defendant and provide the report on such issues there and then to the court (usually verbally) should in theory remove the necessity for the

order. As the Chief Magistrate freely admitted, however, most such orders are used primarily to find accommodation and/or psychiatric care for those in need. That being the case the motivation of the magistrates to co-operate with a rapid, on the spot, assessment process, would be low. The orders are performing a social work function primarily, and probably a much needed one. That placing a 'forensic label' on a patient may compromise their access to general mental health services, now and into the future, is not appreciated by the magistrates. Every time they send a patient to the Frankland Centre on an order they potentially create another psychiatric pariah as far as some general services seem to be concerned.

4. A realistic solution would be to set up 7-10 beds on the Graylands campus, similar to the 8-10 beds already set aside for long term low security forensic patients. The medical input, including report writing and court appearances would be provided by the existing forensic services medical and psychological staff. Potentially there are nursing staff who could be redeployed to such a unit from the Frankland Centre. Long term we would prefer to see the nursing staff positions redeployed to the prison service, but in the short to medium term such a unit could be established with only a moderate cost implication in terms of staffing. Only the very occasional person on a seven day magistrates order requires the security of the Frankland Centre. The vast majority would be appropriately managed in a general bed. For this service to work general mental health services would have to be obliged to take patients ultimately placed on a hospital orders and not leave them languishing in the Graylands assessment unit. Obviously without the co-operation of general services to take back the patients they have previously cared for, and to accepting these new patients from their area, the Grayland unit would rapidly clog up.
5. The most cost effective solution for the majority of those currently being placed on these seven day assessment order would be a psychiatric bail hostel. The Chief Magistrate noted few such defendants need a secure psychiatric bed, or even a general psychiatric bed but "just a place to reside". The psychiatrist and psychologists from the forensic mental health service could visit to assess and provide reports. We

suspect however the creation of such a hostel would be a far longer term project than funding ten beds in Graylands.

4.1 Summary

The current roles of the service are largely being determined by reactions to immediate pressures rather than by any coherent set of priorities. This reflects –

1. The compromised autonomy of the service which leaves administrators in North Metro to, on occasion, subordinate the forensic service to the wider needs of their general mental health service.
2. The lack of an effective management structure capable of articulating and maintaining priorities and a coherent service plan.
3. The lack of clinical leadership and a figure of sufficient status to defend the service's core functions against the demands to fill gaps in the service provisions for other types of patients.
4. The inefficient organisation of staff resources and bed usage.
5. The lack of cohesion between the inpatient and community arms of the service on aims and objectives.

In the final analysis the WA forensic mental health service must function as best serves the needs of WA. It is conceivable that the government's priority for the service really is the provision of an assessment service to the lower courts and hostel accommodation to the disturbed and homeless thrown up on the shores of the states magistrates courts. We doubt however that this will be seen as the appropriate use of the states' most expensive mental health resource. The service does however need to be clarifying with its stakeholders what they hope for and can expect from the service with its existing

resources. Any argument for greater resources is aided by being able to point to the optimal usage of existing resources. Your stakeholders should be your advocates in waiting.

5. RISK ASSESSMENT

In the Western Australian forensic mental health service there is a divorce between community and the Frankland Centre on the approaches to risk assessment. The community employs the HCR 20 which forms the template for a multidisciplinary approach to risk assessment and contemporary approach to risk assessment and management. The Frankland Centre has a less clearly articulated approach and we suspect is more medically focused than multidisciplinary. The use of the DASA by the inpatient teams is fine for day to day ward management but does not provide a basis for longer term risk management nor can it usefully inform discharge decisions. In our view the service should embrace a broadly similar approach to risk assessment and management in all areas. Inpatient, prison based, and community services have specific as well as shared needs in the area of risk assessment and management. Local variation is therefore to be hoped for, but the overall approaches should still be compatible. Given the model of a multidisciplinary approach based on the HCR 20 already exists we would suggest this be extended into the inpatient services.

The purpose of risk assessment is to improve risk management, it is not about assigning levels of dangerousness to individual patients. In the inpatient setting the focus is on likely behaviour over the next day or so and assigning adequate staff inputs and support to vulnerable patients moving towards changing behaviour. In the context of reporting to courts the needs are for medium and long term strategies likely to reduce the recurrence of offending. In discharge decisions the current level of risk takes on a higher profile but again strategies for reducing risk, if they remain on the unit, and continuing to manage risk, if they leave, are central.

Risk assessment should be a multidisciplinary exercise. Nursing staff who usually spend the greatest amount of time with the patient will often have the largest store of relevant information. Reading patient file notes we were impressed with the quality of entries by nursing staff and of their obvious awareness of risk issues. Psychologists usually have the greatest expertise in the use of standardised risk assessment tools. Social workers can

provide the context in which any progress back to the community should be considered. Last, but not least, occupational therapist's can provide the best information about current functioning. Whichever approach to risk assessment prevails, ensuring the maximum use of all professionals' knowledge and skills is essential.

Given risk assessment is primarily a route to improved risk management it is important that treatment plans reflect the risk assessment findings and are adjusted as the risk profile shifts. Ensuring a constant link between risk assessment and current management strategies is essential. We were not convinced that the pattern of care in the Frankland Centre adequately reflected this imperative.

The service has recently experienced the tragedy of a member of the staff being attacked and seriously injured by a patient. Inevitably this has been followed by a heightened sensitivity to the possibility of being attacked among the whole staff. Hopefully the understandable, but exaggerated, aspects of this enhanced apprehension of personal risk will gradually abate. It appeared to us that there are currently levels of fear among some staff which are unjustified, and expectations for the guarantee of future safety which are unrealisable. In the end if we are afraid of our patients we cannot function as their therapist or carer. Many of us, from time to time, develop fears of a specific patient's potential for harming us. This is managed by transferring the patient's care to a colleague. When however the fear becomes generalised to a whole range of patients then one's ability to continue effectively and safely in forensic mental health is at an end. Nothing is so provoking of attack as fear.

Risk assessment and management is about reducing risk. At best it minimises risk but never removes risk. Realistic appreciation of the level of risk and the ability to manage your own apprehension for the patient, for their potential victims, and lastly for yourself, is the essence of our professionalism.

6. CLINICAL AND CORPORATE GOVERNANCE

The State Forensic Mental Health Service (SFMHS) sits within the mental health program of the North Metro Health Service. Whilst having a fairly independent organisational structure SFMHS reports to NMMHS and is essentially governed and managed by this service.

The current organisational structure appears 'top heavy' for the size of the service with three Director level positions; 1 for Inpatient Services; 1 for Community Services and 1 for the entire SFMHS. We were advised that the current structure was developed when SFMHS was first established. At that time it was envisaged that SFMHS would expand and grow and so the structure was developed for future rather than current needs. Unfortunately, ten years on, the service has not grown in line with those aspirations which has led to the structure now appearing top heavy and inefficient.

When addressing matters of governance we have considered three distinct streams of leadership; clinical, operational and professional. We believe that there are issues at SFMHS with all three streams.

Clinical leadership will always be the responsibility of the Clinical Director (and delegate/s). This role has overlap with aspects of operational and professional leadership however whilst we would advocate for cohesion and integration of these roles and functions, they should never be amalgamated. It is the responsibility of the Clinical Director to ensure that there are care systems and pathways that provide contemporary mental health service provision and optimize patient outcomes. This does not only encompass direct service provision but also includes the protocols that establish clear expectations regarding the standard of care that is to be provided, of which specialist assessment and management planning are important components. Clinical decision making should never be compromised through blurring of leadership responsibilities. It is important that psychiatrists have clinical autonomy but they must also ensure that they are aware of operational realities when making patient care and treatment decisions.

Whilst the Clinical Director sets the standards and broad principles for patient management, it is the responsibility of the service manager to operationalise and integrate these in practice. Operational leadership is potentially one of the most important roles within the leadership team. In the absence of a skilled and experienced manager who shares the vision and values of the Clinical Director real and sustained change cannot occur. The partnership between clinical and operational leadership ensures consistency and efficiency. Responsibilities that are within the role of the operational leader include; service development and quality improvement, strategic planning, policies and procedures, compliance monitoring and auditing and resource utilisation. However, to achieve this (and as we have outlined elsewhere) the manager who is the operational leader needs to have the authority to actually undertake these functions. There is no point in having a manager who has responsibility but no authority.

Professional leadership supports, but is offline from, clinical and operational leadership. This is the framework within which discipline specific standards and processes are managed. Professional leaders are the discipline seniors who are in the best position to understand and establish the expectations regarding staff within their professional discipline. Areas of responsibility include; performance monitoring, research and training, professional development, clinical supervision.

One of the most striking things when we first commenced this review was the level of leadership instability and uncertainty. We do not believe that we have ever encountered a service before that has such a high number of staff that are 'acting' in their positions. Of the members of the Governance Executive there is only one SFMHS staff member who is in a substantive role. We were further advised that the Clinical Director position had not had a substantive occupant for 6 years. This is astonishing, particularly given that there was a very capable and experienced person acting in this position for virtually the entire 6 year period. There is nothing more paralysing and destabilising for an organisation than to have staff in key leadership positions not having the full confidence and authority to effect change and develop the service. Regardless of how long someone is acting in a position (and no matter how much they are told that they should behave as if the position

they are occupying is their substantive appointment), they will never fully realise their authority and others will also not accept their level of authority.

It is also as if SFMHS have become trapped in a 'time warp' and everything seemed to stop (developmentally) six years ago. The appointment and the subsequent departure of Professor Greenburg appears to have been pivotal in the developments and then the stagnation of SFMHS. Professor Greenburg had the vision for SFMHS and when he left no-one was charged with the responsibility and thereby the authority for this vision to be realized.

We believe that as the service is currently configured there should only be one **Director** and that is the Clinical Director for SFMHS. Earlier in this report there has been commentary regarding the importance of appointing to this position and we will not repeat this within this section. However we also believe that one important and significant element that is missing in the way forward is the establishment of a management position that is empowered with the rights and responsibilities of an operational management position. It was with some concern when we first viewed the organisational structure of SFMHS that we identified that the service manager had only one position reporting to it, and this position was their administrative assistant. It is not appropriate or desirable for a manager to have no authority, and the main way in which a position receives authority is through having line management responsibility. We can understand the desire to have the **Director** positions having ultimate responsibility for clinical leadership, but this is only one element of leadership as we have already outlined. It appears to be a WA phenomenon that 'management positions' (operational leadership) and clinical leadership positions are integrated. From our experience this is very unusual. To have a structure that requires medical qualifications for essentially a management role is not cost effective and is also not contemporary. This harks back to the 'old days' of the Clinical Superintendent. Generally medical staff do not want to have responsibility for managing issues such as budgetary control, staff performance management, resource utilisation, key performance indicator compliance etc, and nor should they. Their expertise and time is much more effectively focused upon the provision of high quality clinical service provision to their patients. There are many more managers than there are

psychiatrists, so why would any service utilise a very expensive and scarce resource in dealing with operational issues that are essentially outside of their area of expertise. Please refer to Appendix III to view the proposed organization chart for SFMHS.

In terms of professional leadership, the range of multi-disciplinary professionals is so limited that it is difficult to identify professional structures. For example there is only one Occupational Therapist across the service and no-one would expect them to provide professional supervision and leadership to themselves. With all due respect to the medical leadership group they are not in a position to provide advice and leadership to someone outside of their discipline. It would in fact be offensive to suggest that a psychiatrist has expertise in the role and function of a mental health Occupational Therapist. In other parts of this report (see Section 7.1) we have commented on the expansion of allied health positions across the service, however in the absence of this (or potentially with this expansion), SFMHS should identify the discipline specific structures that exist within NMMHS and link in with these professional structures for professional leadership. However for the purposes of suggesting a workable structure for SFMHS within the proposed organization chart we have placed allied health staff under the Director of Clinical Services for clinical and professional leadership, with the expectation that discipline specific supervision and leadership would be provided through NMMHS.

Within any forensic service the greatest number of staff (and often the most influential) are nursing staff. Within the SFMHS structure professional leadership for nursing staff is provided by someone who has a dual role- they are nominally 0.5 SFMHS and 0.5 for nursing leadership across the rest of Graylands hospital. This is an unhappy marriage for all involved. The Graylands' role in anyone's estimation is already a full time position. It is both insulting and demoralising to have this position take responsibility for all of the professional and performance management issues for nursing staff working within SFMHS. The reality is something has to give and we are convinced that the current incumbent tries to balance the competing demands, but this is an impossible role and task. This position also currently sits 'off line' and appears to have limited line

management authority or influence over the nursing staff, which is reflected as a dotted line on the organizational chart.

We believe that this role would become much more effective and efficient if it was integrated with the Manager role to create an Executive Manager position that is adequately remunerated and has the appropriate level of responsibility and authority. For this to ultimately be achieved the organisational structure should reflect the partnership (on all levels) required between the Clinical Director and the Executive Manager. We understand that the remuneration of the current SFMHS Manager position has been questioned by North Metro MHS as it is classified at a much higher rate than other equivalent 'program management' positions. We believe that this is appropriate as the role, responsibilities and risks associated with this position should exceed any other comparable position within North Metro MHS. By creating a role that is both a senior manager and senior nurse you provide professional and operational leadership to the staff group that are the largest and most influential over organisational culture. We do not believe that SFMHS is a service that is large enough to justify a separate full time senior nurse and separate manager, although we are acutely aware of the importance of providing authoritative and expert nursing leadership. Whilst we have stated that the current role split of the senior nurse across SFMHS and the Graylands campus is an ineffective mix, we believe that the integrating of the manager and senior nurse role will provide the position with adequate status and authority. We also believe that there are sufficient commonalities between the roles of service manager and senior nurse to minimize the risk of the role becoming unwieldy. Appendix III provides information regarding our views of the functions that this new position would have responsibility for.

The committee governance structure should also be reviewed to reflect what we believe is contemporary practice and to ensure service integration. The fact that there are three governance committees we believe impacts on service integration and cohesion. As with the leadership structure the committee structure is top heavy and actually promotes service fragmentation. We believe that for a service of this size only one governance committee is required. If NMMHS were to accept our recommendations regarding the

organizational structure the Executive Governance Committee membership would require review. We would suggest that this committee should comprise the Director of Clinical Services, Executive Manager and Director of Nursing Practice, a Senior Consultant Psychiatrist from both the inpatient and community programs and the Clinical Nurse Managers for the Frankland Centre and CFMHS. Given the role that NMMHS has in the administration of SFMHS consideration should also be given to a representative of NMMHS sitting on the Executive Governance Committee. Ideally this representative should be someone whose skills would be value adding to the current composition which is clinically dominated, for example a senior financial manager.

7. PHYSICAL ENVIRONMENT AND PROGRAM- SHORT TERM

7.1 The Frankland Centre

The Frankland Centre is a 30 bed secure facility that is configured as three (3) units comprising;

- Acacia Unit- 8 bed Acute Assessment Unit
- Banksia Unit- 12 bed Sub Acute Unit
- Casia Unit- 10 bed blended Sub Acute and Rehabilitation Unit

Whilst these are referred to as units, they are essentially 'pods' within the one unit. There are dedicated nursing staff for each 'unit', however the remainder of the multi-disciplinary staffing (as few as they are) appear to cover all units.

We do not believe that the current configuration is conducive to contemporary forensic mental health service provision. In addition staffing resources are not being efficiently utilised as a result of the need to create 3 distinct nursing teams for all shifts.

The area available on each unit to facilitate vocational, educational, recreational and therapeutic programs is very limited and program spaces off unit (the OT workshop and Gymnasium) are under utilised due to their location. The external courtyards are also poorly utilized. However patient bedrooms are spacious and have good natural light. Each bedroom has it's own ensuite which is providing a contemporary standard of amenity.

One of the factors/issues that was raised with us was the fact that the current Frankland Centre environment and the absence of meaningful patient activity (which is not environmentally created alone) has resulted in long term patients, specifically the Mentally Impaired Defendant population being placed in prison, at times, at the request of the patient. This is an unsatisfactory situation as management and treatment of this population we would consider to be the core business of a comprehensive forensic mental health service. However, we understand why these patients might find prison a more

tenable long term option as they are able to work and participate in a structured (although regimented) routine.

To address this issue we believe that there is an opportunity to reconfigure the current inpatient facility to provide a more rehabilitation and recovery focused environment, as well as achieving resource efficiencies that could be used to expand and enhance current service provision.

The proposal we are suggesting is to retain Acacia Unit as an 8 bed acute assessment unit and to retain this unit's current nursing staff profile. However we believe that this unit should have a dedicated treatment team and would suggest that the staffing profile in addition to the nursing staff comprise:-

- 1 x OT
- 1 x SW
- 1 x Welfare Officer
- 0.5 x Psychologist
- 1 x Consultant Psychiatrist
- 1 x Medical Officer/Registrar

We would also suggest/recommend that as far as practicable Hospital Order admissions are reduced or beds are 'capped' (if they are to continue to be admitted to the Frankland centre) to minimise the risk of these patients overwhelming the unit and preventing mentally ill prisoners from gaining access to these beds or being unable to have treatment consolidated due to forced returns to prison to accommodate a Hospital Order patient. Historically Hospital Order patients have been automatically referred to the Frankland Centre regardless of the risk that the individual may pose. This is not required under the legislation. Essentially any authorised mental health unit can accept Hospital Order patients, however we were advised that this does not occur due to a lack of beds within the general mental health services. This poses an interesting dilemma as the Frankland Centre is in exactly the same position but they are expected to create a bed for a Hospital Order patient, even if this means that an acutely mentally ill prisoner is discharged and

returned to an environment with very limited access to specialist mental health care and treatment.

Although we are not proposing any structural changes to Acacia Unit, we believe that this unit requires environmental and programmatic review. During the times that we were on the units (which we acknowledge was limited) we did not see any patient participating in any educational, vocational or therapeutic programs. In addition, the furnishings on the unit were sparse and austere. We accept that this is an acute unit but we still believe that there is an opportunity to make the unit look and feel more homelike – this should be able to be achieved without it being cost prohibitive.

If this unit has a dedicated multi-disciplinary team we also believe that there will be increased capacity to provide meaningful occupation/activities for the patients.

Perhaps more contentiously, we propose that Banksia and Casia Units are amalgamated to form a 22 bed blended sub acute and continuing care unit with a dedicated multi-disciplinary team. This would double the available space to provide a range of program and recreation spaces. Whilst we are not architects or engineers, we believe that this could be reasonably easily achieved through the removal of 2 walls, the blocking off of one door into the staff station and the construction of a new wall in the main corridor. The patient bedrooms are already more than adequate as they have individual ensuite bathrooms and are very spacious. However as with Acacia Unit, we would observe that the furnishings are sparse. We do not see why longer term patients (after an appropriate assessment of risk) cannot have personal electrical items in their bedrooms together with additional furniture. For example, portable televisions, stereos etc.

We would suggest that the current open plan dining/lounge area on Banksia be retained and the games room would also be retained but made accessible without the requirement for supervision. This could be achieved by having windows placed in the wall between the open plan dining/lounge area and the games room. This would become the recreation precinct for the unit. This would then allow the Casia living areas to be redeveloped into

program spaces. We would suggest an expansion of the patient kitchen to become an Occupational Therapy kitchen. The interview room could become a secure program storage area. The former smokers room is a nice bright space that could be converted into a 'wet' activity space with the potential for art and craft activities and even 'cottage industry' type horticultural programs.

The remainder of the space should be utilised for vocational and educational programs. This would include patient access to the computers and with appropriate supervision there is no reason why patients could not have limited access to the internet.

If these units were to be amalgamated we believe that there would also be scope for a review of the staffing profile. Currently the two units combined have the following nursing staffing;

Nursing- Morning shift: 8

Afternoon shift: 7

Night shift: 4

We understand that the ANF has set a minimum number of nursing hours per patient day for Banksia and Casia Units, however given that the function would be changing it would be reasonable to have the nursing hours reviewed in collaboration with the industrial representatives. Regardless, the current nursing staffing exceeds the minimum hours set and therefore there is already some scope for achieving resource efficiencies. We believe that up to 7.26 nursing FTE could be redeployed into other program areas. An opportunity would then also exist for identifying the allied health professional needs of this patient population and redeploy some of the reconfigured resources into increasing the range of health professional staff available to provide specialist treatment and care.

7.2 Community Forensic Mental Health Service

There was a great deal of discussion when we met with the staff of the community program regarding the traumatic and violent incident that resulted in serious injury to a community forensic mental health nurse in 2007. This incident appears to have resulted

in the community program feeling increasingly marginalised. It has also exposed the perceived and real sense of vulnerability that community staff feel they are subjected to on an ongoing basis. We believe that the perception and reality of the risk may not always be compatible. We acknowledge that working within a community program is a far less structured and therefore controlled environment if compared to an inpatient facility. However, overall, patients who are being managed within the community would and should have been assessed as low risk. Additionally, this is a specialist forensic community mental health service and so the risks of the patient population should be well known and understood by the clinicians working within this setting. The management of the patient/client involved in the incident is the subject of controversy and conjecture between the Frankland Centre and CFMHS staff. There are clear differences of opinion regarding the level of risk of this patient at the time of his discharge to the care of the community program, however this incident is outside the scope of our terms of reference and we have determined that it would not be helpful at this stage to make specific commentary on the management of this patient. This incident was a tragedy for all involved, not only the nurse and other CFMHS staff but also for the patient and their family. If SFMHS are to move forward they will need to reconcile the differences in clinical opinion regarding this and other individual cases and accept that within a dynamic and contemporary service there will always be differences of opinion. The challenge for SFMHS is to identify a way in which this can be worked through to ensure best outcomes for all stakeholders.

We do, however, want to raise our concern regarding the actions taken following this incident. We were provided with a copy of the recommendations of the Root Cause Analysis (RCA). These recommendations appear sensible and considered. However the recommendations will always be limited by the information provided when the RCA is undertaken and the process that is utilised. It is our understanding that the RCA process was essentially a file review. There were no meetings, whether group or individual, with key individuals who were affected by or involved in the incident. This process appears to be fundamentally flawed. It is our experience that RCA's provide several functions. One is to identify areas for improvement and provide learning for organisational change, but

another is to assist staff/key players in developing an understanding of the circumstances of the incident (who, what, why, when, how) and also to assist in the beginning of the 'healing process' for individuals who have been involved. If the individuals involved are part of the RCA process they are also much more likely to have ownership of the recommendations and outcome. In this case no-one appears to believe that the RCA process was comprehensive and therefore they do not value or have a commitment to the final outcome.

An issue that was not identified through the RCA but has been identified by SFMHS is the suitability of the current premises that CFMHS occupy. We did not necessarily share the concerns that have been expressed about the suitability of the CFMHS accommodation for the following reasons; the front entry is located on a fairly main and busy road, there are a large number of other health services within close proximity, the reception waiting area is isolated from the office accommodation, access to the office accommodation is controlled by pin code, the receptionists area is well screened and protected. It is also noteworthy that it is highly unusual for CFMHS patients to be seen at the clinic. Patient contact is predominantly outreach based. It seems that the major concern is the fact that staff are required to walk approx 100metres from the open car park to the CFMHS building. It should also be noted however that this service currently operates only during core business hours (although there is a nurse rostered on Saturday for court liaison they do not work from the CFMHS clinic) and therefore staff would only be walking to and from the car park during hours of daylight and when there would normally be a number of other people within the vicinity. Having said this, an incident has occurred and from a risk management view point if at all possible the risk should be eliminated. We understand that SFMHS are currently looking for alternate accommodation for the CFMHS.

The staff of the CFMHS are extremely dedicated and it was clear that they are a very cohesive team. However we believe that the level of cohesion is to some extent created by a 'siege' mentality. It seems that the CFMHS staff feel that they need to protect themselves, and each other, from not only their patients but also from the bureaucracy

and the Frankland Centre. This is not healthy or helpful however to some extent we can understand how this has occurred.

The risk assessment and management processes of CFMHS are excellent. They are thorough and contemporary. The risk assessment tools and processes utilised are ones that we would advocate. Their quarterly intensive case reviews are of a very high standard. We believe that there needs to be greater standardisation between the risk assessment and management processes between the CFMHS and the Frankland Centre and would recommend that the CFMHS approach be adopted at the Frankland Centre.

'A week in the life of a CFMHS nurse' was outlined for us during the course of the review. It is clear that the staff are working hard, but we do not believe that they are working efficiently. It was explained to us that several years ago there were 2 nurses who specifically focused on court liaison work, however this model was changed so that all of the nurses at CFMHS had an understanding of the courts and had a profile and identity with court staff. Therefore the tasks associated with the CFMHS functions were distributed across all nursing staff. This has resulted in what we would consider 'multi-tasking' not necessarily 'multi-skilling'. In addition this has resulted in an inefficient use of resources with staff moving locations during their working day. All nursing staff case manage up to 8 clients. The 'week in the life' identified that only 4-6 hours per week are dedicated to case management with the rest of the week being spread across court liaison, duty/intake work and rehabilitation group intervention and activities.

We believe that the CFMHS need to go back to having dedicated roles of their staff to create greater efficiency in resource utilization. It is our view that 2 staff should be dedicated to court liaison and duty work. There should also be a staff member dedicated to morning duty work. This would allow (of the 6 nursing staff) 3.5 staff to be dedicated to case management work. If the CFMHS want to have their staff to have experience of all programs they could rotate staff on an annual basis. At the moment each case manager only has a maximum of 8 clients. This seems quite reasonable given the other roles these

staff have. If the above restructure was to occur it would not be unreasonable for case loads to be increased to 15 per case manager.

It also came to our attention that the CFMHS are providing rehabilitation activities and programs. This is to be applauded and the staff who have initiated these programs should be congratulated. However, we believe that this is a function that should be provided by the non-government sector rather than a specialist forensic mental health service. We believe that the energy of the CFMHS staff should be focused on linking their patients in with NGO supports and programs rather than replicating the programs that they are able to and should provide. This will also establish longer term support for the patient, as CFMHS is clearly not intending to create a 'silo' by having their patients in their care indefinitely.

8. BED NUMBERS AND CONFIGURATION- LONGER TERM

The number and ideal configuration of beds within a forensic mental health service cannot be divorced from either the expectations of the service's functioning or the resources available.

Currently Victoria has approximately 155 beds [35 prison based], with a further 60 beds in the planning phase. New South Wales (NSW) will soon have a far larger number available, the United Kingdom (UK) has more than three times this number on a population base, and California and several other States within the United States (USA) are expanding at such a rate it is difficult to keep up [most new beds in the US being earmarked for 'sexual predators' and those 'dangerous' offenders transferred from prison at the end of their sentences]. The wide variations not only in forensic mental health services bed numbers but in the extent of their community based services reflect the different expectations placed on the particular service.

At issue is not just bed numbers but the distribution between high, medium and low security settings. In the UK for example over 2,000 high secure beds exist with more than twice that number in medium secure facilities, but with a paucity of prison based beds. WA essentially has a medium secure unit of 30 beds and a low secure facility of 8-10 beds on the Graylands campus. There are currently no effective prison based beds for the seriously mentally ill.

High secure beds should not be defined simply in terms of the adequacy of perimeter security, or the internal security of the buildings, but also in terms of the number of adequately trained staff. The functions of a high secure facility include providing the space and facilities for humane long term detention and active rehabilitation. The Frankland Centre currently lacks the level of perimeter and internal security as well as the space and facilities to act as a high secure hospital. The number and training of its nursing staff do however currently allow for the safe and reasonably secure containment of a small number of patients who require high security. Similarly, reconfiguration of the

centre's internal structure could allow a more appropriate range of rehabilitative and recreational activities for long term patients.

The Frankland Centre in our opinion is a medium secure unit that could be modified to also provide limited high secure facilities. This is the reverse of the Victoria's Thomas Embling Hospital which is designed as a high secure facility also capable of playing the role of a medium secure hospital. Such compromises are forced on services that have to provide for populations varying between 2 and 6 million rather than numbered in the 10's of millions as in the UK and USA. In our view such comprises can be beneficial in avoiding the disasters created by geographically and professionally isolated high secure hospitals housing hundreds of institutionalised patients and staff [e.g. Broadmoor and Nappa Valley High Secure Hospital].

Currently in WA the demand for beds that are both long term and high secure is limited. The usual occupants of such beds are those found by the higher courts to be unfit or to have a mental impairment rendering them not responsible. The defence bar of WA appears less than enthusiastic about pursuing mental state defences. This is unsurprising given that currently such a defence, if successful, is likely to result in a finding of not guilty, but indefinite detention in prison. In Victoria where this defence is being used with greater and greater frequency a finding of mental impairment results in the patient coming to Thomas Embling Hospital where in most cases treatment and rehabilitation will have them back in the community far faster than serving a prison sentence. They will however remain under close psychiatric supervision in the community, with the potential for return to hospital should their behaviour and/or mental state raise concerns of reoffending. This system provides, in most cases, shorter incarceration but longer supervision, and a negligible re-offence rate. Should WA move in this direction it is likely that as with Victoria the popularity of the mentally impaired defence will increase, and the demands for beds rapidly increase.

In our opinion the WA forensic mental health service could, with the modifications to the Frankland Centre outlined, [See Section 7.1] move to admitting all those people on

governors pleasure orders because of serious mental illness currently housed within the prison system. Once a coherent system of management and rehabilitation is set up, and linked to eventual follow up and supervision by the community arm of the service, there should be a greater willingness to move suitable patients back into the community. We would predict if the rehabilitation of governor's pleasure patients begin to operate properly there will be a demand for more beds. If the uptake of the defence approaches that in Victoria eventually 30-40 beds will be required for this group. It is probable that indigenous Australians will form a significant proportion of such patients which will create a fascinating challenge in terms of developing for them effective management and rehabilitation strategies.

As discussed elsewhere the existing facilities should be able to cope with being the secure hospital section of a coherent system of care for seriously mentally ill prisoners. Currently no such coherent system exists. Should policies change and give proper priority to seriously mentally ill prisoners, either out of basic humanity or the pragmatics of reducing offending, then the Frankland Centre is currently capable of playing its part. Long term with a prison population of 4,000 we would suggest between 50 and 80 beds will be required distributed between the prison units and the Frankland Unit. Our view is that eventually 30 – 40 of these beds should be at the Frankland Centre or more precisely at its successor.

WA's forensic mental health service currently has 8- 10 beds for long term low security care and rehabilitation (though the rehabilitation aspect may be under resourced). This is an important addendum to the service which should suffice at least until major rebuilding of the Frankland Centre is undertaken.

The issue of a 7 – 10 bed in Graylands to cope with 7 day assessment orders was discussed earlier in the report.

An important role for any forensic mental health service is supporting the general mental health services. Important though it is, it can only claim a relatively low priority set

against the needs of insanity acquitees and psychotic prisoners. This is because unlike those requiring psychiatric admission from prison or on governors pleasure orders it is not their only available service. In an ideal world those in the general mental health service unmanageable because of violence, or identified as at particularly high risk of violence, should be transferred to the forensic mental health service. Only when this can occur will the forensic mental health service be able to play a full role in reducing violence among the seriously mentally ill. Equally only at that point are colleagues in the general mental health services likely to appreciate the contributions of forensic mental health services. That point is well in the future, however, for the WA services. For the present all they will be able to accomplish is playing a liaison role, sharing responsibility with their general colleagues and occasionally admitting a civil patient as a last resort.

8.1 Summary

There is an urgent need for 7 – 10 beds carved out of the general bed stock at Graylands to house those placed by magistrates on a 7 day order. Without this immediate reform the Frankland Centre will stagger from crisis to crisis unable to establish priorities or provide the services which it is equipped and funded to provide.

The development of an adequate service for the current mentally ill governors pleasures patients can be provided within existing resources. Long term it will require additional beds.

The provision of hospital based services for psychotic prisoners will only become effective when the provision of services to mentally ill prisoners within the correctional services is properly organised. Should that happen and a 20 – 30 bed unit be opened within the prison system the current needs at the Frankland Centre can be met within existing resources. Long term new beds will be required.

The required back up to general mental health services by forensic mental health services in patient facilities will have to await future expansion in bed numbers.

9. FILE REVIEWS

Five current inpatient files were reviewed. 1x female and 4x male files ranging from remanded prisoners charged with homicide through to civil involuntary patients whose sentence had ended.

The files were well ordered. Information was easily identifiable and retrievable. Progress note entries were comprehensive and regularly completed. In one file there was a well developed and structured nursing management plan however these documents were not evident in all files reviewed. Generally there appeared to be an absence of clearly articulated future management or care plans. This is probably indicative of the short stay, acute assessment nature of current service provision. Good observation charts were evident.

An issue identified during the file review, that would seem to be indicative of the service more broadly, is the lack of clear identity of SFMHS and the Frankland Centre. Forms and documentation used were branded as Graylands Hospital. In several of the files it was difficult to clearly distinguish between entries and documentation that was prison based and that which was Frankland Centre based. On a number of occasions prison based bradmar labels were continuing to be used on Frankland Centre documentation. This is a service that does not have a clear identity.

During the file review a number of issues were raised for us as reviewers;

1. Mixed gender acute environments- we only reviewed one female patients file, but within that file there was evidence of an alleged sexual assault. The file evidenced a delay in this assault being reported to authorities from the time of initial reporting to staff. It is not the place of mental health services to determine if an offence has or has not been committed. There should be a mandatory reporting requirement for allegations of assault. In some circumstances where it would appear that the allegation could not reasonably have occurred, it is appropriate for an immediate review of the patient by a consultant psychiatrist. A protocol should

be developed with local police to establish the parameters of reporting allegations and how the police will respond to these reports. Copies of incident reports did not appear to be contained within the patient's medical record- it was not clear to us where these are located.

2. DASA appears to be the only formal risk assessment tool currently being utilised at the Frankland centre. This tool as part of a range of risk assessment measures is helpful, however on it's own only provides a brief snapshot of risk. There does not appear to be a longer term risk assessment process being undertaken.
3. A matter of concern was the various types of medication treatment sheets potentially available. We identified the following medication treatment sheets; Long Term; PRN for agitation and arousal; Depot medication; Nicotine Replacement Therapy. More than one treatment sheet increases the risks of errors.

There was no evidence of seclusion being used for any of the patients' files reviewed, however high levels of medication appeared to be utilised. We have also been advised that a practice of placing a patient in 'time out' in their bedroom is often used in place of seclusion. Time out can only be considered an alternative to seclusion if it is coercion free. We believe that there are occasions where 'time out' is used and where varying degrees of coercion are used to facilitate this- we would consider this to be a seclusion episode.

10. POLICIES AND PROCEDURES

Not all Policies and procedures were reviewed in detail, however there were a small number that were identified as having particular significance and these were reviewed in more detail.

Overall the Policy and Procedure Manual (called Quality Manual) was reasonably comprehensive. The State Forensic Mental Health Service manual is supplemented by the North Metro Mental Health Service Policies and Procedures and the North Metro Health Service Policies and Procedures, which SFMHS are required to comply with, unless they have received dispensation.

The SFMHS Quality Manual was integrated and incorporated Inpatient, Community and Corporate Policies and Procedures. The framework/template for the policies and procedures is contemporary and demonstrates best practice. The structure of the manual itself was a little confusing. It was clear that the ACHS EQUIP functions had been utilised to group policies and procedures, however it was a little difficult at times to locate specific policies and procedures that we were looking for. In addition the structure is no longer as relevant as EQUIP version 4 has reduced the functions from 6 to 3, however the manual continues to use the now outdated 6 functions.

In a random sampling of policies and procedures, all were current and had been reviewed within the timelines specified for review.

Given the patient population managed by SFMHS, particularly the Frankland Centre, we felt that there were two crucial policies and procedures that were absent from the manual. The first related to our concern regarding the mixed gender environment within the Frankland Centre. All three units at Frankland accept male and female patients, this includes their acute, sub acute and continuing care units. We believe that it is unsafe to have male and female acutely disturbed patients being managed in the same environment without providing some capacity for gender segregation. Given that this does not appear

to be an option currently within the unit configuration, it is incumbent upon staff to have a clear framework and understanding of how they will meet the gender specific needs of their patients. The absence of any Gender Sensitive Practice Policy (or equivalent) will result in individual staff making their own determinations or interpretations of what is the best way in which to meet patients' gender specific needs. We believe that this exposes the patients, the staff and the service more broadly to significant risk. We have already outlined earlier our concerns regarding the process for managing an incident where an allegation of sexual misconduct was made by one patient against another. When reviewing the Quality Manual the only policy and procedure that we were able to find that might provide advice for staff about how they manage this incident was titled, 'Complaints of misconduct of a sexual nature made by staff or others'. We could only assume that patients were considered 'others'. The fact that this policy appears to be focused on staff being the victim (or perpetrator?) is inconsistent with our experience of who is most likely to be vulnerable to sexual exploitation and assault. We would suggest that patient to patient sexual assault and misconduct is a much more common occurrence than patient to staff or staff to patient. The most serious of these is obviously allegations of staff to patient sexual assault and misconduct and it should be managed in quite a different way to other forms of allegations, therefore requiring quite a separate policy and procedure. The way in which the policy and procedure was framed would suggest that the policy was focused on staff being the perpetrator, rather than the victim, however the title would be very misleading if someone was looking for guidance about how to manage an allegation of sexual assault or misconduct. If we accept that the fore-mentioned policy and procedure also applies to patient to patient complaints this policy was not adhered to in relation to the allegation that we identified during the file review.

The only policy and procedure that we found relating to physical assault was titled, 'Assault on Staff by patients'. This is another example where the policy that is available is not consistent with our experience. By far the highest number of assault incidents are patient to patient. Whilst patient to staff assault is always a significant risk and there must therefore be policies to guide how staff manage these incidents, there must be equal

weight given to providing staff guidance regarding how they manage patient to patient assaults.

We have been advised by a number of individuals that the WA State prison population is approximately 4,000. 47% of this population comprises indigenous prisoners. The Frankland Centre indigenous population is not representative of the prison population, but nonetheless comprises a significant population with approximately 30% of patients being indigenous. Given the significance of this component of the target population we would have expected to see a comprehensive policy and procedure regarding cultural and spiritual safety and well being (or equivalent). There did not appear to be any direction or framework for staff to work within in relation to providing service to patients from indigenous or culturally diverse backgrounds. Given that there was an Indigenous Audit for Cultural Competence undertaken in 2007 and this audit identified a general lack of competence and we understand made 34 recommendations, this would seem to support the need for a policy as outlined above (as a minimum).

We also noted that a CFMHS policy and procedure that was last reviewed in April 2007 was, 'Prevention and management of violence within clinic'. Given the incident that occurred at the community program offices in September 2007, we believe that this policy and procedure should have been reviewed as a matter of priority. It is interesting to note that there was no reference to this policy and procedure in the Route Cause Analysis (RCA) recommendations. This may of course be because the RCA panel determined that the policy was quite appropriate and did not require review, however it is our experience that all critical incidents identify areas for improvement in policy and procedures. Regardless, we are aware that since the incident other measures have been put in place to manage risk at the clinic, such as the presence of a security officer who escorts staff to and from their vehicles, and this in itself should be a trigger for the review and amendment of the policy.

11. THE (DRAFT) NATIONAL STATEMENT OF PRINCIPLES FOR FORENSIC MENTAL HEALTH SERVICES

Please note that the assessment of compliance with these principles is limited by the time and resources available for this review and also the role that State Forensic Mental Health Service has in the provision of forensic mental health services.

11.1 Equivalence to the non-offender

Given that the SFMHS are not providing comprehensive mental health services within prisons it would be unreasonable for us to assess their compliance with this principle in relation to this population. In relation to the population who are receiving treatment and care within the Frankland Centre and CFMHS we are confident that these programs are meeting the principle of equivalence and that standards of care are at least consistent with, if not superior to general mental health services. However, we believe Mentally Disordered Defendants would not be receiving the appropriate level of care when they are managed within the prison and given that the bulk of these patients appear to be located in prisons, we do not believe that the principle of equivalence is being applied to them.

Although we have stated that we should not assess SFMHS against this principle for prison based services, we believe that we should comment that we do not believe that mentally ill prisoners are receiving adequate or appropriate mental health services in comparison to non-offenders. The evidence in support of this view is contained elsewhere within this report.

11.2 Safe and Secure Treatment

Based upon how this is defined within the principles document SFMHS are not providing treatment in an appropriate environment that is compatible with the individual's treatment and rehabilitation needs (for the reasons outlined in section 5.1).

There does appear to be an appropriate level of security for all security domains at the Frankland Centre- the physical environment is secure; the staffing levels support relational security and there are fairly comprehensive policies and procedures that support procedural security. All of these in turn contribute to staff, patient and community safety.

Prior to our review it had been identified that security, and thereby safety, at the Community Forensic Mental Health Service is potentially compromised. This was highlighted following an incident in 2007 that occurred between the staff car parking area and the entry to the CFMHS building. This is an issue that we have discussed in section 5.2.

11.3 Responsibilities- Health/Justice systems

This principle relates to the partnership between health and justice in the provision of forensic mental health services. It emphasises the requirement for joint responsibility and the processes for how this is facilitated.

As we have already discussed, there does not appear to be a partnership between SFMHS and Corrections Health (the Justice Department overseeing health services within prisons). Communication appears patchy and we were advised that a Memorandum of Understanding between the services had only recently been progressed. As a result of a combination of personality characteristics and lack of response by SFMHS Corrections Health appear to have essentially decided to 'go out on their own'. This is in direct contradiction of this principle which specifically requires, *'Mental health services will be staffed by mental health personnel employed by a health service, not correctional*

agencies'. With the recent decision of Corrections Health to employ their own Psychiatrist and Senior Medical Officer (mental health) they are now the employer of all mental health professionals working within the prison system, as they already employed mental health nurses and other health professionals.

The Frankland Centre is completely independent of the prison system and mentally ill prisoners are transferred out of prison to the Frankland Centre for acute assessment and treatment. This is of course if a bed is available.

We did not have the opportunity to review the custodial practices and the services being provided to mentally ill prisoners, however we were advised that the mental health services available were minimal and there are no prison beds/units that have been established to provide psychiatric support, rehabilitation and treatment of mentally ill prisoners.

11.4 Access and Early Intervention

The court liaison service provided by the Community Forensic Mental Health Service is of a very high standard. The service is responsive and is highly valued by the Magistrates Court and police. Although there is capacity within the system for court diversion, in reality this rarely occurs. We were informed that this was as a result of the strain that the broader mental health system is suffering that has resulted in individuals with mental illness waiting in emergency departments up to a week in order to gain access to a mental health bed. This is obviously unacceptable when attempting to divert someone from the criminal justice system.

As already indicated we do not believe that the range of mental health care and professionals available within the prison system is consistent with that available in the general community. We are unable to comment with confidence regarding the prison primary and mental health services, although Corrections Health do appear to have a clear vision for the provision of primary and specialist services, how this works in

practice however is unclear. We do not believe that there are systems in place for detection and early intervention of mentally ill prisoners.

11.5 Comprehensive Forensic Mental Health Services

'A comprehensive forensic mental health service is a specialised mental health service providing integrated in-patient, prison mental health services, court liaison services, and community mental health services, in a coordinated clinical and administrative stream'.

If the above definition is applied to the State Forensic Mental Health Service it is clear that they are not a comprehensive forensic mental health service (as outlined in other areas of this report). SFMHS does not seem to function as a specialised service, it is not integrated and does not provide prison mental health services. Whilst there is a framework for service integration and coordination, this is not utilised effectively. In broad terms the majority of functions of a comprehensive service are provided by SFMHS.

11.6 Integration and Linkages

Service system integration is not necessarily absent, but it is certainly patchy. Whilst there do not appear to be system failures associated with mentally ill prisoners being transferred to the Frankland Centre, this is probably as a result of individual relationships rather than service system integration. As already reported earlier in this document it is only recently that an MoU between SFMHS and Corrections Health has been progressed and in the absence of such a document or protocol it is hard to see how the system could demonstrate integration and be able to provide timely and appropriate care and treatment. There is clear and strong integration between the courts and CFMHS court liaison services- this relationship appears to work well on most occasions. The Frankland Centre has been extremely responsive to the court in facilitating Hospital Order assessment admissions however this has been at the expense of other target patient populations. As a result of the impost created by having to develop discharge plans for Hospital Order patients as they exit the Frankland Centre, the allied health and welfare staff have

established a broad range of linkages with other organisation, however their capacity to respond is limited by their resources and the requirements of a broader system that would appear to be stretched.

The Frankland Centre is co-located with Graylands Hospital which creates opportunities and challenges. It is important for the Frankland Centre to create and maintain it's own identity but at the same time they should be benefiting form their co-location with a much larger mental health service. We do not believe that the Frankland Centre is maximising these opportunities particularly in the areas of peer support, professional development and clinical supervision. However it is over-utilising some things such as the use of Graylands Hospital documentation as outlined earlier.

11.7 Ethical Issues

Consistent with this principle individuals with mental illness are not subjected to coercive treatment within a correctional setting. SFMHS have clear protocols regarding patient confidentiality and access to health information. Although we did not visit any of the prison services, in our discussions with staff who provide mental health service sessions within prisons there is a clear understanding and sensitivity to patient information that is shared with correctional staff who do not have a direct role in providing a patients mental health treatment and care.

11.8 Staff: Knowledge, Attitudes and Skills

The SFMHS workforce is appropriately trained and professional. We would question the cohesion of the leadership and have already outlined our concerns regarding a management structure that has a management position that is not empowered to actually manage. We were advised of mandatory and other staff training opportunities that seem adequate. We are unclear as to the level of clinical supervision amongst the nursing staff- operational supervision is clearly identifiable and again adequate for needs. We have also already outlined the absence of cultural diversity training and protocols.

11.9 Individualised Care

This is an area of concern for us as reviewers. We believe that the Frankland centre has become an 'assessment conveyor belt' which has significantly detracted from the other functions of a forensic mental health service. We do not believe that the service is providing adequate holistic individualised care for its entire target patient population due to the constraints of the physical environment and the current resource distribution. In addition the needs of indigenous patients and women are far from adequately responded to. Whilst there is a clear and comprehensive framework to support the development of individualised care plans the reality is that the high turnover of assessment patients minimises the opportunity and staff capacity to develop meaningful care plans. As indicated under section 9 when we undertook a review of files we were only able to identify one patient file that had a management plan, however this was behaviourally focused rather than forward planning.

11.10 Quality and Effectiveness

SFMHS generally relies upon the quality processes that are available through their auspicing organisation of North Metro Health Service. There is a quality department with whom they clearly have established links, however the time afforded to the needs of SFMHS is limited given the scope and extent of the other programs that the quality program is required to provide a service to. In the absence of their own dedicated resources for this purpose, it would seem that a number of the quality processes in place are tokenistic. SFMHS collect a comprehensive range of data and statistics regarding service provision, however this information is under utilised in guiding program development and improvements. SFMHS have been involved in a national benchmarking project which has provided them with a unique opportunity to reflect upon their services and compare their outcomes with like organisations. Whilst they have actively participated in the process and have utilised the project officer resource that was made available through this project, there is not evidence that they have used the knowledge from this project to effect organisational change in relation to clinical service provision.

An important element of any quality program in mental health services is carer and consumer participation. At CFMHS a consumer is involved in their Governance Committee which is a very good initiative, however there seems to be limited consumer involvement at the Frankland Centre. During the review we met with a carer representative who appears to have an active role in advocating for the service and in raising carer issues, however the role of this individual appears to have become blurred and is much more externally focused rather than being focused on the internal processes to ensure carer participation within the machinations of SFMHS.

This principle also covers the area of research and evaluation. It appeared to us that research related to forensic mental health is invested in individuals and organisations outside of SFMHS. We were aware of research that was undertaken some time ago regarding the mental health issues of WA prisoners however no staff at SFMHS have seen the research findings and do not appear to have a capacity to gain access to them.

11.11 Transparency and Accountability

We are not able to assess the processes for external review and scrutiny of services provided within prisons under the auspices of Corrections Health. However we are aware that there is a body established by Justice that has independence and is able to conduct reviews and audits of individual cases and prison based programs more broadly. We are not aware of any recent reviews or audits that this group have undertaken in relation to the provision of mental health services for prisoners and would suggest that if this has not occurred then it should be undertaken in the near future.

SFMHS are subject to ACHS accreditation as part of the North Metro Mental Health Service. At the time of our review SFMHS had current ACHS accreditation and had undergone an in-depth review against the National Standards for Mental Health in the preceding 12 months. However, as SFMHS are a small part of a larger organisation it is difficult to identify how the accreditation review team were able to separate out issues

associated with SFMHS from the broader service. Ideally SFMHS should undergo their own accreditation process, and if into the future they develop greater autonomy this should occur as it will provide a more realistic and detailed analysis of the service's compliance with relevant standards.

11.12 Judicial determination of detention/release

The WA Criminal Law (Mentally Impaired Defendants) Act 1996 provides a legislative framework for the detention, release and transfer of mentally ill individuals found not guilty or unfit for trial. If a person is found not guilty through unsoundness of mind the Court will determine the order that will be applied to this individual. From the time an order is made decisions regarding leave and transfer are considered by the Mentally Impaired Defendants Review Board. Where the current legislation is at odds with the principle of judicial determination is in relation to decisions of release, including leave of absence. At the current time the WA Governor is the only person who has the power to make a release or leave of absence order. In our opinion this is not contemporary. At the present time there appear to be very few Mentally Impaired Defendants on orders as the mental impairment defence is not considered a tenable option given the indeterminate length of time the person can be detained. The legislation defines the place of custody for a patient as an authorized hospital, a declared place, a detention centre or a prison. However the legislation also states under Division 2 Sec24 (2) that *a mentally impaired defendant is not to be detained in an authorized hospital unless the defendant has a mental illness that is capable of being treated*. This is the opposite of the way in which we would consider future management of this population. We would assert that if a mentally ill individual has been found not guilty due to unsoundness of mind, they should be detained in an authorized hospital unless there are security and/or safety issues that cannot be appropriately managed within an authorized hospital, and transfer to a prison should be the option of last resort.

We understand that a review of this legislation was commenced somewhere between 3 and 6 years ago. The individuals with whom we met were unable to advise us of the

status of this legislative review. We would encourage this review to be finalized as soon as possible.

11.13 Legal reform/issues

We have already outlined issues regarding legislation under section 11.12. It is our understanding that mentally ill prisoners are not coercively treated within a correctional facility. The current process and legislation allows for a mentally ill prisoner to be made an involuntary patient and then transferred to an authorised hospital.

Appendix I

PEOPLE WHO CONTRIBUTED TO THE REVIEW

External Stakeholders

Dr Stephen Patchett, Executive Director of Mental Health, WA (former Clinical Director SFMHS)

Dr Peter Morton, A/Director Inpatient Services

Dr Leighton Chadwick, A/Clinical Head, Graylands Hospital

Dr Ralph Chapman, Director, Corrections Health

Mr Ken Steele, Advisory Council representative

Chief Magistrate Steve Heath

State Forensic Mental Health Service Executive

Ms Monica Taylor, A/Manager SFMHS

Dr Vicki Pascu, A/Clinical Director SFMHS

Dr Adam Brett, Director CFMHS

Mr Michael O'Kane, Director of Nursing

Dr Peter Morton, A/Director Inpatient Services

Dr Deborah Wilmoth, Manager SFMHS (on secondment during review)

Community Forensic Mental Health Service staff;

Ms Belinda Veary, Senior Social Worker

Ms Donna French, A/Service co-ordinator

Ms Donna Hegarty, Administration Officer

Dr Astha Tomar, Psychiatric Registrar

Ms Sacha Pantall, A/Community Forensic Mental Health Nurse

Ms Tracey Westworth, Nurse Practitioner

Mr Tony Harris, Community Forensic Mental Health Nurse

Mr Darren Boey, Community Forensic Mental Health Nurse

Mr Gordon Anderson, Community Forensic Mental Health Nurse (casual)

Mr David Carroll, Community Forensic Mental Health Nurse

Ms Mary Tucker, Community Forensic Mental Health Nurse

Mr David Brown, Community Forensic Mental Health Nurse

Mr Gary Davies, A/Clinical Nurse Manager

Frankland Centre staff;

Ms Janet Hicks, Social Worker

Ms Michelle McDonnell, Occupational therapist

Mr Ivan Elliott, A/Clinical Nurse Manager

Ms Leslie Barr, A/Clinical Nurse Specialist

Ms Jo Potts, Welfare Officer

Mr Bob Evans, Psychologist

Dr Robert Store, Registrar

Dr Barbara Zawadzki, Senior Medical Officer

Dr Vesna Stanojevic, Medical Officer

Dr Mircea Schineanu, Consultant Psychiatrist

Appendix II

DOCUMENTS REVIEWED

Submission to the Expenditure Review Committee: Business case for Improved Mental Health Services for Offenders; February 2006.

Draft National Statement of Principles for Forensic Mental Health Services, 2002.

State Forensic Mental Health Service Quality Manual

WA Criminal Law (Mentally Impaired Defendants) Act 1996

State Forensic Mental Health Services Annual Report 2002

State Forensic Mental Health Service website

Appendix III



