Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Te Korowai-Whāriki

Central Regional Forensic Mental Health Services
Draft 5 Year Development Plan

For the Ministry of Health

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INTRODUCTION

In October 2005 the Ministry of Health carried out a review of Forensic Mental Health Services within New Zealand. This was in the form of a stocktake of those services at that time. The review included a census of current clients on one day in October and a month long data collection process. The outcome of this review was published in February 2007 ("Census of Forensic Mental Health Services 2005"). The Ministry has now requested a 5 year plan and provided a framework for developing this plan: "Review of Forensic Mental Health Services: Future Directions". Previous Ministry reviews of Forensic Mental Health Services have occurred in 1994 and 2001.

This 5 Year Plan outlines the current service provision, the response to the 2001 review, and future direction and key developments for the Central Regional Forensic Mental Health Service. It takes into account both national and regional requirements. Issues of national significance which have been identified include:

- Forensic services for youth
- Specialised forensic services for women
- Culturally appropriate forensic services for Maori and Pacific peoples
- The expansion of forensic services
- Developing agreed assessment and reporting criteria

In the Foreword to the "Future Direction for Forensic Mental Health Services" document, it is noted:

"Forensic mental health services are a highly specialised component of New Zealand's continuum of mental health assessment, treatment and rehabilitation services. Forensic services exist at the interface between the mental health and criminal justice sectors. They focus on managing and giving expert advice about serious mental health conditions in a variety of settings including prisons, courts, specialised inpatient units and the community. New Zealand is recognised as a world leader in the provision of forensic mental health services, and there remains a high level of support for the current policy direction that informs their structure and operation.

It is important to note that many of the factors that drive demand for forensic services are outside of the control of these services. Demand depends, for example, on wider social and economic factors in the community, levels of drug abuse, and the quality and availability of general mental health and alcohol and other drug addiction (A&D) services. Further, the proposed building of new prisons, and the consequent increase in prison muster, will have a flow-on effect on forensic services that will need to be addressed in future planning".

As noted in this document (at page 2), "the fundamental principle for forensic services is that people within the criminal population, or those who have been charged with a crime, have the right to expect the same level of mental health services, relative to need, as the general population".

Other principles for forensic service delivery were enunciated in the 2001 forensic service framework and include the following:

- Consumers' needs for mental health care should govern their access to services.
- Consumers should be accommodated in facilities that match their need.
- Consumers should be treated in the least restrictive environment that their circumstances allow.

- Services should be client-focussed, enhancing well-being and preserving dignity.
- Services must balance individual rights against the need to protect the public.
- Services should be culturally appropriate, treating the whole person and involving whanau and families.
- The approach to care should be holistic, integrated, open-minded, and non-judgemental.
- Service provision should minimise negative public perceptions of people with mental illness, including those who have both a mental illness and contact with the criminal justice system.

The proposed plan recognises the financial implications to the health sector and endeavours to estimate as realistically as possible the service development cost. A summary of financials and FTE's are given below. It is noted that CCDHB will be indicating the additional proposed capital expenditure of $13.9 million during the "updated capex intentions" that is due to be presented to the National Capex Committee in late 2007.

Financial Summary[1]

Appendix	Proposal	Beds	FTE	Personnel Cost	Non Personnel Cost	Total Opex	Total Capex	Timeline
1	Regional Community Youth Forensic Service	Nil	15.50	1,133	381	1,514	Nil	
2	Regional Youth Forensic Inpatient Service	8.00	33.70	2,033	1,145	3,178	4,000	2009/10
3	Regional Secure Women's Inpatient Service	12.00	48.15	2,973	2,193	5,166	9,900	2010/11
4	Prison Liaison Service	Nil	14.00	1,292	373	1,665	Nil	
5	Prison Screening Service	Nil	1.60	205	52	257	Nil	
6	Forensic Residential Service	12	NGO Partnership			1,185	Nil	Jan 08/ Jul 09/ Jul 10
		32.0	112.95	7,635	4,145	12,965	13,900	

[1] Indicative estimates only on confirmation more detailed calculations can be undertaken

FTE Summary

Medical	
Consultant Psychiatrist	6.60
MOSS	1.00
Resident Medical Officer	0.50
	8.10
Nursing	
Registered Nurse	43.00
MH Support Workers	19.00
Nurse Specialist	2.00
Registered Nurse - for Local CAMHS/ AOD	4.00
Registered Nurse A&D	1.00
Escort and client transportation (FTE Equivalent)	3.00
	72.00
Allied Health	
Maori Cultural Clinician)	6.00
Pasifika Clinician	2.00
Clinical Psychologist	4.00
Occupational Therapist	2.00
OT Support Worker	2.00
Social Workers	3.50
Complementary Therapists (eg Music, Drama, Art)	0.50
Drug and Alcohol Counsellor	2.00
	22.00
Management & Admin	
Team Leader	4.00
Other Admin staff	4.00
Other Non Clinical	2.85
	10.85
Total FTE	**112.95**

BACKGROUND TO FORENSIC SERVICES

In 1987 in Auckland, a serious incident occurred when a man took a carving knife from the kitchen at the boarding house he was staying in, went outside and stabbed another man waiting at a bus stop. He returned to the boarding house and early next morning he fatally stabbed another boarder and wounded 2 others.

It was this event which precipitated the Government establishing a Committee of Enquiry, resulting in the 1988 Mason Report. Judge Mason and fellow committee members travelled the country and also overseas. This foundation document established the model around which specialist Forensic Mental Health Services were developed and delivered.

Following the Mason Report, 6 regional (although 5 were recommended by the Mason Report) forensic services were established, 2 of these in the central regional area at Wanganui and Wellington. These regional services were additional to the existing National Secure Unit at Lake Alice Hospital.

In 1994, the Ministry of Health reviewed Forensic Services, in particular benchmarking them against the Mason Report recommendations. This report was known as "5 Years Out" and noted that services were largely being delivered in accordance with the Mason Enquiry recommendations.

In 1998 the Government announced the closure of the National Secure Unit at Lake Alice Hospital. A national facility did not reflect the philosophy of keeping people within their communities and close to family / whanau. As a result, Extended Forensic Care Services became attached to Regional Forensic Services from November 1, 1999. There was a nationally co-ordinated decommissioning process that oversaw the closure of the National Secure Unit and transfer of patients to regionally based facilities.

In 1999 the Department of Corrections published a "National Study of Psychiatric Morbidity in New Zealand Prisons". A significant outcome of this study was to establish the number of people in prison with a mental illness. It also considered the impact of the increasing prison population on Forensic Mental Health Services.

Through 1999/2000/2001 the Ministry of Health undertook a further review of Forensic Mental Health Services. The purpose of the review was to:

- Establish benchmarks for levels of service for forensic mental health clients
- Clarify responsibilities of forensic services through identification and resolution of interface issues between health and criminal justice services
- Identify current and future resource requirements
- Develop a comprehensive, best practice model for forensic mental health services

A Summary of the Review findings presented in 2001 is as follows:

- Forensic Services directly treat only a few people overall (189 inpatients and 256 outpatients)
- Court and prison liaison staff of regional forensic services assess about 2500 people at court and 4500 prison inmates per annum
- The vast majority of inpatients and outpatients are male
- A disproportionately high number of Maori are forensic service consumers

- Many forensic service consumers are diagnosed with schizophrenia or another serious mental illness, most of whom are required to receive care under legislation
- For most inpatients and outpatients, index offences are “serious” (i.e. violent or sexual) offences.

There was also a consensus around:

- Workforce and resource issues with particular increasing demand for and shortages of Maori and Pacific staff.
- Screening for mental illness in prisons.
- Lack of step down or community based residential facilities for forensic clients.
- That the current model for forensic services is appropriate.
- Inadequacy of facilities for women and long term patients.
- Inappropriateness of forensic care for people with intellectual disability, behaviour problems associated with head injury or challenging high risk behaviour.

REGIONAL HISTORY

Regional Forensic Services were established after the Mason Report in 1988, each with a medium secure unit at Wanganui Hospital and Porirua Hospital. Each service included a prison liaison service, court liaison service and community forensic service.

In 1997, the Central Regional Health Authority carried out its own review of the 2 Regional Forensic Services in the central region. This review was chaired by Dr Phil Brinded of the Canterbury Regional Forensic Service. The principal conclusion from this review was that a single regional forensic mental health service be contracted to provide for the regional responsibilities within the central region. A number of key advantages from this structure were highlighted. Consequently, the Central Regional Health Authority put out a Request for Proposal for the provision of regional forensic services and this contract was awarded to the Wellington Regional Forensic Service. The Central Regional Forensic Mental Health Service was established. At the same time the process for the closure of the National Secure Unit occurred and a second Request for Proposal for the provision of these services was requested. Again, this contract was awarded to Capital Coast Health. After extensive discussion and negotiation resulting in the contract for extended forensic care beds changing from Capital and Coast Health to Good Health Wanganui (10 beds at Stanford House), the current configuration of forensic mental health services was arrived at.

CURRENT SERVICE PROVISION

The Central Regional Forensic Mental Health Service has 28 regional secure beds and 12 step down beds incorporated into the Inpatient Rehabilitation Service at Ratonga Rua-o-Porirua. The Central Regional Forensic Mental Health Service also has forensic community teams established in Wanganui, Palmerston North, Hawke's Bay, Wellington/Hutt Valley/Porirua, Wairarapa and Gisborne. These teams are multidisciplinary based with their principal role to cover all prisons and courts in the region and provide consultation and liaison services to local mental health services. The Central Regional Forensic Mental Health Service is also involved with the Youth Court through its justice liaison nurses and in completing specialist psychological or psychiatric assessments ordered by the court through Children Young Persons & Family Act, 1989 (section 333).

As well as the Central Regional Forensic Mental Health Service, Wanganui DHB through Stanford House provides 10 Forensic Extended Care beds. These are the beds for the Central region that were allocated from the closure of the National Secure Unit at Lake Alice Hospital. They are accessed by the Central Regional Forensic Mental Health Service.

Also at Stanford House are 5 regional mental health beds which have been allocated to local mental health services for (high risk) general mental health clients. These are not part of the Forensic Service.

In summary, the specific service provision of the Central Regional Forensic Service is in four areas. These are:

- Courts
- Prisons
- Community
- Inpatients setting

Courts

Within the courts, the principal role of the Forensic Service is to provide triage, consultation, liaison and advice. Principally this is the role of the justice liaison staff that assess people being processed through the court system, to identify those who have mental health problems, and who may need to be diverted into the mental health system. They also provide gate-keeping to ensure that the mental health system does not receive inappropriate referrals from the court. In identifying those with mental health problems or possible mental health problems, many or most will be diverted to or assessed in general mental health settings. Current consumers of mental health services may have court appearances from time to time.

The provision of advice to the court operates at a number of levels, both at an informal and formal level. Informal verbal advice is provided to a variety of criminal justice agencies including advocates, the judiciary, police, probation service and corrections staff. More formal advice is provided to the courts through reports under Sections 38, 35, 25 and 23 of Criminal Procedure (Mentally Impaired Persons) Act 2003, and Section 333 of the Children, Young Persons & Their Families Act, 1989. These court reports are completed by "health assessors", legally defined as psychiatrists and psychologists.

Additionally, services to courts provides an important public interface in which mental health issues are often held up to public scrutiny. This requires the provision of advice to the courts to be authoritative and accurate as the quality of mental health services

may be judged in a very public manner on the way that those services are presented in court.

Prisons

In a prison setting there are 4 levels of input:

- Consultation and liaison with prison staff and assistance with behavioural/management plans
- Assessment and ongoing treatment of inmates who have a mental health illness/mental health issues
- Transfer to hospital at Ratonga Rua o Porirua, for those inmates whose mental illness requires hospital treatment
- The provision of reports and oral evidence as necessary to the Parole Board

In the prison setting the service provided is similar to that of a general community mental health service. The findings of the National Epidemiology Study in Prisons (1999) which indicated that 10% of the prison population have significant mental health issues impacts on and informs service delivery. In the Central Region there are 6 prisons (Hawke's Bay, Wanganui, Manawatu and 3 in the Hutt/Wellington, including a women's prison). The growth in prisoner numbers in the central region has been very significant.

Inpatient Settings

The inpatient arm of the Central Regional Forensic Mental Health Service is in a range of settings.

i) Acute Mental Health Services: For those in prison, the Central Regional Forensic Mental Health Service provides the acute inpatient service. This is for inmates transferred under Section 45 or 46 of the Mental Health Act, 1992 who require mental health care and treatment in a secure setting. After their inpatient treatment they are transferred back to prison.

ii) Assessment: The regional secure units provide facilities for inpatient assessment principally under the Criminal Procedure (Mentally Impaired Persons) Act 2003.

iii) Special Patients: Those found Insane or Unfit to Stand Trial and who are made Special Patients by the courts are managed by the Central Regional Forensic Mental Health Service. Special Patients' "journey" through secure settings and to the community is typically over a long period of time. As well as clinical decisions, they are subject to "checks and balances" via 6 monthly Special Patient Reviews through to the Ministry of Health. Leave is subject to Ministerial approval. Often there can be a long period in hospital waiting for trial.

The court now has an additional sentencing option whereby a person can be sentenced to a term of imprisonment and to receive treatment in hospital, and their time in hospital counts as part of the prison sentence. In these circumstances, the person is also a Special Patient. When the person no longer needs to be in hospital, the Service must arrange a transfer to prison to complete their sentence.

Forensic inpatient services also play a role in "mopping up" general mental health clients who have offended and been sentenced to prison, but who become too unwell to be managed in prison. Unfortunately, this becomes a larger group when general services are not working well. Such patients potentially end up

staying in the Forensic Inpatient Service for a long time due to lack of rehabilitative capacity, or supported community accommodation in the general mental health services.

iv) Rehabilitation**:** The Central Regional Forensic Mental Health Service has 12 "step-down" beds in the Central Regional Inpatient Rehabilitation Service at Ratonga Rua o Porirua.

Te Korowai-whariki contracts Care New Zealand to provide drug and alcohol services including screening, counselling, groups and training.

Community

In a community setting the Central Regional Forensic Mental Health Service provides:

i) Management of Specific Patients: Special patients who are transitioning from hospital or who are continuing to reside in the community on short or long leave remain under the care of the Forensic Service. Other specific patients with certain "high risk" profiles may be managed by the Forensic Service for specific reasons. Primarily the forensic services "community" is the prisons and the forensic service should directly manage only a few clients in the community.

ii) Consultation and Liaison: The Forensic Service provides support, advice, and liaison to other mental health services. This is predominantly assessment of potential risk, management of specific problems or advice on any legal interfaces which may be affecting a client's treatment.

iii) A specialised community support service (Forensic Package of Care) provides funding for enhanced community support for clients who are re-integrating back into the community after a period in an inpatient forensic setting.

RESPONSE TO MINISTRY OF HEALTH 2001 REVIEW

In April 2002 a Regional Forensic Implementation Plan was completed on behalf of the Central Regional Mental Health & Addiction Network. A Reference Group was established to consider the current delivery of Forensic Mental Health Services in the Central Region. The Regional Plan outlined the history nationally of the development of Specialist Forensic Psychiatric Services, the history regionally and the current service provision and model. Through the Reference Group many strengths in the regional model of service delivery were identified as were a number of issues. The Reference Group supported the model of service delivery and acknowledged its quality and effectiveness.

There were 6 identified areas proposed for building on the model which were considered important for service enhancement. The Implementation Plan was updated in February 2004. These 6 areas of service enhancement were:

1) Top Slicing

At a national level, 22 new regional secure beds and 12 new positions for services to the prison were allocated. The Central Regional Forensic Service was allocated 3 new beds and 2 additional clinical staff positions. A 3 bed extension was built onto one of the existing regional secure units, Rangipapa, and new Justice Liaison Nurse and Maori Mental Health positions were established.

2) Prison Model of Care

The aim was to provide a more consistent approach for clients remanded to and released from prison. The model suggested that when a mental health client is admitted to prison a referral needed to be made to Forensic Mental Health Service. Prior to prison release date, the community mental health team needed to be advised by the Forensic Mental Health Service. The Reference Group did recognise that prison inmates could be released without prior warning or appropriate planning. It was recommended that the Regional Forensic Mental Health Service work with prison management to establish a system that ensured that its clients in prison were not disadvantaged by unplanned release.

Although every effort is made to ensure that releases are notified, in some cases the Forensic Mental Health Service is still not aware of all release dates. A Memorandum of Understanding between the Service and the Prisons is in place and is reviewed regularly. The Forensic Mental Health Service clinical director meets regularly with the regions' prison managers and their key staff including Health Services Managers. The prisons regularly provide a list of inmates appearing before the Parole Board as well as outcomes from these hearings.

3) Youth Court

The aim of this enhancement was to establish a triage role in the region's Youth Courts through the Justice and Community arm of the Regional Forensic Mental Health Service. This was to build on the Service's initiatives in providing services to the Youth Court, particularly psychological and psychiatric assessments. The limited expansion into the Youth Court was welcomed and enthusiastically endorsed by Judge Andrew Becroft, the principal judge for the Youth Court system for New Zealand.

Funding was allocated for 3 positions and a research project was undertaken to collect and analyze data from psychological / psychiatric reports ordered by the Youth Court.

4) Transfer of Community Clients

The Reference Group acknowledged that the Central Regional Forensic Mental Health Service had difficulty transferring clients from its current community list to the appropriate Adult Mental Health Service, and needed to establish an ongoing process for the transfer of future clients.

Significant progress has been made in this area with good relationships between the Services, including a working understanding of the role of each service. There is also in place a Memorandum of Understanding between the Service and each local mental health service. There is still work to be undertaken to build confidence in the General Mental Health teams to contain and treat "difficult to manage" clients and assist those teams with the management of their "high risk" clients. The Central Regional Forensic Mental Health Service provides formal liaison to General Mental Health Services.

5) Maori and Pacific Staff

Both Maori and Pacific Island people are over represented in justice and forensic services. Following on from the Ministry of Health framework for Forensic Services 2001, recruitment of several additional Maori and Pacific clinicians has occurred.

6) Services to Women

The regional plan at that time recognised the unmet needs of women in secure care. This was highlighted by the increasing muster in New Zealand's biggest women's prison (Arohata), the prison epidemiology study identifying high levels of psychiatric morbidity in the female prison population, an increasing number of women being remanded directly to hospital, and the need for focussed rehabilitation programmes/strategies for women in secure care. In 2003, women accounted for 14% of admissions to the regional secure units.

A report on the implementation plan (February 2004) concluded that progress had been made in some of the 6 service enhancement areas, particularly in the provision of additional secure beds, two extra clinical positions for prison and services to women. There had been some development in the model of care to the 6 prisons in the region. There had also been progress in the development of a forensic youth service but the full development of this service was limited by a lack of funding.

SERVICE DEVELOPMENTS: 5 YEAR PLAN

1. Youth Forensic Service

One of the service enhancements from the 2001 review has been the establishment of a Youth Court Forensic Service. The Central Regional Forensic Mental Health Service undertook a trial (in 2002/03) involving current resources (justice liaison nurses) in the Wanganui and Wairarapa courts. This proved to be very successful and was subsequently expanded to the other Youth Courts in the region. The trial and subsequent expansion as resources allowed into other Youth Courts have been welcomed and enthusiastically endorsed by Judge Andrew Becroft, the Principal Judge for the Youth Courts for New Zealand. It is of some significance that the Principal Judge has made specific comments on the development in the Central Region of the service to Youth Courts. Data that has been collected indicates that over 40% of youth seen are Maori.

It is envisaged that within the court system the Youth Forensic Service will:

- Continue to provide specialist mental health screening, advice and triage
- Continue to complete court ordered psychological and psychiatric assessments
- Provide a critical link with the Central Region's Youth Mental Health and Alcohol & Drug Services
- Have brokerage role with community treatment services and statutory agencies, particularly CYFS

With regards to the court ordered assessments, most are for psychological assessments ordered under Section 333 of the Children Young Persons and their Families Act (1989). This will continue to be a role of the Service and one that is highly valued by the courts. From July 2006 to June 2007, for example, the Regional Forensic Mental Health Service completed/brokered 107 section 333 psychological reports. There was particularly high demand in the Wellington (Upper Hutt, Lower Hutt, Wellington and Porirua) and Hawke's Bay regions. The purpose of these reports is to:

a) assist the court in determining the appropriate disposal options for the young person through the court system;
b) to provide assessment and formulation of mental health/psychological and offending issues; and
c) to provide recommendations for interventions to address identified treatment needs.

These reports are often about young people with high and complex needs and involve gathering information from multiple sources.

Overall, the aims and objectives of the service provided to the Youth Courts by the Youth Forensic Service will be:

a) to identify and ensure all mental health referrals and Section 333 orders are triaged appropriately by a comprehensive mental health screening process that will enable any immediate interventions that may be necessary;

b) to provide the court with guidance, recommendations and advice about mental health issues;

c) to enhance cost effectiveness and timeliness by ensuring that inappropriate orders for Section 333 reports are not made; and finally

d) to ensure that young people with major mental illnesses or intellectual disabilities are dealt with appropriately within the justice system and receive appropriate treatment.

The Ministry of Health has recently circulated a discussion document, following on from a national meeting held in February 2007, concerning mental health services to youth within the justice system. As well as the youth courts, in the central region there are also 2 youth units within prisons (at Hawke's Bay and Rimutaka prisons), young women aged 17 and under in Arohata Prison, and the Lower North Youth Justice Facility (for remand and sentenced youth through the Youth Court) in Palmerston North (there are 2 equivalent facilities in Christchurch and Auckland). International data suggests that the rate of mental illness within the incarcerated youth population is more than double that of the general adolescent population. There is also evidence that intensive interventions such as Multisystemic Therapy (MST) programmes can intervene successfully with at-risk youth even after they have begun offending. The Service is currently involved in a pilot in providing forensic mental health services to the Lower North facility.

Youth Forensic Service developments need to include provision for multidisciplinary teams in the region in order to:

- Enhance the current service to the Youth Courts
- Provide a consultation/liaison service to the local youth mental health services and other agencies such as Child Youth & Family Services
- Provide developmentally appropriate mental health and drug and alcohol services to the young people incarcerated in Youth Offender Units within the adult prisons

  This would also involve the establishment of a mental health screening tool.
- Consolidate the service provided to the Lower North Youth Justice Facility, based on the model of service to prisons, and also providing drug and alcohol services
- Provide treatment and case management for a small group of adolescents with complex mental health needs and high risk offending behaviour, as well as community follow-up for those adolescents discharged from youth forensic inpatient facility

Table 1 summarises the community youth forensic service positions. The costings of the service are presented in Appendix I.

In addition, there needs to be provision of specific inpatient beds for assessment and treatment and transfer from prison and the Lower North facility. Currently no such specialist inpatient youth forensic facility exists in New Zealand and young people are being held in inappropriate environments. This facility could have a regional or North Island or national focus. The Central Regional Forensic Mental Health Service is interested in progressing discussions around this issue and being a provider of specialist youth forensic inpatient services. Preliminary estimates suggest a requirement of six to eight regional beds and cost effectively be achieved through an extension to an existing forensic facility. Detailed capital and operational costing is presented in Appendix II.

As well, there are implications for local Child & Adolescent Mental Health Services and additional resources required given that the model includes triaging young people with mental health needs within the Youth Court to local services.

Table 1

Area	Existing Positions	Additional Positions Proposed
Wellington (Rimutaka Youth Unit)	1FTE psychologist 1FTE social worker	1FTE Justice Liaison Nurse 1FTE Maori clinician 1FTE psychologist 0.5FTE admin 0.5 Pasifika clinician 0.5 Drug and Alcohol counsellor
Hawke's Bay/Gisborne	1FTE psychologist	1FTE Maori clinician 1 FTE Justice Liaison Nurse 0.5 FTE admin 0.5 Pasifika clinician 0.5 Drug and Alcohol counsellor
Wanganui/Manawatu		0.5 FTE psychologist 1.0 Drug and Alcohol counsellor
Regional		1 FTE consultant psychiatrist 1FTE Team Leader

Note 1 4 additional FTEs for local CAMHS for Central Region

Note 2 In the greater Wellington area a number of new adult courts are being trialled which require the service of Justice Liaison, hence a specific Youth Court liaison nurse for the Wellington region for the 3 Youth Courts. In Hawke's Bay, the adult and youth court sittings clash and the Hastings Youth Court is the second busiest in the country, hence a specific Youth Court liaison nurse.

2. Women in Secure Care

Arohata Women's Prison is situated in the Wellington region and can accommodate up to 165 remand and sentenced prisoners with minimum, low-medium and high-medium security classifications. Until the opening of Auckland Region Corrections Facility, Arohata was the largest correctional facility for women. Arohata also operates the 20 bed National Women's Prisons Drug Treatment Unit, with Alcoholism and Drug Dependency Care Limited (NSAD Care). There are four self-care units for use by approved prisoners in the months prior to their release, in order to help re-integration to community living. Each accommodates up to four prisoners. The units are also able to accommodate mothers and babies. The table below summarises the growth in numbers of women in prison.

Table 2: Female Prison Population Census

Period	Number of Women	Increase	% Increase
1997	200		
1999	230	30	15%
2001	234	4	1.7%
2003	335	101	43.16%
2005	408	73	21.79%
2006	434	25	6.13%

In the 9 years to 2006, the female sentenced prisoner population increased by 117%.

There are four categories of women within the regional forensic facilities – those who have been remanded by the Courts for assessment; those awaiting trial; those who have been transferred from prison for hospital mental health care; and those who have been through the court process and who are now Special Patients. The Ministry of Health identified that:

> "Women inpatients have specific needs relating to gender, dislocation from family, and their status as a minority in a predominantly male environment.
>
> Separate areas in regional secure inpatient units should be developed, to ensure women are safely and appropriately assessed and have good access to family and whanau. Special consideration should be given to this development in view of the expected increase in women prisoners over the next 10 years. If numbers increase by more than predicted, services may also need to consider developing separate secure forensic facilities (within existing forensic units) near women's prisons.
>
> Likewise, in developing step down beds and residential services, the needs of women require careful attention."
>
> (Ministry of Health, 2001 "Services for People with Mental Illness in the Justice System: Review Findings", p. 41)

The national study into psychiatric morbidity within prisons study showed high rates of mental illness among women. The numbers of women in custody have continued to rise with the sentenced female population predicted to have increased by around another 15% for the period 2004/05 to 2009/10 (Ministry of Justice website).

This increasing demand is demonstrated by the Central Regional Mental Health Service's own data. Table 3 shows the increasing admission rate of women into the regional forensic units. This trend and demand will continue.

Table 3: Women's Admission Numbers – 1992-2007

Period	Number	Period	Number
1992	0	2000	7
1993	4	2001	9
1994	4	2002	13
1995	4	2003	8
1996	4	2004	14
1997	4	2005	13
1998	2	2006	14
1999	2	2007 (to June 30)	6

It is to address the increasing demand and growing unmet need that a secure forensic mental health service for women is proposed. This proposal is in line with the international development of gender specific services, for example, in the UK and Australia. It is also in keeping with the differences in the social and offending profiles of women and men, their experience of mental ill health, and patterns of behaviour. Women's care and treatment needs are even more distinct in forensic populations. In its Strategy Consultation Document, "Women's Mental Health: Into the Mainstream" (Department of Health, 2002) the Department of Health (UK) summarised the major gender differences in the forensic population. This includes that women are much more likely to:

- have a history of fire setting or criminal damage but are less likely to have committed a violent or sexual offence
- have a history of abuse and/or self harm

  Estimates suggest that at least 70% of women in high secure care may have histories of child sexual abuse and over 90% self harm.
- have physical ill health

  25% of those in high secure care have significant physical health needs.
- have a diagnosis of personality disorder, particularly borderline personality disorder

While secure mental health services for women have traditionally developed without a definite focus on the needs of women (and thus typically operated as mixed gender units) because of a paucity of clinical information upon which to base treatment strategies, it is now recognised that these are women with complex mental health care needs who typically:

- have more than one mental disorder including mental illness, substance misuse, learning disabilities, eating or personality disorders, particularly borderline personality disorder;
- have a history of significant and sustained violence and significant experience of separation and loss, including that of their children;
- experience intense feelings of powerlessness and vulnerability with difficulties in forming trusting relationships;
- present with self-harm, pervasive anger, depression, mood instability, dissociation and/or anxiety;

In New Zealand, as in the UK, women represent a small minority within a system primarily designed for men. Women admitted to the Central Regional Forensic Service have primary diagnoses of schizophrenia, schizoaffective disorder and affective psychoses, complicated by substance misuse, histories of abuse, traumatic stress reactions and personality disorder. It is of note that Maori women are over-represented.

Within a mixed gender facility:

- Women do not have adequate privacy
- Vulnerable female patients are placed in potentially risky situations of sexual abuse, harassment and assault
- Regimes of care do not reflect society's current values regarding women's roles, including women who are mothers and/or carers of older relatives
- The secure environment can resonate with earlier experiences of powerlessness and exacerbate current illness behaviour

While the focus on specialist services for women is a critical one it also needs to be acknowledged that the overall mental health service remains dominated in terms of numbers by males as demonstrated by the 2006 prison population (see table 4) and the admission pattern to the forensic inpatient units. There will continue to be significantly greater demand on male beds. The number and nature of inpatient forensic services for females and males are interlinked with both a need to increase the number of beds for males and ensure a secure, safe environment for females. Currently, 10 of the 13 clients in Rangipapa are women. Women who require mental health care and treatment in secure settings are a highly vulnerable group, with complex problems and differing needs from their male counterparts. Current service provision fails to adequately address those needs.

The proposal is to build a new 12 bed regional secure facility for women only. This proposal enables Rangipapa, the current mixed gender unit, to become a 13 bed male facility aligned directly with the other regional secure facility, Purehurehu, thereby creating a continuum of 28 acute and rehabilitation male beds. Through this, both an appropriate service environment for women and increased inpatient bed numbers for men (the acute and minimum secure rehabilitation elements) will be achieved. For the women's service academic and research links will be forged with appropriate university departments.

Costings are presented in Appendix III

3. Prison Service

a) Prison Liaison Service

The growth of prisons has had significant implications for, and impact on, the Service's role in prisons. This is graphically illustrated by the reduction in reach. Currently only around 5% of prisoners are seen. This reduction from around 7% reach has occurred because the Service's resource for prisons has remained static during a time of significant increase in the prison muster (almost 25% from 2002 to 2006 for the central region prisons), which will continue over the next 5 years. For example, a further 60 beds are to be opened in Rimutaka Prison in August 2007 and the population for that prison is projected to rise to over 1200. The prisoner population in the Central Region will reach between 3200 and 3500 by 2012, based on past growth and best information at this point.

Table 4: Prison Population

PRISONS	1997	2002	2006
Wellington	120	120	100
Arohata	105	165	120
Rimutaka	356	666	950
Wanganui	320	373	538
Manawatu	190	272	290
Hawke's Bay	400	547	666
TOTAL	1491	2143	2664
Percentage increase per period		43.7%	24.3%

The model of care to prisons needs to reflect a combination of full assertive case management and standard CMHT level care. The requirements can be different between the remand and sentenced prison populations. The latter group makes up the main case load having needs for long term rehabilitation assessment, planning and intervention with similar profiles of clients of the community assertive intervention teams. Typically, they have a major mental illness, are not well engaged with treatment, and there is both co-morbid substance abuse and co-morbid personality disorder. In the remand population is found greater acute mental illness with need for rapid assessment, triage and intervention. From the Forensic Framework Review (Ministry of Health, 2001) 10% of the prison population require mental health services (12% would not be an unreasonable projection) with additional workload arising from the prison screening to be introduced. Staffing required is calculated on the basis of the model of care, prison population, ratio of staff to prisoners and skill mix. As well, the prison setting places other demands for higher servicing such as complexities of gaining access to prisoners, travel time, report writing to the parole board, and release planning. Informal and formal education and training occurs for prison staff and is part of the Forensic Service staff role. Effective linkages with local mental health services are critical.

A working model of 10% of 3200 inmates and 1 to 15 staff ratio (although anything between 1:10 and 1:15 is not unreasonable) indicates 21 to 22 FTEs would be required. For a 1 to 12 ratio 27 to 28 FTEs is needed required. A prison population of 3500 in 2012 would require 23 to 24 FTEs (based on a 1 to 15 ratio) or 29 FTEs (based on a 1 to 12 staff ratio). The current staff complement to prisons is 10.3 FTEs (which reflects 2002 prison census levels). Alcohol and drug speciality requirements will be considered in implementing the recruitment strategy.

The staffing mix required and costs are presented in Appendix IV.

b) Prison Screening

Screening for mental illness upon reception into prison has been trialled in Christchurch. Approximately 30% in this trial were screened as positive for mental illness and requiring further assessment. Of this identified group a second tier of screening (triaging from forensic psychiatric nurse) identified approximately 10% as requiring specialist treatment from the Forensic Service.

Screening and triaging will be introduced into all the prisons. Ministry of Health estimations are that nationally 2.6 FTEs will be required to carry out triage on screening for male receptions to prison, which will in turn generate increased referrals to prison liaison services increasing the level of psychiatric assessments. It is estimated that these assessments would require a further 1.8 psychiatrists nationally. Based on prison numbers approximately 33 to 35% of these projected numbers (0.6 of psychiatrist and 1 other FTE) should be allocated to the Central Region Forensic Mental Health Service.

Costings are presented in Appendix V

c) Increased inpatient capacity, especially for male prisoners

The Central Regional Forensic Mental Health Service is neither able to respond appropriately to the increasing numbers of prisoners with significant mental health needs requiring admission nor to the remand to hospital from the courts for health assessor assessments. Many of these clients have to remain in hospital awaiting trial. There is also the ongoing management of Special Patients. The occupancy of the 2 regional forensic units at Ratonga Rua has averaged 113% for the past year and the extended care service at Stanford at 100%.

There are a number of reasons for this situation having developed:

(i) The growth in prison numbers in the regions prisons with a corresponding reduction in service reach into the prisons. There are 6 prisons in the Central Region (see Table 4).

(ii) The increasing number of Special Patients in this region. Currently the Central Region has 40 (including restricted patients, who are as special patients). That is, approximately 1 per 21,250 (assuming population base of 850,000 in central region).

(iii) Significant legislative changes, including two new Acts – the Criminal Procedure (Mentally Impaired Persons) Act, 2003 and the Intellectual Disability (Compulsory Care and Rehabilitation) Act, 2003. Both of these became law in September, 2004 and introduced new categories of "Special Patients".

(iv) The changes to delivery of general mental health services within CCDHB, initially to relieve pressure on the acute admission unit, has led to a "drying up" of the downstream resources, particularly in community placements.

These factors have led to a steady decline in the ability of the Service to admit from prison. There is in place a waiting list and any admission can only occur if there is a "swap", often meaning clients are inappropriately returned early to prison which has down-stream effects for that client, the prison and the forensic prison team. With occupancy running at 113% there is no further capacity to find space within the regional secure facilities. This is an unacceptable situation as there is effectively a statutory requirement to be able to admit people for assessment if the Court deems it necessary.

This proposal is cost neutral, based on an additional regional secure facility for women being built as per Appendix III. As pointed out the proposed Service development around women in secure care and increased inpatient capacity for men are interlinked.

4. Maori and Pacific peoples

The Service has dedicated positions for Maori and Pacific staff. These include a Kaumatua and Whaea and Pasifika Consultant. As well, there are dedicated cultural positions for Maori and Pasifika as part of the Forensic Service teams throughout the region. At Ratonga Rua o Porirua there is a Maori cultural centre, Ruamoko, and a base for Pacific people, Vaka Pasifika. Culturally focussed programmes are run out of these bases.

Both Maori and Pacific people are over-represented in admission statistics. In the prisons, 58% of the population is Maori, Pacific women admissions in prison are approximately 5.1% and Pacific men 10%. Approximately 35% of admissions to the forensic regional secure units are Maori. Currently 40% of young people assessed in the Youth Court by the Regional Forensic Mental Health Service are Maori. As well, in the Lower North facility over 50% of the young persons are Maori.

The Service requires further dedicated Maori and Pasifika clinicians. These have been identified within each service enhancement. The costings for the Maori and Pacific clinicians are incorporated into each individual costing template in the appendices. Appendix VII summarises the new positions and where they sit within the Service developments.

Enhanced access for Maori and Pacific people will occur through increased services to prisons and increased inpatient provision. This is in keeping with CCDHB strategic/policy intent of improving Maori health, reducing disparities and tackling inequalities as outlined in Te Plan II[2]. The specialist dedicated cultural positions are part of building the work force; a priority identified in Te Plan II. Te Plan II is guided by the National Maori Health Strategy, He Korowai Oranga, and the Maori Health Action Plan, Whakatataka Tuarua 2006 – 2011.

5. Other

Forensic Residential Service

There are increasing and significant difficulties in accessing community resources for the Central Regional Forensic Mental Health Service. The acute forensic inpatient units are operating at a state of continuous bed crisis. The only male client moved to a forensic rehabilitation bed in the past two years is one who was "swapped" for a client in a forensic rehabilitation bed. The Service is at increasing risk of neither being able to respond appropriately to prisoners with significant mental health needs requiring admission nor to the remand to hospital from the courts for health assessor assessments. Many of these clients have to remain in hospital awaiting trial. There is also the ongoing management of Special Patients.

Most of the clients of the Central Regional Forensic Mental Health Service need significant support when returning to the community. It is recognised that clients of Forensic Services have a combination of serious offending and severe mental illness. Typically there are complex family and whanau presentations, a history of poor work skills, social exclusion, co-morbidity with drug and alcohol use, traumatization and poor education. There is often community stereo-typing and antagonism. It is agreed that the first community house will be established in the Porirua area. The inpatient arm of the Central Regional Forensic Mental Health Service is at Ratonga Rua o Porirua. While clients come from the whole of the Central Region the Service experience shows people generally relocate to the greater Wellington area, irrespective of what region they came from. Typically, clients who have been in hospital for an extended period

[2] Te Plan II, CCDHB Maori Health Action Plan 2007-2012

have made community contacts through this time, and established friendships and other social supports. As well, there is often community (and sometimes family and whanau) hostility in their region of origin. This is particularly so for Special Patients.

In the 2007/2008 financial year the first dedicated community house will be established in the Porirua area in conjunction with an NGO provider. An RFP process will be undertaken to identify the appropriate NGO provider. Dependent on funding it is proposed a second community house will be opened in 2008/2009 and a third community residential facility in 2009/2010. Each house of the residential service will accommodate 4 clients and be staffed from 7.00am to 10.00pm 7 days per week. Location of one of these subsequent facilities will take account of the extended forensic care service in Wanganui. Clients in these residences will be supported clinically by the Central Regional Forensic Mental Health Service community teams. The central regions Portfolio Managers have allocated 275k per residence from Blueprint for 2007/2008 and a further 275k for 2008/09 (550k per annum). The annual operating cost of each residential facility is 395k. (see costings appendix VI)

Primary Care Service

There is ongoing attention to the general health needs of the inpatient population of Ratonga Rua o Porirua, including the longer stay forensic inpatient group. The issues related to physical issues for mental health consumers are becoming of increasing concern, with many studies highlighting the increased incidence of metabolic syndrome associated with antipsychotic medication, particularly the newer medications. Metabolic syndrome is a combination of medical disorders that increase risk for cardiovascular disease and diabetes. To enhance the Service's capacity to monitor this and other health issues, and to provide ongoing care and education, a primary care service which includes 2/10th equivalent of a general practitioner and 1/10th equivalent of a practice nurse per week has commenced. A specific GP consulting room is established on site.

Nursing responsibilities include chronic disease management (reviewing patients, maintaining a register of chronic diseases and recalling patients for follow-up, and supporting unit nursing staff with aspects of physical healthcare, e.g. advice on wound management). The doctor's responsibility is to provide general practitioner services including the management of acute and chronic conditions, and referral to specialists as appropriate. Post admission physical assessments may be required.

The majority of appointments take place at the primary care clinic room but on occasions, due to the legal status of certain clients, consultation occurs on individual units.

6. Performance and Reporting Measures

The Regional Forensic Mental Health Service, with the Regional Funding & Planning Managers' Group, is developing an agreed quarterly reporting format. This proposed format is presented in Appendix VIII. There is still more work to be done before it is finalised. The form of this report could be the basis for reporting to the Ministry of Health.

Other considerations include the following:

a) Two major initiatives for CCDHB Mental Health Services are planned in the 2007/08 year.

   - The implementation of the Orion information system will initiate electronic filing that will capture data more readily than existing methods. The Orion system will also enable more sophisticated reporting.

- The introduction of Health of the Nation Outcome HoNOS tool as part of the MHSMART programme. This tool will report the clinical progress of people who use mental health services. HoNOS data enhances the MHS ability to plan and deliver clinical and support services for individual clients as well as enabling planning from a population health perspective.

b) The safety of people who use mental health services is paramount. To enhance service delivery and reduce mistakes the CCDHB MHS will evaluate a Queensland programme, Human Error and Patient Safety (HEAPS), with a view to adapting and implementing similar practices during the 2007/08 year. HEAPS is a health sector adaptation of an aviation industry safety initiative.

FUTURE DIRECTIONS

In the Ministry of Health document "Review of Forensic Mental Health Services: Future Directions", 13 specific questions are presented, 4 identified as national issues and 9 as regional issues. While many of these have been answered through the 5 Year Plan, each question will also be specifically addressed.

a) National Issues

1) *Describe your plan for managing the issues for youth on a national basis.*

Specifically outlined in the plan. Nationally there needs to be consideration on inpatient assessment and treatment beds, particularly to manage remand from court and transfer from prison and youth justice facilities. While this will be determined by the modelling process as to how many beds will be required nationally, a critical element is the location of youth units in prisons and the CYFS youth justice facilities. There are 4 prison youth units (total population of approximately 143) and 3 youth justice facilities (total population approximately 75), plus young women in the respective women's prisons. Two of the prison youth units and one youth justice facility are located in the Central Region, together representing approximately half of the combined muster.

2) *Describe in your plan how you will manage services for female forensic clients, and take into account the expected increase in female offending.*

Specifically outlined in the plan. Nationally, it seems that particular attention to women's needs must be paid by the 3 regional forensic services that have women's prisons in their catchment area, that is, Auckland, Central and Canterbury. Services could be supported by a national specialist mobile team operated out of one service.

3) *In your plan, please comment on our forecasts and those in Appendix Two, and describe your FTE estimates, as well as how they will be phased over the five-year period. In addition, identify how you might trial and evaluate an assertive model of care.*

Specifically outlined in the plan. Phasing needs to focus on the prisons which are having the most significant growth. In the Central Region, this is Rimutaka and Hawke's Bay Prisons.

4) *Describe in your plan proposals for discussion with the Ministry on how assessment and reporting measures could be established and implemented.*

Specific suggestions are outlined in the plan.

b) Regional Issues

5) *Your plan should cover the provision of facilities to meet future demands on the forensic services you provide over the next five years. If you expect a waiting list to be created/increase, describe the mechanisms you will use to manage this.*

Provision of facilities is outlined in the plan. In particular, the proposed reconfiguration of the regional secure facilities, Rangipapa and Purehurehu, will address the bed issue for males and the specific needs of women will be addressed by through a new purpose built facility with a precise service focus. This is dependent upon the forensic residential service coming on stream.

Reference has been made to inpatient facilities for youth offenders requiring specialist mental health assessment and treatment.

6) *Your plan should cover FTE requirements for the next five years. Particular attention should be paid to the types of skilled workers are you most likely to need, taking into account any new pressures or demands on services that are likely to occur.*

Specifically outlined in the plan. Supported by the cost templates for each service area identified.

7) *Our plan should set out steps necessary to provide appropriate pathways of care for patients to allow treatment to be carried out in the least restrictive environment.*

Reducing barriers to entry and exiting the Service is inherent to ensuring that clients are placed in the most appropriate environment suited to their needs. Currently, there are significant barriers for clients in some areas because of pressure on service provision. As well, many of the factors that drive demand for forensic services are outside of the control of these services. This plan addresses some of the needs of this client group. While it is critical that there are multiple pathways options available the focus is on the following main pathways:

i) court → local mental health services

ii) court → the regional secure forensic facilities → local mental health services;

iii) prison → the regional secure forensic facilities → prison → local mental health services on release;

iv) court/prison → the regional secure forensic facilities → step-down beds in the inpatient rehabilitation service (including hospital based cottages) → the forensic residential service → other accommodation.

Any combination of the above can be a pathway.

8) *Your plan should describe how you will manage services for intellectually disabled people, or interface with services with this mandate.*

The Central Regional Forensic Mental Health Services and Capital & Coast Intellectual Disability Services are apart of the same mental health group (Te Korowai-Whariki), thus they have the same management structure and there are staff who work across both Services. These Services are regional and/or national in focus. There is already a significant relationship between the two. The national arm of the Intellectual Disability Services includes Haumietiketike and the two step-down cottages. There is also in place a specialist Intellectual

Disability Consultation & Liaison Team which supports all providers who have clients involved with the criminal justice system.

There is an unresolved national issue around the small number of intellectually disabled women offenders and their placement in the two national facilities, Haumietiketike and Pohutakawa (Auckland). A possible solution is for there to be provision of specialised beds for this population attached to the proposed women's secure facility.

9) *Any proposed changes to the management of services in your area should be described in your plan.*

CCDHB has established two mental health services, one focussed on the delivery of local mental health services and the other on what has been known as RFRIDS (Regional Forensic, Rehabilitation, Intellectual Disability Services and the Severe Conduct Disorder Programme). RFRIDS has been re-branded and from July 1, 2007 the Service Group will be known as Te Korowai-Whāriki. Te Korowai-Whāriki is a national and regional service provider with its own unique identity and stakeholders. Both mental health groups continue to share resources. Relevant information is presented in Appendix IX.

10) *Actions planned for improving interfaces between services should be described, with emphasis on the role of your RFS.*

The Central Regional Forensic Service has an operational Memorandum of Understanding with each local mental health service. The regular visits to each local service from the Clinical Director will continue. As well, this is complemented by regular liaison meetings with the Police District areas (3 in the central region) and the respective prison management teams, Probation, the Judiciary, and prison medical managers. The continued effort to have a consistent approach for the transfer of clients admitted to and released from prison will continue.

11) *Your plans should explain how you will manage and cover the resources necessary for your region to meet the needs of women using forensic services.*

Specifically outlined in the plan.

12) *Plans should describe how court liaison services for youth will be provided in your area, pending the development of a wider framework for the provision of services for youth in the justice system.*

Specifically outlined in the plan.

13) *Describe any initiatives planned to improve services for Maori and Pacific peoples.*

Specifically outlined in the plan.

Consideration of a dedicated women's secure unit would provide the opportunity to dedicate one of the 2 male secure facilities for Maori, as a means of allowing people to benefit more fully from the range of cultural support already available.

CONCLUSION

This paper is a response to the Ministry of Health request that the Regional Forensic Services provide 5 Year Development Plans. Given the issues outlined, there is particular emphasis on the development of specific services for women, a youth forensic service, increased FTE resource for the burgeoning prison population and specific inpatient and community facilities. The plan provides costings for each of the areas of service development.

Specifically the 5 year plan outlines the following developments:

1. A new purpose built facility for women in secure care that will address both this particular issue and increase inpatient capacity for males across a range of service elements.
2. Increased FTEs for the prison liaison service to the Central Region prisons, the number and skill mix based on catching up on both past prison growth and taken account of projected numbers over the next 5 years.
3. Required FTEs for the introduction of prison screening, based on Ministry of Health estimations.
4. Establishment of a fully functioning Youth Forensic Service that builds on the Central Regional Forensic Mental Health Services current service to the Youth Courts (and other elements) and takes account of the prison youth units and the Child Youth and Family Service secure residential facility. This requires additional capacity for some local CAMHS teams. Included in this plan is an inpatient youth forensic service of 6 to 8 beds.
5. Establishment of the Forensic Residential Service, with three community houses to be set up in the 2007/08, 2008/09 and 2009/10 financial years, in conjunction with a NGO provider.
6. Highlights throughout each element of service development the dedicated positions for Maori and Pasifika clinicians being established.

Appendix I – Regional Community Youth Forensic Service

Proposed Service | **Regional Community Youth Forensic Service**

Organisation | **Te Korowai Whāriki**

This section has been deleted as it contains commercially sensitive information.

Appendix II – Regional Inpatient Youth Forensic Service

Proposed Service	**Regional Inpatient Youth Forensic Service**
Organisation	**Te Korowai Whāriki**

This section has been deleted as it contains commercially sensitive information.

Appendix III – Regional Secure Women's Inpatient Service

Proposed Service	**Regional Secure Women's Inpatient Service**
Organisation	**Te Korowai Whāriki**

This section has been deleted as it contains commercially sensitive information.

Appendix IV – Prison Liaison Service

Proposed Service	**Prison Liaison Service**
Organisation	**Te Korowai Whāriki**

This section has been deleted as it contains commercially sensitive information.

Appendix V – Prison Screening Service

Proposed Service	**Prison Screening Service**
Organisation	**Te Korowai Whāriki**

This section has been deleted as it contains commercially sensitive information.

Appendix VI – Forensic Residential Service Funding Shortfall

Proposed Service	**Forensic Residential Service**
Organisation	**Te Korowai Whāriki**

This section has been deleted as it contains commercially sensitive information.

Appendix VII – Maori & Pasifika Staff Summary

Summary of Maori & Pacific Positions

Service	Maori	Pacific
Community Youth Forensic	2	1
Inpatient Youth Forensic	1	
Women's Secure Facility	1	
Prison Liaison	2	1

-

Appendix VIII – Proposed Quarterly Report Formats

Court Reports

Type of Report	38(2)(a)	38(2)(b)	38(2)(c)	23	35	333	88	Parole	Other	TOTAL
Hawke's Bay										
Hutt										
Mid Central										
Porirua										
Tairawhiti										
Wairarapa										
Wanganui										
Wellington										
TOTAL										

Explanation:

1 Criminal Procedure (Mentally Impaired Persons) Act 2003 –
Section 38(2)(a),on bail
Section 38(2)(b): – on remand in prison
Section 38(2)(c): – on remand in hospital
Section 23: - enquiries about person found unfit to stand trial or insane (in hospital)
Section 25: - alternative decisions in respect of defendant unfit to stand trial or insane (in hospital)
Section 44: - detention pending hearing or trial (in hospital)

2 Children Young Persons & Their Families Act 1989
Section 333 – Youth Court order for psychological or psychiatric assessment

3 Sentencing Act 2002 Section 88 – assessment for sentence of preventative detention

4 Parole Request from Parole Board

Appendix VIII - continued

Courts New Referrals		WELLINGTON	LOWER/UPPER HUTT	PORIRUA	MASTERTON	NAPIER/HASTINGS	GISBORNE	WANGANUI	PALMERSTON NORTH/LEVIN	OTHER (SMALLER COURTS IN REGION	TOTAL
Gender											
	Female										
	Male										
Ethnicity											
	Asian										
	Maori										
	NZ European										
	Other										
	Pacific Island										
TOTAL											

Appendix VIII - continued

Prisons

New Referrals	HAWKES BAY	WANGANUI	MANAWATU	WELLINGTON	RIMUTAKA	AROHATA	TOTAL
Ethnicity							
Maori							
NZ European							
Pacific Island							
Asian							
Other							
TOTAL							

Prison Caseload	HAWKES BAY	WANGANUI	MANAWATU	WELLINGTON	RIMUTAKA	AROHATA	TOTAL
Ethnicity							
Maori							
NZ European							
Pacific Island							
Other							
TOTAL							

Forensic Service

	NHI	Adm Date	LOS	Court	Prison	Domicile of Origin	Discharge Date	To Where
Purehurehu								
Rangipapa								

Appendix IX – Organisation Charts

Te Korowai-Whāriki

Local MHS

Te Korowai Whāriki

Chief Operating Officer

Te Korowai Whāriki Governance Advisory Board

Group Manager Local MHS

Clinical Director

Group Manager, TKW
Clinical Director, Forensic Service

DAMHS*
Professional Advisors
Nurse Leader
Quality & Monitoring Audit Coordinator
Risk Management Team
Senior Project Manager
RMO Coordinator
Core Competencies
Information Technology
Casual Pool/RN1 Training Coordinator
Kaunihera
Whakapai
HR Administrator
Quality & Safety Council

Associate Clinical Director

EA/Admin Consultant

Business Unit
Strategic Planning Manager
Research & Development
Training Coordinator (TBA)

Family Reference Group
Consumer Council
ID Advocacy Group

Internal Consultancy
Financial
Human Resources
Legal

Consumer Adviser

Transcultural
Kaumatua Nga Whaea
Pasifika Consultant

Clinical Leaders

Service Manager

Nurse Leader

Team Leaders (x7)

Note: Positions shared between MHS Groups

*** Appointed by MoH**

Appendix IX - continued

Te Korowai-Whāriki

Te Korowai Whāriki

Chief Operating Officer
Martin Hefford

Te Korowai Whāriki
Governance Advisory Board

Clinical Director
Murray Patton

DAMHS*
Professional Advisors
Nurse Leader
Quality & Monitoring Audit Coordinator
Risk Management Team
Senior Project Manager
RMO Coordinator
Core Competencies
Information Technology
Casual Pool/RN1 Training Coordinator
Kaunihera
Whakapai
HR Administrator
Quality & Safety Council

Group Manager, TKW
Clinical Director, Forensic Service
Nigel Fairley

Associate Clinical Director - TBA

EA/Admin Consultant
Anne Le'aupepe

Business Unit
Strategic Planning Manager – Anthony deRose
Research & Development - Suzanne Duncan
Training Coordinator (TBA)

Family Reference Group
Consumer Council
ID Advocacy Group

Consumer Adviser - Lynda Thoumine

Internal Consultancy
Financial
Human Resources
Legal

Transcultural
Kaumatua – Kuni Shepherd
Nga Whaea – Areta Koopu/Maria Enoka
Pasifika Consultant – Afele Seuala

Service Manager – Deidre Florance

Nurse Leader – Diane Sadler

Purehurehu Rangipapa
Denis Klue

Forensic Community Team
Maria Campbell

Tawhirimatea
George Underhill

Tane Mahuta
Anna Kempthorne

Haumietiketike
Rosanne Johnston

Intellectual Disability Community Team
Michael Dorofaeff

Severe Conduct Disorder Unit
Joy Collins