Review of Forensic Mental Health Services Future Directions

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Foreword

Forensic mental health services are a highly specialised component of New Zealand's mental health assessment, treatment and rehabilitation services. They 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 services. Further, more rapidly increasing prison musters and expectations about meeting prisoners' health needs have a flow-on effect on forensic services that needs to be addressed in future planning.

Since the introduction of forensic mental health services in New Zealand, following the 1988 Mason Report, the Ministry of Health has regularly reviewed them. Comprehensive reviews were published in 1994 and 2001. These reviews resulted in changes in priorities and funding levels within forensic mental health services. For example, following the 2001 review, priority was given to increasing the capacity of forensic services and to enhancing their links with general adult mental health services.

The purpose of this framework is to reaffirm and extend the vision of the Mason Report and the Ministry of Health's 2001 Framework for Forensic Mental Health Services. It presents an overview of the forensic mental health sector and its complexities. It identifies and analyses current issues of national significance in forensic services; providing strategic direction and leadership to guide the future development of regional forensic mental health services. This is especially important at a time when constraints on future funding are called for in the health sector.

This document provides strategic objectives and highlights the key issues in forensic services that need to be considered over the next five years, including the need for:

- a nationally consistent model for youth forensic mental health services
- specialised forensic services that meet the specific needs of women
- delivery of forensic services to reflect that Māori are the dominant ethnicity of forensic patients
- culturally appropriate forensic services for Pacific peoples and other ethnic minorities
- ensuring that people with personality disorders in the criminal justice system can access an appropriate range of mental health services
- strengthening the interface with community mental health services
- continuing to address severe mental health needs of prisoners at a time when rapid growth is predicted in the prison muster.

There are also a range of issues that face individual regional forensic services. The regions have prepared draft plans for their forensic services, informed by the 2005 Census of Forensic Mental Health Services (Ministry of Health 2007) and their own planning and consultation processes. These draft regional plans have contributed to this document. The Ministry of Health also acknowledges the valuable contributions of Dr Jeremy Skipworth, forensic psychiatrist, Auckland.

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Executive Summary

Over the next five years the Ministry of Health will lead the future direction of forensic mental health services in New Zealand. Increased national interface between key stakeholders will assist in the continued development of a longer-term strategic direction. Increased regional collaboration between key stakeholders will drive the implementation of policy and further efficiencies in multidisciplinary forensic mental health and addiction services.

The Ministry of Health has established four strategic objectives designed to ensure appropriate participation and engagement in the planning and decision-making process at various levels of the forensic mental health system. These objectives are to:

1. further develop national mechanisms for engagement of key stakeholders in the implementation of policy and strategy for forensic mental health and addiction services, led by the Ministry of Health
2. improve intra-regional collaboration between key stakeholders in the development and delivery of forensic mental health and addiction services
3. continue to promote the delivery of comprehensive, multidisciplinary forensic mental health services that are responsive to the needs of forensic populations
4. develop pathways to recovery for people who are able to transition from forensic mental health services to primary mental health care (in prison) and general mental health services (in the community).

Regional forensic service plans have influenced the final composition of this forensic framework document. Draft regional forensic plans identify diverse needs for future forensic service delivery.

There is strong consensus that forensic mental health services will be under pressure to meet expected prison muster growth and the flow-on effects of the New Zealand Prison Reception Mental Health Screen, if this is implemented.[1] Priorities that need to be considered over the next five years include:

- improved youth court liaison services
- improved and increased liaison between forensic services and community adult mental health services
- consideration of how best to manage the effects of increasing prison musters
- continued emphasis on the development of safe and appropriate ways of meeting the needs of women forensic service users
- enhancement of existing services for Māori forensic service users
- improved relationships and mental health service provision for Pacific forensic service users
- improved workforce planning and development
- improved use of the capacity and capability in forensic services
- planning for future implementation and roll-out of the New Zealand Prison Reception Mental Health Screen (in collaboration with the Department of Corrections).

1. New Zealand Reception Mental Health Screen, Simpson S & Evans C, 2007

Introduction

Two decades have passed since the release of the report of the Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients (the Mason Report: Mason et al 1988).

The model for forensic psychiatric services set out in the 1988 report is notable for its focus on the needs of one of the most disadvantaged groups of mentally ill people in our community, and its clarity of vision regarding the services required to meet those needs in a holistic sense. In the post-Mason Report era, successive governments have overseen a remarkable transformation in the development and provision of forensic mental health services in New Zealand.

The purpose of this framework is to continue the vision of the Mason Report and the Ministry of Health's 2001 Framework for Forensic Mental Health Services. To achieve this purpose, it is important to be aware of the current mental health and addiction sector strategy and action plan, the current criminal justice agenda and the corrections environment.

As part of the implementation of Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015 (Ministry of Health 2006), the Ministry of Health and District Health Boards (DHBs) are required to:

- evaluate the implementation of the forensic framework with particular emphasis on children and youth, Māori, Pacific peoples, people with disabilities and women
- examine options regarding the role of the Ministry of Health and DHBs in the planning, funding and delivery of forensic services
- continue to develop and support intersectoral initiatives to meet the needs of people in the criminal justice and youth justice sectors.

This document will contribute to achieving these specific actions. Other contributions include the development of a nationally consistent model for youth forensic mental health services and wider government initiatives to address drivers of crime. There is also a need to recognize that forensic service initiatives must be achieved within the current economic climate that requires constrained spending on health and other social services.

Mental health and criminal justice sectors

Forensic mental health services exist at the interface between the mental health and criminal justice sectors. In almost all cases, users of these services will experience mental illness. (Exceptions are the small number of people with organic brain injuries, intellectual disabilities or personality disorders.) In addition, forensic service users will be convicted of a crime, accused of a crime or considered to pose a degree of risk to themselves or others that cannot be managed by other mental health services.

At the core of forensic expertise is knowledge of the legislation surrounding the assessment and treatment of, and disposition options for, mentally ill people in the criminal justice system. The most important legislation in this area is the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Criminal

Procedure (Mentally Impaired Persons) Act 2003. These Acts and other relevant legislation are outlined in Appendix One.

Principles

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 of forensic services enunciated in the 2001 framework include the following.

- Service users' needs for mental health care should govern their access to services.
- Service users should be accommodated in facilities that match their need.
- Service users should be treated in the least restrictive environment that their circumstances allow.
- Services should be client-focused, enhancing wellbeing and preserving dignity.
- Services must balance individual rights against the need to protect the public.
- Services should be culturally appropriate, treating the whole person and involving whānau and families.
- The approach to care should be holistic, integrated, open-minded and non-judgemental.
- Service provision should minimise negative public perceptions of people with mental illness, including those who have both a mental illness and contact with the criminal justice system.

Additional service principles for culturally effective services to Māori were included in the 2001 framework.

1. Choice from a range of services.
2. Relevant services that are culturally meaningful and address actual needs.
3. Integration of mental health with other health services, with connections strengthened in line with a holistic approach to Māori development.
4. Quality of care and treatment, as reflected in outcomes.
   (Durie et al 1995).

These principles are well established in forensic services, with national and regional consistency in their expression and adherence to them. Their effective operation reflects the strong developmental base for forensic services that was established by the 1988 Mason Report.

Description of Forensic Services

Forensic mental health services are now an integral part of mental health care throughout New Zealand. In contrast to adult mental health services (AMHS) which are now predominantly community based, forensic services remain institutionally focused, with outreach into the prisons, courts and community. In all settings there is a strong commitment to a comprehensive, multidisciplinary, culturally appropriate, integrated approach to forensic mental health care. Māori is the dominant ethnicity of forensic patients, and forensic services need to continue to reflect this representation in staff competencies, culture and rehabilitative programmes.

Each forensic service component has important functional interfaces with the other components, as well as with Corrections, the courts, AMHS and increasingly the youth justice sector. Clarifying the roles to be performed by each part of the service, and in turn by the other services with which forensic services interface is vital and the lack of clear definitions of forensic patients and services remains problematic. Te Tāhuhu, the second New Zealand Mental Health and Addiction Plan, states that 'the special needs of people with mental health needs and addiction who are currently in the justice system or who are special patients are the focus of forensic mental health services'.

Forensic staff will therefore require a detailed knowledge of relevant legal issues, criminal justice systems and the relationships among mental disorder, antisocial behaviour and offending. However, in most cases forensic patients present a level of risk that is no greater than that of many patients in general mental health services. The task of risk assessment and management is a vital skill for general mental health services as much as it is for forensic services.

Organisation of regional forensic services

Forensic mental health services are organised regionally into six regional forensic service (RFS) providers (Auckland RFS; Waikato RFS; Hauora Waikato in the Waikato region; Central RFS; Canterbury RFS; and Otago RFS). These providers operate in five regions – Northern, Midland, Central, Canterbury and, encompassing the lower South Island, Otago/Southland. (See Appendix Two for a map of the regions.)

As set out in Table 1, there are seven forensic inpatient facilities: the Mason Clinic in Auckland; the Henry Rongomau Bennett Centre in Hamilton; Tamahere in Hamilton via Hauora Waikato, Stanford House in Wanganui; Ratonga-Rua-o-Porirua in Porirua; Hillmorton Hospital in Christchurch; and Wakari Hospital in Dunedin.

Within this structure there are some important regional differences. First, while most regions have only one forensic service provider, the Waikato region has two: Waikato DHB and Hauora Waikato, a nongovernmental organisation (NGO) that provides some forensic services particularly for Māori. Second, it is important to note that even though Stanford House is within the Whanganui DHB region, its regional forensic psychiatric beds are funded by Capital & Coast DHB. It is therefore part of the Central region. Third, for community-based forensic services in Southland, psychiatric input is provided on a private contractual basis to the Southland region.

Table 1: Location of regional forensic services

Regional forensic services	Forensic inpatient facilities	Location	Prisons
Northern	Mason Clinic	Auckland	Northland Region Corrections Facility Mt Eden Auckland (Paremoremo) Auckland Central Remand Prison Auckland Region Women's Corrections Facility
Midland	Henry Rongomau Bennett Centre Tamahere	Hamilton	Spring Hill Corrections Facility Waikeria Prison Tongariro/Rangipo New Plymouth
Central	Stanford House Ratonga-Rua-o-Porirua	Wanganui Porirua	Wanganui (Kaitoke) Hawke's Bay Manawatu Rimutaka Wellington Arohata
Canterbury	Hillmorton Hospital	Christchurch	Christchurch Rolleston Christchurch Women's Prison
Otago/ Southland	Wakari Hospital	Dunedin	Invercargill Prison Otago Region Corrections Facility

Inpatient services

Inpatient forensic services include a range of mental health units with security that ranges from medium secure units to unlocked units. These units, which are under considerable pressure, as evidenced by waiting lists for admission in some regions, are currently the only inpatient treatment option for a range of special patients defined in the Mental Health (Compulsory Assessment and Treatment) Act 1992 in the following categories:

- remand or sentenced prisoners (pursuant to section 45 or section 46 of the Mental Health Act)
- court ordered inpatient assessments to assess insanity, fitness to stand trial, or dispositional issues (pursuant to sections 38(2)(c), 35 and 23 of the Criminal Procedure (Mentally Impaired Persons) Act 2003)
- remand prisoners awaiting court hearings (pursuant to section 44(1) of the Criminal Procedure Act or section 171(2) of the Summary Proceedings Act 1957)
- special patients acquitted by reason of insanity or found unfit to stand trial under section 24(2)(a) of the Criminal Procedure Act who require inpatient care and rehabilitation
- 'hybrid' special patients who are both sentenced to a term of imprisonment and placed under a compulsory inpatient treatment order (under section 34(1)(a)(i) of the Criminal Procedure Act)
- special care recipients under section 136(5)(a) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Inpatient forensic services also occasionally provide a service to people under Mental Health Act compulsory treatment whose risk cannot be safely managed within AMHS. Although some flexibility in this area has advantages, it also potentially blurs

the boundaries between general and forensic services, and for this reason transfers of care of this nature should be reserved for exceptional cases, most of whom should return to general adult services as soon as is practicable. This approach must be supported by responsive forensic consultation/liaison services to AMHS.

As well as reviewing target patient populations, it is appropriate to reflect on the models of care that forensic services are following. Questions have been raised for some time about the clinical appropriateness of the lengthy periods of inpatient care for special patients acquitted by reason of insanity, particularly as the waiting list for admission becomes more visible. Although a significant period of administrative oversight from the Director of Mental Health is appropriate from a policy perspective, it may be possible that some of the pressure on inpatient beds could be relieved by earlier transition into the community, without risks to the patient, the public, clinicians or services, depending on their security classification. Future strategies will require further development and careful consideration.

A prominent feature of this planning process has been the emergence of a demand for subspecialisation of forensic inpatient services, including specific services for women and youth. Historically, providing specific inpatient services for these populations has been difficult because of the relatively small numbers of these patients and their diverse criminal justice and rehabilitative needs. With these barriers in mind, combining services across regions, and adopting a national rather than regional approach for some small populations are now emerging as realistic solutions with the reestablishment of the South Island Forensic Governance Group and a South Island strategy for the first time. It is likely that establishing a small number of youth forensic beds nationally will require a similar collaborative approach between regions.

The current options for prisoners who do require admission to hospital may also need to be reconsidered. Currently they are admitted to a secure forensic bed, irrespective of the prisoner's security classification, even when this admission requires a move away from the prisoner's primary supports and when a clinical assessment of risk would not suggest any need for that level of security.

Greater flexibility is needed so that, in appropriate cases, and with the agreement of the Department of Corrections, prisoners can be admitted to the local general mental health unit. Implementing this option will require a collaborative model of care, with forensic liaison available to ensure the unique issues that pertain to special patients are attended to. Selected cases may be better served by a local admission without compromising public safety.

Lastly it is of concern that, in some regions, forensic services are now the dominant provider of long term, secure, hospital-based rehabilitation. This type of care which will be necessary for a small group of AMHS and forensic service users with high and complex needs should not be provided preferentially or solely by forensic services. A failure to meet the needs of the individuals in AMHS who require this function risks the emergence of criminal behaviour driven by untreated mental illness and ultimately direction into forensic services. The lack of long-term, secure, hospital-based rehabilitation in AMHS also prevents the transfer of forensic patients to AMHS when they require this level of care. Regional planning for forensic services should be sensitive to the development needs of other, less developed parts of the mental health sector.

Forensic services to prisons

New Zealand's recent trend to incarcerate an increasing proportion of the population has major implications for the provision of forensic services. It is estimated that 10 percent of prisoners are sufficiently unwell to require specialist mental health services. The introduction of screening would ensure that the majority of these prisoners are identified, thereby significantly increasing the forensic caseload in prisons.

The new reality of the forensic liaison caseload in prison will prompt a re-evaluation of the way in which forensic services are provided to prisoners. All regions are promoting various models of assertive prison treatment that, while having face validity, lack an empirical research base supporting better outcomes. Closer examination of such models emerges as a fertile area for outcomes oriented research.

All areas of forensic services will be affected either directly or indirectly by the increase in prison forensic caseload. There will be flow-on pressure on inpatient beds, and there will be many more transfers of care between forensic and general services as patients go through the courts, are imprisoned or are released back into the community. This greater identification and cross-referral will also increase demand on AMHS, who may struggle to meet that demand without appropriate upskilling.

The increased demand for forensic services in courts and prisons, and the associated downstream consequences, emerge as the dominant issue currently relating to forensic services.

The model of care in the Mason Report described prison psychiatric units offering multidisciplinary treatment on an outpatient basis, with access to administration offices, interview rooms, large all purpose rooms, an occupational therapy centre, school room and library. Today this comprehensive multidisciplinary model for forensic treatment in prison does not exist in New Zealand, nor is it a model promoted in any of the current regional plans. Perhaps its absence relates to the necessity of realising it by integrated and well co-ordinated planning among the Department of Corrections, the Ministry of Health and regional forensic psychiatry services.

This type of planning has not been a dominant feature of the recent building of new prisons around the country. Ideally prisons should be built close to services. However due to limited location options and strong community resistance, new prisons have been built in areas where limited forensic resources were previously required, raising important logistical issues for forensic service development. Earlier and more robust consultation between the Department of Corrections, the Ministry of Health and regional forensic psychiatry services is necessary if prisoners' mental health needs are to be met.

Nonetheless, the need to consider different models of forensic care in prisons remains. Large prisons may be better served by a permanent presence of forensic mental health staff, with offices for the multidisciplinary team and administrative support within the prison rather than some distance away at the regional forensic services base. Location of forensic services within prisons may lead to more intensive input from forensic and other specialist services and closer links to

primary health teams in prison, and may make possible some interventions that reduce pressure on waiting lists for inpatient beds.

From the data from the Census of Forensic Mental Health Services 2005 (Ministry of Health 2007), it appears that up to a third of the mentally ill prisoners on the waiting list for inpatient admission to forensic services could be managed in prison. For this group, inpatient transfer would not be necessary if intensive input from forensic services could be provided in the context of high quality primary health and nursing care. The 'clozapine waiting list' and draft protocol to prescribe clozapine in prison represent the best example of this sort of initiative.

Although, there is currently no prison environment in New Zealand that provides a level of care compatible with safe initiation of clozapine a draft policy is currently under development, intended to make it safe to do so. Further discussion will continue at a national level to develop agreed protocols for the prescription of clozapine in prison. The process of development will include:

- defining the circumstances in which a prisoner may commence or recommence clozapine in custody
- defining the roles and responsibilities for the clinical interventions related to clozapine initiation and maintenance
- providing guidelines for the selection of prisoners eligible to commence clozapine for the first time and for those recommencing clozapine after a break in treatment
- ensuring that commencement of clozapine within prison conforms with best practice guidelines.

The problems associated with improving primary healthcare in New Zealand prisons are well known. Improved leadership and collaboration between the Department of Corrections and the Ministry of Health would represent an opportunity to develop a close, mutually beneficial relationship that can support an assertive treatment model in the prison environment.

At the same time, both agencies need to address respective responsibilities for corrections and health in relation to providing alcohol and other drug treatment, and the management of people with severe personality disorders.

Community-based services

The 2001 forensic framework suggested that community forensic patients should be defined principally by their status as special patients or restricted patients resident in the community. Despite this guidance, the data from the Census of Forensic Mental Health Services 2005 show that nearly three times as many forensic community patients were subject to a compulsory treatment order as compared with those subject to special and restricted patient orders.

This situation has developed in part because of the difficulties in transferring the care of forensic inpatients to AMHS at the point of discharge into the community, and in part because of the shortage of appropriately supported accommodation options. Consequently, forensic community residential services are now seen as an essential component of forensic community services. They enable the appropriate community transfer of inpatients ready for discharge.

However, there remains a need to better understand the reasons for the apparent reliance on forensic community care for patients who could be managed by AMHS, in

partnership with forensic services. There is an understandable natural tendency for more fully developed services to retain or take over the care of patients who might otherwise be cared for by AMHS.

Also likely to influence the ability to refer this group of patients back to AMHS is the availability and capacity of AMHS assertive treatment teams which is currently highly variable throughout the country. Well-resourced, mobile and proactive teams are best placed to manage the community reintegration of many forensic patients as they leave prison or transition out of forensic inpatient services, or following court disposal. Their availability can reduce the duration of inpatient care, and in some cases may provide an alternative to inpatient care, thereby freeing up forensic inpatient resources. Establishing these services in all areas of the country is an important component of regional service development.

Court liaison services

The presence of court liaison staff in adult courts around the country has now been achieved. They facilitate the provision of informal assessments and advice to the court, broker formal court reports, and co-ordinate the care of mentally ill people appearing before the courts. The success of this model has led to a call for youth courts to be provided with the same service as part of a comprehensive range of youth forensic services to be developed

Forensic Service Development Issues

Māori

He Korowai Oranga: Māori Health Strategy (Ministry of Health 2002) places whānau at the centre of public policy. It is aligned with mental health through Te Puāwaiwhero, the second national Māori Mental Health and Addiction Strategy (Ministry of Health 2008).

The overall aim of both strategies is whānau ora: Māori families supported to achieve their maximum health and wellbeing. It provides an overarching principle for recovery and maintaining wellness. As a population group, Māori have on average the poorest health status of any ethnic grouping in New Zealand. Te Rau Hinengaro – The New Zealand Mental Health Survey provides further evidence of ongoing mental health and addiction disparities between Māori and other population groups (Oakley Browne et al 2006). Māori experience higher prevalence, severity and burden of illness with a greater lifetime risk of developing a mental illness than others.

At the time of the Census of Forensic Mental Health Services 2005 (Ministry of Health 2007), the ethnic make-up of New Zealand prisons was 49 percent Māori, 30 percent New Zealand European, 10 percent Pacific peoples and 11 percent other ethnicities. Although it is disturbing to note the over-representation of Māori in New Zealand prisons, it is important to note that the ethnicity of forensic service users at the time of the 2005 census accurately reflected this target population. As Table 2 shows, Māori comprised 48 percent of forensic inpatients and 45 percent of community based service users; New Zealand Europeans comprised 39 percent of inpatients and 43 percent of community-based service users; while Pacific peoples made up 8 percent and 11 percent of inpatient and community-based services respectively.

Table 2: Ethnicity of forensic inpatients and community-based service users, 1999 and 2005

Ethnicity	Inpatient				Community			
	1999		2005		1999		2005	
	Number	%	Number	%	Number	%	Number	%
Māori	95	50	104	48	73	29	74	45
New Zealand European	68	36	85	39	158	62	71	43
Pacific peoples	14	7	16	8	13	5	18	11
Other	12	6	10	5	12	5	2	1
Total	**189**	**100**	**215**	**100**	**256**	**100**	**165**	**100**

Responsiveness to Māori overrepresentation within the criminal justice system remains critical. With the anticipated implementation of the mental health screening tool in prisons and the predicted increase in the number of offenders with severe mental illness requiring specialist care, cultural assessment and Māori specific therapeutic processes will be under increased pressure.

Effective delivery of forensic services for Māori requires consideration and further growth of essential Māori paradigm components. These components must then be utilised in all forensic settings, including prisons, courts, secure inpatient units, step-down services and the community, and must encompass all AMHS to ensure a continuum of care that is effective for Maori.

Key components to successful recovery include the following.

- Iwi, hapū, whānau and other Māori community participation and engagement: Participation and engagement in the development of and decision-making for a pathway of recovery are necessary for the wellbeing and recovery of Māori consumers. These relationships will ensure appropriate engagement and participation at all levels of planning and decision-making for forensic services for Māori.
- Te reo Māori: Where appropriate, the use of te reo Māori is a key driver to identity and wellbeing, and a contributing mechanism in relation to an effective pathway of recovery.
- Tikanga Māori: Common traditional and re-established customs – including rongoa, traditional healing techniques; karakia, spirituality; and tohunga, use of specialist traditional healers – are integral parts of the journey towards wellbeing. Agreed processes need to be utilised in understanding and determining the appropriate use of each custom; for this reason, effective and robust relationships are important.
- Kaupapa Māori services: Based on Māori philosophy and spirituality, these services take a holistic approach to treatment and recovery, focusing on the total lifespan of a consumer. All regional forensic services need to sustain a strong commitment to delivering clinical and cultural services through Māori worldview paradigms that integrate the best of forensic psychiatric care and rehabilitation. Past and current gains need to be built on.

Pacific peoples and other minority ethnicities

The New Zealand Health Strategy (Ministry of Health 2000) and the New Zealand Disability Strategy (Minister for Disability Issues 2001) provide the overall direction for improving the health and wellbeing of people living in New Zealand and for ensuring services are of the highest quality.

Given the increasing and diverse nature of New Zealand's prison population, consideration must be given to culturally appropriate forensic services for all service users. As such, regional forensic services agree on the need for greater emphasis on effective and culturally appropriate mental health and addiction pathways of care for all service users. Regional forensic services will need to ensure access to appropriate cultural and spiritual support that allows people of all ethnicities to access safe, effective and responsive specialist services.

All regional forensic services should be taking initiatives, and should be planning future initiatives, for services that can assess and provide cultural and spiritual needs in an effective, responsive and appropriate manner, irrespective of a person's ethnicity, culture and personal background.

The Census of Forensic Mental Health Services 2005 provides evidence that Pacific peoples are overrepresented in the New Zealand prison population and forensic services compared with the general population. The establishment and maintenance

of effective and robust relationships with key Pacific service providers is increasingly seen as an essential forensic service component.

A commitment to continued workforce development to deliver clinical and culturally appropriate services to Pacific peoples is required. As such, all regional services will:

- be able to provide or have access to safe, effective, responsive and appropriate cultural and spiritual services, when required, for all ethnicities accessing forensic services
- ensure that future service development initiatives are sensitive to the cultural and spiritual needs of all forensic service users

Youth

The 'youth' demographic comprises three separate age groups.

- Children, aged 10 to 13 years inclusive, are covered by the care and protection provisions of the Children, Young Persons, and Their Families Act 1989 (CYPF) and if arrested are dealt with in the family court.
- Young offenders aged 14 to 16 years are covered by the youth justice provisions of the CYPF and if charged are usually dealt with in the youth court
- Young offenders aged 17 to 19 years are covered by the adult criminal justice system.

Jurisdiction is determined by their age at alleged commission of the offence. Children can be held criminally responsible from the age of 10 for either murder or manslaughter. For all other offences the age of criminal responsibility is 14 years. Young people aged 14 to 16 who commit serious offences may be referred to the district or high court and may be processed by the adult criminal justice system.[2]

There are approximately 7000 youth court appearances in New Zealand each year. Many of the young people appearing in court are likely to have mental health and/or AOD issues. While New Zealand does not have its own epidemiological data on the mental health of young offenders, extensive international literature identifies high rates of psychiatric morbidity, psychotic illness, drug and alcohol disorders as well as behavioural issues. Informal studies undertaken in New Zealand indicate a consistency with international literature.

Differences in the age ranges used to define service provision for mental health services, AOD services and the justice system have implications for co-ordination across agencies. For example, the Child and Adolescent Mental Health Services (CAMHS) and youth AOD services cater for young people from 0 to 19 years of age. Adult forensic mental health services cover young people from the age of 17. Consideration should be given to the young offender's developmental needs when determining treatment needs and whether youth or adult focused services are provided for them.

The Northern region proposes that a youth forensic service should also cover children under age 14 who are charged. Evidence confirms that intervention at such a young age is very effective both in terms of reducing re-offending and of improving mental health and AOD outcomes.

2. Young people (12 to 16 years) can receive prison sentences. If, because of their age and/or vulnerability they are assessed as being too vulnerable to serve their sentence in a youth unit of a prison, they can be transferred to Child, Youth and Family's Youth Justice facility in Auckland. Young people aged 12 to 14 will automatically be held in the Youth Justice facility.

Māori rangatahi/youth are proportionately three times as likely to be apprehended for non-traffic offences as other youth. In 2006 Māori rangatahi/youth made up 53 percent of all prosecuted cases through the youth courts. While the ethnicity split is comparable with that of adult offenders, youth forensic services will need to demonstrate a high level of cultural responsiveness and acceptability.

A snapshot of young people aged 15 to 17 years in custody under the adult jurisdiction as at 23 July 2007 showed the following national picture.

Table 3: Number of youth in custody by age, July 2007

Age (years)	Number in custody
15	4
16	19
17	91

All but two of the youth in custody at 23 July 2007 were in youth units at adult prisons. These numbers show a snapshot in time and not the total numbers throughout a year. In 2006, there were 65 cases of offenders aged 14 to 16 years that were finalised in the district or high court resulting in a sentence of imprisonment.

There are currently 116 beds in Child, Youth and Family youth justice residences. Young offenders aged 14 to 16 years may be in these residences while on remand and/or while on a supervision with residence order (two to three months' duration). In 2006, there were 238 youth supervision residence orders made. A key element of reducing offending will be youth forensic mental health and AOD service provision for young people in a range of settings.

A Te Kōkiri work programme identifies youth forensic services as a medium-term action (for implementation within the next three to five years). Work in this area has been highlighted as a priority by the joint Ministry of Health–DHB Te Kōkiri implementation group and is under way. A first draft of a nationally consistent model for youth forensic services is expected to be ready for feedback in 2010.

All regions acknowledged the need for this model in their draft regional forensic service plans. At a meeting of key stakeholders in the youth justice, forensic and CAMHS/youth AOD sectors in February 2007, general agreement was reached on the following key issues. Specifically, those issues related to the need for:

- development of an integrated, national framework or model for youth forensic services as specified in Te Kōkiri
- workforce development, with responsiveness to Māori and a focus on systems interface between CAMHS, Child, Youth and Family, regional forensic services and AMHS, The Werry Centre has been contracted by the Ministry of Health to do this work
- development of stronger relationships and co-ordination across agencies and across the health sector
- a comprehensive approach in both community and residential (secure) care facilities.

Draft regional forensic service plans raise the need for a small number of secure youth forensic beds, either as inpatient or step-down community beds. This is in line with the 1998 Blueprint recommendation for 15.1 beds (or care packages) for youth offenders in New Zealand.

Three of the four regions signal that placement of such beds and their management would be primarily with CAMHS or youth services, not with adult forensic services

New Zealand's endorsement of the United Nations Convention on the Rights of Children (UNCROC) includes acceptance of the need for segregation of children and young people from adults in service settings, to maintain their safety. This must be a consideration when addressing the placement of any secure facilities for youth.

Court liaison services were identified at the February 2007 meeting of key stakeholders as a key component of current services that needed to be improved, and highlighted as a viable place to start the process of improving services for youth. This has been reconfirmed both nationally and regionally.

Projects in youth courts at Rotorua and Hamilton have already started. Youth court liaison is also provided across the Central Region by youth forensic nurses attached to the adult forensic service. A realistic goal is to introduce universal screening at all youth courts over the next five years. Agreement is needed over the most appropriate screening tools to be used and the management of follow-up assessment and treatment. In particular, there will be very high demand on AOD service provision.

A comprehensive youth forensic service would include:

- secure youth forensic beds
- in-reach[3] and consultation/liaison with youth justice and corrections facilities where youth are in custody
- CAMHS
- screening and follow-up of youth in courts • needs assessment and service co-ordination
- access to short-term interventions
- family group conference participation
- youth offending team participation
- integrated mental health and AOD approach to treatment, given high rates of co-morbidity among youth.

The development of a nationally consistent model for youth forensic services will assist in explaining and prioritising components of a comprehensive service. The development of youth forensic services should be informed by the successful development of adult forensic services over the last 19 years, while recognising special characteristics of youth and their vulnerabilities as well as the different legislative provisions for youth populations.

At this stage there are few formally contracted youth forensic services in New Zealand and none that provide comprehensive coverage of all or most necessary components of care. New Zealand has fallen behind countries such as the United Kingdom where a small, highly specialised system of care has been developed for young, mentally ill offenders.

3. 'In reach' refers to clinical interventions (assessment, risk assessment, treatment, consultation liaison, discharge planning etc) provided in Youth Justice residences or in Youth Units in prisons by community-based mental health and AOD services to people who have mental health or AOD problems but who are incarcerated (and/ or to support those working with them)

A starting point is youth court liaison and, following on from this, the provision of a specialized youth forensic assessment service. This is the model adopted in the Northern and Central regions.

Success depends in part on the willingness and ability of CAMHS to case-manage and treat young offenders. Hauora Waikato's working model already includes youth court appearances and consultation/liaison as part of its overall kaupapa Māori work and will provide the youth court liaison service, in Midland. In the South Island some districts have been providing informal liaison services to youth courts but there are no dedicated full-time equivalent staff (FTEs) for youth forensic services.

Women

Previous reviews of forensic services have recognised that females who use these services have specific needs relating to differences in their profile of mental illness and in their life experiences from those of men.

A study on the prevalence of psychiatric disorders in New Zealand prisons (Brinded 2006) and a prison screening project at Christchurch Women's Prison (Earthrowl et al, cited in South Island Regional Forensic Plan September 2008) suggest that among women in prison:

- between one-third and one-half have a history of self-harming and about 12 percent will self-harm during their period of incarceration
- between 3 percent and 6 percent will present with psychosis
- more than 10 percent will have a current depressive disorder
- about 16 percent will have post-traumatic stress disorder or a related anxiety spectrum disorder
- between one-third and one-half will have a personality disorder, often borderline personality disorder
- more than 70 percent will have a history of addiction or related problems.

Women are more likely than men to have a history of abuse, social exclusion or poor physical health and are more likely to have dependent children. Separation from children during periods of incarceration either in prison or a secure mental health unit means that women's offending carries a higher individual and social cost than offending committed by men.

There are currently three women's prisons in New Zealand: Auckland Region Women's Corrections Facility, which falls within the area of the Auckland RFS; Arohata Prison, which is serviced by Central RFS; and Christchurch Women's Prison, to which services are provided by Canterbury RFS. Until 2006 there was also a female unit at Waikeria Prison in the Waikato forensic region; this unit is now closed and Auckland, Central and Canterbury will provide the bulk of forensic services to female prisoners in the future.

Table 4 shows the number and percentage of females using the various services provided by regional forensic services, as established by the Census of Forensic Mental Health Services 2005. Canterbury and Otago/Southland are combined because the latter forensic region does not have a women's prison within its area

Table 4: Female prison population and forensic service users by service type and region, 2005

	Auckland	Waikato	Central	Canterbury and Otago, Southland	Total
Prison population	94	76	140	111	421
Prison liaison service users	11	5	19	15	50
Inpatients	9	2	12	6	29
Community-based service users	9	3	3	4	19
% prison liaison	11.7	6.6	13.6	13.5	11.9
% inpatients	9.6	2.6	8.6	5.4	6.9
% community-based	9.6	3.9	2.1	3.6	4.5

Source: Ministry of Health (2007)

At the time of the 2005 census, 14 percent of forensic inpatients were female compared with 8 percent in 1999 (Ministry of Health 2007, p 19). This rise is due to the increase in the proportion of female prisoners between these years. Some regional forensic services, most notably Central, consider females to be a priority group.

Unlike for youth, where a separate specialist forensic service system is indicated, for women there are good reasons to continue with mixed-gender services across most of the system. The low numbers of mentally ill women offenders compared with men would rule out provision of gender-specific services across all components of the system and in all areas. In addition, placing women in specialised regional services could inhibit their rehabilitation by moving them further away from their children, whānau and support networks.

The main issues for women in the provision of forensic services are:

- safety and security in services
- respect for privacy
- recognition of additional specialist needs relating to higher morbidity
- ability to maintain contact with children
- ongoing vulnerability of women in forensic services that are overwhelmingly delivered to address men's needs.

A national working party for standards of care for women in secure mental health services has confirmed that a minimum requirement for forensic services is to provide secure care, including women-only areas that contain bathrooms and recreational facilities. The two options for meeting this minimum requirement are to provide either women-only inpatient units or mixed-gender inpatient units with women-only areas.

Each region faces different issues in relation to inpatient services for women. The Northern region prioritises the need for a separate step-down facility for Māori women. Midland has included women only facilities in its planned and approved refurbishment of the Henry Rongomau Bennett Centre. Central seeks a purpose-built women's inpatient unit on the forensic campus at Porirua, which would free up around eight beds in the mixed-gender unit on that campus. The Southern region prefers mixed-gender facilities but recognises the need over time to redesign

inpatient facilities in Christchurch and Dunedin, to meet standards of safety and privacy for women patients.

Prison liaison services are provided to the three women's prisons in New Zealand. Increases in women prisoners need to be monitored as higher musters will put pressure on these services in future. Work in Christchurch indicates that referral rates of women to forensic services can double when systematic screening is undertaken. Validation of screening tools for women may be needed before it is possible to reach national agreement on an appropriate tool.

People with alcohol and other drug disorders

People who experience AOD disorders form a large proportion of the prison population. It is estimated that 89.4 percent of the total prison population in New Zealand have a current substance abuse or dependence diagnosis. Furthermore, over 90 percent of those with a major mental disorder have a substance use disorder (Department of Corrections 1999).

Providing comprehensive treatment services for this population is complex. However, imprisonment can be used as an opportunity to address alcohol and other drug dependence, with the likelihood of achieving significant benefits for offenders' health and wellbeing.

Forensic services need a commitment to develop and build multidisciplinary teams with AOD expertise. Treatment of AOD disorders should be provided alongside treatment of mental illness in order to ensure that the provision of evidence-based practice is part of an integrated multidisciplinary forensic mental health and addiction assessment process. Forensic community teams also require skilled AOD clinicians.

The Ministry of Health is leading a Co-Existing Disorders Project that seeks to address a 'whole of systems' approach. The Ministry of Health will also lead workforce development initiatives in order to enable mental health and AOD services to become more skilled at managing co-existing disorders. In addition, determining the best model for providing AOD treatment to mentally disordered offenders requires further discussion.

Patients who have severe AOD issues and are transitioning from forensic to AMHS will require ongoing access to specialist AOD services. Such access will be important to minimise the risk of relapse.

The place of specialist AOD expertise in the courts setting also needs to be addressed. Screening for AOD disorders is crucial at the front end to ensure appropriate advice on dispositional and treatment issues is given to the courts.

People with personality disorders

Personality disorders are characterised by long-lasting, rigid patterns of behaviour or thoughts that deviate markedly from the expectations of the person's culture and cause significant distress or impairment. Research suggests a high prevalence of personality disorder among the prison population. For example, the National Study of Psychiatric Morbidity in New Zealand Prisons (Department of Corrections 1999) indicated that nearly 60 percent of all prisoners have at least one personality disorder, with antisocial and borderline personality disorder featuring prominently.

People with personality disorders are difficult to manage in a custodial environment, from both correctional and treatment perspectives. At the time of the Census of Forensic Mental Health Services 2005, there were 10 forensic inpatients nationwide whose primary diagnosis was a personality disorder, accounting for 5 percent of all forensic inpatients (although personality disorder as a secondary diagnosis is much more common). Four of these inpatients were in Auckland. There were also four community-based forensic service users with this primary diagnosis, accounting for 2 percent of all community-based service users.

Under the current service framework, responsibility for the management of prisoners with a personality disorder generally falls to the Department of Corrections. Accordingly, the overwhelming majority of prisoners with a personality disorder are not managed by forensic services, although forensic service input into a Department of Corrections sentence management plan for these prisoners is not uncommon.

Importantly, if a person becomes mentally ill, they can be referred to forensic services for assessment and treatment, which may at times include hospital assessment and/or treatment. However, it is well recognised that inpatient treatment for this group of prisoners is generally unproductive, and can worsen outcomes for the individual. As such, their care and management should remain primarily within the prison, while both corrections and forensic services contribute to care and management issues as they arise.

It is recognised that prisoners who have a personality disorder but who are not also mentally ill are not well served. The Northern region proposes to look at the feasibility of a pilot project, working with the Department of Corrections staff in Auckland prisons, to target the needs of people with serious personality disorder but without mental illness.

In a report on mental health services for prisoners, the Controller and Auditor-General (2008) recognised the complexity of managing people with a personality disorder and recommended that the Department of Corrections and Ministry of Health formally outline the roles and responsibilities of various agencies in relation to management of people with personality disorders. A proposed National Operational Leadership Group, comprising Department of Corrections and Ministry of Health representatives, will lead the process of further defining roles and responsibilities and resolving longstanding issues of managing people with a personality disorder in correctional facilities.

Management of intellectual disability services

Forensic intellectual disability services are at an early developmental stage. Following the introduction of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, the first steps in their development have involved the establishment of a range of inpatient and community services.

National secure inpatient services for people with intellectual disabilities who offend, or are likely to offend, have been established in the Northern and Central regions. Midland has dedicated beds at the Henry Rongomau Bennett Centre for intellectually disabled offenders. The Southern region recognises that there are significant gaps in services but considers it inappropriate to manage the two distinct groups of mentally ill and intellectually disabled people in the same inpatient service. There is limited access to the Central unit for South Islanders.

Most regional forensic service plans identify ongoing problems relating to the workforce and the unavailability of various secure community and inpatient services. Some regions have indicated that differences in philosophy and the funding stream are major barriers to further development of the forensic intellectual disability sector. Yet forensic services are often best placed to advise on and support the development of these services. Greater national consistency is needed.

Although technically the forensic intellectual disability services are outside the scope of this framework and have separate policy and funding streams, it is proposed that forensic national leadership networks should continue to provide advice and expertise to the intellectual disability sector on workforce, service developments and service provision.

Forensic Systems

Merging/centralising management

Some individual regions have suggested merging forensic services or regions, particularly in the sense of sharing the workforce. The aims of such measures would be to benefit from the strengths of neighbouring regions, and to collaboratively handle pressures that are common to their geographical areas.

In the Midland region a two-provider, single service model is developing between Hauora Waikato and Waikato RFS. This development offers some interesting lessons.

The idea of a single service for the whole of the South Island has been put forward by both Canterbury and Otago. This service would comprise a single funding system, with direction to be provided by DHB representatives, service managers and clinical directors through a South Island Regional Governance Group. A single draft forensic plan has been developed for the first time, covering the entire South Island.

As mentioned before (see the section on 'Description of Forensic Services'), there is scope for combining services across regions to provide national services, particularly inpatient services, where population groups are small and their needs are specialised. Secure inpatient intellectual disability services are already combined in this way. However, an even smaller group of intellectually disabled women needing secure care are not well provided for and would benefit from a national approach. Secure forensic inpatient services for youth represent another area that would benefit from national or cross-regional planning.

Developing agreed assessment and reporting criteria

A variety of agencies have an interest in information about the provision of forensic services. The Ministry of Health has an overall role of national co-ordination of forensic services and co-ordination of government policy; the national DHB body (the National Co-ordinating Group for Inter-District Flows: IDF NCG) agrees funding for inpatient beds; regional groups of DHB funders oversee funding for the balance of services funded through inter-district flows; and individual DHBs and services have an interest in improving service quality.

The types of information required will vary widely according to the functions of the individual body. These functions range from monitoring service delivery, through

determining future resource requirements and assessing value for money, to taking performance improvement measures.

Within each of these areas there will be a range of information of interest. For example, in determining future requirements for beds, important information is likely to include bed occupancy rates, discharge rates and the demographics of service users. Information relevant to performance improvement will encompass diverse areas such as use of seclusion, patient safety, and recovery measures such as whether service users achieve employment.

All services have provided a variety of information to Mental Health Information National Collection (MHINC) and, from 1 July 2008, to another national collection, the Programme for Integration for Mental Health Data Project (PRIMHD). Frequently the feedback loops from those processes do not reach services, although there is an intention to provide comprehensive reporting from the PRIMHD.

In addition to these national data collections, information is provided to a number of ad hoc national collections, regional groups and local boards. For example, the Northern region provides a comprehensive regional six-monthly report detailing qualitative and quantitative data, and the Central region is developing a similar reporting process.

The following principles should guide the identification of reporting measures.

- Information provided should be specific to need.
- Information should be nationally consistent.
- Compliance costs should be minimised.
- Existing information sources should be utilised wherever possible.

The Ministry of Health and the New Zealand Forensic Psychiatry Advisory Group will work together to build on current initiatives in order to arrive at a national set of information to meet all needs. Wherever possible, they will also specify reporting from national collections that would help to fill those needs.

Workforce

Forensic services share the difficulty of recruiting and retaining a properly trained and skilled workforce. The Census of Forensic Mental Health Services 2005 revealed moderate levels of vacancies for community staff, although at that time Auckland reported 10.3 vacancies on a total funded base of 40. All services were handling the levels of referrals in prison, court and community services, with no issues reported in this area. However, prison forensic caseloads were running at 5 percent of the muster, rather than the 10 percent targeted.

However, in regions such as Waikato and Otago, difficulties have been reported in maintaining the required level of FTEs. For example, both service providers in the Waikato region have identified difficulties in recruiting high-quality staff to this area. The reasons cited include the existence of two providers, and the location of both of them in a rural area. Otago reported a similar problem in recruiting a forensic psychiatrist in the 2005 census. Canterbury was likewise concerned about the unavailability of a trained and experienced workforce.

In Auckland, there were workforce issues in relation to the need for culturally specific staff, particularly Māori and Pacific registered staff. Developing a 'climate' that would

encourage innovation and research was also considered to be important. Waikato likewise reported a lack of specific resources to apply to Māori-specific and culture-specific FTEs.

Two further issues of workforce difficulties cited in the draft regional forensic plans related to obtaining skilled staff to work with intellectually disabled people and the emerging area of developing specialist youth forensic services. There is also increasing recognition of the need to ensure the forensic service workforce can recognise and address alcohol and drug issues, along with mental illness.

Throughout this framework document, a range of workforce issues have been mentioned. These issues include recruitment and retention, cultural competencies and specialised skills needed for working effectively with various population groups such as youth, people with intellectual disabilities, and people with co-existing AOD disorders and/or severe personality disorders. Although a range of workforce initiatives are being taken in the mental health and addiction sector there is no single coherent plan for addressing forensic workforce issues specifically. This is an issue for national forensic leadership networks to promote and address.

Service expansion

The main changes that have been made in forensic services between 2001 and 2005 are summarised in Appendix Three. Key changes include the delivery of an additional 28 inpatient beds and 22.4 prison liaison FTEs nationally, at a cost of $6.9 million per year, and the opening of a 10-bed Māori unit at the Mason Clinic in Auckland. Funding has also been approved for a significant upgrading of the Henry Rongomau Bennett Centre in Hamilton.

Each regional forensic service currently faces a high level of demand on its services. In some regions, increasing prison musters will continue to exacerbate this problem for both inpatient services and prison liaison services. Future planning is particularly important for inpatient services as they are resource-intensive, and the lead time required to build extra capacity is significant.

At the time of the Census of Forensic Mental Health Services 2005, it was estimated that 11 percent of women and 5 percent of men in prison were receiving forensic services. There were 51.6 funded FTEs to provide the service, although not all positions may have been filled at the time. As noted above (see the section on 'Description of Forensic Services'), it is estimated that at least 10 percent of prisoners require treatment from prison forensic services. Innovative solutions and new models of care may be required to provide this level of service, which will be higher in women's prisons and remand populations, and in prisoners detained in higher levels of security.

Screening for mental illness on reception into prison has been trialled in Christchurch Men's Prison and in Auckland, under the 2007 New Zealand Prison Reception Mental Health Screening Study by the Department of Corrections and the Ministry of Health.[4] From these trials, approximately 30 percent of prisoners screened positive for possible mental illness on reception and therefore subsequently required triage. Of this group, approximately one-third were identified as requiring specialist forensic mental health treatment. Thus the study confirmed the need for treatment of mental illness in approximately 10 percent of prisoners, as well as highlighting the importance of triaging prisoners who screened positively on reception.

4. New Zealand Prison Reception Mental Health Screen, 2007.

The Ministry acknowledges and supports the implementation of the New Zealand Prison Reception Mental Health Screen but recognises that its future introduction will have significant funding implications for the Department of Corrections and for forensic services. Joint national and regional planning will be needed in advance of the introduction of the screening tool.

The other contextual issue to factor in to service planning at this time is the prison musters, which have been increasing substantially in recent years. Actual yearly prison musters from 1999 to 2007 are set out in Table 5. Over those nine years there was a 35 percent increase in the total number of prisoners nationwide and a 90 percent increase in the number of female prisoners. Most of the increase has occurred since 2003.

Table 5: Number of male and female prisoners, 1999–2007 (note these figures include remand prisoners also)

Year	Male	Female	Total	1999 = 100
1999	5429	232	5661	100.0
2000	5450	270	5720	101.0
2001	5607	280	5887	104.0
2002	5493	246	5738	101.4
2003	5753	306	6059	107.0
2004	6183	374	6556	115.8
2005	6692	408	7100	125.4
2006	6910	426	7336	129.5
2007	7222	445	7667	135.4

Source: Department of Corrections

Overall prison capacity is stretched. The Ministry of Justice forecasts prison populations annually. Its latest scenarios and forecasts for peak and average monthly prison populations are contained in the Justice Sector Prison Population Forecast 2008–2016 (Ministry of Justice 2008). As Table 6 shows, these forecasts predict an ongoing rise in the prison population.

Table 6: Quarterly values for the 2008 forecast

Quarter	Upper Limit	2008 Forecast	Lower Limit
June 2009	8,621	8,392	8,163
September 2009	8,642	8,410	8,178
December 2009	8,701	8,460	8,219
March 2010	8,913	8,656	8,399
June 2010	8,950	8,684	8,418
September 2010	9,059	8,793	8,527
December 2010	9,098	8,818	8,538
March 2011	9,297	9,000	8,703
June 2011	9,360	9,058	8,756
September 2011	9,476	9,149	8,822
December 2011	9,438	9,099	8,760
March 2012	9,673	9,311	8,949
June 2012	9,800	9,417	9,034
September 2012	9,930	9,514	9,098
December 2012	9,933	9,515	9,097
March 2013	10,190	9,741	9,292
June 2013	10,248	9,783	9,318
September 2013	10,365	9,897	9,429
December 2013	10,403	9,912	9,421
March 2014	10,637	10,108	9,579
June 2014	10,731	10,162	9,593
September 2014	10,832	10,264	9,696
December 2014	10,830	10,228	9,626
March 2015	11,079	10,460	9,841
June 2015	11,160	10,507	9,854
September 2015	11,233	10,560	9,887
December 2015	11,263	10,564	9,865
March 2016	11,528	10,798	10,068
June 2016	11,561	10,795	10,029

Source: 2008-2016 Justice Sector Prison Population Forecast (Ministry of Justice 2008).

Increases in prison muster in turn strengthen the demand for prison liaison services. In addition, increases in muster are likely to increase the number of transfers to inpatient facilities that are required. These associations are complex as the epidemiology of illness varies across prison subpopulations, for example, males and females, remand and sentenced prisoners, and prisoners of different security ratings. Decisions on regional forensic service expansion must be made within the context of DHB, regional and national funding processes.

Funding and service development

In 2006/07 DHBs spent $79.4 million (excluding GST) on forensic mental health purchase units, an increase of $4.0 million over 2005/06. This expenditure is broken down by service type and region in Tables 7 and 8 below.

Table 7: Expenditure on forensic services by service type, 2004/05–2006/07

Year	Inpatient beds	Community FTEs (excluding prison/court liaison)	Prison and court liaison FTEs	Total
2004/05	54,763,565	15,321,077	2,010,142	72,094,784
2005/06	56,088,133	16,497,583	2,488,477	75,074,193
2006/07	60,907,545	15,620,834	2,832,106	79,360,485

Note: These data may not align with data from the Census of Forensic Mental Health Services 2005 provided elsewhere in this report.

Expenditure for community FTEs dropped in 2006/07 due to a decrease of 5.7 FTEs in Waikato and 3.4 FTEs in Whanganui, and a price decrease in the Northern region.

Table 8: Expenditure on forensic services by region, 2004/05–2006/07

Year	Northern	Midland	Central	Southern
2004/05	27,630,058	15,524,222	15,010,187	13,930,317
2005/06	29,447,827	15,931,858	15,004,750	14,689,757
2006/07	30,589,535	15,044,164	15,764,407	15,275,660

Note: These data may not align with data from the Census of Forensic Mental Health Services 2005 provided elsewhere in this report.

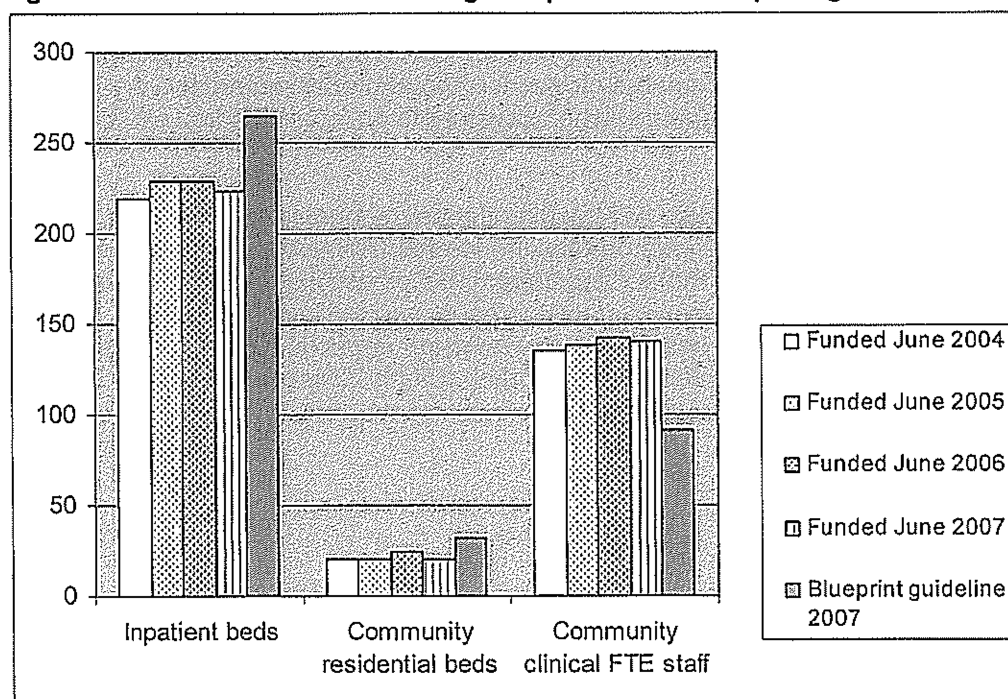
Forensic services are funded by DHBs in each forensic region through inter-district flows to the DHB that directly provides (and, in the case of Waikato, funds) those services. Since 2001 the Ministry of Health and DHBs have agreed that forensic inpatient services should be funded by way of a 'top slice', subject to DHBs' agreement on the level and distribution of funding. Forensic inpatient service funding for 2007/08 was promulgated under this arrangement.

Apart from inpatient services, there is no separate funding stream for forensic services. Forensic service development needs must therefore compete with the development needs of other mental health services in seeking priority within any available resources, such as *Blueprint* funding or Future Funding Track and demographics.

District Health Boards, through regional planning processes, are responsible for funding, planning and direct or indirect provision of forensic services. The NGO sector, which formerly contributed little to the provision of forensic services, accounts for about a third of funding in mental health services overall, and is now increasingly providing forensic services. This NGO–DHB partnership model of provision, which is most developed in Midland, is extending to other regions as a way to provide residential services and other support services.

Figure 1 summarises growth in forensic funding since June 2004 and shows its position in relation to the *Blueprint* funding guideline. It is approaching *Blueprint* levels for inpatient beds and significantly exceeds *Blueprint* guidelines for community FTEs.

Figure 1: Forensic services funding compared with *Blueprint* guideline



It should be noted that the *Blueprint* funding formula does not adequately take into consideration matters such as the large increase in prison capacity from commissioning two new prisons in recent years and the increasing musters at most prisons. The formula does not take account of the additional costs arising from the remote location of the new prisons.

Appendix Four provides details of increased capacity in prisons throughout New Zealand.

An additional $2.6 million of new funding to DHBs was obtained for 2008/2009 to commence implementation of this forensic framework. The regional split of that funding is close to a population basis, with an equivalent of eight FTEs for the Northern region, six FTEs for the Midland region, four FTEs for the Central region and four FTEs for the Southern region.

Priority areas for the allocation of that funding were:

- forensic liaison with AMHS
- either prison muster growth, or
- Youth Court liaison to begin to address the lack of effective forensic services for youth in the absence of a national framework.

Further funding for forensic services has been approved for the 2009/10 financial year and DHBs have submitted proposals, reconfirming their priorities for additional

forensic capacity. The allocated funding is $2.61 million with at least $360,000 of that amount earmarked for dedicated youth forensic services.

New service developments on their own will not address all growth demand and will exacerbate other issues such as workforce shortages. This framework is intended to address growth issues by identifying some new and innovative ways of delivering services and by setting in place the means to prioritise forensic funding and service development needs collectively with DHBs and the Department of Corrections. The establishment of a strategic group allows for appropriate agency collaboration that will positively and effectively contribute towards improved access and delivery of health services to offenders at a time when constraints on future funding can be expected.

An operational group is be tasked with leading the operational implementation of the national strategies and policies captured by the forensic framework. Furthermore, a core objective of this group is for the Department of Corrections, Ministry of Health and Justice to jointly prioritise service developments and sustainable funding paths. The New Zealand Forensic Psychiatry Advisory Group (NZFPAG) continues to address forensic clinical issues in collaboration with the Director of Mental Health and the Ministry.

Future Directions

The following strategic objectives are intended to enhance, reconfirm and maintain a strong focus on the continued development of effective national strategic and regional operational relationships that ensure appropriate participation and engagement in the planning and development of multidisciplinary forensic mental health and addiction services.

1. Further develop national mechanisms for engagement of key stakeholders in the implementation of policy and strategy for forensic mental health and addiction services, led by the Ministry of Health.
2. Improve intra-regional collaboration among key stakeholders in the development and delivery of forensic mental health and addiction services.
3. Continue to promote the delivery of comprehensive, multidisciplinary forensic mental health and addiction services that are responsive to the needs of forensic populations.
4. Develop pathways to recovery for people who are able to transition from forensic mental health and addiction services to primary mental health care in prison and general mental health services in the community.

Table 9 elaborates on these strategic objectives and the actions required to drive and achieve them, as well as detailing the lead players, milestones and key stakeholders involved.

Table 9

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Glossary

AMHS	Adult mental health services
AOD	Alcohol and other drug (addiction). In relation to service providers
Assessment	A service provider's systematic and ongoing collection of information about a service user to form an understanding of the service user's needs. A clinical assessment forms the basis for developing a diagnosis and an individualised treatment and support plan with the service user, their family, whānau and significant others.
DHB	District Health Board
FTE	Full-time equivalent (staff). For example, an FTE of 1.0 means that the person or people working in the position are working in a job equivalent to that of one full-time worker.
Mental disorder	This legal rather than medical term is defined to include but not be restricted to mental illness. Mental disorder, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it: 1. poses a serious danger to the health or safety of that person or of others, or 2. seriously diminishes the capacity of that person to take care of himself or herself.
Mental illness	Any clinically significant behavioural or psychological syndrome characterised by the presence of distressing symptoms and/or significant impairment of function.
Mental impairment	A legal term used in the Criminal Procedure (Mentally Impaired Persons) Act 2003. It includes mental disorder and intellectual disability, as well as other mental impairments (for example, those caused by a degenerative condition or acquired brain injury).
Morbidity	The prevalence of people with mental illnesses in prison – that is, the total number of cases at a particular point in time
NGO	Non-governmental organisation
NZFPAG	New Zealand Forensic Psychiatry Advisory Group
Outcome	A measurable change in the health of an individual, or a group of people or a population, which is attributable to interventions or services
Primary diagnosis	The most clinically significant diagnosis of a patient
Prison muster	The number of prisoners in a particular prison at a given time
Psychosis	A primary disturbance of thinking, which is reflected in certain symptoms, particularly a loss of contact with reality,

	disturbances in perception (hallucinations), disturbances in belief and interpretation of the environment (delusions) and disorganised speech patterns (thought disorder). Schizophrenia is one of the causes of psychosis; however the cause can be organic or emotional.
Recidivism	Re-offending
RFS	Regional Forensic Service. There are six RFSs in New Zealand, one each based in Auckland, Hamilton, Wanganui, Wellington, Christchurch and Dunedin. RFSs provide forensic inpatient and community-based mental health services.
Secondary diagnosis	Clinically significant diagnoses that are additional to the primary diagnosis
Service user	A person who uses forensic mental health services
Special patient	A forensic services client who has come into forensic services via the criminal justice system, either through remand or trial outcomes, or who has been transferred from prison because they have been assessed as needing treatment for mental illness

Appendix One:

Legal Framework

Two key pieces of legislation relate specifically to the provision of forensic mental health services: the Criminal Procedure (Mentally Impaired Persons) Act 2003 and the Mental Health (Compulsory Assessment and Treatment) Act 1992. Each of these is described briefly below.

The Criminal Procedure (Mentally Impaired Persons) Act 2003

This Act provides courts with appropriate options for the assessment, detention and care of offenders and defendants who are or may be mentally impaired. Where mental impairment is due to mental disorder, the Criminal Procedure Act provides for the diversion of the defendant/offender into the Mental Health Act. In other cases when the defendant has been found not guilty by reason of insanity, or unfit to stand trial, a special patient order may be made under the Mental Health Act, irrespective of the presence of mental disorder. The Criminal Procedure Act replaced Part 7 of the Criminal Justice Act 1985, changing the disposition options available to courts significantly (Ministry of Justice 2004).

Where mental impairment is due to intellectual disability, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 provides details of the disposition options available. Since the passage of this Act, specialist facilities for the care and rehabilitation of such individuals have been opened, and have strong links to forensic services.

The Mental Health (Compulsory Assessment and Treatment) Act 1992

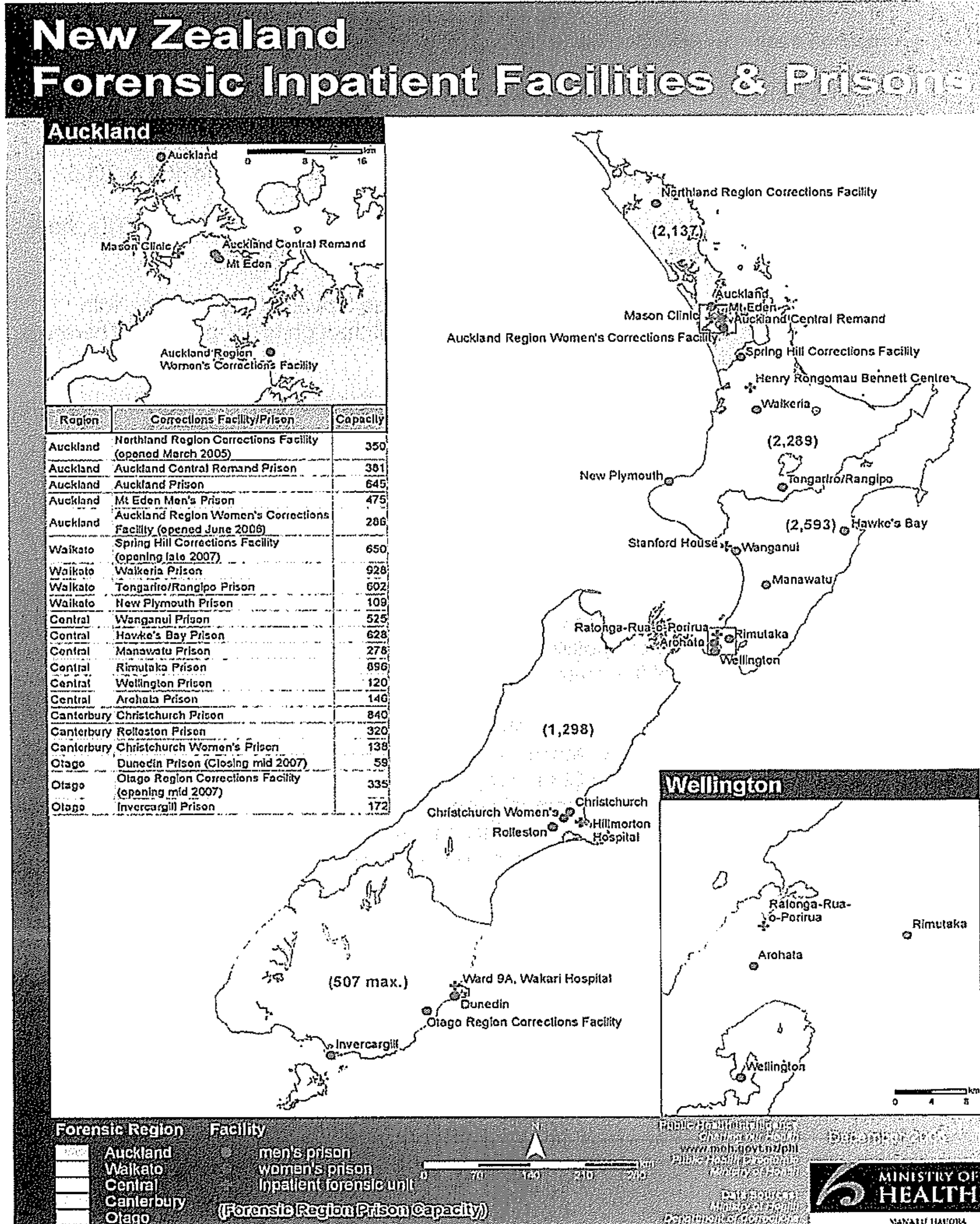
This Act defines the circumstances in which and the conditions under which people may be subjected to compulsory psychiatric assessment and treatment, including people with mental illness who are in the criminal justice system. It also defines the rights of such people and provides protection for those rights.

If a court believes that it is inappropriate to make a defendant a special patient following conviction, a finding of insanity or unfitness to stand trial, they can order that they be subject to a compulsory treatment order under the Mental Health Act. Expert evidence is required that the defendant is mentally disordered (section 25(1)(a)). Such an order lasts only as long as the person remains mentally disordered. The review of these orders typically rests with clinicians, with a right of appeal to the Mental Health Review Tribunal.

The Mental Health Act also allows for the courts to impose a restricted patient order in the case of a civilly committed patient who poses special difficulties because of the danger they pose to others. These patients may not have committed any crime. Restricted patient status results in a level of ministerial oversight of leave similar to that with special patients. Forensic services are generally charged with the responsibility of managing restricted patients.

Another piece of legislation relevant to the provision of forensic services is the Children, Young Persons, and Their Families Act 1989. This Act is the legal basis for New Zealand's separate justice system for children (ages 10–13 years) and young people (ages 14–16 years). In many cases, the offending of children and young people may be linked to mental health issues, the most common of which is conduct disorder.

Appendix Two:
Map of Prisons and Regional Forensic Mental Health and Addiction Services in New Zealand



Region	Corrections Facility/Prison	Capacity
Auckland	Northland Region Corrections Facility (opened March 2005)	350
Auckland	Auckland Central Remand Prison	381
Auckland	Auckland Prison	645
Auckland	Mt Eden Men's Prison	475
Auckland	Auckland Region Women's Corrections Facility (opened June 2006)	286
Waikato	Spring Hill Corrections Facility (opening late 2007)	650
Waikato	Waikeria Prison	928
Waikato	Tongariro/Rangipo Prison	602
Waikato	New Plymouth Prison	109
Central	Wanganui Prison	525
Central	Hawke's Bay Prison	628
Central	Manawatu Prison	278
Central	Rimutaka Prison	896
Central	Wellington Prison	120
Central	Arohata Prison	146
Canterbury	Christchurch Prison	840
Canterbury	Rolleston Prison	320
Canterbury	Christchurch Women's Prison	138
Otago	Dunedin Prison (Closing mid 2007)	59
Otago	Otago Region Corrections Facility (opening mid 2007)	335
Otago	Invercargill Prison	172

Appendix Three:
Changes in Forensic Services from 2001 to 2008

The following are among the major changes that have occurred in the forensic mental health and addiction services sector since the publication of the 2001 review.

- The prison population (both male and female) has increased from 5887 in 2001 to 7100 in 2005.
- The female prison population has increased from 280 in 2001 to 408 in 2005.
- Additional services, namely 28 inpatient beds and 22.4 prison liaison FTEs, have been put in place nationwide, at a cost of $6.9 million per year.
- Prison liaison services are reaching on average 5 percent of prisoners, with variability across the country (from 8.8 percent through to 3.7 percent). There are no comparable figures for 2001.
- The National Secure Unit at Lake Alice Hospital has closed and its secure beds have been divided up among and located within regional forensic services.
- New inpatient facilities for the care and rehabilitation of people with intellectual disabilities have been opened, as well as community-based services developed for these individuals. These facilities and services have strong links to forensic services.
- The need to transfer community-based forensic service users to general mental health services, where possible, has received greater emphasis, decreasing the number of users of this forensic service.

There have been many other innovations and changes at the level of individual regional forensic services. Examples include the development of a service providing reports to youth courts in the Central region and in Waikato by Hauora Waikato; the use of a dedicated hostel in community-based forensic service provision in Auckland; the development of youth forensic services by Auckland DHB; and the increasing (yet informal) use of a 13-bed unit at Ratonga-Rua-O-Porirua as a women's inpatient facility.

Appendix Four:

Changes in Prison Capacity since the Census of Forensic Mental Health Services 2005 to 2008

The Department of Corrections' Regional Prisons Development Programme, begun in 1997, involved the construction of four new prisons. One of these, the Northern Region Corrections Facility at Ngawha, had opened before the 2005 Census of Forensic Mental Health Services, and another (the Auckland Region Women's Corrections Facility) opened in 2006. Two prisons, one outside Dunedin (the Otago Region Corrections Facility) and one near Meremere on State Highway 1 between Auckland and Hamilton (the Spring Hill Corrections Facility), opened in 2007.

The following is a summary of how each of the three prisons that have opened after the 2005 census period have affected and will affect regional prison capacity.

The 286 beds in Auckland Region Women's Corrections Facility have taken in women who were previously incarcerated at Mt Eden Women's Prison and Waikeria Prison, freeing up 94 beds for male prisoners at Mt Eden Men's Prison and 80 in Waikeria. The net gain in beds for the Auckland region is 286.

All 650 beds at Spring Hill are new beds for which extra services must be provided by Waikato forensic services.

As the 335-bed Otago Region Corrections Facility will be followed by the closure of Dunedin Prison, the subsequent net gain in capacity for the region is 276 beds.

Further, the following increases in prison capacity have occurred since the 2005 census in the Central region.

Approximately 220 beds have been added at Rimutaka Prison, with further expansion planned.

Just over 60 beds have been added at Wanganui Prison.

These changes in regional and national prison capacity as of December 2006 are summarised in the map in Appendix Four.

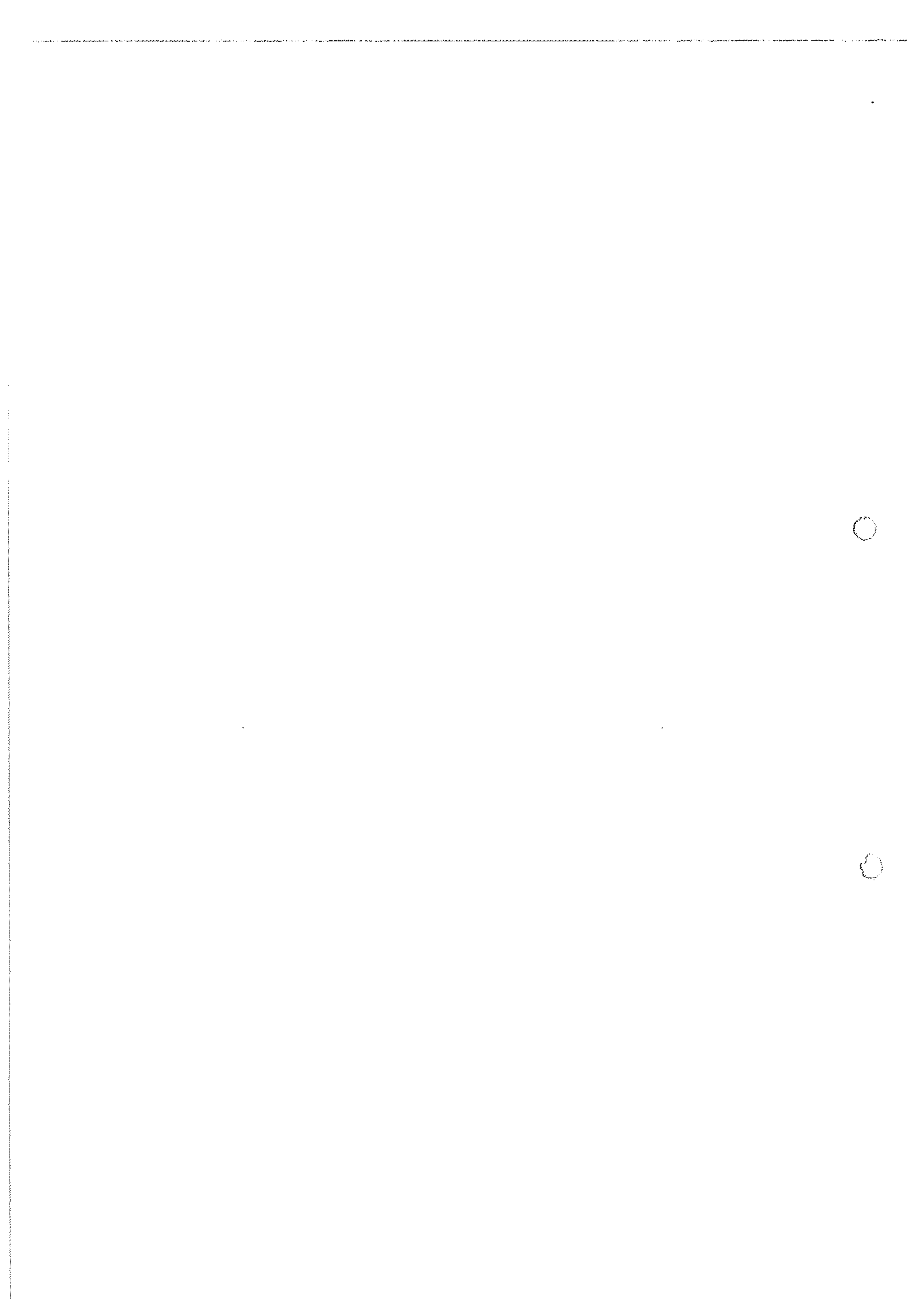


Table 9: Future directions action plan

Actions	Milestone	Lead	Key Stakeholders
Ministry of Health to lead further development of national mechanisms of engagement for key stakeholders in the development and implementation of policy and strategy for mental health care and addiction for people within the criminal justice system.			
National strategic leadership: Establish a national forum of the Ministry of Health, Department of Corrections and the Ministry of Justice, to be led by the Deputy Director-General, Population Health			
This forum will be tasked with setting strategic direction including the responsibility of each agency in regard to the health of offenders (includes mental health and addiction); to provide a long-term response to the growing prison population and their changing health needs; and with maintaining a watching brief over progress towards the future directions in this framework.	Year 1	Ministry of Health	Ministry of Health, Corrections, Ministry of Justice
This forum will be tasked with leading the operational implementation of the national strategies and policy that require inter-regional or national collaboration	Year 1	Ministry of Health	Ministry of Health, Corrections, NZFPAG
Provide national leadership to achieve greater co-ordination between prison primary health services (including mental health and addiction), regional forensic services and general mental health services.	Ongoing	Ministry of Health	
Engage with Corrections on future planning of facilities and protocols that will enable location of forensic services (multidisciplinary treatment on an outpatient basis) within prisons	1-5 years	Corrections, Ministry of Health	Ministry of Health, Corrections, DHBs, RFS
Establish protocols and agree roles and responsibilities of each agency for the management of people with personality disorder. • Develop plans for prison management of prisoners who exhibit ongoing, extreme behaviours that require specialist management including the interface with primary mental health services and Regional Forensic Services.	2-5 years	Corrections	Ministry of Health, NZFPAG, Corrections, RFS
National operational leadership: Establish a national mechanism to engage key stakeholders in national and inter-regional operational policy and implementation.			
• Agree and implement nationally consistent roles and responsibilities for the provision of services to intellectually disabled people	2-5 years	Ministry of Health	Ministry of Health, Corrections, NZFPAG
• Provide national leadership to the development of forensic mental health workforce issues including: recruitment and retention; responsiveness to the clinical and cultural needs, in particular to the high Māori consumer population; responsiveness to those with co-existing disorders; and ongoing training and development needs.	Ongoing	Ministry of Health	Ministry of Health, NZFPAG, National network of DAMHS, National network of Mental Health Managers, Corrections, Te Pou, Te Rau Matatini
Alcohol and other drug services: Lead the improvement of comprehensive treatment for people with co-existing AOD disorders.			
• Regional Forensic Services to become co-existing disorder capable and to formally establish protocols that determine the roles and responsibilities of each agency in relation to providing specialist alcohol and other drug treatment to all consumers.	1-2 years	Ministry of Health	Ministry of Health, DHBs, RFS, Corrections, NZFPAG, Courts
• Identify and implement alcohol and other drug training and development options for forensic services, as part of the enhanced multidisciplinary team providing assertive in-reach care in both prison and other corrections facilities.	1-3 years	RFS, DHBs	Ministry of Health, DHBs, RFS, Matua Raki
• Implement and improve screening for alcohol and other drug disorders to inform custodial options and forensic inpatient service assessment in both the police and court setting.	3-5 years	Ministry of Health, RFS	Ministry of Health, DHBs, RFS, Corrections
• Collaborate to ensure patients transitioning to general mental health services, are supported and have access to specialist alcohol and other drug services (for those with severe AOD issues) to optimise recovery.	1-5 years	Ministry of Health	Ministry of Health, Corrections, NZFPAG
National clinical leadership: Engage clinical leadership in the development and implementation of forensic mental health and addiction services through the New Zealand Forensic Psychiatry Advisory Group (NZFPAG).			
This forum will continue to contribute to national policy development and to the interface with Corrections and other national networks	Year 1		
Investigate clinical and service management options to reduce the increasing pressure on existing inpatient services. • Reduce inpatient phase of the rehabilitation of special patients. • Provide more comprehensive, co-ordinated health services in the prison environment. • Transfer of selected prisoners to Adult Mental Health Services. • Restriction on adult mental health service admissions to exceptional cases. • Reduce the ratio of non-special to special patients in forensic community teams.	3-5 years	NZFPAG	Ministry of Health, NZFPAG
Build on current initiatives towards national information set on the provision of forensic mental health services that meets the requirements of the various stakeholders.	1-3 years	Ministry of Health	Ministry of Health, NZFPAG, Corrections, Te Pou
To improve intra-regional collaboration between key stakeholders in the development and delivery of mental health care and addiction services to people within the criminal system.			
Regional forensic service planning: To engage key stakeholders in the development, implementation and monitoring of the regional forensic service plans.			
Regional forensic service planning to be aligned with national priorities, including priorities for efficiency gains and service delivery in the least restrictive environment. The Ministry of Health will work with RFS and DHBs on prioritisation process. • Demonstrate how the regional forensic service will respond to the national priorities and the needs of forensic populations (see below).	Year 1	DHBs, RFS	Ministry of Health, RFS, DHBs, NGOs, Māori (Health and Iwi networks), Corrections, Te Pou

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<tr><td>

Describe regional collaboration with key stakeholders to develop pathways to recovery and transition from forensic mental health services (see below).
Identify region specific priorities and issues for forensic mental health and addiction services.
Outline regional forensic service expansion (decisions to be made within the context of DHB, regional and national funding processes).

</td><td></td><td></td><td></td></tr>
<tr><td>Court liaison: Continue to build on the success of court liaison staff in adult and youth courts, maintaining and facilitating advice to the courts that better informs custodial sentencing options and inpatient forensic assessment</td><td>Ongoing</td><td>RFS</td><td>Ministry of Health, Corrections, DHBs, RFS, AMHS</td></tr>
<tr><td colspan="4">To continue to develop comprehensive, multidisciplinary forensic mental health and addiction services that are responsive to the needs of forensic populations.</td></tr>
<tr><td colspan="4">Improving Māori health outcomes and whānau ora: Forensic mental health and addiction services take responsibility for their role in improving Māori health outcomes and whānau ora.</td></tr>
<tr><td>Improving outcomes for Māori in forensic mental health and addiction services is the responsibility of all involved in these services and applies to all sections of this framework.

Broaden the range, quality and choice of services and support for tāngata whaiora severely affected by mental illness and their whānau.
Prioritise Māori: Act on the evidence of Māori needs and disparities in relation to mental health and addiction, to ensure that new and existing services are effective for Māori.
Build on the gains: Ensure current initiatives for tāngata whaiora and whānau are sustainable and have a development path for the future.
Responsiveness to Māori: Build on the link between health and culture to ensure initiatives are responsive to the unique needs of Māori.

</td><td>1-2 years</td><td>RFS</td><td>Ministry of Health, DHBs, RFS, NGOs, Te Rau Matatini, Te Pou</td></tr>
<tr><td colspan="4">Other ethnicities including Pacific peoples: Develop effective and culturally appropriate forensic mental health and addiction pathways of care.</td></tr>
<tr><td>Implement forensic services that access appropriate cultural and spiritual advice and provide safe, effective and responsive specialist services for all other ethnicities, in particular Pacific peoples.

Pacific peoples: Implement forensic services for Pacific consumers that utilise appropriate cultural and spiritual advice and support.</td><td>1-3 years</td><td>RFS</td><td>Ministry of Health, DHBs, RFS, Te Pou</td></tr>
<tr><td colspan="4">Youth forensic services: Lead the development and implementation of an Integrated National Youth Forensic Service Framework for youth offenders who experience mental illness and addictions.</td></tr>
<tr><td>Develop a nationally consistent model for youth forensic services, for consultation and feedback from all key stakeholders.</td><td>1 year</td><td>Ministry of Health</td><td rowspan="2">Ministry of Health, DHBs, RFS, CAMHS, CYF, Youth Justice, Werry Centre</td></tr>
<tr><td>

Implement the model for youth forensic services.
This framework does not pre-empt the outcome of the youth forensic framework. However, a description of a comprehensive youth forensic service is included in the framework.

</td><td>3-5 years</td><td>Ministry of Health</td></tr>
<tr><td colspan="4">Specific needs of women: Develop forensic mental health and addiction services that are safe and responsive to the specific needs of women relating to their profile of mental illness and their life experiences.</td></tr>
<tr><td>Develop forensic services that respond to the specific needs of women: Women are more likely to have a history of abuse, social exclusion and poor physical health, their role in the family and, in particular, their relationship with children; and traditionally receive shorter sentences with fewer opportunities for intensive rehabilitation.</td><td>2-3 years</td><td>RFS</td><td>Ministry of Health, Corrections, RFS</td></tr>
<tr><td>Improve current services to women patients by providing safe and secure, private, women-only areas (in mixed-gender settings), noting that segregation is not a prerequisite for effective services for women.</td><td>3-5 years</td><td>RFS</td><td>Ministry of Health, Corrections, RFS</td></tr>
<tr><td>Review, further develop and, if approved, implement a prison screening tool for women to better inform forensic service inpatient assessment.</td><td>3-5 years</td><td>Corrections, RFS</td><td>Ministry of Health, Corrections, RFS</td></tr>
<tr><td colspan="4">To develop pathways to recovery for people who are able to move from forensic mental health services to prison primary mental health care care and general mental health services.</td></tr>
<tr><td colspan="4">Improve interface and agree protocols for the transfer of people across services (between regional forensic services, prison primary mental health care and Adult Mental Health Services) to provide a completer pathway of recovery for forensic consumers.</td></tr>
<tr><td>Regional forensic services and AMHS agree and implement protocols that facilitate earlier transition of forensic service consumers into general mental health services, and greater flexibility for them, without risk to the patient, public, clinicians or services.</td><td>1-3 years</td><td>DHBs, RFS</td><td>Ministry of Health, DHBs, RFS, Corrections, NZFPAG</td></tr>
<tr><td>Establish and implement protocols to select offenders requiring inpatient treatment to be transferred to local AMHS rather than regional secure units.</td><td>2-5 years</td><td>NZFPAG</td><td>Ministry of Health, Corrections, NZFPAG</td></tr>
<tr><td>Establish a process restricting AMHS admissions to exceptional cases.</td><td>2-5 years</td><td>NZFPAG</td><td>Ministry of Health, Corrections, NZFPAG</td></tr>
<tr><td>Increase the capacity and capability of supported community accommodation for regional AMHS to ensure continuity of care and a complete pathway to recovery for forensic consumers.</td><td>1-3 years</td><td>DHBs, RFS</td><td>Ministry of Health, DHBs, RFS, AMHS</td></tr>
<tr><td>Support AMHS assertive community treatment teams to ensure continuity of care and a complete pathway to recovery for forensic consumers.</td><td>1-3 years</td><td>DHBs, RFS</td><td>Ministry of Health, DHBs, RFS, AMHS</td></tr>
<tr><td>Promote and support capacity and capability of hospital-based rehabilitation in AMHS to better care for forensic consumers and provide them with a complete pathway of recovery.</td><td>2-5 years</td><td>RFS</td><td>Ministry of Health, Corrections, DHBs, RFS, AMHS</td></tr>
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