

REVIEW OF QUEENSLAND FORENSIC MENTAL HEALTH SERVICES

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EXECUTIVE SUMMARY

1. This review followed a period of adverse publicity for the Queensland forensic mental health services triggered by a patient absconding from Wolston Park.
2. The review was undertaken during a period of transition for Queensland mental health services, with the change from the Mental Health Act 1974 to the Mental Health Act 2000 scheduled to occur on 28th February 2002.
3. The review highlights a number of deficiencies at the time of the absconsions.
4. The government had already addressed many of the deficiencies in the areas of service provision and in the legislative framework, particularly through Queensland's new Mental Health Act and through the imminent opening of the new secure forensic facilities at Wolston Park and in Townsville.
The report was therefore able to focus on process and procedures, which might further improve the service functioning.
5. Queensland is fortunate in having arguably the most coherent legislative framework for dealing with mentally abnormal offenders. With the opening of the new secure forensic units, Queensland will have one of Australia's most sophisticated forensic inpatient service systems, with impressive purpose built secure facilities which have the capacity of providing varying levels of secure care, treatment and containment.
Given the high quality of clinical and administrative staff already working within the service, there is a real prospect of establishing Queensland as a centre of excellence for forensic mental health services.
6. Forensic mental health services must retain the public's confidence and support. This requires that they be seen to be giving proper weight both to the issues of community safety and to alleviating reasonable public anxieties over issues of the control and containment of mentally abnormal offenders. Currently the Queensland services appear to be less than entirely successful in this regard.

7. A finding of unsoundness of mind removes the mentally abnormal offender from the criminal justice system and from any question of being the proper subject for punishment or deterrence. This should not however negate the place for victims, should they wish, to have their voice heard both in the new Mental Health Court and the new Mental Health Review Tribunal. The provisions of the Mental Health Act (2000) provide a legislative framework for this to occur. A greater sensitivity to victim's legitimate concerns should be fostered through education, and through engagement in service provision and research focussed on victims.

8. Police play a minor, but all important, role in the functioning of effective mental health services to the community. All too often in Queensland and other jurisdictions, cooperation is impaired by misunderstandings fostered in a clash of attitudes and priorities. The ongoing dialogue, at local and state level, between health and police in Queensland about protocols and approaches in areas of mutual responsibility is welcome. The report recommends that a stage be rapidly reached where when the police are called on by mental health services to intervene to facilitate admission or a return to hospital of a patient, that mental health professionals are available to assist the police, ideally in person or failing that by telephone.

9. Findings of unsoundness of mind are now being made at an annual rate of over 100 per year. As a result there are currently nearly 700 section 36 patients. The offences committed by these patients cover the whole range from minor indictable crimes to homicide, but no differentiation is made in terms of the patient status. This leads to inappropriately intrusive restrictions being placed on the majority who present no ongoing threat to the community. Equally it might on occasion obscure the need for a level of continuing containment and control consonant with the seriousness of the offending history.

We recommend a distinction be made from the outset between those found of unsoundness of mind who in view of their current and past offending behaviour are considered to present a foreseeable serious danger to the community, and those not considered to pose such a risk.

10. Given the seriousness of the implications for the patient of being on a Section 36, or its equivalent in the new Act, those no longer requiring such restrictions should be discharged to civil patient status at the earliest opportunity.

11. Evaluations of future risk to the community are central to the progress of mentally abnormal offenders back towards non secure and community based environments.

Evaluations of risk should always take into consideration the full range of factors which impinge on the likelihood of serious offending in the future and cannot simply focus on the patients current symptoms. Further, reasonable public perceptions of risk should have some place in such evaluations. Some concern is expressed about the rapidity with which certain patients who have been found of unsound mind following very serious crimes of violence are obtaining leave in the community. It is right and proper that leave should reflect the individual case and not be subject to some imposed general rule. It is worthy of note, however, that currently Queensland's forensic mental health services are out of step with other Australian jurisdictions in this regard.

To facilitate more comprehensive and sensitive approaches to evaluating risk, there should be even greater involvement of all types of mental health professionals, both in assessment processes and in providing reports to the new Mental Health Tribunal. The culture promoted by senior staff, though admirable and progressive in most ways, should perhaps take greater notice of issues of control and containment. There is currently little opportunity for the forensic services around Australia to share experiences and provide peer review on practices, such as those around leave and return to the community. The proposed National Forensic Mental Health Forum, to be hosted by Queensland Health, will go some way to rectify this deficit.

12. There needs to be greater levels of standardisation in the systems providing information to the Mental Health Review Tribunal. We believe that the critical decisions made by the Tribunal around the granting of leave and return to the community need to be made on the very best information. To facilitate this there should not only be multi disciplinary input at the level of the treating team, but an internal review process which ensures adequate considerations of such issues as community safety, reasonable public expectations and the coherence of the proposed leave plan in terms of the patient's long term rehabilitation. The efforts of the new Chairperson of the Mental Health Tribunal, Mr Clare, to develop straightforward and concise forms for reporting information to the Tribunal are strongly supported.
13. It is essential that the leaves granted by the new Mental Health Tribunal and the conditions attached to those leaves be strictly adhered to in practice. We make a number of suggestions in how the monitoring and supervision of leave could be improved.
14. The forensic mental health services of Queensland are not just in transition but in a phase of rapid growth and development. The services have attracted a range of high quality

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professionals. Retaining them and allowing them to progress their own knowledge and skills will however be a continuing problem. Further there is a real hunger in the wider mental health community for information about forensic issues. We believe active encouragement is needed to develop some form of academic centre for forensic mental health, which will facilitate teaching and research. Most importantly this centre must provide opportunities for nursing, in both academic appointments and training.

PROLOGUE

Following an incident of a patient absconding from Wolston Park Hospital in January 2002, the Queensland Premier and Minister for Health announced an External Review of the systems and processes which govern the assessment, care and treatment of forensic mental health patients across the State. This announcement was made on the 21st January 2002.

Professor Paul Mullen, Professor of Forensic Psychiatry, Monash University, Clinical Director, Victorian Institute of Forensic Mental Health and Ms Karlyn Chettleburgh, General Manager, Inpatient Operations, Thomas Embling Hospital were appointed under Section 55 of the Health Services Act to undertake the review. The instrument of appointment was signed by the Director General of Health on the 25th January 2002.

The following are the terms of reference for the review;

1. To review the systems and processes used in Queensland:
 - To assess mentally ill offenders charged with serious violent offences;
 - To provide the Patient Review Tribunal with the information which it requires to conduct its review of individuals;
 - To implement treatment and rehabilitation programs (including leave of absence) once approved by the Patient Review Tribunal.
2. To comment on the adequacy or otherwise of the system and processes outlined above, including in particular the adequacy or otherwise of the implementation of risk management strategies for mentally ill offenders charged with serious violent offences.
3. To examine the issues that impact on the implementation of the system and processes outlined above, including the factors that may negatively impact on the implementation.
4. To make recommendations in relation to the above, including, if appropriate, improvements to the system and processes.

In preparation for undertaking the review, a range of documents were sighted and reviewed. The full list of documents is attached as Appendix 8.

The review team, through representatives of Queensland Health, provided the opportunity for individuals and groups to make verbal submissions and participate in discussion of the issues. Site visits were undertaken to Wolston Park Hospital campus, John Oxley Memorial Hospital, Royal Brisbane Hospital Acute Inpatient Unit and Community Care Unit and Prince Charles Hospital Medium Secure Unit. The visits and meetings occurred between February 4th and February 8th 2002. A full list of individuals and groups who met with the review team is attached as Appendix 7.

The reviewers ability to conduct the review within the required timelines, was assisted by the level of support they received from all staff working within the mental health service system, together with the cooperation and assistance provided by external stakeholders and groups who met with the review team and made verbal and written submissions. All individuals who met with the review team were open in their communication, and impressed as knowledgeable, professional and extremely committed.

In addition to verbal submissions, written submissions were provided by a number of organisations which, with their permission, have been attached as Appendices to this report.

A total of 154 clinical staff working with forensic mental health patients, completed and returned a questionnaire which was developed for the purpose of ensuring that all mental health staff had an opportunity to contribute to the review. The questionnaire is attached as Appendix 3.

INTRODUCTION

This review occurs in the context of public disquiet about the management of mentally abnormal offenders in Queensland. There has been extensive media coverage of the absconding of two patients who had high public profiles by virtue of their offences, which in both cases involved a killing. The media coverage had extended to highlight a number of other instances of offenders found of unsound mind who had absconded, or fallen out of the mandated supervision. These cases raised questions not just about absconsion and escape but about the decisions and processes which led to these, and other patients with histories of serious violence, being in situations of low, or no security so soon after their offences.

It was put to us by a small minority of those who made verbal or written submissions that the problem began, and ended with a media ‘beat up’. We do not accept this. There is nothing to be gained from blaming the messenger, however overexcited and flamboyant they might have been in conveying the bad news. The media comments, and comments by public figures, drew attention to matters of proper concern to the community.

Aspects of the media coverage have caused distress to some patients and their families, as well as to mental health workers, who have no connection whatsoever with offending or with the management of mentally abnormal offenders. It is virtually inevitable, however, that when public confidence is shaken in the care and containment of that tiny minority of people with serious mental disorders who have committed major offences involving violence, that a shadow will be thrown across the whole of the mental health services: And by association over their clients. There is no escaping the pivotal role of forensic mental health services in maintaining, or on occasion undermining, the public’s confidence in mental health services as a whole. Forensic services are a tiny part of the mental health services as a whole, just as the mentally ill person who has committed serious violence is the rare exception. Nevertheless a lack of public confidence in the forensic services threatens public acceptance of the whole mental health service and, even more importantly, risks an increase in fear and prejudice directed at all mental health clients.

We are no strangers ourselves to media and public criticism. Some may think that coming from a forensic mental health service where there have also been absconsions disqualifies us from making a useful contribution. We are convinced the opposite is the case. Our service received considerable

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adverse attention last year following the absconding of patients. We are aware of the temptation to focus exclusively on the unfair aspects of criticisms which follow such incidents and to ignore the legitimate questions and concerns raised. This is a temptation which should be resisted. We accepted the task of undertaking this review in the hope of sharing some of the positive outcomes, in terms of improved practices and procedures, which have emerged from our own periods of public scrutiny and self-examination. We would also hope to minimise the effects of the purely destructive fall out which can occur. The critical issues, in our experience, raised by absconsions are not just about security, but about whether particular patients should have been in positions where they could so easily escape from supervision. Also usually in question are the adequacy of the responses to the absconding of patients. Improving and tightening up procedures and practice will not guarantee there are no future absconsions but will hopefully reduce the chances, and, in particular, ensure levels of supervision and containment are more appropriate to the risks presented by particular patients. It is acknowledged that even in the best systems, there continues to be an element of risk which can be managed to minimise the frequency and consequences, but is rarely able to be abolished.

It was put to us by one psychiatrist, not directly involved in the forensic service, that this review would turn the clock back on mental health reform by giving legitimacy to issues of control and containment as well as care and treatment in the management of mentally abnormal offenders. It was his view that forensic mental health services should differ as little as possible from general services and it was, to use his words, “all about treating schizophrenia”. Though we respect the progressive and reforming zeal which drives such enthusiasms, we believe such views are unhelpful and if allowed sway would bring down not just the forensic mental health services, but endanger the future of the whole reform agenda in Queensland mental health.

Queensland has a unique legal framework both for ascertaining which offenders should benefit from a defence of unsoundness of mind and for the subsequent regulation of the care and treatment of these mentally abnormal offenders. When the Mental Health Tribunal (soon to be renamed the Mental Health Court) was created in 1985 it represented a bold experiment in establishing a rational and humane system for regularising the traditionally problematic insanity defence. Queensland’s Mental Health Tribunal and system of Patient Review Tribunals (soon to become Mental Health Review Tribunal) are no longer an experiment. They have become an established system for managing an important section of the mentally abnormal offender population. With the new Mental Health Act the functioning of both the Mental Health Court and more particularly the Mental Health

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Review Tribunal will be further refined and improved. This is a system which is widely admired outside of Queensland and which it was clear from the submissions made to us has attained a broad consensus of support among professionals in the legal, mental health and law enforcement communities. Like any system for managing the highly contentious and emotive issues around criminal responsibility, and the regulation of the mentally abnormal offender, it is at all times subject to intense public scrutiny and occasionally to intense public criticism. This review takes as a 'given' Queensland's established legal framework for dealing with mentally abnormal offenders. In this report we make a number of recommendations about the processes governing the subsequent management of those offenders found of unsound mind. These recommendations include suggestions to increase the rigor with which subsequent progress through the mental health system, and return to the community, is monitored and supervised. We also recommend that reasonable and understandable public concerns about safety be given due and increased weight in the decision making processes around leave in, and return to, the community. These recommendations will be, we believe, easily accommodated within the structure of Queensland's new Mental Health Act and in no way conflict with the principles and practices of the existing legal framework.

In the past a number of practices had become established in Queensland in regard to the granting of leave and decisions about transfer of patients to less secure placements which, we believe, overtly or covertly, reflected a response to a perception that the resources available to forensic mental health services were inadequate to meet the demands placed on those services. Discharges from John Oxley Hospital were, we were told, on occasion driven in part by the need to create beds for new admissions, rather than, as they should be, entirely by issues of clinical need and public safety. Leave arrangements, we were informed, on occasion reflect primarily a need to humanise the nature of the patients' confinement in the impoverished environment of John Oxley. These problems were recognised by the health department long before the present crisis, and positive actions have already been taken to address them including the construction of the new Secure Unit within 'The Park'. This hospital is designed to provide an appropriately secure environment for long term and humane detention when this is required. The new forensic mental health centre in Townsville will also increase the availability of secure beds. In recent years Queensland has also built a number of medium secure beds, which potentially provide an important resource in managing the clinical challenges presented by mentally abnormal offenders. Optimum functioning of the inpatient resources may require, however, a more coherent approach to the utilisation of those resources, as well as an augmentation of the community forensic mental health services.

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We are heartened to note the draft Forensic Mental Health Policy addressed the current deficiencies in community forensic mental health provisions. The increased bed number will relieve pressure to discharge prematurely. The new Mental Health Act (2000) will provide greater powers for health staff to control admissions, though the Queensland system will continue to place considerable pressure on the mental health services to accommodate those sent from the courts.

The forensic mental health services have great difficulty regulating the demands placed on their system. The number of section 36 orders imposed by the Mental Health Tribunal has steadily increased over the last decade and is now running at between 120 & 140 a year. (See Appendix 2, Breakdown by Financial Year). Though not all such patients require specialist forensic mental health services, nevertheless they nearly all spend some time being cared for in those services. The increased rates of patients entering the system with a 'forensic label' is not matched by those exiting the system. In the last four years for which figures are available 502 orders have been made and only 24 revoked. This would not be a cause for concern, and might even be reassuring, if such orders were only made in respect of individuals who present a continuing risk to the peace and safety of the community. In fact less than 4% involve homicide and nearly half (47%) follow charges in respect of property offences (see Griffin C. 2001, The Mental Health Tribunal thesis presented to RANZCP). The group of people on section 36 (currently over 700) have offending histories which cover the whole spectrum, from nuisance to homicide. The future threat to the community presented by such a disparate group ranges from the negligible to the profound. In the face of such variability there must be an equally wide range of practices with regard to control and containment. A number of individuals who made submissions pointed out that at one end of this spectrum people with mental illness found of unsound mind in respect of relatively minor charges were being subjected to controls and intrusions into their everyday life which were far greater, and lasted far longer, than would have occurred if they had been convicted of the particular offences. Equally it was emphasised by some submissions that at the other end of the spectrum those who had committed very serious acts of violence seemed to be reappearing in the community with unseemly haste. There are a number of possible solutions to this problem canvassed in the report which could easily be incorporated within the existing legal and service frameworks. Events of recent weeks surely make clear the dangers of confusion over the needs for security and supervision between those with histories of extreme violence and those in whom fecklessness and dishonesty are their worst attributes.

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To ensure that staff working with forensic mental health patients had an opportunity to contribute to the review a questionnaire was developed and distributed to all staff (See Appendix 3). A total of 154 completed questionnaires were returned, with 66% of the respondents having worked with forensic mental health patients in excess of two years. Whilst there were often variations in how staff perceived the issues, the majority of respondents expressed concerns regarding the short period of time between the offence and the patients ability to access leave. Whilst some may suggest that the individuals who completed the questionnaires were not representative of all staff, the number of respondents would lead us to believe that there is a genuine concern amongst some mental health professionals within Queensland regarding a range of issues which are outlined further below. Clearly these concerns are either not being expressed or not being heard when decisions regarding patient leaves are being made by the treating team. This may come about as a result of a dominance of the medical approach to managing mentally disordered offenders, and the perception of nursing and allied health staff that they do not have adequate opportunities to contribute to decision making. Several respondents stated that they did not believe that their views were listened to or factored into decisions regarding patient management generally and patient leaves specifically. Whilst it is recognized that the treating psychiatrist carries ultimate accountability and responsibility for decisions regarding patient care and treatment, the burden of these responsibilities can be eased when there is a genuine commitment to multi disciplinary team functioning. To maximize patient outcomes and successfully implement treatment plans, the team must have ownership of and commitment to planning and decisions.

Whilst it is impossible for us to do justice to the quality and content of the information provided to us via the staff questionnaires, the general themes which we have identified are;

- A need for greater multi disciplinary input into the assessment of patients.
- Inadequate opportunities for allied health and nursing staff to contribute to care planning and decision making.
- A requirement for increased resources to assist in effectively managing forensic mental health patients, particularly within community services.
- A need for recognition of the challenges facing practitioners within rural and remote areas of Queensland, particularly when they are attempting to manage difficult patients with limited resources.
- Increased training opportunities required.
- Reduction in the number of casual staff currently being utilised.

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- A need for greater consistency and a more standardized approach to risk assessment and management.
- A need for increased communication and consultation between secure services and District services regarding the discharge of restricted patients.
- Concerns expressed regarding pressure on beds, focus on discharge at earliest opportunity, serious offenders progressing through the system too rapidly.

In addition to the staff questionnaire, and the verbal submissions made, we received several written submissions from a range of individuals. We have attached these to our report as appendices, to ensure that the views of these individuals are adequately represented.

Attitudes of health professionals often differ at some points from those of even the best informed members of the general public. This is inevitable given the proper primary focus of health professionals on the care and interests of their patients rather than primarily on broader social issues. Nobody with any sense would wish to be treated by a health professional whose main interest was reducing the cost of health care to the nation. However, health professionals have, to some extent, be responsive to issues of cost. Similarly, the community would be ill served by a forensic mental health service which put control and containment of its patients at the forefront of its thinking about service provision. They would be ill served because effective treatment and rehabilitation are the best guarantee of reducing future risk in mentally abnormal offenders. However, a forensic mental health service must take issues of control and containment seriously if it is to retain public confidence. Further, if it is to progress the quality of its therapeutic services it has to justify its practices not just in the court of peer review, but in the court of public opinion.

It is shortsighted to attempt to hide practices in forensic mental health from public scrutiny on the grounds that they will be misunderstood or subjected to ill informed and prejudicial criticism. The public has a legitimate interest in the ongoing care of mentally abnormal offenders and forensic services have to be able to publicly explain and defend their practices. On occasion they will need political support in resisting ill informed public criticism which may generate demands for changes which will harm their patients in the short term and harm the community in the long term. That political support is likely to be more readily forthcoming when politicians and the public have available good quality information on what is being done, why it is being done and what the long term benefits to the community are likely to be.

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It was put to us that events such as patients absconding are inevitable and should not evoke blaming responses. We agree. Errors occur in any system dependent on judgement and adherence to potentially complex procedures. When such errors occur there is a responsibility to examine current practices and procedures with a view to reducing the chances of any particular form of error recurring. This is not about pointing the finger of blame at individuals or systems but of grasping the opportunity for learning from adverse events. This report is not about assigning blame, if blame there be, for any particular events, but of reviewing systems and practices in the hope of reducing the frequency of adverse events in the future.

A wide range of individuals went to the trouble to provide information to us in the form of oral and written submissions. There were, on occasion, marked differences in how issues were perceived between individuals, between professional groups, and between various levels in the different organizations. Doubtless, on occasion, individuals or groups were attempting to advance particular agendas. Often as outsiders we may have failed to perceive the particular bias, or particular agenda, underlying aspects of the representations. We should perhaps in the report preface every comment, and every recommendation, with the caveat that ‘if the submissions made to us accurately represent current reality then, etc’. Perhaps, on the other hand, an innocence about the motivations of some of those who made representation may be an advantage, avoiding, as it does, pre-judgement. The report, we would emphasise, is a reflection of what we read and heard, and is therefore partial and fallible, but we hope still helpful.

THE CONTEXT IN WHICH FORENSIC MENTAL HEALTH SERVICES FUNCTION

The legal implications of a finding of unsoundness of mind (or of mental impairment in other Australian jurisdictions) are that the accused is not legally responsible for the offences and should neither be the subject of punishment nor be employed for the purposes of deterrence. This is a long established legal principle. Queensland has a system which gives clearer and more rational expression to these legal implications than most other jurisdictions. In Queensland when an offender is deemed of unsound mind, unlike many jurisdictions, the future responsibility for their care and containment passes entirely to the mental health system. The criminal justice system ceases to have a direct say in such individuals' future management.

The exempting of the offender of unsound mind from punishment is traditionally balanced by making them subject to controls which will ensure, as far as possible, that they will not endanger their fellow citizens in the future. Until relatively recently this often resulted in permanent incarceration in a secure hospital. Given that the mental illness led to the offending, given (at least until the last 30 or 40 years) the mental illness was persistent and essentially untreatable, then public protection required continuing, and potentially life long, separation of the individual from the community. With the emergence of more effective strategies for the management and rehabilitation of those with severe mental disorders has come the prospect of safely returning many, though not all, mentally abnormal offenders to the community. This, in its turn, necessitates the development of procedures and practices which give expression to the rights of patients who have recovered sufficiently to live safely in the community. Equally, procedures become necessary to ensure the rights of the public to be protected from foreseeable danger when leave in the community is contemplated. In this process views differ widely on how to balance the interests of the public with those of the individual patient.

Some of those who made submissions appeared to advocate for a process of "normalisation" in which all patients, irrespective of how they entered the mental health system, should be managed in the least restrictive environment compatible with their current mental state and behaviour. The past offending was viewed as relevant only in terms of its likely recurrence should the mental disorder recur. There appeared to be an assumption that the patient should be able to return to the community as soon as their disorder was in remission, or under reasonably stable control. Those who hold this position tend to argue that continued detention is only justified in the face of

continuing active psychiatric symptoms and positive evidence of continuing dangerousness. Some more robust souls even argue that continued detention is unacceptable without ongoing evidence of active symptoms irrespective of the level of apprehended dangerousness.

On the other hand many mental health professionals took the view that in those who have committed serious crimes of violence, their future management must take account of the implications of the past violence. This perspective emphasises that there should be good reasons for discounting the risks of recurrence of the violence, not simply an absence of positive reasons for believing it will recur. This position tends to take a broader view of the patients' disorder and behaviour than a narrow focus on the presence or absence of positive symptoms of active mental disorder. Similarly this approach is more open to incorporating likely community reactions to the patients return to the community. Those who hold to this argue this is not a matter of pandering to prejudice or irrational fears, but of giving some weight to the likely responses of ordinary people equipped, as they almost always are, with a capacity for both reason and compassion.

Most reasonable people accept that mentally abnormal offenders, however awful their past offending, should have the chance of eventually returning to live in the community when they are fit to do so. Nobody who made submissions to our review argued against this as a proper goal. Questions were legitimately raised around how long does it take to be reasonably sure that the violence will not recur, and how long to ensure the patient will continue to cooperate with the necessary treatment. Questions were also raised about whether following acts of serious violence, the community was not entitled to a reasonable period of time to recover from the immediate impact of such acts, before the perpetrator is once more living among them.

It is not this review's task to decide on public policy. It is ultimately a political decision how best to balance the rights and aspirations of people who have committed crimes whilst mentally disordered, to return to live freely in the community, with the public's right not to live in fear. It would be disingenuous, if not frankly dishonest, however, not to acknowledge our own attitudes towards issues of control and containment. We believe that issues of control and containment are central to running forensic mental health services. We incline to the view that progress back to the community must take account of legitimate concerns about public safety.

In practice, in our view, it is rare for the active symptoms of a mental disorder to account entirely for criminal offending. Those with mental disorders who commit serious acts of violence are far

more likely than others with similar illnesses to both have histories of drug and alcohol abuse and to have previously shown personality disturbances associated with antisocial behaviours. Furthermore those mentally disordered people who commit offences are more likely to have been treatment resistant or non compliant with treatment prior to the offending. The offending history in many cases will have predated the first psychiatric contact. Mentally abnormal offenders not infrequently share with other non-disordered offenders increased rates of childhoods marred by a range of social, educational and economic disadvantages. In addition, brain damage and intellectual limitations are found more frequently. In short, managing the risks of a recurrence of the offending behaviour can only rarely be reduced to simply controlling active symptoms of illness. In most instances assessment and management involves taking account of the interactions between the mental illness, substance abuse, personality problems, organic impairments as well as social and cultural factors. This requires a multi-disciplinary approach and takes time and resources. Forensic patients do tend to be more complex and challenging to manage than most general psychiatric patients. When to this is added a history of serious violence and the need to minimise a recurrence of such behaviour, it is unusual to be able to move rapidly to a satisfactory and proven effective strategy of management. It takes time. It takes the special skills of a range of mental health professionals, and it takes appropriate resources. But carried out properly the management of the mentally abnormal offender contributes not only to the long-term health and stability of the patient, but to the safety of the community.

VICTIMS

The representatives of the victims groups (Ms Bernadette Shanahan, Ms Cathy Miller and Mr Dennis Denning) were critical of the virtual exclusion of victims from any role under the current legislation. They were also sceptical about how the new Mental Health Act provisions with regard to victims will be realised in practice.

The spokespersons for the victim's groups all made clear their desire for the voice of the victim to be heard at appropriate points in the process of the ascertainment and subsequent management of those found of unsound mind. They recognised, and with one exception accepted, that a finding of unsound mind excluded punitive considerations, such as length of sentence. They argued persuasively, however, that the Mental Health Court should have provision to allow the receipt of victim impact reports and that the court should make copies of those reports available to those who will be responsible for the later management of the patient. In particular they believe that victim impact reports should form part of the documentation available to the Patient (Mental Health) Review Tribunals. They would wish that a structure modelled on the Justice Department's Concerned Persons Register be established to ensure victims who wish for information can be informed of the progress of the offender through the mental health system. In cases where there have been serious acts of violence they would wish victims to have an opportunity for requesting specific conditions on leave arrangements, for example ensuring that areas where victims live and work are placed out of bounds as part of the leave conditions. They insist that the victims and relatives should be informed before the offender begins having leave in the community and before they move to placements either of lower security or in the community. Above all, they believe victims and their families who have registered as concerned persons have a right to be informed if the patient absconds. The new Mental Health Act (2000) provides victims with the opportunity of making an Application for Notification which, when effectively implemented, will provide victims with the voice that they desire and need.

There was a broad acceptance that those found of unsound mind required treatment and that their effective treatment was in the community's best interests. There was no resistance to the idea that most, if not all, people found of unsound mind would eventually return to live in the community. Only one of the victim's representatives argued for the imposing of a mandated period of detention equivalent to a sentence. All, however, expressed concern over the speed with which certain

Victims

offenders, found of unsound mind following killing or maiming victims, returned to the community. They argued that such haste was compatible neither with public safety nor with there having been sufficient time to adequately assess and treat disorders, which had had such grievous consequences for others. There was also a feeling expressed that it was proper to allow a reasonable period of time to elapse before returning seriously violent offenders to the community. This would allow victims, and concerned members of the public to accommodate to the idea of the return of the offender to the community.

Historically the decision to remove an offender from the criminal justice system and place them in the mental health system is attended by a loss of any voice for the victim, which may have been contributed to by a lack of clarity and communication issues between police, the DPP and the victim. Removing a mentally ill offender from a context where punishment is appropriate does not, in our opinion, necessitate silence being imposed on the victims. It could be argued that the decision to manage the offender as a suitable case for treatment, rather than for punishment, should be accompanied by an equally concerned attitude to the victim. In making leave and discharge decisions thought should always be given to the effects on the feelings of the victim. Whilst there have been occasions where victims have made submissions to the Patient Review Tribunal, this has not been the general standard. It is an error to assume victims are only, and always, bent on revenge and retribution. In our experience they are usually interested primarily in being heard and being acknowledged.

In our view the damage and suffering inflicted by a mentally abnormal offender continues to be relevant to their future management for as long as they are the responsibility of the mental health services. It should quite properly influence decisions on leave and discharge. For example in the case of a patient on a section 36 who is requesting leave and whose most serious offence involved theft, then the risk of recurrence of the offending can be viewed if not with equanimity, at least without great anxiety. This is not so with serious violence where the evidence should be clear and convincing that the risk of recurrence is absolutely minimal. Given what should be a continuing concern for and focus upon, the offending during the care and treatment of the mentally abnormal offender, there seems no theoretical bar to giving victims a voice. We hope the new Mental Health Act will be realised in a manner that makes this possible.

The Academic Department of Psychiatry at the Royal Brisbane Hospital has had a history of commitment to studies on the impact of victimisation, which has included work on victims of

domestic violence and of child abuse. There would be considerable benefits in members of the forensic mental health service becoming more familiar with the results of such research. There should also be a policy of actively engaging in such research. As part of the research interests of Queensland academics, such as Beverly Raphael, not only research but services for victims were fostered. Again, taking initiatives in the development of services for neglected victim groups is a proper and appropriate use of the special skills of forensic mental health professionals. Not only has this the potential for providing a much needed service it also fosters a culture in the organisation which is interested in, and sensitive to, issues for victims.

RECOMMENDATIONS:

- 1. That the mechanisms available under the provisions of the Mental Health Act (2000) to allow victims to submit appropriate impact reports to the new Mental Health Court are implemented with regular monitoring to ensure that they remain effective. That these reports become part of the patients record during the period of their compulsory treatment initiated by the court.**
- 2. That the equivalent of a Concerned Persons Register be established in respect of offenders deemed of unsound mind to allow victims appropriate information about the patients' placements and eventual discharge. The Notification Order provisions of the Mental Health Act (2000) which will be administered by the MHRT, would meet this recommendation. A review of the implementation and effectiveness of this provision should be undertaken within 12 months.**
- 3. That the new Mental Health Review Tribunal develop mechanisms to ensure that persons who have made a Notification Order are able to provide information to the Tribunal when considering the nature and scope of leaves.**
- 4. That a culture be fostered in the forensic mental services which is aware of, and sensitive to, issues for victims. This could be advanced by education, engagement in research and participating in services for victims.**
- 5. That victims who have registered as concerned persons be promptly informed should the patient, who has harmed them in the past, abscond. This notification should be made by**

the police, and will be facilitated through the introduction of the Information Form which has recently been developed by Queensland Health and Queensland Police Services.

INTERFACE BETWEEN QUEENSLAND POLICE SERVICES AND MENTAL HEALTH SERVICES

The management of the mentally ill is the primary responsibility of mental health services, however it is an unfortunate inevitability that there will be times when mental health services are unable to safely manage and contain a patient or a situation. Whilst we accept that police do not have mental health expertise, they will never the less often be actively involved in assisting in managing the mentally ill within the community. It is therefore an essential requirement, to ensure the safety of the mental health staff, the police, the patient and the community more generally, that there is a positive working relationship between these two services. This relationship must be built on mutual trust and respect.

During the discussion held between representatives of Queensland Police Services and the review team, there were a number of legitimate concerns and issues raised. From our perspective one of the key issues was the reported number of occasions when police were responding to requests from the mental health services to perceived mentally ill persons with no mental health professional support or assistance. Whilst police felt that the number of calls that they received was a significant drain on their resources, they did not argue that they had no role in responding to disturbances within the community. Their major concern was in relation to the lack of mental health support that they had available when they did respond. We believe that this is potentially very dangerous, as police are not mental health experts and should not be expected to provide the first line response for the mentally ill.

A general perception of police was that mental health staff appear to take little responsibility for patients once they have absconded from the inpatient environment. During a group interview an experienced nursing staff member made the comment to us that when a patient was standing at the door saying they were going to leave, there was nothing that the nurse could do to prevent the patient leaving. The nurse went on to say they had to let them go as attempting to stop the patient placed the nurse in danger. Involuntary and restricted patients attempting to leave hospital without authorisation is not a new or unexpected occurrence. Over the years psychiatric nurses have become extremely skilled in managing these behaviours through the use of advanced negotiation and communication skills, and when required, using physical restraint. This is part of the role of a psychiatric nurse working within an inpatient environment, and whilst it is often unpleasant, nurses

must not abrogate their responsibilities for containment of patients. It is, however, unwise for a nurse to attempt to undertake patient containment on their own. There should never be a situation where a single staff member is left to manage a patient who is attempting to abscond. Ensuring that there are appropriate resources, as are currently available in Queensland mental health services, available to assist treating teams to manage difficult behaviours, including absconding, such as the number and skill mix of staff, an effective duress alarm system and emergency policies and procedures, is critical to maintaining a safe environment for all.

Whilst a number of staff we spoke with indicated that often police perceived that someone was mentally ill, when they may be acutely disturbed due to intoxication by substances, this does not negate the concerns expressed by the police, and that we share, about the potential dangers posed to patients and police members when they are dealing with a mentally ill person with no mental health support.

Both groups agreed, however, that a service or process for providing a safe environment for the detoxification of persons impaired by substances, particularly amphetamines, was required. Police and mental health professionals both perceived that their services were not the appropriate venue for this type of intervention and identified a range of options including a short term assessment and detoxification centre co-located with a general hospital as providing a solution. This may be something that Queensland Police Services and Queensland Health may wish to explore into the future.

The majority of police present expressed concern regarding the amount of information provided to them when they were requested to assist with apprehending a mentally ill person, or when a mentally disordered patient who had committed a serious violent offence was discharged back into the community. They stated that often mental health services would provide them with little or no information due to confidentiality issues. Patient confidentiality is of paramount importance, but safety of the patient, police members and the community is also important. We believe that mental health services should be able to provide relevant, meaningful information to the police without breaching confidentiality. Police do not need or require details about a patient's diagnosis, medication and treatment, but if they are expected to assist in managing mentally ill persons they must be provided with enough information to assist them in containing the patient and managing risks. For this to occur there will need to be a level of trust between police and mental health services which may not currently exist. The development of joint protocols, such as the

Memorandum of Understanding and the Information Sharing Form, between Queensland Police Services and Queensland Health will assist in strengthening the relationship between these services. We were advised that at least one District mental health service was working on developing local protocols with the police, as part of a statewide project which will see the development of local protocols in all Districts. This is where the greatest benefit lies. In order for centrally developed policies to be effectively implemented there must be a genuine commitment at the local level to the principles and actions contained within the policies. It has been our experience that developing collaborative relationships with local police has enhanced our ability to respond to and manage emergency situations, and has also assisted police in broadening their understanding of our service and patients. This ultimately leads to benefits for all.

RECOMMENDATIONS:

- 6. That work continue on the development of joint protocols between District Services and local police with a focus on responding to absconded patients and the provision of mental health support to police who are responding to calls regarding known mental health patients.**
- 7. That each District mental health service and police region create liaison positions which will provide a single contact point for raising concerns between the services. Regular meetings should be held between the liaison personnel.**
- 8. That discussions occur between Queensland Police Services and Queensland Health regarding future management approaches to persons intoxicated with substances and who are presenting in a disturbed manner.**
- 9. That the interim protocol developed between Queensland Police Services and Queensland Health regarding the information which will be provided to police when a patient absconds, be reviewed within 6 months of implementation. To ensure that there is an adequate knowledge base the protocol must be disseminated widely across Queensland Police and Mental Health Services.**

PROCESSES AND SYSTEMS TO ASSESS MENTALLY ILL OFFENDERS CHARGED WITH SERIOUS VIOLENT OFFENCES

The current process for a patient entering the mental health service system as a forensic patient is as follows;

- Patient apprehended. Generally taken to the nearest Emergency Department, or District Mental Health Service.
- Patient is assessed by admitting/triaging medical officer and a 3 day holding order is made.
- Regulated patient status.
- Once the patient has been charged with an offence the relevant service notifies the Director of Mental Health.
- Change of status to Section 29 (a) or (b).
- Referred to the Mental Health Tribunal (Court).
- Assessment, for the purposes of providing advice to the Mental Health Tribunal, is generally undertaken by a minimum of 2x forensic psychiatrists, one of whom is assessing on behalf of the Director of Mental Health.
- If found to be unfit to be tried or of unsound mind, order made as a Section 36 patient.

As discussed in the introduction, one of the initial issues identified through the review was the large number of restricted patients (section 36) currently within the system. There are presently close to 700 section 36 patients identified by the Queensland Forensic Mental Health Service system, and this number is growing by approximately 120 additional patients each year. A large proportion of these patients have committed relatively minor offences, and often do not pose any great risk to the community. The current system does not provide any capacity to differentiate between mentally disordered offenders who have committed serious violent offences and those who have committed minor indictable offences.

An example provided to the review team which identified the potential issues was;

A man with a mental illness who was placed on a Section 36 order, following committing credit card fraud. This order was commenced in the early 1990s. The patient subsequently moved to a

rural area in Queensland, to live with a family member. The patient gained employment and was engaged in treatment with a private psychiatrist. There is no evidence of further offending behaviour or of relapse of his mental illness. Following the recent publicity and identification of Section 36 patients who had breached conditions of their leave of absence, or who were AWOL, this man was apprehended by police and returned to a District Mental Health Service. After having committed a fairly minor offence, this patient had remained a section 36 patient for many years. It may be conjectured that if he had not been lost to follow up, through relocating without notification, he may have already been discharged from the section 36 order. However there is other evidence which suggests that there has been at times reluctance to discharge patients from this order for reasons including the inability under the current Mental Health Act (1974) to transfer a restricted patient to a regulated patient status. This means that a restricted patient must be discharged from their order and then re-certified as a regulated patient in order to ensure there is a capacity to continue with compulsory community treatment. Whilst this is not a barrier when the patient is acutely ill, there is an issue when they are stable and do not meet the criteria for certification.

Another example is a patient who was the subject of media attention in Northern Queensland, with the unfortunate headline of 'Captured' and a large front page photograph of the individual. This patient's offence was to have written a cheque for \$64 million dollars. He had been on a section 36 order for approximately ten years, however was listed as an AWOL patient, and was therefore apprehended, with the impression being created that this was a patient who was considered dangerous and a risk to the community. Again there is no evidence that during the preceding ten years the patient committed any further offences.

Whilst the current system is theoretically coherent from both mental health and legal perspectives, as well as having a focus on ensuring patients rights are adhered to and respected, the system may also lead to situations where the restrictions which are placed on the mentally ill who have committed minor offences are not only onerous, but at odds with principles of treatment in the least restrictive environment.

The new Mental Health Act (2000) scheduled for implementation at the end of February 2002, will provide increased opportunities to divert mentally ill patients at key points in the process. This can be achieved through the utilisation of provisions available to the Director of Mental Health to refer patients who have committed minor indictable offences to the Attorney General. In turn the Attorney General is able to recommend that the charges against the person be discontinued or that

referral to the Mental Health Tribunal (Court) should proceed. Assuming that both the Director of Mental Health and the Attorney General use their powers to divert mentally ill offenders from the restricted patient status path, this should lead to a reduction in new Section 36 orders being made. Additionally the new Act provides a mechanism to transfer patients from restricted status to regulated status. With this provision now available, the Patient Review Tribunal should have increased capacity to discharge restricted patients in a timely manner, which should result in the number of Section 36 discharges being greater than the current 24 patients per year.

At the other end of the spectrum there are patients who have committed serious violent offences who are accessing leaves within the community within a time frame that is not in keeping with other jurisdictions. This situation may come about as a result of the focus upon patient clinical outcomes, without giving due weight to the original offence. Patients who have committed serious violent offences may respond quickly and positively to treatment. This may result in the patient having a greater capacity to access leaves within the community, if the risk is considered low, on the basis that the patient's illness is effectively treated without considering other factors. The following information provides an example of these issues.

We were provided with a sample of leave records for fifteen (15) patients who had been charged with murder in the past five years. When reviewing these records it was at times difficult to identify the type of leave the patient was accessing, due to the frequent number of Patient Review Tribunal decisions being recorded as 'leave at the discretion of the psychiatrist'. This issue is discussed further elsewhere in the report. In analysing the information provided we identified the following outcomes;

- 14 patients were accessing some type of leave, prior to all leaves being suspended in early February 2002. 1 patient was recorded as absconded.
- 4 (27%) of patients had escorted leave only.
- The average period of time from the Mental Health Tribunal decision and access to
 - Escorted leave was 7.5months
 - Unescorted leave was 15.5 months
- 8 (53%) of patients were residing in the community. This was defined as patients who were either on leave of absence, or who had overnight leave for 4 nights or more per week. The average period of time between the Mental Health Tribunal decision and living in the community was 20 months.

The process for the assessment of mentally disordered offenders is considered by most of those who made verbal submissions, to be rigorous and appropriate. Whilst there were questions raised regarding the role of the Department of Public Prosecutions in representing the interests of the community in the Mental Health Tribunal process, there was little criticism of the final outcomes. It was put to the review team that at times the DPP and police appeared to take little active interest in the case once the referral was made to the Mental Health Tribunal, which may lead to a lack of rigor and integrity of evidence and appropriateness of charges.

At times the patient who has offended and is referred to the Mental Health Tribunal is already in active treatment with a District Mental Health Service. On a number of occasions it was put to the review team that there were limited opportunities for mental health professionals, other than the psychiatrist, who may have an extensive knowledge of the patient, to provide reports and information to the tribunal. This is particularly relevant in relation to psychologists and case managers who may have been working with the patient and have knowledge of a range of psychosocial factors which have contributed to the offending behaviour. However, identifying whether a patient is in treatment or has been in treatment with another service is often difficult, as there is currently limited capacity to track patients who move from one area to another. Although there is a centralized HOSPAC database, this is neither comprehensive nor user friendly. More recently Queensland Health has been exploring options for the development of a patient information management system which will provide patient related information and has greater access than HOSPAC. The progress of this has been hampered with the introduction of new privacy legislation which will impact on the way in which the system is developed and managed. A centralized, integrated patient information management system which is able to be accessed by all services, and provides details including patient demographics, where they have previously received treatment, their legal status and any offence issues is required as soon as possible. This will ensure that itinerant patients are able to be adequately tracked and monitored, as well as providing adequate information to assist services in making appropriate judgements regarding risk and ongoing requirements for supervision, support and containment. In the recommendations of the Briscoe Review, January 2002, it was recommended that a register of serious offenders be developed to assist in providing an additional safety net for monitoring these patients. Whilst this recommendation is endorsed, it may be more effective to develop a data base as described above that will provide information on all patients.

RECOMMENDATIONS:

10. That future reviews of the Mental Health Act (2000) consider amending the section equivalent to the former Section 36 status to provide capacity to make orders which differentiate between patients who are serious violent offenders and patients who have committed non-violent offences. This could be achieved through the provision of a Section 36(a) and Section 36(b) classification.
11. That there is appropriate utilisation of processes available through the Mental Health Act 2000 to reduce the number of forensic patients who have committed minor indictable offences.
12. That practices be developed and promoted which ensure that patients no longer requiring the restrictive conditions inherent in a Section 36 order are able to be discharged from these orders or have their restricted patient status transferred to regulated patient status.
13. That discussions are held between the Mental Health Tribunal, Queensland Health and the Department of Public Prosecutions to identify expectations and a shared understanding of the role of the DPP in the tribunal process.
14. That there is increased involvement of other mental health professionals, allied health and nursing, in the provision of reports and information to the Mental Health Tribunal to assist them in making determinations.
15. That a comprehensive, centralized Patient Information Management System, which is managed by the office of the Director of Mental Health, is established.
16. That the information kit being developed by the DPP in consultation with Queensland Health is commended and that work continue to be progressed, ensuring there is appropriate consultation with relevant Victims Groups. This kit should include information regarding the outcomes of the Mental Health Tribunal and the general standards and processes regarding a patients treatment, and access to leave following a finding of unsoundness of mind.

PROCESSES AND SYSTEMS TO PROVIDE THE PATIENT REVIEW TRIBUNAL WITH THE INFORMATION IT REQUIRES TO CONDUCT ITS REVIEW OF INDIVIDUALS

In reviewing the processes and systems of the Patient Review Tribunal (PRT), it became clear that the information currently provided to this body is inconsistent, and does not always include all relevant information. This was supported by a number of individuals who made verbal submissions to the review team, including representatives of the PRT. Based upon the information conveyed to the review team it is not unreasonable to state that there appears to be a general concern with the information provided to the PRT and the manner in which leave is subsequently approved. This is not a criticism of the PRT but is a reflection of the current lack of clearly articulated requirements and structures for the provision of information to this body. Additionally there are five PRTs which operate across Queensland, which can very easily lead to inconsistency in the absence of a clear framework and structure. The changes to the Mental Health Act and the implementation of the Mental Health Review Tribunal, which will take the place of the PRT, with a single president will address most issues relating to consistency of functioning and decision making. Representatives of the newly formed Mental Health Review Tribunal (MHRT) identified processes which they are putting in place to assist them in their functioning, including the development of a proforma which will provide a framework for mental health professionals to provide information. This is strongly supported and further consultation between services and the MHRT is encouraged.

Although there were a number of examples given where there was comprehensive information, including detailed treatment plans, provided to the PRT by the treating psychiatrists on behalf of the team, this was not the usual standard. It was conveyed that perhaps the role and function of the PRT was not always adequately understood or appreciated, resulting in reports being provided late, reports which lacked appropriate content and at times the psychiatrist not being available to appear at the PRT hearing. It was suggested that at times members of the PRT were having to read through multiple volumes of the patients' medical record to obtain the information they required for the purposes of making decisions, as the information provided in reports by the treating team did not have adequate content, particularly relating to progress of the patient from the time of the offence through to current presentation. This is a situation which places unreasonable demands on the PRT to identify all relevant information within the time available to them. We saw examples of decisions

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Processes and Systems to Provide the Patient Review Tribunal with the Information it Requires

of the tribunal which had a significant amount of reliance upon the treating psychiatrist taking responsibility for implementing very broad leave approvals, for example ‘leave at the discretion of the psychiatrist’ was on occasion the only direction provided. As discussed later in the report, with the exception of a very few number of pre discharge patients, these types of leave approvals should not occur. Without exception, those who spoke with the review team emphasized that the PRTs were hard working and committed, appropriately patient focused, respectful of patients’ rights and were acutely aware of the enormity of their responsibilities. There was a general perception that by reducing the number of members of the PRT who sat on hearings in relation to forensic patients there would be:

- an increase in consistency of decision making
- greater opportunities to discharge patients off forensic patient status
- development of longitudinal knowledge of forensic patients
- increased emphasis on issues which are unique to the mentally disordered offender population

Issues relating to victims and the role of the PRT have been discussed elsewhere within the report and will therefore not be repeated.

Whilst it is essential for the treating team to promote opportunities for the patient to progress through the system and to have appropriate access to leave in a timely manner, it is also essential that there be an independent panel which will act as a ‘brake’. This panel needs to consider not only clinical issues but also issues as they relate to risk, control, containment and community safety. It is not unreasonable to assume that the focus of the treating team will, and should be, on the patient and their needs. The advocacy role that is an important component of the treating team’s working relationship with the patient should not be compromised or misinterpreted. Whilst we would propose that the team’s advocacy role does not exclude issues such as community safety and the rights of the victim, it will at times dilute the weight these are given when the treating team is making decisions regarding patients’ leave. To suggest that these issues should be a major focus for the treating team can compromise their ability to work in a collaborative and therapeutic way with the patient. It was acknowledged by the majority of individuals and groups who met with us that one of the most important factors in promoting community safety in the future is ensuring that mentally disordered offenders receive the best possible care and treatment to assist in minimising future risk of violence. Therefore it is essential that the treating team is able to engage the patient to

the extent that they believe that the treating team is acting in their best interests. This may at times put the treating team in a conflictual situation, particularly if they are to consider broader interests.

In order for the PRT to have available to them all relevant information which they must consider and balance, our experience has been that having an additional layer in the process, one which falls between the treating team and the leave approving body, can be extremely helpful to not only the approving body but also to the treating team.

For the purposes of this report we will hereafter refer to this additional layer as the Leave Review Committee. This committee would be an internal body with the membership comprising senior clinicians of the service and senior operational management representatives. Whilst this committee would not have any powers to approve or not approve leave, they would have the opportunity to make recommendations to the PRT, including provision of information regarding their discussions and conclusions. The Leave Review Committee would serve several functions, including;

- Controlling quality of information being provided to the PRT
- Ensuring that there is a comprehensive treatment and leave plan for the patient, which clearly identifies the links between the proposed leave and rehabilitation goals.
- Reviewing the timing of the proposed leave in the context of the patient's illness, offence, behaviour, reportable incidents involving the patient, risks presented by the patient, and the likely public perception of the safety and suitability of the proposed leave.
- Suggesting modifications which may be made to the leave to address issues of risk minimization and community safety. This may include suggestions regarding the number and type of escorting staff or the proposed location of the leave.
- Reviewing how the patient has utilised previous leaves
- Feedback to the treating team regarding care planning for their patients, a type of peer review mechanism.
- Increasing consistency with the standard and quantity of information being provided to the PRT.

Later in the report issues specific to the implementation of leave once approved by the PRT will be discussed in detail, however it is important to note that these processes must be integrated as the PRT must have clarity when it makes its decisions regarding how the leave will be implemented.

Therefore the team must have already made decisions regarding the manner in which they plan to supervise, monitor and facilitate the leave prior to the application being heard by the tribunal.

RECOMMENDATIONS:

- 17. That a clearly articulated and standardized format for providing information to the Mental Health Review Tribunal is developed. This should include the development of guidelines for the treating team as well as a standard proforma which must be completed and forwarded to the Mental Health Review Tribunal, via the Leave Review Committee, at least three working days prior to the scheduled hearing.**
- 18. That a special Mental Health Review Tribunal be established which will specialize in hearing applications in relation to forensic mental health patients.**
- 19. That all steps in the leave planning and decision making process have regard to and incorporate the views and opinions of the multi disciplinary team, consistent with the policy outlined by the Director of Mental Health in 1997. Whilst it is not expected that there will always be consensus within the team there must be ownership of decisions by the team. This may require a re-emphasis on the role and functions of each discipline comprising the team.**
- 20. That each service managing forensic patients establishes an internal review process for making recommendations in relation to patient leave applications, notionally called the Leave Review Committee. (Refer to Appendix 4 and 5 for flow charts). The Leave Review Committee will have a clear focus upon risk and reasonable control and containment and will review all forensic applications for leave prior to them being submitted to the Mental Health Review Tribunal.**
- 21. That a standardized format for documenting immediate and long term patient leave plans be developed to contribute to a more consistent and coherent leave program. The leave plan must clearly link the leaves being sought with rehabilitation, discharge planning or specialist service provision goals and should form a component of the patient's Individual Service Plan. The Leave Plan must also accompany documentation forwarded to the Mental Health Review Tribunal three working days prior to a scheduled hearing, again**

via the Leave Review Committee, and should be comprehensive enough for the approving body to clearly understand the manner in which the leaves will be facilitated and the future plans the team may have in relation to the patient progressing through the system.

22. That, wherever possible, the treating psychiatrist and the patient's case manager are present and available to provide additional information to the Mental Health Review Tribunal during hearings. Additionally the patient's primary or contact nurse has an opportunity to provide information to the Mental Health Review Tribunal if required.

IMPLEMENTATION OF TREATMENT AND REHABILITATION PROGRAMS (INCLUDING LEAVE OF ABSENCE) ONCE APPROVED BY THE PATIENT REVIEW TRIBUNAL

As described earlier within the report, issues relating to the implementation of treatment and rehabilitation programs should be addressed as part of the approval process. These include factors such as;

- The purpose of the leave
- The relationship between the leave and the rehabilitation goals for the patient
- Management of potential risks associated with the leave. This includes escorted or unescorted leave, number and type of escorting staff, duration and frequency of the leave, appropriateness of the location of the leave/activity, potential impact of the leave on victims, access to contraband items, substance use during leave.
- Consequences of non-compliance with conditions imposed for the taking of leave.

Refer to Appendix 6, Actioning of Leave Granted flow chart.

It is our opinion that the leave which is approved, and consequently implemented, must be prescriptive and precise to ensure that there is no ambiguity for the staff who are facilitating patients accessing the leave. It is reasonable for a patient who is in the pre-discharge planning phase of treatment, to be tested in relation to their ability to cope within a less structured environment. This should only be the rare occasion when the approval given will be for leave to be taken at the discretion of the treating team.

There was some suggestion that unescorted ground leave for patients was perceived as being more restrictive than unescorted off ground leave. In reality there is very little difference. An example of this is the co-location of John Oxley Memorial Hospital with Wolston Park Hospital. Forensic inpatients of John Oxley Memorial Hospital who have unescorted ground leave, have access to the very extensive grounds of Wolston Park Hospital. This situation is likely to occur within other secure services where 'the grounds' are broadly defined. This creates a number of problems

associated with monitoring and supervising patients, particularly if they are late in returning from leave. Searches of the grounds are complex and time consuming as the boundaries are not clearly delineated and the area covered is large. Queensland Police Services representatives who met with us expressed concerns regarding the development of protocols regarding staff responses to patient late return from leave, and the manner in which searches are conducted. We were able to find evidence that there were clearly documented policies and procedures for managing these issues. There is perhaps an opportunity to consult with local police to establish joint protocols which further clarify the roles and responsibilities of each party, and how and when notification will occur. Extensions of the leave period must be authorized by the consultant psychiatrist and maximum periods of extension must also be documented.

In policies and procedures which were reviewed there appeared to be a rather liberal approach to responding to patients' late return from leave. For example, it was suggested that staff would contact the patient using the contact details provided for that leave. They would then re-negotiate a return time with the patient. These types of policies and procedures do not provide the required level of certainty and structure for the patient. The patient must be clearly advised of the time they are to return and the consequences for them not returning at that time. Patients must be given some level of responsibility for appropriately managing the leave if the leave is part of an overall rehabilitation program. This should include a clearly expressed expectation about what actions the patient must take if they are going to be late in returning from leave, for example immediately contacting their unit if they miss a train or bus.

Information regarding how patients have utilized leaves must also be recorded and collated. This type of information should be provided to the PRT when further leave applications are being made. It is important for the Tribunal to be aware for example that a patient has taken 50 leaves during the previous six months and that on 10 occasions they returned late from the leave and could offer no explanation for their lateness. Alternately, the fact that a patient who has taken 50 leaves has always returned within the required time lines and has provided feedback to the team regarding the leave is also important information for the PRT to consider. There is extensive documentation within the patients' medical record regarding leaves taken. An additional system, which captures information specifically in relation to leaves taken by the patient and the outcomes of the leave, would be beneficial in providing statistical data for research purposes as well as a longitudinal history of patient leave. The opening of the new High Security Inpatient Unit at the Park scheduled

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for later this year will go some way to resolving the issue of ground leave as it will be confined to the grounds within the perimeter wall.

In reviewing leaves taken by patients from a number of facilities, the review team found the vast majority of leaves that have been taken by patients had been appropriately approved by the PRT. The review team saw a very small number of examples where there have previously been patients who were given leave when none had been approved by the PRT. We accept that the systems have been improved in relation to managing this following these incidents, but there still appears to be room for human error and potential coercion or compromising of staff by patients. Currently the practice is for staff from within the treating team to facilitate patients proceeding on leave by undertaking a series of checks, including mental state. We believe, however, that this potentially leaves the service and the team vulnerable. There is nothing to suggest that there has been a major incident related to a patient having leave which is not approved, but there is still a potential for this to occur. Having an additional mechanism for verifying the leave, to ensure that the leave being taken is in keeping with the leave that has been approved, would provide a more robust and accountable process. This additional verification of leave would be undertaken by a staff member who is external to the treating team, for example a nursing supervisor who has operational management responsibilities but who does not comprise part of the treating team.

In discussion with representatives of the PRT there was a perception that mental health professionals were at times slow to respond to patients who were non-compliant with conditions imposed by the tribunal on their leave. This may include patients who were known by the mental health professional to be abusing substances, and upon whom the PRT had imposed a requirement that the patient refrain from using illicit substances. Often the PRT believed that a 'blind eye' was turned to these situations, when the appropriate action may be to revoke the leave. Clearly articulating the consequences of not complying with restrictions imposed on the taking of leave at the time the leave is granted may provide clarity for the patient, the treating team and the PRT.

During the review there were vague references to the inclusion of personnel other than clinical staff participating in escorting of high risk patients, such as security officers. Whilst it was never directly stated that this was an option being considered we would like to express an opinion on this matter. Our experience is that the use of security staff adds little value to the quality of the escort, and can in fact be quite detrimental to achieving positive patient outcomes. There may be a perception that a security officer will have greater skills in apprehending or containing a patient who is attempting

to abscond. However, an appropriately trained mental health professionals will generally have skills and knowledge that assist them in managing all aspects of a patients behaviour outside of the hospital environs. We acknowledge there are, at times, patients who pose a significant risk, but who require leave for the purposes of attending specialist medical and health service appointments. We would instead encourage the development of on-site service provision for these patients. This can be achieved through the use of video conferencing as well as negotiating on-site sessions from a range of specialist and allied health professionals.

In order to effectively implement recommendations which we propose, there needs to be consideration of the impact of the changes in practice on the resources available within the existing services. A concern that was expressed through the questionnaires as well as the verbal submissions made to us was the pressure on available beds, not only high and medium secure, but also District acute inpatient beds. We recognise that there will always be a limited amount of resources available. There also needs to be recognition that because of the nature of specialist forensic mental health care, traditional benchmarks in relation to bed day costs, staffing profiles, rehabilitation programs and performance indicators such as average length of stay are not always appropriate.

This also leads to additional concerns expressed regarding the impact that longer periods of hospitalisation of mentally disordered offenders will have on resources. The issues specifically relate to the need to expand the existing vocational, educational and recreational programs for patients who are being managed within secure environments for prolonged periods of time, as well as bed availability within secure environments. We were advised that there are plans to engage external service providers such as the YMCA and TAFE to expand the range of programs available to patients within the high secure environment of John Oxley, and we would encourage these plans to be progressed as soon as possible. Ongoing monitoring of the staffing profiles for all high and medium secure facilities may also be warranted to ensure that there is an appropriate number and skill mix of staff to effectively meet patient needs.

As discussed earlier in the report a clarification of the role and function of high and medium secure facilities may go some way to assisting with perceived bed pressures, together with diverting forensic patients who have committed minor offences to District Mental Health Services.

The opening of the new High Security Inpatient Unit at the Park in Brisbane and the new Townsville forensic mental health service with high and medium secure beds will greatly expand the number of secure beds currently available. We believe that the projected number of beds should be adequate with other changes occurring within District services. There does, however, seem to be a level of anxiety by the District acute services about their capacity to effectively meet the needs of the forensic mental health population, which has resulted in some resistance to accepting referrals. This anxiety and concern will clearly need to be addressed for the service system to be able to respond appropriately to patients, staff and community needs.

Queensland has unique problems associated with providing specialist services due to the geographic area that it covers and the population spread. Rural and remote mental health services expressed concerns regarding their ability to access forensic services, including consultation and training.

Recent changes to the structure and functioning of the Community Forensic Mental Health Service have seen considerable improvements in the process for responding to the needs of rural and remote services, as well as providing a more consistent and coordinated approach to assertive follow up of patients. However, the resources still do not appear to be adequate to effectively meet the needs of patients and services. The principle of District self sufficiency is commended and is one of the few ways in which the geographic disadvantages can be overcome. Support to these Districts in developing the skills to effectively manage clients, and provide them with the levels and quality of service outlined within the Forensic Mental Health Policy will require creative solutions. These solutions must consider issues of funding, recruitment, access to support and consultation, and most importantly training.

The recent increase in resources for the forensic community mental health team will have a significant impact on their capacity to meet the needs of District services. The full implementation of the draft Forensic Mental Health policy will also provide the level of resources that will be required to effectively meet the current and future needs of patients and services. Forensic patients who have been discharged on leave of absence by the PRT require a high level of support and monitoring. A number of individuals raised with us their concerns about the transitional period when patients are moving from a very structured secure environment to the community. A recommendation was made in the Briscoe Review for the establishment of a transitional program which will provide an opportunity for patients to have a seamless progression from inpatient secure

Implementation of Treatment and Rehabilitation Programs

care to community care. This is certainly one solution to a high risk period for the patient. Another solution may be developing individual community transition programs for patients, which incorporate graduated exposure to independent living. This can be achieved through the utilisation of the supported living beds which will be available at the new John Oxley Hospital. The role of Extended Rehabilitation and Treatment programs should be reviewed and strengthened to ensure that they have capacity to provide a community transition program. This could include having patients spending their day at the ERT program and sleeping in the secure inpatient environment.

These programs need to have the capability of monitoring and supervising patients more regularly than may currently occur. In reviewing a recent incident it appeared that the standard requirement for patients to be observed by staff was four times per day. Whilst this may be appropriate for a proportion of patients it may not be for others, particularly patients who have recently been admitted. We would suggest that a patient who has been transferred from a secure inpatient environment to an open environment should be observed by staff a minimum of two hourly for the first 4-6 weeks. It was difficult to determine from the documentation provided in relation to this incident, what rehabilitation activities the patient was participating in. We would therefore also suggest that there is a clearly documented and structured rehabilitation program with associated activities that engage the patient. Wandering the grounds for prolonged periods of time would seem to provide little rehabilitative value and also poses a significant problem for staff in attempting to supervise and monitor the patient. If the patient is participating in a range of activities this provides a greater opportunity for staff to assess the patients progress, as well as having knowledge of where the patient can or should be located at any given time.

The centralized Patient Information Management System discussed earlier in the report would also assist services in monitoring and tracking patients who tend to be itinerant and can easily become lost to follow up. The role of the community forensic mental health service is explained as predominantly having a training and consultation role. Whilst there is a huge need for this service, it may also be worthwhile exploring this team's capacity to have a case management role with forensic patients who have committed serious violent offences and are residing within the community. It may be very difficult for them to provide case management to all of these patients due to the geographic challenges. A shared case management role with District mental health services may provide additional support for these services, as well as providing opportunities for practical education and training.

Fostering and supporting links with family and care givers during and following admission to secure facilities must be a priority. Not all patients have been able to maintain contact with their family members and have become estranged. Therefore ensuring patients who do have contact with family maintain these links and supports becomes even more important. Successful placement back to their area of origin may be enhanced through the maintenance of links between the family, patient and treating team.

RECOMMENDATIONS:

- 23. That leave plans and approvals incorporate prescriptive and precise actions for facilitating leave. Refer to earlier recommendations.**
- 24. That a process be established for external (to the treating team) verification that the leave that is being taken is the leave that has been granted, to minimize errors and provide additional security measures that will protect staff from being compromised by patients or others.**
- 25. That policies and procedures be reviewed to ensure that there are clear requirements for staff in relation to how they respond to a patients late return from approved leave, including who has authority to extend a patients leave period and under what circumstances.**
- 26. That there is a reinforcement of the requirements for strict adherence to the conditions set by the Mental Health Review Tribunal, for a patient to access leave. This includes revocation of leave when a patient is residing in the community and does not comply with the conditions of their leave of absence.**
- 27. That the proposed discussions with YMCA and TAFE services for the provision of vocation, education and recreation programs at the High Security Inpatient Unit at the Park be progressed and expanded to incorporate the provision of these services to the Townsville Forensic Mental Health facility.**
- 28. That forensic specific training and education be provided to all mental health staff, particularly those in District mental health services as a priority.**

- 29. That the staffing profiles for high and medium secure facilities be monitored to ensure that they are consistent with meeting the short and long term needs of patients and will promote multi disciplinary team functioning. Monitoring should ensure that not only the numbers of staff are adequate but also the skill and discipline mix is appropriate.**
- 30. That a Centre for Forensic Mental Health Research and Education be established with links to the Royal Brisbane Hospital. This should incorporate the development of joint academic appointments in all disciplines with a priority in nursing and psychiatry.**
- 31. That the draft Forensic Mental Health Policy be fully implemented as soon as possible, to ensure that the community mental health resources available are appropriate to meet the needs of patients and respond to community safety concerns.**
- 32. That the rehabilitation programs offered in Extended Rehabilitation and Treatment programs be reviewed to increase these services capacity to meet the community transitional requirements of forensic patients.**
- 33. That a statewide mental health forum be held to address the current and future mental health staffing requirements including training and recruitment. Some issues that may be considered include the creation of scholarships for postgraduate studies, the strengthening of tertiary linkages at undergraduate and post graduate levels and the ongoing training needs of mental health practitioners.**
- 34. That the Community Forensic Mental Health Service takes an active case management role with forensic patients who have committed serious violent offences. This may be a shared case management role with rural and remote District mental health services.**
- 35. That a fund be established to support and maintain links with family, and to ensure that patients living in rural and remote areas of Queensland are able to attend regular outpatient appointments.**

RISK ASSESSMENT AND MANAGEMENT

We learnt of a number of approaches to risk assessment employed by Queensland mental health services dealing with forensic patients. There was a clear commitment among the forensic mental health professionals to whom we spoke to developing improved approaches to managing risk. Among those outside of the forensic service there was an equal recognition of the need to improve knowledge and skills in this area.

In one of the risk management protocols we were shown the areas of risk were sensibly divided into, the risk of self-harm, the risk of harming others, and the risk of absconding. Though it was not always apparent in the protocols, there was an awareness among the professionals of the differences between the weighting of risk factors in the short (hours to days), medium (weeks to months) and long term (months to years). We attribute the widespread interest in, and knowledge of, risk management strategies to the efforts that have been made over recent years to raise the profile of the area.

There are a number of misconceptions about existing risk management strategies. It is often assumed that reliable and relevant risk assessment tools already exist and that it is simply a matter of choosing the right instrument and applying it appropriately. This assumption is fed by enthusiastic advocates for particular approaches, who seem to come almost exclusively from North America. In reality the extant risk assessment approaches based on actuarial methods (e.g. Violent Risk Appraisal Guide) have only limited relevance to day-to-day clinical decision making in a forensic mental health service. Approaches which combine clinical and actuarial judgements like the HCR-20 have greater immediate promise, bringing, as they do, a systematic approach to applying both empirically established risk factors and broader clinical knowledge. Forensic mental health services in Canada, Germany and Sweden have successfully applied the HCR-20 in structuring their risk management approaches to leave and discharge decisions, and we are examining this approach in our own service. The route being followed at the moment in Queensland of developing locally relevant approaches which incorporate current knowledge is, however, not only acceptable but probably ideal. This is as long as there is reasonable uniformity and a sufficient level of knowledge about both the advantages and limitations of the chosen methods.

A number of criticisms were made to us, particularly in the staff questionnaires, about the opportunities for staff other than medical to effectively have input into decisions about leave, transfer and discharge. Assessing risk in most forensic patients requires balancing, as a minimum, information about current mental state, past and current behaviour, vulnerabilities, current social pressures, substance abuse issues, as well as the patients level of understanding and capacity to control impulses. Such assessments are, in their essence, multidisciplinary. Further they require good channels of communication. You need to know not just how the patient performed at interview with a doctor, but what has been happening at night, in the yard, when the relatives visited etc. That requires good interdisciplinary communications and an acknowledgement of the skills and roles of the different professional groups.

Standardised risk assessments are one contribution to the clinical decision making processes around leave, discharge and transfer decisions. They focus attention on aspects of the history and current state which have particular relevance to risk. They are not, in our view, a substitute for clinical judgement and, most particularly, for common sense. The level of experience and training among the staff applying any risk management strategy is, in our view, by far the most important determinant of the likely success of the approach. Checklists, standardised questionnaires, iterative decision trees or whatever, cannot be substituted for properly trained and experienced staff. In the hands of the inexperienced, standardised risk assessment protocols can potentially make the situation worse not better.

There are real dangers in blindly applying existing actuarial risk approaches which have been developed by research on particular populations and in particular social contexts, which often differ dramatically from our own in Australia. As an example the VRAG and the Macarthur risk assessment approaches both treat having schizophrenia as a protective factor for future violence. This may be understandable when you know the population on which these guides were developed, but would be less than helpful if applied in our forensic services in Australia. Actuarial approaches are derived from studies on large populations but not so large as to allow some important, but infrequent, clinical indicators of risk to emerge as statistically significant. Delusional jealousy for example does not appear as an established risk factor in any instrument of which we are aware and yet is one of the best established clinical correlates of violent re-offending among forensic mental health patients.

Risk management remains a clinical process, which at its best is informed by the available actuarial knowledge. Risk assessments, it should be remembered, are better at identifying areas of high risk than of guaranteeing the absence of risk. Risk assessments alert us to potential risks, they do not exclude the possibility of a recurrence of the unwanted behaviour. Actuarial and clinically based risk assessment strategies also have the unfortunate characteristic of either falsely attributing risk to a wide range of subjects if the cut off is placed too low, or of missing many who will be violent if the cut off is too high. Even with optimal placement there will usually be more actual re-offending among the low risk groups, who, though they re-offend less frequently, proportionally usually form the great majority of the subjects and therefore generate larger numbers of re-offences. All this amounts to an emphasis on good risk management approaches being a method of improving decision making processes not substituting for them.

The efforts to improve decision making around risk of self harm, harm to others, and absconding in Queensland in recent years deserve recognition and praise. We believe communication and the effective application of risk management strategies would be improved by greater uniformity of approaches between different areas of the mental health services. We would urge that training continue to emphasise an awareness of the importance of weighing the apprehended risks appropriately. For example, the risk of absconding or re-offending in someone with a history of property offending and someone with a history of homicide require quite different thresholds for decision-making. Finally we would emphasise once more that well trained staff, operating in effective multi-disciplinary teams with good communication, are the main determinants of the effective application of risk management strategies.

RECOMMENDATIONS:

- 36. That Queensland continue to emphasise education and training of staff in risk management.**
- 37. That greater uniformity be encouraged in risk assessment and management strategies across the forensic and general mental health services.**
- 38. That a multi-disciplinary approach to risk management be given real effect in clinical practice.**

EXHIBIT 259

Risk Assessment and Management

39. That levels of staff working in the forensic area be closely monitored to ensure not just adequate numbers but an adequate mixture of training and experience.

SUMMARY OF RECOMMENDATIONS:

1. That the mechanisms available under the provisions of the Mental Health Act (2000) to allow victims to submit appropriate impact reports to the new Mental Health Court are implemented with regular monitoring to ensure that they remain effective. That these reports become part of the patients record during the period of their compulsory treatment initiated by the court.

2. That the equivalent of a Concerned Persons Register be established in respect of offenders deemed of unsound mind to allow victims appropriate information about the patients' placements and eventual discharge. The Notification Order provisions of the Mental Health Act (2000) which will be administered by the MHRT, would meet this recommendation. A review of the implementation and effectiveness of this provision should be undertaken within 12 months.

3. That the new Mental Health Review Tribunal develop mechanisms to ensure that persons who have made a Notification Order are able to provide information to the Tribunal when considering the nature and scope of leaves.

4. That a culture be fostered in the forensic mental services which is aware of, and sensitive to, issues for victims. This could be advanced by education, engagement in research and participating in services for victims.

5. That victims who have registered as concerned persons be promptly informed should the patient, who has harmed them in the past, abscond. This notification should be made by the police, and will be facilitated through the introduction of the Information Form which has recently been developed by Queensland Health and Queensland Police Services.

Summary of Recommendations

6. That work continue on the development of joint protocols between District Services and local police with a focus on responding to absconded patients and the provision of mental health support to police who are responding to calls regarding known mental health patients.
7. That each District mental health service and police region create liaison positions which will provide a single contact point for raising concerns between the services. Regular meetings should be held between the liaison personnel.
8. That discussions occur between Queensland Police Services and Queensland Health regarding future management approaches to persons intoxicated with substances and who are presenting in a disturbed manner.
9. That the interim protocol developed between Queensland Police Services and Queensland Health regarding the information which will be provided to police when a patient absconds, be reviewed within 6 months of implementation. To ensure that there is an adequate knowledge base the protocol must be disseminated widely across Queensland Police and Mental Health Services.
10. That future reviews of the Mental Health Act (2000) consider amending the section equivalent to the former section 36 status to provide capacity to make orders which differentiate between patients who are serious violent offenders and patients who have committed non-violent offences. This could be achieved through the provision of a Section 36(a) and Section 36(b) classification.
11. That there is appropriate utilisation of processes available through the Mental Health Act (2000) to reduce the number of forensic patients who have committed minor indictable offences.

Summary of Recommendations

12. That practices be developed and promoted which ensure that patients no longer requiring the restrictive conditions inherent in a Section 36 order are able to be discharged from these orders or have their restricted patient status transferred to regulated patient status.

13. That discussions are held between the Mental Health Tribunal, Queensland Health and the Department of Public Prosecutions to identify expectations and a shared understanding of the role of the DPP in the tribunal process.

14. That there is increased involvement of other mental health professionals, allied health and nursing, in the provision of reports and information to the Mental Health Tribunal to assist them in making determinations.

15. That a comprehensive, centralized Patient Information Management System, which is managed by the office of the Director of Mental Health, is established.

16. That the information kit being developed by the DPP in consultation with Queensland Health is commended and that work continue to be progressed, ensuring there is appropriate consultation with relevant Victims Groups. This kit should include information regarding the outcomes of the Mental Health Tribunal and the general standards and processes regarding a patients treatment, and access to leave following a finding of unsoundness of mind.

17. That a clearly articulated and standardized format for providing information to the Mental Health Review Tribunal is developed. This should include the development of guidelines for the treating team, as well as a standard proforma which must be completed and forwarded to the Mental Health Review Tribunal, via the Leave Review Committee, at least three working days prior to the scheduled hearing.

Summary of Recommendations

18. That a special Mental Health Review Tribunal be established which will specialize in hearing applications in relation to forensic mental health patients.

19. That all steps in the leave planning and decision making process have regard to and incorporate the views and opinions of the multi disciplinary team, consistent with the policy outlined by the Director of Mental Health in 1997. Whilst it is not expected that there will always be consensus within the team there must be ownership of decisions by the team. This may require a re-emphasis on the role and functions of each discipline comprising the team.

20. That each service managing forensic patients establishes an internal review process for making recommendations in relation to patient leave applications, notionally called the Leave Review Committee. (Refer to Appendix 4 and 5 for flow charts). The Leave Review Committee will have a clear focus upon risk and reasonable control and containment and will review all forensic applications for leave prior to them being submitted to the Mental Health Review Tribunal.

21. That a standardized format for documenting immediate and long term patient leave plans be developed to contribute to a more consistent and coherent leave program. The leave plan must clearly link the leaves being sought with rehabilitation, discharge planning or specialist service provision goals and should form a component of the patients Individual Service Plan. The Leave Plan must also accompany documentation forwarded to the Mental Health Review Tribunal three working days prior to a scheduled hearing, again via the Leave Review Committee, and should be comprehensive enough for the approving body to clearly understand the manner in which the leaves will be facilitated and the future plans the team may have in relation to the patient progressing through the system.

Summary of Recommendations

22. That wherever possible the treating psychiatrist and the patient's case manager are present and available to provide additional information to the Mental Health Review Tribunal during hearings. Additionally the patient's primary or contact nurse have an opportunity to provide information to the Mental Health Review Tribunal if required.

23. That leave plans and approvals incorporate prescriptive and precise actions for facilitating leave. Refer to earlier recommendations.

24. That a process be established for external (to the treating team) verification that the leave that is being taken is the leave that has been granted, to minimize errors and provide additional security measures that will protect staff from being compromised by patients or others.

25. That policies and procedures be reviewed to ensure that there are clear requirements for staff in relation to how they respond to a patient's late return from approved leave, including who has authority to extend a patient's leave period and under what circumstances.

26. That there is a reinforcement of the requirements for strict adherence to the conditions set by the Mental Health Review Tribunal, for a patient to access leave. This includes revocation of leave when a patient is residing in the community and does not comply with the conditions of their leave of absence.

27. That the proposed discussions with YMCA and TAFE services for the provision of vocation, education and recreation programs at the High Security Inpatient Unit at the Park be progressed and expanded to incorporate the provision of these services to the Townsville Forensic Mental Health facility.

28. That forensic specific training and education be provided to all mental health staff, particularly those in District mental health services as a priority.

Summary of Recommendations

29. That the staffing profiles for high and medium secure facilities be monitored to ensure that they are consistent with meeting the short and long term needs of patients and will promote multi disciplinary team functioning. Monitoring should ensure that not only the numbers of staff are adequate but also the skill and discipline mix is appropriate.

30. That a Centre for Forensic Mental Health Research and Education be established with links to the Royal Brisbane Hospital. This should incorporate the development of joint academic appointments in all disciplines with a priority in nursing and psychiatry.

31. That the draft Forensic Mental Health Policy be fully implemented as soon as possible, to ensure that the community mental health resources available are appropriate to meet the needs of patients and respond to community safety concerns.

32. That the rehabilitation programs offered in Extended Rehabilitation and Treatment programs be reviewed to increase these services capacity to meet the community transitional requirements of forensic patients.

33. That a statewide mental health forum be held to address the current and future mental health staffing requirements including training and recruitment. Some issues that may be considered include the creation of scholarships for postgraduate studies, the strengthening of tertiary linkages at undergraduate and post graduate levels and the ongoing training needs of mental health practitioners.

34. That the Community Forensic Mental Health Service take an active case management role with forensic patients who have committed serious violent offences. This may be a shared case management role with rural and remote District mental health services.

Summary of Recommendations

35. That a fund be established to support and maintain links with family, and to ensure that patients living in rural and remote areas of Queensland are able to attend regular outpatient appointments.

36. That Queensland continue to emphasise education and training of staff in risk management.

37. That greater uniformity be encouraged in risk assessment and management strategies across the forensic and general mental health services.

38. That a multi-disciplinary approach to risk management be given real effect in clinical practice.

39. That levels of staff working in the forensic area be closely monitored to ensure not just adequate numbers but an adequate mixture of training and experience.