Waitematā
District Health Board
Best Care for Everyone

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16 August 2019

[redacted]

Dear [redacted]

Re: OIA request – Mason Clinic policies

Thank you for your Official Information Act request received by Waitematā District Health Board (DHB) on 24 July 2019. We understand that, on behalf of the family of [redacted] you seek the following of Waitematā DHB - Mason Clinic:

a) *A copy of the risk assessment report recommending transfer of [redacted] from the community team to the Mason Clinic following [redacted] release from Mount Eden Correctional Facility at the end of [redacted] sentence.*
b) *A copy of the Mason Clinic Communications policy and all policies applying to the Mason Clinic and relating to communications between patients and their family.*
c) *A copy of the Mason Clinic Visitation policy and all policies applying to the Mason Clinic and relating to visits of patients by relatives.*
d) *All medical records for [redacted] from the period of time [redacted] spent at the Mason Clinic.*
e) *The date of [redacted]*

Of the requests above, only parts b and c will be dealt with in this response under the Official Information Act (OIA). Parts a, d and e will be dealt with as a request for information under the Privacy Act 1992 and responded to separately.

Before responding to your specific questions under the OIA, it may be useful to provide some context about our services to assist your understanding, and the understanding of your client/s.

Waitematā DHB Specialist Mental Health and Addiction Services serves a population of more than 630,000 within the Waitematā district and is the largest service in the country by volume of service-users seen. The Regional Forensic Psychiatry Service (Mason Clinic), operated by Waitematā DHB, serves the entire Northern Region of DHBs, a population of approximately 1.5 million.

Mason Clinic is a secure forensic inpatient mental health facility, located in Point Chevalier, Auckland. The service provides for the assessment, treatment and recovery of persons with a mental illness or intellectual disability who have criminal justice issues, or who are considered to be at high-risk in the community. Mason Clinic consists of eight inpatient units, with a total of 114 beds at different levels of therapeutic security, including a 12-bedded intellectual disability unit.

b) A copy of the Mason Clinic Communications policy and all policies applying to the Mason Clinic and relating to communications between patients and their family.

Mason Clinic acknowledges the significance of communication between family and service-users and, therefore, encourages family contact with service-users within our care. Mason Clinic does not have a specific communications policy regarding communication between service-users and their family. However, telephone procedures are outlined in each unit's operating procedures and mobile phones and other electronic devices are covered in the Personal Electronic Technology – Service-user Use Policy (See Appendix 1).

The safety procedures and restrictions regarding telephone and IT procedures vary across Mason Clinic in response to the differing levels of security in the various units. [redacted] is a patient in [redacted] where access to telephones and internet is restricted and supervised. Please see an excerpt from the [redacted] Operations Manual regarding telephone use in Appendix 2.

c) A copy of the Mason Clinic Visitation policy and all policies applying to the Mason Clinic and relating to visits of patients by relatives.

Mason Clinic acknowledges the importance of visitors to the care of service-users and, therefore, supports the involvement of whānau/family and support people in contributing to the recovery of the service-user. Mason Clinic has an overarching Visitors to Mason Clinic Policy which reflects the principles of partnership, participation and protection encompassed in Te Tiriti o Waitangi (see Appendix 3). Visiting procedures are found in each of the individual unit's operating procedures. In [redacted] visiting procedures are supervised to maintain the unit's security. An excerpt from the [redacted] Manual regarding visiting procedures can be found in Appendix 4.

<u>*Second request*</u>
You made a second request on 8 August 2019 by email to Amanda Mark, Waitematā DHB's General Counsel, for Waitematā DHB's:

- *Whānau and Family Engagement and Participation protocol*
- *Adult in-patient model of care*

The Whānau and Family Engagement and Participation policy is enclosed (see Appendix 5). This policy applies to all Waitematā DHB mental health services, including the Mason Clinic.

The Mason Clinic's model of care is guided by The Mason Approach (see Appendix 6).

I trust that this information meets your requirements. Waitematā DHB, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare.

This includes the proactive publication of <u>anonymised</u> Official Information Act responses on our website from 10 working days after they have been released.

If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider this.

Yours sincerely

Dr Susanna Galea-Singer
Director
Specialist Mental Health & Addictions Services
Waitematā District Health Board

Personal Electronic Technology – Service user Use

Contents

Overview

This document

Outlines the policy and guidelines relating to service user use of personal electronic technology.

Purpose

This document describes the policy and procedures of Regional Forensic Psychiatry Services with regards to in-service users' use of personal electronic technology.

Scope

All in-service users of Regional Forensic Psychiatry Services

Associated documents

Type	Title/Description
RFPS Policy	Personal Property - Security of Unit Indemnity Form (Pohutukawa Unit)
WDHB Policy	Lost or Damaged Property

Policy

Rationale

As technology develops and becomes more affordable, service users are increasingly possessing complex devices which are becoming smaller and more feature-packed. Many of these devices have the capability to either record audio or video or may be able to connect to wireless internet networks. This can present a risk to service users, the public, others privacy or WDHB.

Regional Forensic Psychiatry Services acknowledges that personal technology can be of therapeutic benefit to service users and permits reasonable access to, and use of such technology subject to the guidelines in this policy. It is also accepted that electronic technology is now able to have wireless access. For Forensic Services the challenge is to provide an overall framework to allow less restrictive access to the digital platform for education and social needs as Service Users move through the clinic.

Personal Electronic Technology definition

Personal Electronic Technology is defined as any electronic device that is used as a medium for receiving, transmitting, recording or storing of audio, digital imagery, voice calls, data and music. The electronic devices include but are not restricted to: laptop computers; ipads and tablets; mobile telephones with or without a built-in digital camera or audio and video recorder; still/video cameras; film cameras; MP3s; ipods; PDAs; USB memory sticks, and entertainment consoles (PS2, PS3, Xbox etc)

General rule

As a general rule, no item with the ability to record, transmit or receive pictures, sound or other forms of digital information should be in the possession of service users at any time without approval and/or a completed Use of Personal Electronic Technology Agreement placed in the service user's clinical file.

Personal Electronic Technology – Service user Use

Breach of policy

Breach of policy will be subject to the usual procedures for complaints and disciplinary matters.

Mobile phones and Still/Video Cameras

Mobile phones and still/video cameras are not permitted to be used by Service Users in any of the units. Rehab units may allow some use off units subject to the service users Use of Personal Electronic Technology Agreement.

Documentation

The staff member supervising the personal computer use is to document in HCC stating the therapeutic or rehab purpose.

Personal Computers

Service Users granted permission by their clinical team to have a personal computer or laptop will have to consent and sign an agreement to allow filtering software to be loaded onto their PC/Laptop and this may have access restrictions activated. This will be organised and managed by Associate Service Manager – Non Clinical Support. There will also be agreed times to have the PC examined for content and sites accessed. The monitoring programme will be removed from the PC on discharge.

Liability

Unless wilfully damaged by staff, the Regional Forensic Psychiatry Services will not accept liability for any damage to electronic devices while stored in nurses' station.

Acute Units

Personal Computers / Laptops

Personal computers and laptops are not to be accessed or used on the Units. These are to be stored in a secure place.

Mobile Phones and Still/Video Cameras

Mobile phones and still/video cameras are not to be accessed or used on the Units. These are to be stored in a secure place. Service users can have access to a landline phone as per Unit policy.

MP3 / I-Pod Devices

MP3/I-POD devices must have the recording function disabled with the consent of the service users before they can be used.

CD/DVD discs

These can be snapped by hand to create a dagger-like shard. Service users should not have unsupervised access to CD's/DVD's or plastic cases. These need to be kept in a secure place.

Memory sticks

Due to the various designs of memory sticks the potential danger from breaking these needs to be assessed in deciding whether use of these needs to be supervised. Service users need to be informed that random checks of content may be made.

Service User Shared Computer

1. There is no internet access from these computers.
2. The shared computer for Kauri and Totara is housed in the Mason Clinic occupational therapy (OT) room. Pohutukawa's computer is housed in the activity room behind the sliding screen.
3. Service users are to be made aware that 'saved' items and files on the shared computers are able to be accessed by others users

Personal Electronic Technology – Service user Use

4. Service users are required to adhere to WDHB policies and guidelines on computer use including restrictions on websites able to be accessed
5. Service users will not be able to and are not permitted to download any software applications or to install or use any copyrighted material including music and movies
6. Serious or persistent breach of this policy or related Unit guidelines by service users will result in termination of their access to the shared computer
7. The service users shared computer is not supported by Health Alliance IT. For assistance with any technical or related issues contact Associate Service Manager (Non Clinical) or Associate Service Manager (Acute).

Rehab Units

Personal Computers / Laptops

Service users may apply to have their own computer in the Unit. The request must be considered at a Clinical Review. If approved, a Personal Electronic Agreement specifying conditions of its use must be written up and signed by the key worker and the service user. Filtering software must be installed onto the PC/Laptop before the service user has access to their PC/Laptop. Laptops / personal computers are to be kept and used only in the service users own rooms.

Mobile Phones and Still/Video Cameras

Mobile phones and still/video cameras are not to be used on the Units. Service users have access to landline phone as per Unit policy. Mobile phones and Still/video cameras are to be kept locked in a safe in the clinic. Requests for having a mobile phone and /or a still/video camera are to be made to the Clinical Team for consideration. If approved a protocol is to be written up specifying conditions of use. The agreed protocol must be signed by the key worker and the service user. On return to the Unit the mobile phones and still/video cameras are to be placed in a secure place.

MP3 / I-Pod Devices

MP3/I-Pod devices must have the recording function disabled with the consent of the service users before they can be used subject to the Personal Electronic Agreement conditions for each service user.

Memory Sticks

Memory Sticks storage and use is subject to the Personal Electronic Agreement conditions for each service user.

Service User Shared Computer

1. Service user requests for Internet access must be discussed in Clinical Review and an approval given before a service user may access the internet.
2. Staff will have the access password to give service user's entry to the Internet.
3. Staff are required to do regular sweeps of the contents of the resident's shared computer.
4. Staff will do intermittent observations while residents are using the computer. The computer will be so positioned in the room to enable this observation.
5. Residents are to be aware that 'saved' items and files on the shared computer are able to be accessed by other users.
6. Residents are required to adhere to WDHB policies and guidelines on computer use including restrictions on websites able to be accessed.
7. Residents are not able to or are permitted to download any software applications or to install or use any copyrighted material including music and movies.
8. Serious or persistent breach of this policy or related Hostel's guidelines by residents will result in termination of their access to the shared computer.
9. For assistance with any technical or related issues contact Clinical Support Manager or Associate Service Manager (Acute).

Personal Electronic Technology – Service user Use

10. Internet use by service user-service user requests for Internet access must be discussed in Clinical Review and an approval given before a service user may access the Internet.

Personal Electronic Technology – Service user Use

Use of Personal Electronic Technology Agreement

This form is to be completed by key worker and service user and approved by Unit Manager and placed in the service user's clinical file.

Service user Name:			
Unit:			
Requested Date			
Approved/Declined Date		Unit Manager	

I request access to and use of the following:

ITEM	TICK	DESCRIPTION	APPROVED DECLINED
Mobile phone			
Laptop computer			
MP3 player			
CD discs			
DVD discs			
Memory stick			
Camera			
Game console			
Comments: (i.e. returned to the nurses' station, kept in own room etc)			

I agree to the following rules for access and use of the approved items:

- To observe Unit protocols on the access and use of each device.
- To comply with privacy and mental health legislation e.g. no photos, recording or other forms of identification taken on the units of other service users or off the units without their permission
- To allow the Mason Clinic to install filtering software onto my PC/Laptop
- This software is to be removed from my PC/Laptop upon my discharge.
- My memory stick will only contain personal documentation and digital images (photos).
- I Acknowledge that random checks can be made on any of my devices to monitor breaches of the protocol, i.e. phone calls, text messages, digital images or video clips, & recordings
- I acknowledge that supervision may be required when using a device
- I will report immediately loss of or damage to any device
- I will take full responsibility for loss or damage to any device while in my care.

Service user Signature: _____ Date: _____

Operations Manual - [redacted]

32. Telephone/Phonebook Access

Purpose

[redacted] acknowledge that contact with family and friends is an important part of a patient's recovery. Access to the telephone is one way of maintaining such contact and therefore a set of guidelines has been adopted by the unit to facilitate use of the telephone. The purpose of this document is to inform staff and subsequently patients of these guidelines with a view to consistency of care for all patients.

32.1 Guidelines for Telephone Use

- Personal calls (including Toll calls/ mobile phone calls etc) are limited to two per day. This includes both out going and incoming calls and are for the duration of 10 minutes.

Calls can be made at the following times:

- ✓ Monday - Friday 1630hrs - 2100hrs
- ✓ Weekends & Public Holidays 0830hrs - 2100hrs

- Incoming calls can be transferred to patients at the same times as above
- International calls. An individual management plan will be sanctioned by the Unit Manager.
- Calls requiring operator assistance need to be facilitated by [redacted]
- Contact numbers of family and friends should be listed on the Patient Phone list held in the clinical file. Staff should refer to this list prior to making a call to check for any party that has requested not to be
- contacted.
- Both incoming and outgoing calls must be marked off on the Patient Phone call list held in the unit office.
- Outgoing calls should be announced to the recipient by staff, identifying who is calling to allow for opportunity for the call to be declined.
- Incoming calls should be announced to patients to allow for the call to be declined if they so wish
- Phone calls to lawyers, the District Inspector and Government agencies e.g. WINZ, MP's etc will be facilitated for patients upon request between the hours of 0900-2100. Should a patient request a call to these parties after hours, a voice mail message can be left requesting that the patient be contacted at the earliest possible convenience.
- Patients are not permitted to access the WDHB operator via the "O" line.
- The use of personal cell phones is not permitted on the unit by staff or patient.
- Patients are not permitted to have internal telephone access to other Mason Clinic units.
- Phone calls for patients are transferred to the patient cordless phone (ext [redacted]) which is held in the unit office.
- Calls may be terminated at the discretion of staff if content and/or behaviour are deemed to be inappropriate.
- There may be occasion to monitor phone calls as part of clinical assessment of as patient.
- In exceptional circumstances, a patient may be given access to the unit office to make or receive a phone call. This will be approved by the
- Nurse in Charge.
- Patients are not given access to the White Pages. It is normal practice for staff to access phone numbers from the telephone book for patients
- Patients may have supervised access of the Yellow Pages.
- Practices outside of the above guidelines must be discussed and ratified by the wider team and documented in individual management plans.
- July 2016 See the High Care policy manual for guidelines for telephone use whilst in this area.

Visitors to Mason Clinic

Contents

1. Overview

Purpose

This policy outlines the principles for managing visitors to the Mason Clinic and applies to the all staff in contact with visitors.

Regional Forensic Psychiatric Services acknowledges the significance of visitors to the care of services users and therefore support the involvement of whanau/family/support people and professionals in the service user's care. The principles of partnership, participation and protection encompassed in the Tiriti o Waitangi are embraced by this policy.

Staff may need to balance service users' needs with family / whanau expectations and available resources. Service user needs should have precedence over the requests of visitors.

Visitors must adhere to Fire Safety Compliance and Building Code Standards and other legal requirements.

Scope

This policy applies to all staff, business visitors (including contractors, cleaning services, probation officers, police officers, District inspectors, Lawyers, any persons visiting for business advancement), families visiting service users and service users at the Mason Clinic.

This policy is intended to:

- Provide staff with authority to clarify the purpose of a proposed visit.
- Provide staff with guidance on authorising access.

Visitors to Mason Clinic

- To provide a physical and procedural security process to manage access and egress.
- To manage health and safety risks associated with visitors being on the premises of Mason Clinic.

2. Key concepts

2.1 Principles

- Appropriate visiting provides an opportunity for visitors to be involved in the support, care, treatment and community reintegration of service users during their stay at Mason Clinic.
- In this policy, visitors include people deemed helpful to service-users' treatment and recovery by the service user and staff.
- The contribution of visitors works best when seen alongside that of staff. A cooperative relationship between visitors and staff will maximize the value of service user care.
- It is important that visitors respect their surroundings and act appropriately within the Mason Clinic setting.
- Due to the nature of the environment, it may at times be necessary to place some constraints/restrictions on visiting.
- Service User care shall take priority over the requirements of visitors.
- Visitors may be asked to leave the ward when a service user is receiving care.
- When visitors are behaving inappropriately, or not demonstrating consideration for service users, they may be asked to leave the premises.
- Mason Clinic will support staff who ask visitors to leave.
- Business visitors will not have unauthorised access to the wards.
- Business visitors must be identified and adhere to the procedures of each unit.
- Where a business visitor fails to adhere to the this policy they may be requested to leave immediately and if they fail to do so will be escorted off the premises by security staff or in the case where there is no security arrangements in place, by staff authorised to do so by the Clinical Director.
- A majority of clients are from custodial settings and therefore in situations where intelligence is required on prospective visitors, staff can liaise with Corrections intelligence department. If there is any intelligence on the prospective visitors then staff would then review visiting on an individual basis.

2.2 Standards for visitors

- All units have a visitor's book in main reception areas and all visitors must be accountable by signing in and out of the visitors' book. Proof of identification must be provided on request if identity is questioned.
- When visitors are signing in at each Unit's security bases, security staff are to ask visitors if they have any items that are considered to be contraband (listed below). Visitor's mobile phones, cameras, any device capable of recording audio or visual images/video, tobacco/cigarettes and matches/lighters are to be placed in lockers provided.
- All visitors visiting service users at the Mason Clinic must be given a copy of the Family/Whanau brochure. Mason clinic staff will consider the needs and privacy of the service user and other service users in the near vicinity with regard to visiting.
- Visiting rights may be withdrawn if the service user or staff safety is compromised. Safety is a paramount for service users, staff and visitors.

Visitors to Mason Clinic

- Visitors wearing gang regalia shall be asked to remove the gang regalia prior to visiting and will not be permitted to visit unless they comply with this request.
- Staff must be aware of any food and gifts that are brought into the visits and must advise visitors of any inappropriate gifts. Any opened drinks brought into the visit will not be permitted.
- Staff reserve the right to screen all incoming goods deemed potentially harmful to the safety of the service users and staff.
- Articles that are considered to be a danger to service users or others include but are not limited to:
  - Potentially dangerous implements (knives, razors, other sharps, cigarette lighters, matches)
  - All glass containers and objects.
  - Belts (including studded belts) and braces
  - illicit drugs
  - alcohol
  - Steel capped boot
  - Gang regalia
  - Cameras, mobile phones or any device capable of capturing audio or visual imagery.
- The standards in the WDHB Behaviours of Concern: Search of Patients and Security Service Protocols for North Shore and Waitakere Hospitals shall apply to visitors suspected of harbouring dangerous articles.
- Staff are to adequately inform the visitor/s of emergency procedures.
- Staff are to advise visitors of ensuring adequate infection control measures.
- Visitors are informed of WDHBs no smoking Policy on the premises.
- Visitors are informed that WDHB has a zero tolerance towards violent or aggressive behaviours.
- Visitors are informed that alcohol and illicit drugs are NOT permitted on the premises of Mason Clinic.
- Visitors that have transgressed either of the latter TWO may be declined visitation rights.
- Visitor/s are informed that numbers of visitors may be restricted based on the clinical assessment of any service user.

2.3 Safety Expectations

- Any adult visitors must be supervised by a member of staff at all times. Staff supervising the visit must carry with them a radio transmitter.
- Any children under the age of 16 years must be accompanied and supervised by an adult family member (i.e. one adult per child), or visitor at all times. Staff are to remind visitors with children of their responsibilities. Staff must provide oversight that this occurs during the visit.
- Visitors are informed of any hazards/safety issues usually via notices and discussion.
- In the event of an emergency staff must ensure visitors are adequately informed and staff are to follow the emergency response protocol of that unit. Visitors already with patients at the time of the emergency must remain where they are. As the area is vacated they move with the clients and staff as one unit, so that their whereabouts is accounted for.
- Visitors are not permitted to visit if they are under the influence of drugs and alcohol.

Visitors to Mason Clinic

- Visitors are not permitted to visit if they are abusive to the service user, other service users or Mason Clinic staff.
- Visitors are not permitted to smoke on the premises and shall be advised accordingly.
- If visitors are behaving inappropriately or without consideration Mason Clinic staff shall:
  - advise the visitor of expected behaviour in a non-confrontational manner.
  - Discuss the areas of concern with the family/whanau.
-
- In the event of a visitor requiring any urgent medical attention while at the Mason Clinic staff are to call an ambulance if needed.

2.4 Protected Persons Visits:

- On admission of a service user to the service, the social worker of that unit must make every effort to check if the service user is subject to a Court order which may either be:
  a) Protection order under the Domestic Violence Act 1995,
  b) A Restraining order under the Children, Young Persons and Their Families Act 1989,
  c) A restraining order under the Harassment Act 1997,
  d) A non-contact order under the Victims' Order Against Violent Offenders Act 2014

- On receipt of the orders staff must check the exact conditions of the order as information contained in the order is used for:
  a) Managing the service user's care and ensuring compliance with any conditions set out by the court.
  b) Protecting the protected person (s) by ensuring the Court ordered non-association and non-contact directions are in place.
- If the unit has been advised by a third party / external agency of the name, and or address of the protected person/visitor the unit must take all practical steps to ensure the conditions of the order are met as these orders contain conditions specific to the service user.
- Staff must check outgoing mail from the service user to the "protected person" is withheld. Allowing any contact from the service user to the "protected person" may facilitate the commission or possible commission of an offence.
- Where the service user is the "protected person" there should be no contact between the visitor and service user.
- Where the visitor is a victim of alleged offending by the service user (who would therefore be on remand), there should be no contact (face to face, phone, etc), as the visitor may be a police witness in the court case.

2.5 Restraining Orders (Children, Young Persons and Their Families)

- If there is a restraining order in place made by a Family Court under the Children, Young Persons and Their Families Act 1989 against the service user, all contact between the service user and any child or caregiver is prohibited until the terms of the order are known. Any conditions should be taken into consideration before allowing contact to take place.

Visitors to Mason Clinic

- If a staff member believes that a child or young person is at risk of serious danger steps should be taken to escalate these concerns to the Unit Manager/on call Manager who will then inform Ministry for Vulnerable Children – Oranga Tamariki. This applies whether or not there is a protection or restraining order is in force.

- Any staff who believe that a child or young person has been, or is likely to be, harmed (whether physically, emotionally, or sexually), ill-treated, abused, neglected, or deprived must report the matter to Ministry for Vulnerable Children – Oranga Tamariki or the Police. See WDHB Child Protection: Child & Family Policy.

- Disclosure of this information is permitted by section 15 of Children, Young Persons, and their Families Act 1989. The limitations on disclosure in the Privacy Act 1993 and Health Information Privacy Code do not apply.

- No civil, criminal, or disciplinary proceedings can be taken against any person in respect of the disclosure or supply of information concerning a child or young person (whether or not that information also concerns any other person) to the Ministry for Vulnerable Children – Oranga Tamariki, if the information was disclosed or supplied in good faith (section 16 of the Children, Young Persons, and their Families Act 1989).

- The Police or the Ministry for Vulnerable Children – Oranga Tamariki will inform the person who made the report whether or not the report has been investigated and if so, whether any further action has been taken with respect to it, unless it is impracticable to do so.

- Source: Corrections website Protected Persons Visits
http://www.corrections.govt.nz/resources/policy_and_legislation/Prison-Operations-Manual/Public-RL/V.02.Res-10.html

3. Planned group events/visits

- Any group events/visits planned at the Mason clinic requires a formal request to be made to the Service Manager and the Clinical Director to gain permission to hold the event.
  - The convenor is then required to give notice to the service (all teams and units) at least two weeks before the event.
  - The convenor would then remind the service (all teams and units) within 24 hours of the event.
  - Clinical teams will assess service users who have access to the grounds or leave prior to the event.
  - Staff are to generate an electronic incident form on Risk Pro of any accidents, incidents, near misses that involve visitors.

Visitors to Mason Clinic

4. Visiting Procedure

4.1. Arranging a Visit

Each unit at Mason Clinic have specified visiting hours and durations. This reflects the differing acuity and staffing within the units. The information on visiting hours is available on each unit and is included in the family/whanau brochure.

5. Professionals/ Business Visitors

- All business visitors report to Mason Clinic reception and sign the Security/Fire visitors register.
- All contractors to the ward shall be escorted on to the ward by a designated staff member. All tools brought into the ward by contractors must be accounted by them prior to exiting the units.
- Business visitors (lawyers, probation officers) shall not approach service users directly. A staff member will be appointed to escort the visitor to visit the service user.
- All contractors and Cleaning Services personnel on the ward shall be informed of the Health and Safety protocols (including emergency response plan) of Mason Clinic and shall have completed an orientation.
- Mason Clinic staff are responsible for ensuring business visitors are informed of any hazards and any special requirements in the unit they are visiting.
- All business visitors must report any hazards observed or created, which could potentially endanger staff/service users and property to Mason Clinic staff. This is in accordance with the Health and Safety at Work Act 2015.
- If business visitors do not comply with this policy, the visitor may be asked to leave the premises. The staff that had invited them as well as the Charge Nurse Manager will then be informed.

6. Visits by Police

- When representatives of Police and other agencies seek access to service users, they should always be advised that:
  1. An appointment is required.
  2. The appropriate point of contact is the Unit Manager or Service Manager.
  3. Entry is always at the discretion of the Unit Manager or Service Manager, Responsible Clinician or DAHMS.

7. Managing Unauthorized Visitors

- Where a visitor arrives without having first made arrangements for a visit, the visitor will be explained the unit's visiting times and processes and be given an opportunity to making an earliest appointment.
- The rationale for declining / deferring any visits, and the name of the staff member who communicated that to prospective visitors, should be recorded in the Service User's notes.
- Entry access is declined to unauthorised visitors after hours.

Visitors to Mason Clinic

8. Emergency Situations

In the event of an emergency, visitors are not allowed into Mason Clinic while the alarms are sounding.

9. Associated documents

WDHB	• Visiting including after hours to NSH and WTH • Visits to Inpatient Units: Police and other agencies • Visiting Guidelines for Acute Adult mental health inpatient Units • Behaviours of concern: Search of Patients • Fire Protection, Management and Evacuation - General • WDHB Core Values • Maori Values and Concepts (Tikanga) • Security • Core Processes: Safe and Appropriate Environment • Core Processes: Consumer Rights • Unit's Operational Manuals: Guidelines for Visits • Child Protection: Child & Family
Legislation	• Health and Safety at Work Act 2015 • Domestic Violence Act 1995, • Children, Young Persons and Their Families Act 1989, • Harassment Act 1997, • Victims' Orders Against Violent Offenders Act 2014
HDSS	Health & Disability Sector Standards – NZS 8134:2001 – section 1
Other	Involving Families: Guidance Notes, November 2000. Community Liaison Committee of the Royal Australian and New Zealand College of Psychiatrists.

Operations Manual - [redacted]

36. Visiting Procedures

[redacted] acknowledges that contact and participation from family and friends is an important part of the recovery process. Visits are encouraged and accommodated during scheduled times throughout the week. The purpose of this document is to inform staff about the protocols adopted by [redacted] when facilitating visits for patients.

36.1 Guidelines for Visits

Arranging a Visit

- Visits are scheduled at the following times throughout the week:
  Wednesdays 14.00 – 15.00
  Saturdays and Sundays 13.30 – 15.00
- Visits are for a 30 minute duration unless otherwise negotiated.
- Visits as per the standard unit schedule are permitted on all public holidays with the exception of Christmas Day and New Year's Day.
- When booking visits, staff must ensure that they note the contact number of the visiting party should the visit need to be cancelled.
- Visits may be non-contact at the discretion of staff. Rationale and protocol for these visits should be communicated to patients and visitors. Any decision made by the wider team re. non-contact visits should be clearly documented in the multi-disciplinary notes.

During a Visit

- Visits take place in the visitors room located opposite security. This room allows for only one visit at a time to take place and also allows for patients and visitors to remain in full view of staff supervising the visit. Security may be contacted if assistance is required to terminate the visit.
- A minimum of two staff must be present during visits.
- One of the escorting staff greets the visitors and assesses their suitability to visit. visitors that are found to be under the influence of alcohol or drugs will be refused entry.
- No gang members or known gang affiliated persons will be allowed to visit.
- The 'check nurse' also ensures that the visitors are aware of the visiting protocols and have placed their possessions in a locker at security. No cell phones, cameras, lighters or non-prescription sunglasses are permitted in the visiting areas.

- All parties i.e. staff, patient or visitors have the right to terminate a visit at any point. Staff will terminate visits if safety is compromised in any way or behaviour of any party is deemed inappropriate.

After the Visit

- **Any items** bought in for patients by visitors are placed in security and checked for illicit content by the security staff. Food items should be stored appropriately. Any inappropriate items will be returned to the visitors upon cessation of the visit. Personal property must be listed on the property forms.
- Patients will remain supervised in the visiting room until such time that visitors have left the immediate vicinity.
- Patients are escorted back to the unit via the [redacted] at which time a safety check is carried out.
- Staff must avail themselves for feedback with visitors if requested to do so or if needed for the multi-disciplinary documentation

Whānau and Family Engagement and Participation

Contents

1. Overview

Purpose

The purpose of this policy is to outline the principles, approach, and objectives that Specialist Mental Health and Addiction Services (SMH&AS) use to achieve best practice in whānau engagement and participation.

The best health outcomes are achievable only by working consistently in partnership with services users (tangata whai i te ora) and their whānau, wherever possible. Whānau engagement and participation is required at all levels of the organisation to inform policy, decision-making, practice, and clinical decision-making. It is an integral part of continuous quality improvement to "Improve health outcomes and reduce inequalities[1]".

This policy provides guidance about what is expected of all staff in engaging whānau and supporting whānau participation **in individual treatment, care and recovery planning, and all quality improvement and service evaluation or development activities.** Whānau engagement and participation will inform strategic planning, processes, operations, and everyday engagement between services and people using them.

Scope

This policy applies to all staff, students and NGO staff embedded in Waitematā DHB (WDHB) clinical teams working in service planning or service delivery. The principles may also be applied to how members of the community are engaged and supported to participate in service development and service evaluation.

Note: Services working with children and youth are likely to have additional guidelines around engaging parents and caregivers.

All clinical staff are expected to be competent in engaging whānau into treatment, care and recovery planning. SMH&AS offer some training which staff may register into (see Ko Awatea for a list of upcoming training), and other competency development is available via Te Pou's (2018) *Let's Get Real: Real Skills* programme (see www.tepou.co.nz – search Real Skills) and the CALD (Culturally and Linguistically Diverse) programme (www.ecald.com).

[1] WDHB Northern Region Health Plan 2017/18. November 2017.

Whānau and Family Engagement and Participation

Glossary

Term	Definition
Tangata whai i te ora	A tangata whai i te ora is a person who accesses treatment and support from a mental health and addictions service, in this case, Specialist Mental Health and Addiction Services. Tangata whai i te ora, service user, person accessing the service are terms used interchangeably in this document in reference to the person who accesses the services. Consumer is another common term for a person who accesses mental health and addiction services, based on the concept of "consuming" services in the sense of a consumer of goods or services in the commercial sector.
Family/whānau	Family and whānau are used interchangeably through this document. For the purposes of this policy family and/or whānau can only be defined as family by the tangata whai i te ora and is not limited to biological or legal relationships. It may therefore include: • Relatives of the tangata whai i te ora, including children, spouse, or partner • Immediate or extended family/whānau • Any combination of friends, non-relatives, hapū/iwi, relatives, or others in a supportive network (MoH, 2017, p.31)
Tangata whai i te ora/ Consumer Advisor	Someone employed by the DHB to engage with tangata whai i te ora to offer information, education, navigation, and/or connection to resources, services, organisations, groups and/or people to assist in recovery goals. Consumer Advisors also support service evaluation and planning.
Family/whānau Advisor	Someone employed by the DHB to engage with families/whānau of tangata whai i te ora to offer information, education, navigation, and/or connection to resources, services, organisations, groups and/or people to assist in recovery goals. Family/whānau Advisors also support service evaluation and planning
Principal Caregiver	The MH Act defines the 'principal caregiver' to mean 'the friend of the patient or the member of the patient's family group or whānau who is most evidently and directly concerned with the oversight of the patient's care and welfare'. The fact that the patient does not give the name of the principal caregiver, or does not authorise, or even forbids, the principal caregiver being contacted, does not affect the statutory duty to send the principal caregiver a copy of the certificates at preliminary, further assessment, final assessment stages, and a copy of a certificate of clinical review that states that the patient is not fit to be released from compulsory status (source: MoH)

Associated policies and information sheets

This policy should be read in conjunction with the following policies and information sheets:

- **WDHB information sheets**
  - Your Health Information (can be printed from the Controlled Documents/Information Sheets /Organisation-wide webpage or here)
- **WDHB policies**
  - Informed Consent
  - Health Information
  - Health Information/Privacy – General (can be accessed from Controlled Documents/Policies / Procedures/Organisation Wide – Clinical Practices or here)
  - Health Information/Privacy – 3rd Party Requests (can be accessed from Controlled Documents/Policies / Procedures/Organisation Wide – Clinical Practices or here)

Whānau and Family Engagement and Participation

- **SMH&AS policies**
  - Supporting Whānau After An Unexpected Death In The Community
  - Risk Assessment and Safety Planning

2. Benefits of whānau engagement and participation

This policy aligns with the Te Tiriti o Waitangi (The Treaty of Waitangi), the New Zealand Health Strategy's People –Powered Actions/Mā te iwi hei kawe (MoH, 2016a), Waitematā DHB's values and engagement action plan (see section below) and reflects the Government's priority of delivering 'better public services'.

Benefits of whānau engagement and participation include:

- improved health outcomes for people accessing the service
- improved support for whānau who support people accessing the service
- improved recovery and wellness planning
- Improved experience of care
- improved quality of risk assessment and safety planning
- people-centred health services which support people to be 'health smart' and have greater control over their health and wellbeing
- fostering of genuine two-way communication between providers and health system users, so that providers have a good understanding of people's needs and aspirations for wellbeing before taking a course of action (MoH, 2016a)
- improvements based on feedback and recommendations from whānau
- co-designed service developments
- improved cultural competence of staff

Whānau has a unique role in contributing to the wellbeing of the service user. They have an innate understanding of their family member and can make important contributions to their assessment, treatment and recovery. In addition, effective engagement results in better services that reflect the strengths, needs and resources of our community. Better services means better outcomes enrich whānau and community. This means 'my' or 'our say' in decisions about planning, funding and delivery of services that achieve the desired outcomes. Service users, whānau and community/hapu/iwi provide direction and guidance for services, identifying and contributing to longitudinal recovery resources and environments.

Other key legislative documents and processes underpinning whānau engagement include:

- The Code of Health and Disability Services Consumer Rights Act
- Privacy Act
- Mental Health (Compulsory Assessment and Treatment) Act 1993, including references to Principal Caregiver and family/whānau consultation
- Ti Tiriti o Waitangi
- Protection of Personal and Property Rights Act 1988
- Enduring Power of Attorney (EPOA)

Whānau and Family Engagement and Participation

3. Approach

At Waitematā DHB we acknowledge that we serve our service users and their whānau with the shared aim of person's recovery, and individual, collective, and societal wellbeing. As such it is expected that staff act as a resource on which service users and whānau can draw on for **information, education, connection, efficient services, and working towards health equality for disadvantaged communities especially Māori and Pasifika.** Specialist Mental Health & Addiction Services aims to ensure that whānau are involved and included in all aspects of the service user's journey. This includes the children of service users. Working in partnership with the service user and their whānau is an essential part of the service delivery model.

Waitematā DHB values

Waitematā DHB sees engagement with tangata whai i te ora and whānau, and their equitable participation in service delivery, as central to **person-centred care.** It contributes to continuous quality improvement (Better, Best, Brilliant), improved experience or care (everyone matters – including staff) working in partnership (compassion) and community links (connected).

The Waitematā DHB values and behaviours underline the importance of engagement with tangata whai i te ora and family/whānau and their participation in health service delivery, for example:

Everyone matters: Welcomes different views/cultures; motivates others by making time to listen to their views and feelings

Better, best, brilliant: Is positive about what we can achieve, has high standards, and motivates others to meet them; proactively finds ways to improve their own knowledge and skills. Engagement happens at multiple levels of contact, and in a multitude of ways. Engagement can involve groups of people who access our services and/or their family/whānau or individual people at governance, service, or team level.

With compassion: Is calm and patient even when under pressure; is aware of the impact of things they say and do on other people

Connected: Appreciates good work, says "thanks"; involves patients, families and colleagues in everything they do.

Te Tiriti o Waitangi

This section is extracted from Te Pu o te Awhina – Waitematā DHB Māori Mental Health Strategy:

> *Waitematā DHB recognises Te Tiriti o Waitangi as the founding document of New Zealand. In doing so, we commit to the intent of Te Tiriti o Waitangi that established Iwi as equal partners alongside the Crown, with the Articles of Te Tiriti providing the strong foundation upon which our nation was built.*
>
> *Within a health context, the four Articles of Te Tiriti provide a framework for developing a high performing and efficient health system that honours the beliefs and values of Māori patients, that is responsive to the needs and aspirations of Māori communities, and achieves equitable health outcomes for Māori and other vulnerable members of our communities.*
>
> *We recognise the importance of our Memoranda of Understanding (MOU) partners, Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust, in the planning and provision of healthcare services to achieve this system and Māori health gain.*

Whānau and Family Engagement and Participation

Article 1 – Kawanatanga (governance) is equated to health systems performance. It covers the structures and systems that are necessary to facilitate Māori health gain and reduce inequities. It provides active partnerships with mana whenua at a governance level.

Article 2 – Tino Rangatiratanga (self-determination) is concerned with opportunities for Māori leadership, engagement, and participation in relation to DHB activities.

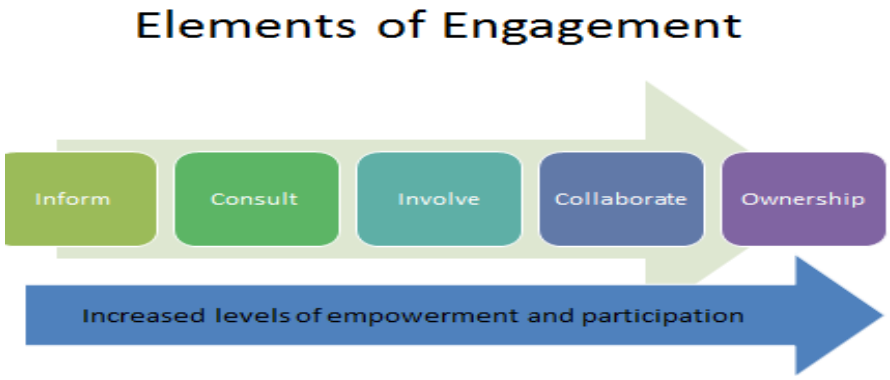
Article 3 – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequalities in the determinants of health, health outcomes and health service utilisation.

Article 4 – Te Ritenga (right to beliefs and values) guarantees Māori the right to practise their own spiritual beliefs, rites and tikanga in any context they wish to do so. Therefore, the DHB has a Tiriti obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

Measuring and extending engagement and participation

At SMH&AS we both value and benefit from engagement with the people who access our services and whānau. The figure below shows the growth in levels of empowerment and engagement that will be achieved if we collectively develop our levels of engagement. Examples of how and when to use each element can be found in the table below. This information can also be used to assess the maturity of a clinical or planning team's engagement.

Figure 1: Elements of engagement



Source: Unknown

Table 1: How and when to use progressive elements of engagement

Element	Suitable occasions for use	Strategies and examples for extending engagement
Information and education	• When factual information is needed to describe a policy/program/process • When decision has already been made • When there is no opportunity to influence the outcomes • If the issue is simple	• Stakeholder engagement, regular newsletters and information sheets

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	• In crisis	
Consultation and gathering information	• When the purpose is to listen • When policy is being shaped • When there is no firm commitment to do anything	• Public meetings or forums • Questionnaires and interviews • Collaborative note-taking • Summits or communal events
Discussion	• When a two-way information exchange is needed • When people have an interest in an issue and are likely to be affected by the outcomes • When there is an opportunity to influence the outcomes	• Discussion about specific issues related to e.g. service model and delivery • Focus groups on specific topics, issues • Guided interviews • Peer consultation
Engagement and collaboration	• When there is a need to talk about complex issues • When there is capacity to shape policies • When there is an opportunity to share agenda setting an open timeframe • When options generated together will be respected	• Expert panels • Tangata whai i te ora Advisory Group • Consumer representation on working or steering groups • Co-design processes
Empowerment and tangata whai i te ora ownership	• When tangata whai i te ora manage the process • When tangata whai i te ora groups have accepted the challenge of developing solutions themselves • Where there is an agreement to implement the generated solutions	• Tangata whai i te ora identify the priorities and projects of most importance to them and their whānau • Tangata whai i te ora lead or co-lead research about specific areas • Tangata whai i te ora organisations lead or co-lead research about specific areas • Tangata whai i te ora groups plan and lead support group-based interventions

Te Pou *Real Skills*

The Te Pou (2018) *Let's get real: Real Skills Framework* consists of seven skill areas for staff working in mental health and addiction services. SMH&AS staff are encouraged to use the *Let's get real: Real Skills Framework* and the related learning resources. *Let's get real* does not replace professional competency frameworks, but is a useful complementary framework. The seven skill areas are:

1. Working with people experiencing mental health and addiction needs
2. Working with Māori
3. Working with whānau
4. Working within communities
5. Challenging discrimination
6. Applying law, policy and practice
7. Maintaining professional and personal development

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Several of the *Real Skills* areas above are relevant to working with whānau, as are the *Real Skills* values of respect, manaaki, hope, partnership, wellbeing and whanaungatanga. Staff wanting to develop competence in whānau engagement and participation should refer to the *Real Skills* framework and the Real Skills Plus Seitapu framework for guidance about assessing and building their skills against the three-tier framework (essential, practitioner and leader). Staff should visit www.tepou.co.nz – Search Real Skills or Seitapu.

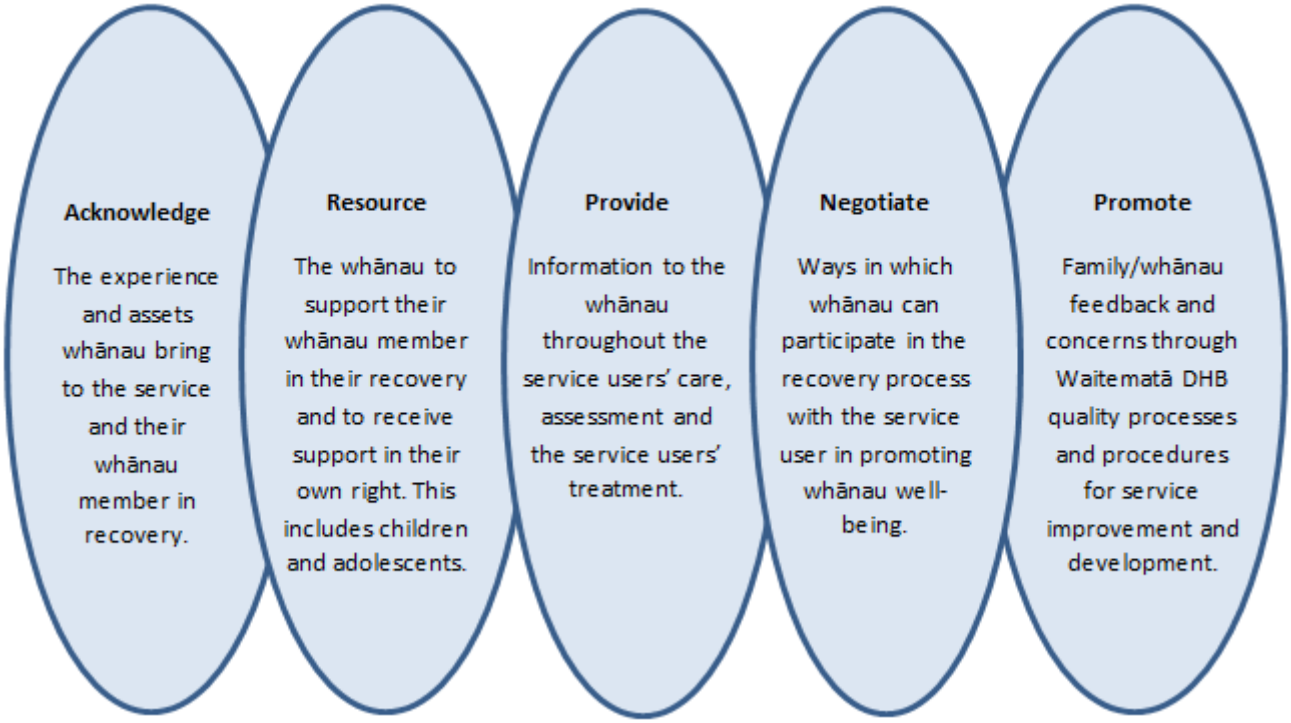
4. Expectations for whānau engagement and participation in clinical settings

Every day staff working in services have enormous potential to make a positive difference in the lives of people accessing those services. Most of the time workers will never hear how useful, meaningful and recovery-enhancing their interactions have been. These experiences often stay with people long after they no longer need to access the service.[2]

It is well recognized that involving whanau supports recovery and resilience development. After all whānau are the person's main support particularly after discharge from health services.

All staff are expected to take an active role in working with tangata i te whaiora to identify supportive and constructive whānau relationships, and to engage the identified whānau into treatment, care and recovery planning. **This will often include supporting whānau to build their skills and knowledge to help build the resilience of the person who is accessing the service.**

Figure 2: Staff actions to for whanau engagement and participation



[2] Te Pou o te Whakaaro Nui. (2018). Ibid. www.tepou.co.nz/letsgetreal

Whānau and Family Engagement and Participation

Engagement to me means a person feels welcomed, respected, heard and hopeful….[3]

4.1 Consent and privacy

Talking with the person you are working with, about who they would like from their family, whānau or friends to be involved and how, is very important. Sometimes people will not want to include their biological family for various reasons and identify close friends as the people they want supporting them. Encourage the person to discuss their situation with their identified whānau member and invite the whānau member to contact the service or attend the next and/or following appointments. Alternatively with the person's consent clinicians should contact the identified whanau member/s to engage them and to identify if they have support needs.

Privacy and health information legislation and frameworks actually promote sharing of some or all health information with a service user's supports and it is expected that family/whanau will be included and involved in the care of the service user. The Waitematā DHB 'Your Health Information' information sheet details that staff may need to share information regarding the service user with their family, caregivers, general practitioners (GP) or other healthcare professionals, in order to provide appropriate care and treatment. This brochure must be provided to all service users as part of the welcome pack.

Discuss with the person what they are happy to have discussed openly and what they would prefer to remain private. Best practice is to work in an open and transparent way with people and their friends and whānau, but there will be times when there is a need to be aware of what the person does not want discussed (Cree et al., 2015, in Te Pou). If you are not sure about whether information can be shared in a particular situation, discuss with colleagues, a clinical coordinator or team leader or contact the Waitematā DHB privacy advisor Amanda Mark by phone (see WDHB phone book) or email. In the case of a dispute about information sharing the Director of Area Mental Health Services/Clinical Director will make the decision, with advice from the clinical staff and the Waitematā DHB legal team.

Liaison with family is particularly important around decisions to stop medication or other behaviours and decisions that may impact on wellbeing, as whānau are in a good position to notice early warning signs. Even if the person confirms they will discuss stopping medication with their whānau it is good practice to check in with whānau (seek consent if necessary).

People may opt out of having whānau engaged or having information shared with them. In this case clinicians should create a pop-up alert on the electronic clinical record to alert all clinicians about the situation. Where a service user has opted out this should be revisited often as a person's sense of privacy, perceived need for support or sense of isolation may change as they move through recovery. Any pop-up alert information will need to be amended.

Support people when things are going relatively well may be different from the whānau who provide meaningful support in a crisis situation - this is often more likely to be blood bio kin. Clinicians must ensure that emergency contact details are up to date, and ensure any particular arrangements are recorded in an advance directive or a note on their recovery/wellness/transition plan.

[3] Te Pou o te Whakaaro Nui. (2018). Op. Cit. www.tepou.co.nz/letsgetreal

Whānau and Family Engagement and Participation

4.2 Engaging whānau

Engagement is about the relationships, connections and interactions between mental health and addiction workers, the services they offer and the people and whānau who access them.

There is good evidence that whānau engaged early stay engaged. Whānau must be engaged on entry to service where ever possible. Key elements for effective engagement of whānau by clinicians are:

- Ensure engagement and **cultural competence** training is current
- Use **Open-dialogue** and Whānau ora meetings where possible
- Use appropriate cultural engagement **language, processes, and customs** where possible
- Use **collaborative note-taking** with Tangata whai I te ora and Whānau; give Tangata whai I te ora and/or Whānau original copies of notes and record copies
- **Feedback to participants** at every step of engagement next steps, reasons for the decision, and expected process
- Ensure **people feel seen, heard, understood and cared about**
- **Connect** in the first stages of engaging with people – this will influence people's future engagement with the service
- Use **recovery language**
- Explore your own **values, beliefs and attitudes** and the way these shape your approach to engaging with people

Source: www.ecald.com

Working with whānau members should include a family meeting or home visit, and whānau members may be involved in subsequent meetings, if the person wants this. You may need to be flexible in scheduling appointment times to allow everyone to attend. Working out what will work well for friends and whānau when meeting together will include providing information about mental health and/or addiction and the services and treatment options. This is an opportunity to ask if there are any existing family networks or people they can talk to, and offering the details of whānau support services if not. Letting them know what to do and who to contact if they are worried or have questions can be helpful too.

In Waitematā DHB engagement is essentially about meeting, communicating with, providing resources, education, information, links, supports and planning with whānau and/or tangata whai i te ora.

Risk assessment and safety planning is based on the principle of self-determination, as much as possible, and is also an important place for clinicians to actively engage whānau participation. The whole process of risk assessment and safety planning should promote communication and collaboration with service users and whānau.

Likewise treatment, care, wellness, and recovery planning also require clinicians to actively engage whānau participation.

An important element of working with whānau includes recognising and supporting people when they are parents or caring for others. This will involve asking about children and/or dependants and supporting people in their parenting, as appropriate to their needs and your role. Guidelines for supporting people who are parents are available in the resources section on the Te Pou website. (www.tepou.co.nz – search COPMIA or SPHC)

Whānau and Family Engagement and Participation

Using the appropriate cultural context

New Zealand's diverse ethnic population requires flexibility in terms of the definition of whānau. Wherever possible staff will consult with a cultural advisor of the same ethnicity as the person they are working with.

For many cultures such as Māori and Pasifika, the inclusion of whānau is essential. Service and treatment decisions and goals may need to be understood, discussed and agreed by the collective group and time needs to be allowed for these processes.

Māori whānau have distinctive cultural values that are to be acknowledged and respected. Any contact with Māori whānau will ideally be made by cultural advisors (kaumātua or taurawhiri), with involvement from the tangata whai i te ora, clinical team, and any advocate/s of the tangata whai i te ora's choice. Whānau should receive services based on the principles of partnership, participation and protection to support Māori whānau to achieve maximum health and wellbeing. For Māori whānau, you will need to be prepared to acknowledge their tikanga Māori through participating in the cultural norms of their home (for example, karakia, mihi whakatau and kai).

Pacific Island whānau /fono also have distinctive cultural values that are to be acknowledged and respected. Any involvement with Pacific whānau /fono should be made by the Pacific cultural advisors with the involvement of the clinical team and service user, and any advocates of the service users' choice.

All staff should be familiar with procedures for booking interpreters and engaging cultural supports.

Other models of whānau engagement and participation

Several healthcare conceptual models provide guidance on working with whānau, including structuring sessions and working out responsibilities together. For example, Single Session Family Consultation and Open Dialogue are both well-known models in which treatment involves family members and extended social networks in the person's care or support. These models also help whānau identify and address their own needs.

Working with people in groups

Where a person is receiving only group input from a service it can still be assumed that whānau are providing the main support and whanau contact by phone is still encouraged.

When things aren't going so well

Being honest and transparent about awkward or confronting things can be highly useful but needs to be approached with sensitivity and awareness of who you are working with. If the relationship has been founded on finding shared values and clearly understanding each other's contexts, then this becomes easier.

The quality of relationships between people accessing and those providing mental health and addiction services can, like any relationship, vary over time. Sometimes there are misunderstandings or disagreements, and this can create tension and strain the connection between clinicians and the person and/or whānau. If it feels the relationship is strained clinicians may attempt to:

- Share what they are observing, sensing or feeling can be helpful and model that it is safe to share thoughts and feelings
- Check for and clarify any misunderstandings
- Check that the identified tasks or goals are still relevant
- Check in about any other issues between the parties that are interfering with the relationship

Whānau and Family Engagement and Participation

The Mental Health Act and requirements for consultation

Section 7a of the Mental Health Act requires that the Responsible Clinician consult with family/whānau prior to or at each review of Mental Health Act status. This needs to be documented on the appropriate Section form (Section 76), including when it is not in the best interests or not practicable to consult with whānau.

5. Professional development

The SMH&AS approach assumes that whanau are the primary supports for a person accessing the service. As such staff are expected to actively work in this approach and are responsible for developing their professional skills in this area. Professional development might take the form of:

- In-house training. Book via Ko Awatea - look for trainings in family inclusive practice (or similar) and single session family consultation
- Real skills (www.tepou.co.nz –Search Real Skills)
- CALD modules (especially Modules 1-5) – this is a mix of e-learning and face to face (www.ecald.com)
- External training, particularly Single Session Family Consultation (SSSC) and Open Dialogue

6. Measuring whānau engagement and participation

Whānau engagement and the readiness of SMH&AS clinicians to work with whānau is measured in a range of ways, such as:

- Staff participation in formal in-house training and professional development
- Staff completion of CALD modules
- Whānau contacts recorded in the electronic clinical record
- Whānau input to the WDHB patient experience feedback system
- Feedback given to Family Advisors
- Compliments and complaints
- Co-designed quality improvements

Whānau and Family Engagement and Participation

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Mental Health Commission	• Blue Print II Improving Mental Health for All New Zealanders 2012 • Family Inclusion in Mental Health and Addictions Services for Children and Young People (2009) • Legal Framework for Family Inclusion in Child/Adolescent and Youth Mental Health and Addiction Services (2009)
Māori legislation and strategy	• Te Tiriti O Waitangi • He Korowai Oranga – Māori Health Strategy (2002) • Te Puawaitenga Māori Mental Health National Strategic Framework 2002 • Whānau Oranga Hinengaro: Northern Regional Māori Mental Health Addictions • Implementation Plan 2006-2008 NDSA • Te Pu O Te Wai Awhina – Waitematā DHB Māori Health Strategy
Pasifika legislation and strategy	• The Pacific Mental Health and Addiction Northern Region Implementation Plan 2009-2012 • Pacific Consumer 'Tiare Ruperupe' Leadership Framework for the Mental Health and Addiction Sector March 2010 • Let's Get Real – Real Skills plus Seitapu – Working with Pacific Peoples

THE MASON APPROACH

THE MISSION, VISION, VALUES AND APPROACH OF THE MASON CLINIC

MASON CLINIC

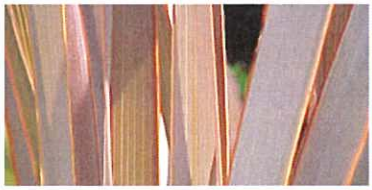
Auckland Regional Forensic Psychiatry Services

AUCKLAND REGIONAL FORENSIC PSYCHIATRY SERVICES

IMPROVING LIVES THROUGH RESPONSIVE FORENSIC SERVICES

OUR CORE VALUES:

- Provide respectful, safe and involving services to those we serve
- Provide recovery and strengths focused-care that is culturally appropriate
- Provide services that are evidence and values based
- Aspire to excellence

MAURI ORA! MAURI KAHA!

FORWARD

IMPROVING LIVES THROUGH RESPONSIVE FORENSIC SERVICES

This manual aims to inform and unify staff about the history, values, philosophy and focus of the Mason Clinic and the Auckland Regional Forensic Psychiatry Services. Some staff will be new to the concept of forensic mental health and some will join the staff with previous experience from other services both in New Zealand and from other countries.

The small group of people who were initially tasked with setting up the service, did so with guidance from 'The Mason Report' (published in 1988) but drew heavily from a Māori world-view and the best that could be discerned in services in Australia (South Australia at that time) and the UK. At that time there was an emphasis on containing 'dangerous behaviour' and indeed the romantic notion of the forensic clinician working amidst a dangerous clientele.

The world has since moved on and it is now well recognised that 'danger' cannot be predicted within any degree of certainty. However, risk can be measured, contextualised, and consequently managed. The task of the forensic clinician is to assess and manage risk in the context of their illness and legal presentation and within the dimensions of their personhood (mental illness, integrity of brain functioning, personality, family dynamics, social demographics and their 'transcendental' world view–a spiritual concept).

It is a powerful thing to be reminded of the value base (chapter 2) of the Auckland forensic mental health services. The realisation that people who present to the service have families, have aspirations, feel pain, deal with loss and struggle to regain a sense of balance and ownership over their lives is important. This makes working in forensic mental health services quite different and special from other services in the need to look past the stigma, the illness and disability in order to see the person and guide and encourage them through their personal journey of recovery. To do this takes courage, fortitude, a holistic and balanced perspective on life and a good deal of support from your family and peers.

So…I commend this manual to you. I enjoyed reading it. I know it will be useful.

D G Chaplow (Dr)
Director Mental Health, Wellington

THE PURPOSE OF THIS MANUAL

The Auckland Regional Forensic Psychiatry Service has developed The Mason Approach as a manual to guide our staff in meeting the needs of people who have a mental illness and/or intellectual disability within the context of criminal offending. It also serves as a resource to help other providers of mental health services across the region better understand the role and function that ARFPS has in the mental health sector. It is anticipated that this manual will help staff members, particularly new staff, understand what the Mason Clinic does and why.

The mission, vision, values and approach of the Auckland Regional Forensic Psychiatry Service are set out in the document. These are reference points for staff to use in developing and prioritising goals, management and operational strategies. They provide the values base by which we aim to commence the delivery and evaluation aspects of individual care, programme delivery, staff function, training and team processes; and guide us in prioritising and defining pathways.

We are a values-based service provider. By this we mean that core values guide and direct our service or intervention.

To date, the manifestation of our approach can be seen in the respect in which we are held, and the quality of the results we achieve at all points of the service: courts, court reporting, prison, inpatient and community.

It is vital that we continue to confirm our service's ethos and the principles that we seek to uphold and, in this way, keep ourselves accountable to one another, to the forensic mental health service users we serve, and to other stakeholders. All Mason Clinic employees should familiarise themselves with the principles contained in this manual.

As new clinical, scientific and technological developments take place, this manual will be revisited and updated to reflect those changes.

Finally, the manual should be considered as complementary to other regulations, policies, codes of conduct and guidelines that set out codes of practice and behaviour of mental health professionals.

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CHAPTER 1

INTRODUCTION

Introducing Jeff

Jeff is 25. He is the middle of three children to Max and Lilly. It was a close and loving family, but Max had a problem with alcohol. When he drank too much, he and Lilly would argue, and at times Max would be violent to her and the children. When it got too much for Lilly, she would take the kids and move back up north to be with her family, especially her mum and dad. Jeff loved his maternal grandparents, who spoiled him. Max would then clean up his act and swear to Lilly that he had given up drinking, so she would move back to Auckland and their lives would be great for a while, until Max started drinking again. This cycle continued for several years till Max eventually managed to give up alcohol for good.

Jeff had enjoyed school when he was young. He was bright and athletic. He especially liked mathematics, woodwork and sports. He had done well in his studies initially, but as he got older he started hanging out with boys who weren't interested in schooling, they just wanted to have a laugh. Jeff had his first drink when he was 10, and started smoking cannabis occasionally when he was 13.

By the age of 16 Jeff was using alcohol and cannabis regularly, skipping lessons and cruising into town with his mates. Jeff experimented with other substances of abuse like magic mushrooms, LSD and P or methamphetamine, but did not like the effects. He decided not to drink alcohol anymore, as he had seen what it had done to his father, but started smoking cannabis more heavily instead. Jeff noticed cannabis made him more anxious and slightly paranoid, but thought he could handle it.

Jeff left school without any qualifications and took a series of jobs he didn't care about; working for a cousin's lawn mowing business, casual labour work, and shop work. He did not put any effort into these jobs, and did not last long. Eventually he made his living from selling small amounts of cannabis to his circle of friends and committing the occasional burglary.

Following the death of his maternal grandmother when he was 18, Jeff began to have increasingly serious mental health problems. He believed he was being watched by the CIA, who planned to kidnap him and torture him because they thought he was a terrorist. He also believed his father was not his real father, but a CIA agent sent to spy on him. He reported his concerns to the police but they did not take him seriously, and suggested he lay off the drugs and visit a psychiatrist. Jeff thought the police must be part of the conspiracy against him. He became irritable and withdrawn, stopped working and stayed at home in his room smoking cannabis.

About six months later Jeff began to hear sounds of cameras whirring and clicks on the phone line that proved to him the CIA were stepping up their surveillance. He also started to hear whispered conversations, saying terrible things about him, saying he had killed people and needed to be put down like a mad dog. He believed this was caused by a feedback loop in the bugs they had planted, and what he heard was the CIA discussing him.

These experiences and thoughts caused Jeff to fear for his life.

Early one morning after lying awake all night waiting to be killed, he went to confront his father. Jeff's father was confused by the accusation, and refused to admit he was a CIA agent. Jeff lost control. He picked up a hammer and attacked his father, striking him on the head and upper body causing serious injury. Jeff ran away, but was caught by the police later that morning and charged with wounding with intent to cause grievous bodily harm.

His extended family were upset by his actions but they understood he was driven by his mental illness and forgave him. To Jeff's surprise, even his father stood by him and supported him.

1.1 WELCOME

Kia ora and welcome to the world of forensic mental health services (FMHS).

Jeff's short history is fictional, but typical of the type of problems that people who come to us for care present with: illness, a life that is drifting because of illness not well cared for, serious issues of risk to others and facing serious criminal charges. Jeff and those with similar problems are also part of a family who are suffering: loving, but not necessarily able to cope with the problems they have together, and who hope that somehow it will be possible to find a way through the problems to build a better life. Keep Jeff, his family and the legal system in mind as you read this manual, and think of them as you go about your work.

These are the opportunities and challenges of our work. An opportunity to help a person and a family at a time of major crisis, and in partnership with other related services (in particular the criminal justice system and the mental health system), assist them to rebuild a life and be accountable for their actions as the law sees fit. It is our role to work with people who have some sort of major problem with their mental health or intellectual function, and have fallen foul of the law, or are seen as being at risk of doing so.

People come to FMHS from a variety of pathways with a variety of problems, but there are certain common needs that we should remember. Firstly, their initial presentation may well be high profile and have attracted scrutiny of outside agencies and the law. Secondly, while people like Jeff come to this service because of a psychotic illness that has led to violence, they usually face challenges on many other levels. These can include substance use and addictions, being victims of violence or abuse in their own lives, dislocation from family and other support, failure in social or occupational roles and social adversity more broadly. It is very important to remember that 50% are Māori, and over 15% are of Pacific Island origin.

Thirdly, and at times as a result of these problems, forensic service users often have few people to support or advocate for them. They are often disliked in prison for being disruptive, violent and self-harming. In general mental health settings they create challenges which services struggle to cope with, and from a societal perspective, they are the people who engender fear, dislike, stigma and scrutiny. Their care is often complex, challenging and difficult.

This section has referred to major psychotic mental illness. However there are many other psychiatric problems common in people who come through the courts and prisons. Many of these conditions, such as depression and anxiety, may be the product of previous life circumstances or of incarceration. Forensic service users often also have personality difficulties, and occasionally we care for people for whom personality disorder is their major problem. In addition, people with intellectual disability may also present risk to self and/or others. The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, (IDCCR) and the Regional Intellectual Disability Care Agency (RIDCA), which purchases services for the intellectually disabled criminal offender group, provide for structured care and rehabilitation for these people.

1.2 WHO ARE WE?

The Auckland Regional Forensic Psychiatry Service (ARFPS) is still quite young. The service was established in 1989, and the first units on the current Mason Clinic site were opened in 1992, with the most recent units opened in 2006. The court liaison team was established early in the service's history. The prison service, initially for remand prisoners only, became responsible for all prisoners in the region in 1997. The first community step-down facility was opened at South Head in 1996, and the community team was established in 1998.

The intellectual disability service developed its two elements: the Intellectual Disability Offender Liaison Service [IDOLS] community team and inpatient unit in 2005 and 2006 respectively. The service continues to grow and refine its service models. It is responsive to increasing demand (such as the growth of new prisons) developments in the mental health sector in general (like the recovery model) and new legislation and service design in the case of the intellectual disability services. We now have over 440 staff employed serving the area from Cape Reinga to Meremere.

The service as a whole is called the Auckland Regional Forensic Psychiatry Service. The inpatient service is called the Mason Clinic, which is often used as shorthand for the total service. We are one of five regional forensic services which form the national network of FMHS, the other regional FMHS being located in Midland, Central Region, Canterbury and Otago.

1.3 WHERE DID WE COME FROM?

People with mental illness and forensic needs have long been recognised as a part of mental health services, dating back into 19th century Britain and here in colonial New Zealand. Historically forensic services were inpatient services delivered as part of large institutions with very little mental health care, if any, being provided to prisons. From the 1960's and 1970's, as mental hospitals downsized and prisons grew, an increasing need to help offenders with mental illness developed.

This need was not well planned for in New Zealand. There were homicides by forensic service users rejected from community care and suicides of mentally ill prisoners, especially in Auckland from 1983–1987. This resulted in a Ministerial Inquiry, The Mason Inquiry of 1988, headed by Family and District Court Judge Ken Mason (Ngai Tahu) after whom the Mason Clinic is named. That inquiry defined a blueprint for FMHS that we still follow to this day. The inquiry gave us **six key principles:**

1) Mentally ill offenders have the same right of access to mental health assessment and treatment as non-offenders.
2) Mentally ill offenders are primarily the responsibility of the health system not the corrections system.
3) A forensic system needs to be able to find the people it should be caring for at any point in the criminal justice system or mental health system. This has meant the development of liaison services with the courts, services in the prisons and with adult community mental health services.
4) A cultural understanding and response is an essential clinical requirement. Given the over-representation of Māori and the Treaty of Waitangi principles of partnership, participation and protection, FMHS are designed with the involvement of Māori in the governance, management and provision of all aspects of forensic mental services.
5) Given the complexity of need that forensic service users present, the integration of multidisciplinary, cultural and family perspectives is required in their clinical assessment and care.
6) Security and therapy must be integrated. This is achieved through purpose-built facilities and sophisticated clinical and policy systems to ensure safe, responsive care.

The ARFPS has many elements:

- court
- prison
- inpatient
- community
- liaison functions.

It is designed to be flexible to people's needs. Although The Mason Inquiry was focused on mentally ill offenders, the principles apply equally to intellectually disabled offenders.

1.4 WHO DO WE SERVE?

First and foremost, we serve the people who use our services. We also of course cannot help them unless we enhance their membership of families/whānau, and so we also work with their families. We are committed in respect to the personal and cultural identity of service users including accepting guidance from cultural specialists to ensure the breadth of human engagement necessary to achieve our goals and vision.

Serving this population means enabling them to become fully participating members of society. To achieve this we must also work with the other key agencies in their lives; on entering the service this may be the criminal courts. If seen in prison, it is the need to work with and alongside prison health and custody staff to meet the person's health care needs in that context, and help with their progress and community reintegration upon release from prison. To complicate matters further, sometimes the two roles of caring for the FMHS user and providing advice to the court are in conflict. This can happen if the expert advice may undermine the service user's recovery. For this reason we sometimes need to try and separate these roles.

For inpatients, promoting clinical care and recovery means that we must work with the Director of Mental Health and ultimately the Minister of Health about people's progress and recovery, as decisions about their reintegration into the community and discharge from hospital sometimes must be agreed at that level. As people progress to the community we must help them engage with other key supports in their lives, such as NGOs supporting them in work and accommodation, employers and landlords.

At all points we are accountable to outside agencies such as officials under the mental health and intellectual disability legislation (lawyers, district inspectors, review tribunals, health and disability advocates). As forensic care means that people lose a great deal of the power over their lives, so too there must be powerful protections for them to ensure we are doing our job properly and respectfully. We need to welcome the scrutiny of these agencies and officers. They help guide us to ensure the person has voice, involvement and respect during their care and recovery through the FMHS.

It is very important that we are at all times open; to review and audit, to new ideas, to learning new approaches, to research and to insights of those with a lived experience of mental illness, to families, iwi Māori and non-forensic colleagues. Outside agencies, students and university researchers are welcome for the questioning and scrutiny they bring. Such openness helps ensure we remain fresh, open and thoughtful about our work.

1.5 A WORD ABOUT NAMES

The people we are here to serve have many names, some legal, some professional, and some taken by themselves. These include patients (a Mental Health Act and older professional term), people with a lived experience of mental illness, consumers, clients, service users, offenders, inmates, residents, care recipients (a term under the IDCCR Act), and Māori terms for a person pursuing health tangata whaiora, turoro, or simply whānau. In this manual we use service user or forensic service user in a general sense, as referring to people who have contact with our teams and inpatient services. We also use other specific terms or phrases i.e. people with mental illness or intellectual disability, or people in recovery, though at times the legal context will mean patient or care recipient or prisoner as required in that context.

KEY LEARNING POINTS

- The Mason Inquiry provided the blueprint for FMHS in New Zealand.
- The **key principles** of FMHS are:
  1) The care of people with mental health problems involved in the criminal justice system is the business of health.
  2) That meeting cultural need is vital and needs to be designed into all levels of the service.
  3) Services must be carefully integrated.
  4) Security, therapy and rehabilitation work together to aid people's recovery.
- The ARFPS has court, prison, inpatient and community teams for people with mental illness or intellectual disability and problems of offending.
- The ARFPS has multiple and important accountabilities.
- The ARFPS functions as an integrated service meeting people's needs in a flexible manner.

CHAPTER 2

THE MASON APPROACH

The security van stopped and Jeff knew he had arrived at the Mason Clinic. When the van door opened he saw Jackie, his prison nurse, who with security men accompanied him through the back door of what appeared to be a loading bay. Once inside he was welcomed by two more Mason Clinic staff. Jeff was then taken through empty corridors to a ward called Totara.

The ward seemed empty, but he didn't get to explore it as he was quickly ushered into a lounge area. The lounge was surprisingly spacious and comfortable, and there was an open door to a courtyard that let in sunlight and fresh air. Jeff was offered some food and drink, and he couldn't help comparing this to how he was treated in prison. Here he felt much more respected and safe. It was a huge relief to him. He accepted the offer of food and soon was tucking in to soup and a chicken salad roll.

2.1 WHY HAVE A MASON APPROACH?

Jeff's complex clinical and legal situation requires engagement with FMHS. He is facing serious criminal charges, and appears to be suffering from a mental illness. Admission to the Mason Clinic is often the best way to facilitate resolution of the many clinical and legal questions. However, responding appropriately to Jeff's clinical needs when there are potentially conflicting security needs, staff health and safety needs, and a requirement to report medico-legal issues to the court requires a thoughtful approach.

Many people work at the Mason Clinic. We all come from different backgrounds, with different learning and experience, professionally and in life. This is a strength of our service. Service users need a diverse range of skills and different types of people to help them on their journey of recovery. They will encounter a number of us, and have different issues or tasks to achieve on their journey. We all need to work consistently together, so people know what to expect from us, and we can hold one another to our core values and expectations. That is why we aspire to this shared approach and vision.

2.2 OUR CORE VALUES

All people receiving care from the FMHS should receive care in keeping with our core values which are to:

- provide respectful, safe and involving services
- provide recovery- and strengths-focused care that is culturally appropriate
- provide services that are evidence- and values-based
- aspire to excellence.

Consider how these values guide our work. Consider the way Jeff entered the Mason Clinic. In the past he may have been met by the two biggest staff members available, rushed through to "High Care", searched, put in stitched pyjamas and then placed in a seclusion room, empty apart for a mattress. The justification for that approach was he was an unknown quantity and potentially a high risk. However, with good communication between the wards and the prison team, and a careful multidisciplinary clinical assessment at the point of admission, this is less of an issue, enabling Jeff to be treated in a culturally appropriate way with respect and dignity.

Jeff liked the way the staff and residents of Totara mixed easily, and how staff involved him in decisions about his care and treatment. Staff seemed happy to chat, and they were all polite, respectful and interested. They played cards with him, and encouraged him to play table tennis or volleyball. There were also some organised activities, like art, which helped to pass the time. It was nice having women around too. He also liked the idea that all these different staff wanted to help him recover. It was so much better than prison.

But he still had concerns. He still believed that the CIA were behind the whole process, and they would eventually get him. He could still hear them plotting against him. He was also worried about some of the other residents. Some of them seemed really unwell, and some of them were gang members. There were a few scary instances where things got out of hand and staff had been forced to restrain a resident and take them through to High Care.

He also didn't like the medication they forced him to take. It made him feel drowsy and confused and he couldn't stop dribbling. The staff assured him that the side effects would go away. The doctor also promised to reduce the medication once he thought Jeff's illness was properly treated.

Jeff wasn't sure he could trust what they said though as they might also be CIA agents. Jeff also disliked all the rules and protocols which meant he couldn't live like he wanted; although he could appreciate that some of the other residents needed those rules to keep everyone safe. Most of all Jeff was sad about his losses: his freedom and independence, his friends and whānau, his music, his hobbies and interests, his privacy, his sex life and drug use, and his mana.

2.3 PRINCIPLES

The **five key principles** that guide our work are:

- **Principle 1:** Recovery as a philosophy and a journey
- **Principle 2:** The importance of cultural and personal identity
- **Principle 3:** The importance of understanding risk
- **Principle 4:** Recovery in the forensic setting
- **Principle 5:** Excellence

PRINCIPLE 1: RECOVERY AS A PHILOSOPHY AND A JOURNEY

The basis of the Ministry of Health (MoH) and Mental Health Commission's (MHC) vision for mental health services is described in Our Lives in 2014 (MHC 2004). This vision was developed with MHC by consumers using mental health services.

The vision is that all mental health consumers will have "... personal power, a valued place in our communities and services that support us to lead our own recovery".

Our task as providers of recovery-based services is to work alongside forensic service users to make this happen.

It envisages a whole-of-life concept of service delivery, including understanding the person's life history, respectfully involving them in their care and assisting them in being fully involved as family members, workers and members of society.

This approach is entirely in line with principles of best practice in the care of people with mental disorder and criminality. Good FMHS do not only confine themselves to a narrow approach of treating illness, but look broadly at a person's life and assist them in overcoming an often complex array of illnesses or educational disadvantage, trauma, offending, and substance-related problems. We embrace that vision.

The concept of recovery was first described for New Zealand in a paper by Laurie Curtis (1997). This described a philosophy of service delivery that looks at the process from the journey of the consumer; that of recovery, rather than what we as providers do to or with the person, such as assessment, treatment, rehabilitation and support.

It is about the process by which people meet the challenge of illness or disability, re-establish a sense of integrity and purpose and aspire to live, work, love and contribute to one's community. It requires what can be referred to as participatory self-management, actively developing a sense of mastery over the challenges that one faces. Absence of illness or disability is not the aim; achieving a sense of purpose and mastery, mana perhaps, is the aim.

The concept includes hope, personal responsibility, self-advocacy, education and understanding and support. It is a process and an attitude, not a place. It is an active ongoing often circular process, of learning about oneself, understanding what happens and why, so that one gains control and mastery over these patterns. It occurs within the person, and with the people around them. It is about the process of finding meaning in one's experience. It draws on the person's strengths, as well as addressing the person's difficulties.

PRINCIPLE 2: THE IMPORTANCE OF CULTURAL AND PERSONAL IDENTITY

Personal identity is crucial for a sense of hope and development of a successful life. Identity links us to family/whānau and connects us to a history and a set of values that helps to define who we are.

Good clinical practice is the key to effective risk assessment and management, and for Māori forensic service users this must incorporate cultural dimensions and perspectives, while maintaining and observing medico-legal responsibilities. The capacity to incorporate Māori forensic service users' cultural needs into a clinical context are achieved by means of a kaupapa [philosophy] Māori approach. This approach is culturally safe and expressed throughout forensic services in ways that do not compromise the underpinning values and expectations of cultural identity.

Tane Whakapiripiri offers forensic service users an alternative rehabilitative pathway. Within this kaupapa Māori environment, forensic service users can expect a full range of both clinical and culturally appropriate services that support customs, values and beliefs systems.

Further, as one Māori commentator said of the recovery philosophy, "which one of my iwi did you steal that from?" (Tangitu, 2006). Recovery and Māori principles are mutually supportive. Because of our responsibility as a Crown agency under the Treaty of Waitangi, and because half the people we serve are Māori, we structure our services inclusive of tikanga Māori values and concepts. We share these values as part of our service philosophy. Our mission statement expresses these as:

- Manaakitanga: generosity and mutual respect
- Whanaungatanga: family approach
- Wairuatanga: spirituality
- Rangatiratanga: self-management, self-respect
- Kaitiakitanga: wise stewardship over the things we value
- Whakapaitia: excellence at all levels of what we do.

For all people who enter the service, the building of a sense of personhood is central. For many, deprived or disorganised early life history means these areas of their sense of self are uncertain and underdeveloped. Further, the processes of criminal acts and alienation from family may have increased this lack of identity. By providing an opportunity to have the sense of self respected and enhanced enables the establishment of a safe therapeutic space for all concerned. Respecting tikanga Māori provides a platform to address the same themes for people of all ethnicities who enter the services. We come together in our work secure that who we are in our identity is respected as we approach our work each day.

PRINCIPLE 3: THE IMPORTANCE OF UNDERSTANDING RISK

Recovery principles include the understanding of things that have occurred in life, and learning from observing one's own mental and emotional behaviour, what Curtis refers to as "remembering your track record" (Curtis, 1997).

The problems people bring to FMHS are often complex and deep rooted. The tragedies of violence, frequently both perpetration and victimisation, as well as the effects of mental illness or disorders, problems in family background and lack of sense of personal identity and hope, all create challenges on this pathway of recovery.

People commonly come to FMHS because of multiple problems including mental disorder or mental health needs, and offending. The relationship between mental disorder and offending is complex, involving life experience, behavioural patterns and symptoms arising from illness. Each person has a particular pathway to violence or risk which must be understood with them.

Remember, it is not possible to recover and continue to commit acts of violence. The effects of offending, including being disrespectful to others, ongoing secure care or imprisonment; do not provide the possibility for the type of recovery that forensic service users aspire to. Thus, recovery requires the cessation of violence and criminal behaviour. Understanding why this arises is central for the person's recovery.

This is more commonly referred to as risk formulation, the type envisaged in the MoH Guideline on Risk Assessment for Violence in Mental Health Services (2006). This process of risk formulation involves the development of a shared understanding with the forensic service user of their particular pathway to risk, and thus developing an innate understanding of pathways to safety. This understanding will help to define the recovery tasks and goals.

In responding to individual risks, external security (building design, staffing levels, policies etc) is only one way to create safety. Building a meaningful therapeutic relationship can also be a powerful and effective security measure.

In all forensic services there is a tension between security and therapy. An overly cautious approach to physical security may frustrate therapeutic activity and recovery. Forensic service users have the right to be treated in the least restrictive environment, and therefore we are constantly alert to their changing levels of security needs and try to adjust our restrictions to fit their current level of need.

An example of this would be the number of escorts required to ensure safety during periods of leave from an inpatient unit. Instead of applying the same rules across everyone in a certain unit, we consider every individual separately. We need to be thoughtful, flexible and creative in how we interpret all our rules to ensure they are both appropriately managing the identified risks and therapeutic in their effect.

PRINCIPLE 4: RECOVERY IN THE FORENSIC SETTING

Early in their journey, some FMHS users may lack awareness of their risks, or lack the skills to manage their risks. Forensic staff have to take control of many aspects of their life to keep them and others safe. They need to do this with a minimal use of coercion or force, and give the person as much choice and control over their care as their risk allows.

A variety of staff work with service users to raise their awareness, motivation and skills around recovery and risk. As recovery advances, so does the service user's ability to manage their own risks, and to reflect this progress they are given more responsibility to do so. Staff typically withdraw their control in a structured, graded and supportive way.

The thoughtful combination of security and therapy provides a safe and supportive environment for the service user to regain hope, self-control, self-respect, self-esteem and a positive identity. These are the basic building blocks of a robust recovery.

This psychological, interpersonal journey is also a physical journey through the service: as the person moves from more secure to more open settings of care, from escorted to unescorted leave, to full community independent living.

Recovery in a forensic setting is also a legal journey, as legal status shifts from inpatient to community status, to informal status, and from special patient status to compulsory treatment order, to informal.

All journeys have particular processes and milestones along the way. Recovery doesn't clearly begin or end anywhere: it is continuous. All steps occur in relationship with support staff, and with family.

Recovery in this context means accepting and learning from mistakes made in the past, but is much bigger than stopping doing things. People find powerful reasons to give up old patterns, such as drug or alcohol use, when they have new

things in their lives they do not wish to lose, such as a job, relationships or a place to live. We must help people develop these positive aspects of their lives to motivate them to give up the negative aspects and influences.

Helping service users recover is a long but highly rewarding process characterised by being respectful, actively engaging people, creating hope, being transparent and providing opportunities for voice and choice in defining their care programme.

PRINCIPLE 5: EXCELLENCE

This principle is what we aspire to. It is in our core values, and expressed by Māori in the concept of whakapaitia. Aspiring to excellence, like recovery, is a striving, not an achievement. It means many things:

- Being thorough and doing the little things well.
- Offering a full range of the best types of care we can provide.
- Being up to date with latest evidence and practice.
- Being innovative and finding new strategies to help people.
- Being thoughtful and constructively critical of each other, challenging each other to do better.
- Being a learning organisation: one that thinks, does research and evaluates what we do.

Jeff's experience changed as he moved through the service. He started doubting the CIA conspiracy, but didn't want to accept it had all been in his head. He didn't want to be labelled as schizophrenic or crazy and he didn't want to think about what he had done to his father. Jeff shared his thoughts with his key worker, Rawiri, later that day as Rawiri had always been kind, respectful and supportive to him.

Rawiri listened carefully to him, and was able to guess all the emotions and thoughts that were running around his head. Rawiri helped Jeff straighten his thoughts out. He reaffirmed that this was all part of recovery, and that he would support Jeff through this difficult time. Jeff felt relieved that he was understood and not judged, and felt more able to share with other members of staff. He came to believe that the medication had helped stop the voices and clear up his thinking. He still wasn't happy about the side effects, and hoped he could stop taking it one day.

After several months Jeff moved on from the acute unit to the rehabilitation unit where he enjoyed more personal freedom and could attend a wider range of rehabilitative programmes, the gym and library. He also started to develop his life outside the Mason Clinic with friends, family and work. In the unit he started to go to weekly clinical reviews where he found being able to speak for himself very empowering and beneficial.

Although Jeff still perceived his rate of progress through the Mason Clinic to be too slow, he increasingly came to appreciate the collective efforts of the staff and the programmes and activities in which he had engaged. He had turned his life around and felt well prepared for the next stage of his life. Together, Jeff and the clinical team agreed on a treatment approach and a pathway back to the community.

KEY LEARNING POINTS:

The Mason Approach notes:

- People come to us with complex needs, and on a number of pathways.
- Our care for them is based on our core values.
- Recovery principles guide us in helping people achieve their goals for recovery.
- Recovery is based in respect for one's culture and identity, assisted by us imbedding our service philosophy in Māori cultural values and beliefs.
- Defining pathways to risk with the service user allows us to help them ensure pathways to safety.
- Recovery in a forensic setting requires a progressive taking of responsibility for the tasks necessary to stay well, and stay safe.
- We aspire to excellence in the little things we do and the way we think about and deliver recovery-based services.

TIP

Did you know that our vision, mission and values are inclusive; founded on a therapeutic commitment to the patients, their family and the community? We are committed to both process and outcome quality, best evidence-based practice, a management environment that is respectful of all staff and an ongoing learning environment.

CHAPTER 3

COMPONENTS OF THE SERVICE

Jeff, and others with similar issues, may have appearances in court; they may be detained in prison, or may require a secure forensic unit admission. The purpose of this chapter is to describe the different components of FMHS that Jeff may need to access.

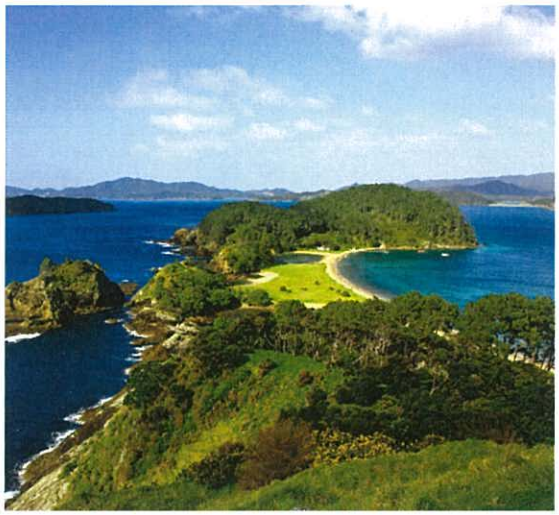
3.1 OUR MANDATE

We are contracted by the Northern Region District Health Boards [DHBs] to provide FMHS to the people of the Northland/Auckland region: a population of 1,467,753 people, or 36.5% of the country [2006 Census]. We also provide some services for other parts of the country, and 15% of our bed days are for people from outside the Northern Region. The population is serviced by four DHBs: Northland, Waitemata, Auckland and Counties-Manukau. Our service is delivered by Waitemata DHB on behalf of the region. For the intellectual disability inpatient facility Pohutukawa, we serve the population as far south as Taupo.

We provide all mental health care to the prisons in our region. These prisons are:

Prison	Type	Muster at December 2010	Comment
Auckland Prison, at Paremoremo	Male, sentenced including maximum security	626	Located on Auckland's North Shore. Also has specialist sex offender treatment unit
Auckland Central Remand Prison [ACRP]	Male remand	357	ACRP is co-located with Mt Eden Men's Prison. Both will become privately run in 2011
Mt Eden Men's Prison	Male remand and sentenced	407	
Auckland Regional Women's Correctional Facility	Female remand and sentenced	300	Located at Wiri
Northern Regional Correctional Facility	Male remand and sentenced	390	Located at Ngawha in Northland and serving the Northland population
TOTAL		**2080**	

We provide services to all adult criminal district and high courts from Pukekohe to Kaitaia. We provide all inpatient care for people needing forensic inpatient services, and follow up some forensic service users in the community and provide assistance to the broader mental health services regarding issues of risk and treatment.



3.2 KEY EXTERNAL RELATIONSHIPS

The ARFPS sits at the crossroads of the criminal justice system and the mental health or intellectual disability service systems, so very effective relationships with other key external agencies are necessary. Working well with them is vital for us to be able to help people on their pathways through care. The agencies we encounter most often are listed below.

Agency	Role	Function
Ministry of Health	Director of Mental Health	Oversees the legal and clinical aspects of special and restricted patients and the Mental Health Act generally. Key relationship to the Minister in terms of patient leave decisions and incidents
	Director General of Health	Similar function for Special Care Recipients and Care Recipients under the IDCCR Act. These functions are delegated to other MoH officials
Legal officers relevant to the MHA and IDCCR Act		Includes Family Court judges, Review Tribunals, District Inspectors and legal counsel for patients. Their role is to make and review compulsory orders and protect the rights of people under such orders
DHB district mental health services		Provide all other secondary and tertiary mental health and addiction services across our region. Key partners in the forensic service user journey
Department of Corrections	Prison service	Responsible for custody and rehabilitative programmes for remand and sentenced prisoners
	Prison health service	Responsible for provision of primary health services to prisoners, including primary mental health and addiction services
	Psychological service	Responsible for psychological needs for prisoners, though primarily focused on reoffending issues
Criminal courts (adult)		Responsible for the administration of justice
NGOs, including Challenge Trust, Raukura Hauora o Tainui and Penina Trusts		Responsible for a range of services not provided by clinical services, including support, vocational assistance and accommodation for people in the community
Regional Planning and Funding Group		To ensure we meet the needs of all populations we serve and to plan for better performance and service growth if that is needed
Tertiary institutions including universities and technical institutes		Provide training and research opportunities for professional and non-professional staff, including placements for student nurses (over 100 per year), medical students and allied health professionals

We work with and support other FMHS in New Zealand to share knowledge and skills and learn from each other. We are also part of international networks and organisations and encourage the exchange of ideas, experience and personnel with them.

3.3 KEY SERVICE ELEMENTS

We will now list the services that Jeff might encounter on his journey through the ARFPS.

Court liaison service

The court liaison service is the first of our services Jeff will encounter. This service has two main functions:

1) a nursing triage, assessment and coordination service
2) a formal court-ordered psychiatric or psychological reporting service, under the Criminal Procedure (Mentally Impaired Persons) (CP(MIP)) Act 2003.

The court liaison service is delivered by eight court liaison nursing positions across the northern region criminal courts. Court liaison nurses (CLNs) are available to take referrals from anyone in the court: the judge, the police, the defence, the defendant themselves, concerned others including family or other mental health services who are aware they have clients appearing in court. The CLNs also actively look for people who might be known to them or to mental health services to see if they need help or support.

CLNs perform assessments and give an outline of key health issues to the judge, such as how unwell the person is and whether there are issues from their mental illness or intellectual function that may impede the person's ability to participate in the court process, or whether their mental condition is relevant to the charges the person is facing. CLNs can recommend that the person has a formal court-ordered psychiatric or psychological report. The CLN will often liaise with other clinical teams to ensure the person's treatment and support needs are met when they leave court.

The judge may order a psychiatric or psychological report under S38, 35 or 23 of the CP(MIP) Act. This report assists the court in determining some important questions:

- Is the defendant fit to stand trial?
- Does the defendant have a defence of insanity against the charge?
- How are mental health issues relevant to sentencing options?

These reports for the court are provided by psychiatrists or psychologists through the forensic service. We have agreed standards that must be followed when completing these reports.

When Jeff appeared in court his lawyer asked the CLN to assess him because of his previous mental health problems and the seriousness of the charge he was facing. Consequently Jeff's first contact with Mason Clinic staff was with Evelyn, a court liaison nurse. She was polite and respectful, and asked him some questions about his alleged offence and past experiences, thoughts and feelings. Jeff felt that she really listened to his answers, didn't judge him, and that she was on his side, so he told her all the details of the conspiracy against him, and how his father was really a CIA spy.

Evelyn reassured him that he was safe where he was, and that she would be helping him recover. At assessment, he was acutely psychotic as his delusional beliefs, especially toward his father, were prominent and he was seen as a serious risk to others if he was released on bail. The police were opposed to bail being granted and he was remanded into prison custody for two weeks for a report under Section 38 to be completed. There was also the issue of whether a defence of insanity was available to Jeff given his beliefs towards his father.

The psychiatrist visited Jeff in prison and completed the report for the court. The psychiatrist had access to all available clinical notes from his contact with general mental health services, and had lengthy discussions with Jeff's family, and his lawyer.

The report concluded that Jeff was so unwell he was currently unfit to stand trial. However if he got to hospital and received treatment, he would most likely become well enough to face trial at a later date. The report also advised that a defence of insanity may be available but would need to be formally addressed once Jeff's mental state improved and he was deemed fit to stand trial.

The CLN ensured the formal forensic report was circulated to all parties (judge, prosecution and lawyer) before the hearing and discussed its findings and recommendations. Bail was still opposed by the police and so once more Jeff was returned to custody to await his next hearing in two months time. An urgent referral was sent by the CLN to the prison medical unit asking that a referral be forwarded to the Forensic Prison Team (FPT). After the FPT assessed Jeff, he was transferred from prison to the Mason Clinic for treatment under Section 45 of the Mental Health Act (MHA) for assessment and treatment of his psychosis.

By the time of his next court appearance Jeff's mental state had stabilised and he was pronounced fit to stand trail. The issue of whether an insanity defence was available to him was then to be considered when the court ordered yet another report pursuant to Section 38 CP(MIP) Act.

Prison mental health services

There are more than 2000 prisoners in our region. Internationally, New Zealand has a very high rate of imprisonment with projections that this will rise further in the next decade.

FMHS provides all secondary mental health services in prison and support for prisoners with intellectual disability. We have over 20 multidisciplinary team members who provide this care and make up the FPT. Some prisons screen prisoners for mental illness and refer to us. All contacts are by referral from the prison health service. Sometimes, as in Jeff's case, referral comes because the CLN team notifies the prison and the FPT of the person needing care.

There are two major groups of service users:

1) prisoners on remand who have acute mental health needs to be attended to and are returning to court or the community soon
2) prisoners with longer sentences of imprisonment who have major mental health problems and are in need of ongoing care.

Whilst most of the care is like that of a community mental health team, we also provide group-based psycho-education, cultural and cognitve behavioural therapy [CBT] work for groups of sentenced prisoners with mental health problems. The team has a vital role in care and release planning, together with custody and parole authorities, to plan for care and support for the person at the time of their release from custody. The team must have very good referral relationships with the prison and with other mental health services who have been, or will be involved in helping the person.

The court and the prison teams are in effect the gateways to the inpatient service. They receive the new referrals and help determine, along with the courts, who needs to come to the inpatient service. That prioritisation process, performed via the prison waiting list, is coordinated closely by those teams.

The inpatient services

Our inpatient service for people with mental illness has seven units, listed below.

Inpatient unit	Type	Function
Kauri	Medium secure (highest level of security), 15 beds, male	Acute and sub-acute care, performs some assessments for the courts.
Totara	Medium secure, 11 male and 4 female (with some flexibility)	Acute and sub-acute female and assessment for the courts. Sub-acute male.
Rata	Long term secure, 15 male beds	Long-term secure and early rehabilitation engagement
Kahikatea	16 male and 4 female beds	Minimum secure rehabilitation, more active path.
Tanekaha	8 male and 2 female beds	Minimum secure rehabilitation slower path
Tane Whakapiripiri	7 male and 3 female beds	Kaupapa Māori-based minimum secure rehabilitation, culture specific path
Rimu	9 beds both male and female	Open rehabilitation hostel-based programme
Pohutukawa	10 male beds and 2 assessment beds	For intellectually disabled service users

Each unit has a distinct emphasis and programme designed around the needs of forensic service users at particular phases of their recovery process. Units are highly staffed to provide safe care, each with a unit manager, responsible clinician and multidisciplinary team who are responsible for the assessment and care planning. Programmes, staff numbers and staff type vary according to the needs of the people in the unit. All care, programmes and interventions are covered by policies and agreements to ensure that safety and clinical quality are maximised at all times. It is important to note that all must link their care plans so that each person's movement is planned and coordinated across their journey through the service.

Community follow-up services

Once Jeff no longer needs the inpatient service, he may be referred on to a district mental health service, but more likely he would be cared for by the forensic community team (FCT). The FCT was established because we realised the time of leaving hospital was a very difficult one where things could go wrong and progress could be lost if the person did not have good continuity of support into the next phase of their life.

The FCT was established as a multidisciplinary team to assist in the transition of service users from long-term inpatient FMHS care to community-based general mental health services. About half of those under the care of the FCT are subject to special or restricted patient status as specified under Part 4 of the MHA.

In the FCT there is a high staff-to-patient ratio compared to standard community mental health teams. Small case loads allow time for case managers to maintain close and assertive follow up, providing a high level of support to prepare forensic service users for discharge to general mental health services. Care provided is individualised and gives importance to the quality of the relationship with the service user and the service user's family or whānau.

The FCT has access to supported accommodation for 19 individuals within four "step-down community houses". These step-down houses are managed in partnership with three NGOs. One of these is a Kaupapa Māori provider, and one a Pacifica provider, so people can select culture-specific routes for their rehabilitation. Service users also have access to mainstream accommodation providers or might be living independently, with varying degrees of support.

Intellectual disability services

The service for people with intellectual disability who have criminal justice issues has two arms, an inpatient facility and a community liaison service. If Jeff's IQ was lower than 70 and he lacked life skills (adaptive skills) he may have accessed these services. The court and prison teams are involved in detecting intellectually disabled people in the criminal justice system and working with the assessment agencies – Taikura Trust, and – Regional Intellectual Disability Coordination Service (RIDCA) (for individuals with high and complex needs) – to ensure they are assessed and the appropriate legal pathway is actioned.

The IDOLS has 4.5 full time equivalent staff in their multidisciplinary team with a case-load of up to 30 people. Their task is to provide assessment and advice to other providers of services for people with intellectual disability who offend, to assist them in their care of the person. Unlike the FCT, they are not responsible for the community supports or the overall care of the person.

Pohutukawa Unit is the secure inpatient service, also called a National Intellectual Disability Secure Service (NIDSS), which provides 10 beds and 2 assessment beds for people from the northern and the midland regions (i.e. down as far as Taupo). The unit delivers assessment, care and rehabilitation as ordered by the court. Within the intellectual disability specialist team on site sits the statutory role of 'Care Manager' as dictated by the IDCCR Act.

Liaison services to other mental health services

It is also our job to help other mental health services with people who are presenting concerns about risk of violence or other offending. These may be people we have previously looked after and for whom there are rising concerns again, or people who have not yet offended but who are at risk of behaving violently. For example, this may extend to helping a team who might have been caring for Jeff before he attacked his father.

We do this in different ways according to how each of the DHBs want us to help, as they each have slightly different service models according to local community needs. The usual approach is to have in-depth case discussions with their team, at times also seeing a referred person with the team. Occasionally we may recommend the person is admitted to the Mason Clinic to receive care if that is most appropriate. We also offer training and supervision to other teams. ARFPS has also funded four nurses to be embedded into the General Adult Assertive Community Treatment Teams throughout the region in acknowledgment of the forensic need of these service users.

So all up we are a team of more than 440 full-time equivalent staff serving people in a variety of settings with a variety of problems.

KEY LEARNING POINTS

- We are a big team.
- We serve a community of almost 1.6 million people, 2080 of whom are prisoners.
- We have services in courts to find people in need of our help, and to assist the court.
- We have services in all prisons to provide specialist care.
- The court and prison teams are best placed to prioritise those who need admission to forensic inpatient services.
- The inpatient service is made up of eight units with complementary functions to provide different venues for people to be assessed, and recover.
- The FCT provides continuity of care into the community to help people make a successful recovery.
- The intellectual disability service provides expert assistance and advice to intellectually disabled people and community providers, and inpatient assessment, treatment and rehabilitation services for people from the northern and midland regions.

CHAPTER 4

PATHWAYS

Jeff's pathway through ARFPS has been briefly referred to earlier. This chapter describes in more detail the range of possible pathways for Jeff and different forensic service users.

4.1 WHAT DO WE MEAN BY PATHWAYS?

People come to the FMHS by many pathways. The most common ones are through the courts and prisons, but a small number come from other routes, such as directly from general mental health services with the aim of preventing offending behaviour. Once in FMHS, some service users will spend a brief period of time in the acute unit before discharge, while others will remain in FMHS for a longer period of time. Their pathway may involve a move from the acute units to the rehabilitation units and then on to the community.

It is helpful to think about pathways because every service user will have certain rehabilitative goals that need to be achieved during their admission. Some are short-term goals that can be met in the acute units, while others have longer-term goals that will require a referral to the rehabilitation units. Legal status can also have a major influence on pathway and goals. But everyone is different, and an individualised assessment which identifies needs, rehabilitative goals and a recovery pathway or shared vision with the service user is necessary. This provides a reasonable expectation for each person in terms of what they can and should expect from us. It also allows us to define what the gaols of a FMHS period of care are, and what we need to do to deliver that care over time.

Defining pathways allows us to make sure we deliver care to a specific standard and are clear with the forensic service user, their family/whānau, and other authorities about care and assistance we can offer. At all times it is necessary to note that people's needs change and we may need to alter direction.

For instance we may think that a person with a mental illness is coping well in prison and will not need inpatient rehabilitation prior to release. After discussion with the community team who will care for him we may review that decision and see that he needs more intensive care before returning to the community. The nature of a person's needs and our response should be regularly reviewed as we understand more and gather new information.

Jeff's tasks: what are they?

Jeff's illness has driven him to commit a major act of violence against his father. He is before the court. He needs treatment for his illness, as well as understanding about what he did and why. He needs legal advice and the court need expert opinion about whether he is insane in a legal sense and what options the "court has to dispose of his case". So in addition to requiring a full range of assessment and treatment for his illness, he needs exploration and understanding of his behaviour and assistance through court.

Jeff is in an acute forensic unit, a place many service users find frightening and intimidating, even if well supported. He needs care that is sensitive and to be informed about the types of emotional reactions people have to being in a locked environment. More broadly, he has also caused great fear and suffering within his family, so needs services that can start to understand and slowly rebuild his relationship with them.

Jeff's pathway into FMHS has been through the court liaison contact and the FPT contact, leading to the Mason Clinic admission. One important clinical task at this stage is to identify Jeff's rehabilitative needs and which pathway will best meet those needs.

COMMON PATHWAY #1: COURT → PRISON → COMMUNITY

Many people who have mental health needs are arrested or remanded into custody. We think that 10–15% of all prisoners have assessment and treatment needs from secondary mental health services. Most are on less serious charges and do not need to come to hospital. Our contact with many such people is reasonably brief (1–4 weeks, a few appointments only). There are four major things we need to do for these people:

1) Identify them. We need court and prison staff to find who these people are and refer them to us, as well as looking for them ourselves. We are probably missing out on seeing many because they either don't know about us or for many reasons do not seek care from us.
2) Assess their mental health needs. Talk with them, their family and others who have been involved in their care. Assess their treatment and safety needs and provide for them. They need a treatment plan and list of treatment interventions.
3) Provide care for them whilst in prison (liable to be time limited). Many may not need ongoing mental health care and can be referred for primary care by the prison GP and prison health nurses.
4) Refer on to community services at the point of release to continue their care. Refer to the Regional Prison Model of Care for more details, located at: www.networknorth.org.nz (Look under publications.)

COMMON PATHWAY #2: COURT/PRISON → LONGER-TERM CARE IN PRISON

Some people who have been referred and assessed, as described under pathway #1, are facing or have been convicted of more serious offences. Although they have the same needs under 1 and 2 (above) they are likely to be in touch with our service for much longer and need ongoing treatment. They usually have diagnoses of a psychotic illness or bipolar disorder or major depressive illness. They require ongoing recovery-based interventions from us, but largely or fully in prison. Thus in addition to the thorough assessment described in 2, they also need:

- Comprehensive treatment planning. They may be cared for by us for many years, and need a recovery action plan.
- Our interventions will include psychiatrist and key worker engagement, with cultural assistance and, at times, specific individual and group-based interventions.
- Crucially, we also need to be involved with Corrections staff and the Parole Board in ensuring their health care needs are properly addressed during their imprisonment and, if need be, considered in the type and nature of parole conditions provided for the person. This is done with the person's consent.
- The Parole Board may occasionally ask a psychiatrist to write an independent assessment on a prisoner not known to us to help address risk. This is a different activity, performed as an expert function. It may or may not result in the FPT picking up a treatment role for the prisoner.



COMMON PATHWAY #3: COURT/PRISON → INPATIENT ACUTE FMHS CARE → COMMUNITY (NOT USUALLY FCT)

Some prisoners who are receiving care as per 1 (under pathway #1) above become so unwell that they need inpatient care. Prisoners in need of psychiatric inpatient care can only come to a forensic service. They can transfer voluntarily (under section 46 of the MHA) or compulsorily (under section 45).

Typically there are too many people requiring an inpatient bed and there is currently a waiting list. They are asked to wait only if it is deemed safe for them to wait. If only needing a short admission, they may return to prison for follow-up as per pathway #2 or may be referred back to general mental health services when they are no longer subject to an order of imprisonment. When admitted as an inpatient to FMHS they receive the following:

In addition to comprehensive clinical assessment and rehabilitation as described in 2 (in pathway #1) and comprehensive treatment planning, a full risk assessment and risk formulation process will be engaged in, and other aspects of multi disciplinary assessment (cultural, OT, psychological and social work) integrated into their comprehensive evaluations.

Comprehensive treatment appropriate to their needs.

COMMON PATHWAY #4: COURT/PRISON → FMHS LONGER-TERM INPATIENT CARE → FORENSIC COMMUNITY TEAM (OR OTHER COMMUNITY-BASED CARE)

This pathway is the one for most people who stay in the inpatient service, and is the one that Jeff is starting on. These are people whose illness or intellectual disability is largely or wholly responsible for their risk of offending, for which FMHS can therefore use health-based care to intervene to treat that risk. This includes people who are so unwell or intellectually disabled that they are unable to understand court proceedings, those not guilty on the grounds of insanity and those who the courts direct us to take for treatment even though they may have been found guilty.

We also may find people in prison who are so unwell that they can't be released until they have received effective treatment for their illness and any associated problems that give rise to their risk to others.

Such people can be with us for many months or many years, and proceed through the acute to less acute and rehabilitation settings, and in the case of those under the IDCCR Act, to residential rehabilitation services within the community. In addition to all in pathway #3 they should receive:

- Comprehensive recovery-based treatment included in the recovery action plans, with individual and group-based interventions across the key dimensions of need: illness intervention, risk understanding and intervention, substance misuse treatment, family and social network interventions, culture and identity, occupational development.

- (Specific only to people with Intellectual Disability who are subject to IDCCR Act) Comprehensive individual rehabilitation specific to the court-ordered Care and Rehabilitation Plan
- Gradual progress with increasing responsibility and autonomy from acute units to full community re-engagement
- Regular review and oversight to assist with the legal review steps necessary to make these transitions.

KEY LEARNING POINTS

Care pathways are a way of describing the types of needs that people receiving care from us have. Each major pathway grouping has specific types of assessment and interventions from us, matched to the needs of each individual.

This chapter describes the four most common pathways through the service. They are:

1) Court or prison assessment with rapid evaluation and referral of the person's need to primary health care or other health care providers.
2) People referred at court or prison who are in prison for a significant period of time and have major mental health treatment needs, and remain on our case load in prison for some time.
3) People from prison who require brief periods of inpatient care, either to be returned once more to prison, or who can then be transferred to the care of adult mental health services when their imprisonment ends.
4) People who require long-term forensic recovery-based rehabilitation, and require many months or years of inpatient care prior to forensic community follow up from FMHS.

A fifth pathway relates to people with intellectual disability whose risk profile dictates specialist rehabilitation in a forensic secure setting.

Not every person fits neatly into one of these pathways, but these are the pathways for most people.

CHAPTER 5

STRUCTURES, RESOURCES AND PROCESSES: THE OPERATIONAL EXPRESSION OF OUR VALUES

Jeff's needs are responded to by a complex interacting system which helps organise and support the delivery of service to him and other forensic service users. It can be difficult to understand how all the different components relate to each other, but it is necessary to do so if we are to achieve the vision for service delivery described in the earlier chapters. The purpose of this chapter is to look behind the scenes and answer some of these basic structural, resource and process-based questions.

5.1 WHY DO WE HAVE A SERVICE STRUCTURE?

FMHS is large and complex with people progressing through the service via different pathways according to their needs. To make sure that people get the care they need, at the quality they require and by staff supported in delivering that care, we need a structure that coordinates and develops the service.

This section describes how we are structured and why; what staff need to work well and how the service must support staff and service users. Good services need the following things:

- an agreed approach
- skilled staff
- resources and facilities to support staff in their work
- coordination and leadership.

5.2 SERVICE DESIGN

The aims of the service are stated in our mission and values described in Chapter 1. All elements of the service must work to the mission and vision, ensuring clinical, cultural and managerial cohesion in meeting service user's needs. How do we do this?

Our main model is what we call a "clinical governance structure". This means a shared leadership at each level of the service of clinicians, managers, cultural staff and consumer consultants and advisors working together with a shared vision. So, the service:

- is headed by the Service Manager and Clinical Director, with Cultural Guidance from a Service Kaumatua (Māori Elder), and Matai (Samoan Chief), accountable to the General Manager of Mental Health Services, and ultimately the Board and CEO of WDHB.
- has divisions built around functional needs called sub-services:
  - Court liaison team
  - Forensic prison team
  - Acute inpatient units
  - Rehabilitation service (including the Kaupapa Māori service and the FCT)
  - Intellectual disability services (including Pohutukawa and a community-based service: the IDOLS).

At the operational level, there is a senior medical officer and an associate service manager with overarching responsibilities in each of the following service areas: acute; rehabilitation; intellectual disability; courts; and prisons.

Each sub-service:

- develops measures of their effectiveness, monitors quality issues and tracks these and reports on progress
- has individual units and teams with a unit manager or team leader and clinician responsible for the delivery of service to a defined part of the service. Each of these has a multidisciplinary team of professionals to work together to provide care and work with other teams to encourage the person's recovery

- has a component responsible for the infrastructural support including: the need to do our jobs. This includes a business infrastructure with elements such as IT, clerical, HR, payroll, buildings and plant, cars, and financial planning and budgeting. It also includes a clinical infrastructure which encompasses education and training, research, quality systems, programme provision and coordination and discipline-specific support. These are supported by the quality team, responsible for working with teams to ensure both compliance- related quality (focused on key elements of reporting and policy and procedure) and outcome quality (key performance indicators, performance measures, incident reviews)
- has processes for involving and enhancing both consumer and family voice in the development and delivery of care. We do this by developing a culture of consumer partnership and responsiveness under the recovery principles. We have in our teams senior cultural and consumer consultants and advisors, to help ensure services are responsive to service user needs, and specific cultural requirements.

Quality, or the degree to which the services provided meet the needs of service users and increase the likelihood of desired outcomes, is monitored by the Quality and Training Team. It is this team's responsibility to ensure that the quality systems are in place and being used effectively. Systematic documentation across all aspects of the service impacts on the needs of service users, continually improves effectiveness and efficiency of service delivery and demonstrates clear procedures for meeting the required standards. These systems include complaint, incident reporting, significant event investigation, trend analysis, document control processes and internal auditing activities.

The overarching "Clinical Governance Meeting" (CGM) occurs monthly, and is chaired by either the clinical director or service manager. It receives and reviews operational reports of each subservice and tracks quality, strategic and development issues. It is the decision-making forum for the service. It is made up of the clinical director, the two deputy clinical directors (responsible for strategic planning and development in the main service areas), service manager, associate service managers, heads of disciplines, consumer consultant, general manager mental health services, Kaumatua and Matai. The minutes of the CGM are placed on the internal DHB G:drive after each meeting.

5.3 WHAT SKILLS AND COMPETENCIES DOES THE INDIVIDUAL PRACTITIONER AT THE MASON CLINIC NEED?

Working in FMHS is interesting, challenging and at times stressful, but always rewarding and important work. Our staff need specific qualities and competencies to work in this environment. Although not all of FMHS staff are health professionals, we still expect and select staff for the professional skills they demonstrate, and also for their personalities and attitudes. This skill set includes the following areas:

- Knowledge in mental health intellectual disability and addictions e.g. skills in assessment, risk assessment, cultural understanding and treatment.
- Knowledge in recovery: to help people achieve their ability to live well in the presence of their mental illness by drawing on the service user's own skills, their communities and family's skills and helping people have an active role in improving their lives.
- Reflection/supervision/ preceptorship/guidance: to be able to see what could be done better next time, to help others learn and grow; to keep oneself growing and learning by keeping a view towards self improvement.
- Interpersonal skills: communication and listening skills, compassion, ability to be therapeutic (that is, to make a difference through listening or communicating with consumers), awareness of boundaries, or what I can do and what I can't or should not do.
- Cultural competency skills: all staff require a working understanding of the cultural needs of Māori given that the

Crown has a special relationship with Māori tribes to fulfill Treaty of Waitangi obligations. Other significant cultural ethnic groups are of Pacific Island and Asian descent. There is an increase of service users from other minority ethnic groups in which language is a barrier.

- Courage and determination: an ability to deal, in what may sometimes be stressful or difficult situations, with other people's issues and stress and be able to cope with one's own issues at the same time.
- Risk assessment skills: to make appropriate decisions based on a sound process around a person's degree of risk to themselves or others and to implement and follow policies and procedures thoughtfully.
- Non-judgmental and open-minded approach: we seek to overcome stigma and discrimination, not add to it.

5.4 HOW WILL WE HELP YOU DEVELOP YOUR SKILLS AND COMPETENCIES?

In FMHS, as in all clinical services, it is vital to help you develop yourself to fulfil your potential in your work and career. We do so by:

- **training to improve quality and outcomes**

  The Quality and Training Team assists staff to meet their mandatory requirements in training by providing information and support about the training when needed. They are also committed to ensuring that staff are kept up to date with current trends in mental health.

  They do this by sending out articles of interest regularly, and ensuring that all staff are aware of training available from appropriate sources such as Te Pou. The Quality and Training Team ensures that information and training packages such as Let's Get Real and Trauma Informed Care are circulated and made available to ensure that innovative and fresh perspectives are discussed and that there is adequate reflection on practice within the service.

- **personal responsibility and professional responsibility**

  Evidencing the maintenance of professional skills and knowledge is common for most health professionals (Health Practitioners Competence Assurance Act 2003), but workers have a requirement under Health and Safety legislation to maintain their own safety and that of others. All employees must take time to ensure they meet these requirements.

  We must all learn and keep fresh our most basic and important skills, such as CPR, calming and restraint, avoiding infectious diseases, how to de-escalate high-risk situations and how to deal with fire. Orientation to the work environment is also an example of mandatory training which helps people work effectively in their new workplace.

- **change management**

  To achieve the high standard of care we aspire to means that continued research and ongoing adaption of new methods and ideas will be part of who we are and the service we provide. To help staff manage change successfully we offer education and support.

- **university and postgraduate education**

  FMHS needs to have a strong relationship with tertiary learning institutions. We have assisted people through Mental Health Support Worker training (certificate and diploma), postgraduate nursing studies (post-graduate certificate and masters) and full nursing training. We work with institutions to assist the learning of student health professionals from many disciplines of the multidisciplinary team.

- **discipline-specific activity**

  While services are delivered by multidisciplinary teams, there are key functions of professional accountability, support and supervision that must be health-discipline specific, and therefore each discipline has a professional head: of social work, psychology, OT, nursing, and medicine with discipline-specific meetings. Additional support comes from Pharmacy and the Chaplaincy. It is important that as colleagues we acknowledge that each

discipline's competencies can overlap but are also to some degree distinct. Each must share in and retain unique areas of practice.

We encourage staff to take opportunities to learn, seek supervision and develop their skills.

5.5 HOW DO TEAMS WORK AT THE MASON CLINIC?

There are two main reasons why we work in teams: first, the people we care for have complex needs that no one of us can meet alone; and second, the work can be very stressful and we need the support of others of our own discipline and other disciplines to work effectively. Let's look at each.

Forensic service users have complex needs. These include:

- issues emerging from their personal life, background, family and identity
- issues emerging from their experience of illness
- issues directly related to their offending or risk behaviour
- problems commonly linked to illness and offending like substance use and educational and occupational non-achievement.

To meet these needs, we need clinicians and cultural staff with a variety of skills. No one individual or clinical discipline has sufficient skills to meet all these needs. Further, risk and security issues mean we need a large number of staff to look after a unit over 24 hours. An effective FMHS requires teams. Best evidence is that teamwork, not separate clinical practitioners, is the most effective way to deliver care.

Forensic care is complex, some areas highly technical and legal, others very human and social and family oriented. It can be stressful, and the severity of the risks and the types of behaviour that people have committed before coming to us can be overwhelming. Teams are well placed to share skills, and share burdens of this work, through team meetings, shared plans and understandings. We need this to support each other. It may involve challenging each other if we slip up. This includes support, informal supervision, formal supervision and ensuring the maintenance of appropriate boundaries.

Effective teams have clear communication and expectations. People need to know and understand their roles and responsibilities. Tasks given and expected should be completed and reported back. Decision making should have a clear process that is open and understood. It should be inclusive and respectful of the opinion and expertise of all disciplines. Decisions are shared and implemented.

Not everyone will agree all the time, and sometimes decisions may have legitimate competing perspectives. But a decision must be made and agreed to, and it should be reviewed at a later agreed time to see whether it needs to be changed or modified. Consensus is sought, but it is not democracy! Most of all, remember that the most important team member is the forensic mental health service user and their family. They should be involved and informed to the greatest degree possible.

5.6 SERVICE USER SUPPORT AND ADVOCACY

People undergoing FMHS care have major intrusions into their life, from the courts, in prison or in a secure hospitalisation. Whenever people have lost freedom or capacity to make decisions for themselves they are vulnerable to exploitation. Robust processes to protect their rights, ensure their dignity and support them to have involvement in the care they receive are needed along with high quality professional care.

These systems of support and protection are multi-levelled:

- All health care professionals have a duty to provide and ensure provision of care that meets people's needs in a manner that is acceptable to them. Our ethical standards and the Code of Consumer Rights require it.

- The service has a duty to provide policies and procedures which support good care. Policies include our mission and values, and the manner in which we perform our work including our approaches to assessment and care.
- Consumer advisors and the consumer consultant are employed within the service to ensure consumer voice is influential in how we design and deliver care so that it is recovery-informed and consumer-responsive.
- Cultural staff including Kaumatua and Matai guide and assist us in ensuring the care is delivered in a culturally responsive manner.
- We must respond to complaints and concerns from forensic mental health service users or family members unhappy about the service we give.
- Statutory roles: within the service, there are staff with particular duties under the MHA and IDCCR Act which include obligations to ensure rights are respected and duties are met. These include the Director of Area Mental Health Services, duly authorised officers, responsible clinicians and care managers.
- Legal officers: The Acts also provide for district inspectors, judicial reviews and mental health review tribunals to ensure people's rights are upheld and the Acts are properly applied. Forensic service users have a right to legal counsel to speak for them and advocate for their rights and views.
- Independent advocacy from health and disability sector advocates are available for complaints, as are other statutory complaints mechanisms such as the Privacy Commissioner, the Health and Disciplinary Commissioner and the Ombudsman.

These processes are vital for helping forensic service users feel supported and respected and keeping us safe in our practice.

KEY LEARNING POINTS

- FMHS are complex and require clear structures to function well.
- The main decision-making body for running the service is the Clinical Governance Group. Clinical governance means the partnership between clinicians and management in the planning, provision and quality management of the organisation.
- Clinical care is delivered by teams who also have an involving and cooperative approach to decision making. Decisions need to be clearly made and roles clearly defined.
- Individual clinicians need understanding, courage, training and support to do their jobs well.
- Service users have a right to careful support of their rights and needs through different levels of scrutiny of their care, support for concerns and ensuring their needs are adequately addressed.
- Policies, procedures and quality activities help monitor and support the service and seek to ensure that standards are maintained and excellence is promoted.
- Requirements to change aspects of practice, service delivery, or procedure may come from national or external sources and present a range of challenges to the service.

CHAPTER 6

ELEMENTS OF PRACTICE

So we have described the service, our values, different forensic service user's pathways, and the way we organise ourselves as staff. This chapter describes how we do our work, how we assess people's needs and risks, how we plan interventions for individuals like Jeff and organise programmes across the service. This will allow you to understand how we think about forensic service users and their needs, how we come to understandings about what we should do to help people and how we organise our responses to them.

These elements of practice occur in the context of competing tensions between the interface of health and justice. There is a need to take into consideration the safety of staff, the community, the public's need to see justice has occurred, the rights of the victim and the needs of the service user. Security and safety are therefore fundamental to our practice and these elements are an everyday reality of forensic settings. Many factors influence safety and security but the key influences are building security, staffing mix/skills, safety protocols, and engaging relationships with service users. The elements of practice described in this chapter ensure safety and security measures are based on appropriate and relevant service-user related data that should be used as a positive therapeutic tool.

6.1 INDIVIDUAL ASSESSMENT PACKAGE.

All forensic service users have a package of assessments, contributed to by each member of the multidisciplinary team, which is organised into a shared understanding with the person.

Comprehensive clinical summary

This is the key document which summarises information from personal background, past medical history, family/whānau interviews, staff observations and Service-User interviews. Each clinical and cultural discipline needs to have input into it, as the integrated summary of the information necessary to understand the person and their whānau. The time frame for completion is within six weeks of admission for inpatients, and it should be reviewed and updated at least at six-monthly intervals. Its key headings are:

- Reason for admission
- Detailed account of the index offence
- Past forensic history
- Personal history
- Family history
- Medical history
- Drug and alcohol history
- Psychiatric history
- Spiritual/cultural history
- Mental state (including specialist and discipline specific evaluations)
- Clinical and risk formulation
- Comprehensive list of treatment goals

Risk assessment

Risk is simply the likelihood of something happening; it can be good or bad. In our case the risk is that something bad will happen to a forensic service user or that they will act in a harmful way to others. We understand risk in certain important ways:

- Risk is not simply about the person, but also about their circumstances and their mental state
- We try and to understand risk by understanding things that we know can be associated with the particular risk (referred to as risk factors) and by understanding the way risk has emerged for this person (called risk pattern or risk formulation).
- Protective factors are just as important in assessing and managing risk as these factors reduce or mitigate risk and can be strengthened to help manage risk it.
- Risk is always changing, it is not a static state, and we must always be reassessing our understandings of risk it..
- Risk for people who have an intellectual disability differs in that the nature of intellectual the disability is often permanent even if adaptive functioning can change,

thereby presenting different treatment and management challenges.

Here we will talk mainly about assessing risk to others, but the same principles also apply to assessing other risk.

The risk assessment process has three main phases: information gathering, risk assessment and risk communication. Some of this we do as clinicians, later it is done with the person, and they develop their own risk statement that summarises the issues, so they understand their pathways to violence and pathways to safety.

- Information gathering

  This starts on admission and continues with ongoing data collection. We use different information for detecting short-term risk of violence (such as agitation, irritability, fearfulness and threatening behaviour) than we do for understanding long term risk.

  Historical information is gathered in two types of ways: firstly by looking for risk factors and secondly by compiling information regarding past episodes of dangerous and risky behaviour.

  The first process is supported by awareness and knowledge of the research and thinking in violence risk assessment. Much of the research is pulled together in standardised instruments such as the Historical-Clinical-Risk Management 20 which is routinely employed in the ARFPS. The HCR-20 is a structured tool that rates factors from the person's past, their current mental state and future situations to guide clinicians in assessing how at risk of violence a person may be. It looks at things that don't change (the past factors) as well as ones that can change in treatment and recovery (Clinical and Risk Management factors). The HCR-20 encourages a process of structured professional judgment whereby an experienced clinician can use knowledge of nomothetic (population based) and ideographic (individual and patient-specific) variables to create an overall estimation of risk. Collation of data for the HCR-20 is a task for the whole team. The structured professional judgment is made by team members with appropriate levels of expertise and training, often the psychiatrist or team psychologist. The HCR-20 must be completed prior to completion of the first CCS and at each review of the person's care plan.

- Risk formulation

  The next step is to analyse each of the major incidents of violent behaviour that the person has committed. We record what happened (what the person did, to whom, with what injury or outcome) under what circumstances (things that had given rise to the situation, behavioural pattern, treatment engagement, drug use etc) and what motivated the person (how they were feeling, emotional state, illness factors, delusions or hallucinations). After analysing each such incident, patterns quickly emerge. It is usually possible to develop a statement, with the person, called a risk statement or formulation. Jeff's Risk Statement might read as follows:

Jeff's Risk Statement

I am at risk of: assaulting others with weapons, especially my father, causing significant injury

When I experience: thinking that people are against me, thinking the CIA are after me for crimes I haven't committed, hearing voices talking about me or plotting against me, feeling scared and angry

In these situations: smoking and selling cannabis, financial difficulties, committing burglaries, poor housing and rows with family members.

A good risk statement should allow you to come up with a clear risk management plan: the things relevant to risk should be summarised there. With the HCR-20 and knowledge of Jeff, you can then say what risk he currently is at. Jeff's risk statement won't change dramatically over his recovery but his HCR-20 Clinical and Risk Management scale scores will fall and he will build skills and awareness on how to avoid risk patterns emerging in the future.

These understandings may not be shared early on in his recovery, but become increasingly shared as he recovers. Eventually the hope is that it becomes his own formulation.

For the individual with an intellectual disability, the risk formulation would be shared with future service providers as part of the risk management plan to ensure maximum safety of both the individual and those around them.

The information gained from risk assessments and formulation and the comprehensive clinical summary enables a thorough consideration of information used for ratings, promoting consistency between notes, entries and ratings. A collaborative approach to these tasks with Jeff will increase the likelihood of accuracy and efficacy of this process. The process of risk formulation should help identify interventions to assist in managing and reducing risk. These interventions can be included in the Health Care Recovery Plan and made central to everyday management.

The time frames set out within the documentation policies ensure regular updates and reviews are completed and indicate which discipline is responsible for this. These consist of a comprehensive clinical summary, health care recovery plan, HCR-20 and risk assessment and risk formulation.

Health care recovery plan

This should be completed with the FMHS user by six weeks into their stay for inpatients and is reviewed at no more than six-monthly intervals. It lists a series of goals that the person must achieve and things we will work on together with them, including who is to do the work. At the end of six months, the plan is reviewed, issues if dealt with removed, and new goals added to the plan.

Relapse planning and early warning signs

As people progress in their recovery, it is important that they learn the patterns of symptoms of illness or behaviour that they and their family/whānau need to look out for if to avoid relapses of illness and risk. We do this using two tools, the first listing early warning signs so the person can monitor themselves and with support for signs of things coming unstuck, and a relapse plan which helps the person define what they should do and they want done should things start to go wrong again. For the individual with an ID for whom care and support is based on rehabilitation rather than recovery, a behaviour management Plan is formulated to support optimum functioning.

Recovery plan

Another key document is the service user's recovery plan: a small personalised booklet that they keep. It focuses on their hopes and dreams, and how they can achieve their goals by using identified strengths and supports. The recovery plan also contains information about their personal triggers and warning signs, and how they can manage them, i.e. a relapse prevention plan for managing their own risks.

Jeff attended his first recovery group whilst still in prison. He didn't take too much notice of what was said at first, as he was feeling overwhelmed by his problems. However the simple message of hope got through to him eventually, and he began to believe that he might recover given time and effort. He was pleased to see the same staff run a recovery group when he was transferred to Mason Clinic as he liked and trusted them.

One session in particular really affected Jeff. An ex-resident of the Mason Clinic, Steve, came in to talk about his own recovery. Steve had a similar background to Jeff, but had committed a more serious offence. He had spent several years in the Mason Clinic working on his recovery and now had his own flat in the community, was working, and had got a new partner. Jeff felt a real connection with him, and was inspired not only by his story but also by how he looked and talked so well. Steve seemed really confident, happy and together. For the first time, Jeff realised that he too would recover.

6.2 OVERALL APPROACH

Programmes are available to help all FMHS users recover, and then maintain their recovery. There are several types of programmes available, each addressing different needs.

A programme consists of groups, individual sessions and homework, all within a supportive environment. If the environment doesn't support the gains made in programmes, then the gains will quickly be compromised or lost.

There are four sequential aspects to most programmes; information giving, motivation, skills training, and then integration of new learning into behaviour changes. Other groups have a focus on exploration and reflection.

As many programmes as possible use the same language and concepts to enable forensic service users to learn and remember concepts, and to see the links between, for example, drug and alcohol use and mental health issues. The core programme information is gathered together into a Recovery Workbook.

To improve effectiveness programmes are designed to have meaning for people, so they are internally motivated to attend and participate. Programmes are responsive to people's wishes. The "one-size-fits-all" approach disadvantages certain people, who due to their personality, culture or cognitive ability, prefer interventions to be delivered in different ways.

Programmes are integrated into their environment as well as across different therapeutic areas. Staff are encouraged to use specific language and concepts, so that the burden of integration is not put onto the client. Programmes are coordinated across the service, so that people can access the programmes they need when they need them. Programmes are evaluated by facilitators, the participants and the multidisciplinary team. If a programme isn't meeting the needs of the people in a cost effective manner, then it is reviewed.

Peer support is seen as a valuable part of the process of recovery, and this is reflected in programmes. We have two peer support programmes that are facilitated by outside providers, namely Narcotics Anonymous and the Hearing Voices Support Group. There are also peer support groups available with a focus on recovery and on gender.

Core areas

The core areas of the programmes were developed from an understanding of what the participants need to do to move to a less restrictive environment, and what keeps them safe in their progress. These six areas are core to forensic mental health:

1) mental health issues
2) offending behaviour
3) substance abuse issues
4) vocational rehabilitation
5) family/whānau work
6) cultural and spiritual programmes.

For the individual with an intellectual disability all programmes are unit based and delivered by the intellectual disability specialist team and specific to the individual's court-endorsed care and rehabilitation plan.

Other interventions are also central to the broader concept of recovery including:

- healthy living groups
- cognitive rehabilitation
- literacy
- women's groups
- spiritual services
- sports and leisure.

Once Jeff completed the Recovery Group he had an idea of what sort of future he wanted, and how he could achieve it. He knew he had many strengths, but that he also knew he had some problems that he needed to address. He asked to do some programmes around his drug use, and was pleased to find that they used the same language and concepts in that group as they did in the recovery group and that it helped him understand and make links between his drug use and his recovery.



Organisation and communication

The programme manager works alongside key staff to organise the programme for the core areas. Each month key staff meet together with other stakeholders (e.g. a consumer representative and senior management) to ensure that all the programmes are coordinated, integrated and evaluated. Communication is a key aspect of a successful programme, and a multitude of strategies are used, including newsletters, group emails, shared computer drives, ward and service-wide presentations, information booklets, posters and meetings.

Individual units may also have specific programmes or groups that reflect its ethos and the typical needs of the people on that unit. Cross-service programmes are also available for participants who are atypical for that unit, for example a sexual offending relapse prevention group. There is an emphasis on unit-based programmes that staff and participants attend together. This has been found to promote improved communication and enable the creation of a supportive environment.

Liaison with outside providers

External providers are encouraged and supported to work with our service users. Work Foundations offers career counselling, skills training, literacy and computer training, a sheltered workshop, a market garden, and job seeking support and guidance. Framework Trust offers more vocational options. Narcotics Anonymous hold regular meetings onsite, and other facilitators with valued skills and experiences are invited in, for example a voice hearer co-facilitates a Hearing Voices Support Group. The National Intellectual Disability Secure Service also has an established relationship with the SAFE ID programme (for intellectual disability sexual offenders).

Evaluation

Feedback is gained through several different forums, for example each programme is evaluated by group members and the facilitator, and a yearly consumer survey reveals overall satisfaction with programmes. Programmes typically have the second highest satisfaction rating when service users are asked to rate their satisfaction with all aspects of the Mason Clinic: between 80% and 90% usually express satisfaction with programmes.

Recovery plan

We aim for all forensic service users to develop a recovery plan to help them progress their recovery.

The first part is developed in the recovery group, and contains the dream that motivates the service user to walk down the long, hard path to recovery. The dream is then broken down into goals based on their strengths. Supports are identified and strengthened, along with natural coping strategies.

The second part is developed in the "pathways to safety" group, which explores risks and how to manage them. Service users get to identify the triggers and warning signs that they are sliding towards harmful behaviour, and what they can do to get back into recovery.

These two parts are then combined into a small booklet which the service user designs before it is printed professionally. It has been our experience that this small personalised booklet has more meaning than a large collection of programme handouts, and is more likely to be used in the future.

Most programmes reference the recovery plan in some way. For example in the Hearing Voices Support Group, service users are encouraged to write down their coping strategies into the booklet.

Jeff was really pleased when he finished pathways to safety. He thought it was an important group, and he felt he had learnt a great deal about risks and what he needed to do to move out of Mason and stay in recovery. The booklet was cool too. He had a picture of his family on the front to remind him why it was important to recover.

Kaupapa Māori services

FMHS provide Māori cultural services across all the units and teams. Māori cultural assessments and interventions are included in the care plan of Māori service users. The growing recognition that over 50% of services users are Māori supported the development of Tane Whakapiripiri Unit: a minimum secure rehabilitative facility based on Māori concepts, values and beliefs. This provides some Māori service users with a Kaupapa Māori pathway choice in place of one of the other rehabilitation units. This kaupapa Māori pathway links closely with the Kaupapa Māori step-down facility, Te Patate and other Māori mental health providers delivering similar Kaupapa Māori services. Tane Whakapiripiri provides a combination evidence-based practice to Māori forensic service users, e.g. psychiatric rehabilitation and recovery models, in an environment of care through practices and/or principles that underpin Māori values and traditions.

- The principle of wairuatanga (spirituality) is important to Māori and therefore recognition of services and/or practices that acknowledge forensic services users' aspirations to seek and develop spiritual identity is provided across all the units in the service.
- The principle of whānau is one of identity and is an important aspect of service provision. The whānau is the core of Māori social units and Kaupapa Māori models of care are organized around the concept of whānau. Whanaungatanga (kinship) also gives recognition to the ambilateral links Māori have toward each other.
- The principle of rangatiratanga (indigeneity), acknowledges the aspiration and determination of Māori forensic service users to retain their unique identity and avoid assimilation by exercising a degree of autonomy while receiving best evidence-based treatment and/or therapies available within forensic services.

Leave

Leave relates to any departure or period of absence from our inpatient units. Leave has three primary purposes to facilitate:

1) rehabilitative activity
2) transfers between hospitals or units (which includes medical appointments)
3) attendance at non-medical, non-rehabilitative events such as tangi.

Leave is therefore not only a clinical tool which is used to facilitate the recovery of an individual service user but it may also be required for non-rehabilitative purposes, such as to attend medical appointments. Whatever the purpose of any particular leave, it must occur within the context of an assessment of the risks involved for the individual, the community and the service, and it must comply with legal requirements. Individual eligibility for longer leave periods and/or relaxation of leave conditions occurs progressively as recovery goals are reached and the risks associated with leave are managed.

Approval from the relevant authorities must be gained before leave can be taken. However, it is an important principle that leave approval does not automatically lead to leave. Whether the individual service user is appropriate for a specific episode of leave must be assessed prior to any leave being taken. Clinical/risk concerns will always override approved leave. The responsible clinician and key worker are accountable for ensuring it is appropriate for the leave to proceed. Whether it is appropriate for leave to proceed must always be assessed within the hour prior to any leave being taken.

KEY LEARNING POINTS

- All staff are required to deal with the tensions which exist between safety, security and therapy in a recovery-promoting way.
- All service users under the care of the FMHS have a comprehensive care package.
- Elements of this package include the Comprehensive Clinical Summary, health care recovery plan, risk assessment and risk statement and risk and relapse plan.
- These elements are prepared at different recovery stages and regularly reviewed. They become shared documents that describe our joint understanding of the person's problems, needs and strengths.
- Therapeutic programmes address core areas of need, namely mental health issues, offending behaviour, drug and alcohol issues, work and education, family/whānau work and identity issues such as culture and spirituality.
- Other therapeutic needs are addressed in ward-based and individual interventions.
- Programmes are delivered on a unit basis as well as cross service. They are coordinated, integrated and evaluated.
- With the exception of ID service users, all service users have a Recovery Workbook and a Recovery Plan that they work on individually, in group, and alongside key staff. It outlines their recovery dream and how they will achieve it, and their risks and how they will manage them.

CHAPTER 7

LEGAL FRAMEWORKS AND LEGAL TESTS

All people like Jeff who require forensic mental health care have their assessment and treatment defined within clear legal structures. In earlier chapters we have referred to the common Acts that may apply to FMHS users: the MHA, the CP(MIP) Act, and the IDCCR Act. Their existence is necessary to ensure protection for FMHS users whose ability to make decisions may be impaired, or there may be issues of criminal justice accountability that require the criminal law to be involved. All clinical care is also delivered according to the ethical and care standards that health professionals must abide by at all points of their practice.

This section covers the common legal questions and orders that people will be under, structured around Jeff's story. It also contains a list of orders and officers working under specific Acts that you will come across.

7.1 JEFF AND THE LAW

When Jeff approached each stage in his recovery, he struck important decision points when the court asked about how much his mental illness affected his decision making and judgment. The common legal questions are:

- Is Jeff well enough to understand what is going on in court and can he defend himself in court?
- When he committed the offence, was he so sick that he should not be seen as a criminal, but rather be found not guilty on the grounds of insanity?
- If he is convicted, should care and treatment be part of any sentence the court imposes?
- Are his mental health problems so serious that he needs to be treated compulsorily for his sake and others?

Each of these questions is really important as they deal with vital interests of justice or the well-being of Jeff. Each has its own legal section and procedure attached to it. As Jeff and other people you look after will be affected by it, it is important you understand a little of the law in relation to these questions, why it is there, and how the courts determine if someone should be made subject to an order consequent on one of these tests.

7.2 CAN JEFF DEFEND HIMSELF?

One very important principle of law is that no one should appear in a court who is unable to defend themselves adequately. For hundreds of years courts have had ways of working out whether a defendant understands enough to be able to defend themselves, even though a lawyer is usually giving the person assistance. Section 4 of the CP(MIP) Act defines unfitness to stand trial as follows:

4 Unfit to stand trial, in relation to defendant –

(a) means a defendant who is unable, due to mental impairment, to conduct a defence or to instruct counsel to do so; and

(b) includes a defendant who, due to mental impairment, is unable –

(i) to plead;

(ii) to adequately understand the nature or purpose or possible consequences of the proceedings;

(iii) to communicate adequately with counsel for the purposes of conducting a defence.

If someone seems to have problems understanding the court process, because of their mental illness, intellectual problems or other mental problems such as head injury or dementia, the judge may ask for a psychiatrist or psychologist to see whether the person has a "mental impairment", and if so, whether that means they are unable to do the things listed at section 4(b) above.

Basically, it refers to someone who is unable to think clearly enough or understand court process, or may have delusions about the court process, in a manner that means they are unable to make rational sense of what is going on. Or they may be unable to work with their lawyer in a way that allows the lawyer to conduct their defence.

Jeff was initially suffering from symptoms of a psychotic nature indicating he was detached from reality. He felt

paranoid and couldn't trust others, including his lawyer. He was confused about his charges, and initially didn't think he needed to be in the Mason Clinic at all. In this kind of mental state it is not appropriate to proceed with a trial, as Jeff would not be able to defend himself. What Jeff needed was an expert to advise the court about his clinical state and the way in which it impacted on his ability to have a fair trial.

Whenever it looks like a defendant may be unfit to stand trial, the court orders two reports and holds a hearing to check that the person does indeed have a case to answer (referred to as an 'inquiry into involvement'). If the court is satisfied that the defendant was involved, and they are mentally impaired to the extent that they are unfit to stand trial, then the court can make one of the following orders:

- A special patient or special care recipient
- A committed patient under the MHA or a compulsory care recipient under the IDCCR Act
- The court may simply release the person.

Which order is made depends on two things:

1) The seriousness of the offence (the more serious the more likely you will be made a special patient or special care recipient)
2) Whether you have a mental illness (where you may become a special patient or committed patient) or are intellectually disabled (where you become a special care recipient or a compulsory care recipient).

People with mental illness are committed under the MHA and those with intellectual disability receive orders under the ID (CCR) Act.

What happens to the charge the person was facing if they are found unfit to stand trial? If they are made a special patient or special care recipient, the charge remains suspended until they either become fit to stand trial (when they can go back to court and face the charges) or until half the period of sentence they could have received lapses, at which point they cease to be a special patient or special care recipient.

Being unfit to stand trial and subject to a special patient order is not an easy position, as when you recover, even years later, you can be required to return to court to be tried for the charges. And in the meantime you remain in forensic services. For most people it is best to come to trial as soon as possible so the issue can be dealt with once and for all. As a special patient unfit to stand trial, most forensic service users are frustrated by the uncertainty surrounding time frames, and what the future holds. So being clear about these issues is very important.

7.3 WAS JEFF RESPONSIBLE FOR WHAT HE DID?

When Jeff does recover sufficiently to face his charges, he is deemed to be "fit to stand trial". At that stage, the next really important issue of justice is that if the offence was the result of being mentally ill, he may not be held totally responsible for his actions. It may make more sense for a defendant like Jeff to receive treatment for his illness rather than receive punishment. However, it is not enough simply to have a mental illness; the illness must have directly, and in a rather special cognitive way, given rise to the offence. The legal test for this is a rather old legal term called the test for insanity. It is contained in Section 23 of the Crimes Act 1961, and states:

Insanity

1) Every one shall be presumed to be sane at the time of doing or omitting any act until the contrary is proved.
2) No person shall be convicted of an offence by reason of an act done or omitted by him when labouring under natural imbecility or disease of the mind to such an extent as to render him incapable—
   (a) Of understanding the nature and quality of the act or omission; or
   (b) Of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.

If a jury (or sometimes just a judge) is convinced that these criteria apply to Jeff, then he will not be punished for his actions in the way that most convicted defendants are. The same range of disposition orders is available here as are listed above for defendants unfit to stand trial.

7.4 CONVICTED AND NEEDING TREATMENT

The court will sometimes be faced with a situation where a convicted person is in need of mental health care and treatment. They may have pleaded guilty to their charges, or may have gone through a trial and been found guilty. The court has two options to consider at sentencing:

1) Making a Compulsory Treatment Order (under the MHA), or Compulsory Care Order (under the IDCCR Act) instead of punishing the person

2) Making a Compulsory Treatment Order (under the MHA), or Compulsory Care Order (under the IDCCR Act) as well as punishing the person by imposing a term of imprisonment

The first option may be preferred if the offending is less serious and the mental illness or intellectual disability was a significant mitigating factor. The second option is referred to as a "hybrid order" because the person is sentenced to prison as well as being sent to hospital for treatment.

7.5 IS JEFF ABLE TO BE MADE SUBJECT TO THE MENTAL HEALTH ACT?

Insanity acquittees, defendants unfit to stand trial and convicted individuals may all be made subject to the MHA. However, this is only possible if another legal test is met: the test for "Mental Disorder". This is set out in section 2 of the MHA which states Mental Disorder is:

1) "an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition to such an extent that it..."

2) "poses a serious danger to the health or safety of that person or of others; or seriously diminishes the capacity of that person to take care of himself or herself."

Section 4 of the MHA also says that you can't be made subject to the act solely on the basis of things like criminality, substance abuse, religious or cultural beliefs or intellectual disability. The type of problems that the Act is aimed at are problems that arise from mental illness and the need for treatment for it.

Jeff has a psychotic illness which has contributed to his quality of life declining. He had been unable to live independently and had to return to live with his parents. His illness resulted in symptoms that led to serious harm to his father. People who have that set of problems may be made subject to a Compulsory Treatment Order (CTO) under the MHA.

7.6 PROCESSES FOR A COMPULSORY TREATMENT ORDER UNDER THE MHA

Although Jeff's problems could support the making of a CTO, ultimately this is a decision for a judge. Such orders are either for inpatient treatment or for community treatment. While they can be made by the criminal court as noted above, a more common way to be made subject to the MHA is on application by a responsible clinician to the Family Court. Initiating and continuing a compulsory treatment order is a complex process. It needs to be performed thoughtfully and must adhere to the processes defined in the MHA.

The first step is the application. If someone who knows the person and a medical practitioner are both concerned that the person may meet the definition of mental disorder, they

may make application to the Director of Area Mental Health Services (DAMHS) under section 8. The duly authorised officer (DAO) receives these applications, and ensures they have been completed properly. They also ensure the person is properly informed about the process and then arrange for a formal assessment under section 10.

If at the conclusion of that assessment the assessing clinician believes there are "reasonable grounds for believing the person may be mentally disordered" and that it is desirable that the person receives compulsory assessment and treatment, then the doctor so certifies under sections 10 and 11, and the person is admitted to hospital under the care of a responsible clinician. If the assessing clinician does not believe the person is mentally disordered then the process ceases immediately.

Within five days of assessment under S 11, the service user (now legally referred to as a patient) must be reassessed to see if they still require compulsory assessment and treatment. If not they are released, but if they require ongoing assessment and treatment it continues for up to another 14 days (sections 12 and 13). By the end of those 14 days the responsible clinician must either cease the compulsory assessment or make application to the Family Court for the granting of a compulsory treatment order (section 29 or 30).

At the hearing before the Family Court Judge, the patient is usually represented by a lawyer and may have family present. The responsible clinician explains why the order is needed and the patient has the right to agree to it or oppose the order. A second health professional, most commonly the patient's key worker must also give a report to the court.

The judge may either grant the order or refuse to do so and release the person. If the order is made it must be reviewed again in six months time by the judge, and at six months after that. After one year the compulsory treatment order becomes indefinite.

Family must be consulted throughout the compulsory assessment and treatment order process, and the person's cultural and religious beliefs respected. Also, whilst such orders in a forensic service are almost always inpatient orders, all this process can occur in the community if the services appropriate to the person's needs are present in the community.

The person has the right to seek review of the decision to impose a treatment order, either to the court or to a review tribunal.

During compulsory assessment and the first one month of a compulsory treatment order, the patient is obliged to accept prescribed treatment. Following that, compulsory treatment can only be given with the person's consent or with an independent second opinion from an approved psychiatrist.

Rarely, a special type of legal order may be applied for even if there are no current criminal charges, referred to as a Restricted Patient Order. These orders may be applied to people if there are special difficulties their dangerousness poses (see section 54 of the MHA). These may be former special patients or former prisoners who for various reasons need closer, more accountable care. As at January 2011 there were fewer than ten "restricted patients" in New Zealand.

If the issue for the service user relates more to their ability to manage their personal affairs or finances, the use of another Act called the Protection of Personal and Property Rights Act 1988 may need to be considered. This is more likely if the service user has a permanent cognitive disability such as dementia or an intellectual disability.

7.7 CLINICAL DUTIES

As reiterated throughout this manual, there are many mechanisms in legislation to ensure that vulnerable people who have lost much freedom have their rights respected. But how do we work as clinicians who have both the job to help people and to be asking for a Compulsory Care or CTO? Although we may not be able to resolve all these tensions, there is much we can do to reduce how coerced people feel under compulsory treatment and maximise their sense that they are involved in fair processes. These things help us to remember to stay therapeutic, even when advocating for compulsory care:

- respectful treatment
- clarity of information
- giving the person a chance to be heard
- involving family and support people.

Attendance to these principles both during and following hearings will allow the person to understand why we take the steps we must, even if they don't agree with us doing so.

7.8 PEOPLE WITH SPECIFIC ROLES UNDER THE ACTS

The Acts create important legal roles that you need to know about:

Minister of Health: a senior member of the Government, a Cabinet Minister, who is responsible for aspects of special and restricted patients' care, including the granting of long leave from hospital and reclassification from special patient to CTO status. Sometimes the Attorney General also has this role.

Director of Mental Health: is in the Ministry of Health in Wellington and has overall responsibility to grant short-term leave for special patients, and approve their movements and transfer. The Director of Mental Health has overall responsibility for appointing other people with roles under the Act, such as directors of area mental health services.

Director of area mental health services (DAMHS): is usually the clinical director of the service and has the responsibility of appointing others to work under the Act such as duly authorised officers and responsible clinicians. They are responsible for overseeing all functions under the Act.

Duly authorised officers (DAOs): are mental health professionals appointed by the DAMHS and are involved in the process of initiating and arranging the safe assessment and transfer of people coming under the MHA, and ensuring their rights are properly addressed.

Responsible clinicians (RCs): are clinicians appointed by the DAMHS, usually a psychiatrist, sometimes a senior registrarand are responsible for the care of a person under the MHA.

2nd Health Professionals: are other members of the MDT, usually nurses, called on to give evidence about whether a person needs to be subject to a CTO at judicial hearings.

District inspectors: are senior lawyers appointed by the Minister. They have rights of inspection over any function or care given under the MHA and are seen as 'guardians of the process', that the Act is implemented properly and rights are properly respected.

Under the IDCCR Act, there are other distinct roles: **Care coordinators** are people who are appointed to bring together high-level care plans for people with intellectual disability made subject to this Act. **Care managers** are health professionals who produce care and rehab plans for people under this Act and are responsible for overseeing the implementation of these plans. **Specialist assessors** are specifically appointed psychologists or psychiatrists who provide detailed assessment about the person's eligibility for care under the Act, formulate risks, give advice on legal status and care needs and review progress.

KEY LEARNING POINTS

- People receiving care from FMHS usually have criminal justice issues.
- Fitness to stand trial, legal insanity and mental disorder (as defined in the MHA) are important legal definitions to understand.
- Clinicians advise the court about whether each test applies to a person, but ultimately these are legal tests, not clinical ones.
- The various Acts described in this section provide a legal framework for our clinical work.
- It is very important to work cooperatively with the legal officers involved in court hearings and advocate appropriately so we ensure that patients understand and participate as much as they can in these processes. It is important they feel heard and understand what is taking place.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