This audit looked at the documentation in relation to specific patient admission, discharge, referral and transfer criteria. In relation to referrals, the majority of both inpatients and community mental health patients had evidence of written referrals into the service, with most inpatients being admitted within one day of referral. However, an area for improvement would appear to be in feedback to the referrer of an admission, which was evident in less than half of the records audited. Feedback to the referrer could form part of a robust electronic system.

In relation to assessments, admission psychiatric and clinical risk assessments, these were undertaken on the majority of patients with most completed within a day of admission. Inpatients had a higher rate of full assessment, as opposed to partial assessment, than did community mental health patients. In contrast, documented evidence for physical assessments occurred in half of the inpatients and none of the community mental health patients, with several records in the community group indicating that this was not applicable as the patient was under the care of a GP or specialist.

As for assessments, the large majority of records indicated that patients had evidence of a clinical risk plan and, while there was evidence that patients had contributed to the plan, evidence for carer input was less.

For both inpatient and community mental health patients, the majority received a full or partial risk assessment within a day of discharge. Again, physical assessments were not evident for the majority of patients.

See Recommendation 1: Governance; and Recommendation 2: Patients.

3.11 The judicial system and forensic mental health services

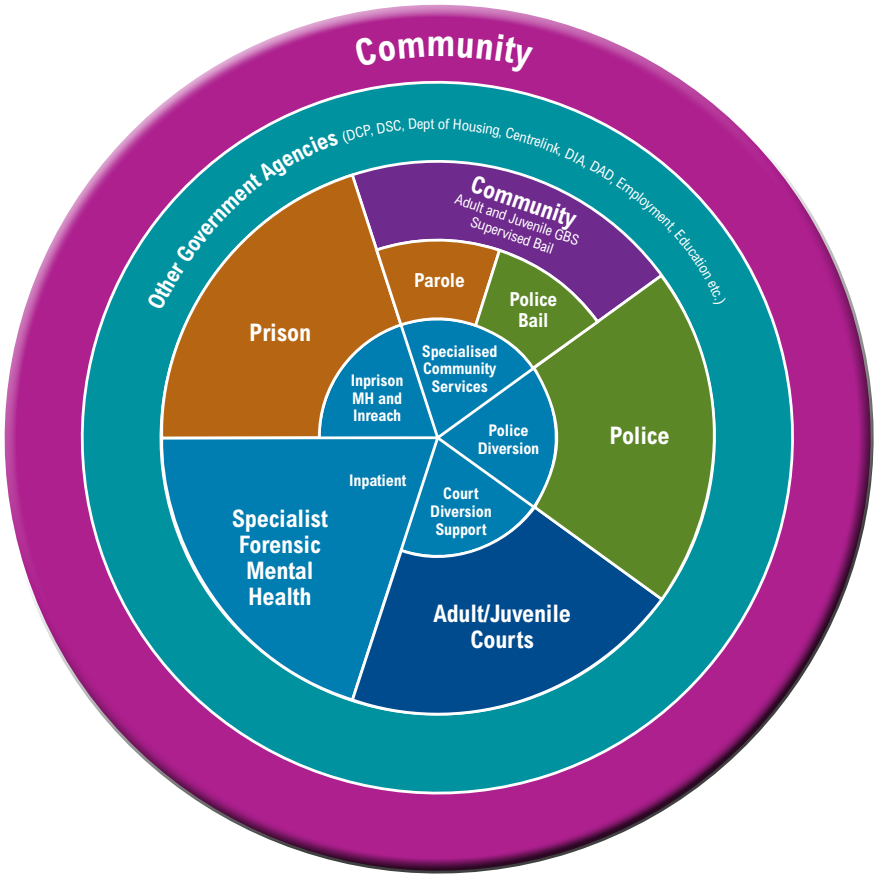
Forensic mental health care encompasses the humane and safe care of individuals who come in contact with the criminal justice system. It involves the assessment, care and rehabilitation of defendants who face charges in the courts; mentally ill offenders who are in prison or in the community; and individuals who have been found unfit to stand trial or who have been found not guilty by reason of unsoundness of mind in the District and Supreme Courts and placed on custody orders (*Criminal Law Mentally Impaired Accused Act 1996*).

Mentally ill individuals are over-represented in the criminal justice system at all levels. Of those who offend, court data cross-linked with the mental health database show that 85 per cent of court attendees have had contact at some previous stage with mental health services (Morgan et al. 2008). A UK survey of attendees at a Manchester Court showed about 5 per cent on any one day were psychotic and in urgent need of mental health care (Shaw et al. 1999).

Australian and New Zealand data clearly demonstrates the high incidence of serious mental illness in prison populations, running at around seven per cent for psychosis and 20 per cent for depressive disorders (NZ Prison Survey, Department of Corrections, Butler et al. 2005). Evidence also clearly shows that mentally ill people are consistently disadvantaged when they find themselves in the criminal justice system with higher arrest rates, higher conviction rates, higher incarceration rates and longer effective sentences because of reduced opportunities to access parole.

Furthermore, service provision to mentally ill defendants and offenders has lagged behind the provision of services to the general population and has led to the observation that mentally ill people who come in contact with the criminal justice system are among the most disadvantaged in our society.

Figure 24 **Elements and relationships of forensic mental health services, 2012**



Notes: DCP = Department of Child Protection; DSC= Disability Services Commission, WA; Dept of Housing = Department of Housing; DIA = Department of Indigenous Affairs; DAO = Drug and Alcohol Office; GBS = Adult and Juvenile Community Corrections.

Source: Dr S Patchett (2012).

The elements and relationships of forensic mental health need to be considered in the development of the mental health clinical services plan for Western Australia.

See Recommendation 1: Governance (1.1.1).

It is generally accepted that services need to be provided at the multiple levels of intersection between mentally ill people and the criminal justice system. This includes working with high-risk groups and individuals in the community prior to offending as well as providing:

- mental health presence and expertise to the police prior to arrest
- comprehensive services at the children's and adult courts to assess and intervene early and divert where possible into mental health care and away from incarceration
- comprehensive assessment and treatment services (also with specialised units in prisons)
- specialised secure inpatient care to defendants and offenders who are very unwell
- assertive community care to those released into the community from prison or on custody orders
- community care to special groups of offenders such as sex offenders, violent offenders, stalkers and arsonists
- consultation/liaison services to support general mental health services and justice-based services in the community.

3.11.1 Judicial system and adult mental health

In 2012 the State Budget provided funds for a Mental Health Court Diversion and Support Program. This Program will aim to develop a dedicated mental health and judicial support service that aims to identify mentally ill people attending court. Identifying mentally ill people will allow assessment and early intervention. Those who are able will be diverted into the community and in many instances back in contact with the mental health services that know them well.

The service will primarily aim to obtain mental health care for those who have slipped through the mental health net and fallen into the criminal justice system, often with relative minor offending combined with issues of homelessness, substance abuse, unemployment and social exclusion.

The program will also aim to reduce reoffending that may be the outcome for very disturbed/disorganised persons and subsequently reduce the burden on both adult and children's courts, on the prisons and detention centres, and on community-based programs. Funding also has been made available for specialist mental health expertise in the Children's Court.

The Court Diversion and Support Program will operate out of a separate court with a dedicated magistrate. It is envisaged the program will lead to the development of dedicated prosecution and defence functions operating in a restorative justice paradigm with some similarities with the functions of the current Drug Court in WA.

The mental health component will have a team based at the Central Law Courts equipped to respond with urgent assessment and care planning that will then inform a diversion plan mandated by the judicial officer.

In the current system, the accused are provided with assessment by court liaison clinicians from the forensic community mental health team. The forensic team explains that they identify accused persons who have a history of mental illness, by comparing arrest lists with patient records in the PSOLIS (mental health) and TOPAS (general health) information systems. When requested, a magistrate may also stand down an accused for assessment if identified in this way.

These assessments are very quick and limited by the lack of collateral information and appropriate private interview facilities. The clinicians must be able to determine if the individual is mentally ill, under the influence of substances such as drugs or alcohol, or has another cause for mental impairment.

The primary task is to assist the court in a decision about whether to impose a hospital order, which leads to admission to the Frankland Centre for seven-day assessment. In remote areas, people are sometimes held in police custody, and assessed by video link by the forensic community mental health service, before a decision to impose a hospital order is made.

The new funding and programs are promising; however, this Review considers that a revision of the *Criminal Law (Mentally Impaired Accused) Act 1996* should also be a priority. Consideration must be given to the inclusion of intellectual disability. Intellectual disability can coexist with mental illness; however, not all people with intellectual disability are in need of psychiatric care. In addition, children are currently included in the CLMIA Act, and consideration of their unique requirements needs to be taken into account.

The relationship between mental illness, criminal behaviour and passage through the criminal justice system is complex, as illustrated by the following example:

> *A young Aboriginal girl who was homeless and suffering from psychosis was arrested four times in one month for four breaches of four different 'move on notices' [Police Act 1982 amended under the Criminal Law Amendments (Simple Offences) Bill 2004 WA]. Three of the 'move on notices' were issued for erratic, unexplainable and aggressive behaviour consistent with her mental illness. After the fourth breach, the young girl appeared in front of a Magistrate who granted supervised bail. Because of the severe nature of her mental illness and disadvantaged social circumstances, she remained in custody for 20 days until her charges were finally dealt with. This incarceration for 20 days stemmed entirely from her mental condition rather than her engaging in any serious criminal misconduct that warranted her being in custody*
>
> (Eggington & Allington 2006).

The CLMIA Act enables judicial officers to make a hospital order if they suspect the accused has a mental illness. If the person is mentally ill, they will be treated under the *Mental Health Act 1996* until they become fit to stand trial. Once fit to stand trial, the courts determine culpability and if the accused is found not guilty by reason of unsoundness of mind, the courts may impose a custody order.

This affects the public mental health system with clinicians providing assessment and reports to the courts in addition to caring for patients admitted under hospital and custody orders.

The new funding announced by the Minister for Mental Health, the Hon. Helen Morton go a long way to assisting this situation.

See Recommendation 9: Judicial and criminal justice system.

3.11.2 Judicial system, the Children's Court and mental health

The President of the Perth Children's Court, Judge Denis Reynolds, informed the Review that 14,500 criminal offenses were committed in WA during 2011 and, of those, 750 (6%) had been committed by children under nine. He is concerned that the Children's Court has inadequate mental health services to meet the level of demand. Judge Reynolds explained that specialist reports addressing the child's psychiatric needs are required to assist judicial officers in determining the best outcome for children appearing in court.

In 2012 the State Budget provided funding over two years to place specialised mental health expertise within the Children's Court.

Currently, there are no specific services within the court and the forensic mental health services provide assessment and reports on an urgent 'as needs' basis. The current forensic services are insufficient. Staff do not have sick leave and annual leave cover, and the provision of reports is not timely. The court may also order psychometric testing via psychologists; however, there are long waits and the child will remain on bail, often with severe dysfunction and often without family support. Judge Reynolds explained that ideally the Children's Court would have a mental health team based in the court, with responsibility for screening all children and families.

Currently, the system does not have a 'least restrictive option' to house children safely while they wait passage through the court so they are placed in Rangeview Remand Centre ('Rangeview'), or return to their family where mental illness can regress to crises. Judge Reynolds told this Review that many children are at real risk, living in a chaotic environment and many are introduced to hard drugs and prescription medication by their parents.

The Bentley Adolescent Unit is not a secure unit (from a Corrective Services' standpoint). However, some children are placed there when they are released on supervised bail. The mix of children at the unit is a concern, as expressed by the Commissioner of Children and Young People (CCYP), and this needs immediate attention (CCYP 2011b).

The Reviewer agrees that it is not appropriate to place children and adults in the same accommodation. Nor is it appropriate to place young children (such as 11-year-olds) with well-developed adolescents and those who are serious offenders.

There are reported plans to close Rangeview and for the children to be transferred to adult prisons. This is of major concern. Western Australia requires a dedicated forensic mental health unit for children and young people.

The mental health needs of children in protective service is an ongoing concern of the CCYP. Judge Reynolds also explained that children with mental illness or criminal behaviours, who are often unfit to stand trial and become wards of the State, are often placed at Rangeview rather than with the Department of Child Protection.

Mental health services at Rangeview are limited to a psychologist assessment and children are rarely able to access psychiatric assessment. The environment is essentially one of incarceration and punishment. Without access to mental health care, the condition of these children can deteriorate rapidly.

The CCYP also raised concern that there are no suitable facilities for young mentally impaired accused made subject to a custody order. She explained that children on remand and bail at the Bentley Adolescent Centre as well as at Rangeview and the Banksia Hill Detention Centre are not protected by the Mental Health Review Board. Commissioner Michelle Scott suggests the CLMIA Act should be reviewed to ascribe special consideration for children, particularly regarding the potential in the *Act* for indefinite detention (CCYP 2011a).

In Scott's submission to this Review, the Commissioner of Children and Young People offered three recommendations in relation to children and judicial system:

1. Priority is given by the mental health service to the assessment, referral, admission and continuity of treatment of children and young people in the out-of-home care or leaving care.
2. A dedicated forensic mental health unit for children and young people be established.
3. Children and young people appearing before the Children's Court of WA have access to appropriate, comprehensive mental health assessment, referral and treatment services.

This Review fully supports the Commissioner's recommendations.

This Review also supports the recommendation of the Review of the *Criminal Law (Mentally Impaired Defendants) Act 1996* (Holman 2003). In addition, the concern expressed for consideration of children in that report and those by Commissioner of Children and Young People above are echoed here.

It is essential that WA has a mental health team including a psychiatrist to address the needs of children in protection. The Review notes that:

- Pre-teen children who appear in criminal justice system need particular care.
- Services to meet the needs of child and adolescent health need to be developed.
- Court liaison processes must be timely and proactive to the needs of the court and at the time of court appearances.

Children aged 10 and older charged with criminal behaviour appear in the Children's Court. Those nine years and under receive intervention by the Department of Child Protection.

Judge Reynolds informed the Review that the best possible mental health investment is in young people. However, the system appears to have invested most heavily in adult mental health where there are poorer opportunities for recovery. The Public Health Association of Australia also promotes investing in strategies and programs to support the early years that increase the life chances of children and ameliorate the adverse effects of social disadvantage on health (PHAA 2009).

See Recommendation 1: Governance (1.5); and Recommendation 8: Children and youth (especially 8.10.5).

3.11.3 Department of Corrective Services

Mentally ill people are over-represented in prison populations throughout the Western world. Many prisoners suffer with comorbid substance abuse disorders and the prison population in WA is no exception.

A survey of the health of Australia's prisoners indicates that one in three prisoners has a mental disorder and one in five is taking medication to treat their mental illness (AIHW 2011). One in 10 seeks assistance for psychological and mental health issues while in custody (AIHW 2011b).

There has been no specific survey of the WA prison population of 5000 prisoners. However, at any given time about 615 patients are receiving mental health care—an estimated 50 per cent of the total number of prisoners who need mental health services.

While these figures reflect disadvantage and poor resourcing of mental health services, custody also offers a unique opportunity to address the needs of mentally ill people who would otherwise go untreated.

The Deputy State Coroner expressed concern to this Review that prisons could be described as a catchment for patients with mental illness. Similarly, the Director of the State Forensic Mental Health Service claimed that prison services have been likened to an acute mental health intensive care unit, with an average length of stay of three to five years, and that they provide care to more persons with psychiatric illness than any other mental health service.

It is reported that 10 per cent of juveniles in prison have major psychiatric illness (not including mental impairment) and that 8–10 per cent of these are affected by head trauma, substance abuse or foetal alcohol syndrome. In addition, approximately 50 per cent of WA's mentally impaired accused persons detained under custody orders are in prison (14 people) and there are no specific services for them. These patients are vulnerable within the prisons and the community.

The Department of Corrective Services governs prison medical services that provide physical and psychiatric care for patients in prisons. In most prisons, psychiatrists are

appointed on a sessional basis and report to the Deputy Governor of the prison services. Recently a psychiatrist position was contracted from the Frankland Centre, with the intention that the position will provide specialist clinics and clinical governance for the private psychiatrists delivering prison services.

Mental health nurses are employed within the prison system. After hours, psychiatrists and medical officers are on call and nursing support is limited. There is a prison addiction service team (PAST) who assess and manage co-occurring drug and alcohol conditions.

Staffs receive ongoing training, including a weekly teleconference and 'Scopia,' an education program led by the College of GPs. Regular case discussions with the psychiatrist further educate and support the staff and enhance patient care.

When first imprisoned, prisoners are assessed by the mental health nurse or GP and referrals are made to psychiatrists when needed. Medical and nursing staff do not have access to PSOLIS and use an independent electronic system (ECHO) to record assessments, interventions and discharge information.

The process of care includes developing management and treatment plans. If the patient has a family and the patient consents to their involvement, the family is involved in the discharge plan.

When patients need acute hospital care, specialised physical and psychiatric care is provided under conditions of security in public hospitals and the Frankland Centre. Within prisons, secondary mental health care is provided in crisis care units, the prison infirmary and safe cells. Non-acute health care is provided within the prison living environment and clinics. Mental health nurses review and follow-up patients on a day-to-day basis.

When release is planned, prisoners receive a medical summary, appointments for follow-up care and an exit interview. The prison health services are not always informed that the prisoner is being released. Some prisoners are released directly from court following successful bail applications and others are transferred to another prison. Sudden 'leaving' is common for younger prisoners.

The judicial system does not have processes to notify the treating psychiatrists of the intent to release a prisoner and there is no mandate or formal process to follow up the care of prisoners once released. Ensuring continuity of mental health care once patients are released is very difficult, but it is especially important within the first three months of release when rates of relapse and suicide are increased (personal communication Dr E Petch, Forensic Unit 2012).

The Director of Medical Services for the Department of Corrective Services, Dr Roslyn Carbon, is currently addressing the difficulty of communicating patients' treatment plans. An objective is to ensure that a discharge plan is completed and that continuity of treatment is provided for prisoners likely to be released using the 'Fit to Travel' mandate. This mandate provides an opportunity for doctors to undertake a clinical assessment before transfer. This service can be augmented with a mental health discharge plan and a letter that prisoners can bring with them to their transfer destination. The medical officer can also request transfer to a prison close to hospital.

The high rate of homelessness and sudden discharge from bail and court proceedings complicate follow-up from the Forensic Community Mental Health Service. Unlike hospital services where the patient can remain in hospital while seeking accommodation, prisoners must leave immediately they are released. The Department of Corrective Services has no model (or step-down facility) to ensure patients have accommodation (personal communication Dr Carbon 2012).

For Aboriginal persons, a recent COAG-funded 'Bridging the Gap' program has enabled improved follow-up care. Arranging community care for others is problematic because some community mental health services are reluctant to accept referrals, especially for adolescents. The Director of Medical Services for Corrective Services informed the Review that rural CMHS accept prisoners more readily than those in the metropolitan and some CMHS have good relationships with prisons and remain involved in care while the patient is serving their prison sentence.

Dr Carbon stated that too often the services' 'attempts to find' the patient to provide outreach results in no follow-up. Clinicians informed the Review that many of these patients do not meet their eligibility criterion. In fact, many meet the services' 'exclusion criteria' because of a history of violence or because they are homeless. The Review observed that the services' triage process of writing letters in response to referrals rather than contacting them by other modes limits the ability of ex-prisoners to respond since many prisoners are homeless and some are illiterate. The referral process effectively disenfranchises prisoners from community care.

The Chief Executive of Acacia Prison provided an example of psychiatric care in prison to the Review. There are 1000 prisoners at Acacia, 40 per cent of whom have a mental illness. At any one time, 10 per cent are experiencing active psychosis. Two full-time GPs (Monday to Friday) and three FTE mental health nurses (seven days a week) provide health and psychiatric care within the prison. A memorandum of understanding with psychiatric services enables three sessions of psychiatrist consultation per week. No mental health staff are on duty overnight.

Prisoners are transferred to the Frankland Centre for stabilisation of acute disorder that cannot be managed within the prison. There is an effective relationship between the prison and the Frankland Centre. This relationship includes reciprocal visits of clinicians between the Frankland Centre and Acacia Prison to foster understanding of environments, service characteristics and an understanding of service limitations (personal communication P McMullen, CE Acacia Prison June 2012).

The three challenges of good practice in mental health care for prisons relate to transition points:

1. *The waiting time for an inpatient bed at the Frankland Centre when the patient is too ill to be cared for in the prison.*
2. *The precipitant discharge of the prisoner back to prison in response to the need to admit a new patient to the Frankland Centre when the prisoner may not have been fully treated.*
3. *The delay in responses from community services when the prisoner is released*

(personal communication P McMullen June 2012).

Prisoners have access to physical and mental health care; however, rehabilitation services in a therapeutic environment are also required for their recovery. An example of a successful model is Broadmoor, a high-security psychiatric hospital in Berkshire, England (personal communication P McMullen 2012).

Community mental health clinicians remarked that when patients receive regular medication in prison they are in relatively better mental health on discharge. Clinicians informed this Review that a secure step-down unit would provide an environment where patients could receive continued care as they safely transitioned into the mainstream community.

The Principal Solicitor and General Manager of the Mental Health Law Centre, Sandra Boulter, informed the Review that there are serious unmet mental health needs within the prison population and that, for many prisoners, mental health deteriorates during incarceration. She also observed that unwell patients in prison do not always receive medications (personal communication S Boulter, Mental Health Law Centre 2012).

A prison peer support volunteer also said that prisoners rarely receive prescribed anti-psychotic medication in prison because the medications are often traded or stolen. These concerns need to be addressed by the Department of Corrective Services.

The Deputy State Coroner advised the Review that to ensure patients receive treatment to alleviate their mental illness, the Department of Corrective Services requires a regular prison psychiatrist presence to enable compliance. She observed that community treatment orders (CTOs) are a mechanism used to enhance compliance with treatment by involuntary patients under the Mental Health Act 1996. She suggested that CTOs be applied to the prison setting. The orders require a treating psychiatrist to take responsibility that the patient receives treatment. Prison mental health care does not extend to rehabilitative care (personal communication Dr S Petch 2012).

See Recommendation 2: Patients; Recommendation 3: Carers and families; and Recommendation 9: Judicial and criminal justice system.

3.11.4 Forensic mental health – Frankland Centre

The Frankland Centre ('Frankland') is WA's only forensic secure inpatient mental health facility. It has 30 beds and is located on the Graylands Hospital campus. The centre was opened in 1993 with the current complement of secure beds. There has been no addition to the bed stock in 20 years despite a significant increase in demand brought about largely by the proclamation of the Criminal Law (Mentally Impaired Accused) Act 1996 in 1997. Clinicians informed the Review that the mix of patients at Frankland comprises approximately 50 per cent from prison, 30 per cent on hospital orders (ordered by a judicial officer of the court, see CLMIA Act Pt 2 s 5) and 20 per cent referred from community health services, predominantly the forensic mental health team.

Inpatient length of stay at Frankland has some unique features:

- Patients under hospital orders usually have a length of stay of seven days.
- Patients admitted under custody orders (those unfit to stand trial or those found 'not guilty for reason of unsound mind') can remain at Frankland for very lengthy periods, often years.
- Patients admitted with psychiatric illness from prison remain until their condition stabilises or unless treatment is disrupted when a bed must be found to accommodate a new admission. In these circumstances, one patient must be moved into prison to make space for the individual on a hospital order from the court. (personal communication S Boulter, Mental Health Law Centre 2012).

Patients from court are admitted within two hours; however, prisoners who require psychiatric care at Frankland sometimes wait up to three or four weeks in prison before a bed becomes available.

The Review heard unanimously from the Director of the State Forensic Mental Health Service, from clinicians within it, from the Deputy State Coroner, from the Mental Health Law Centre and from the Director of Health Services, Department of Corrective Services that the current number of secure beds in the Frankland Centre is highly inadequate to meet demand.

The Review heard that if new secure forensic hospital beds are built they should be close to a prison, such as on the Hakea Prison campus, next to—but outside—the prison walls and designated 'authorised beds' under the *Mental Health Act 1996*. As well as recommendations for a significant increase in total beds, there is a widespread call for designated units or wards specifically for women, adolescents, Aboriginal prisoners and rehabilitation.

Clinicians informed the Review that sudden discharges sometimes occur on Fridays when the prison mental health staffing is minimal. Frankland's contingency is to prepare the 'most well' patient for transfer. Clinicians explained to the Review that when patients are transferred back to custody, the prison's risk management system sometimes requires a prisoner to be kept in a safe cell in an anti-suicide gown until they have been assessed by a psychiatrist, which can take three days or longer. During this period, patients are cared for by nursing staff. Some patients are transferred to the crisis care unit at Casuarina prison.

The Review was informed that accused persons on hospital orders might travel long distances to be assessed at WA's only forensic inpatient service, even in situations of a minor offence. A system is needed to enable people to be assessed locally by video-link in rural courts.

At Frankland, patients develop and sign their care plan with nursing staff and keep a copy along with a copy of their safety plan. Their safety plan contains identified triggers of agitation and is reviewed each two weeks with the patient.

Carer involvement is encouraged by the social worker who contacts the family to obtain collateral information and to provide families with appropriate involvement. Families are invited to face-to-face interviews with the treatment team. However, families are often disengaged because of the joint stigma of mental illness and imprisonment and have often disengaged well before the patient's involvement with the criminal justice system.

The social worker at Frankland commented that by the time patients arrived at Frankland they have usually committed a serious offence. Criminal behaviour is often the result of the longstanding difficulty that these patients and carers have in accessing care in the community, and families often express gratitude that the patient is finally receiving treatment.

Another concern expressed by the clinicians was the vulnerability of female patients in a male-dominated environment populated by sometimes seriously dangerous fellow patients. It was strongly felt that a female-only unit is needed to provide a more protective and appropriate therapeutic environment. It was also drawn to the attention of the Review that the admission of juveniles to Frankland presents significant problems and risks and there was a very strong call for the establishment of a dedicated juvenile secure inpatient unit.

When patients are transferred back to prison, discharge plans are faxed and a copy is sent with the patient. However, Frankland staff are concerned that the care and treatment plans are not always continued. Clinicians expressed concern that persons who are transferred to prison are often not well enough for discharge from Frankland and yet treatment compliance cannot be assured. Opinion is divided on whether this situation could be improved by having community treatment orders available in prisons with the capacity to enforce treatment. This issue also has been raised by the Deputy State Coroner who explained to the Review that in the absence of involuntary mental health provisions, the mental health of patients often deteriorates on return to prison.

When discharge occurs as the result of a court directive (bail or community based order), the Psychiatric Report provides a discharge plan that includes arrangements for accommodation, a treatment plan and appointment with the community mental health service. These are required to satisfy the judicial officer that the patient will receive continuity of care in the community.

The entry and discharge of patients at Frankland is very often outside the control of clinicians but the scarce acute service resource is managed very tightly by the lead clinician in the inpatient team. However, once patients arrive, the admission and care process appear to be of high quality. There are opportunities to improve hospital follow-up when patients are transferred to prison and the community.

See Recommendation 1: Governance (1.2; 1.5; 1.6); and Recommendation 9: Judicial and criminal justice system.

3.11.5 Forensic community mental health

The Community Forensic Mental Health Service (CFMHS) is charged with four key functions:

1. Court liaison services.
2. Assertive care to seriously mentally ill high-risk offenders.
3. Consultation/liaison, advice and support to general mental health services.
4. Targeted clinics for people with problem behaviours such as sex offences, stalking and arson.

The CFMHS currently fulfils three of these functions— providing court liaison (face-to-face assessments in the metropolitan area and video-link assessments in rural and remote areas) and assertive care to a cohort of 'forensic patients' in the metropolitan area.

Referral sources include Frankland, community mental health services, courts and prisons. The services are limited to managing patients with a high risk of reoffending and there is a three-month waiting list for some services, for example, community service consults.

Usual care comprises weekly contact with the patient by the multidisciplinary team and six-weekly medical reviews. Eight clinicians have caseloads of eight patients each. Many visits are undertaken in pairs. However, if the patient resides in a supported hostel, clinicians visit alone.

The CFMHS does not have offices, and clients are more often visited in their homes or in public places. Some 'mainstream' community mental health services provide clinic space for the forensic team and patients can attend these clinics. Many other community mental health services are unable to accommodate the forensic team. Clinicians explained that even though non-forensic services deal with patients at much higher risk, the 'fear' and stigma of forensic clients deters community mental health services from accommodating the forensic clinics.

Forensic clinicians observed that persons who are not followed up are more likely to reoffend and return to jail.

Forensic clinicians are concerned that referrals and discharge plans are often not received from the prisons and that many patients arrive home without medications. Sometimes family members have returned to the prison to pick up medications. When the prison notifies the community mental health service that a prisoner has been released, there is often no fixed address for the forensic service to make contact and information is often incomplete.

Clinicians explained to the Review that when patients are released directly (unplanned) from court, there is no process to notify the community mental health services, which either delays follow-up or results in no follow-up. This is a serious problem. When psychiatric conditions are untreated, it is more likely that a crime and reimprisonment will reoccur.

Forensic clinicians said ex-prisoners often miss out on the mental health care to which they are entitled because the psychiatric services in prisons, the judicial system and the community are not connected.

This differs in some rural areas. Over the past 12 years, the Broome mental health services have embraced the regional prisons as part of the community that they service. The model is based on the British Columbian approach and recognises that imprisoned patients with mental illness are known to have the highest risk of suicide.

The service process is formalised with Department of Corrective Services by a Service Agreement and the community mental health services are paid an annual sum to provide services. The case manager and triage clinicians attend the prison each week, along with a registrar/consultant to provide care for prisoners.

The Kimberley mental health services said they need a court liaison position to identify the people who require services and to track the patients who are released to ensure community follow-up occurs.

In the Midwest, minimal inreach is provided into the prison; however, patients are referred to the community mental health services on release. The local prison would like a local psychiatrist to supply care rather than the fly-in private psychiatrist system currently in use.

In the Children's Court, forensic clinicians explained they provide a limited 'as needs' service and It is imperative to develop a robust court liaison service and system to support the judicial system and mental health services in the Children's Court, as occurs in the adult system.

The Review finds that WA also needs dedicated services for forensic adolescents. There is no forensic unit for adolescents and accommodating young people is difficult. The Bentley Adolescent Unit is not appropriate for accommodating physically violent adolescents on remand. The only services with outreach are YouthLink and Youth Reach South.

A passport system is a solution to assist continuity of patient care with better information across treatment settings. If carried by the patient, illness and treatment plans would thereby be available for prison and community mental health services.

See Recommendation 1: Governance (1.1.1); and Recommendation 9: Judicial and criminal justice system.

3.12 Inpatient mental health facilities and services

The public mental health services provide mental health care for children, adolescents, adults and older people. This care is provided in hospital inpatient services, residential services, community mental health clinics, and in the community.

Figure 25 outlines the patient pathway through the mental health system. On considering the patient pathway and questioning the clinicians, this Review has observed that the flow is somewhat fractured by the required screening at entry to each component.