Census of Forensic Mental Health Services 2005

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1 Introduction

Forensic mental health services were first established in New Zealand as a response to the issues raised in the Mason Report, which presented the findings of the Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in relation to Admissions, Discharge or Release on Leave of Certain Classes of Patients 1989 (Mason 1988). Regional forensic services were established in Auckland, Wellington, Wanganui, Hamilton, Christchurch and Dunedin. These services were in addition to the National Secure Unit at Lake Alice Hospital. The role of these regional services was to assess, treat and rehabilitate people with a mental illness who had, or were alleged to have, committed a crime and those who were likely to offend.

The *National Study of Psychiatric Morbidity in New Zealand Prisons* (Department of Corrections 1999) was produced after the Ministries of Justice and Health sought more information on mental illness in the prison population. It found that, in comparison with the general population, a disproportionately high number of prisoners have mental illness. While the National Study was being undertaken, the Ministry of Health began developing a framework for forensic mental health, *Services for People with Mental Illness in the Justice System* (Ministry of Health 2001a). As part of the development process, a census and qualitative survey of forensic services (as at September 1999) was completed.

Since that framework was developed a number of changes have occurred within the wider environment of forensic services.

- The National Secure Unit at Lake Alice Hospital has closed and replacement beds have been located within regional forensic inpatient units.
- Additional services, including inpatient and prison liaison services, have been put in place.
- Legislative arrangements have changed, with the replacement of part 7 of the Criminal Justice Act 1985 by the Criminal Procedure (Mentally Impaired Persons) Act 2003, and with the enactment of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.
- New inpatient services have been put in place for the secure compulsory care of people with intellectual disability.
- New community services have been developed for people with intellectual disability and a history of offending.
- Intersectoral initiatives are occurring or are in development for meeting the mental health needs of children and young people in the youth justice system (under the Children, Young Persons and their Families Act 1989).
- Prison musters have increased, and new prisons have been (and are being) built.

As a result of these environmental changes, there have been a number of changes to the configuration of forensic services within New Zealand.

In October 2005 a new census of forensic services was carried out. This census had wider coverage than the 1999 census, and information was collected on:

- forensic inpatients and community-based forensic service users at all regional forensic services, and Hauora Waikato, as at 10 October 2005
- prison liaison service users as at census date (10 October 2005), and prison liaison service activity for the month from 10 October to 10 November 2005
- court liaison service activity for the month from 10 October to 10 November 2005, and court reports prepared in the month from 10 October to 10 November 2005
- bed numbers and staffing levels at all regional forensic services, and Hauora Waikato.

These bullet points reflect the structure of sections 2 to 5 of this document.

Services were also asked to provide qualitative answers to 11 questions, including which population groups each service felt they were serving well, the major problems they faced, and their views on the direction the service framework should take in order best to meet need in the future. The answers given to these questions are summarised in section 6 of this report.

The census did not cover specialised youth services or intellectual disability services. With some exceptions, most mental health services to youth who are in contact with the youth justice system are not provided by the forensic service providers included in this census. While a small number of service users captured in the census were below 20 years of age, the census data primarily covers people in contact with the adult justice system.

2 Inpatient and Community Census

This section provides a general overview of the results from the inpatient and community-based forensic service user census of 10 October 2005. It does not include people who are in prison or the court system. Where possible, comparisons are made between the figures obtained in 2005 and the 1999 data. More detailed analysis has also been included where individual regions differ from the overall general results.

The following forensic inpatient facilities exist in New Zealand:

- Mason Clinic, Auckland; 84 beds; Auckland Regional Forensic Service (RFS)
- Henry Rongomau Bennett Centre, Hamilton; 40 beds; Waikato RFS
- Stanford House, Wanganui; 10 beds; Central RFS[1]
- Ratonga-Rua-o-Porirua, Porirua; 40 beds; Central RFS
- Hillmorton Hospital, Christchurch; 34 beds; Canterbury RFS
- Wakari Hospital, Dunedin; 13 beds; Otago/Southland RFS.

Hauora Waikato also provides 15 'step-down' inpatient beds for forensic patients who are being transferred out of secure care.

Community-based services are provided by the five regional forensic services plus Hauora Waikato. However, in the Otago/Southland region, services are provided separately within each District Health Board (DHB) region.

2.1 Number of service users

On 10 October 2005 there were 380 users of inpatient and community services. This compares to 445 service users in 1999, a reduction of 65 (15%).

Within this overall reduction there is significant regional variation in both the direction and magnitude of change. Auckland and Waikato have seen an increase in total service users, in Auckland driven in large part by the continued development of community-based forensic services. Decreases in other regions were due mainly to lower numbers of community-based service users, with inpatient numbers increasing in Canterbury despite a decrease in overall numbers. The overall number of service users in the South Island decreased by 91 (46%). This significant change may indicate that former users of community-based forensic services are now managed by other adult mental health services. On the other hand, there may now be greater levels of unmet need in the South Island than five years ago.

[1] Stanford House is part of Good Health Wanganui and is managed separately from Central RFS beds in Porirua. However, the two facilities cover the same region, and are considered to both be part of Central RFS for the purposes of this report.

Table 1: Inpatient and community-based forensic service users, 1999 and 2005

Region	Number of service users		% change
	1999	2005	
Auckland	81	119	*47*
Waikato*	70	75	*7*
Central	96	79	*–18*
Canterbury	124	67	*–46*
Otago/Southland	74	40	*–46*
TOTAL	445	380	*–15*

* The 2005 census includes Hauora Waikato patients, who were not included in the 1999 census.

The mix of inpatient and community services users has also changed. In 2005, 215 (57%) were inpatients and 165 (43%) were community-based forensic service users. In 1999 there were 189 (42%) in inpatient facilities and 256 (58%) using community-based services.

The number of forensic inpatients nationwide increased by 14% (26) between the two census dates, and community forensic service user numbers decreased by 36% (91). This decrease is the result of service users moving to general, non-forensic mental health services in the community.

Table 2: Inpatient and community-based forensic service users, by region, 1999 and 2005

Region	Inpatient			Community		
	1999	2005	*% change*	1999	2005	*% change*
Auckland*	61	72	*18*	20	47	*135*
Waikato	29	43	*59*	41	32	*–22*
Central	58	53	*–9*	38	26	*–32*
Canterbury	27	33	*22*	97	34	*–65*
Otago/Southland	14	14	*0*	60	26	*–57*
TOTAL	189	215	*14*	256	165	*–36*

* At the time of the census, nine inpatient beds in Auckland's Rimu unit were closed due to construction.

2.2 Age

As shown in Table 3, in October 2005 age range patterns for both inpatient and community forensic service user groups were quite similar. Eighty-seven percent (186) of inpatients and 92% (151) of community forensic service users were 25 years old and

over. Fifty-two percent (112) of forensic inpatients and 61% (101) of forensic community forensic service users in 2005 were over the age of 35 years.

Table 3: Age of forensic inpatient and community-based service users, 10 October 2005

Age group	Inpatient	Community	TOTAL
< 20 years	6	1	7
20–24 years	23	13	36
25–34 years	74	50	124
35–44 years	62	62	124
45+ years	50	39	89
TOTAL	215	165	380

2.3 Referral source

2.3.1 Referral sources to inpatient and community-based forensic services

As in 1999, the major sources of forensic inpatient referrals in 2005 were courts (32%), prisons (25%) and other regional forensic services (20%). For forensic community service users, as might be expected, the major referral source was from forensic inpatient units (56%), followed by prisons (17%).

Table 4: Referral sources to inpatient and community-based forensic services, 1999 and 2005

Referral source	Inpatient				Community			
	1999		2005		1999		2005	
	Number	%	Number	%	Number	%	Number	%
Court	67	*35*	68	*32*	22	*9*	11	*7*
Prison	44	*23*	53	*25*	18	*7*	28	*17*
Department of Corrections	–	–	–	–	5	*2*	1	*1*
Child, Youth and Family	–	–	–	–	1	*0*	–	–
Police	–	–	5	*2*	3	*1*	–	–
Forensic inpatient units	–	–	–	–	137	*54*	92	*56*
Forensic community team	5	*3*	6	*3*	4	*2*	–	–
Other regional (or sub-regional) forensic services	27	*14*	42	*20*	2	*1*	13	*8*
National Secure Unit	9	*5*	5	*2*	–	–	–	–
Non-forensic adult inpatient units	26	*14*	17	*8*	12	*5*	9	*6*
Other adult mental health services	–	–	11	*5*	43	*17*	8	–
Child and youth mental health services	–	–	6	*3*	1	*0*	–	–
Intellectual disability service	2	*1*	–	–	1	*0*	–	*56*
Self-/GP-referral	–	–	–	–	6	*2*	–	*8*
Unknown/missing data	9	*5*	2	*1*	1	*0*	3	*6*
TOTAL	189	*100*	215	*100*	256	*100*	165	*100*

Regional variations in referral source were significant. For example, all of Auckland's 47 community-based forensic service users in 2005 were referred from forensic inpatient services, as were 25 (74%) in Canterbury and 19 (59%) in Waikato. However, most referrals (18, 69%) for community-based forensic service users in Central were from the prisons, and only one (4%) was referred from a forensic inpatient unit. Likewise, eight (31%) of Otago/Southland's community-based forensic service users were referred from non-forensic adult inpatient units, another eight (31%) from the courts, and there were no referrals at all from forensic inpatient services.

These variations may indicate significant differences in coding practice between regions. On the other hand, there may be real significant regional differences; for example, in terms of willingness to provide community-based services to ex-inmates.

Table 5: Sources of referrals to inpatient and community-based forensic services, by region, 10 October 2005

Service	Referral source	Auckland	Waikato	Central	Canterbury	Otago/ Southland	TOTAL
Inpatient	Prison	34	4	9	6	–	53
	Court	15	–	25	4	8	68
	Police	4	–	1	–	–	5
	Forensic community team	4	–	1	–	1	6
	Other regional (or sub-regional) forensic services	7	7	13	12	3	42
	National Secure Unit	3	–	2	–	–	5
	Non-forensic inpatient units	3	–	1	11	2	17
	Other mental health services	1	16	–	–	–	17
	Unknown	1	–	1	–	–	2
	Inpatient total	72	43	53	33	14	215
Community	Prison	–	4	18	5	1	28
	Court	–	–	1	2	8	11
	Department of Corrections	–	–	1	–	–	1
	Forensic inpatient units	47	19	1	25	–	92
	Other regional (or sub-regional) forensic service	–	8	–	–	5	13
	Non-forensic inpatient units	–	–	–	1	8	9
	Other mental health services	–	1	2	1	4	8
	Unknown	–	–	3	–	–	3
	Community total	47	32	26	34	26	165
TOTAL		119	75	79	67	40	380

2.3.1 Destination of referrals out of inpatient units

Of the 199 forensic inpatients in 2005, 45 (21%) had already been referred out of the unit at census date, 67% of whom had been referred to either supported accommodation (22) or to the forensic community team (8). The remainder of the referrals were distributed over a range of destinations, as shown in Table 6.

Table 6: Destination of referrals out of forensic inpatient units, 10 October 2005

Destination of referrals	Number	%
Supported accommodation	22	*49*
Community-based forensic services	8	*18*
Rehabilitation	5	*11*
Intellectual disability units	5	*11*
Another regional forensic service	3	*7*
Missing data	2	*4*
TOTAL	45	*100*

2.4 Legal status

Fifty percent (189) of forensic inpatients and community-based service users were subject to compulsory treatment orders in 2005, and a further 39% (147) were either special or restricted patients. Most (103) special and restricted patients were forensic inpatients. There were three forensic inpatients who were care recipients or special care recipients under the Intellectual Disability Act, and 34 (21%) community-based service users accessed services on a voluntary basis.

Because legal status was analysed in a different way in 1999, no comparison is possible between the two data sets.

Table 7: Legal status of forensic inpatient and community-based service users, by service, 10 October 2005

Legal status	Inpatient		Community	
	Number	%	Number	%
Patients subject to a compulsory treatment order	96	*45*	93	*56*
Special/restricted patients	113	*53*	34	*21*
Care recipients / special care recipients under Intellectual Disability Act	3	*1*	–	–
Voluntary patients	–	–	34	*21*
Data missing/unclear	3	*1*	4	*2*
TOTAL	215	*100*	165	*100*

Table 8 below shows which section of the Mental Health Act was relevant in the case of each forensic inpatient and community-based service user who was subject to a compulsory treatment order in 2005. Section 30 was used in respect of 98% (94) of inpatients, whereas section 29 applied to 90% (84) of community-based service users. In both groups, civil committals initiated while not under section 45 were the most common legal status, followed by committals following conviction.

Table 8: Forensic inpatient and community-based service users subject to compulsory treatment orders, 10 October 2005

Section (description)	Inpatient		Community		Total	
	Number	%	Number	%	Number	%
s29 (unfit to stand trial)	–	-	9	*10*	9	*5*
s29 (insane)	1	*1*	13	*14*	14	*7*
s29 (conviction)	–	–	19	*20*	19	*10*
s29 (civil committal initiated while under s45)	–	–	11	*12*	11	*6*
s29 (civil committal initiated while not under s45)	1	*1*	30	*32*	31	*16*
s29(3)(a) (temporary transfer)	–	–	2	*2*	2	*1*
s30 (unfit to stand trial)	8	*8*	–	–	8	*4*
s30 (insane)	11	*11*	–	–	11	*6*
s30 (conviction)	21	*22*	2	*2*	23	*12*
s30 (civil committal initiated while under s45)	18	*19*	2	*2*	20	*11*
s30 (civil committal initiated while not under s45)	29	*30*	2	*2*	31	*16*
s30 (unspecified)	7	*7*	–	–	7	*4*
s31 (on leave)	–	–	3	*3*	3	*2*
TOTAL	96	*100*	93	*100*	189	*100*

Table 9 shows the specific legal provisions relating to special and restricted patients in 2005. Eighty-five percent (29) of special or restricted patients who were community-based forensic service users had been found to be insane, as had 44% of special or restricted forensic inpatients. Overall, there were six (4%) restricted patients nationwide.

Table 9: Special and restricted forensic inpatient and community-based service users, 10 October 2005

Section (description)	Inpatient		Community		Total	
	Number	%	Number	%	Number	%
CP s23 (insane or unfit to stand trial)	2	*2*	–	–	2	*1*
CP s24(2)(a) (unfit to stand trial)	16	*14*	4	*12*	20	*14*
CP s24(2)(a) (insane)	50	*44*	29	*85*	79	*54*
CP s34(1)(a)(i) (hybrid order)	1	*1*	–	–	1	*1*
CP s35 (convicted remand)	2	*2*	–	–	2	*1*
CP s38(2)(c) (pre-trial remand)	7	*6*	–	–	7	*5*
CP s44(1) (pre-trial remand)	10	*9*	–	–	10	*7*
MH s45 (and s11) (prison transfer)	2	*2*	–	–	2	*1*
MH s45 (and s13) (prison transfer)	8	*7*	–	–	8	*5*
MH s45 (and s30) (prison transfer)	9	*8*	–	–	9	*6*
MH s45 unspecified	1	*1*	–	–	1	*1*
MH s55 (restricted patients)	5	*4*	1	*3*	6	*4*
TOTAL	113	*100*	34	*100*	147	*100*

There is some regional variation in the legal status of forensic inpatients. In particular, 74% (39) of Central inpatients were special or restricted patients, as against 53% (113) nationally and 33% (11) in Canterbury.

Table 10: Legal status of forensic inpatients, by region, 10 October 2005

Legal status	Auckland	Waikato	Central	Canterbury	Otago/ Southland	TOTAL
Patients subject to compulsory treatment order	37	19	13	21	6	96
Special/restricted patients	33	22	39	11	8	113
Care recipients / special care recipients under Intellectual Disability Act	1	1	1	–	–	3
Voluntary patients	–	–	–	–	–	–
Data missing/unclear	1	1	–	1	–	3
TOTAL	72	43	53	33	14	215

2.5 Index offence

2.5.1 Nature of offending

In 1999 violence or the threat of violence was the index offence for 69% of forensic inpatients and 52% of community forensic service users for which this data was available. Combining these two groups, violence or the threat of violence accounted for 58% of index offences. The next most common index offences were wilful damage/trespass (11%) and sexual offences (8%).

Similarly, violent offences were the most common category of index offence among inpatient and community forensic service users in 2005 (225 or 59%). The next most frequent category was sexual offences, which accounted for 34 (9%) of index offences, followed by offences against a person (30 or 8%).2

Table 11: Index offences of forensic inpatient and community-based service users, 10 October 2005

	Inpatient		Community		TOTAL	
Index offence	**Number**	***%***	**Number**	***%***	**Number**	***%***
Violent offences	118	*55*	107	*65*	225	*59*
Sexual offences	21	*10*	13	*8*	34	*9*
Other offences against a person	18	*8*	12	*7*	30	*8*
Arson	18	*8*	8	*5*	26	*7*
Property offences	15	*7*	9	*5*	24	*6*
Offences against good order	9	*4*	5	*3*	14	*4*
Drug offences	0	*0*	4	*2*	4	*1*
Traffic offences	3	*1*	1	*1*	4	*1*
Other offence	3	*1*	3	*2*	6	*2*
Unknown offence	4	*2*	2	*1*	6	*2*
No offence	6	*3*	1	*1*	7	*2*
TOTAL	215	*100*	165	*100*	380	*100*

2.5.2 Years since index offence

Nationally, 19% (71) of forensic inpatients and community-based forensic service users committed their index offence less than a year before. A further 27% (103) of index

[2] Offences against a person (other than sexual or violent offences) include obstructing or resisting police or other officials, as well as sexual or intimidation offences which are not serious enough to be in the sexual offence category. Examples of such sexual or intimidation offences include unlawful sexual intercourse, doing an indecent act in a public place, doing an indecent act with or upon another person, or obscene exposure in a public place.

offences had been committed one to four years ago, 18% (67) four to eight years ago, 9% (36) eight to twelve years ago, and 11% (43) more than twelve years ago.

Sixty (28%) forensic inpatients had committed their index offence less than one year before. For a further 66 (33%) inpatients, the index offence had been committed between one and four years previously. There were 25 (12%) inpatients whose index offence had occurred over 12 years ago.

Eleven (7%) community-based forensic service users had committed their index offence less than one year before. For 33 (20%) the index offence had occurred between two and four years previously. There were 18 (11%) community-based forensic service users whose index offence had occurred over 12 years ago. No information was available, however, in relation to 50 (30%) community-based forensic service users.

Because of the high levels of missing data, comparisons with 1999 figures are limited. However, on the data available, 32% of forensic inpatients had committed their index offence less than one year prior to the census, and for 20% of patients more than five years had passed since the index offence. For the largest grouping (49%) the time span was between one and five years since the index offence. There was no corresponding information in relation to 1999 community forensic service users.

Table 12: Years since index offences for forensic inpatient and community-based service users, 10 October 2005

Years since index offence	Inpatient		Community		TOTAL	
	Number	%	Number	%	Number	%
< 1 year	60	*28*	11	*7*	71	*19*
1–2 years	27	*13*	9	*5*	36	*9*
2–4 years	43	*20*	24	*15*	67	*18*
4–6 years	23	*11*	18	*11*	41	*11*
6–8 years	10	*5*	16	*10*	26	*7*
8–12 years	18	*8*	18	*11*	36	*9*
12+ years	25	*12*	18	*11*	43	*11*
Unknown	7	*3*	50	*30*	57	*15*
N/A	2	*1*	1	*1*	3	*1*
TOTAL	215	*100*	165	*100*	380	*100*

2.5.3 Years since index offence, by region

Central had the greatest number of inpatients who had committed their index offence within the last year (23, 41% of their total). Auckland had the greatest number of inpatients (12, 17% of their total) who had committed their index offence over 12 years ago. Auckland also had the greatest proportion of both inpatient (25, 35%) and community-based service users (30, 64%) whose index offences were committed more

than six years ago. Comparisons with 1999 could not be made, as corresponding data was not reported in the last census.

Table 13: Years since index offence for forensic inpatient and community-based service users, by region, 10 October 2005

Service	Years since index offence	Auckland	Waikato	Central	Canterbury	Otago/ Southland	TOTAL
Inpatient	< 1 year	13	12	23	4	8	60
	1–2 years	8	7	4	4	4	27
	2–4 years	19	9	9	5	1	43
	4–6 years	7	5	4	6	1	23
	6–8 years	3	3	4	–	–	10
	8–12 years	9	1	4	4	–	18
	12+ years	12	5	5	3	–	25
	Unknown	1	–	–	6	–	7
	N/A	–	1	–	1	–	2
	Inpatient total	72	43	53	33	14	215
Community	< 1 year	–	–	8	2	1	11
	1–2 years	1	4	1	2	1	9
	2–4 years	6	10	–	5	3	24
	4–6 years	10	6	1	1	–	18
	6–8 years	11	–	–	2	4	16
	8–12 years	10	5	–	–	3	18
	12+ years	8	3	1	3	3	18
	Unknown	1	4	15	19	11	50
	Community total	47	32	26	34	26	165
TOTAL		119	75	79	67	40	380

2.6 Length of current admission

In 2005 the length of current admission was less than one year for 92 (43%) forensic inpatients, the largest single group in this category, as well as for 31 (19%) community-based forensic service users. The largest group of community-based forensic service users (53, or 32%) had a length of current admission of two to four years.

Twenty inpatients (10%) and 26 (16%) community forensic service users had long-term admissions of six or more years, while 47% (102) of inpatients and 65% (107) of community forensic service users had current admissions in the range of one to six

years. These figures are generally comparable to 1999 results, allowing for missing data at that time.

There may be regional differences in coding for this variable with respect to community-based service users. For example, it is not clear whether length of current admission was considered to include or exclude immediate prior admissions to forensic inpatient units.

Table 14: Length of current admission of forensic inpatient and community-based service users, 10 October 2005

Length	Inpatient		Community		TOTAL	
	Number	%	Number	%	Number	%
< 1 year	92	*43*	31	*19*	123	*32*
1–2 years	37	*17*	27	*16*	64	*17*
2–4 years	39	*18*	53	*32*	92	*24*
4–6 years	26	*12*	27	*16*	53	*14*
6–8 years	8	*4*	11	*7*	19	*5*
8–12 years	7	*3*	13	*8*	20	*5*
12+ years	5	*2*	2	*1*	7	*2*
N/A	1	*0*	1	*1*	2	*1*
TOTAL	215	*100*	165	*100*	380	*100*

2.7 Previous referrals

Nearly all (199, or 93%) of forensic inpatients had a previous referral to general adult mental health services, and 68% (146) had been previously referred to specialist forensic services. Figures were lower for community-based forensic service users, less than half (79, or 48%) of whom had been referred to forensic services in the past.

Considerable regional variation was observed in the data. For example, although all 53 forensic inpatients in the Central region had previously been referred to forensic services, the corresponding figure for Auckland was just 49% (35). Similarly, all 34 Canterbury community-based service users had previous referrals to forensics, compared with just 15% (four) of those in Otago/Southland and Central. These results may reflect coding differences.

Table 15: Previous referrals to inpatient and community forensic and adult mental health services, 10 October 2005

Service	Previous referral	Auckland		Waikato		Central		Canterbury		Otago /Southland		TOTAL	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Inpatient	Forensic	35	*49*	24	*56*	53	*100*	27	*82*	7	*50*	146	*68*
	AMHS	65	*90*	39	*91*	52	*98*	30	*91*	13	*93*	199	*93*
Community	Forensic	14	*30*	23	*72*	4	*15*	34	*100*	4	*15*	79	*48*
	AMHS	33	*70*	24	*75*	14	*54*	24	*71*	17	*65*	112	*68*

Note: AMHS = adult mental health services.

2.8 Primary diagnosis

As in the 1999 review, schizophrenia was the most common diagnosis among inpatients (157, or 71%) and community forensic service users (121, or 73%) in 2005. Table 16 compares 1999 with 2005 primary diagnosis figures for inpatient and community forensic service users. It should be noted that as well as a primary diagnosis, many people will have a secondary diagnosis that has not been recorded in this survey.

Each primary diagnosis for forensic inpatients occurred in roughly the same proportions in 1999 and 2005. However, there was an increase in the proportion of community-based forensic users with a primary diagnosis of schizophrenia from 48% to 73%. This increase was due to lower numbers of community-based forensic service users with a primary diagnosis of bipolar affective disorder, personality disorder, substance abuse and no diagnosis. The actual number of community-based forensic service users with a primary diagnosis of schizophrenia was in fact stable from 1999 (123) to 2005 (121).

Table 16: Primary diagnoses of forensic inpatient and community-based service users, 1999 and 2005

Primary diagnosis	Inpatient				Community			
	1999		2005		1999		2005	
	Number	%	Number	%	Number	%	Number	%
Schizophrenia	137	72	157	73	123	48	121	73
Psychosis not otherwise specified	11	6	9	4	8	3	10	6
Substance-induced psychosis	1	1	3	1	3	1	–	–
Bipolar affective disorder	14	7	10	5	28	11	8	5
Personality disorder	5	3	10	5	23	9	4	2
Major depression	2	1	3	1	10	4	7	4
Substance abuse	1	1	–	–	9	4	1	1
Anxiety disorders	–	–	–	–	6	2	2	1
Mental retardation	4	2	4	2	4	2	–	–
Brain injury	3	2	1	0	4	2	5	3
Delusional disorder	–	–	4	2	4	2	2	1
Adjustment disorder	1	1	6	3	1	0	1	1
Aspergers	–	–	1	0	2	1	–	–
Dementia	2	1	–	–	2	1	–	–
Post-traumatic stress disorder	3	2	–	–	2	1	2	1
Attention deficit/hyperactivity disorder (ADHD)	–	–	–	–	1	0	–	–
Huntington's chorea	2	1	1	0	1	0	–	–
Obsessive compulsive disorder	–	–	–	–	1	0	–	–
Paedophilia	1	1	1	0	1	0	–	–
No diagnosis	2	1	5	2	23	9	2	1
TOTAL	189	100	215	100	256	100	165	100

2.9 Approved leave of forensic inpatients

The most common type of leave for forensic inpatients was staff-escorted community leave, which was granted to 33% (70) of all inpatients. Twenty-seven percent (58) of forensic inpatients had had no access to approved leave.

Table 17: Approved leave for forensic inpatients, 10 October 2005

Type of leave	No. service users	*% service users*
Staff-escorted community leave	70	*33*
Staff-escorted ground leave	21	*10*
Unescorted community leave	33	*15*
Unescorted ground leave	13	*6*
Overnight leave	20	*9*
No leave	58	*27*
TOTAL	215	*100*

2.10 Residence of community forensic service users

In the 1999 census, 162 or 63% of community forensic service users lived either in their own homes or in rented accommodation. As at 10 October 2005 the number of community forensic service user numbers had decreased by 36%, from 256 to 165, and the majority, 58% (96), lived in their own homes or in rented accommodation. A further 30% (50) service users lived in supported accommodation, including 16% (27) in level 4 accommodation.

Table 18: Residence of community-based forensic service users, 10 October 2005

Residence	No. service users	% service users
Unsupervised	100	*60*
Level 1 supervised	2	*1*
Level 2 supervised	9	*5*
Level 3 supervised	12	*7*
Level 4 supervised	27	*16*
Other	10	*6*
Unknown	5	*3*
TOTAL	165	*100*

2.11 Gender

This section gives a brief overview, by gender, of inpatient and community forensic service users.

2.11.1 Service users, by gender

At the time of the 2005 census, 184 (86%) people in forensic inpatient facilities were men and 31 (14%) were women. Comparison with 1999 information shows that the number of women inpatients had nearly doubled since 1999 (from 15 to 31), making up 14% of inpatients in 2005 as compared with 8% in 1999.

Of the 165 community forensic service users in 2005, 89% (147) were male and 11% (18) were female. The number of female community-based forensic service users has dropped since 1999, when there were 27 such users, but has stayed constant in percentage terms.

Of the 31 women inpatients in 2005, 12 (39%) were located in Central, nine (29%) in Auckland, five (16%) in Otago, four (13%) in Waikato and one (3%) in Canterbury.

2.11.2 Referral source of inpatients, by gender

Female forensic inpatients were more likely to have been referred from the courts (39%) and prison (29%) than male inpatients, while proportionally twice as many males (21%) as females (10%) were referred from other forensic services.

Table 19: Referral source of forensic inpatients, by gender, 10 October 2005

Referral source	Male		Female		Total	
	Number	%	Number	%	Number	%
Court	56	*30*	12	*39*	68	*32*
Prison	44	*24*	9	*29*	53	*25*
Police	4	*2*	1	*3*	5	*2*
Other regional forensic service	39	*21*	3	*10*	42	*20*
Forensic community team	6	*3*	–	–	6	*3*
National Secure Unit	5	*3*	–	–	5	*2*
Adult inpatient	14	*8*	3	*10*	17	*8*
Other adult	14	*8*	3	*10*	17	*8*
Unknown	2	*1*	–	–	2	*1*
TOTAL	184	*100*	31	*100*	215	*100*

2.11.3 Legal status of forensic inpatients and community-based service users, by gender

In 2005, 19 (39%) of the 49 women who were forensic inpatients or community-based service users were subject to a compulsory treatment order, compared with 51% (170) of males. Proportionally more women (55%) than men (36%) were special or restricted patients.

Table 20: Legal status of forensic inpatients and community-based service users, by gender, 10 October 2005

Legal status	Male		Female		TOTAL	
	Number	%	Number	%	Number	%
Patients subject to compulsory treatment order	170	*51*	19	*39*	189	*50*
Special/restricted patients	120	*36*	27	*55*	147	*39*
Care recipients / special care recipients under Intellectual Disability Act	3	*1*	–	–	3	*1*
Voluntary patients	31	*9*	3	*6*	34	*9*
Data missing / unclear	7	*2*	-	-	7	*2*
TOTAL	331	*100*	49	*100*	380	*100*

2.11.4 Primary diagnosis of forensic inpatients, by gender

In 2005 almost three-quarters (74% or 126) of male inpatients had a diagnosis of schizophrenia. This compares to just 55% (16) of females service users. On the other hand, female service users (14%) were more likely to have an unspecified psychosis than males (3%).

Table 21: Primary diagnosis of forensic inpatients, by gender, 10 October 2005

Primary diagnosis	Male		Female		TOTAL	
	Number	%	Number	%	Number	%
Schizophrenia	139	*76*	18	*58*	157	*73*
Psychosis not otherwise specified	5	*3*	4	*13*	9	*4*
Substance-induced psychosis	2	*1*	1	*3*	3	*1*
Bipolar affective disorder	8	*4*	2	*6*	10	*5*
Personality disorder	8	*4*	2	*6*	10	*5*
Mental retardation	3	*2*	1	*3*	4	*2*
Major depression	2	*1*	1	*3*	3	*1*
Paedophilia	1	*1*	-	-	1	*0*
Adjustment disorder	5	*3*	1	*3*	6	*3*
Delusional disorders	3	*2*	1	*3*	4	*2*
Other	3	*2*	-	-	3	*1*
No diagnosis / missing data	5	*3*	-	-	5	*2*
TOTAL	184	*100*	31	*100*	215	*100*

2.12 Ethnicity

2.12.1 Numbers of service users

Table 22 shows the recorded ethnicity of forensic inpatient and community-based service users in both 1999 and 2005. Of particular interest is the fact that the number of Māori community-based service users remained constant between 1999 (73) and 2005 (74), and the numbers of Pacific service users increased from 13 to 18, whereas the number of New Zealand Europeans using community-based forensic services fell by 55% (from 158 to 71) over the same period.

The ethnic make-up of New Zealand prisons on 9 October 2005 was 49% Māori, 30% New Zealand European, 10% Pacific and 11% other.

Table 22: Ethnicity of forensic inpatient and community-based service users, 1999 and 2005

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

2.12.2 Referral source by ethnicity

Table 23 shows referral sources for Māori, NZ European and Pacific peoples in 2005. The proportions of each referral source are broadly similar to those in 1999. As might be expected, for all three groups the courts and prisons were the major sources of referral. However, for Māori and NZ Europeans, referrals from other regional forensic services were also significant (22% and 20% respectively).

Table 23: Referral source of forensic inpatient and community-based service users, by ethnicity, 10 October 2005

	Inpatient				Community			
Referral source	**Māori**	**NZ European**	**Pacific**	**Other**	**Māori**	**NZ European**	**Pacific**	**Other**
Court	29	28	8	1	3	8	-	-
Prison	30	16	4	2	15	9	3	1
Police	4	1	-	-	-	-	-	-
Forensic inpatient unit	-	-	-	-	42	37	12	1
Forensic community-based services	2	3	1	-	-	-	-	-
Other regional forensic service	23	17	1	-	9	3	1	-
National Secure Unit	2	3	-	-	-	-	-	-
Other inpatient unit	6	8	1	2	2	6	-	-
Other mental health service	7	8	1	5	2	6	-	-
ID service	-	-	-	-	2	-	-	-
Unknown	1	1	-	-	1	2	2	-
TOTAL	104	85	16	10	74	71	18	2

2.12.3 Legal status of inpatients, by ethnicity

As shown by Table 24, proportionally more Pacific peoples (59%) and Māori (55%) are subject to a compulsory treatment order than NZ Europeans. NZ Europeans were more likely than Māori and Pacific peoples to be special/restricted patients (41%) and voluntary patients (14%).

Table 24: Legal status of forensic inpatient and community-based service users, by ethnicity, 10 October 2005

Legal status	Māori	NZ European	Pacific	Other	TOTAL
Patients subject to compulsory treatment order	98	65	20	6	189
Special/restricted patients	67	64	10	6	147
Care recipients / special care recipients under Intellectual Disability Act	-	2	1	-	3
Voluntary patients	11	22	1	-	34
Data missing / unclear	2	3	2	-	7
TOTAL	178	156	34	12	380

2.12.4 Primary diagnosis for forensic inpatients, by ethnicity

Within each ethnic group, schizophrenia was the most common primary diagnosis. Pacific peoples were most likely to have this primary diagnosis (81%), followed by Māori (75%). Among NZ Europeans the second most common primary diagnosis was personality disorder (seven, or 8%); among Māori, it was bipolar affective disorder (six, or 6%). Overall rates of each primary diagnosis for forensic inpatients have not changed significantly since 1999.

Table 25: Primary diagnosis of forensic inpatients, by ethnicity, 10 October 2005

	Māori		NZ European		Pacific		Other		Total	
Primary diagnosis	**No.**	***%***	**No.**	***%***	**No.**	***%***	**No.**	***%***	**No.**	***%***
Schizophrenia	78	*75*	58	*68*	13	*81*	7	*70*	156	*73*
Psychosis not otherwise specified	5	*5*	3	*4*	1	*6*	-	-	9	*4*
Substance-induced psychosis	1	*1*	2	*2*	-	-	-	-	3	*1*
Bipolar affective disorder	6	*6*	2	*2*	1	*6*	1	*10*	10	*5*
Personality disorder	3	*3*	7	*8*	-	-	-	-	10	*5*
Major depression	1	*1*	-	-	-	-	1	*10*	2	*1*
Paedophilia	-	-	1	*1*	1	*6*	-	-	2	*1*
Adjustment disorder	2	*2*	4	*5*	-	-	-	-	6	*3*
Delusional disorders	3	*3*	1	*1*	-	-	-	-	4	*2*
Dementia	1	*1*	-	-	-	-	-	-	1	*0*
Brain injury	-	-	1	*1*	-	-	-	-	1	*0*
Aspergers	-	-	1	*1*	-	-	-	-	1	*0*
Huntington's	-	-	1	*1*	-	-	-	-	1	*0*
Mental retardation	3	*3*	1	*1*	-	-	-	-	4	*2*
No diagnosis	1	*1*	3	*4*	-	-	1	*10*	5	*2*
TOTAL	104	*100*	85	*100*	16	*100*	10	*100*	215	*100*

2.12.5 Cultural assessments and Māori therapeutic processes

Cultural assessment refers to 'the process through which the relevance of culture to mental health is ascertained' (Durie 1995). Nationwide, 176 cultural assessments were carried out for forensic inpatients and community service users, representing 85% of all Māori and Pacific service users. Cultural assessments were also carried out for small numbers of people of other ethnicities. Regionally, this figure varied from 80% (65) in Auckland to 94% (32) in Central.

Māori who are culturally assessed may have access to a Māori therapeutic process, which takes account of tikanga Māori and the importance of cultural wellbeing to Māori mental health. Seventy percent (120) of Māori forensic service users accessed a Māori therapeutic process as part of their treatment. In Auckland, the figure was 61% (36), whereas in Canterbury 89% (24) of Māori service users used this process. In Waikato, two Pacific people also went through this process.

Table 26: Cultural assessments and Māori therapeutic processes, by region, 10 October 2005

	Auckland	Waikato	Central	Canterbury	Otago/ Southland	TOTAL
Cultural assessments	65	46	32	23	10	176
As % of Māori/Pacific service users	*80*	*84*	*94*	*85*	*91*	*85*
Māori therapeutic process	36	35	19	24	6	120
As % of Māori service users	*61*	*71*	*70*	*89*	*67*	*70*

3 Prison Liaison Service Census

Note: No prison liaison service census was conducted in 1999, and therefore no comparisons can be made.

Forensic services provide prisons with specialised services, including mental health clinics (within the prison) for community forensic service users, assessments, transfer of mentally ill prison inmates to medium secure hospital facilities when necessary, and consultation, liaison and support services for prison staff. These services are additional to the primary health care services provided by the Corrections health staff and psychologists.

This section records information gathered from:

- a 'snapshot' census of service users on current case loads, as at 10 October 2005
- a month-long census of service activity, taken from 10 October to 10 November 2005 and including the service users whose data was captured in the snapshot census.

On 10 October 2005 the total prison muster was 7264.[3]

3.1 Snapshot census

3.1.1 Volumes

There were 376 forensic prison liaison service users on 10 October 2005, representing 5% of the total prison muster at this date. Of these, 326 were male and 50 were female. Table 27 shows the numbers of prison liaison service users by prison.

While comparisons between prisons are not straightforward due to differences in security level and prisoner mix, it is clear that there is considerable regional variation. For example, Canterbury has the fewest male forensic prison liaison service users as a percentage of prison muster, with 3.2%, while the figure in Otago/Southland is 8.9%. There are also significant differences in the overall rate for men (4.7%) and for women (11.9%). These differences may be due to higher rates of mental illness in female prisoners, or to the existence of more effective services for women than for men. It is noteworthy that a much lower percentage of female prisoners in Waikato are forensic prison liaison service users than is the case in other regions.

The 1999 prison study[4] suggested that the burden of psychiatric morbidity in New Zealand prisons was 10–15%. With the exception of Invercargill Prison, this figure is not met in any male prison, and is not met in the case of the female prisoners in Waikeria.

[3] Appendix 1 gives details of the maximum muster level and security classification for each prison at that date.

[4]

Table 27: Forensic prison liaison service users as a percentage of muster, by prison, 10 October 2005

Region	Prison	Service users	Muster	%
	Men's prisons			
Auckland	Auckland	57	645	*8.8*
	Mt Eden	17	381	*4.5*
	NCRF	8	308	*2.6*
	ACRP	23	371	*6.2*
	Total	105	1705	6.2
Waikato	Waikeria	50	843	*5.9*
	Tongariro	1	479	*0.2*
	Ohura	2	97	*2.1*
	NP	4	109	*3.7*
	Total	57	1528	3.7
Central	Hawke's Bay	28	628	*4.5*
	Manawatu	13	278	*4.7*
	Rimutaka	36	743	*4.8*
	Whanganui	21	458	*4.6*
	Wellington	7	120	*5.8*
	Total	105	2227	4.7
Canterbury	Paparua	22	839	*2.6*
	Rolleston	15	320	*4.7*
	Total	37	1159	3.2
Otago/Southland	Dunedin	4	59	*5.1*
	Invercargill	18	165	*10.3*
	Total	22	224	8.9
Total (men)		**326**	**6843**	***4.7***
	Women's prisons			
Auckland	Mt Eden	11	94	*11.7*
Waikato	Waikeria	5	76	*6.6*
Central	Arohata	19	140	*13.6*
Canterbury	Christchurch	15	111	*13.5*
Total (women)		**50**	**421**	***11.9***
TOTAL		**376**	**7264**	***5.1***

Note: NCRF = ; ACRP = ;NP = ;

Table 28 shows the case load as a percentage of the remand and sentenced population in each forensic service region.

Table 28: Remand and sentenced forensic prison liaison service users, by region, 10 October 2005

	Remand			Sentenced			TOTAL		
Region	Service users	Muster	%	Service users	Muster	%	Service users	Muster	%
Auckland	35	619	*6*	81	1180	*7*	116	1799	*6*
Waikato	4	204	*2*	58	1400	*4*	62	1604	*4*
Central	14	274	*5*	110	2093	*5*	124	2367	*5*
Canterbury	8	138	*6*	44	1132	*4*	52	1270	*4*
Otago/Southland	6	50	*12*	16	174	*9*	22	224	*10*
TOTAL	67	1285	*5*	309	5979	*5*	376	7264	*5*

3.1.2 Age

The largest group of the case load in prisons was in the age range of 25–34 years (36%, or 135). Eighty-six people (23%) were under 25 years of age and 53 people (14%) were aged 45 years or over. Regionally, Canterbury had the highest percentage (27%) of people over 45 years of age.

Table 29: Age of forensic prison liaison service users, 10 October 2005

Age group	Auckland	Waikato	Central	Canterbury	Otago	Southland	TOTAL
< 20 years	2	3	8	1	-	2	16
20–24 years	14	15	30	6	-	5	70
25–34 years	53	17	34	18	3	10	135
35–44 years	31	18	38	13	1	1	102
45+ years	16	9	14	14	-	-	53
TOTAL	116	62	124	52	4	18	376

3.1.3 Referral source

The 2005 prison census showed that, as expected, the majority of referrals 89% (334) are received from the prisons. While this majority was reflected in each of the regions, there was wide variation in the number of referrals from other sources. It is probable that much of this variation is due to coding differences.

Table 30: Referral sources for forensic prison liaison service users, 10 October 2005

Referral source	Aucklan	Waikat	Central	Canterbury	Otago/	TOTAL

	d	o			Southland	
Prison	116	62	94	46	16	334
Courts	-	-	15	3	2	20
AMHS	-	-	12	1	1	14
CAMHS	-	-	1	2	-	3
Other regional forensic service	-	-	1	-	-	1
Community forensic team	-	-	1	-	-	1
Police	-	-	-	-	1	1
Other	-	-	-	-	2	2
TOTAL	116	62	124	52	22	376

Note: AMHS = Adult Mental Health Services; CAMHS = Child & Adolescent Mental Health Services

3.1.4 Index offence

The most common category of index offence among service users on current prison service case loads at 10 October 2005 was violent offences (129, 34%). Sexual offences accounted for 18% (69) of index offences and property offences accounted for 13% (48).

Compared to forensic inpatients and community-based service users, prison liaison service users are nearly half as likely to have a violent offence (34% against 61%) as their index offence, but twice as likely to have a sexual offence (18% against 9%).

Table 31: Index offence of forensic prison liaison service users, by region, 10 October 2005

	Auckland		Waikato		Central		Canterbury		Otago/ Southland		Total	
Index offence	**No.**	***%***	**No.**	***%***	**No.**	***%***	**No.**	***%***	**No.**	***%***	**No.**	***%***
Violent offences	41	*35*	22	*35*	42	*34*	14	*27*	10	*45*	129	*34*
Sexual offences	24	*21*	7	*11*	27	*22*	10	*19*	1	*5*	69	*18*
Property offences	10	*9*	9	*15*	13	*10*	15	*29*	1	*5*	48	*13*
Other offences against a person	4	*3*	18	*29*	7	*6*	1	*2*	3	*14*	33	*9*
Arson	1	*1*	-	-	3	*2*	1	*2*	1	*5*	6	*2*
Drug offences	7	*6*	-	-	10	*8*	4	*8*	1	*5*	22	*6*
Offences against justice	3	*3*	-	-	1	*1*	2	*4*	-	-	6	*2*
Offences against good order	2	*2*	3	*5*	11	*9*	-	-	1	*5*	17	*5*
Traffic offences	5	*4*	3	*5*	2	*2*	1	*2*	3	*14*	14	*4*
Other	1	*1*	-	-	8	*6*	4	*8*	-	-	13	*3*
Unknown	18	*16*	-	-	-	-	-	-	1	*5*	19	*5*
TOTAL	116	*100*	62	*100*	124	*100*	52	*100*	22	*100*	376	*100*

Although no data on years since index offence is available for two-thirds of prison liaison service users, including all service users from Waikato and Canterbury, the data collected shows that service users tend to have committed their index offence less than two years ago. This category accounts for 59% of the available data.

Table 32: Years since index offence for forensic prison liaison service users, 10 October 2005

Years since index offence	Number	%
< 1 year	43	*11*
1–2 years	33	*9*
2–4 years	27	*7*
4–6 years	12	*3*
6–8 years	6	*2*
8–12 years	4	*1*
12+ years	3	*1*
Unknown	248	*66*
TOTAL	376	*100*

3.1.5 Primary diagnosis

For prison liaison service users on 10 October 2005, the most common primary diagnosis was schizophrenia, which accounted for 30% of the prison case load. The next largest group (11%) had a primary diagnosis of bipolar affective disorder.

Table 33: Primary diagnosis of forensic service prison liaison service users, 10 October 2005

Primary diagnosis	Number	%
Schizophrenia	113	*30*
Psychosis not otherwise specified	18	*5*
Substance-induced psychosis	16	*4*
Bipolar affective disorder	40	*11*
Substance abuse	18	*5*
Personality disorder	28	*7*
Major depression	27	*7*
Obsessive compulsive disorder	3	*1*
Paedophilia	3	*1*
Post-traumatic stress disorder	10	*3*
Adjustment disorder	24	*6*
Delusional disorders	2	*1*
Anxiety disorders	14	*4*

Other	6	*2*
No diagnosis	18	*5*
Unknown	26	*7*
Dementia	2	*1*
Brain injury	1	*0*
Aspergers	1	*0*
Huntington	1	*0*
Mental retardation	1	*0*
Attention deficit/hyperactivity disorder (ADHD)	4	*1*
TOTAL	376	*100*

3.1.6 Length of sentence

Of the 376 people in the prison census, 18% (67) were on remand and therefore had not been sentenced. Data was missing for a further 199 people (53%).

Table 34: Length of sentence of forensic prison liaison service users, 10 October 2005

Length of sentence	Service users	*%*
< 1 year	35	*9*
1–2 years	25	*7*
2–4 years	25	*7*
4–6 years	12	*3*
6–8 years	6	*2*
8–12 years	4	*1*
12+ years	3	*1*
Remand	67	*18*
Missing data	199	*53*
TOTAL	376	*100*

3.1.7 Previous referrals

Fifty-nine percent (222) of prison liaison service users had been previously referred to forensic services. However, figures differed quite markedly between regions, from 11% (seven) in Waikato to 85% (105) in Central. Previous referrals to adult mental health services applied to 48% (181) of forensic prison liaison service users. Again, figures varied across regions, from 80% (99) in Central to 21% (13) in Waikato. No Southland prison service users had previous contacts, whereas all Otago service users did.

Table 35: Previous referrals to forensic and adult mental health services of forensic prison liaison service users, 10 October 2005

Previous referral	Auckland		Waikato		Central		Canterbury		Otago/ Southland		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Forensic services	59	*51*	7	*11*	105	*85*	24	*46*	8	*36*	222	*59*
Adult mental health services	41	*35*	13	*21*	99	*80*	24	*46*	4	*18*	181	*48*

3.1.8 Gender

At the time of the 2005 census, 326 (87%) of the forensic prison service case load were men and 50 (13%) were women. Women prisoners (11%) were more than twice as likely as men (5%) to use forensic prison liaison services. Proportionally fewer women used this service in Waikato than in other regions, and proportionally more men used this service in Otago/Southland.

Table 36: Forensic prison liaison service users, by gender, compared to prison muster, 10 October 2005

Region	Male			Female			TOTAL		
	Service users	Muster	%	Service users	Muster	%	Service users	Muster	%
Auckland	105	1705	*6*	11	94	*12*	116	1799	*6*
Waikato	57	1528	*4*	5	76	*7*	62	1604	*4*
Central	105	2227	*5*	19	140	*14*	124	2367	*5*
Canterbury	37	1159	*3*	15	111	*14*	52	1270	*4*
Otago/Southland	22	224	*10*	-	-	-	22	224	*10*
TOTAL	326	6843	*5*	50	421	*11*	376	7264	*5*

3.1.9 Ethnicity

At the time of the 2005 census, 165 (44%) of the forensic service case load were Māori, 149 (40%) were NZ European and 36 (10%) were of Pacific descent. Twelve people (3%) were from other ethnic backgrounds, while the ethnic origins of 14 (4%) forensic service users were unknown.

Table 37: Ethnicity of forensic prison liaison service users, 10 October 2005

Ethnicity	Auckland	Waikato	Central	Canterbury	Otago	Southland	TOTAL	*% of total*
Māori	46	37	65	14	-	3	165	*44*
NZ European	33	25	41	32	4	14	149	*40*
Pacific peoples	20	-	14	1	-	1	36	*10*
Other	9	-	1	2	-	-	12	*3*
Unknown	8	-	3	3	-	-	14	*4*
TOTAL	116	62	124	52	4	18	376	*100*

Although Māori are over-represented in prison liaison services compared to their percentage of the New Zealand population, they are slightly under-represented compared to their prison presence: Māori make up 49% of New Zealand's prison population, but they account for just 44% of prison liaison service users. NZ Europeans are over-represented (40%) in prison liaison services when compared to their proportion of the prison muster (30%). However, given the data on ethnicity of prison liaison service users over the month of 10 October – 10 November 2005 (see section 3.2.4), the data presented here may not give an accurate picture.

Table 38: Ethnicity of forensic prison liaison service users compared to prison muster, 10 October 2005

Ethnicity	Forensic service users		Prison muster		% ratio
	Number	%	Number	%	
Māori	165	44	3590	49	90
NZ European	149	40	2118	30	133
Pacific peoples	36	10	572	10	100
Other	12	3	295	10	30
Unknown	14	4	-	-	-
TOTAL	376	100	7264	100	-

3.1.10 Cultural assessments and Māori therapeutic processes

Nationally, and excluding Waikato (which did not provide data in this field), 42% of Māori or Pacific prison liaison service users on 10 October 2005 received a cultural assessment. Forty percent of Māori service users accessed a Māori therapeutic process. Regional figures are summarised in Table 39.

Table 39: Cultural assessments and Māori therapeutic processes among prison liaison service users, by region, 10 October 2005

	Auckland	Waikato	Central [#]	Canterbury	Otago/ Southland	TOTAL
Cultural assessments	14	-	49	4	2	69
As % of Māori/Pacific service users	*21*	*-*	*62*	*27*	*50*	*42*
Māori therapeutic process	6	-	39	4	2	51
As % of Māori service users	*13*	*-*	*60*	*29*	*67*	*40*

3.2 Month-long census

Note: Data for Southland is not included.

This section covers the data collected on prison liaison service activity during the month 10 October to 10 November 2005.

3.2.1 Volumes

During the month of 10 October to 10 November 2005, a total of 1046 people used forensic prison liaison services. This total includes those service users covered in the snapshot data presented in section 3.1. Fifty-two percent (540) of all prison liaison service users for the month were in the Auckland region.

3.2.2 Gender

Of the 1046 service users during the census period, 915 (87.5%) were men and 131 (12.5%) were women. This result reflects the proportions seen in the snapshot census data in section 3.1.

Just over half of male service users (489, or 53%) and 39% (51) of female service users were in Auckland. The next largest group of service users was in Central, which accounted for 20% (180) of all men and 31% (40) of all women service users nationally.

Table 40: Prison liaison service users, by gender and region, 10 October – 10 November 2005

Gender	Auckland	Waikato	Central	Canterbury	Otago	TOTAL
Male	489	102	180	84	60	915
Female	51	8	40	32	-	131

TOTAL	540	110	220	116	60	1046

3.2.3 Age

Of the 1046 people who used prison liaison services for the month of October/November 2005, 59% (613) were aged between 20 and 34 years, while 40% (414) were aged 35 years or over. The age range 25–34 years accounted for 37% (383) of service users, and of the 1046 total this was the largest grouping according to age. Nationally there were 19 (2%) prison liaison service users who were under the age of 20 years and 152 (15%) who were over the age of 45 years.

Table 41: Prison liaison service users, by age, 10 October – 10 November 2005

Age group	Auckland	Waikato	Central	Canterbury	Otago	TOTAL
< 20 years	-	2	12	4	1	19
20–24 years	115	21	65	17	12	230
25–34 years	225	42	63	32	21	383
35–44 years	131	32	45	34	20	262
45+ years	69	13	35	29	6	152
TOTAL	540	110	220	116	60	1046

3.2.4 Ethnicity

In the census month, over half (52%, or 543) of prison liaison service users were Māori, which was significantly higher than the next largest group, NZ European, at 36% (372). Pacific peoples made up 9% (89). Ethiopians formed the next largest single ethnic group of prison liaison service users, representing 2% (16) of service users. There were 14 people of Asian ethnicities.

Table 42: Prison liaison service users, by ethnicity, 10 October – 10 November 2005

Ethnicity	Auckland	Waikato	Central	Canterbury	Otago	TOTAL
Māori	307	85	116	31	4	543
NZ European	123	25	87	81	56	372
Pacific	72	-	15	2	-	89
Other	35	-	2	2	-	39
Unknown	3	-	-	-	-	3
TOTAL	540	110	220	116	60	1046

3.2.5 Referral to forensic units

Table 43: Referrals to forensic inpatient units for prison liaison service users, 10 October – 10 November 2005

3.2.5 Cultural assessment

Of the 1046 prison liaison service users seen over the month, 13% (133) had received a cultural assessment. Regionally, the proportion of service users who had received cultural assessments varied from 28% (61) in Christchurch to 2% (one) in Otago.

Table 43: Cultural assessments of prison liaison service users, 10 October – 10 November 2005

Cultural assessment	Auckland	Waikato	Central	Canterbury	Otago	TOTAL
Yes	49	15	61	7	1	133
No	491	95	159	109	59	913
TOTAL	540	110	220	116	60	1046

As shown in Table 45, for the month of 10 October to 10 November 2005 the proportion of Māori or Pacific service users who received a cultural assessment varied significantly from region to region, from 13% (49) in Auckland to 47% (61) in Central.

Table 44: Cultural assessments as a percentage of Māori and Pacific prison liaison service users, 10 October – 10 November 2005

	Auckland	Waikato	Central	Canterbury	Otago/ Southland	TOTAL
Cultural assessments	49	15	61	7	1	133
Māori/Pacific service users	379	85	131	33	4	632
Percentage	*13*	*18*	*47*	*21*	*25*	*21*

3.2.6 Other clinical assessment

There were many gaps in the month-long census data. However, in Auckland, out of a total of 540 clinical assessments, 507 were face-to-face; of these 39 (7% of the total) were first-time assessments, 234 (43%) were follow-up assessments, 233 (43%) involved professional care co-ordination, and one involved court liaison attendance. In addition, 22 phone assessments were undertaken. These included 19 (4% of total) care co-ordination assessments with a professional, two psychiatric assessments and one medicines administration assessment. A further 11 assessments – including first-time, follow-up and care co-ordination – were undertaken by letter, fax, email, or TV/audiovisual.

The length of time for assessments in Auckland varied from 15 minutes (180, or 33%) to three hours (9, or 2%). Fifteen percent (80) of assessments took between one and two hours and 184 (34%) took between 25 minutes and half an hour.

In Waikato, 17 assessments were recorded. These included 9 (53%) with a psychologist and four (24%) with a cultural facilitator, as well as two (12%) psychological and two (12%) GP assessments. Central reported a total of 35 assessments, including 19 (54%) psychiatric, 10 (29%) psychological, five (14%) to assess mental state, and one (3%) to assess need for addiction treatment services. Otago reported 27 assessments with a psychiatrist during the census period.

4 Court Liaison Service Activity

Note: This section does not include information on Southland.

Forensic court liaison services include providing advice, assessments, reports and recommendations to courts. Court liaison service staff, who generally have backgrounds in psychiatric nursing, work to ensure that the mental health needs of people within the courts system are recognised and taken into account by courts. The service also consults and liaises with non-forensic adult mental health services, prisons, community probation officers and the Police.

This section contains information on:

- court liaison service users during the month of 10 October to 10 November 2005
- court reports provided by regional forensic services.

4.1 Court liaison service users

4.1.1 Court liaison service volumes

There were 1061 court liaison service users during the census period. Of these, 513 (48%) were in Auckland and 53 (5%) were in Canterbury. Table 46 shows the number of people seen by the court liaison service during the month recorded compared to the estimated monthly court convictions per region. The monthly court conviction estimates were obtained by dividing annual totals by 12, and are used as a proxy for court case volumes. The total does not include cases seen in the Youth Court, which does not have the power to convict. Appendix 2 contains data on annual convictions in each court district.

Table 45: Court liaison service users and court convictions, by region, 10 October – 10 November 2005

Region	Forensic court liaison users	Convictions per month (est.)	*%*
Auckland	513	4998	*10*
Waikato	104	3271	*3*
Central	269	3519	*8*
Canterbury*	53	2098	*3*
Otago	122	1166	*10*
TOTAL	1061	15,052	*7*

* Canterbury has noted that this month represented abnormally low volumes for their service.

4.1.2 Gender of court liaison service users

During the census month, 839 men (79%) and 222 women (21%) used the court liaison service. Regionally, the proportion of women service users varied form 15% (8) in Canterbury to 25% in Waikato (26) and Otago (30).

Table 46: Court liaison service users, by gender, 10 October – 10 November 2005

Gender	Auckland	Waikato	Central	Canterbury	Otago	TOTAL
Male	400	78	224	45	92	839
Female	113	26	45	8	30	222
TOTAL	513	104	269	53	122	1061

4.1.3 Age of court liaison service users

During the census month 135 (12.7%) of court liaison service users were under 20 years of age, and the majority of these service users (104) were in the Central and Auckland regions. The largest grouping by age (383, or 36%) was in the range 25–34 years. There were 138 (13%) court liaison service users who were 45 years or over. Users of court liaison services in Otago tended to be older than those in other regions of New Zealand.

Table 47: Court liaison service users, by age, 10 October – 10 November 2005

Age	Auckland	Waikato	Central	Canterbury	Otago	TOTAL
< 20 years	47	12	57	8	11	135
20–24 years	123	26	38	8	21	216
25–34 years	201	31	94	20	37	383
35–44 years	82	20	45	11	28	186
45+ years	60	12	35	6	25	138
Unknown	-	3	-	-	-	3
TOTAL	513	83	269	53	122	1061

4.1.4 Legal status

Two-thirds (708) of people who had contact with the court liaison service over the census month did not have a legal status, and were therefore voluntary service users. Twenty-one percent (224) were subject to a compulsory treatment order.

Table 48: Legal status of court liaison service users under compulsory treatment orders, 10 October – 10 November 2005

Section (description)	Number	*%*
s29 (unfit to stand trial)	3	*1*
s29 (insane)	1	*0*
s29 (conviction)	7	*3*
s29 (civil committal initiated while under s45)	2	*1*
s29 (civil committal initiated while not under s45)	32	*14*
s29(3)(a) (temporary transfer)	7	*3*
s30 (unfit to stand trial)	6	*3*
s30 (insane)	1	*0*
s30 (conviction)	7	*3*
s30 (civil committal initiated while under s45)	4	*2*
s30 (civil committal initiated while not under s45)	29	*13*
s30 (unspecified)	2	*1*
s31 (on leave)	2	*1*
Unknown / other	121	*54*
TOTAL	224	*100*

Sixty-six court liaison service users (6%) during the census month were special or restricted patients, as shown by Table 50.

Table 49: Legal status of special and restricted court liaison service users, 10 October – 10 November 2005

Section (description)	Number	%
CP s23 (insane or unfit to stand trial)	9	*14*
CP s24(2)(a) (unfit to stand trial)	-	-
CP s24(2)(a) (insane)	-	-
CP s34(1)(a)(i) (hybrid order)	4	*6*
CP s35 (convicted remand)	5	*8*
CP s38(2)(c) (pre-trial remand)	9	*14*
CP s44(1) (pre-trial remand)	12	*18*
MH s45 (and s11) (prison transfer)	23	*35*
MH s45 (and s13) (prison transfer)	-	-
MH s45 (and s30) (prison transfer)	3	*5*
MH s45 (unspecified – s15(1))	1	*2*
MH s55 (restricted patients)	-	-
TOTAL	66	*100*

4.2 Court reports

Court reports are ordered and paid for by the courts. This section describes the court reports carried out by forensic services during the census month from 10 October to 10 November 2005.[5]

4.2.1 Gender

During the month, reports were prepared for 105 males and 24 females, a total of 129 people. Central accounted for 53% (56) of the 105 reports prepared for males. Females in Central and Auckland accounted for two-thirds (16) of the 24 reports prepared for females.

Table 50: Court reports, by region and gender, 10 October – 10 November 2005

Gender	Auckland	Waikato	Central	Canterbury	Otago	TOTAL
Male	15	19	56	13	2	105
Female	6	3	10	3	2	24
TOTAL	21	22	66	16	4	129

[5] Auckland notes that volumes for this period were unusually low.

4.2.2 Age

Of the 129 court reports required, 28 were for people aged under 20 years. Of that group, 22 (79%) were located in Central. Almost one-third of reports (41) were for people in the age range 25–34 years, and 19% (24) for people 45 years or over.

Table 51: Court reports, by age, 10 October – 10 November 2005

Age	Auckland	Waikato	Central	Canterbury	Otago	TOTAL
< 20 years	2	2	22	1	1	28
20–24 years	4	1	5	2	-	12
25–34 years	8	9	17	5	2	41
35–44 years	3	6	11	3	-	23
45+ years	4	3	11	5	1	24
Unknown	-	1	-	-	-	1
TOTAL	**21**	**22**	**66**	**16**	**4**	**129**

4.2.3 Ethnicity

Analysis of the 2005 ethnicity data indicates that of the 129 Court reports, 57 (44%) were for Māori. Of that group, 26 (44%) were located in the Central region. NZ Europeans, the next largest group (48), made up 37% of reports. Just over half (54%, 26) of that group were located in the Central region.

Table 52: Court reports, by ethnicity, 10 October – 10 November 2005

Ethnicity	Number	*%*
Māori	57	*44*
NZ European	48	*37*
Pacific	8	*6*
Other	6	*5*
Unknown	10	*8*
TOTAL	129	*100*

4.2.4 Type of court report

Reports are called for by the courts under a range of different legislation and for a variety of different purposes. There was considerable regional difference in the sections under which reports were ordered by courts from forensic services in 2005. The most notable variation was in s333 reports in the Youth Court, with Central providing 88% (14) of all such reports done by forensic services. Auckland's not having provided any s333 reports is explained by the existence of the Regional Youth Forensic Service

(RYFS), which is part of Auckland DHB's general child and adolescent mental health services and is administratively unrelated to the Auckland regional adult forensic service.

Table 53: Types of court report, by region, 10 October – 10 November 2005

Report type	Auckland	Waikato	Central	Canterbury	Otago	Total
Criminal Procedure (Mentally Impaired Persons) Act 2003						
Section 23	-	-	2	-	-	**2**
Section 38(2)(a)	10	9	-	4	4	**27**
Section 38(2)(b)	11	4	-	7		**22**
Section 38(2)(c)	-	3	-	-	-	**3**
Section 38 undefined	-	4	38	-	-	**42**
Section 44(1)	-	-	1	-	-	**1**
Children, Young Persons and Their Families Act 1989						
Section 333	-	2	14	-	-	**16**
Sentencing Act 2002						
Parole	-	-	-	3	-	**3**
Section 88	-	-	-	2	-	**2**
Unknown	-	-	11	-	-	**11**
TOTAL	**21**	**22**	**66**	**16**	**4**	**129**

4.2.5 Time taken to complete court report

The time taken to complete court reports varied from one hour to twelve hours.

Table 54: Time taken to complete court report, by region, 10 October – 10 November 2005

Time taken to complete report (hours)	Auckland	Waikato	Central	Canterbury	Otago	TOTAL
1.0	1	-	-	-	-	**2**
1.5	-	-	2	-	-	**2**
2.0	-	-	1	1	-	**2**
2.5	-	-	3	1	-	**4**
3.0	1	4	7	-	-	**12**
3.5	-	-	-	1	-	**1**
4.0	6	6	6	2	-	**20**
4.5	-	-	5	1	-	**6**
5.0	2	3	7	2	-	**14**
5.5	-	-	1	1	-	**2**
6.0	-	-	5	1	1	**7**
6.5	-	1	2	2	-	**5**
7.0	5	1	2	-	-	**8**
7.5	-	-	5	1	-	**6**
8.0	4	-	1	-	3	**8**
9.0	1	1	1	-	-	**3**
9.5	-	-	2	-	-	**2**
10	-	-	4	-	-	**4**
10.5	-	-	1	-	-	**1**
11	1	-	-	-	-	**1**
12	-	-	2	-	-	**2**
Still in progress	-	5	5	-	-	**10**
N/A	-	1	3	3	-	**7**
Total	**21**	**22**	**66**	**16**	**4**	**129**

5 Staffing and Bed Numbers

This section summarises information received by the Ministry of Health from forensic service providers on their staffing levels, as well as the number and security level of their inpatient beds. Because many staff in forensic services work across all service types, some services found it impossible to provide a breakdown other than along the lines shown in the tables below.

Table 55: Inpatient service staff full-time equivalents, by region, 2005 [*]

Staff	Auckland	Waikato	Central[**]	Canterbury	Otago
Psychiatrist	5.7	4.0	3.0	1.34	.8
Registrar	7.6	2.5	1.0	0.5	1.0
House surgeon/MOSS	3.5	-	1.0	-	0.2
Psychologist	4.9	4	2.0	-	0.9
Nursing	217	58	40	60	18
Nurse specialist	-	-	1	-	-
Mental health assistant	-	-	-	-	11
Occupational therapist	5	3	2	2.5	1
Social worker	4	3	1	1.8	0.5
Cultural advisor	7	3	2	2	-
Recreation officer	2	-	-	-	-
Support worker	-	27	26	-	-
Clothing assistant	5	-	-	-	-
Educator	-	-	3	-	-
Education facility	-	-	-	-	-
Administration	4	-	-	-	-
Consumer advisor	1	-	-	-	-
TOTAL	**266**	**123**	**82**	**68**	**33**
Māori specialist within total	6	39	6	2	[***]
Vacancies within total	11	2	21	-	-
Bed numbers	82	55	28	35.8	13
Staff per bed	**3.2**	**2.2**	**2.9**	**1.9**	**2.5**

[*] Includes vacant positions

[**] Does not include full-time equivalent staff for either the 12 non-secure 'step-down' beds in Porirua or Stanford House in Wanganui.

[***] Advisory services provided from outside the forensic team

Table 56: Combined prison liaison, court liaison, and community-based service staff, full-time equivalents, by region, 2005 *

Staff	Auckland	Waikato	Central	Canterbury	Otago
Psychiatrist	6.4	4.0	5.0	3.5	0.7
Registrar/MOSS	1.9	0.5	1.0	1.4	0.4
Psychologist	1.5	5	3.7	2.5	0.1
Nursing	24	15	13	7	3
Community support worker	-	-	-	2	-
Occupational therapist	-	-	-	0.6	-
Social worker	3	3	2	1.5	0.5
Cultural advisor	2	2	7	-	**
Alcohol and other drug worker	-	2	-	-	-
Educator	-	-	1	-	-
Administration	0.5	-	-	-	-
Cultural advisor	-	-	-	1.3	-
Consumer advisor	1.0	-	-	-	-
TOTAL	**40**	**31**	**33**	**20**	**5**
Māori specialist within total	1.5	8.4	5.0	1.3	**
Vacancies within total	10.3	2.0	2.8	2.0	-

* Includes vacant positions

** Advisory services provided from outside the forensic team

There were a total of 236 beds in 2005, 159 of which were secure (acute, sub-acute or long-term). In 1999 there were 206 forensic inpatient beds.

Table 57: Inpatient beds, by security level and region, 1999 and 2005

Region	Secure	Non-secure	2005 total	1999 total
Auckland	55	29	84	64
Waikato *	30	25	55	30
Central **	38	12	50	72
Canterbury	23	11	34	27
Otago	13	-	13	13
Total	**159**	**77**	**236**	**206**

* Includes Waikato DHB and Hauora Waikato.

** Includes beds at Stanford House in Wanganui.

6 Regional Forensic Services Responses to Questionnaire

This section summarises the responses of regional forensic services to questions asked at the time of the 2005 census.

1. What populations do you believe that you are not serving well at present? What needs to change?

The youth population was identified by both Canterbury and Central as requiring additional focus. Canterbury noted that there needed to be clear agreement and funding streams to identify who held responsibility and to ensure alignment between forensic and CAMH services, and felt that designated inpatient youth facilities would be needed in the future. Central, on the other hand, highlighted that post-court processes such as accessing youth services and appropriate therapy were required for their youth population. More resources were required in order to set up a comprehensive youth forensic service.

Canterbury, Waikato and Hauora Waikato identified women as a group that could be better served. In Canterbury there were only nationally co-ordinated secure beds for women. In Waikato there were no separate sleeping or living spaces for women within inpatient areas.

People with intellectual disabilities were identified by both Canterbury and Waikato as a group not currently served well. To address issues for women and people with intellectual disability, Waikato was aiming to redesign existing space to better meet the needs of these people. Hauora Waikato noted a lack of adult mental health support services for the management of complex and challenging clients.

In Canterbury intellectual disability services made no provision for appropriate secure beds, and it was felt that the South Island required its own secure beds for people with intellectual disabilities. It was also considered that more involvement with local organisations was needed for Pacific people in forensic services in Canterbury.

Lack of beds in Auckland not only meant that services were not adequately serving the Auckland prison population, but also affected the service's ability to provide courts with reports. To alleviate this situation, Auckland was aiming to provide more extensive prison programmes as an alternative to admission to hospital. An increase in inpatient bed capacity was under way.

Auckland also noted that liaison and placements within general adult mental health services needed attention, and for this reason it was improving liaison with adult mental health services (AMHS) with an expansion of their capacity to care for difficult patients.

Central noted that there was a waiting list for inpatient beds. They suggested improving mental health screening mechanisms within prisons and having more

dedicated staff for prison clinics. It was felt that identified crisis beds should be available for identified forensic community clients.

Otago noted that there had been a steady increase in the number of women service users, with currently six of thirteen clients female. Most found sharing facilities with males uncomfortable, and sometimes embarrassing and intimidating. Separate bedrooms, ablution, lounge, dining and kitchen facilities within the unit were required.

2. Is there a population group which could be better serviced by another form of service, or a population you are serving by default because there is no other service provided for them?

Canterbury and Waikato identified the intellectually disabled as a population group better suited to another form of service. Canterbury had no secure intellectual disability beds. Waikato had capacity issues around 'community secure' for intellectually disabled offenders and the way in which the service should be defined and delivered. They suggested developing a less secure, or 'relational' secure, service on the campus.

Secure rehabilitation was a key issue for Auckland because in Auckland and Northland there was only secure rehabilitation available for women, with very restricted access to male secure rehabilitation outside forensic services.

Hauora Waikato felt that clients who were difficult to manage could be more appropriately cared for in their own local areas, with involvement and support from regional forensic psychiatric services. A range of different services needed to be developed for this group, including intensive community care teams and an inpatient longer-term rehabilitative facility.

The highest priority for Hauora Waikato was the development of clear, consistent and appropriate protocols for the treatment of Māori offenders. There also needed to be a review of models of care and clinical pathways utilised between Waikato Regional Forensic Psychiatry Service (Health Waikato) and Hauora Waikato.

Canterbury also considered that youth offenders should be screened as part of the screening programme and given extra resources (eg, for alcohol and other drug education and CADs services).

Central did not respond to this question.

For Otago, young males of 15 and 16 could be better served. Sometimes Otago was approached to assess risk when it had been necessary to hold young males in prison or the police holding cells. Otago did not provide a secure service for youth but recognised that there is a service deficit for this age group.

3. Please specify the population group you consider you should be focusing your service on.

Waikato pointed out that the existing forensic framework adequately defined its population group.

Auckland's focus was on mentally ill prisoners, consulting and assisting with high-risk GMHS patients and with the care of mentally normal prisoners who have mental-health-related issues.

Hauora Waikato considered that their approach of a kaupapa Māori unit providing assessment, treatment and rehabilitative services was of the most benefit for Māori youth.

Central listed prisons, courts, youth services, special patients (both inpatient and community) and consultation and education services to adult mental health teams. A similar response from Canterbury listed remand and sentenced prisoners, court assessments, special patients and patients at serious risk to the public. However, they did not consider that their service should focus on the 'difficult to manage'.

Otago's service focused on mentally ill people who were involved in the criminal justice system. They attended to court processing, including reports, people in prison on remand or sentenced, special patients, and people considered high risk of re-offending, transferring from the medium secure unit to the community.

4. What are the five major problems confronting your service?

Auckland's problems centred on lack of beds, together with increased complexity of the service required and the populations that needed to be served. Cost price differentials also created problems for Auckland. There were workforce issues in relation to the need for culturally specific staff, particularly Māori and Pacific registered staff. The development of a 'climate' that would encourage innovation and research was also considered to be an important requirement.

For Waikato, there were environmental limitations in relation to existing inpatient facilities. The geographical spread of services created tensions in relation to ensuring that services were well integrated with existing community networks in each location, while also ensuring that practitioners did not become isolated. Waikato felt that throughout the sector there was a lack of clarity around implementation of IDCCR and the best ways to interface to better meet the needs of this population. There were capacity issues in general adult services for those no longer requiring a forensic service and, in light of population demographics, a lack of specific resources to apply to Māori-specific and cultural-specific full-time equivalents.

Hauora Waikato noted that there was no clear inter-relationship model of care nor clinical pathways to assist structural and functional alignment with other providers. There was also no clear interface between regional forensic psychiatric services and AMHS, nor clear protocols for referring patients back to

their regions once their legal proceedings had been completed. There was also a lack of services for those with high and complex needs, and in terms of workforce Hauora Waikato had difficulty attracting and retaining high-quality staff to a semi-rural area which has two providers.

In the Central region an increase in prison beds, the failure of AMHS and the requirements of the Intellectual Disability Act had led to a shortage of regional secure beds. AMHS were resistant to picking up their clients released from prison and the courts, and the stigma attached to the forensic 'label' caused difficulties for clients trying to access appropriate services. Central also saw the need to have appropriate prison screening tools and noted a shortage of residential community beds. Another concern was that residential beds had to be accessed through each service co-ordination of each DHB in the Central region and a current proposal from TAS was to cut forensic service packages of care.

For Canterbury the availability of a trained and experienced workforce was an important issue. They noted that there was insufficient secure provision for population sub-groups such as women and people with intellectual disabilities. The interface with adult mental health services needed strengthening, as did the provision of primary care within prisons. As with the Central region, Canterbury also noted that lack of clarity around the definition of 'forensic' led to difficulties in liaison with other services. There was variable commitment to service delivery and liaison with the other regions.

For Otago a major problem was the recruitment of a forensic psychiatrist, because the incumbent was leaving and there had been no responses to advertisements. There were concerns at the increasing prison population in Otago as well as the requirement to provide specialist services for the Milburn Prison, due to open in June 2007, and the impact this would have on admission rates to the medium secure unit and the existing limited access to long-stay beds in Canterbury. There were interface problems with services responsible for people under the intellectual disability legislation, and the expectation of utilisation of beds in the forensic medium secure unit when no other secure beds were available. There was also a need to educate general AMHS about the role of forensic psychiatric services.

Otago had taken on the provision of an intense rehabilitation programme, but there were difficulties balancing the demands of acute care, assessment, long-term care and rehabilitation all in the one unit. Other problems related to the establishment and ongoing working relationship with Southland and being able to find support accommodation willing to take service users from forensic services.

5. What is your service's opinion on how forensic services are configured in the future to achieve best possible outcomes for the population group that you serve?

Auckland's current service configuration had proven to be sound over the last 15 years. It was seen as essential that services continue to follow international quality standards with integrated forensic services including courts, prisons,

inpatient and community services. The continuing growth in Corrections was a key issue, along with the effective management of the interface between Auckland services and AMHS. There needed to be further attention to models in relation to difficult-to-manage prisoners, screening for mental disorders in prisons and liaison with AMHS. With the establishment of a kaupapa Māori service within the Mason Clinic, development of culturally specific models of service should be considered.

In Waikato, increased bed numbers were necessitating the development of more step-down facilities. There was also a need for increased capacity in order to provide for long-term secure patients. Although the two-provider model in Hamilton was working satisfactorily, it was felt that ideally there should be one single regional service in the Waikato region.

Hauora Waikato suggested the development of an evidence-based best practice model of care (including both clinical and cultural paradigms). As with other regions, they felt that greater consultation and liaison with AMHS was needed across the region to support the management of those with high and complex needs. Increased interaction was also needed with the housing and work rehabilitation sectors to increase available accommodation options and work placements.

To improve workforce recruitment and retainment, a greater focus on academic development was required, and to maximise efficiencies of scale small regional services could be amalgamated into a larger service. It had been suggested that Hauora Waikato could amalgamate with the Auckland service so that resources could be shared, creating a unified focus of quality care and service provision across the upper North Island.

Central suggested that more consideration should be given to forensic service delivery targeted to women in secure care. Youth services needed to be expanded and appropriately funded. It was suggested that rather than part of Stanford House in Whanganui providing extended forensic care, the whole facility should be part of the regional forensic service.

Canterbury suggested having one integrated service for the South Island, with areas of sub-specialisation. Funding would be over-arching, and clinical directors, service managers and DHB representatives would provide governance. In prisons there was a requirement for more dedicated nurses/co-ordinators, and better liaison was needed with acute services and ID services.

Otago suggested forming a youth forensic service in conjunction with specialist youth mental health services and, in relation to offending and court processes, some integration of forensic psychiatric and intellectual disability services.

6. Is the model of forensic mental health that we have the right one (eg, are the boundaries in the right places)?

As noted previously, interface issues with AMHS were a cause for concern for Auckland. Rather than defining forensic service users by strict legislative limits,

Auckland preferred to build a relationship with AMHS via shared policies for the assessment and management of risk, and to develop clearer service expectations to determine appropriateness of entry to forensic services and timeliness of return back to AMHS.

Waikato felt that in theory the model was the right one but that boundaries often blurred because of lack of capacity within AMHS to manage high and complex / difficult-to-manage patients.

For Hauora Waikato, protocols between forensic psychiatry services and AMHS were also an issue. They suggested amalgamating services, with possibly one in the South Island, one in the Midland/Eastland area and one in the Upper North Island. They felt there should be more focus on additional after-care options for AMHS to allow a quicker and more efficient processing of patients through forensic services.

Central's model of service delivery was working well. All beds were located in one place (Ratonga-Rua-o-Porirua) with a network of community forensic services around the Central region. Step-down beds were within the adult rehabilitation service, which supported the transition of clients to AMHS.

Although for Canterbury the model generally worked well, the boundaries between AMHS and intellectual disability need further clarification. They noted that the lack of service provision supporting the Intellectual Disability Act had directly affected the forensic service.

Otago felt that the current model was the right one.

7. The interaction between regional forensic services and the AMHS was highlighted as being a concern in the last review. Have improvements been made in this area? What are the problems which remain? How would you approach these problems?

Waikato and Auckland shared the same interface issues. Auckland felt that there had been improvements since the last review, particularly in the relationship with Counties Manukau (eg, in the ability to liaise with intensive care and Māori assertive teams). However varying levels of engagement with, and having liaison support from, forensic services has meant that while some AMHS teams in the region are enthusiastic, keen and receptive, others are resentful and reject approaches. Development of the risk tool as a national policy could be very helpful.

Hauora Waikato suggested the establishment of an ongoing forum to address issues between AMHS and forensic services in relation to geographical and philosophical differences, lack of clarity around roles and responsibilities, interface processes, and the de-skilling and lack of confidence in AMHS in areas of assessing and managing risk. This forum would bring together senior management and clinical leadership from both services, and would initially consider urgent issues relating to agreement over roles and responsibilities,

protocols for entry and exit between services, a process for conflict resolution, and a shared workforce development plan.

Central also noted that relationships had improved and that the clinical director and staff visit AMHS within the region on a regular basis. Boundaries and service responsibilities were clearer through the introduction of signed memoranda of understanding and terms of reference. There continued to be occasional reluctance to pick up or transfer clients being released from prison and a slowness in picking up long-term community clients (who are no longer special patients), and in relation to clients who have offended in a minor way there was still a reluctance from local AMHS to accept other than well-known clients, both from prison and from court.

As with Hauora Waikato, Canterbury commented on possible de-skilling of AMHS in relation to risk assessment/management. It was felt that AMHS needed support, including financial support, from regional forensic services in order to function as 'the hub'. There needed to be a dedicated nurse to liaise with each sector. Case conferencing on a structured, regular basis – involving information sharing and clarifying boundaries and roles – would prevent the service user and family from splitting services. The dual case management model was considered to be ideal.

Otago considered there had been some success in clarifying the role of regional forensic services in relation to AMHS. Some AMHS continued to believe that forensic services should be responsible for all difficult-to-manage patients, and Otago are working with other services to clarify roles. However, over time they had successfully transferred many service users back to generalist, community-based AMHS, and they work on a consulting liaison or shared care basis for a set period with AMHS to help them to implement more appropriate management plans. In Invercargill the court liaison role is not well recognised or understood by court personnel or the AMHS, and Otago and Southland meet regularly to give support to standardising the process and educating all legal and mental health services.

8. Please describe in detail the services throughout your region that exist for women, including any regional variations, and identify any service gaps in the service provision for women

In Auckland, rebuilding and expansion had taken place in all areas to accommodate the needs of women. The Buchanan clinic was an important referral pathway. The major challenge for Auckland, from August 2006, was the increase in service provision from 90 to 286 female forensic service users, requiring collaborative planning for the range of services that would be needed, and possibly a reconfiguration of services. The new kaupapa Māori unit had three female beds.

In Waikato there were currently no specific services for women in the region and no plans to develop prison units for females. Women who require forensic services were cared for within inpatient services with male patients.

Hauora Waikato had clear gender-specific policies and operation procedures, which also recognise age-specific requirements for women. Tamahere has a separate accommodation wing for women and several gender-specific programmes such as wahine groups.

Wellington's Arohata prison is the largest New Zealand women's prison, and the service has a specialist dedicated forensic consultant for women. However, they note that there is a lack of secure provision for women within inpatient units.

Otago has no specific services or prison for women, but women have equal access with men to all services. Although they do not serve women in prison, they sometimes accept women from Christchurch prison if the secure unit is unable to take them. The inappropriateness of the inpatient facility was a cause for concern.

9. Please describe in detail the services that exist for Māori in your region, including any regional variation, and identify any gaps in the service provision for Māori.

In Auckland, from its inception the forensic service was established on bicultural principles. The service employs kaumātua, kuia, an associate service manager, kaupapa Māori services and three Māori cultural advisors. Five step-down beds are contracted with a kaupapa Māori provider, and a cultural centre is provided within the service. Major development of a 10-bed rehabilitation facility will be a centre for kaupapa services within the forensic service. Increases in culture-specific staff to support all services under ARFPS were planned and cultural support was available for all patients within the forensic service.

In Waikato, services for Māori are provided by the regional forensic service and by Hauora Waikato. Hauora provides both court liaison and a step-down facility for forensic service users. However, Waikato felt there were service issues relating to the interface between the two services, and lack of resourcing. Hauora Waikato's underlying philosophy of health reflects the importance of kaupapa Māori and tikanga Māori. Ninety percent of staff are of Māori descent, and there were links with whānau, hapū and iwi Māori at all times.

In Central there was a marae/cultural centre for the regional forensic service, with its own kaumātua and whāea. The service employed cultural advisors, and units had their own cultural worker. It was felt that there was a need for more specialist Māori clinicians and cultural advisors. There were strong links between the Central service and Capital & Coast DHB Māori mental health service and Te Whare Marie, and a service-level agreement with the Māori mental health service. The lack of a specific inpatient unit for Māori was seen as a gap.

In Canterbury there was a Māori mental health service, Te Korowai Atawhai, available to all forensic clients. In Otago there was an additional service for Māori.

10. Please describe in detail the services that exist for Pacific people in your region. Are these equal throughout the region? What is the gap?

In Auckland a matai and a Pacific cultural advisor are employed and run Pacific-based programmes within a Pacific Cultural Centre. Links are maintained with other Pacific mental health services in the community, and a step-down facility for Pacific peoples is provided by a Pacific trust.

Waikato has no specific forensic service for Pacific peoples but does maintain relationships with Pacific non-government organisation services. Hauora Waikato's kaupapa Māori services are open to all forensic service users, although if a whānau member of Pacific origin is admitted then Hauora would contract in culturally specific services for that person and their whānau (extended family).

Central's service has its own full-time Pacific advisor as well as dedicated Pasifika clinicians and Pasifika health workers. However, there is no dedicated Pasifika building, although the DHB has agreed that an appropriate facility can be located and brought on to the site for this purpose. The services could use the services of more dedicated culture-specific clinicians.

In Canterbury there are key contact people, contactable over 24 hours, employed within Canterbury DHB and in the community to provide support to all ethnic/pacific service users and staff. Booklets and handouts for service users and families are available.

In Otago, Pacific people have the same access to services as other population groups, but there is a gap in terms of Pacific peoples advisory services.

11. Which staff were consulted to assist with this questionnaire?

In Auckland all senior staff members within the Mason Clinic, including all associated service managers, taumata, Pacific staff, consumer representatives, heads of discipline and senior medical staff were consulted. Auckland was the only area that indicated consumer representation.

The service manager and clinical director were consulted in Waikato, and all other staff were involved in discussions on many of the issues above in a number of forums. Hauora Waikato consulted with psychiatric contractors and registered nurses. There were also general discussions with senior management and kaumātua/kuia.

In Central, consultation was with the multidisciplinary team, clinical director, service manager and kaumātua. In Canterbury consultation was through the regional forensic psychiatric service structure. Otago's listed staff did not include kaumātua/kuia or consumer representatives.

Appendix 1: Prison Maximum Muster and Security Levels

To give context to the 2005 findings, Table A1, obtained from the Department of Corrections, gives information on the prison muster, maximum capacity and security level as at 10 October 2005.

Table A1: Prison population, maximum capacity and security classification of New Zealand prisons, 10 October 2005

Institution	Muster	Maximum capacity	Security level(s)
Northland Region Corrections Facility	308	350	min, med
Auckland Central Remand Prison	371	381	med
Mt Eden Men's Prison	381	381	med
Mt Eden Women's Prison	94	94	med
Auckland	645	645	min, med, max
Waikeria Prison	919	926	min, med
Ohura Prison*	97	97	min
Tongariro/Rangipo Prison	479	482	min
New Plymouth Prison	109	109	min, max
Wanganui Prison	458	462	min, med
Hawke's Bay Prison	628	628	min, med
Manawatu Prison	278	278	min, med
Rimutaka Prison	743	676	min, med
Arohata Women's Prison	140	146	min, med
Wellington Prison	120	120	med
Christchurch (Paparua) Prison	839	840	min, med, max
Christchurch Women's Prison	111	138	min, med
Rolleston Prison	320	320	min, med
Dunedin Prison	59	59	med
Invercargill Prison	165	172	med
TOTAL	7264	7304	

*Ohura Prison was relocated to Tongariro/Rangipo Prison in March 2006.

Appendix 2: Extract from Conviction and Sentencing of Offenders in New Zealand 1994–2003

Table A2: Convictions finalised by court, 2003

Court	Total
Kaitaia	1260
Kaikohe	2090
Whangarei	4935
Dargaville	582
Warkworth	466
Auckland	18,745
Waitakere	7167
North Shore	6645
Manukau	14,553
Papakura	2189
Pukekohe	1346
Thames	1026
Huntly	772
Waihi	1275
Morrinsville	843
Hamilton	10,237
Te Awamutu	480
Tauranga	7419
Whakatane	2360
Opotiki	527
Ruatoria	318
Tokoroa	1413
Rotorua	4783
Te Kuiti	397
Taupo	2103
Gisborne	3941
Wairoa	462
Taumarunui	621
New Plymouth	4611
Taihape	383
Napier	4512

Court	Total
Hastings	3929
Hawera	1621
Wanganui	2979
Marton	410
Waipukurau	361
Dannevirke	382
Feilding	646
Palmerston North	3697
Levin	1406
Masterton	1831
Porirua	3102
Upper Hutt	1829
Lower Hutt	3915
Wellington	6887
Nelson	3801
Blenheim	1781
Westport	371
Greymouth	692
Kaikoura	103
Christchurch	15,147
Rangiora	765
Ashburton	561
Timaru	1949
Oamaru	879
Queenstown	760
Alexandra	449
Dunedin	5587
Gore	980
Balclutha	525
Invercargill	4816
Total	**180,622**

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