Dr Peter Norrie, B.H.B, M.B.Ch.B, FRANZCP
pdnorrie@gmail.com
Senior Consultant Psychiatrist
Former Chief Psychiatrist, ACT

Report on the Independent Review of Part IIA Orders ...prepared for the Chief Executive, Northern Territory Department of Health (through the Chief Psychiatrist)

Background

In 2017 and early 2018 there were a small number of absconding incidents across both Disability and Mental Health Services. Some attracted sensational and adverse media attention such that the Chief Minister and Minister of Health requested an urgent review by an independent senior clinician.

The terms of reference for the review are attached as an Appendix.

Review process

In late January/early February a paper-based review of the available documentation on current custodial and non-custodial reviews was undertaken including some initial reports to the Court and most ongoing review reports provided by Disability or Mental Health Services.

A visit to Darwin occurred in mid-February 2018 when staff, advocates, Managers and Executives from both Disability and Mental Health Services of both Top End Health Service (TEHS) and Central Australia Health Service (CAHS) were interviewed. There was interim feedback to senior Executives at the conclusion of that visit and a decision made to proceed with a visit to Alice Springs to better understand the issues in CAHS. This occurred in mid-March 2018, concluding with a further visit to Darwin to undertake final interviews. Site visits were also undertaken to better understand the particular aspects of care, treatment and management of those both in Disability and in Mental Health under custodial and non-custodial orders.

Following the collation of the information the reviewer has clarified issues and then in confidence discussed some findings with Senior Psychiatrist peers to assure the best chance of perspective. It became clear during the course of the review that some matters beyond the Terms of Reference should have comment so that the report would best address the challenges for managing this client group and also be of constructive support to the staff.

An external independent reviewer cannot hope to completely understand every context, and thus some of the opinions expressed will be best managed by those with greater knowledge of the Northern Territory (NT) services (i.e., the value of this report will be in how it is translated by Clinical staff, Managers and Senior Executives to best fit ongoing and future practice in the NT).

Findings.

Treatment and care is being well provided, often with limited resources. At all times during my visits staff were professional and courteous. From my observations and review of reports there is compliance with the orders of the Supreme Court. When it is time for an order to be reviewed, all efforts seem to be made to look at non-custodial options where appropriate. I did note however that there were occasions when a less restrictive placement just was not available which resulted in the continuation of a custodial order.

Case management was sound and reflected the individual's need balanced against legal requirements. There were regular reviews of medication where needed. Whilst I noted on a few occasions that this was not specifically outlined in a report, a check of notes affirmed ongoing reviews to provide the best in modern psychopharmacology.

Risk management overall was sound. The flashbriefs provided subsequent to the absconding incidents covered a few instances of less than ideal management and I will not repeat those details in this report. I am more than satisfied however that there has been learning from these incidents which is always a factor in quality improvement of Services. Comprehensive training provided in recent months around risk management and incident management should do much to mitigate future risks of absconding.

Notwithstanding these recent efforts, it must be pointed out that Mental Health and Disability facilities, even including custodial units, are focussed (and should be) on treatment and care. They are NOT Correctional facilities, and as such there will always be a somewhat heightened risk of absconding compared to more secure facilities, which means appropriate management of any absconding is crucial. It also remains a matter of ongoing education for the public, not helped by sensationalist media. Many of those now on orders pose little risk compared to the time of the index offence because treatment and care has been well provided. This is often difficult for public and politicians alike to comprehend, but Clinicians and Executives together must strive to advocate this fact in discussions around incidents, and not be lured into media speculation.

Protocols for advising incidents are sound and have also been further reviewed in recent months. In the light of recommendations I will make there may be need for further revision to clarify escalation of contact with the NT Police and also NT Health Executive's role in liaison with the Minister's office.

There would appear to be a sound communication process (electronically and verbally),when incidents occur though enhancing this at senior level with a dedicated response "committee" which can ensure co-ordination will be, in my view, beneficial. I have discussed the advantages of this already with senior executives at NT Health. Any report needs to be based on risk, current diagnostic state, and the context of absconding. Escalation of the information needs to be managed in this context but it would always be prudent for the information to be available to government. Notwithstanding this the

management of the media should rest with the NT Police, with any media release handled by them similar to what would be done with an absconding from correctional facilities. In serious incidents the absconding can be managed similarly to an escape from custody.

There are three further issues related to part IIA orders that should receive comment.

Firstly reports to the Court whilst of a high standard are varied in content. Some consistency may be provided by a proforma for an initial and subsequent report which could assist the Court in decision making. It is possible that a disproportionate amount of Psychiatrist time is being used to provide comprehensive follow-up reports The preparation of these reports may be able to be delegated to other clinicians, or co-authored if particular need for psychiatrist input. (Of note the disability progress reports are not authored by medical staff). Subsequent reports could focus more on issues/changes since the initial or last report was tendered rather than a further full assessment unless clinically necessary. This would potentially free up Psychiatrists and allow less pressure on their clinical loads. It may also allow the NT Psychiatrists to manage all initial reports. The current need to outsource these has led to issues with reports sometimes recommending treatment and care options which may not be feasible in the NT context. These reporting issues are just some of the examples discussed with me. Moving forward, there should be full consultation with clinicians, legal advisors and managers to ensure any changes are practical and can be supported within the principles of quality improvement.

Of note in the NT, Orders are managed by the Justice system. In the longer term with legal review this could be revised and handed over to a tribunal review system after the initial report is prepared for the Court.

Secondly the process of electronic monitoring, whilst initially appearing restrictive can paradoxically enhance a person's freedom if used effectively in an overall treatment program. There would seem to be an increasing use of electronic monitoring outside of a correctional facility but the Corrections department have the infrastructure to best monitor and support the monitoring. Communication issues and confusion seem to have arisen where the monitoring is handed over to other departments.

Thirdly, I refer again to the lack of placement options at times to support a move to a non-custodial order. Frequently there could be benefit in a slow stream rehabilitation unit with 24 hour professional care that sits between custodial and community care. The current situation is at times that a person on a custodial order will move from 24 hour custody to a non-custodial placement where there is limited professional care or supervision. This is not to criticise the excellent community models of care, more to suggest that part of the Rehabilitation/Recovery model is missing without this "step-down" interim option of full time supervised care before transition to the community. This will be addressed further with a recommendation below.

In reviewing the issues of Part IIA orders it became clear that there is a wide disparity of resources between the forensic components of the service in TEHS and CAHS. Indeed the TEHS supports the CAHS with fly in/fly out medical staff. Whilst this assists care there is no formal face to face forensic medical cover outside these visits. It is understood that there may be a service-wide review of mental health forensic services imminent which is strongly supported by this reviewer.

On a wider level there would seem to be a variation of resourcing on a number of other levels for mental health and disability services in the 2 areas of the NT which leads to differing levels of care. I reinforce my earlier comment that there was good care and treatment in the sites visited, and that the more important question is to address if it is possible to enhance funding overall. Funding models vary but a simple initial consideration is to look at percentage of mental health funding compared to the overall health budget. In many states it is now above 8% whereas in the NT it would appear to be between 4-5%. Each state/territory has its particular issues around funding. Certainly the enormous distances, physical co-morbidities and indigenous health challenges are significant for the NT however the mental health needs are also important to address.

Recommendations

In summary, I found no major discrepancies within the management of part IIA orders, but the findings suggest a number of areas for service review and enhancement. These will be covered within four grouped areas of Recommendations. The first three could be considered and supported for implementation in the short to intermediate term. The last group may have a longer time frame.

A) Service/Policy/Planning Issues

1. Review interstate "AWOL" and absconding protocols to check if there are processes working well in other jurisdictions can be adopted for use in the NT.
2. Further revise the 09 FLOWCHART to cover more fully the notification to the NT Police, their role in advising media and to indicate the place of the Executive in co-ordinating the process following notification and also managing communication through to Government.
3. Look at enhancing clinical support and co-ordination within Disability services to ensure staff receive clinical support in managing persons on orders where appropriate. (this was noted to be more prominent in the past but possibly due to recruitment issues is less visible now or even sometimes absent).
4. Continue to develop a closer working relationship with Mental Health and Disability services and also into the future with the NDIS.
5. Develop a Part IIA report proforma for both initial and subsequent reports. In particular for the subsequent reports develop a Summary page for the front page which would include for example…..Diagnosis, medication, a brief note on current treatment/care plan, legal details carer involvement and current care team. I believe this would greatly assist the Supreme Court.
6. Liaison with Corrections Department to have them co-ordinate fully all Electronic monitoring and reporting with the current infrastructure. There would not seem a need to duplicate the systems in Disability and Mental Health.
7. Proceed with a service wide review of Mental health Forensic services in the NT in 2018. In this context, consider the value of a single stand-alone Forensic service that can work across all areas and departments in the NT.

B) Workforce Service Issues

8. Review and enhance Court liaison services in both Darwin and Alice Springs to assist the Court in identifying those needing more intensive assessment or review. There are good models of Court liaison interstate which the NT could adopt/adapt.
9. Appoint a departmental liaison officer to work within Police Operations with an on call service out of hours. At the same time encourage the NT Police to appoint a liaison officer to work closely with Disability/Mental Health. These 2 positions should allow for improved sharing of information and enhanced communication between the agencies (again, service models could be adapted from interstate).

10. Review current workforce shortages. There are a number of areas where treatment/care of those under orders or entering the forensic system could be improved. My examples would be Disability clinical co-ordination (as No 3 above), Forensic team in CAHS, the possibility of an additional Registrar in forensics based in Darwin that would assist both TEHS and CAHS in the current model, .and Community case managers. Service Managers, Directors of Psychiatry and the Chief Psychiatrist can advise further based on local knowledge.
11. Consider interstate mentoring and support for isolated groups of workers particularly in Specialist areas such as forensic psychiatry. This promotes a culture of continued professional development and learning.

C) Executive level

12. Investigate the Human Rights and other legislation to evaluate whether the Media can be cautioned not to name individuals in their reporting and to keep to appropriate protocols in line with the release of information from the NT Police about incidents.
13. Encourage Government to establish and put in place regular Minister's meetings with Senior Executives which as needed can include the Chief Psychiatrist and Senior Disability Manager. Directors of Psychiatry and Senior Managers can be co-opted as need. Interstate models would evidence that this greatly enhances communication at a senior level, builds trust and allows for good flow of information at a "routine" level and also effective communication when there are incidents
14. Consider establishing a high level committee within the Executive and Senior TEHS/CAHS managers to manage absconding and other potentially serious incidents that could attract media and/or legal scrutiny. This would form immediately (with delegates if personnel absent) to manage the flashbrief process, to ensure communication with the Police, to review what the Police may release to the Media and to ensure direct and efficient communication to the Minister. Following incidents this group would also ensure quality improvement and feedback to service staff.

D) Future Strategies

15. Consider at an early opportunity the development and building of a slow stream Rehabilitation mental health unit, most likely best placed in Darwin but could include a few dedicated additional beds in Alice Springs. This is highly desirable to assist transition from custodial to non-custodial orders with the ongoing goal of transition to a community placement wherever possible.

16. Look at Justice and Mental health legislation to consider if the ongoing management of orders could be transferred from the legal system. This would likely involve setting up a Tribunal to receive supplementary reports and to supervise and monitor the ongoing care and treatment of those who require long term treatment/care orders. The concept of custodial/non-custodial could be reviewed and likely kept in revised form. This transfer would release the Supreme Court from a significant amount of ongoing review work and with the Tribunal process put the NT more in line with other jurisdictions (Once found “not guilty” people can be best managed in a health context without the complexities of Court orders). The NT may wish to look at this as an intermediate term review of legislation, or consider it in the wider context of a full review of Mental Health legislation.
17. Review the 4% funding for Mental health in a comparison with other jurisdictions and consider if commitments can be made within other priorities to ensure an enhanced funding base. Increases could be made on a progressive basis within the forward estimates.

Conclusions and Acknowledgements

This report is presented respectfully knowing our ongoing goal is to ensure quality and to enhance and improve health services. I have tried to match the information gathered with findings and recommendations, but if clarification or further elaboration is required I am happy to expand some points and/or meet with the Health Executive or Government to discuss the report.

Thanks to many in the NT Disability and Mental health services for meeting with me, often at short notice to meet the visit schedule. Particular thanks to Ms Jo Murray and Ms Erin Ingham for administrative support, and to Dr Denise Riordan, Chief Psychiatrist, NT for co-ordinating the review.

Dr Peter Norrie

April 2018

TERMS OF REFERENCE

INDEPENDENT REVIEW OF SUPREME COURT PART IIA CUSTODIAL AND NON-CUSTODIAL SUPERVISION ORDERS

Part IIA of the Criminal Code – (Mental impairment and unfitness to be tried)

There are two types of supervision orders, subject to the conditions the court considers appropriate. They are:

(a) Custodial supervision order whereby they commit the accused to custody in a custodial correctional facility or in another place (an appropriate place as considered by the Court); and
(b) Non-custodial supervision order.

The court must not make a custodial supervision order committing the accused person to custody unless it is satisfied that there is no practicable alternative given the circumstances of the person.

Purpose

To commission an independent clinician to critically review Part IIA Supreme Court Custodial and Non-Custodial Supervision Orders focussing on:

1. Compliance with Supreme Court orders
2. Case management including:
    a. supervision
    b. medication management
    c. risk management
3. Protocols for escalation for absences
4. Communication and public messaging protocols including with Police.

The Reviewer will undertake a clinical record audit along with face to face interviews as required.

Following the review the revised protocols will be tested by way of a scenario and simulation exercise.

The Independent Clinician will determine and make recommendations as required and provide a Report to Government.

Timelines:

It is anticipated that this Review will be completed within two months.

APPROVED

_____