



The Hon Kevin Humphries MP

Minister for Mental Health

Minister for Healthy Lifestyles

Minister for Western NSW

MEDIA RELEASE

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NSW GOVERNMENT TO STRENGTHEN FORENSIC MENTAL HEALTH SYSTEM

The NSW Government will prioritise reforms designed to strengthen the State's forensic mental health system, Minister for Mental Health, Kevin Humphries, announced today.

Mr Humphries said the recommendations stem from the Chief Psychiatrist's report into circumstances relating to forensic mental health patient, Trent Jennings, failing to return from leave from Morisset Hospital in December.

"When this incident occurred, the Director General of NSW Health and I immediately asked the Chief Psychiatrist to review the case. It is vital that we learn from events like this in order to ensure that the best services and systems are in place for both patients and the broader community," Mr Humphries said.

"One of the key findings of the Chief Psychiatrist's report is that while Morisset Hospital had mechanisms in place to record leave arrangements for Mr Jennings, aspects of the process of monitoring leave within the forensic mental health system can and should be improved.

"Following the release of the Chief Psychiatrist's report today, I have asked the Ministry of Health to immediately take forward these recommendations to ensure that we strengthen these areas of our mental health system. Hunter New England Local Health District has already strengthened processes at Morisset Hospital.

"While it is vital that we review the circumstances of this event, it is important to note this situation was unusual. Overall, our system is working well.

"In the vast majority of cases, treatment is effective and, over time, people recover and return to the community in a safe way."

The Minister for Health, Jillian Skinner, said the Chief Psychiatrist's recommendations reflected the NSW Government's commitment to implementing improved governance arrangements for the NSW health system, including an integrated state-wide clinical governance structure for forensic mental health services under the auspices of Justice Health.

"One of the reforms the Government is committed to within the NSW health system is to put in place arrangements for better integration, clinical governance and regulation of state-wide forensic mental health services. This will ensure a consistency of approach, training and policy," Mrs Skinner said.

A summary of the Chief Psychiatrist's report is below.

Chief Psychiatrist Review Outcomes – Jennings case

The recent case involving Mr Trent Jennings, a forensic mental health patient who absconded from Morisset Hospital, has prompted a review of both the Jennings case specifically, as well as procedures, protocols and management of forensic patients more broadly.

Chief Psychiatrist's review

At the request of the NSW Minister for Mental Health and the Director-General of NSW Health, the Chief Psychiatrist conducted an immediate review of Mr Jennings' clinical care, supervision and monitoring. Associate Professor John Allan also reviewed Hunter New England Local Health District's compliance with leave orders made by the Mental Health Review Tribunal.

The Chief Psychiatrist has now provided his report to Government.

The report contains a significant amount of personal and confidential details. For that reason, it is not appropriate that the full report be publicly released. The following is a summary of its contents and recommendations.

Scope of the report

The Chief Psychiatrist's report considers the events that initiated the review, provides a brief summary of Mr Jennings' history, diagnosis and clinical care, and the findings of an audit of Mr Jennings' record of leave-of-absence from Morisset Hospital.

Key findings

The Chief Psychiatrist found that while the Hospital had mechanisms in place to record leave arrangements for Mr Jennings, there were gaps in the process of monitoring his movements while on leave, and in relation to some of the arrangements around monitoring his access to the Internet and social media sites.

Recommendations

The Chief Psychiatrist has made a number of recommendations, detailed below. The key proposed actions are:

- arrangements for a statewide forensic mental health network to be finalised to enable a consistent approach to training, policy and care of forensic patients;
- changes to be made to leave monitoring arrangements of forensic patients;
- greater supervision and monitoring of Internet access for forensic patients;
- additional staff training, as well as access to expertise on other specialist issues, as appropriate.

Government Action on Recommendations

The NSW Government supports the Chief Psychiatrist's recommendations.

The Minister for Mental Health has asked the Ministry of Health to coordinate an implementation plan which includes actions to:

- Improve day to day monitoring and decision making: review, improve and strengthen arrangements for leave, record keeping, monitoring of patients' Internet usage, staff training, and clinical oversight;

- Strengthen and simplify governance of forensic patients: fast-track arrangements for an integrated state-wide clinical governance structure for the forensic health system, including services located within Local Health Districts, in line with action already underway through the NSW Health Governance review. This will make one entity – Justice Health – responsible for coordination and clinical oversight of all forensic patients.

Some recommendations have already been implemented by Morisset Hospital, others are to be implemented within three months (for example, review of guidelines and policies are to be undertaken). The Chief Psychiatrist has indicated that a number require a longer time frame to ensure appropriate and comprehensive planning is undertaken to maximise success once implemented.

The Chief Psychiatrist will be closely monitoring implementation of these actions.

Chief Psychiatrist's recommendations in full

- *Monitoring of leave of forensic patients.*
 - Additional systems to check the location of forensic patients on leave should be devised.
 - Improved information sharing between health services and agencies that are attended by forensic patients on leave. This is to include a framework for sharing information about risk, behaviour and attendance.
- *Internet and social network access.*
 - Improved supervision of internet use to allow staff to check browsing history is recommended as well as a formal system of regular audit.
 - A system of auditing internet capable devices used by forensic patients is developed and conducted regularly and randomly.
- *Management of psychopathic behaviour.*
 - Consideration of training for all staff in forensic services about assessment and management issues for patients displaying degrees of psychopathy.
- *Sexual violence.*
 - Consideration of training for all staff in forensic services about assessment and management of issues associated with violence in a sexual context.
- *Health care record.*
 - Morisset Hospital to review files of all forensic patients to identify gaps in information and include any missing documents.
 - Morisset Hospital to develop and deliver an education package on documentation / health care record requirements for staff.
- *Therapy.*
 - The type, dates, themes and progress of therapy provided to forensic patients should form part of the health care record.
 - Supervision should be provided to all clinicians providing therapy to forensic patients.
- *Governance.*
 - Arrangements for the better integration, governance and regulation of state-wide forensic mental health services should be put in place as soon as possible, to enable a consistency of approach, training and policy.
- *Peer review and support.*
 - The state-wide forensic mental health services should support clinicians caring for forensic patients through supervision from senior clinicians. This is particularly important for complex patients that present with symptoms and behaviour outside the framework of usual psychiatric practice.
- *Further review.*
 - The Chief Psychiatrist will review progress on the response to these recommendations in three months and provide a further report to the Minister for Mental Health, by which time further relevant investigations will be complete.