David McGrath Consulting

Tarnanthi Forensic Inpatient Rehabilitation Service

A post occupancy review on behalf of the South Australian Government

Final Report

June 2021

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Executive Summary

The Tarnanthi Subacute Unit (TSU) was established in 2019 subsequent to the relocation of the pre-existing Psychiatric Intensive Care Unit (PICU) from the Glenside campus to the, then, new Royal Adelaide Hospital. A planning exercise was undertaken by the Chief Psychiatrists Unit within the SA Health Department involving consultation with senior mental health clinicians and administrators to determine the best use of the vacated space at Glenside. The determination of this process was to establish a new 10 bed forensic rehabilitation unit specifically for a cohort of forensic patients with intellectual disability and acquired brain injury. The primary opportunity foregone as part of this deliberation was a potential increase in general use psychiatric intensive care beds.

It was expected that the commissioning of the TSU would allow for those forensic and correctional patients resident in other PICUs in CALHN and NALHN to be transferred to the freed-up capacity created in the forensic system through greater access to sub-acute forensic beds. This is in turn was expected to reduce bed block for transfer from ED and thus reduce waiting time in ED for patients seeking a PICU bed. The extent to which these expectations have been met is a key query for this review.

This review followed a relatively standard information gathering process to inform its deliberations. This included a desktop review of key documents, requests for and review of additional material and data to evidence the assertions of relevant parties and key informant interviews with approximately 20 staff across various services. A site visit was undertaken to the TSU in March 2021.

The review was confronted by a paucity of planning detail, available data that allowed appropriate system comparison of pre and post effects and a lack of clear performance expectations for services.

It is clear that a comprehensive forensic mental health services plan is required to create greater transparency regarding commissioning expectations and performance. By comparison to other jurisdictions South Australia has significantly less forensic acute capacity and significantly more forensic rehabilitation capacity. The problem identified regarding PICU and ED bed block was a problem of acute care, however the solution was to commission a rehabilitation unit in the expectation this would amend admission practice in other units. A longer-term plan will help identify if this strategy was appropriate or expedient.

The physical asset at Glenside has limitations as a long stay rehabilitation facility particularly for a forensic cohort. Capital works will be required to get the best use of the asset.
Forensic patient flow into the community is a substantial problem with the NDIS failing to provide a timely and effective pathway for community supports, the failings of this process must be raised with the Commonwealth Government under the bilateral agreement. Any flow through the forensic system will be dependent upon effective operation of the NDIS for this cohort.

A formalised data collection is required to improve the capacity to monitor the forensic system and to negotiate with justice agencies. The reliability and certainty of data was a key problem in fulfilling the requirements of this review. It is understood a data report is in the process of being constructed.

A summary of the recommendations can be found on page 43.

Introduction

Background

This review was commissioned by the Chief Psychiatrist of South Australia Health as a post occupancy review of the Tarnanthi Sub-acute Forensic Unit (TSU), which has been operational since late 2019. The decision that underpinned the funding of the unit was predicated on it delivering a number of system benefits, particularly with regard to patient flow and bed utilisation, and the Chief Psychiatrist wished to assess, amongst other things, whether these benefits had been realised.

The TSU was established in 2019 subsequent to the relocation of the pre-existing Psychiatric Intensive Care Unit (PICU) from the Glenside campus to the, then, new Royal Adelaide Hospital. A planning exercise was undertaken by the Chief Psychiatrists Unit within the SA Health Department involving consultation with senior mental health clinicians and administrators to determine the best use of the vacated space at Glenside. The determination of this process was to establish a new 10 bed forensic rehabilitation unit specifically for a cohort of forensic patients with intellectual disability and acquired brain injury. The primary opportunity foregone as part of this deliberation was a potential increase in general use psychiatric intensive care beds.

The Glenside campus uniquely accommodates services from each of the South Australian Local Health Networks despite being geographically housed within the Central Adelaide Local Health Network (CALHN). The TSU is part of the South Australian Forensic Mental Health Service (FMHS), a state-wide service operated by the Northern Adelaide Local Health Network (NALHN). It is the only inpatient service within the FMHS not located within the geographic bounds of NALHN. The remaining forensic inpatient beds are located at the Oakden facility in the northern suburbs of Adelaide.

It was expected that the commissioning of the TSU would allow for those forensic and correctional patients resident in other PICUs in CALHN and NALHN to be transferred to the freed-up capacity created in the forensic system through improved access to acute and sub-acute forensic beds. This is in turn was expected to reduce bed block for transfer from ED and thus reduce waiting time in ED for patients seeking a PICU bed. The extent to which these expectations have been met is a key query for this review.

It is important as part of the review to distinguish between two classes of patients that are a focus of bed utilisation in this context. The first is forensic patients subject to court orders that are the

responsibility of the health system and whose legal status with regard to an alleged index offence is either not guilty or unfit to plead/stand trial.

The second class are correctional patients who have had an adverse criminal finding against them or are on remand awaiting trial, are the day-to-day responsibility of the corrections system and whose mental health status has become so acute that specialist inpatient mental health treatment is required. Due to the nature of their correctional status this treatment can only be provided in a secure facility that meets correctional facility defined standards, meaning a secure forensic unit or a secure PICU. Generally, there are non-trivial security costs associated with their care in health facilities. The presence of security or correctional officers in the inpatient ward can also have deleterious effects on the therapeutic milieu of the unit.

This review has been commissioned to interrogate the impact of the TSU on the South Australian mental health system and to assess if the anticipated benefits of the commissioning have been realised. It also provides an opportunity to assess additional benefits and issues not documented in the planning process and to recommend improvements to service models based on experiences in other jurisdictions. It is noted the original planning document for the TSU anticipated a post implementation review after two years of operation and that this review is occurring earlier than that anticipated timeframe.

Terms of Reference

The Department for Health and Wellbeing seek an independent post-occupancy review commissioned by the Office of the Chief Psychiatrist on behalf of itself, Provider Commissioning and Performance, DHW, and the Division of Mental Health, NALHN and have commissioned David McGrath Consulting to undertake this review of the Tarnanthi Sub-acute Unit (TSU) with the following terms of reference.

This review should consider how the creation of the Tarnanthi Unit at Glenside has delivered on the project and strategic expectations for the service. This includes delivery of care for people with forensic disability or dual diagnosis in the unit, and also how the increased bed capacity has assisted with managing demand for forensic mental health beds across the service.

The review should consider:

1) The model of care at Tarnanthi, and the suitability of the modified Glenside ward for delivery of this model of care.

2) Consideration of the use of acute and rehabilitation beds 'freed up on the James Nash site' and the extent to which the anticipated strategic benefits in responding to forensic mental health demand has been delivered.
3) The performance of the new service for people who require the Tarnanthi model (considering accessibility, continuity, effectiveness, efficiency, sustainability and safety).
4) The performance of the 'freed up' James Nash capacity for people who require an acute or rehabilitation mental health service (considering accessibility, continuity, effectiveness, efficiency, sustainability and safety with consideration of the building design and model of care)
5) Suggestions for further improvements in the delivery of care to Tarnanthi clients and to the overall use of forensic mental health beds.

A reporting timeframe of 3 months from project commissioning was agreed along with a list of key informants to be interviewed.

The full terms of reference are available in Appendix 1.

The Legislation[1]

The operations of the South Australian Forensic Mental Health Service (FMHS) interact with three key pieces of legislation within South Australia. These are the *Criminal Law Consolidation Act 1935* (CLCA), the *Criminal Law (High Risk Offenders) Act 2015* (HRO), and the *Sentencing Act 2017*.

The *Criminal Law Consolidation Act 1935* is the primary act that interfaces with the South Australian Forensic Mental Health Service, particularly inpatient services. Part 8A of the CLCA addresses the possible mental impairment of a defendant. Sections 269F and 269G both address the mental competence of a defendant to commit an offence and allow a trial judge to require a defendant undergo an examination by a psychiatrist or other appropriate expert on the application of the prosecution or defence, or on the judges own initiative, and require the results of the examination to be reported to the court.[2]

Sections 269K, 269M and 269N of the CLCA address the defendant's mental fitness to stand trial and allow the court to require production of psychiatric or other expert reports that may exist on the

[1] Some material from this section is drawn from an earlier review of the Forensic Court Assessment and Diversion service conducted by the same author in 2020.
[2] South Australia *Criminal Law Consolidation Act 1935 s269F and s269G*

defendant's mental condition and may, if it thinks fit, itself have a report prepared on the defendant's mental condition[3].

Division 4 of Part 8A the CLCA deals with the disposition of persons subject to supervision orders under the Act. For example, section 269O deals with the conditions of supervision orders. Importantly it specifies that the court must fix a term (a ***limiting term***) equivalent to the period of imprisonment or supervision that would, in the court's opinion, have been appropriate if the defendant had been convicted of the offence of which the objective elements have been established without taking account of the defendant's mental impairment (s269O (2)). At the end of the limiting term, a supervision order in force against the defendant under this Division lapses (s269O (3)).

This requirement for a limiting term to be equivalent to the period of imprisonment if found guilty is unusually restrictive by comparison with other forensic mental health legislation around the country which, while incorporating the concept, provides alternative pathways that create greater flexibility in determining the time in the forensic system[4].

Section 269Q deals with the diagnosis, prognosis and treatment plan of defendants declared liable to a supervision order and section 269R requires reports addressing the views of the victim and defendants next of kin on reducing the stringency of supervision proposals. Section 269T requires prior to release or a decrease in supervision, an expert report on the mental condition of a defendant and on the possible effects of the change in supervision on the behaviour of the defendant.[5]

Section 269V places the individual in the custody of the Minister who may place the defendant under the custody, supervision and care of another; and if there is no practicable alternative direct that a defendant be kept in custody in a prison.[6]

Importantly the provisions that allow for variation or cessation of a supervision order require consideration by the court and there is no provision in the South Australian system for the operation of a designated mental health review tribunal for this purpose, as exists in most other Australian jurisdictions.

[3] South Australia *Criminal Law Consolidation Act 1935 s269K.*
[4] See for example the NSW Mental Health (Forensic Provisions) Act 1990.
[5] South Australia *Criminal Law Consolidation Act 1935 s269Q and s269T*
[6] South Australia *Criminal Law Consolidation Act 1935 s269V (2)*

Finally, Division 5 of Part 8A allows the court at s269WA to order an examination and report on the defendant by a psychiatrist or other appropriate health expert at the pre-trial stage to expedite proceedings. Section 269X allows the court to release the defendant on bail or commit the defendant to an appropriate form of custody until the conclusion of the investigation of mental competence. A new form of s269X came into force on April 1, 2021 during the review period. The new form of this provision removed an earlier preclusion on the use of prison as a form of custody unless there was no practicable alternative.

New subsections have been added presumably to add greater flexibility of options in the housing of a defendant under s269X including if, at the time at which a defendant is committed to custody under subsection (1)(b), the defendant is an involuntary inpatient at a treatment centre in accordance with the *Mental Health Act 2009* (because the defendant is subject to an inpatient treatment order under that Act) the defendant must continue to be confined at the treatment centre for the duration of the inpatient treatment order and each subsequent inpatient treatment order that follows on from that order.[7] A new subsection (5) provides for the prescribing of a designated officer under the regulations who can at any time during the detention of a defendant for the purposes of investigating a defendant's mental competence, if satisfied that the defendant is not being detained in an appropriate form of custody, may determine an appropriate form of custody and that determination is sufficient authorisation for the detention of the defendant in that alternative form of custody. Currently the Clinical Director of the FMHS is the only designated person under the regulations.

The *Criminal Law (High Risk Offenders) Act 2015* (HRO) is an Act to provide for the making of extended supervision orders and continuing detention orders to protect the community from being exposed to an appreciable risk of harm posed by serious sexual offenders and serious violent offenders.[8]

Section 7 of the HRO outlines the process required prior to the making of an extended supervision order and requires the Supreme Court, before determining whether to make an extended supervision order, to direct that 1 or more prescribed health professionals examine the respondent and report to the Court on the results of the examination, including an assessment of the likelihood

[7] South Australia *Criminal Law Consolidation Act 1935 s269WA and s269X*
[8] *Criminal Law (High Risk Offenders) Act 2015* (HRO) chapeau and s3.

of the respondent committing a further serious sexual offence or offence of violence or terrorist offence.[9] The paramount consideration of the Supreme Court in determining whether to make an extended supervision order must be the safety of the community.[10]

In addition to considering the likelihood of a further offence the Supreme Court must also consider the reports of any prescribed health professional and any treatment or rehabilitation program in which the respondent has had an opportunity to participate, including his or her willingness to so participate and the extent of such participation.[11]

The *Sentencing Act 2017* (Sentencing Act) is an Act to make provision in relation to the sentencing of offenders in the criminal justice system. Division 5 of Part 3 of the Sentencing Act addresses offenders incapable of controlling, or unwilling to control, their sexual instincts. Section 57 of the Sentencing Act requires that the Supreme Court must before determining whether to make an order that a person be detained in custody until further order, direct that at least 2 legally qualified medical practitioners inquire into the mental condition of that person and report to the Court on whether the person is incapable of controlling, or unwilling to control, the person's sexual instincts. The paramount consideration being the safety of the community.

Section 59 deals with applications to release an individual on license and similarly requires the Supreme Court to direct that at least 2 legally qualified medical practitioners inquire into the mental condition of the person and report to the Court on whether the person is incapable of controlling, or unwilling to control, the person's sexual instincts.

The involuntary treatment provisions of the *Mental Health Act 2009* (MHA) have a small role for certain patients who may be subject to both the CLCA and the MHA. [12]

Service Arrangements

The Forensic Mental Health Service

The State-wide Forensic Mental Health Service (FMHS) is a predominantly clinical service housed within the Northern Adelaide Local Health Network of the South Australian health system. Within

[9] *Criminal Law (High Risk Offenders) Act 2015* (HRO) chapeau and s7 (3).
[10] *Criminal Law (High Risk Offenders) Act 2015* (HRO) chapeau and s7 (5).
[11] *Criminal Law (High Risk Offenders) Act 2015* (HRO) chapeau and s7 (6).
[12] A Prof E Heffernan, B Clugston and Dr S Patchett. Review of the South Australian Forensic Mental Health Service. July 2015

the South Australian health system each of the three metropolitan local health networks takes responsibility on a state-wide basis for super-speciality mental health cohorts. Forensics is the responsibility of Northern Adelaide having taken it on from Central Adelaide Local Health Network around 6 years ago.[13]

In South Australia there are two predominant target populations serviced by the Forensic Mental Health Service. These are the 'mentally disordered offender' under the supervision of the Department for Community Corrections who may reside in a correctional facility or in the community, and forensic patients who have been declared Liable to Supervision under Part 8A of the CLCA due to mental incompetence to commit an offence, or having been found unfit to stand trial and are under the supervision of the Minister for Mental Health and Substance Abuse. Forensic patients are either given custodial orders to remain 'in detention' in a suitably designated facility, ideally a forensic hospital, or are released on non-custodial orders or 'licence conditions' for ongoing supervision.[14]

The Forensic Mental Health Service has a number of streams including inpatient services, community based forensic services, and services to support the activities of the courts such as the Forensic Court Assessment and Diversion Service. Once a patient is designated a forensic patient, accountability for their care resides with the FMHS in NALHN. Generally, most patients will enter the forensic service via an inpatient admission and will be admitted to a secure facility at James Nash House for initial assessment and treatment planning.

The FMHS currently has 70 designated beds with most of these on the Oakden campus in Northern Adelaide. These include the wards at James Nash House; Aldgate (8 acute beds), Birdwood (14 acute beds) and Clare (8 sub-acute beds). Additionally, there are 20 beds in the Kenneth O'Brien Rehabilitation Unit and 10 step-down beds at Ashton House. Patients at Ashton House must have community leave authorised by way of a licence under their supervision order.[15] The TSU at Glenside makes up the remaining 10 beds.

At times, inpatient mental health beds within Psychiatric Intensive Care Units (PICU) are also utilised. Additional DCS security staff are needed with costs borne by LHNs for additional security. These

[13] Informant interview
[14] NALHN. Glenside Campus Forensic Beds. Operational Service Plan May 2019.
[15] A Prof E Heffernan, B Clugston and Dr S Patchett. Review of the South Australian Forensic Mental Health Service, p12. July 2015.

'overflow' beds are primarily accessed for acute admissions when a bed in a High Security Inpatient Service is not readily available.[16]

The Community Forensic Mental Health Service (CFMHS) provides state-wide supervision of forensic patients on community licences, and limited case management to a select number of complex community forensic patients. Generally, the CFMHS manages forensic patients under co-care arrangements with their mental health supervision licence requirements monitored by the CFMHS and their mental health treatment needs met by general mental health services in the Local Health Networks. The Forensic review undertaken in 2015 by Heffernan et al indicates that forensic patients with an intellectual disability have co-care arrangements with Disability Services SA, however it is understood that this is no longer the case with the NDIS intended to provide relevant supports.[17]

The Forensic MHS has recently begun an in-reach service into prison for specialist mental health needs to augment the general prison health service which is run by CALHN.[18] This service was established subsequent to a trial run five years prior.

Information on court liaison and court assessment and diversion services can be found in the review of the FCADS undertaken for SA Health by the author of this paper in 2020.

The role of Local Health Networks

Local Health Networks provide adult mental health services to the general community, both inpatient and community, and support each other with super-speciality state-wide services, such as child & adolescent mental health or older persons mental health, aggregated in individual networks. General adult acute wards are generally not secure in South Australia and secure mental health services are generally provided by PICUs. While the Northern, Central and Southern Adelaide Local Health Networks all have PICU's, the PICU in SALHN does not meet the security standards set by the Department of Corrective Services and as such does not take forensic or mentally disordered offenders. A roster operates between NALHN and CALHN for determination of the place of first admission for forensic or correctional patients to prevent the impact of these admissions disproportionally affecting one LHN.

[16] A Prof E Heffernan, B Clugston and Dr S Patchett. Review of the South Australian Forensic Mental Health Service, p12. July 2015.

[17] A Prof E Heffernan, B Clugston and Dr S Patchett. Review of the South Australian Forensic Mental Health Service, p12. July 2015.

[18] Informant interview.

Forensic patients transferred into the community are intended to be co-managed by the FMHS and local health network mental health services, with some complex patients retained by the FMHS.

Tarnanthi Sub-acute Unit (TSU)

Planning

The relocation of the PICU unit on the Glenside campus to the Royal Adelaide Hospital Ward 2G created an opportunity to seek funding for new service capacity within the mental health system in South Australia. The physical asset at Glenside remained fit for commissioning for new activity and the Chief Psychiatrist established a consultative process with senior clinicians to determine the most suitable commissioning outcome to propose to the Chief Executive of SA Health and the SA Health Minister for funding.

In the immediate period leading up to the planning process for determination of the use of the vacated unit at Glenside, SA Health had identified significant difficulties with mental health presentations in emergency departments. An analysis from November 2018 that informed the deliberations indicated that[19]:

- There had been an increase in demand in emergency departments, with presentations increasing by 18.9% between 2014-15 and 2017-18.
- Visit times in the ED despite having have fallen by 23% between 2014 and 2018 were still 11.4 hours per presentation in 2018/19 significantly higher than the 4-hour National Emergency Access Target.
- There had been a decrease in the number of breaches of the 24-hour ED target by 55% since 2014-15, but some 948 patients waited more than 24 hours in 2017-18 and the annualised trends at the time of the drafting of the analysis in 2018 were for 1,700 in 2018-19.
- There were 30 individuals on the waiting list for admission to James Nash House. Of these, nine were in emergency departments, acute units or Psychiatric Intensive Care Units, 12 were held in a prison under Ministerial Order and nine were in prison. The number of persons in ED had risen markedly since January 2018.
- The Average Length Of Stay (ALOS) across all SA PICUs had risen from 84 days to 9 days between 2016 and 2018. Bed occupancy increased from 99.3% to 101.3% over the same period.
- The PICU bed requirements in 2018 for various scenarios range from a current surplus of 2.1 PICU beds if resetting ALOS for each unit to 2016 levels (8.4 days) up to the need for an additional 7.1 beds if reducing the occupancy rate to 85% and maintaining the 2018 ALOS (9 days) for each unit.
- There are currently 69 acute beds at Glenside and the risks of no PICU was noted.

[19] SA Health. Attachment 2: Psychiatric Intensive Care (PICU) and Forensic Analysis. November 2018.

- If a PICU was established at Glenside issues of governance and access would need to be resolved with four LHNs operational on the site.

The summary paper detailing the outcomes of the consultative process indicates five options were initially considered by the consultation group, however these were honed to two substantive options; continued use as a PICU unit or repurposing as a secure forensic inpatient unit. The discounted options included a women's only ward, acute behavioural assessment beds and complete closure of the ward.[20]

The paper discounted the option of complete closure given the demands on the mental health service as a whole. The necessary service planning was not in place to implement a behavioural assessment unit model and this option was deferred for future consideration. The gender streamed ward was considered as an option that could be implemented contemporaneously with either a PICU or forensic ward and was to be considered from an implementation perspective after the determination between a forensic ward and a PICU was finalised. It is noted that the TSU forensic unit is not currently women's only and it must be assumed that the implementation of this approach was discounted at a later date.

The Chief Psychiatrist when considering the remaining options noted three key policy considerations pertinent to final decision making. First, the segregation of forensic and civil patients is an explicit planning strategy in South Australia and not one that should be amended. Second, the preferred model should fit within a 'stepped' model of care that targets resources to the level of care required to achieve better efficiency of care. Third, the cost of the selected option was relevant as it closed off other strategic opportunities in the system given the finite envelope of funding available.

This discussion paper concludes[21]:

- *Support for extra beds can be justified both on an analysis of forensic mental health demand, and PICU bed demand.*
- *A review of forensic bed use indicates that approximately 10 - 13 forensic patients are located in the general mental health system each day– in hospital emergency departments, acute beds with security, or PICU beds. This is in addition to the designated 50 forensic mental health beds at James Nash House. The daily waiting list for James Nash House is approximately 30 patients. An expansion of 10 forensic beds would meet the needs of most of those patients currently in the hospital system, but not those in prison.*

[20] SA Health. Discussion Paper, Future Use of Psychiatric Intensive care Unit Space – RAH and Glenside. 28 December 2018.
[21] This content is reproduced verbatim from the paper. See note 10 for reference.

- *An analysis of the demand for additional PICU beds in South Australia suggests there is a need for an extra 5 – 7 PICU beds, in addition to the existing 37 PICU beds in the state. This need is based on both the demand for beds by civil patients, and the overflow of forensic patients into PICU beds which usually about 5 patients.*
- *Patients in a PICU may have different care needs. In particular civil patients are likely to require PICU level care because of symptoms of agitation or risk to self. This clinical need may similarly apply to forensic patients, but many forensic patients are admitted to closed wards because of security rather than clinical requirements, and may only require a rehabilitation or general acute ward level of mental health care rather than a secure closed unit if it were not for their forensic patient or prisoner status. For this reason there can be inefficiencies in admitting less acutely unwell patients where security is the driver for closed ward placement into full PICU level units, if full PICU level care is not needed.*
- *The need for local PICU access for Glenside services is considered. It is recognised that there are advantages in on site PICU access for Rural and Remote Services, and the beds at Eastern Acute, and Helen Mayo House. At this time with high PICU occupancy rates, patients already need to wait on their open ward prior to transfer to a bed so this situation would be unchanged. If PICU services were not available at Glenside for a period of time, ambulance transfer would also be required*

The recommendation [presumably to the CE and Minister][22]:

- *The Glenside PICU Unit becomes the **Glenside Forensic Secure Inpatient Unit** for forensic patients who have a security or absconding risk who require a secure bed but do not require a PICU.*

- *For this to occur the Glenside Forensic Secure Inpatient Unit, be staffed to meet the needs of patients who require a secure locked ward environment, but an intensity of clinical care which is at the level of a rehabilitation unit, and up to an acute general inpatient unit, not a PICU.*

- *The current seclusion room located just outside the Glenside PICU space, would remain available for use by the entire campus if required – for example if waiting for a PICU bed to become available.*

- *It is anticipated that this service would primarily be operated for forensic patients who need secure care. This would not preclude the ward, at least initially having discretion to admit civil patients who may represent an absconding risk if this was in the patients interest, can be safely done and a bed was available. This would be an occasional reverse of the current overflow arrangements.*

- *The objective of the planned Glenside Secure Inpatient Unit:*
    - *To provide 10 extra forensic mental health beds in the system so that forensic patients currently waiting in emergency departments, acute wards, and PICUs can be admitted to a designated forensic mental health bed.*
    - *It would achieve this by providing secure care to two groups: forensic patients in need of secure care who are currently admitted to James Nash House, to free up capacity for James Nash House to accept the transfers of acutely unwell patients from prison who*

[22] Ibid.

currently are admitted to PICUs; forensic patients who are referred to emergency departments who are assessed as needing a lower level of secure care.

The paper also made other pertinent points in the 'Future context' section:[23]

- *Any decision is likely to operate in the short and medium term with changes in the long term. It is possible and desirable that the demand for PICU beds will be reduced in the future, with a greater attention to the provision of non-hospital emergency care, early intervention in the course of an illness prior to escalation of behavioural symptoms, and better supports for people with chronic and complex needs who may be readmitted (including people experiencing mental illness with drug and alcohol co-morbidity). In addition the demand for PICU beds from forensic patients will also reduce with the operation of a court diversion service (estimated at approximately 3 beds saved), prison in reach, and ultimately if an expansion of forensic beds occurs at the James Nash site, beds at the Glenside site can be closed.*
- *Any decision to expand secure beds, therefore, should be reviewed in the context of the future implementation of the Mental Health Services Plan.*
- *Options below are suggested to operate for a 2 year period, with evaluation occurring prior to further extension.*
- *In evaluating potential models cost is a relevant factor to consider. In a stepped model, any approach that places consumers in a higher than necessary level of care is wasteful of resource. This is an opportunity cost for the delivery of other mental health interventions. This is relevant if a person needs a secure unit but not PICU level care.*

It was obviously expected that the recommended option would increase forensic capacity and provided segregated care for forensic patients, but it was also expected to reduce demand on PICUs to treat forensic patients and reduce time in ED for mental health patients wanting a PICU bed.

The paper however does not reference that the Glenside forensic unit (later to be the TSU) would be specifically for long stay Acquired Brain Injury (ABI) and Intellectual Disability (ID) diagnosed forensic patients. This specificity of cohort is not mentioned at all in the discussion paper. While the cohort is a subset of the stated '*forensic patients in need of secure care who are currently admitted to James Nash House'* the planning process that led to this group being singled out is not available in the paper.

The paper precedes publication of the Mental Health Services Plan 2020-2025 and as such it does not feature in the deliberations although reference is made to a 'services plan' in the future context section of the paper. This reference may be prospective as no content is transcribed.

[23] Ibid.

Prison in-reach services are the primary forensic service priority described in the Mental Health Services Plan 2020-2025 ('the Services Plan'). Notwithstanding this the plan references the need for an increase from 50 beds to 80 beds for Forensic mental health services[24]. Confusingly however, the bed table that describes existing bed capacity at the time of the plans release indicates that 70 beds (not 50) already were in place at that time.[25] This discrepancy does not appear to be explained. Given the discrepancy above it is difficult to know the timing of the Services Plan drafting relative to final decision making regarding the TSU, despite the Services Plan being released and dated 2020.

The Services Plan does not indicate that forensic rehabilitation capacity is a priority or that those with ABI or ID are a particular need. It does not indicate the ideal mix of forensic beds for the required 80 bed capacity, nor does it provide the quantitative analysis that led to the conclusion that 80 beds were required. Subsequent interrogation of key informants as part of the review process identified that in the absence of an agreed forensic module to the National Mental Health Services Planning Framework (NMHSPF), a quantitative analysis was difficult. However, no modelling of historical forensic demand and growth patterns were available to the review either.

The CE South Australia Health wrote to the CE NALHN on 14 February 2019 subsequent to an announcement by the Minister for Health on 30 January 2019 that the Glenside beds would transition to forensic beds.[26] Subsequently internal planning occurred within the FMHS at NALHN for the funding and configuration of the beds. An internal brief to the CE of NALHN states '*FMHS has reviewed the options and propose to relocate the Tarnanthi group of patients and those with cognitive impairment already located at JNH to the Glenside beds.'* The rationale behind this determination to focus on the cognitive impairment patients is not provided in substantial detail in the brief however the brief does state '*the transition to the Glenside campus will provide a low stimulus environment and allow the implementation of a full rehabilitation program and access to a wider range of rehabilitation resources for the Tarnanthi and Sub-Acute patients*.' The anticipated consequence of this was '*FMH and DCS patients will have direct access to acute JNH beds which will improve access to intensive treatment, bed flow, and decrease lost bed days.'* [27] This latter benefit is not quantified however. It is noted that the recommendation to choose this cohort for the unit is

[24] SA Health. Mental Health Services Plan 2020-2025, p30. This is reiterated on p45.
[25] SA Health. Mental Health Services Plan 2020-2025, p42. This is reiterated in the text on p43.
[26] SA Health. Internal Memorandum from CE NALHN to CE SA Health on the Commissioning of a 10 bed secure forensic inpatient unit at Glenside. Dated 13/3/2019.
[27] NALHN. Internal memorandum from Director FMHS to Chief Executive Officer NALHN on the Commissioning of a 10 bed secure forensic inpatient unit at Glenside. Dated 5/3/2019.

consistent with part of the unnumbered recommendation from the 2015 FMHS review to which the SA Government did not respond referenced later in this report.

The advice from the FMHS to the CE NALHN formed the basis of subsequent advice from the CE of NALHN to the CE of SA Health with a view to securing the necessary funding to commission the unit. Amongst the advice provided some additional commitments however were made by the CE NALHN in this memo as below.

- The beds will relieve pressure on LHNs mental health and emergency department beds.
- The Glenside campus will provide safer and more appropriate environment for rehabilitation of sub-acute patients due to access to Glenside facilities.
- Direct admission to JNH for FMH DCs patients where appropriate.
- An SLA will be developed between CALHN and NALHN regarding retention of resources on site and access to the gymnasium and art facilities.

The previous Tarnanthi ward patients were co-located in James Nash House Forensic inpatient hospital in the Birdwood ward however only seven beds were utilised for this purpose. The new TSU was foreseen to provide access to three additional beds 'for other forensic consumers who would benefit from the specialised rehabilitation program'.[28]

The operational plan for the TSU, dated May 2019, provides some additional insights to the decision to focus on cognitive impairment as the primary cohort. The plan states that there are approximately 70 forensic patients in total at the time of writing, and that the forensic disability cohort make up approximately 30% of people under a forensic order. This would suggest around 21 of the patients in the forensic mental health system. The integration of the stand-alone cognitive impairment cohort into the mental health treatment system is again a relatively unusual approach by comparison to other Australian jurisdictions, as the care requirements differ for this cohort compared to those with a mental illness.

As noted in the operational Plan, '*Combined with oversight of the day-to-day issues resulting from their cognitive disability, criminogenic needs and community risks, it is essential that forensic disability consumers have access to behaviour intervention and rehabilitation that is tailored to their cognitive requirements.* '[29]

[28] NALHN. Glenside Campus Forensic Beds. Operational Service Plan May 2019.
[29] Ibid.

It was this consideration that drove the decision to establish the TSU as a specialist cognitive disability service be enable comprehensive service provision for this cohort. The objectives identified that were required to support optimum outcomes were[30]:

- establish a specialist accommodation hub for ID/ABI patients and develop a stepped system along the continuum of care from inpatient to community
- provide long term accommodation due to length of Limiting Term, therapeutic input, rehabilitation focus, and the need for any rehabilitation programs to be slow stream to be effective.
- staffing profile to include specific intellectual disability expertise.
- ongoing supervision due to unchanging issues of risk.
- a thorough understanding of how the developmental and clinical needs of offenders with Intellectual Disability relate to the risk of reoffending to determine the most appropriate management and rehabilitation, and the support needs in the community to prevent re-offending.

Notwithstanding all of the above the staffing model for the service was predicated on the requirements of the Mental Health Act 2009 and the mental Health Review Amendment Act 2016 with mental health qualified nurses available on each shift. No reference in the staffing model is made to specific ID or ABI qualifications.[31]

Despite not specifying ID or ABI training in the staffing model in the plan the rehabilitation model states '*The ward will operate utilising a Recovery/Rehabilitation model with evidenced based specialist disability components (my emphasis). This will include the provision of Positive Behaviour Support (PBS) plans for consumers who require support to develop strategies and methods to assist in reducing challenging behaviour and increasing the person's quality of life.*' [32]

The nursing description of duties in the plan is relatively standard for a mental health unit with no obvious digression for a cognitive impairment cohort, however there is significant investment in allied health support and professional skills that would add value to this cohort including social work, psychology and occupational therapy. While a peer specialist is included in the staffing plan the

[30] Ibid.
[31] NALHN. Glenside Campus Forensic Beds. Operational Service Plan May 2019, p7.
[32] Ibid, p8.

diagnostic categorisation of this individual (e.g. with specific lived experience of ID or ABI rather than a mental health diagnosis) is not captured in the description of duties in the operational plan.

Finally, the operational plan requires that '*discharge planning commences on admission and is reflected in comprehensive, multidisciplinary mental health care plans that are regularly reviewed and updated*.'[33]

Model of Care

The TSU model of care was documented in 2019. A "Model of Care" broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place. [34] The TSU Model of Care was considered an adjunct document to the Forensic Mental Health Service Model of Care operational at that time (V8-2017).

The TSU model of care acknowledges the 'outlier' location of the TSU, with the remainder of the forensic inpatient service based on the Oakden campus in the NALHN, a twenty minute drive from Glenside.

The model of care outlines the following aims for the TSU:

- Care and rehabilitation that reflects the differing, complex needs of patients.
- Risk management that minimises offending behaviour and creates long term behaviour change
- Ongoing support and role modelling through strategies such as cognitive coaching.
- An underlying philosophy of the least restrictive option that details individuals' specific rights.
- Community involvement and integration in the provision of care and rehabilitation.
- Providing holistic interventions that address offence related behaviours, rather than offence specific behaviours.
- Therapeutic alliances with patients that take into consideration the non-criminogenic needs of the patient such as personal distress and self- esteem.
- Collaboration with patients in developing treatment goals.

[33] Ibid.
[34] NALHN. SA Forensic Mental Health Service. Forensic mental health beds – Glenside Campus. Model of Care 2019.

Forensic mental health consumers in the TSA Ward are persons aged from 18 years of age, who have a diagnosis of a mental illness and/or intellectual disability or Acquired Brain Injury, and are subject to a court order.

The TSA Ward provides treatment and rehabilitative inpatient services for the care and treatment of complex forensic patients and prisoners referred from correctional institutions, who require ongoing mental health care. Individuals are cared for within a high secure environment.

The TSU has a specialized focus on delivery of care for consumers with major cognitive impairment or autism spectrum disorder. TSA Ward recognises the importance of delivering mental health care that caters to the specific needs of different groups within this population. '*Developing a profile of the people who use services, together with an understanding of their social context and circumstances and the way they interact with the system, is the basis for realistic planning, service design and effective delivery.'* [35]

The model of care document states 'Consumers with non-psychiatric mental impairment may have a range of functional and behavioural issues that require an intensive behaviour modification and developmental approach. They are identified as having high risk and high support needs and traditionally have been poorly prepared for society on leaving institutions. They may also display behaviours that may not be tolerated in institutions that are 'unacceptable' in the mainstream community especially related to issues with Impulsivity and severe aggressive outbursts'[36]

The model of care delineates six core service delivery principles that underpin the care model including access, person and family centred care, collaboration and continuity of care, multidisciplinary care, recovery focused care, and safety and quality.

These principles are to be applied when implementing the care model, which is also based on five pillars:

- Physical Health
- Mental Health

[35] NALHN. SA Forensic Mental Health Service. Forensic menta health beds – Glenside Campus. Model of Care 2019.
[36] NALHN. SA Forensic Mental Health Service. Forensic menta health beds – Glenside Campus. Model of Care 2019.

- Tobacco, Alcohol and other Drug Recovery
- Complex Trauma Histories
- Psychosocial and Occupational Rehabilitation

The model of care provides detail on how each pillar will be applied however it is not necessary to replicate these here. The application of the principles and pillars is to be considered within the context of an expected average length of stay of more than six months for each patient.

The model of care describes a multidisciplinary care team, inclusive of medical, nursing, allied health and both a peer specialist and a carer consultant. It also anticipates specific expertise in co-morbidity in order to meet the intention of the third pillar regarding alcohol and other drug recovery.

The security approaches mirror those at other FMHS units and is inclusive of physical, procedural and relational security approaches. '*FMHS aims to balance the degree of intrusiveness of any security system and the degree of containment that is required, while maintaining safety for staff and others visiting the facility, as well as the safety of consumers and the general community. The security system in place enables effective treatment, by providing the structure within which clinical care can be provided safely while maintain the privacy and dignity of patients.*'[37]

The model of care also outlines the expected approaches to service partnerships and the availability of supports for patients, the principles of records management, arrangements for safety and quality that are integrated with the broader mental health and NALHN arrangements and recognition of the roles and powers of official visitors.

Performance Measurement of the TSU

The model of care outlines expected performance indicators for the TSU to be monitored through data collections, feedback and file audits. These include:

- Level of engagement in Inpatient rehabilitation activity
- Reduced SLS rates of seclusion and restrictive practices
- Reduced SLS rates of aggression and violence
- Analysis of ISBAR and Multi-Disciplinary Care Plans adherence
- Monitoring of baseline functional ability on admission and discharge

[37] NALHN. SA Forensic Mental Health Service. Forensic menta health beds – Glenside Campus. Model of Care 2019.

- Ongoing monitoring of the SA Health Safety Learning System in relation to consumer care, risks and feedback
- Risk Management measures and protocol adherence, including review of dynamic risk factors as an outcome measure
- Review of patients medical and psychosocial outcomes once community transition has been completed
- Monitoring of readiness for TSA discharge, including length of stay o Rates of readmission and recidivism

It is noted however that all of these performance measures relate to aggregate individual care. They are not system measures. It is interesting to also note that the SA Mental Health Services Plan 2020-2025 states that the 'ability to efficiently record and report on the number of forensic consumers in EDs and other inpatient units' is 'Future Requirement' arising from 'Current gaps and inefficiencies.'[38]

Previous Evaluations and Reviews

Forensic Mental Health Service Review 2015

A review was commissioned in 2015 to '*consider the Forensic Mental Health Service (FMHS) in South Australia (SA) and James Nash House in particular, and make recommendations about the management, culture and standards of care within that system to the Chief Executive Officer, Northern Adelaide Local Health Network*.'[39] The review was given relatively broad terms of reference and, other than the request to focus attention on James Nash House, could comment on any aspect of the operations of the FMHS.

The review report commented that there was insufficient forensic bed capacity to meet need, acknowledging that the report was written prior to the commissioning of an additional ten beds at the Kenneth O'Brien unit and the opening of the TSU. The review however pinpointed high secure bed stock as the most pressing need commenting on the inappropriate number of forensic patients detained in prison and the inability to treat mentally unwell prisoners.

[38] SA Health. Mental Health Services Plan 2020-2025, p25. The link made in this paragraph between future requirements and current gaps is implied by the placement of the text but is not explicit in the text.
[39] A Prof E Heffernan, B Clugston and Dr S Patchett. Review of the South Australian Forensic Mental Health Service, p12. July 2015.

Further the report stated, '*(t)he detention and care of individuals with intellectual disability in the mental health service system is a longstanding concern.'* At the time of the writing of the review report there were 64 forensic patients in the South Australian system with a primary diagnosis of intellectual disability. This seems at odds with the numbers presented in the planning analysis reported earlier which suggested only 30% out of a total of 70 would have a diagnosis of ID.

The report opines '*(i)t is critical that any specialist forensic disability unit be established with clear relationships, referral pathways and links to Disability Services SA to ensure patient flow and continuity of care for forensic disability patients returning to the community.'*[40]

The report also comments on the difficulty aggregating data on forensic patients across the justice and health systems, making planning and clinical decision making more inefficient. Monitoring of forensic patients by the FMHS was done by spreadsheet at that time.

The report makes substantial commentary regarding the operation of the legislation including concerns with use of the Ministerial prerogative under s269V to keep a forensic patient in prison, discussion of the benefits of a mental health court or a mental health review tribunal, the importance of legislated periodic review of supervision orders and the transfer of responsibility for patients with intellectual disability to the Minister for Disabilities. These are all strong recommendations and will be dealt with further in the benefits realisation section.

The review team made 24 recommendations. The ones pertinent to this review of the TSU were:

- (Recommendation) 1.2 - the additional 10 beds in the Kenneth O'Brien Rehabilitation Unit be commissioned as a matter of priority.
- 2.3 - Develop a model of service for the Community Forensic Mental Health Service, which includes clear mechanisms for collaboration with key stakeholders, and as part of future planning for the forensic mental health system, consideration of the resources required to manage forensic patients in the community.
- 2.4 - Establish a dedicated multi-disciplinary Prison Mental Health Service to provide assessment, treatment and care services in custodial settings.
- 3.2 - Review information and reporting systems and consider options for consolidating forensic mental health and general mental health data.

[40] Ibid, p 22.

- 4.1 - Remove or transfer to the judiciary the option for the Minister to direct that forensic patients be detained in custody.
- 4.2 - Restrict the detention provisions of Part 8A of the *Criminal Law Consolidation Act 1935 (SA)* to Supreme and District court jurisdictions only, with alternative legislative options, such as community treatment options, made available to Magistrate courts.
- 4.6 - Consider establishing a dedicated mental health court with Supreme and District court jurisdictions to deal solely with matters relating to mental competence.
- 4.7 - Consider requiring legislated periodic reviews of supervision orders.
- 4.8 - Consider the establishment of a specialist mental health review tribunal that can oversight and review, in a cost effective and efficient manner, forensic patients.
- 4.9 - Require the Minister for Disabilities to have oversight of the custody, supervision and care of forensic patients with a primary diagnosis of intellectual disability.
- Unnumbered - The development of a specialist forensic disability unit or service response must be established with clear relationships, referral pathways and links to Disability Services SA to ensure patient flow and continuity of care for forensic disability patients returning to the community. [41]

Government response 2017

The SA Government provided a response to the review in 2017, providing an opportunity to progress some recommendations in the interim. The response document provided responses to the key recommendations above although the unnumbered recommendation above was not captured in the response table.

The Government confirmed that the additional 10 beds at the Ken O'Brien unit had opened. It committed to the establishment of a Forensic Expert Advisory Group and the development of a model of community FMHS as part of a SA MH clinical services plan in consultation with the Advisory Group. It did not commit to further prison in-reach services pending the development of a business case. A working group was formed to review data sets and improve KPI reports.[42]

[41] This recommendation appears on page 24 but is not replicated in the summary table of numbered recommendations at the front of the document or in the end of section summary. This appears to be an editing error.
[42] SA Health response to the recommendations of the forensic mental health service review. 2017.

While the concept of a mental health review tribunal was supported, the stated commitment was to consult further with relevant ministers. Similarly, recommendations 4.2, 4.6 and 4.7 all were deferred pending further consideration and consultation.

The recommendation to remove the ministerial prerogative in s269V was not supported as it '*removes the capacity for SA Health to manage patients appropriately within available clinical and custody resources*.' Similarly, the recommendation to transfer oversight to ID forensic patients to the Minister for Disabilities was not supported as '*under the NDIS arrangements, the Minister for Disabilities will have no program funding responsibilities and therefore it would be inappropriate for the Minister for Disabilities to have oversight of the custody, supervision and care of forensic patients with a primary diagnosis of intellectual disabilities.*' [43]

Chief Psychiatrist Inspection of TSU 2019

The Mental Health Act 2009 (the Act) empowers the Chief Psychiatrist to conduct inspections of facilities providing care and treatment to people with a mental illness. Under Section 90 (1) (a) (b) and (c) of the Act, the Chief Psychiatrist has prescribed functions and under section 90 (4) and (5) of the Act, the Chief Psychiatrist can conduct inspections of the premises and operations of any hospital that is an incorporated hospital under the Health Care Act 2008 and be taken to be an inspector under Part 10 of the Health Care Act 2008.'[44]

As a consequence, the Chief Psychiatrist may 'at any reasonable time, enter the premises of an incorporated hospital and, while on the premises, may; inspect the premises or any equipment or other thing on the premises; and (b) require any person to produce any documents or records; and (c) examine any documents or records and take extracts from, or make copies of, any of them.'[45]

Under these powers an inspection team led by the Chief Psychiatrist Dr John Brayley inspected the Tarnanthi Sub-Acute Unit on Monday 22 July 2019. The ostensible purpose was to review the service subsequent to its gazettal.

[43] SA Health response to the recommendations of the forensic mental health service review. 2017.
[44] SA Department of Health and Wellbeing. Unannounced inspection of the Tarnanthi Sub Acute Unit conducted by the Office of the Chief Psychiatrist 22 July 2019. Report released 14 February 2020.
[45] SA Department of Health and Wellbeing. Unannounced inspection of the Tarnanthi Sub Acute Unit conducted by the Office of the Chief Psychiatrist 22 July 2019. Report released 14 February 2020.

The inspection team made the following key findings:[46]

1. *There is insufficient space for the patient cohort in the general shared areas. This lack of patient accessible space has contributed to some altercations between patients and a number of code blacks.*
2. *The main patient lounge is noisy with sound echoing. There are two televisions in this area which, if both were on, would add to the noise levels and potentially exacerbate a patients' distress.*
3. *Staff, upon arriving to work, have to walk through patient areas to access the nurses station, without prior information about any current or recent escalations or concerning behaviour in that area.*
4. *The notes indicated a medical approach to care within the unit. There was a belief amongst the clinical team that the care within TSA was moving towards a Learning Disability approach rather than a standard mental health model, given the patient group currently being cared for. One senior clinician on the team noted in particular that there appeared to be a gap in the provision of ID-oriented care and treatment.*
5. *There appeared to be a lack of meaningful activity for patients at the time of the inspection. It had been anticipated that patients would be able to use the Shared Activity Centre that encompasses a gym and rehabilitation facilities such as art and music therapies. This has not eventuated.*
6. *The duress alarm system was not tested during this inspection, however there was a lack of clarity regarding the process of testing the system and alarm pendants. Agency nursing staff were unaware if the pendants were remotely checked or if there was a ward based checking system.*

The team made the following recommendations for action[47]:

- That the Operational Model/Model of Care provide more specific strategies to address the need for this patient cohort.
- Exploration of responses addressing the noise levels within the main patient lounge.
- Clarify patient access to the Shared Activity Centre.
- Ensure all staff (including agency/casual) are aware of the duress process – including checking of pendants.
- Explore appropriate training, relevant to the patient group, is available to staff.

Review Process

This review followed a relatively standard information gathering process to inform its deliberations. This included a desktop review of key documents, requests for and review of additional material and data to evidence the assertions of relevant parties and key informant interviews with approximately 20 staff across various services. The list of key informants interviewed can be found at Appendix 2.

[46] SA Department of Health and Wellbeing. Unannounced inspection of the Tarnanthi Sub Acute Unit conducted by the Office of the Chief Psychiatrist 22 July 2019. Report released 14 February 2020.
[47] SA Department of Health and Wellbeing. Unannounced inspection of the Tarnanthi Sub Acute Unit conducted by the Office of the Chief Psychiatrist 22 July 2019. Report released 14 February 2020.

A site visit was undertaken to the TSU in March 2021. This visit allowed an opportunity to assess the physical asset and discuss the model of care with staff. A group interview with four staff was conducted including the consultant psychiatrist, a registrar, a psychologist and an occupational therapist. The information gathering occurred across a period of approximately six weeks and information continued to be provided across that time. Follow-ups on key questions yielded further data. The focus of the interviews and information gathering was to ascertain the answers to the key questions posed in the terms of reference and where issue went beyond these bounds they were noted but not interrogated.

Benefits Realisation

The model of care at the TSU and the suitability of the Glenside ward

At the most fundamental level the segregation of forensic patients with a primary intellectual disability or acquired brain injury diagnosis from those with a primary mental health diagnosis is clinically appropriate. This cohort has a different symptom trajectory, and the care paradigm has substantial differences in objectives to a mental health cohort requiring novel skill sets and a variation in the mix of clinical resources. In the larger Australian jurisdictions forensic disability patients are treated in separate services to mental health patients and can have separate enabling legislation[48]. This is in recognition that this patient group are not best treated in mental health units that are established to treat specific diagnostic criteria and with specific diagnostic objectives. The staff at the TSU identified in the provided TORs that segregating the ID cohort allowed for greater freedom for these patients and less distress. This would be supported by the general clinical literature.

The original documentation of the model of care however had many of the standard features of a forensic mental health model, and while the operational plan acknowledges the differing needs of the ID/ABI cohort, the staffing model and assessment and treatment approaches documented did not readily reflect this. The unannounced review by the Chief Psychiatrist identified that the operationalisation of the unit did not reflect an ID model of care, tending towards the medical and recommended adjustments as an outcome from the review.

[48] See the application of the concept of 'forensic resident' in the *Disability Act (2006) Victoria*, or the *Forensic Disability Act 2011* in Queensland.

It is clear that the TSU team have attempted to respond to this feedback. Recruitment of specialist allied health ID expertise has occurred, treatment planning incorporates necessary disability support planning and functional development activities are built into the treatment program. The overall staffing model however is still heavily reliant on mental health expertise.

However, the original facility in which the TSU is operating was designed as a short stay PICU unit and is not best suited to a long stay rehabilitation cohort. A single central recreation area, including an internal lounge that flows out to an external central courtyard, is insufficient space for a ten bed long stay unit. It provides limited opportunity to undertake skills training or recreational activity. While there were anticipated benefits in the use of the Glenside grounds these have not been realised due to legal and resource impediments. For rehabilitation patients with ALOS of six months, the physical space is unsatisfactory.

The central courtyard space, which provides the only security controlled external access is limited, has little shade and is surrounded by windows on all sides. While the staff have worked hard to improve it with plants and a basketball ring, it is not a particularly engaging space. Given the difficulties accessing the grounds this lack of external space must have a deleterious effect on patient mood over time.

The documented use of seclusion and restraint is pleasingly very low and reflects effective staff approaches to managing distressed patients and effective training, policies and procedures. However, the location of the seclusion room, and the fact that it can be used by other units in the complex is problematic. The seclusion room can be accessed from shared staff amenities and administration space and when in use these spaces are difficult to access. While the room was not in use during the site visit it is easy to see that use by other units may impact the general atmosphere in the TSU. It is not clear how use is prioritised either if the room was required by two separate clinical teams at the same time.

The patient interview room is also in the shared administration space and is not readily visible from other parts of the ward. This creates staff safety issues, particularly as the second egress point leads into the same corridor as the primary entry and egress point, mitigating the safety benefit.

Overall, the physical facility is not best suited to providing rehabilitation care, particularly when legal status impedes the opportunity to spend time outside the unit. The staff of the TSU are to be

commended for their efforts in getting the best outcomes they can with the facility they have to work with. The asset itself does not readily lend itself to either long term secure rehabilitation care due to limited recreational options or to secure acute care, given the location of interview and seclusions rooms.

Recommendations

1. SA Health should undertake service and capital planning to identify an alternative facility in the medium term for the management of this TSU cohort. While the facility can be used in the interim it is not ideal for the care needed for this group.

2. If SA Health determines to repurpose this facility, capital works should be undertaken to ensure it is fit for purpose and meets the Australian Health facility Guidelines for the intended service type.

The performance of the new service for people who require the TSU model

Crucial issues regarding the performance of the TSU were raised during the review process. The first relates to impediments to discharge that impact on ALOS, bed utilisation and the general rights of the patient cohort. There were two issues raised that impacted on bed flow and discharge, access to the NDIS for the forensic cohort and access to accommodation options. The combined effect of these two issues was estimated at 2 to 3 bed equivalents on annualised basis by the staff of the TSU or viewed another way a 20-30% drag on potential annual separations. On the day of the site visit a review of the extant cohort by the consultant psychiatrist indicated that three of the patients on the ward were appropriate for discharge however suitable support options had not yet been found. The impact at the level of the individual patient was an estimated additional three to five months on the TSU that could alternatively been a placement in the community.

The issue of NDIS access is not unique to the forensic service. CALHN reported similar issues with the general adult cohort, describing access as 'an example of market failure'.[49] CALHN data indicates that nearly half their inpatient bed cohort were NDIS participants, and for those in their Inpatient Rehabilitation Service all, or nearly all, were reliant on it.

There are legislative requirements as to who can determine what "reasonable and necessary supports" are required. Depending on the necessary supports an assessment can only be compiled

[49] Informant interview.

by a psychologist, occupational therapist, or developmental educator. The health responsibilities for accessing the NDIS predominately therefore fall to allied health staff to complete due to these requirements.[50]

The NDIS can broadly be broken down into three phases:

1. NDIS eligibility and access, where a patient's eligibility is determined.
2. NDIS Planning where the NDIS plan and funding is determined to enable sustainable discharge with the immediate supports needed for the first 12-18 months. It must have robust clinical reasoning, use specific language based on NDIS policies and legislation and the reports must meet requirements of the NDIA Act. Failure to get the language or report structure correct leads to delays and requests for further information.
3. Once funding is approved implementation of the NDIS plan occurs. Implementation includes the provision of services such as care hours and other supports, accommodation and the transitioning process to community.

The TSU cohort, is particularly reliant on the NDIS for access to the community given the predominance of ABI and ID diagnoses. The review of the FMHS in 2015 identified in its unnumbered recommendation the importance of pathways to disability services in the community, albeit prior to the operation of the NDIS in SA, and also the need for oversight of the patient cohort by the Minister for Disability. Each of these recommendations was made in recognition of the role of community-based disability services in patient flow.

The unannounced review by the Chief Psychiatrist of the TSU in 2019 noted that the model of care at TSU needed a greater disability focus and there has been some response to this feedback by the TSU team. There is a greater focus on disability assessment and support planning amongst the team at TSU in both their documented processes and their follow-up plans. Internal processes have also been sensibly adjusted to fit NDIS assessment policy, language and report structure and early identification of the timing of eligibility processes have been built into the treatment planning process. These are all sensible improvements within the scope of the responsibilities for phases 1 and 2 that the clinical staff can influence for NDIS access. It is important that the TSU staff stay on top of the phase 2 needs and embed them in ongoing clinical practice, modifying these requirements as the NIDA modifies the entry processes.

[50] Unpublished CALHN briefing.

These however do not address the difficulties with the third phase of NDIS access in SA. There is a deficiency in service availability for this TSU cohort. There are multiple factors for this including insufficient staff skills within NDIS providers, insufficient providers for this cohort and a general reticence to accept this complexity of patient in a scheme that already has excessive overall demand.

There are certainly arguments for an intergovernmental response to this issue. Recent budget announcements regarding additional funding to the NDIS[51], which while likely aimed at core business predominantly, may create an opportunity to negotiate different provider models for forensic patients in South Australia. Certainly the aggregate cost impacts, approximately 2 beds per annum at TSU but much larger across the whole system, should be quantified and raised at appropriate intergovernmental forums.

The bilateral agreement between South Australia and the Commonwealth holds the Commonwealth accountable for ensuring the strength of the market.[52] Clause 42 of the agreement states '*The Parties agree to share responsibility for consulting with stakeholders and partners to Inform advice to governments about entrenched or systemic market risks (including in particular sub-markets or geographies), their severity and likely impacts.'*[53] The circumstances surrounding forensic disability patients would seem to warrant a referral to the Commonwealth under this clause.

The NDIA market enablement framework does recognise the capacity of the NDIA to commission a service in a thin market[54]. In submissions made to the Productivity Commission in 2017, the NDIA stated that:[55]

> [It] is prepared to act to reinforce thin markets where intervention is necessary to ensure market supply, and to act as a Provider of Last Resort where the market fails to provide this supply.

There may be a case for such an intervention to determine a provider of last resort for forensic disability patients in South Australia, and the South Australian Government should prosecute this case.

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[51] See Federal Budget 2021/22 announcements at www.budget.gov.au
[52] Bilateral Agreement between the Commonwealth of Australia and the State of South Australia on the National Disability Insurance Scheme. Clause 41.
[53] Ibid. Clause 42.
[54] National disability Insurance Scheme Market Enablement Framework. October 2018.
[55] Victoria Legal Aid. Submission to Productivity Commission on Market Readiness. 16 March 2018.

Similar discharge issues were raised with regards to post discharge accommodation options. The TSU, like many mental health inpatient services, runs a 'no discharge into homelessness' policy. This is an appropriate policy setting but in the absence of suitable housing stock for this cohort an onus is placed on the TSU team to be the accommodation provider of last resort. The long-term nature of forensic system admissions mean that previous accommodation arrangements have often lapsed by discharge, thus new arrangements will be needed for the majority of patients. It was reported that an impediment to placement of these patients, beyond a general paucity of housing stock, is a reticence to place this cohort in some locations due to the perceived risks associated with their history of offending.[56]

The TSU staff indicated that patients are being retained in the unit beyond clinical necessity and the courts will not consider release on licence unless all the relevant supports are confirmed. It is not clear what processes are utilised when a limiting term expires, although it is possible that some patients are retained in the unit pending available accommodation options either voluntarily or on involuntary treatment orders under the Mental Health Act. The Chief Psychiatrist should review what policy and procedure arrangements are in place for patients whose limiting term expires while still in the TSU and whose community based supports are not in place.

It is understood there are state based support services provided by Disability Services SA that have continued post NDIS implementation for cases with exceptional circumstances, however access to this program is difficult and TSU staff indicated it may be winding down. It is also understood that SA Health operates a Housing and Accommodation Support Partnership (HASP) that links clinical providers with accommodation and psychosocial support providers to build a framework for effective community support. NSW has a similar model, called HASI, which has a specific forensic package. SA Health may wish to investigate this model for the purposes of funding specific forensic HASP support packages that would assist in enhancing bed flow or repurposing some existing HASP packages to forensic patients. There may be greater value in preferentially funding this model in future over and above further funding of sub-acute or rehabilitation beds.

Earlier commentary on the appropriateness of the modified Glenside ward focussed on the inadequacy of the recreational space, notwithstanding the commendable efforts of the clinical team to get the best value from what they have to work with, including installation of a basketball area

[56] Interview with TSU staff.

and some garden beds. One of the anticipated benefits of the utilisation of the Glenside location for a forensic rehabilitation service was access to the recreational facilities on the Glenside campus including the gym, music room and art room. It is understood that agreements are in place to allow such access but the opportunities that have been offered to the TSU patients in those agreements are reported to be impractical and generally limits any meaningful use.[57]

The unannounced review by the Chief Psychiatrist in 2019 raised issues with access to recreational activity and there is no visible improvement in the outcomes for patients nearly two years later, despite efforts by the TSU staff to negotiate a better outcome. It is also noted that the TORs for this review specifically referenced this problem.

This lack of access combined with the inadequacy of the courtyard space, the legal impediments to getting leave for patients and resource impost to get best use out of the grounds, reduces the rehabilitation benefits of the TSU program. There is no obvious resolution to these issues for the TSU population and there is a question as to whether the anticipated recreational opportunities referenced in briefing notes were viable at the time of service planning. It also raises the question as to whether this facility would be more appropriate as an acute shorter stay facility, a purpose for which it was originally designed.

Recommendations

3. Policies and procedures for the TSU must be constantly updated consistent with changes to the NDIS planning process, and planning for community supports on discharge is built into assessment and treatment planning.
4. The South Australian government exercise the market failure clause in the bilateral agreement with the Commonwealth Government on the NDIS to pursue arrangements for a provider of last resort for forensic patients.
5. The Chief Psychiatrist undertake a review of the current practices at the TSU for dealing with patients whose limiting term expires and whose community supports are not in place.
6. SA Health develop specialised forensic packages of HASP supports to assist to build community support capacity in the system.

[57] Interview with TSU staff.

Delivery of the anticipated strategic benefits and the performance of the 'freed up' capacity

In order to assess an effective response to the query regarding whether the strategic system benefits have been realised from the opening of the TSU two important variables need to be available. First a quantifiable frame of reference, or target, for the anticipated measurement of the benefit, and second data of a satisfactory quality that allows that measurement to be calculated.

The quantification of the anticipated benefits

At the time of the planning process there was considerable pressure on hospital beds from 'outlier' forensic patients occupying beds in PICSs and Emergency Departments with between 10 and 13 forensic patients located in the hospital system each day. The discussion paper in 2018 indicated it was expected, in general terms, that the creation of an extra 10 forensic rehabilitation beds would 'meet the needs of most of those patients currently in the hospital system, but not those in prison.' The paper does not really unpack the variables in this assumption any further, which is material. Similarly, the briefing from NALHN to the CE SA Health does not commit to targets for separations or improved bed utilisation.

The substantive rationale appeared to be that increasing overall capacity would automatically shift patients through the system. Despite the documented need being improved utilisation of acute capacity, the decision was made on efficiency grounds to commission rehabilitation capacity. In order therefore for the assumption to hold that increased forensic rehabilitation capacity would remove the impact on hospital-based services the following factors were required:

- The estimates of 10-13 patients in the hospital system to be accurate.
- Clarity over whether s269X patients were included in these numbers.
- No overall increase in Forensic demand once additional capacity was available.
- No increase in referrals from prisons due to improved in-reach or screening practices.
- No decrease in bed occupancy in forensic acute wards
- A maintained decrease in ALOS in the acute forensic facilities in recognition of greater rehabilitation capacity to move patients on to.
- No change to the time required post admission needed to move patients out of rehab into the community.

Unless all these factors hold then the assumption of a straight increase in capacity leading to a concomitant decrease in hospital system impost will not apply in a directly causal fashion. To use an analogy, building a bigger reservoir or dam on a property will allow you to hold more water but it does not cause the water to move any further or faster. It is a wider and faster river that the forensic system needs to resolve the system concern and not a bigger dam.

It is noteworthy that there were no performance requirements on the NALHN service agreement related to an increase in forensic separations.[58] The expected performance improvements in acute ALOS in particular were not quantified and imposed upon the health service to deliver. The staff at TSU also indicated they were not aware of any performance targets imposed on them for separations or ALOS.[59]

It is possible therefore that there may not have been a shared understanding of the performance expectations that would have been necessary to translate the commissioning of new forensic rehabilitation beds managed by NALHN into reduced bed block and improved patient flow in general acute services in CALHN.

Measuring the impact

Notwithstanding lack of clarity about the targets to be met, accurate data collections can assist to form assumptions about the impact. Some data is available to test the system parameters described above and the impact of the beds. This data however is not purpose designed and often was collated manually for the review from other secondary sources.

In terms of overall number of forensic patients, data provided by the FMHS indicates there have been 3178 forensic orders made between 2010 and 2020, or around 300 per year. The number of patients on forensic orders as at the 10 March 2021 was 373 or around 25% higher than the 10-year average. No reason was provided for this growth, which is obviously driven in part by court practice. The preceding numbers do not include those on s269X orders, and no historical data was provided on these.

Outliers in the hospital system are not measured routinely. The capacity to report on them appears to require manual collection by spreadsheet and one data manager questioned the accuracy of the

[58] Informant interview
[59] Informant interview

coding in the hospital information systems in non-forensic hospital locations. Having queried however the baseline outliers to inform the impact of the TSU the review was offered a number of data-points.

The FMHS collects data manually by spreadsheet. This data shows for the period of October 2020 through to January 2021, around twelve months into the operation of the TSU, there was substantial variation in the recorded number of outliers. At the beginning of October only 1 outlier was recorded however by the end of that month there were 6 and the monthly average was 3. The average however climbed to 7 per day through November and December before rising to 10 per day on average in January, the reported average amount prior to the commissioning of the TSU. The peak was 13 on January 13, 2021. It was in February 2021 when this review was commissioned.

However earlier data is instructive. The average number of outliers per day in the 2016/17 FY rarely climbed above 1, with a brief peak of 4 per day in August 2016. The first half of the 2018/18 FY is similar before the beginning of a steady climb through early 2018.

The peak period for average outliers, comparable to the October 2020 to January 2021 period, was from August 2018 to March 2019 when the figures were routinely above 10 per day. It was at this time that the TSU planning was undertaken. The numbers dropped away again from April 2019.

However, in the context of the last five years, it is these two periods August 2018 to March 2019, and October 2020 to January 2021 that appear to be the aberrations. The drivers of these two periods, both over the summer, may be the critical issue that requires response. No informants however could suggest a reason for these two peaks.

It should be noted that there has been a substantial drop in forensic outliers in the month of April 2021 from 8 at the start of the month to 2 by the end of the month. The average over the course of the month was 4.9 per day, substantially lower than during the summer period. Senior staff cannot yet attribute a cause to this, although the new forensic provisions for s269X providing greater flexibility for placement of defendants under investigation for mental competence came into effect on the first of April. There was no evidence however of any change in the number of individuals subject to the ministerial prerogative who were in the prison system over the same period.

Data was provided from the adult acute information system on separations coded as 'forensic' from general mental health wards however these appear unreliable as the numbers from the 2017/18FY to the current FY (YTD) are only 9, 22, 14 and 14 per annum. These would not appear to reconcile to the outliers recorded manually and leads to questions about the accuracy of coding.

It would not appear that growth in the prison population is a driver of forensic inpatient demand. While there was substantial growth in the imprisonment rate in South Australia prior to 2015, there has been no appreciable change in the imprisonment rate between 2015 and 2020 and the actual total number of prisoners declined slightly over this period. The imprisonment rate in SA is roughly equivalent to the national average as of 2020.[60] Data was provided on the number of presentations to emergency departments from prisons during 2020 and this indicated that there were 84 presentations over this time. No comparative data was provided for the prior period to assess whether any change in demand was visible there.

Data from the prison in-reach service indicates that prisoners in contact with the prison in-reach service grew from 875 to 1041 between 2018/19 and 2019/20, however the number of ITOs in place under the Mental Health Act for this population decreased substantially between these two years.

Data was provided on activity in the acute units in James Nash House. It is noted that between 2018 and 2020 the bed occupancy rate at Aldgate dropped slightly from 99.4% to 97.5%. It similarly rose slightly at Birdwood and thus the occupancy across the two units over this period appears largely the same pre and post TSU.

There is also not a lot of change in the number of patients treated per year at the two units between 2018 and 2020. Aldgate treated 87 in 2019/20 down from 89 in 2017/18. Birdwood rose from 61 in 2017/18 to 73 in 2019/20.

There is relatively wide variation in ALOS across years for the two units. Historically this is not unusual. As a result it is difficult to assess if the TSU had any impact on ALOS, however on the bald numbers it would appear to have had the reverse of the intended effect. Aldgate reports an increased ALOS from 20 days in 17/18 to 41 days in 18/19 up to 44 days in 19/20. Birdwood is an even stronger effect up from 41 days in 17/18, to 151 in 18/19 and then down to 88 days in 19/20.

[60] Australian Bureau of Statistics. Report 45170DO002_2020 Prisoners in Australia, 2020

The drop at Birdwood from 18/19 to 19/20 may be attributable to the TSU but there is no compelling evidence to support this.

It is tremendously difficult to make comparisons across jurisdictions with regard to appropriate numbers of forensic beds as legal frameworks differ, interaction with other parts of the service system differ and jurisdiction over various patient cohorts is managed by different agencies. However, some small observations from national AIHW data are worth noting.

The most recent AIHW data for the 2018-19 year, which ought to include the TSU beds, indicates that South Australia has the highest rate of non-acute beds per 100,000 population of any jurisdiction (3.1 per 100,000). This may reflect the inclusion of the ID cohort in the South Australian forensic system, however the rate is nearly two thirds higher than the national average (1.8 per 100,000) and three times higher than Victoria (1.1 per 100,000).

Conversely the rate of acute forensic beds in SA (0.6 per 100,000) is less than half the national average (1.6 per 100,000) and slightly more than a quarter of the rate in NSW and Victoria (both are 2.2. per 100,000). Given wide variation between jurisdictions an appropriate rate or an appropriate ratio between acute and non-acute beds is hard to identify, however this paucity of acute beds is reflective of the acute system stressors that led to the commissioning of more forensic beds.

The intended outcome of the TSU commissioning was that more sub-acute beds would free up capacity in acute forensic services via additional patient flow and this would increase acute bed availability, but this is obviously dependent upon that freed up capacity not extending the length of stay on the acute wards. If ALOS in the forensic acute beds prior to the additional bed availability at TSU was being artificially truncated due to demand pressure on clinicians then the arrival of the TSU may only have allowed for clinically appropriate growth in ALOS in the acute units.

It is acknowledged that it is impossible to form a view on the data available about the performance of the forensic service with regard to the impact on the general hospital system, and whether the TSU has had any material impact on the concerns that drove its commissioning. It is clear that a better formalised data set is required and that this data set allows for clearer measurement of performance and contributes to future service planning.

Recommendations

7. SA Health commission the development of a forensic service dashboard and associated data collections that monitor forensic patients and prisoners in the SA Health system, their locations, resource utilisation and the legal status associated with their presentation.

8. the CE of SA Health build quantifiable performance targets into the NALHN service agreement for the performance of the forensic service that reflects the desired impact of this service on the remainder of the SA Health system.

Suggestions for further improvements

The TORs for this review require the reviewer to address the following proposal:

'The NALHN staff and managers have proposed that to build on the benefits and to address the challenges of the Glenside site that the Tarnanthi service be swapped with a forensic rehabilitation service currently housed in the Kenneth O'Brien Centre. These transitioning rehabilitation clients would move to Glenside, and forensic disability clients would move to either Kenneth O'Brien East or West. As part of undertaking this post occupancy review, it is expected that this particular proposal be considered part of the analysis.'

Prior to responding to the specific proposal, it is important to address the issue of mental health clinical services planning generally in South Australia with a particular focus on forensic services and the materials provided to the reviewer.

The overall impression given from the material read is that forensic services have generally been planned within the context of the existing legacy services, adjusted for whatever envelope of funding appears available, with a view to solving the problem currently facing the system. That is, planning for forensic services appears reactive and not proactive. This nature of the proposal above reinforces this view.

The analysis that led to the commissioning of the TSU was not within the context of larger service planning, is not referenced to an existing forward capital plan for forensic services, does not analyse the likely demand characteristics and the mix of services necessary to respond to it, and does not fit within a broader analysis of the mental health system interfaces that would be necessary to operationalise a given model such as community services availability. Superficially at least it appears

to be a reactive problem-solving exercise to an acute system problem, without unpacking the basis of the problem and the long-term planning solutions necessary to resolve them.

The subsequent proposal above, drawn from the TORs, is presented in very much the same way. That is, the TSU model has provided only a temporary solution to the ED and bed block problem, and now with the underlying problem reappearing, a new solution is necessary. Granted there are other problems with the TSU physical asset at Glenside that led to this thought process, although another rehabilitation service is going to face many of those asset problems as well.

First and foremost the SA mental health system needs to develop a long-term asset plan for its forensic mental health service based on a predictive model of demand, transparent assumptions about patient flow models, agreed bed and workforce mix, and long term asset requirements. Only then can individual decisions be framed within a long-term solution. It is accepted that the absence of a forensic module for the National Mental Health Services Planning Framework has hampered this sort of approach. It is also accepted that the outcomes of such a planning process are both open to internal debate amongst clinical leaders and should be adapted over time as data improves. Nonetheless a template for the forensic system is necessary.

The current SA mental health services plan does not provide such a template for forensic services. It provides a global number for beds, 80, but not the point in time when this would be considered the appropriate number, nor how it was calculated, nor what mix of sub-acute, acute and step-down places are appropriate for the South Australian model of forensic care, nor the right mix of age cohorts, gender cohorts or any specialised services for particular sub-populations. In short, it is not a satisfactory template for decision making for forensic services.

Frequently throughout this review, informants indicated that it was hard to answer specific questions as data sets weren't available and often data could only be compiled manually from file reviews. Sometimes conflicting data was provided depending upon who was the asked question and how they chose to source the data to answer it.

An earlier recommendation acknowledged the need for a clearer formalised data set regarding forensic patients to performance and planning purposes but this data set will also assist to manage discussions with justice agencies regarding budget and operational issues.

The earlier review of the FMHS by Heffernan et all made a number of recommendations regarding potential legislative change that ought to be pursued by the SA Government. This reviewer would like to reinforce support for those recommendations and single out two points in particular for note.

First, there would be considerable benefit in establishing a mental health review tribunal to monitor the operation of forensic orders and vary them as seems appropriate. Such a tribunal may increase the timeliness of decisions regarding community placement and improve the movement of forensic patients through the system. The introduction of psychiatric and community expertise, along with management of relationships with victims, have led to improved practice in most jurisdictions.

Second, the recommendation to preclude the placement of forensic patients in a prison setting is a fundamental recognition of the breach of human rights of such a placement and a contravention of the international treaty instruments to which Australia is a signatory. Planning for forensic need should not include provision for placement of forensic patients in prison settings.

Finally in response to the proposal to swap patient cohorts between Glenside and the Kenneth O'Brien rehabilitation centre, the reviewer would note that the physical asset would still have many of the limitations described earlier in this report that would impact on the care paradigm. The issues relating to the courtyard space, use of the grounds, the positioning of the interview room and seclusion room would remain. A non-forensic cohort may be able to make better use of the grounds and potentially the gym and other facilities although still be faced with the physical design concerns.

It would seem however that the primary forensic bed need in SA is for further acute forensic beds. It appears that it is the patient cohort requiring acute care is the cohort blocking PICU and ED access. While the Glenside facility may not be best placed to accommodate such a cohort, planning for meeting that acute bed need appears necessary.

The ideal is a twenty-year capital plan for forensic mental health services that envisages the capacity for purpose built facilities ideally at the same location. It is noted that the 2018 discussion paper prepared by the Chief Psychiatrist did see the TSU commissioning as a medium term solution with a view to long term consolidation on the JNH campus. A capital plan to support such as outcome is recommended.

It is noted that Infrastructure SA has developed a twenty-year capital plan for required capital infrastructure across the South Australian government. The 'Health' chapter of this document

includes at priority 7, '*implement an integrated health service and infrastructure planning framework that clearly articulates the service need*'.[61] In explaining priority 7 the plan states[62]:

> *'This framework should provide a needs-based methodology to prioritise infrastructure investment. It should identify the challenges and opportunities facing the health system now and into the future to optimise health services and existing infrastructure, look to improve the efficiency of health services and patient flows, and consider substitution strategies to avoid hospital presentations where possible. This framework should provide a system-wide approach to managing demand and be embedded through a hierarchy of documents from the Statewide Services Plan, Local Health Network Clinical Services Plan, Local Health Network Master Plans and Asset Plans to individual business cases that inform prioritisation.'*

These principles are sound planning principles and apply equally well to mental health and its sub-specialties. An approach of this type is warranted for forensic mental health service provision.

Recommendations

9. SA Health develop a forensic mental health services plan that identifies long term bed need, service mix, workforce need and patient flow models. This plan should form the basis of new service commissioning in future.

10. SA Health develop a twenty-year capital plan to develop fit for purpose forensic facilities ideally co-located on a single campus that provides effective models of care to get the best patient outcomes.

11. SA Health revisit the legislative change recommendations of the 2015 FMHS review and reconsider the creation of a MHRT and the preclusion of the placement of forensic patients in prison settings.

Summary of Recommendations

1. SA Health should undertake service and capital planning to identify an alternative facility in the medium term for the management of this TSU cohort. While the facility can be used in the interim it is not ideal for the care needed for this group.

2. If SA Health determines to repurpose this facility, capital works should be undertaken to ensure it is fit for purpose and meets the Australian Health facility Guidelines for the intended service type.

3. Policies and procedures for the TSU must be constantly updated consistent with changes to the NDIS planning process, and planning for community supports on discharge is built into assessment and treatment planning.

[61] https://www.infrastructure.sa.gov.au/__data/assets/pdf_file/0006/197511/20-Year-State-Infrastructure-Strategy-Full.pdf
[62] Ibid, p68.

4. The South Australian government exercise the market failure clause in the bilateral agreement with the Commonwealth Government on the NDIS to pursue arrangements for a provider of last resort for forensic patients.

5. The Chief Psychiatrist undertake a review of the current practices at the TSU for dealing with patients whose limiting term expires and whose community supports are not in place.

6. SA Health develop specialised forensic packages of HASP supports to assist to build community support capacity in the system.

7. SA Health commission the development of a forensic service dashboard and associated data collections that monitor forensic patients and prisoners in the SA Health system, their locations, resource utilisation and the legal status associated with their presentation.

8. The CE of SA Health build quantifiable performance targets into the NALHN service agreement for the performance of the forensic service that reflects the desired impact of this service on the remainder of the SA Health system.

9. SA Health develop a forensic mental health services plan that identifies long term bed need, service mix, workforce need and patient flow models. This plan should form the basis of new service commissioning in future.

10. SA Health develop a twenty-year capital plan to develop fit for purpose forensic facilities ideally co-located on a single campus that provides effective models of care to get the best patient outcomes.

11. SA Health revisit the legislative change recommendations of the 2015 FMHS review and reconsider the creation of a MHRT and the preclusion of the placement of forensic patients in prison settings.

Appendix 1 -Terms of Reference

Post Occupancy Review of Tarnanthi Terms of Reference

Background

The Tarnanthi Unit opened in July 2019. It is a 10-bed closed unit operated by the Forensic Mental Health Service, which is governed by the Northern Adelaide Local Health Network (NALHN).

It added capacity to the Forensic Mental Health Service. Previously it operated 50 hospital beds, and 10 step-down beds. The hospital beds were all located at James Nash House – 30 in an original built in 1988, and 20 in the Kenneth O'Brien Centre which is now five years old.

At the time of commissioning this unit, there was significant forensic mental health client demand on general and intensive care beds in the wider mental health system. Increasing forensic capacity, was intended to have benefits to consumers, and to the system. Consumers could receive care in a purpose build unit, as opposed to being admitted to acute wards. In addition, the expansion would reduce demand on general mental health beds, and emergency departments, freeing up open acute beds, and intensive care unit beds that would have otherwise been occupied by forensic mental health patients, to be used by community patients.

The unit was accommodated within an existing Psychiatric Intensive Care Unit (PICU). This became available at the Glenside site when patients and staff of this unit moved to the new royal Adelaide hospital.

Post Occupancy Review

This review should consider how the creation of the Tarnanthi Unit at Glenside has delivered on the project and strategic expectations for the service. This includes delivery of care for people with forensic disability or dual diagnosis in the unit, and also how the increased bed capacity has assisted with managing demand for forensic mental health beds across the service.

The review should consider

1. Model of care at Tarnanthi, and the suitability of the modified Glenside ward for delivery of this model of care.
2. Consideration of the use of acute and rehabilitation beds 'freed up on the James Nash site' and the extent to which the anticipated strategic benefits in responding to forensic mental health demand have been delivered.
3. The performance of the new service for people who require the Tarnanthi model (considering accessibility, continuity, effectiveness, efficiency, sustainability and safety).
4. The performance of the 'freed up' James Nash capacity for people who require an acute or rehabilitation mental health service (considering accessibility, continuity, effectiveness, efficiency, sustainability and safety with consideration of the building design and model of care)
5. Suggestions for further improvements in the delivery of care to Tarnanthi clients and to the overall use of forensic mental health beds.

This review is being commissioned by the Office of the Chief Psychiatrist on behalf of itself, provided Commissioning and Performance, DHW, and the Division of Mental Health, NALHN.

In considering this review management and staff of the Forensic Mental Health Service and the Division of Mental Health, NALHN met to discuss it and provide a summary of benefits and challenges.

The benefits seen by staff and managers were:

- Additional 10-bed capacity for forensic beds state-wide, reducing the impacts of forensic bed demand on patients, prisoners, emergency departments and acute inpatient wards.
- Development of disability focus and expertise in the Tarnanthi team.
- Development of a Model of Care for disability forensic patients.
- Segregation of some disability forensic patients from other forensic patients, providing greater freedoms and less distress for those individuals.

The challenges seen by staff and managers were:

- Complexities with the legal status of patients and capacity to get leave for the Glenside site grounds.
  There is no or very little access to the music or art room for Tarnanthi patients, with varied gym time allocated (usually at the end of the day).
- Difficulties in managing dysregulated patients in the Glenside site.
- Escorts for patients in the Glenside grounds must include one security guard and one clinician, limits the time spent outside of the ward in the area.
- Glenside ward environment is smaller and creates difficulties in separating patients effectively and impacts on the types and variety of rehabilitation activities that can be offered.
- Interview rooms are not visible from other staff areas.
- Limited digital capacity for communication and entertainment for patients in the Glenside site.
- Seclusion room is shared with two other wards, limiting access for Tarnanthi patients.
- These challenges mean that some disability forensic patients with increased complexity cannot be accommodated at Tarnanthi and remain in James Nash House, impacting their access to disability expertise and care on a daily basis.

The NALHN staff and managers have proposed that to build on the benefits and to address the challenges of the Glenside site that the Tarnanthi service be swapped with a forensic rehabilitation service currently housed in the Kenneth O'Brien Centre. These transitioning rehabilitation clients would move to Glenside, and forensic disability clients would move to either Kenneth O'Brien East or West. As part of undertaking this post occupancy review, it is expected that this particular proposal be considered part of the analysis.

Documents provided

- The Tarnanthi model of care proposal for the use of the 10 bed unit at Glenside (as tabled at the Mental Health Leadership Group).
- Activity data for the Tarnanthi Unit, and the Forensic Mental Health Unit.
- A summary of forensic mental health 'overflow' clients categorised by their legal orders

The Forensic Mental Health Service at the time was appropriately concerned at the mixing of forensic mental health and forensic disability clients in its James Nash facility. The opportunity to open an extra 10 beds enabled forensic disability clients to be placed together.

Appendix 2 – List of Interviewees

NALHN
Ms Maree Geraghty, **CEO NALHN**
Dr Narain Nambiar, **Clinical Director FMHS**
Ms Anna Laval, **Nursing Director, FMHS, James Nash House**
Ms Di Callahan, **Director of Nursing, Mental Health NALHN**
Ms Karen Puvogel, **Chief Operating Officer - NALHN**
Sujeeve Sanmuganatham, **Divisional Director, MH, NALHN**
NALHN - Tarnanthi Unit
Dr Oliver Burgess, **Consultant Psychiatrist TSU**
Collective meeting with four clinical staff of the Tarnanthi Unit
Central Adelaide Local Health Network (CALHN) and *Prison Health*
John Mendoza, **Executive Director, Mental Health and Prison Health Services (CALHN)**
Anna Baggoley, **Clinical Program Delivery Manager MH Royal Adelaide Hospital (CALHN**)
Lesley Legg, **Mental Health Nursing Lead**
Tracey Kroon, **Mental Health Allied Health Lead**
Dr Marcia Fogarty, **A/Medical Director**
Mr Alan Scarborough, **Director SA Prison Health Service**
Department for Health & Wellbeing
Dr Tarun Bastiampillai, **Mental Health Strategy, Policy and Legislation SA Health**
Dr John Brayley, **Chief Psychiatrist, SA Health**
Marc Currie, **Mental Health Information Manager**
Carers & Consumers
Courtney Teague, **Consumer Peer consultant**
Jane O'Sullivan, **Carer consultant**
Southern Adelaide Local Health Network (SALHN)
Emma Altman on behalf of Dulcey Kayes, **Co-Director Mental Health SALHN**
Michael Vance, **Clinical Director Mental Health SALHN**
Invitations Extended but interviews not possible
Mr John Strachan, **Principal Advisor Offender Services**
Andrew Wiley, **Incoming Director SA Prison Health Service**
Ms Helen Chalmers **Executive Director, Health Services Programs & Funding**
Ms Mary-Louise Hribal, **Chief Magistrate**
Dr Dan Pronk, **Medical Head of Unit, SA Prison Health Service (PHS)**

A Note on the reviewer

This review was undertaken by David McGrath, the principal consultant at David McGrath Consulting. David has thirty years experience in the Mental Health and Drug & Alcohol fields incorporating research, clinical, operational, policy and leadership roles and has extensive experience in policy development, intergovernmental relations, clinical systems and governance. He has qualifications in psychology, business and law.

David McGrath Consulting has undertaken projects in most Australian Jurisdictions including development of the Fifth National Mental Health and Suicide Prevention Plan on behalf of Commonwealth Health, a review of the forensic mental health system in the Northern Territory, an assessment of the impact of the NDIS on psychosocial service provision in mental health and the development of a new policy model for Non-Government Drug & Alcohol Services in NSW.

David was previously the Executive Director of Mental Health and Drug & Alcohol Programs for the NSW Government for ten years and held national leadership roles in both Mental Health and Drug & Alcohol. This provides extensive knowledge of the operation of mental health service systems within whole of government frameworks and the interoperation of government agencies.

More recently David was the Chief Operating Officer of the Special Commission of Inquiry into the Drug 'Ice' and other Amphetamine Type Stimulants for the NSW Government working with senior judicial and legal staff to present options to the NSW Government to respond to the use of these drugs in NSW. This experience further built on his experience in the interaction of clinical and legal paradigms.