APPENDIX 2

"Offence Prevention through Enhanced Mental Health Care and Better Mental Health"

FACULTY OF FORENSIC PSYCHIATRY (VICTORIA) SUBMISSION TO THE ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

APPENDIX 2

Contents

APPENDIX 2

APPENDIX 2

Introduction

Forensic psychiatrists work at the interface between psychiatry and the law. The RANZCP Faculty of Forensic Psychiatry comprises psychiatrists with special expertise and training in this subspecialty. The Victorian Branch of the Faculty has over 100 members and is very active in advocacy and education. Its members have broadly based expertise, covering both 'civil' and 'criminal' fields.

This submission has particularly drawn on the expertise and experiences of members working in public mental health at its various interfaces with the criminal justice system in Victoria.

It was developed under the auspices of the Victorian Subcommittee of the RANZCP Faculty of Forensic Psychiatry, with all members being invited to make submissions and participate in relevant meetings. The final document was developed by a Working Group comprising four experienced Victorian forensic psychiatrists: Ann Brennan, Andrew Carroll, Gunvant Patel and Carolyn Simms.

The Faculty of Forensic Psychiatry, having no direct role in service management, is well-placed to provide expert, objective advice to the Royal Commission regarding forensic mental health that is free of any conflicts of interest.

This is intended to function both as a 'stand alone' document and also to assist with the development of the broader submission developed by the Victorian Branch of the RANZCP.

Andrew Carroll
Chair, Victorian Subcommittee of RANZCP Faculty of Forensic Psychiatry

June 2019

APPENDIX 2

Executive Summary

Investment in high-quality, recovery-oriented, best-practice forensic mental health services for forensic consumers[1] should be a priority for the Victorian government for the following reasons: public safety; cost-effectiveness; and human rights.

Specialist multidisciplinary forensic mental health services that provide evidence-based interventions, in both community and inpatient sectors, can play a significant part in enhancing the safety of the Victorian public.

Investment 'up-front' to reduce the risks of offending and of imprisonment amongst persons with serious mental illness – a population at disproportionately high risk of these outcomes, will yield positive future returns in both human and financial terms. This is in line with established principles of 'justice re-investment'. Cost-effectiveness of forensic mental health services can be enhanced by better adherence to principles of efficient delivery of care.

The provision of high quality forensic mental health services is a matter of meeting the Human Rights of some of our most vulnerable citizens.

We urge the adoption of 10 key principles for forensic mental health service delivery in Victoria:

1. Consumers must be at the centre of the care provided by forensic mental health services. Recovery principles, including consumer involvement in service design and delivery, are essential for optimising the safety of consumers and the general public. There must be a dual emphasis on promoting and enabling individual recovery and independence, while also ensuring the protection of the public. Critically, these are not mutually exclusive aims or outcomes: high quality, recovery-oriented care will result in improved protection of the public. Recovery themes of enhanced connectedness to the community, hope for the future, positive self-identity and empowerment align well with evidence-based approaches to risk reduction that promote prosocial activities and responsible self-management.
2. Access to specialist forensic services must be based on the risk/needs of the consumer regardless of legal status.

[1] We define forensic consumers in line with accepted international best practice as:

- individuals with a mental disorder (including neurodevelopmental disorders) who
- pose, or have posed, risks of serious harm to others and
- whose risk is usually related to their mental disorder.

APPENDIX 2

3. Service models, both community and inpatient, must provide a spectrum of care to enable a matching of security levels, intensity and duration of specialist interventions to the risk/needs of the consumer.
4. Preventative principles must be embedded into service design, encouraging proactive, early therapeutic interventions.
5. Effective treatment of mental illness must be recognised as a necessary, but generally not sufficient, intervention to reduce the risks of harm posed by forensic consumers.
6. The recovery of forensic consumers requires access to the full range of evidence-based treatments for complex mental health problems, including evidence-based psychotherapies.
7. Forensic consumers require a broad-based holistic approach that addresses their full range of health, 'criminogenic' and psychosocial needs.
8. Forensic consumers require a collaborative multi-agency approach that incorporates mental health, physical health, legal, correctional, substance misuse, disability, social and housing service sectors. Forensic consumers hence require key service elements, including health, justice and police to be enabled to share relevant information in a timely and ethically judicious manner.
9. Forensic consumers require equivalence of care regardless of status and setting. Prisons therefore need to be accepted as *part of* the Victorian community.
10. FMH services need to be sustainable, evidence-driven and innovative. This requires a focus on training, research, reflective practice, staff well-being and service evaluation.

We make 10 specific recommendations:

1. Establish key principles for all departments and services dealing with forensic consumers
2. Strengthen community public mental health capacity to support forensic consumers by establishing local forensic specialist treatment teams
3. Develop a statewide secure inpatient bed base, according to a 'stepped model' across a spectrum of security levels
4. Ensure community equivalence and integration for prison-based services
5. Develop low/medium secure options for women
6. Develop a range of specialist options for forensic consumers with cognitive disabilities
7. Develop a range of specialist options for youth forensic consumers
8. Develop low secure specialist units for Aged consumers
9. Develop forensic psychotherapy expertise in Victorian psychiatry
10. Develop a sustainable workforce

APPENDIX 2

Why Victoria should prioritise the development of high-quality forensic mental health services

Forensic mental health services are those mental health services that are provided to meet the needs of consumers with ;'forensic needs', referred to in this document as 'forensic consumers' (FCs).

We define forensic consumers in line with accepted international best practice (Anonymous, 2013) as:

- individuals with a mental disorder[2] (including neurodevelopmental disorders) who
- pose, or have posed, risks of serious harm to others and
- whose risk is usually related to their mental disorder.

FCs, compared to non-forensic consumers, generally show:

- a higher level of clinical complexity such as 'treatment-resistance' and multiple co-morbidities (especially personality disorders and substance use disorders);
- a higher level of current psychosocial adversity and need; and
- a higher prevalence of being significantly affected by past trauma.

Recovery in the forensic context can be defined in various ways, including:

- a consumer-defined 'life worth living'
- a 'good life' including desistance from offending
- clinical recovery from the symptoms of a mental disorder that may have been related to high-risk behaviours.

Most FCs, at some point in their recovery journey, will require care involving a degree of security. This involves not merely secure buildings ('structural' security), but also robust processes and procedures ('procedural' security) and, most importantly, therapeutic relationships with staff ('relational' security).

Working effectively with FCs often places particular demands on staff, who may be placed at high risk of 'burnout'.

[2] *Another term in common usage in the extant literature and policy documents is 'serious (or 'severe') mental illness' (SMI). There is no satisfactory standard definition and hence its intent is often shaped by the perspective of the user. In the setting of publicly-funded mental health services it is generally accepted to mean enduring mental disorders associated with the greatest impact on functioning and risk of harms and that place a disproportionate significant demand on the health-care system. SMI does not implicate any single diagnostic category and in adult mental health it usually encompasses psychotic disorders and bipolar disorders and personality disorders (with recurrent serious risk of self-injury). The term is narrower in scope that 'mental disorder', a term that also includes neurodevelopmental disorders such as autism.*

APPENDIX 2

We believe that investment in high-quality, recovery-oriented, best-practice forensic mental health services for FCs should be a priority for the Victorian government for the following reasons: public safety; cost-effectiveness; and human rights.

APPENDIX 2

Public safety

Mental illness is related to public safety

Mental illness is only implicated in a small proportion of serious offences and the majority of the mentally ill never offend (Wallace et al., 1998) . Public apprehension of risk from persons with SMI is markedly disproportionate to the actual risks posed. Nevertheless, local and international evidence does indicates that SMI is a significant risk factor for offending.

With respect to serious violence:

- The relationship is particularly strong - especially for homicide in the presence of schizophrenia (Wallace et al., 1998).
- People with schizophrenia have been found to be nearly 20 times more likely to commit murder than people in the general population (Fazel et al., 2009).

With respect to people presenting to general mental health services at the onset of SMI:

- A history of offending is common in young adults with emerging psychosis when they make contact with mental health services (Large and Nielssen, 2011): one in three males will have a conviction for an offence involving some degree of violence and one in five for serious violence.
- Subsequent to this first contact, this 'already offended' cohort has a high risk for further offending (Hodgins et al., 2011) that is greatest in the first five years but remains elevated long-term.

Why does this relationship exist?

The relationships between mental disorder and offending are complex and diverse. A recent summary of the relevant empirical research (Skeem et al., 2011) concluded that:

- In approximately 10% of cases, there is a simple direct link between offending (e.g. violence) and active symptoms of mental illness (e.g. persecutory delusions regarding the victim).
- In the vast majority of cases, there is an indirect link, whereby the manifold psychosocial effects of SMI expose the sufferers to known 'general risk factors' for offending such as substance misuse, procriminal social networks, homelessness and lack of access to prosocial peers/activities.
- In only a small proportion is the offending totally independent of mental illness.

What should be done?

It follows from the above findings that:

APPENDIX 2

- Treatment of SMI is a **necessary** element of achieving desistance from offending (and hence improving public safety) in all persons with mental illness who offend.
- In most cases, such treatment is **not sufficient** to achieve that aim: it is also necessary to target broader psychosocial needs (including 'criminogenic needs' – those empirically related to reduced offending risk).

A very solid evidence base (Bonta and Andrews, 2017) now exists demonstrating that there is a set of modifiable risk factors for offending – 'criminogenic needs' – that are amenable to rehabilitative interventions:

- substance abuse
- leisure/recreation
- work/education
- family/marital supports
- antisocial personality patterns
- antisocial cognition
- antisocial associates

The vast majority of FCs will have unmet needs in some or all of these areas and, provided their mental illness is also treated, can benefit from such interventions.

In incarcerated populations, there is limited research regarding the effectiveness of standard correctional approaches to reduce offence risk for offenders with mental illness. Correctional rehabilitation research indicates that mental illness is a 'responsivity factor' (Bonta and Andrews, 2017): a factor that needs to be addressed if other interventions are to have optimal chance of success.

Expert forensic psychiatric consensus (Till et al., 2015) is that prison programs generally fail to take account of the impact of mental illness and the importance of personalized interventions incorporating an integrated approach to their complex treatment needs: siloed, parallel and group-based offender interventions thus fail to be effective for this group and recidivism is not reduced.

At the community level:

- Unsurprisingly, reducing offending risk in FCs challenges the skills of generic adult assertive community teams: studies suggest that such services do not reduce the likelihood of further criminal offending despite successfully reducing hospitalisations (Calsyn et al., 2005).
- Specialist 'Forensic Assertive Community Teams' that have forensic expertise and target criminogenic needs (***as well as*** assertively treating mental illness) have demonstrated better outcomes on recidivism (Lamberti et al., 2017).

For incarcerated offenders with SMI:

- Evidence regarding outcomes from prison-based care versus secure forensic hospital care for this group strongly favours hospital care as a means of

APPENDIX 2

reducing recidivism. Specialist forensic inpatient mental health services (providing broad-based forensic specialist treatment and rehabilitation) are more effective at reducing reoffending (especially for violent offences) in FCs than are prisons. Immersion in an environment where all elements are co-managed by a multi-disciplinary team has better outcomes and hence maximizing future public safety. This is particularly so for those with a diagnosis of schizophrenia and when the index offence involved violence. (Coid et al., 2007)

- UK Ministry of Justice data shows that the reconviction rate within a two year period for violent and sexual offences for patients conditionally discharged from hospital between 1996-2006 was 2% (Anonymous, 2008); the equivalent rate (from a different study) for those released from a prison sentence was around 20% (Cunliffe and Shepherd, 2007).

Specialist multidisciplinary forensic mental health services that provide evidence-based interventions, in both community and inpatient sectors, can play a significant part in enhancing the safety of the Victorian public.

APPENDIX 2

Cost-effectiveness

Crime costs the public purse an annual amount running into the tens of billions. Every homicide has been estimated by the Australian Institute of Criminology to cost a sum that runs into several millions of dollars, when all associated costs are considered (Anonymous, 2003).

A very vulnerable subpopulation–those with inadequately treated SMI and unmet psychosocial needs – are at very high risk of early return to prison. Anecdotal evidence locally suggests that in Victoria this is often because of the absence of adequate housing and other broader psychosocial supports, as well as difficulties with accessing mental health care on release. The result is recurring reoffending and returns to prison, imposing heavy financial costs to the public purse in terms of both offending and ongoing imprisonment.

Efficient delivery of care

Since FCs often have complex clinical and security needs, forensic mental health services are 'high cost, low volume' services : generally, the level of security and complexity of consumer need means that forensic mental health services are relatively more expensive to provide than general services. However, when designing services for FCs, there are established ways to ensure that the funding is used in the most cost-effective way:

- Adherence to the evidence base by using staff with specialist forensic expertise in areas including:
    - The assessment and management of risk and security (physical, procedural and relational) needs.
    - Rehabilitative interventions that address offending risk as well as mental disorder.
    - Effective interface with other stakeholders, including the criminal justice system and Corrections.
- Stepped care provided according to need:
    - Risk and security needs, as assessed by a qualified forensic psychiatrist, should be the major determinant of placement and transition of consumers.
    - Better matching between consumer needs and length of stay/level of security helps to ensure efficient use of resources.
    - Patients should make progress through the care pathway according to their risk to others and the stability of their mental health.
- Care based on integrated clinical pathways:
    - Currently, very complex consumers in Victoria may be referred for bespoke packages of care, often brokered by the Multiple And Complex Needs Initiative (MACNI): this is an expensive way to deal with the barriers inherent in a broken, fragmented system.

APPENDIX 2

  - A stepped, Statewide model of care would allow for integrated pathways of care, facilitating a consumer's recovery journey, based on dynamic changes in their risk-needs, and negating the need for such expensive, inefficient individualised packages of care.
  - The time of highest risk for individual consumers is during the transition between different parts of the pathway – it is essential this transition is managed safely and effectively. This is particularly the case for the transition from the security and support in secure settings to increased independence and responsibility in the community. It is essential that this transition is managed safely and effectively by clinicians who are familiar with the individual and with whom the individual has already developed and built a positive and trusting therapeutic relationship.
- Cross-sector Integration
  - Integration requires a range of government departments to work collaboratively, including judicious sharing of information.
  - Cost-effective forensic mental health services would work collaboratively with multiple stakeholders, including:
    - other mental health professionals
    - Disability services
    - NGOs involved with FCs
    - NDIS
    - General Practitioners (GPs)
    - The Courts
    - Agencies working in the criminal justice system.
    - Corrections
    - Agencies (such as Justice Health) that oversee prisoner health care

Investment 'up-front' to reduce the risks of offending and of imprisonment amongst persons with serious mental illness – a population at disproportionately high risk of these outcomes, will yield positive future returns in both human and financial terms. This is in line with established principles of 'justice re-investment' (Anonymous, 2018b). Cost-effectiveness of forensic mental health services can be enhanced by better adherence to principles of efficient delivery of care.

APPENDIX 2

Human Rights

Mental disorders are over-represented in forensic settings

Over the last decade, despite the absence of any significant trend indicating increased offending (other than for sexual offences), the rate of imprisonment in Victoria has increased by 80% and the unsentenced portion had gone from a fifth to over a third (CV prisoner statistics 2007/08 to 2017/18) (Anonymous, 2018a).

Australian research, similar to that conducted overseas, strongly suggests that prisoner populations have disproportionately high levels of mental disorder; given the elevated rates of offending even prior to first mental health contact, remand prisoners have an increased likelihood of an undiagnosed psychotic disorder (White et al., 2006).

A NSW study found a 12-month prevalence of 'any psychiatric illness in the last year' of 80% in prisoners (compared to 31% in the community) (Butler et al., 2006).

Some 66% per cent of Victorian female prisoners were found to meet criteria for a mental disorder – after excluding substance-related disorders (Tye and Mullen, 2006).

Prisoners show very high rates of history of chronic childhood abuse and repeated incidents of serious trauma in adulthood: Post Traumatic Stress Disorder (PTSD) in prisoners is several-fold higher than in the community (Butler et al., 2006). PTSD is associated with increased risk of substance abuse and offending.

There is also an increased prevalence of intellectual disabilities among individuals in the criminal justice system (Hellenbach et al., 2016).

There are likely a range of reasons for this. As well as the factors that increase offending risk in those with mental disorders (see above), persons with mental disorder often struggle to access bail or early release on parole for various reasons including:

- police anxiety about predictability and ability to comply with conditions
- limited access to legal representation
- lack of suitable release accommodation options
- courts lacking confidence in the adult mental health service to properly manage ongoing mental disorder and related risks.

Services for forensic consumers fail to meet their needs

Currently in Victoria:

- Acutely unwell prisoners wait far longer than their community equivalents to access psychiatric hospital care.

APPENDIX 2

- Imprisoned FCs are generally unable to access adequate multidisciplinary care; mental health care is limited to brief risk assessments and generally focussed on biological modes of treatment.
- Treatment is inadequately trauma-informed.
- Prisoners cannot generally access psychological modes of treatment.
- Prisoners with treatment-resistant schizophrenia are generally unable to access gold standard treatment (clozapine commencement), which requires admission to hospital.
- Release planning for FCs in prison is often rushed, ad hoc, with grossly inadequate community-based provisions in place to meet the person's needs in the community.

This represents a clear breach of the State's commitment to 'community equivalence' of care for prisoners.

Also, a growing number of SMI offenders have been placed on post-sentence detention and supervision orders in Victoria. They are housed in a remote location with limited access to basic mental health care and with no prospect of receiving proper forensic psychiatric rehabilitation. It is no exaggeration to regard this practice as 'criminalisation' of the seriously mentally ill.

Perhaps most egregiously of all, there is a subset of prisoners with neurodevelopmental disorders and/or other cognitive disorders (such as acquired brain injuries) – some of whom are detained after a finding of 'unfitness to stand trial' or 'not guilty by reason of mental impairment'. Victorian DHHS facilities currently contain no options with adequate security and expertise to accommodate many of these individuals. Their plight has recently been highlighted by the Ombudsman (Glass, 2018).

Forensic Consumers have rights to appropriate care

As well as being very unlikely to reduce the long-term risk of reoffending posed by this group, inadequate service provision for FCs, both in the community and in custodial settings, means that the State of Victoria -that holds itself out as the "most progressive" in the Commonwealth - is at risk of challenge on the basis of a number of Human Rights concerns:

- Failure to provide adequate care arguably contravenes the UNHR Convention on the Rights of Persons with Disabilities (Anonymous, 2006) to which Australia is a signatory.
- The United Nations' Basic Principles for the Treatment of Prisoners (Anonymous, 1990) mandate that prisoners shall have access to the health services available in their country without discrimination on the grounds of their legal situation.
- The Victoria's Charter of Human Rights and Responsibilities enshrines a right to "humane treatment when deprived of liberty".

APPENDIX 2

The following vignette, based on a real case, highlights these concerns:

[redacted] is a [redacted] year old single man who is currently in prison on both breach of his Supervision Order (SSOSDA, now Serious Offenders Act 2018) and violent reoffending (assault of staff member at [redacted]
He has a history of indecent assaults against adult female and teenage girls. He is a complex patient with a diagnosis of chronic treatment resistant schizophrenia co-morbid with cognitive impairment verging on intellectual disability, intractable substance use disorder and both a deprived and traumatic development (sexual abuse, removal from family, parental mental illness, 80 plus foster homes) resulting in attachment disorder and disruption of personality development.
[redacted] has a long psychiatric history with first diagnosis at age [redacted] but probable symptoms from early adolescence. He subsequently had admissions at least yearly and spent 2 years in his regional SECU.
His most recent offending occurred in the context of non-compliance and destabilisation once discharged from this secure setting. Many options have been looked at to try and get [redacted] bailed from prison, all unsuccessful. He has been deemed unsuitable for a (non-secure) brain disorders unit. [redacted] is not a suitable option for him. He is currently in a mental health bed within the Victorian prison setting and takes his medication voluntarily. He has persistent psychotic symptoms and violent fantasies but retains a positive view towards mental health services and articulates a desire to be treated long term in a mental health facility.
In line with his mental illness and cognitive impairment he is grossly functionally impaired (was noted to mop floor with his own urine at [redacted] and does not possess the requisite skills to maintain independent living. He is bereft of social connection or supports, has no family, no home.
[redacted] requires a long term medium secure bed in Forensic facility or forensic bed. His needs currently do not meet the threshold for the Statewide High Secure Forensic beds and even if they did he is neither "acutely" unwell nor of the right legal disposition (he is a "civil" patient) to be eligible for one. Within the state of Victoria, [redacted] therefore defaults to the SECU system when released from prison, a system that will not provide a long-term option to manage his risk and needs and means that he is placed in a general psychiatric mixed gender setting. However, even his regional SECU has refused him service based on part that he is homeless and therefore does not have an "exit plan".
[redacted] has previously benefitted from treatment with clozapine. He cannot access recommencement of this treatment in prison. His general service has previously refused to consider re-trialling him on clozapine as neither their acute unit or SECU is deemed to be able to undertake this for this man. [redacted] thus cannot access the best evidence based antipsychotic medication that we have available to treat his schizophrenia.
The State of Victoria appears to have no answers for him.

The provision of high quality forensic mental health services is a matter of meeting the Human Rights of some of our most vulnerable citizens.

APPENDIX 2

Recommendations

Establish key principles for all departments and services dealing with Forensic Consumers

Forensic Consumers invariably elicit input from a diverse range of professionals and services. They are therefore the legitimate concern of a range of government departments, notably Health, Human Services, Justice and Police. Too often, this diversity means that professionals and services are at 'cross-purposes', leading to inefficiencies and conflicts that fail to assist either the consumer or the general public. We therefore propose the development of a set of 'core principles' to be shared across all sectors when working with FCs. We propose the following ten points for consideration. In part these are derived from internationally accepted best-practice models (Anonymous, 2013):

1. Patients must be at the centre of the care provided by forensic mental health services. Recovery principles, including consumer involvement in service design and delivery, are essential for optimising the safety of consumers and the general public. There must be a dual emphasis on promoting and enabling individual recovery and independence, while also ensuring the protection of the public. Critically, these are not mutually exclusive aims or outcomes: high quality, recovery-oriented care will result in improved protection of the public. Recovery themes of enhanced connectedness to the community, hope for the future, positive self-identity and empowerment align well with evidence-based approaches to risk reduction that promote prosocial activities and responsible self-management.
2. Access to specialist forensic services must be based on the risk/needs of the consumer regardless of legal status.
3. Service models, both community and inpatient, must provide a spectrum of care to enable a matching of security levels, intensity and duration of specialist interventions to the risk/needs of the consumer.
4. Preventative principles must be embedded into service design, encouraging proactive, early therapeutic interventions.
5. Effective treatment of mental illness must be recognised as a necessary, but generally not sufficient, intervention to reduce the risks of harm posed by FCs.
6. The recovery of FCs requires access to the full range of evidence-based treatments for complex mental health problems, including evidence-based psychotherapies.
7. FCs require a broad-based holistic approach that addresses their full range of health, 'criminogenic' and psychosocial needs.
8. FC's require a collaborative multi-agency approach that incorporates mental health, physical health, legal, correctional, substance misuse, disability, social and housing service sectors. FCs hence require key service elements, including health, justice and police to be enabled to share relevant information in a timely and ethically judicious manner.

APPENDIX 2

9. FCs require equivalence of care regardless of status and setting. Prisons therefore need to be accepted as *part of* the Victorian community.
10. FMH services need to be sustainable, evidence-driven and innovative. This requires a focus on training, research, reflective practice, staff well-being and service evaluation.

APPENDIX 2

Strengthen community public mental health capacity to support Forensic Consumers by establishing local forensic specialist treatment teams

Current challenges in Victoria

Current limitations of the Victorian Community Forensic Mental Health Service, managed by Forensicare in Clifton Hill, include:

- Direct treatment is limited to : treatment of Forensic Patients who have exited Thomas Embling Hospital under the Crimes (*Mental Impairment and Unfitness to be Tried*) Act, in the initial year(s) after their release; and a small number of 'Problem Behaviour Program' clients, primarily receiving psychological interventions.
- Although videolink is widely used, face-to-face contacts generally require attendance of the client at the offices in Clifton Hill, limiting access for regional clients in particular.
- 'Forensic Clinical Specialists' are employed by AMHSs. Their role however is primarily limited to assessment and liaison work.

It is clear that the mainstream AMHSs throughout Victoria consider there to be substantial unmet need for assistance with ongoing treatment and management of clients who are at risk of offending or who have already been involved with the criminal justice system.

Proposed solutions

Evidence suggests (Lamberti et al., 2017) that enhanced outcomes for public safety and consumer wellbeing can be achieved by specialist forensic community mental health teams with the following characteristics:

- location close to consumer, to facilitate regular contact
- small case-loads (up to 10 clients per case manager)
- treatment focus on both treatment of mental illness and on addressing criminogenic needs such as substance use and procriminal attitudes
- leadership by a psychiatrist with forensic expertise
- close integration with social support agencies (including housing) and with legal/criminal justice services where appropriate.

Pilot services in the North West (MH-FIT) and South East (MH-FACT) with most of these features have recently been established, to provide enhanced clinical mental health services for those at risk of serious offending. They provide an Assertive Community Treatment (ACT) model of care characterised by lower caseloads, community based treatment (outreach/intensive) and a team based approach, as well as forensic expertise. This may include but is not limited to, medication

APPENDIX 2

management, psychosocial support and referral (housing, financial, vocational), counselling, crisis admissions/assessments, motivational interviewing for dual diagnosis, offence chain analysis and cognitive-behaviour therapy for comorbid conditions.

An outreach service has recently been funded in Ballarat to provide mental health services to the correctional residential facilities in the Western District that house persons subject to post-sentence detention.

Forensic specialist services in the youth sector have also recently been established based at The Alfred and Orygen.

Evaluation of these pilot services will be important in informing future developments.

Ideally, forensic community teams could provide care to a range of FCs, for periods dictated by clinical and risk-need, before transition back to the general AMHS community team. FCs in particular need of such services may include:

- FCs exiting from secure care (whether that be Thomas Embling Hospital, other secure facilities, or prison) back to the community
- FCs who have offended and who are under the supervision of Community Corrections Officers
- FCs identified by general services as being at high risk of violence or other offending.

Such specialist forensic teams could also assist services by:

- playing a preventative role by way of assessments and/or secondary consultations.
- taking a lead in education and support of local clinicians around forensic issues.
- taking on the role of 'court liaison/diversion' work in local Magistrates Courts, thus facilitating integration between courts and the local mental health services

Co-location of specialist forensic teams with local adult general mental health services would facilitate a close working relationship to allow step-up and step-down of care in response to changes in the client's needs. It would also facilitate access at the local level to inpatient care, as and when needed. It is recognized however that, ideally, at least some FCs may require access to inpatient care at a higher level of security than is provided in mainstream acute psychiatric units.

APPENDIX 2

Develop a statewide secure inpatient bed base, according to a 'stepped model' across a spectrum of security levels

Current challenges in Victoria

Victoria currently has 124 specialist forensic mental health beds, all located at Thomas Embling Hospital in Fairfield. Nearly all long-term patients there are 'Forensic Patients' subject to a Custodial Supervision Order after a court finding of 'Not Guilty by Reason of Mental Impairment' or 'Unfitness to be Tried' under the Crimes (Mental Impairment and Unfitness to be Tried) Act (CMIA). Long-term placement of FCs there is thus determined by 'legal status' rather than by their actual 'risk needs' for specialist intensive care or for high-secure hospitalization. It is likely that many could be safely managed in less expensive conditions of lower security – either 'medium secure' or 'low secure' forensic facilities, without compromising their access to specialist forensic mental health care or endangering the community. Unfortunately, no such alternatives exist in Victoria for Forensic Patients. Unlike New South Wales (Adams et al., 2019), there is no 'spectrum of security': medium secure regional facilities do not exist and so specialised forensic secure care is confined to a single facility in Fairfield.

Conversely, a number of regionalized low secure 'Secure Extended Care Units' (SECUs) exist in Victoria, managed by general mental health services with no formal linkages to the forensic sector. Such facilities are not specialized, are variable in the level of actual security provided and do not generally offer specialist forensic interventions that target broader risk needs, beyond mental illness. They are also in high demand and struggle to meet the needs of general mental health services working with clients at high risk of offending. In addition, exit pathways for consumers from SECUs are often limited, due to the lack of suitable community accommodation options and the lack of specialist forensic community-based services.

Hence, there is a lack of access for consumers to long-term secure, forensic beds until after a serious crime occurs and even then only if they are deemed eligible for a CMIA disposition. This state of affairs is expensive, wasteful, anti-Recovery and places both consumers and the Victorian public at needless risk of serious harm.

Over the past decade, the Victorian government has invested significantly in facilities (such as 'Corella Place' and 'Rivergum' in Ararat) that house offenders assessed as high risk of violence and/or sexual offending at the end of their prison sentence. Such facilities house a disproportionate number of persons with SMI[3] but have not been designed in alignment with best-practice principles for FCs and fail to meet either the clinical or risk needs of such persons; long-term expensive 'warehousing',

[3] *A review at Corella Place recently put the prevalence of residents diagnosable with SMI there at over 10% (personal communication, Ann Brennan).*

rather than recovery and safe re-integration into the community, are likely outcomes. These initiatives have therefore done little to assist with the challenges posed by this group.

At the acute end of the spectrum, over the past decade, the secure acute units at Thomas Embling Hospital have experienced intense demand resulting in a state of perpetual crisis management for the acutely psychotic prisoner. Transfers of compulsory patients certified under the Mental Health Act to the acute units at Thomas Embling Hospital, that used to take days, now routinely take months.

If acutely psychotic FCs are fortunate enough to make it to Thomas Embling Hospital, they are generally returned to prison as soon as their mental state and behavior is settled enough to allow; such FCs can no longer access long-term hospital-based rehabilitation, even where this is clearly indicated. Prison-based services such as those at Ravenhall, are unable to implement best practice rehabilitation interventions (such as graduated community re-integration programs) due to their correctional rather than clinical focus.

The majority of acutely unwell prisoners are low level offenders; they do not pose a serious risk to others and could receive optimal care in conditions of lower security without compromising safety to others. Most will have previously been managed by general psychiatric services prior to arrest.

After arrest but prior to imprisonment, although low-risk offenders could be diverted at the Magistrates Court level, either on bail or on court-based treatment orders, to mainstream inpatient units, this rarely occurs in practice in Victoria.

Proposed solutions

Specialist inpatient Forensic mental health services have been shown to be more effective at reducing reoffending (especially for violent offences), than for equivalent offenders released from prison. Local data shows that even homicide offenders are at low risk of serious offending post-release from forensic rehabilitation services (Ong et al., 2009). Evidence regarding outcomes from prison-based care versus secure forensic hospital care for FCs thus strongly favours the latter as a means of reducing recidivism and hence maximizing future public safety. This is particularly so for those with a diagnosis of schizophrenia and when the index offence involved violence. In summary, a serious offender with SMI, who presents a moderate to high risk of serious reoffending requires transfer from prison to a hospital-based forensic rehabilitation unit.

In terms of specific unmet need in Victoria:

- Despite Victoria's claim to be "the most progressive State" in Australia, comparison with other states shows a significant shortfall in forensic psychiatric beds

APPENDIX 2

- NSW, Queensland and SA have twice as many such beds based upon population size.
- The UK over the last decade has seen an ongoing expansion in low and medium secure units to accommodate the need for secure forensic rehabilitation of the SMI serious offender.
- Scotland (a state with a slightly lower GDP per capita than Victoria), with a million less people and a similar rate of incarceration has 293 low secure and 146 medium secure forensic beds. They comprise units of up to 15 beds located in regional health service catchments. 52% of low secure (117) and 82% (110) of medium secure patients were on orders made via the courts; the rest were under civil commitment.
- Based on the Scottish figures, Victoria requires some 150 low secure forensic **and** some 140 medium secure forensic beds for extended rehabilitation.
- The current complement of beds at Thomas Embling Hospital may only require modest expansion if FCs are instead managed, based on security needs, in significantly less expensive local mainstream adult in-patient settings or in low/medium secure forensic beds.

We recommend a 'Stepped Model' of forensic inpatient resource provision, that interfaces directly with community forensic services (see above) as part of an integrated care pathway, based on the following principles:

- Access based on needs and risk, not legal status
- A spectrum of security, with the **majority** of beds being 'low' or 'medium' security, located and managed on a regional basis
- FCs to move through the system - step up and step down – according to security needs
- Supported by specialist, forensic mental health accommodation services to facilitate eventual exit into independent community living
- A recognition that 'transition points' between different services/locations, are times of elevated risk, requiring more clinical support
- Workforce: trained as forensic specialists in a range of disciplines, to enable focus on modification of reoffending risk (criminogenic needs) as well as treatment of enduring mental illness
- Overarching Statewide governance structures such that access to timely and appropriate level of service is not impacted by service interface issues and does not require "a home address", given the high prevalence of homelessness amongst FCs.
- Local, close integration with the community forensic teams (see above) to facilitate timely discharges and admissions
- Recognition that certain FCs, such as those with developmental disabilities (see later) require specialist facilities.

APPENDIX 2

Ensure community equivalence and integration for prison-based services

Current challenges in Victoria

Basic Principles for the Treatment of Prisoners (Anonymous, 1990) state that prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation. It is accepted throughout the developed world that people in prison should have the same standard of care that is available to the wider (non-imprisoned) population.

Mental disorders of all levels of severity are over-represented in prisoners (see above).

As noted above, acutely psychotic prisoners in Victoria currently face delays in accessing intensive hospital-based care that are far in excess of those faced by persons in the community.

Discharge planning for prisoners with SMI is usually seriously deficient due to:

- poor integration between criminal justice/social support and mental health agencies
- stigmatization and fear of FCs leading to AMHS reluctance to accept FCs for ongoing care
- the 'catchment area' model of service delivery that poses special challenges for more complex FCs, who are often itinerant and recurrently homeless

Resultant lack of access to mental health care and other psychosocial supports, due to these structural deficiencies, thus means that released prisoners with SMI are needlessly placed at very high risk of relapse in terms of both their illness and their offending.

SMI is a significant 'responsivity barrier' for FCs receiving standard correctional 'offence reduction programs' in areas such as substance misuse, violence and sex offending. Poor integration between mental health, offence reduction program providers and the Adult Parole Board means that this issue is often missed, wasting resources and leading to increased future risk.

In addition, prisoners have very high rates of history of chronic childhood abuse and repeated incidents of serious trauma in adulthood. Not surprisingly Post Traumatic Stress Disorder (PTSD) in prisoners is several-fold higher than in a community sample (Butler et al., 2006) and several-fold higher in women prisoners than male prisoners (Goff et al., 2007). PTSD is associated with high levels of substance abuse and offending yet screening and evidence-based treatments for PTSD in prisons in Victoria are almost non-existent. Clinical psychology services to prisoners are often

lacking, since Commonwealth rules do not allow access to Medicare-funded practitioners.

Service models in general, especially in the country prisons, are based on outdated models of care, with limited or no capacity for multidisciplinary working even with prisoners with complex needs.

Proposed solutions

- Promote a philosophical shift amongst all stakeholders wherein prisoners are still recognized as members of the community, with the same rights to access care as everybody else.
- Consistent with the principle of enhanced integration, develop a Statewide electronic mental health notes system that caters to all public mental health services and to the prisons.
- Formally review the model of care, and resultant clinical pathways, provided under the auspices of Justice Health to prisoners throughout the state. This needs to consider the principle of integrated working, including judicious information sharing, between the array of stakeholders working with FCs including:
    - FMH services
    - Primary health
    - Social support services
    - Drug and Alcohol services
    - Offence Program providers
    - Adult Parole Board
    - General mental health services
    - The Courts, especially at the Magistrates level
- Enhance the ability of community adult mental health service to in-reach into prisons, as part of the development of local ‘forensic community mental health teams’ (see above). Community mental health service contact with existing or new clients close to release from custody (either on bail, parole or end of sentence) should be facilitated. Where direct contact is not possible due to distance, video technology is available to overcome the physical barrier. The AMHS can then be an active participant/advocate in arrangements for release, provide continuity of care for existing clients and determine the most suitable model of service delivery needed. A model similar to this currently exists in Queensland. Both the Forensicare ‘Community Integration Program’ and the Forensicare ‘Serious Offender Consultation Service’ have demonstrated the potential value of such in-reach support.

APPENDIX 2

Develop low/medium secure options for women

Current challenges in Victoria

Secure inpatient provision for women prisoners and Forensic Patients is currently limited to Thomas Embling Hospital. There is a female-only acute unit but no female-only rehabilitation unit. As a result, women requiring longer term rehabilitation in secure settings:

- Are housed in a higher level of security than most require
- Are accommodated in settings that are more expensive than necessary
- Are housed in mixed-gender settings with adverse implications for personal safety and access to gender-specific treatment

Proposed solutions

Women require special consideration in the development of contemporary FMH service provision.
Provision of specialist low/medium security facilities for female FCs is required from the perspectives of:

- Security
- Cost-effectiveness
- Human Rights
- Optimising clinical outcomes and reoffending risk

APPENDIX 2

Develop a range of specialist options for forensic consumers with cognitive disabilities

Current challenges in Victoria

There is an increased prevalence of intellectual disabilities among individuals in the criminal justice system (Hellenbach et al., 2016).

In prison contexts, persons are at higher risk of receiving punitive measures in response to their difficulties such as impaired understanding of social and inter-personal rules of engagement. This also applies to those with autism spectrum disorder, even in the absence of associated intellectual impairment.

For a significant proportion of persons with such developmental disorders, their complex needs require specialized management to improve long-term functioning that is simply unavailable in prisons.

Neither Forensicare nor DFATS (DHHS) are able to adequately meet the needs of this group, resulting in egregious contraventions of basic human rights, as outlined in a recent Ombudsman's report (Glass, 2018).

The current state of affairs represents an egregious and embarrassing contravention of Human Rights for this most vulnerable group of citizens, in a State that purports to be the "most progressive" in Australia.

Scotland, with a million less people than Victoria and a similar rate of incarceration, has 63 low secure and 12 medium secure forensic beds ring-fenced for this group of FCs.

In Victoria, such persons may be provided with very expensive, inefficient, individualised care packages in the community (if they are fortunate) or may languish indefinitely in segregation units in prisons, where their functioning and wellbeing inevitably deteriorate further.

Proposed solutions

We flag the need for the **urgent development** of a range of secure options for this group, including secure community-based facilities for FCs with cognitive disabilities who require care and rehabilitation outside of prisons, underpinned by appropriate legal frameworks that safeguard their rights and permit adequate levels of secure care.

Provision of a spectrum of specialist low/medium security options for FCs with cognitive disabilities is required from the perspectives of:

- Human Rights

APPENDIX 2

- Security
- Cost-effectiveness
- Optimising clinical outcomes and reoffending risk

We recommend involvement of psychiatric experts from the RANZCP (specifically the 'Section of Psychiatry of Intellectual and Developmental Disabilities' and the 'Faculty of Forensic Psychiatry') in the design of suitable service models for Victoria.

APPENDIX 2

Develop a range of specialist options for youth forensic consumers

Persons housed in youth detention struggle to access inpatient care for acute mental illness. This places them at high risk of behavioural disturbance and being subject to coercive regimes in custodial settings.

A recent high-level review of youth custody services in Victoria has already flagged the service gaps in that sector (Armytage and Ogloff, 2017).

Given the obvious potential long-term benefits in terms of reoffending risk of evidence-based interventions, we particularly note the cost-effectiveness of high-quality services for this age group.

Proposed solutions

Provision of a spectrum of specialist low/medium security options for youth FCs is required from the perspectives of:

- Human Rights
- Security
- Cost-effectiveness
- Optimising clinical outcomes and reoffending risk

APPENDIX 2

Develop low secure specialist units for Aged consumers

Current challenges in Victoria

Challenges within the system for older FCs in Victoria include:

- The housing of ageing long-term FPs at Thomas Embling Hospital:
  - In conditions of higher security than they require;
  - In a service that is not well-resourced to meet the cognitive or physical health-care needs of aged consumers.
- The increasing number of elderly prisoners, some of whom are diagnosable with dementia, with no access to dementia-specific housing within the prison estate

Proposed solutions

Victoria now requires a comprehensive needs analyses regarding secure bed provision in the area of aged care. The RANZCP Faculties of 'Psychiatry of Old Age' and 'Forensic Psychiatry' would be well placed to provide expert input to such a review.

It is likely that a range of cost-effective, humane options will be required including:

- Low secure accommodation for older FCs currently housed in (more expensive) beds at Thomas Embling Hospital
- Changes to provisions within prisons, building on foundational work already conducted elsewhere in Australia (Anonymous, 2014).

APPENDIX 2

Develop forensic psychotherapy expertise in Victorian psychiatry

Current challenges in Victoria

Loss of psychodynamic expertise in psychiatry

The past two decades have seen a progressive erosion of opportunities for public sector psychiatric trainees and consultants to engage in psychotherapeutic work with consumers. In tandem with this, a 'cultural shift' has occurred, wherein in the public sector at least, psychotherapy (when available at all) is seen as the domain of psychologists and 'counsellors'; the role of psychiatry has increasingly been narrowed down to prescribing biological therapies and making decisions regarding legal status.

The impacts of this are well explored in the Royal Commission submission of the Victorian Faculty of Psychotherapy. For the reasons discussed below, the impact of this shift has been especially problematic in the forensic sector. The development of forensic psychotherapy as a particular sub-discipline has been a serious gap in extant service models for longer-term care of FC's in Victoria. Possible manifestations of this neglect are explored below.

Poor progress in consumers with Severe Personality Disorder comorbidities

Personality difficulties in the FC population are highly prevalent, clinically relevant and linked to poor treatment response and future recidivism. Currently these important factors do not receive the skilled expertise they merit.

Notably, both in the prison and secure hospital settings in Victoria there is a small number of FCs with highly complex comorbidities including severe personality dysfunction, trauma histories and mental illness. These individuals pose a persistent risk of harm to themselves and others and have generally failed to make meaningful progress through the system, incurring very high costs for services along the way. The absence of psychodynamically informed approaches:

- limits access for such consumers to longer term therapies which may bring about clinical improvement (Riordan, 2017)
- limits options for more nuanced clinical formulations that inform decisions regarding security and risk management decisions
- impedes access for staff to reflective practice (see below), increasing risk of burnout and countertherapeutic staff responses (see below).

Lack of trauma-informed approaches to care

Whether in prison, secure hospital or the community, FCs are notable for a high prevalence of significant trauma histories and related psychopathology such as PTSD, substance use and personality dysfunction.

APPENDIX 2

Current models of psychological intervention for FCs in prisons in Victoria, predominantly :

- focus on 'offence risk reduction' rather than enhanced wellbeing
- are delivered in group format
- are not integrated with the consumer's psychiatrist care.

Clearly offence-risk reduction is a key aim for services working with FCs (see above). However, FCs have the same rights to access appropriate health care as other citizens. Notably, they are a group with significant levels of past trauma and the current lack of access for many FCs (especially in the prisons) to treatment that addresses this represents a failure of care.

Adverse impacts of poorly processed interpersonal dynamics on workforce sustainability and safety and on consumer recovery

It has long been recognised (Cordess and Cox, 1996) that working with FCs, particularly in secure in-patient settings involves complex inter-personal interactions amongst consumers, between consumers and staff, amongst staff and between staff and senior managers . Emotional dynamics arising from these interactions – often unseen, unacknowledged and allowed to fester - can foster serious (and at times frankly dangerous) dysfunction at individual, team and even facility levels. 'Parallel processes' can readily emerge with adverse effects on workforce health, safety and sustainability on the one hand, and consumer wellbeing, safety and recovery on the other.

There is a need for psychodynamic expertise to inform supervision, containment and leadership of the workforce, to increase awareness and capacity for reflection regarding dynamics, group and parallel processes, transference-countertransference, thereby reducing unhelpful 'enactments' of emotional dynamics by FCs, clinical staff and management.

A functional, sustainable, cost-effective service requires that these dynamics receive skilled attention and that this requirement be supported at a whole of facility level.

This is a necessity and not a 'luxury'. Furthermore, the up-front costs would be more than offset by savings in terms of:

- staff retention;
- staff wellbeing with reduced absences;
- reduced violent incidents; and
- improved consumer outcomes.

APPENDIX 2

Proposed solutions

- There is a need to promote a 'culture change' in forensic psychiatry in Victoria, alongside a similar shift in general mental health services, wherein at least some degree of expertise in psychodynamics is seen as a 'core skill' for Psychiatrists ; the relevant RANZCP Faculties are well placed to take a lead in supporting this.

- Funding for joint training positions for Advanced Trainees wishing to pursue higher training both in the psychotherapies and forensic psychiatry; such positions could involve training posts at Forensicare, Spectrum and in the private sector.

- Ring-fenced time for staff (including psychiatrists) for reflective practice in forensic settings. We note that the Faculty of Psychotherapy are advocating for 'Balint groups' for psychiatric trainees and for the broader multidisciplinary team to facilitate the development of psychodynamic understandings of their work and increasing reflective process, and support a similar approach in forensic services, including those based in the prisons.

- Build on and evaluate current public sector initiatives that involve psychodynamic expertise in the context of FCs, such as the 'Forensicare Personality Disorder Initiative' and treatment work at Spectrum with consumers who have forensic needs.

APPENDIX 2

Develop a sustainable workforce

Current challenges in Victoria

Forensic services have undergone rapid expansion in recent times in both the public mental health and the non-governmental sectors. Recruitment, retention and training of staff have struggled to keep pace. 'Burnout' is an ever-present challenge in forensic work.

The Centre for Forensic Behavioural Science at Swinburne University of Technology (CFBS) continues to produce world-class research under the leadership of Professor James Ogloff. However, the involvement of forensic psychiatrists at the CFBS remains limited. The implementation of research findings into practice in forensic services remains challenging.
Forensic psychiatrists in the public sector now routinely struggle to access ring-fenced time for service development and/or academic work.

Proposed solutions

Independent active monitoring of services to ensure accountability and prevent a degrading of clinical care

Forensic psychiatrists working predominantly in the public sector to be granted ring-fenced time (as per the current EBA) for non-clinical duties including:

- service development/quality assurance work
- research
- training
- reflective practice

The development of a Statewide Forensic Network for best practice education and training, akin to that existing in Scotland[4] , under the auspices of CFBS and under the leadership of a funded Chair in Forensic Psychiatry. This could usefully focus on:

- Service evaluation and innovation
- Training
- Assisting with implementation of best practice throughout Victoria
- Research

[4] *https://www.forensicnetwork.scot.nhs.uk*

APPENDIX 2

Bibliography

ADAMS, J., THOMAS, S., MACKINNON, T. & EGGLETON, D. 2019. How secure are the secure psychiatric units in New South Wales? *Australasian Psychiatry,* 27.

ANONYMOUS 1990. Basic Principles for the Treatment of Prisoners: UN General Assembly resolution 45/111. *In:* 45/111, U. G. A. R. (ed.).

ANONYMOUS 2003. Costs of Crime. *Crime Facts Info,* 50.

ANONYMOUS 2006. UN Convention on the Rights of Persons with Disabilities (CRPD).

ANONYMOUS 2008. Ministry of Justice Statistics of Mentally Disordered Offenders 2008 England and Wales. . *Ministry of Justice Statistics Bulletin.*

ANONYMOUS 2013. Guidance for commissioners of forensic mental health services. *In:* HEALTH, U. J. C. P. F. M. (ed.). London, UK.

ANONYMOUS 2014. *Dementia In Prison,* North Ryde, NSW, Alzheimer's Australia NSW.

ANONYMOUS 2018a. Corrections statistics: quick reference.

ANONYMOUS 2018b. Pathways to Justice–Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples (ALRC Report 133). Canberra: Australian Law Reform Commission.

ARMYTAGE, P. & OGLOFF, J. 2017. Meeting needs and reducing offending: Youth justice review and strategy. *In:* GOVERNMENT, V. (ed.). Melbourne.

BONTA, J. & ANDREWS, D. A. 2017. *The psychology of criminal conduct,* Cincinnati, OH, Anderson Publishing Co.

BUTLER, T., ANDREWS, G., ., ALLNUTT, S., SAKASHITA, C., SMITH, N. E. & BASSON, J. 2006. Mental disorders in Australian prisoners: a comparison with a community sample. *Australian and New Zealand Journal of Psychiatry,* 40**,** 272-276.

CALSYN, R. J., YONKER, R. D. & LEMMING, M. R. 2005. Impact of assertive community treatment and client characteristics on criminal justice outcomes in dual disorder homeless individuals. . *Criminal Behaviour & Mental Health,* 15**,** 236-248.

COID, J., HICKEY, N., KAHTAN, N., ZHANG, T. & YANG, M. 2007. Patients discharged from medium secure forensic psychiatry services: reconvictions and risk factors. *British Journal of Psychiatry,* 190**,** 223-229.

CORDESS, C. & COX, M. 1996. *Forensic Psychotherapy: Crime, Psychodynamics and the Offender Patient,* London, Jessica Kingsley.

CUNLIFFE, J. & SHEPHERD, A. 2007. Re-offending of adults: results from the 2004 cohort. . *Home Office Statistical Bulletin,* 2006/07.

FAZEL, S., LANGSTROM, N., HJERN, A., GRANN, M. & LICHTENSTEIN, P. 2009. Schizophrenia, substance abuse, and violent crime. *JAMA,* 301**,** 2016-2023.

GLASS, D. 2018. Investigation into the imprisonment of a woman found unfit to stand trial. *In:* OMBUDSMAN, V. (ed.). Melbourne.

APPENDIX 2

GOFF, A., ROSE, E., ROSE, S. & PURVES, D. 2007. Does PTSD occur in sentenced prison populations? A systematic literature review. *Criminal Behaviour and Mental Health,* 17**,** 152-162.

HELLENBACH, M., KARATZIAS, T. & BROWN, M. J. 2016. Intellectual Disabilities Among Prisoners: Prevalence and Mental and Physical Health Comorbidities. *Journal of Applied Research in Intellectual Disabilities,* 30.

HODGINS, S., CALEM, M., SHIMAI, R., WILLIAMS, A., HARLESTON, D., MORGAN, C., DAZZAN, P., FEARON, P., MORGAN, K., LAPPIN, J., ZANELLI , J., REICHENBERG , A. & JONES, P. 2011. Criminal offending and distinguishing features of offenders among persons experiencing a first episode of psychosis. . *Early Intervention in Psychiatry,* 5**,** 15-23.

LAMBERTI, J. S., WEISMAN, R. L. & CERULLI, C. 2017. A Randomized Controlled Trial of the Rochester Forensic Assertive Community Treatment Model. *Psychiatric Services,* 68**,** 1016-1024.

LARGE, M. & NIELSSEN, O. 2011. Violence in first-episode psychosis: A systematic review and meta-analysis. . *Schizophr Res,* 105**,** 209-220.

ONG, K., CARROLL, A., REID, S. & DEACON, A. 2009. Community Outcomes of Mentally Disordered Homicide Offenders in Victoria. *Australian & New Zealand Journal of Psychiatry,* 43.

RIORDAN, D. 2017. Forensic Psychotherapy. *Australasian Psychiatry,* 25**,** 227–229.

SKEEM, J., PETERSON, J. & SILVER, E. 2011. Toward Research-Informed Policy for High-Risk Offenders with Severe Mental Illness. *In:* MCSHERRY, B. & KEYZER, P. (eds.) *Dangerous People: Policy, Prediction and Practice* Routledge.

TILL, A., EXWORTHY, T. & FORRESTER, A. 2015. Integration and offender mental health. J Foren Psychia & Psychol, 26: 11-21. *Journal of Forensic Psychiatry and Psychology,* 26**,** 11-21.

TYE, C. S. & MULLEN, P. 2006. Mental disorders in female prisoners. *Australian & New Zealand Journal of Psychiatry,* 40**,** 266-271.

WALLACE, C., MULLEN, P., BURGESS, P., PALMER, S., RUSCHENA, D. & BROWNE, C. 1998. Serious criminal offending and mental disorder: case linkage study. *Br J Psychiatry,* 172**,** 477-484.

WHITE, P., CHANT, D. & WHITEFORD, H. 2006. A comparison of Australian men with psychotic disorders remanded for criminal offences and a community group of psychotic men wo have not offended. . *Australian & New Zealand Journal of Psychiatry,* 40**,** 260-265.