

SUBMISSION TO SENATE SELECT
COMMITTEE ON MENTAL HEALTH
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**FORENSIC MENTAL HEALTH –
WORKING WITH OFFENDERS WITH A
SERIOUS MENTAL ILLNESS**



Forensicare

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SUMMARY

This submission to the Senate Select Committee on Mental Health is made by the Victorian Institute of Forensic Mental Health, and considers the terms of reference that are relevant to the delivery of specialist forensic mental health services. The submission uses the situation in Victoria as a background. The following terms of reference are addressed -

- b. The adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care
- e. The extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes
- f. The special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence
- g. The role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness
- l. The adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers
- j. The overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people

Where relevant, recommendations are made to address the identified gaps in service delivery.

INTRODUCTION

The Victorian Institute of Forensic Mental Health, known as Forensicare, is a statutory agency that is responsible for the provision of adult forensic mental health services in Victoria. Forensicare, which was established in 1997, is governed by a ten member Council that is accountable to the Minister for Health. In addition to providing specialist clinical services through an inpatient and community program, Forensicare is mandated (under the *Mental Health Act 1986*) to provide research, training, professional education and services to victims.

Services provided by the inpatient program include the 100 bed secure facility, the Thomas Embling Hospital, and a prison based service providing acute assessment and treatment. The community program focusses on the assessment and treatment of offenders and potential offenders with a severe mental illness and people whose behaviours pose a high risk to the community. A Court Liaison Service provides court-based assessments.

Forensicare was established to achieve –

- . improved quality of services in forensic mental health
- . increased level of community safety
- . better community awareness and understanding of mentally disordered offenders
- . increased specialist skills and knowledge
- . policy advice, service planning and research that contributes to the improved delivery of mental health services

FORENSIC MENTAL HEALTH – A SPECIALIST MENTAL HEALTH FIELD

Forensic mental health is a specialist area within the mental health field that provides care and treatment to people within the criminal justice system who have a serious mental illness. It addresses the special needs of mentally disordered offenders, the justice sector and the community, while providing effective assessment, treatment and management of forensic patients in appropriately secure settings.

Traditionally forensic psychiatry was concerned solely with providing long term containment for the criminally insane and providing assessments and opinions to courts on an individual's state of mind. In many jurisdictions, provision for the care, treatment and containment of serious offenders with a mental illness was grossly inadequate, and at times, inhumane.

There has however, been an almost total transformation of what has become known as forensic mental health services over the past two decades. The management and treatment of people with a mental disorder in the criminal justice system are now just as central to a forensic service as to any other mental health service. Forensic inpatient services are no longer primarily psychiatric prisons, but hospitals designed to provide quality care, rehabilitation and eventual reintegration into the community. As with other modern mental health services, a forensic inpatient service is only one

component of a broad service that is becoming increasingly community oriented and community based.

While there have been significant changes in the delivery of forensic mental health services, the role of providing courts with an opinion, and on occasion, advice on management, has not disappeared. Mental health professionals receive an increasing number and diverse range of requests from courts. As a significant proportion of the seriously mentally ill (10-20%) find themselves before the courts at some stage, this is not unexpected. The bulk of the court work of a forensic mental health service is ensuring that people before the courts who need mental health services, or who might benefit from such services, receive forensic services and are effectively managed in the future.

Forensic mental health services provide treatment facilities to those sent to a psychiatric hospital by the courts, to prisoners, to individuals for whom the courts have mandated psychiatric treatment and for patients deemed to present an imminent risk of serious offending.

TERMS OF REFERENCE - RESPONSE

As a specialist mental health provider, this submission will only address the terms of reference that relate, either directly or indirectly, to the delivery of forensic mental health services in Victoria, and discuss the impact of these issues on our service delivery. The response will use the same lettering system as that used in the terms of reference.

- b. The adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care

Current levels of resourcing within forensic mental health impact on the extent to which wide ranging services are able to be provided.

Prevention

In Victoria, some prevention services exist at a tertiary level, ie programs that seek to reduce repeat offending in mentally disordered offenders. In prisons however, the combined lack of acute care beds and the subsequent lack of discharge planning for the significant percentage of prisoners with a mental disorder limit the extent to which prevention programs are able to be provided to reduce the rate of mentally disordered offender recidivism.

Recommendations

Given the high percentage of prisoners with a mental illness and the frequency with which these prisoners return to the prison system¹, the absence of preventative programs in the prison environment is an area that requires prompt attention.

¹ Mullen PE, Holmquist CL, Ogloff JRP (2004) National Forensic Mental Health Scoping Study

A range of primary and secondary prevention programs are also required, eg. at risk groups need to be identified and input provided to existing community services to enable high risk offenders, particularly youths, to be targeted and mental health awareness programs developed. At a very basic level, expanding the availability of anger management groups provided by non-government organisations would make a significant contribution to developing a broad ranging preventative focus within forensic mental health.

Early intervention

An early intervention focus within forensic mental health is required that improves data sharing and provides for case conferences with agencies working within the area. Data sharing currently exists on an ad hoc basis that primarily relies on individuals and the relationship that they have been able to develop with other agencies. The adoption of a formalised approach to early intervention would provide clear benefits to patient and client treatment, not only in the adult and juvenile forensic mental health systems, but also the general mental health system. In Victoria this would involve juvenile justice, ORYGEN (the specialist adolescent mental health service), Forensicare and area mental health services.

Recommendations

The introduction of strategies to formalise the flow of information across the forensic mental health and general mental health systems would have a positive impact on the delivery of services.

Access to non-government organisation-based case management would improve a range of issues that currently face patients and clients of Forensicare, eg. stability of accommodation, substance abuse issues, psychology services (it should be noted that in these areas there is a particular need for services for koori youth in their early teens).

Acute care

Jurisdictions around Australia report a paucity of secure forensic inpatient beds, and the same situation certainly exists in Victoria, where the demand for inpatient admissions places ongoing pressure on Forensicare. Our state-of-the-art 100 bed secure inpatient facility, the Thomas Embling Hospital, was opened in April 2000. Given the lead time to design and build a modern forensic hospital, the bed capacity of the hospital was determined in 1993-94, when the peak prison population forecast was 2,500 (in June 2004 it was 3,624) and the rate of imprisonment was 66 per 100,000 (in June 2004 it was 94 per 100,000).

The bed capacity was also formulated prior to the total reform of the mental illness-criminal responsibility legislation that occurred in 1997. The *Mental Impairment and Unfitness to be Tried Act 1997* is a huge improvement on the earlier system of detaining people indefinitely at the 'Governor's Pleasure', but it has led to more people (appropriately) using the defence. Overseas experience suggests that the current rates of disposition will increase. At 30 April 2005, of our 100 inpatients, 55 were Forensic Patients, detained under the mental impairment legislation – these are patients who will remain in our care for the long-term.

Each admission of a new Forensic Patient reduces our capacity to admit and treat between 4-6 patients per year from prison or the community – that is patients for whom we also have a charter to treat, and in the case of prisoners, we are the monopoly service provider in the state. Pressure on inpatient admissions is great. Seriously mentally ill people wait in prison for admission where conditions are not conducive to well being and recovery.

Recommendations

Forensic mental health in Victoria has a pressing and increasing requirement for additional inpatient beds to meet the needs of the criminal justice system. In particular, step-down medium secure/intensive care beds are required to effectively manage the service demands.

In tandem with the provision of additional beds, consideration needs to be given to developing services to meet emerging trends, eg. the ‘ageing’ of the forensic population. The establishment of a unit for elderly forensic inpatients would ensure that services are provided in the forensic area that bridge those currently provided by psycho geriatric nursing homes and secure units (a similar unit is available at Ararat Prison, Wimmera/Norville). Currently existing psycho-geriatric services are reluctant to accept mentally disordered patients with an offending background.

Evidence based research highlights the need for any forensic inpatient development to incorporate strategies that are aimed at reducing the future demand for inpatient beds. For example, the development of an exit unit to manage forensic patients within the community, with tertiary input from a specialised forensic service, would ensure that forensic mental health patients receive services in an appropriately restrictive environment that is conducive to delivering prevention and reintegration programs.

Community care

In respect to community care, the scarcity of suitable accommodation is a big issue facing forensic mental health clinicians, patients and clients (see p 6-7, response to terms of reference, e.). The dual stigma of mental illness and offending creates serious problems for forensic patients and clients when they are attempting to secure accommodation.

Recommendations

Although not a short-term, low cost remedy, the establishment of ‘forensic hostels’ would fill a much needed void.

Prisoners with a mental illness being released from custody face particular problems in terms of community care. Connecting these people with assertive case management for 6-12 months following release from their custody is a pressing service need. Following their release, these people currently attract little in the way of community care, and most frequently fail to follow up any community care arrangements which may be put in place for them prior to their release.

After hours crisis services

In Victoria a limited after hours forensic crisis service operates. Services are provided 7 days a week, between 9am – 5pm. Outside of these hours, psychiatric crises are handled by the generic Crisis Assessment Team, with the support of clinical forensic

inpatient staff as required for forensic patients. This model generally works well, and rarely fails to provide the level of crisis support required.

Recommendation

The inclusion of forensic-trained staff in a dedicated number of Emergency Departments around the state would however enhance the existing service.

- e. The extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes

Supported accommodation

Area mental health service clinicians report a high level of difficulty accessing suitable supported accommodation for people being discharged from a general mental health inpatient facility. This difficulty becomes even more pronounced when people with a mental illness are being discharged from a prison or a forensic inpatient facility. The stigma that is so frequently associated with a prison sentence or placement in a forensic mental health facility is in itself, often a barrier to accessing suitable and supported accommodation

Access to stable accommodation is a vital element in achieving successful community reintegration for a person with a mental illness being released from prison or a forensic mental health inpatient facility. In particular –

- . bail applications generally require an address to be stated to the Court in order for the application to be successful. There are minimal options for prisoners requiring accommodation to gain bail - mainstream accommodation services are generally unavailable for people as a condition of bail and only one bail hostel operates in Melbourne.
- . area mental health services in Victoria offer services on the basis of address. A smooth prison-community transition for a prisoner with a mental illness, (ie where community mental health supports are in place prior to release), is vital for community reintegration to have a chance of being successful. This can only be facilitated if an address is established prior to release. An address that cannot be arranged until late in the discharge process may lead, at the best, to a prisoner not receiving the optimum level of service, or at the worst, not receiving services at all.
- . a large proportion of the accommodation available to people being discharged from a forensic mental health inpatient facility or from prison is emergency housing. It is uncommon for this type of accommodation to make any special provision for the housing of people with a mental illness, and in addition, it is usually located in high crime neighbourhoods. Close supervision of mentally unwell people in a low crime neighbourhood is vital not only to ensuring that they maintain a level of wellness that allows them to function in a social setting, but to reduce the likelihood of re-offending (both violent and non-violent)².

² Silver, E. Race, Neighborhood Disadvantage, and Violence Among Persons with Mental Disorders: The Importance of Contextual Measurement. *Law and Human Behavior*, 2000; 24(4):449-456

- . A lapse of sentence and subsequent discharge from hospital or prison on a weekend can be problematic in terms of ensuring continuity of care. Most accommodation services provide a reduced level of service on weekends, and without a housing worker to escort people with a mental illness newly discharged from a forensic hospital or prison, discharge planning can unravel quickly.
- . Waiting lists for public housing (even those ‘priority lists’ which operate in Victoria) mean that it is often not possible to discharge patients from hospital to public housing. This applies not only to ‘short term’ patients, but also long term patients whose discharge date may be 12 months away. The availability of public housing for this group would enable a smoother, safer transition back to the community, supported by forensic mental health staff.

Recommendation

Specific accommodation pathways are required to provide the level of assistance necessary to support people with a mental illness being released from forensic mental health care, whether an inpatient facility or prison. These accommodation services, which need to be located in low crime areas, would not only routinely offer a stable address to access area mental health services, but also provide services associated with bail conditions and bail hostel. Supervision of people accessing these services would ideally be provided by a combination of forensic mental health, health and housing workers.

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| <p>f. The special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence</p> |
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Children and Adolescents

As indicated previously in this submission, a consensus exists in forensic mental health that early identification of mental illness is necessary for prevention of later offending to occur (page 4). Increased attention must be paid to mental illness and pre-morbid signs of mental illness in adolescent offenders. Preliminary data from an ongoing study funded by the Australian Research Council, in partnership with the Department of Human Services in Victoria (Juvenile Justice and Child Protection) suggest that young adolescent offenders have a high incidence of cognitive and premorbid mental health and personality problems and symptoms (Lancaster, Ogloff, & Thomas, ongoing).

Recommendation

As has been previously recommended, the introduction of early intervention strategies to formalise the flow of information across the forensic mental health and general mental health systems would have a positive impact on the delivery of services (page 4). This has particular relevance when working with children and adolescents.

Indigenous Australians

In 2002 Corrections Victoria completed a Prisoner Health Study that included a section on mental health³. Forensicare assisted in the report by completing the mental health section. Consistent with data presented later in this submission (page 14), the overall results showed that there is a significant over-representation of people with mental illnesses in our prisons.

Here we shall focus on the important question of the mental health of Aboriginal offenders in Victorian prisons. It is well documented in Australia that there is a significant over-representation of Aboriginal offenders in prison. By contrast, though, the Prisoner Health Study showed, tragically, that while Aboriginal offenders have the same, or even higher, levels of mental illness as non-Aboriginal offenders, the Aboriginal offenders are significantly less likely to have their mental illnesses identified – both in the community and whilst in prison. The results that lead to this conclusion are presented below.

The first part of the study consisted of interviewing prisoners to determine their experiences with health and mental health services in the past and whilst in prison. Overall, 28% of the 451 prisoners in the study had been told by a doctor or psychologist in the past that they have a mental illness. The Aboriginal prisoners – both male and female – were less likely than other prisoners to have been told they have a mental illness. Most surprisingly, only 7% of Aboriginal females recalled having being told that they had a mental illness. By comparison, the non-Aboriginal women were most likely to have been told they have a mental illness (35%) – followed closely by the non-Aboriginal men (28.7%).

Although the above results show that Aboriginal people are less likely to have been previously diagnosed with a mental illness, the second part of the study, which included screening prisoners to identify the presence of mental illness, revealed that in all cases the Aboriginal prisoners were at least as likely as non-Aboriginal prisoners to have a mental illness. For example, 26% of all prisoners met the criteria for at least one major mental illness (including psychotic illnesses and mood disorders). Schizophrenia was identified in about 7% prisoners, with markedly higher rates for Aboriginal females (25%).⁴

With respect to depression, findings were similar for Aboriginals and non-Aboriginals. Thus, the actual objective rates of depression between Aboriginal and non-Aboriginal offenders are likely to be somewhat similar, but depression has been under-diagnosed and treated in Aboriginal people.

The Prisoner Health Study also considered suicide risk and previous self-harmful behaviour. Equal rates of suicide risk were identified in Aboriginal and non-Aboriginal offenders. When actual acts of previous self-harm were considered, 16%

³ Office of the Correctional Services Commission. (2002). Prisoner Health Study. Melbourne, Corrections Victoria.

⁴ There was a relatively small sample of Aboriginal women in the study, so the findings, while valid, should be interpreted with some caution with respect to the actual prevalence of the illness. What can be concluded with confidence is that the rate of schizophrenia in Aboriginal female offenders is higher than found for non-Aboriginal female offenders.

of prisoners had engaged in deliberate self harm. The group that showed significantly higher rates of self harm were Aboriginal women.

Finally, the alcohol and drug use and dependence among prisoners was considered. Forty-one per cent of prisoners were determined to have alcohol abuse or dependence. There was a higher percentage of Aboriginal prisoners with such a finding (67% for Aboriginal men and 46% for Aboriginal women). Similarly, drug use and abuse was high for all prisoners, and even higher for Aboriginal men and women.

Taken together, Aboriginal people are significantly over-represented in the criminal justice system, and those in prison have at least the same level of mental illness as other offenders. They are less likely however, to be diagnosed with a mental illness. Incidents of self-harm are highest among Aboriginal female offenders. Finally, the prevalence of alcohol abuse and dependence and other drug abuse, is higher among Aboriginal prisoners than non-Aboriginal prisoners.

Recommendation

Particular attention should be devoted to the mental health of Aboriginal people in the criminal justice system. Whatever screening and assessment services are in place, steps must be taken to more sensitively identify the mental health needs of Aboriginal people. Efforts must also be made to reliably assess and treat Aboriginal offenders with mental illnesses.

Co-Morbid Substance Abuse and Mental Illness

The association between drugs and crime is well documented and there has been a considerable amount of research conducted in Australia. A recent study examining drug use in New South Wales prisons found that 62% of males and 71% of females report a history of illicit drug use, with cannabis and heroin the most common.⁵ The situation is similar in other states. According to the National Drug Strategy Household Survey, these levels of drug use are significantly higher than in the general community. Heroin use was reported by only 1% of the general community compared with 29% of male and 49% of female prisoners.⁶ Cannabis use was reported by 21% of males in the community compared with 56% of male prisoners and for 15% of females in the community and 63% of incarcerated women.⁷ Alcohol was associated with a significant increased risk of committing violent offences.⁸

Just as substance abuse alone is a significant risk factor for violence, those who have both a substance abuse or dependence disorder and a major mental illness (i.e., those with a so-called dual diagnosis) also have been found to have an increased level of risk for violence. Dual diagnosis has been associated with high rates of violence and

⁵ Butler T, Levy M., Dolan K, & Kaldor J. Drug use in an Australian prisoner population. *Addiction Research and Theory*. 2003, 11(2), 89–101.

⁶ Higgins, K, Cooper-Stanbury, M, & Williams, P. Statistics on drug use in Australia 1998. (Drug Statistics series). 2000, Canberra, AIHW

⁷ Higgins, K, et al, *ibid*.

⁸ Butler, T, et al, *op.cit*.

criminal behaviour.⁹¹⁰ In a Victorian study, the researchers found that the highest rates of violence occurred for patients with schizophrenia who also had a known substance abuse problem.¹¹ As the researchers found, a majority of patients with a dual diagnosis had committed an offence (67%) and approximately 25% committed a violent offence. These results suggest that amongst those with major mental illness, having a co-occurring substance misuse may be one of the most important contributors to the risk of offending.

A recent study conducted in the Thomas Embling Hospital found that 74% of the mentally ill offenders patients have a lifetime substance abuse disorder and 12% have a current substance abuse or dependence disorder (i.e., with symptoms occurring within the past month).¹² Those patients with a lifetime diagnosis of substance abuse or dependence, coupled with a major mental illness, were younger when first hospitalised for a mental illness, had longer periods of psychiatric hospitalisation, have more serious and more complex criminal histories, and are more likely to have a history of self-harming and suicidal behaviour than patients with no substance abuse or substance dependence disorder.

Another recent study, in which re-offence rates of patients released from the Thomas Embling Hospital were considered, confirms that those patients with a co-morbid mental illness and substance use or dependence disorder were at particular risk of re-offending.¹³

The data clearly show that substance abuse and dependence and mental illness are independent risks for future offending, and that when these disorders occur together, there is an exponential risk of re-offending.

Recommendation

Mental health services for prisoners must assess and treat co-morbid substance use disorders. Specialist services are required for prisoners with dual diagnosis as substance abuse services or mental health services alone do not adequately meet the needs of this group.

⁹ Monahan, J, Steadman, H J, Silver, E, Appelbaum, P S, Robbins, P C, Mulvey, E P, Roth, L H, Grisso, T, & Banks, S. Rethinking risk assessment: The MacArthur study of mental disorder and violence. 2001, New York: Oxford University Press

¹⁰ Steadman, H J, Mulvey, E, Monahan, J, & Robbins, P C, Appelbaum, P S, Grisso, T, Roth, L H, & Silver, E. Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry*. 1998, 55, 393-401

¹¹ Wallace, C, Mullen, P, Burgess, P, Palmer, S, Ruschena, D, & Brown, C. Serious criminal offending and mental disorder: Case linkage study. *British Journal of Psychiatry*. 1998, 172, 477-484

¹² Ogloff, J R P, Lemphers, A, & Dwyer, C. Dual Diagnosis in an Australian forensic psychiatric hospital: Prevalence and implications for services. *Behavioral Sciences and the Law*. 2004, 22, 543-562

¹³ Ferguson, M, Ogloff, J R P, & Thomson, L. (in prep.). Predicting Recidivism in an Australian Mentally Disordered Offender Population with and without Comorbid Substance Abuse. Monash University and Victorian Institute of Forensic Mental Health

- g. The role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness
- l. The adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers

Primary carers of patients and clients of forensic mental health services most frequently have needs that are more complex than other carers in the mental health field. Within forensic mental health, most primary carers are family members, and in a large percentage of cases, a member of the family has been the victim of the crime committed by the patient/client¹⁴. The special needs of these carers are often unacknowledged and unmet by generic services - they frequently need specific help in understanding and accepting the issues of mental illness and offending, and the devastation that the offence can have on the remaining family members. They have often lived long-term with violent and unpredictable behaviour, and are fearful of the discharge of their family member.

Not all carers in this category require specific services. For some, the provision of appropriate support and treatment in a known environment through a generic service is a major factor in the rehabilitation of the family. Consideration needs to be given to developing strategies to ensure that this is able to occur.

There are however, a number of carers and family members so traumatised by the offence and mental illness that specialised support is essential. This is especially so in cases where children are involved. (In many cases children have been witness to violent acts perpetrated by a member of their family that has resulted in the death of a loved one.)

An almost unimaginably high level of family disruption occurs when a family member is seriously injured or killed by another member of the family. In these cases, mental illness adds an additional layer of complexity to an already difficult situation. Of the 55 patients currently detained in Thomas Embling Hospital on a determination of the courts under the *Crimes (Mental Impairment and Unfitness to be Tried) Act* (ie. those patients found not guilty on the grounds of their mental impairment), 35 of these patients, or 63%, committed offences against a member of their family. The very long-term trauma and grief that most frequently overtakes the lives of the families involved is profound and should not be underestimated.

Our contact with carers/families of serious offenders who have committed an offence within the family indicates that appropriate support and treatment services available are extremely limited. Not only are services limited, but the only services available for this extremely complex issue are generic. The complexities of the situation include the issue of mental illness, the grief and trauma surrounding the often “shocking”

¹⁴ Nordstrom A, Kullgren G. Victim relations and victim gender in violent crimes committed by offenders with schizophrenia. *Soc Psychiatry Psychiatr Epidemiol*, 2003; 38: 326-330

offence, the need, at times, to accommodate the finding of ‘not guilty on the grounds of mental impairment’ and any thought of future family reunion.

Limited counselling services are provided by police and the Office of Public Prosecutions at the time of the offence and trial. Within our inpatient service, Forensicare employs a family-carer advocate to provide assistance to this group while their family member is in hospital. This is a model increasingly used in all mental health services. For carers to receive the optimal level of support required in forensic mental health however, a more assertive carer advocate model needs to be developed and implemented – a development that can only occur with additional funding.

Most forensic services are provided on a statewide basis, and carers often live long distances from the treating service. Initiatives that promote carer/family members maintaining meaningful contact with their family member and the treating team must be developed and implemented as a priority.

The recovery process for families, both victims and offenders, is very long. All parties often take years to understand and accept the issues. In our experience, family victims often spurn generic counselling services as they have a reluctance to address issues that are so profoundly shocking and painful for them. Leaving issues of such magnitude unresolved has significant long-term emotional and psychological consequences for carers and the perpetrator. In most cases, forensic mental health services have a prolonged relationship with serious offenders and their carers and are well placed to be pro-active to work with them over the long-term.

Recommendation

The implementation of following service delivery framework for the long-term support of carers in the forensic mental health service system who require specialised support is proposed–

Initial Stage	Debriefing/ post-traumatic stress therapy/individual and family therapy
Middle Stage	Long term grief therapy - coming to terms with what has happened/refocus the family
Final Stage	Reunification/family work

CASE STUDY

“T” was a 40 year old woman, with 2 children to her estranged husband (who had custody of the children - a boy aged 9 and a girl aged 6). “T” also had an adult daughter to a previous husband. She had regular access to her children.

“T” had been unwell with undiagnosed and untreated schizophrenia for the two years prior to the incident. On a weekend access visit, “T” went to her husband’s house to collect her 6 year old daughter. At the time, her husband was a little concerned as he thought that his wife seemed quite unwell, and he reluctantly handed the daughter to his wife. During this weekend access visit “T” killed her daughter. She believed it was necessary to do this to save her daughter from the

CASE STUDY – cont

devil. At her subsequent court case, "T" was found "not guilty on the grounds of mental impairment".

Her husband was totally devastated, and felt particularly guilty for allowing his daughter to go with his wife. The 9 year old son remained in his care. Both the father

and son needed intensive support and counselling. It was important that the father become reconciled to the offence and the mother for the sake of their son. The husband's initial response was to have nothing to do with his estranged wife. He reluctantly changed his view because of his son who still wanted contact with his mother (although understandably very fearful at the same time). "T's" two sisters and mother were outraged at how she could have done what she did, as was her other adult daughter. She was isolated, with no family support.

The issues for the family included gaining an understanding of "T's" illness, the notion of "not guilty on the grounds of mental impairment"; allaying fears (especially of the son and his father) that it might happen again if she was ever released; working with the father's guilt and family reconciliation. At this point, five years later, "T" is reconciled with her son, her former husband, remaining daughter, mother and one sister. Her other sister will still not speak to her. In terms of the son's wellbeing, the need to reconcile the family was of paramount importance.

- j. The overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people

Prevalence of Mental Illness Among Australian Prisoners

Table 1 represents the best estimate of the prevalence of Australian prisoners with a mental illness.¹⁵

Table 1

PREVALENCE OF AUSTRALIAN PRISONERS WITH A MENTAL ILLNESS		
Major mental disorder (psychosis)	8% m.	15% f.
Schizophrenias	5% m.	6% f.
Personality disorders	39% m.	49% f.
Substance Abuse		
Alcohol	55% m.	33% f.
- hazardous drinking levels in community		
Regular community use in 12 months prior to imprisonment		
Cannabis	55% m.	33% f.
Opiates	27% m.	50% f.
Cocaine	21% m.	26% f.
Amphetamines	21% m.	20% f.

The above data are based upon a compilation of all existing relevant data sets in Australia and show that the prevalence of mental illness among prisoners is significantly higher than in the community.

Mental Illness and Offending

There has been considerable research into the links between offending and mental illness. Those with severe mental illness, particularly schizophrenic illnesses, are more likely to commit criminal offences and more likely to finish up in prisons.^{16 17} The research literature is currently more advanced in the area of schizophrenia and offending than for other types of mental disorder. This section will therefore focus on schizophrenia.

¹⁵ Mullen P E, Holmquist C L, Ogloff J R P. National Forensic Mental Health Scoping Study, 2004

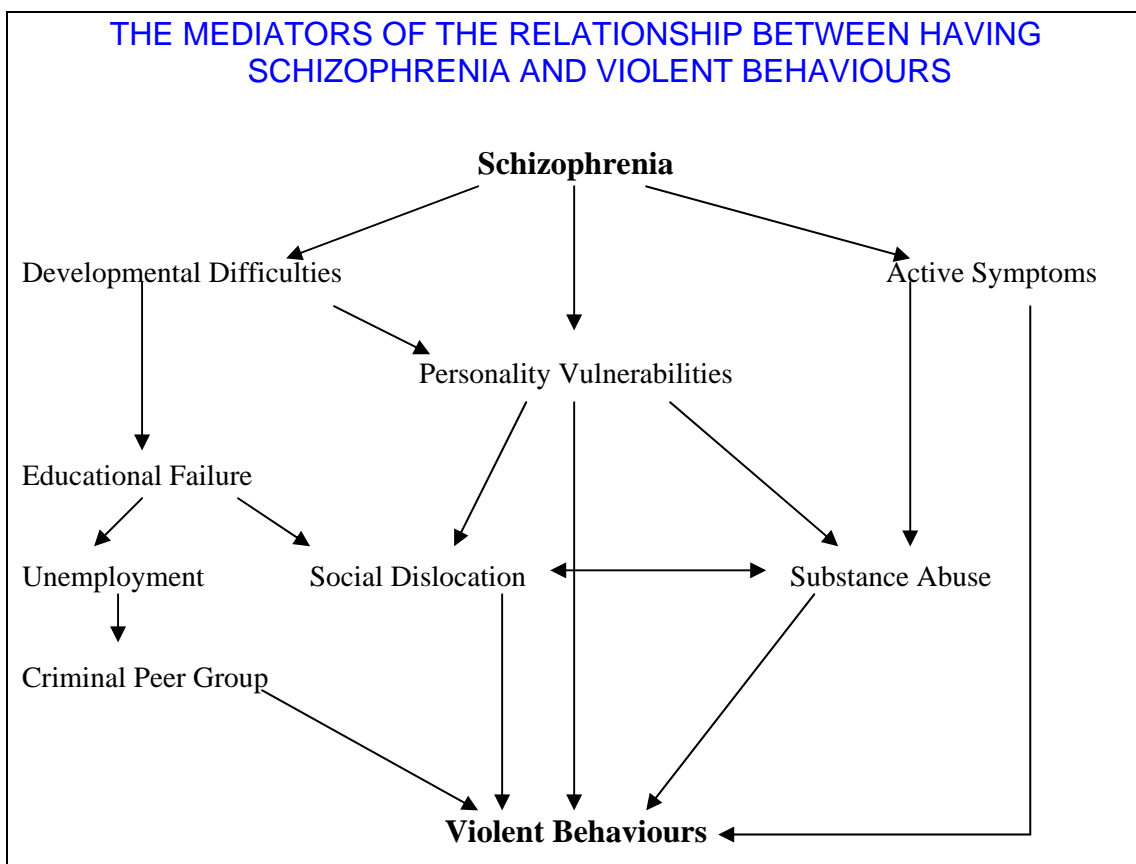
¹⁶ Walsh E, Buchanan A, Fahy T. Violence and Schizophrenia: examining the evidence. British Journal of Psychiatry, 2001; 180: 490-495

¹⁷ Hodgins S, Muller-Isberner R. Preventing crime by people with schizophrenic disorders: the role of psychiatric services. British Journal of Psychiatry, 2004; 185: 245-250

A detailed study conducted of criminal offences in Victoria found that those with schizophrenia make up between 0.5 and 0.7% of the Australian population but are responsible for 5% - 10% of homicide and seriously violent offending.^{18 19} This in part explains their overrepresentation among prison populations, which currently is in the region of 5% in Australia²⁰. It is not higher because they are under represented among sexual offenders and certain types of property offenders (e.g. fraud and deception).

The association between schizophrenia and offending, particularly violent offending is not the result of some immutable relationship. The link is mediated by a mixture of illness related factors, substance abuse, and the impact of the social disadvantage and disorganisation consequent on disability (see Figure 1).

Figure 1



Much of this offending is preventable. Primary prevention depends on providing appropriate services to those in the early stages of their illness, before they commit serious acts of violence. Secondary prevention depends on active support and treatment of mentally abnormal offenders to reduce re-offending. Tertiary prevention would involve avoiding the deleterious impact of imprisonment on those individuals rendered peculiarly vulnerable by schizophrenia. Imprisonment further disrupts their

¹⁸ Wallace C, Mullen PE, Burgess P, Palmer S, Ruschena D, Browne C. op.cit

¹⁹ Wallace C, Mullen PE, Burgess P. Criminal Offending in Schizophrenia Over a 25-Year Period Marked by Deinstitutionalization and Increasing Prevalence of Comorbid Substance Use Disorders. *American Journal of Psychiatry*, 2004; 161: 716-727

²⁰ Mullen P E, Holmquist C L, Ogloff J R P. op.cit

social and work skills and reinforces personality vulnerabilities, symptoms and attitudes conduce to offending.

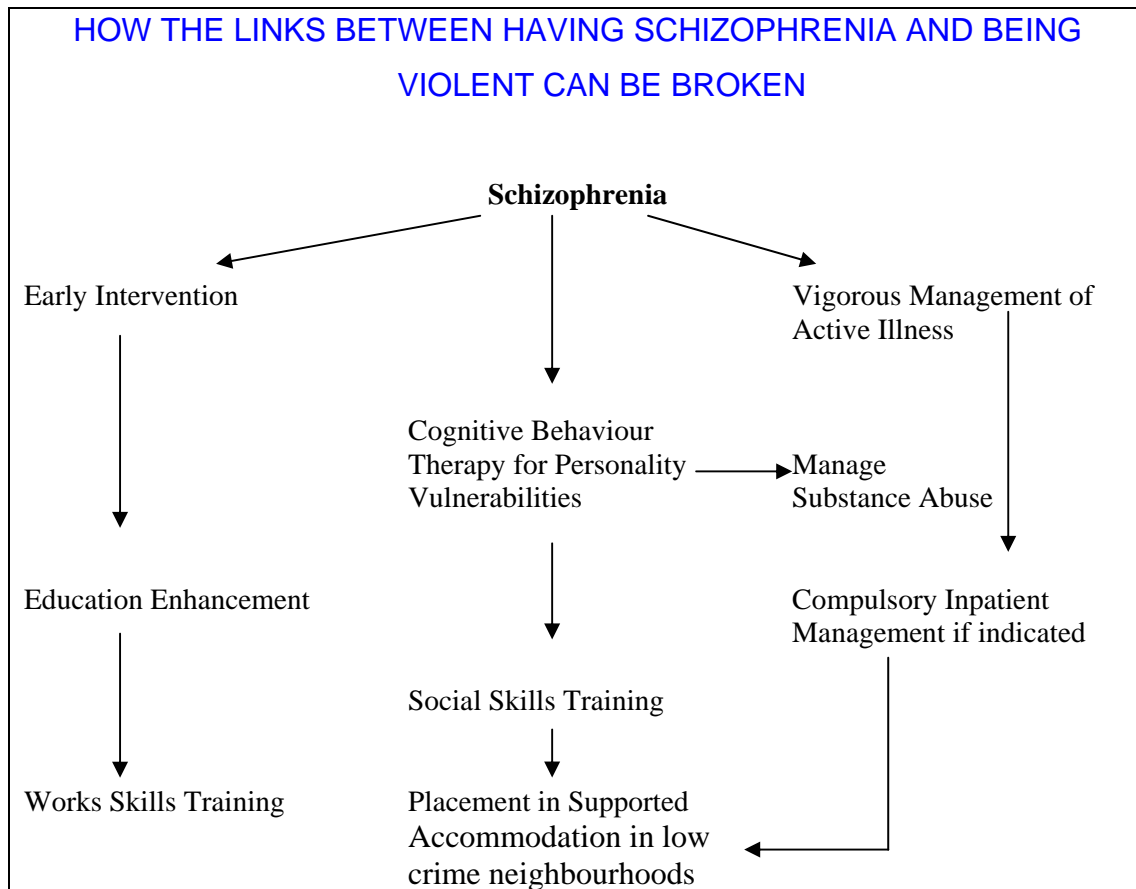
The maximum impact on offending rates would be obtained by targeting high risk groups. Not high risk individuals, because, although violent offending is 5 to 10 times higher in those with schizophrenia, it still remains an uncommon event, and picking out in advance individuals who will be violent is a practical impossibility (see Table 2). What can be identified are the groups from whom almost all the violent individuals will come (approximately 10% - 20% of all those with the illness). Approaches exist that are capable of identifying the high risk groups (e.g. HRC-20).

Table 2

CLINICAL RISKS AND COMMUNITY RISKS - AN APARENT PARADOX	
5 – 10% of violent crime, including homicide, is attributable to the 0.5 to 0.6% of the population with schizophrenia.	
BUT in schizophrenia –	
Homicide rate	1 in 10,000 per year
For males	1 in 2,500 per year
Convictions serious violence	1 in 500 per year
Any violent convictions	1 in 180 per year
For males	1 in 100 per year

The links between having schizophrenia and being violent can be broken (see Figure 2, p.17), and in doing so a major contribution will be made both to the health and functioning of those disabled by schizophrenia and the safety of the community.

Figure 2



Prevention and Management

It is increasingly clear from research over the last decade, which has established a number of critical mediators of violent and criminal behaviour in those with schizophrenia, that the following is required –

1. Those with schizophrenia at highest risk of becoming seriously violent - far from being given high priority in existing mental health services - are often provided limited and ineffective treatment. This is for two main reasons:
 - (a) A failure among mental health professionals to accept the evidence for a link between schizophrenia and violence, or an attempt to minimise that link and reconceptualise it as none of their business.
 - (b) The lack of service provisions necessary to intervene effectively with high risk groups.
2. Offending behaviours in schizophrenia are linked to educational failure and unemployment. Only by early intervention with adolescents who are failing educationally and socially can this be addressed. This population will of course contain mostly young people who will never develop schizophrenia, but buried amongst them are those at high risk of developing psychosis. The ability to

recognise these individuals is rapidly improving. Support for early psychosis services and educational enhancement programs will assist.

Repeat offending in schizophrenia is critically dependent on whether the individual has the ongoing structure provided ideally by open employment, but failing that, sheltered workshop or day centre support. Services have withdrawn from programs of active work rehabilitation in recent years, but this is a critical element in patient functioning and in reducing offending.

3. Poor symptom control increases offending directly, and via increasing social dislocation and substance abuse. In typical high risk individuals (e.g. young, male, substance abusing, angry and disorganised) good symptom control is only likely to be obtained in an inpatient setting, with sufficient controls to hold and support the patient for long enough to have some chance of attaining symptomatic control.

Brief admissions (1-2 weeks) to chaotic acute units make no impact on the illness in such people. This does not mean we have to turn back the clock on deinstitutionalisation, which contrary to popular misconceptions has not led to more offending among the seriously mentally ill²¹. What is required is medium term admissions (4-6 weeks), linked to subsequent day hospital and community treatment. Treatment in the high risk group will often require the use of compulsory admissions, followed by some form of community treatment orders. Utilizing depot medication is important to ensure compliance, and this is made less problematic now the second generation antipsychotics are becoming available in long acting formulations (e.g. risperidone).

We have developed a pattern of mental health care in Australia (and much of the Western world) based on very brief admissions (5-10 days) and subsequent community management. This works for the more pliant and responsive patients, but totally fails the high risk groups who are a potential future risk to themselves and the community. Unless this is addressed there is no hope of making any real impact on the problem.

4. There is an increased incidence of those personality vulnerabilities (traits) associated with Anti-Social Personality Disorder (psychopathy) in those with schizophrenia. This link may be in part genetic, but probably more importantly, it is linked to the developmental difficulties often experienced during childhood among those who will develop schizophrenia. The critical traits are a feckless disregard (or unawareness) of consequences, an interpersonal insensitivity that can verge on callousness, shallow affect, intense distrust and even fear of others, poor behaviour controls, a lack of realistic long term goals, and general irresponsibility.

Such personality traits, if present to any degree, are socially disabling, predispose to substances abuse, and increase the likelihood of criminal behaviour. These traits are not immutable. Though not easy to modify, a great deal can be achieved using cognitive behavioural approaches and social therapies. Addressing these issues does, however, depend on having appropriately trained clinical

²¹ Mullen PE, Burgess P, Wallace C, Palmer S, Ruschena D. Community Care and Criminal Offending in Schizophrenia. *The Lancet*, 2000; 355: 614-617

psychologists and social workers, working in a context conducive to long term treatment and support.

5. One of the major mediators of violence in those with schizophrenia is the social conditions in which they are currently living. If you discharge patients with schizophrenia from hospital, or release them from prison, to live in high crime neighbourhoods, particularly in poorly structured hostels or casual accommodation, you dramatically increase the risk of both violent and non violent offending.²² Sadly it is to just such social conditions that patients in the high risk group are typically directed. This is a disaster. What is required is the development of a sufficient range of accommodation in low crime neighbourhoods for this high risk group of patients.
6. Substance abuse has rapidly increased among young people with schizophrenia over the last decade. Most of the violence is committed by patients who also abuse alcohol and/or drugs (cannabis and amphetamines in particular). This is only in part because substance abuse predisposes to offending (particularly property offences), and partly because those with antisocial personality traits are predisposed to both substance abuse and offending. Managing and minimising substance abuse among the seriously mentally disordered should be a priority if we wish to reduce offending in this population.
7. The seriously mentally ill are often poorly managed in prisons. They are not always recognised at reception. The ability to manage their particular needs in prison is all too often limited if they become seriously disturbed. Exit routes to secure hospital beds, or medium and low security beds where appropriate, either do not exist, are difficult to access, or the hospitals have capacities which fall far short of needs. Adequate mental health services are rare in prisons. At the point of release, coherent plans for a managed return to the community with prearranged mental health support almost never occurs.

Ignored, mismanaged, released unprepared, rapidly reoffending and returning to prison. This is all too often the story of the mentally ill offender, repeated and repeated.

Recommendations

Reducing the rates of offending and re-offending in those with schizophrenia requires the following changes and strategies –

1. Education of mental health professionals and service managers to ensure they recognise and accept their responsibilities to their patients (and the community) to reduce the frequency of offending behaviours in those with schizophrenia.
2. Enhancing the early recognition and treatment of psychosis among adolescents.
3. Restructuring inpatient mental health services to enable –

²² Silver, E. Race, op cit

- . Appropriate (that is longer) periods of admission for acute psychotic patients, particularly from high risk groups.
- . Providing adequate secure continuing care beds for those high risk patients who fail to respond to treatment rapidly.
- . A major increase in the number of medium and high secure forensic mental health beds to support both general mental health services and correctional services in managing the high risk patients.

These are costly recommendations but given the potential benefits in reduced crime, reduced prison numbers, and improved care they could be viewed as a bargain.

4. Restructuring community mental health services to –
 - . Give appropriate priority to the long term support and management of high risk patients.
 - . Ensure that forensic mental health professionals are available in sufficient numbers in the community to assist general services with the recognition and management of the high risk group.
 - . Return to an emphasis on active rehabilitation of disabled patients with schizophrenia to attain open employment, for those able to manage this, and sheltered employment and structured recreational programs for the rest. Ensuring all large employers have a quota of disabled employees, including those with mental illness, would greatly assist.
 - . Change the approach to accommodation of the high risk patient group to ensure placement in properly supervised accommodation in low crime neighbourhoods.
5. Increase the availability of clinical psychologists to provide cognitive behavioural therapy for patients with psychotic disorders, directed at reducing the attitudes and behavioural patterns which underlie violence and other criminal behaviours.
6. People with a psychotic illness who go to prison are not always recognised, often not provided the care and treatment they require, and released without adequate provisions for their subsequent management. Imprisonment is often damaging to those with schizophrenia, but if it is to occur, then at least a reasonable effort should be made to provide care and treatment. If for no other reason than that effective management in the prison and proper transition to the community mental health services will reduce re-offending.
7. Currently in Australia the provision of care to mentally ill prisoners is rudimentary at best. Rarely are proper provisions made, and even more rarely is the transition back to the community managed with even minimal adequacy. There has to be appropriate mental health services to prisoners. Inreach

services, where local community mental health teams, or where available, forensic mental health teams, begin to manage prisoners prior to their release would be a major contribution. One potential reform worth considering is that mental health services in all prisons become part of the area mental health service in which the prison is situated, with special inreach teams, augmented by input from specialist forensic mental health professionals (as is now beginning to occur in the UK).

- k. The practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promotion engagement and minimising treatment refusal and coercion

The use of detention and seclusion within Thomas Embling Hospital, Forensicare's secure inpatient facility, is safely used in accordance with the *Mental Health Act* 1986. Its use is governed by statutory reporting requirements to the Office of the Chief Psychiatrist and is guided by a policy framework that falls within international guidelines and accords with the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) best practice.

The issue in relation to detention and seclusion is not as clear-cut when looking at mental health service delivery in prisons. Prisons are not gazetted mental health facilities, and therefore clearly fall outside the terms of reference of the committee. In terms of providing a mental health service within prisons however, it is not uncommon for a mentally ill prisoner displaying acute and disturbing psychiatric symptoms to be placed in a management and observation cell (known as a 'Muirhead cell'). This placement is not a mental health decision, but one made by correctional administrators when there is no other accommodation available to guarantee the safety of a prisoner displaying disturbing psychiatric symptoms.

The fact that Muirhead cells, which were designed to be used by correctional administrators to safely accommodate prisoners displaying difficult and often violent behaviours, are also used for mental health reasons, is often difficult to reconcile. At the most extreme, this can lead to psychiatric care being seen as punitive within the prison environment.

Recommendations

The ramifications of a punitive view of mental health services developing within a prison are substantial and strategies need to be implemented to address this. The availability of 'turnaround' beds in a gazetted facility, rather than use Muirhead cells for acutely mentally ill prisoners, would be a worthwhile initiative in this respect.

n. the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated

Research and Evidence Based Practice

Considerable high quality research on mentally abnormal offenders has occurred over the last decade. This research has not only provided a clear view on the relationship between offending behaviours and serious mental illness, particularly schizophrenia, but has elucidated the potential mediators of violent offending in this group. In Europe and the United Kingdom large scale trials are being undertaken to evaluate whether forensic mental health services employing these newer approaches lead to significantly less criminal offending in the patients, compared to traditional general mental health services. The early results are not only indicative of a dramatic reduction in crime, but are beginning to suggest which therapeutic approaches are contributing to this reduction. An attempt to link an Australian study to this international initiative has so far been frustrated by funding being declined.

The difficulty funding research into the treatment and management of mentally ill offenders is part of a general problem in mental health of establishing any treatment trials independent of pharmaceutical companies (who understandably have little interest in non-pharmacological approaches or in small groups making up only a tiny proportion of the potential market for their products). The other problem is that forensic mental health researchers and practitioners fall between the traditional funding sources for mental health on the one side, and criminology and justice on the other (the Criminology Research Council is an honourable exception, but their funds don't stretch to large scale medical research). In our own state, only large sums of money are spent by Corrections on sex offenders programs – programs that are aimed at various criminogenic factors, and substance abuse, without any advice or involvement being sought from forensic mental health professionals, let alone seeking research and evaluation into whether public money is well spent.

The traditional approaches to funding research in the mental health field have, by and large, performed well for the community. There are risks in creating small and specialist research funding bodies, in particular a dilution of scientific standards and the risk of capture by sectoral, or plain eccentric, interests. If the government does come to the view that increased research into reducing the 5-10% of violent crime perpetuated by those with schizophrenia is of value, then perhaps the best mechanism would be providing earmarked funding to the Health and Mental Health Research Council or the Criminology Research Council to support active research groups in this area.

Research is only part of the problem. At least as important is ensuring mental health and criminal justice services are aware and applying the results of such research. An abiding frustration for researchers is seeing again and again systems and practices being continued, or even introduced, which have been proven ineffective, or even positively harmful. Among mental health professionals there is at least some awareness of the need for evidence based practice, though they are not always able to translate this into effective change. In correctional services, at best, lip service is paid

to such notions, as each service around Australia dedicatedly pursues its own policies and approaches, innocent of knowledge or precedent. This needs to change.

Education is part of the solution. A major step forward would be establishing a federal structure with the prestige and expertise to advise and inform services, not only just about the seriously mentally ill offenders, but the substance abusing, severely personality disordered and potentially suicidal prisoners.

Recommendations

1. The provision of specific funds to the Criminology Research Council or the Health and Mental Health Research Council to support research into the assessment and management of both the mentally abnormal offender and the high risk patient group.
2. Establish a body to provide education and advice to correctional services and criminal justice bodies on the appropriate use of psychological and psychiatric knowledge and expertise in the management of the mentally ill, seriously personality disturbed, the substance abusing and the potentially suicidal prisoner.

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