Productivity Commission Draft Report on Mental Health: Forensicare Submission

23 January 2020

Contents

1. Introduction

As the only Victorian health service solely dedicated to providing forensic mental health services to people who are, or have been, in contact with the criminal justice system, or who are at risk of offending (**Forensic Mental Health Services**), the Victorian Institute of Forensic Mental Health (**Forensicare**) appreciates the opportunity to share its perspective with the Productivity Commission (the **Commission**).

Forensicare welcomes the Commission's draft inquiry report into mental health and supports the areas identified as requiring reform.

2. Forensicare

Forensicare is a statutory body established in 1998 under the *Mental Health Act 1986* and continued under the *Mental Health Act 2014* (**MH Act**). The Victorian Minister for Mental Health is the Minister responsible for Forensicare and the forensic mental health services it delivers. As Forensicare provides services that span all components of the mental health and criminal justice sectors, it operates under the MH Act in terms of its treatment of consumers, but also has obligations under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) (**CMIA**) in respect of those people it supervises under the CMIA.

Forensicare delivers its services through:

2.1. Thomas Embling Hospital

Thomas Embling Hospital (**TEH**) is a 136-bed secure forensic mental health hospital based in Fairfield with eight units providing intensive care, acute care, continuing care, and rehabilitation/transition programs.

The cohort of consumers receiving care at TEH include:

2.1.1 Forensic Patients

Forensic patients have been found not guilty by reason of mental impairment or unfit to be tried and liable to supervision under the CMIA. TEH is the only hospital in Victoria that forensic patients can be placed. The number of forensic patients has been steadily increasing over time, which, given the indefinite[1] nature of the order, places increased pressure on demand at TEH.

The average length of stay is 6.3 years[2], noting that for some it may be much longer.

Forensicare's scope of practice currently does not include those found not guilty by mental

[1] Section 27(1) of the CMIA

[2] This average is determined in respect of the amount of time it takes a person to be granted extended leave, not the amount of time it takes to have their order revoked.

impairment or unfit due to cognitive impairment. Disability Forensic Assessment and Treatment Services (**DFATS**) is the supervisor of this cohort (known as forensic residents) under the CMIA.

2.1.2. Security Patients

Security patients are prisoners that require hospital treatment under the MH Act and are transferred to TEH on a Secure Treatment Order in accordance with the MH Act. TEH is the only hospital in Victoria that can admit security patients for treatment.

2.1.3. Civil Patients

Civil patients (defined as compulsory patients in the MHA) are those people who are on a temporary treatment order or treatment order at TEH under the MH Act.

TEH consists of the following units:

Unit	Beds	Acuity level	Gender	Current cohort
Apsley	8	Acute	Men	Security patients only
Argyle	17	Acute	Men	Forensic patients and security patients and one civil patient**
Atherton	17	Acute	Men	Forensic patients and security patients and two civil patients
Bass	24	Sub-acute	Men	Forensic patients and one civil patient
Barossa*	12	Acute, Sub-acute and rehabilitation	Women	Forensic patients and security patients
Canning	22	Continuing care	Men	Forensic patients
Daintree	20	Rehabilitation and continuing care	Mixed	Forensic patients
Jardine	16	Community transition, rehabilitation	Mixed	Forensic patients

* Barossa is the only women only unit at TEH.

** As at 23 January 2020, there were 4 civil patients at TEH. These civil patients were not admitted directly from the community, they were initially Security Patient's whose legal status was changed to a compulsory patient under the MH Act at the conclusion of their sentence or period of remand.

With the high percentage of forensic patients on a custodial supervision order at TEH there is only a small number of beds available for prisoners requiring hospital treatment on a secure treatment order; for men, the 8 beds in the Apsley Unit and usually up to 8 beds across the Argyle and Atherton units and for women currently 3 beds in the Barossa Unit. These small number of beds service the entire prison population. There is no capacity to admit civil patients directly from the community.

2.2. Prison Services

Forensicare provides mental health services within a number of Victoria's prisons, including mental health triaging through reception assessments, dedicated custodial mental health units, mobile mental health services, and suicide prevention and assessment services. Whilst Forensicare provides services through dedicated custodial mental health units, it is important to understand that the care provided in the prison setting is not a substitute for hospital care and is more akin to intensive community mental health support. Consequently, prisoners that require hospital care to treat their mental illness must have the equivalent access to hospital care in the same way they would be able to access such care if they were living in the community.

2.3. Community Forensic Mental Health Service

Forensicare's Community Forensic Mental Health Service (**CFMHS**) provides a number of services aimed at diverting people from the criminal justice system and thereby contributing to increased community safety. CFMHS includes:

- Mental health treatment to forensic patients on extended leave (living in the community full time);
- Supervision of those on a non-custodial supervision order (**NCSO**) under the CMIA (note treatment is provided to this cohort by the relevant area mental health service);
- Advice service on the treatment and management of complex individuals;
- A Mental Health Advisory and Response Service in several metropolitan Magistrate's Courts;
- A Fixated Threat Assessment Centre delivered in partnership with Victoria Police; and
- Provision of court reports to inform sentencing and final disposition under the CMIA, and court reports that consider the availability of the mental impairment defence and whether someone is fit to stand trial.

These services are provided to a number of cohorts living in the community, including:

- forensic patients on extended leave;
- those on a NCSO under the CMIA;
- those referred by Community Correctional Services (**CCS**);
- those appearing in the Magistrate's Court and who are referred by the Magistrate, CCS or the duty lawyer;
- those referred by the courts for a pre-sentence report or a report to inform final disposition under the CMIA;

- those referred by the Office of Public Prosecutions for a report on the availability of the mental impairment defence or whether a person is fit to stand trial; and
- self referrers.

2.4. Innovation, research and training

In addition to the provision of clinical services, and as identified in section 330 of the MH Act, the functions of Forensicare also include:

- conducting research in forensic mental health, forensic behavioural science, and associate fields; and
- providing professional development and training in forensic mental health internally to Forensicare staff, and to external stakeholders including medical, legal, and general health programs.

To this end, Forensicare jointly operates the Centre for Forensic Behavioural Science (**CFBS**) in partnership with Swinburne University of Technology to deliver a comprehensive forensic mental health research program, training and ongoing professional education. The research undertaken by the CFBS is used to support the ongoing evaluation and development of Forensicare's clinical services, and to assist in the translation of research into best evidence-based care.

3. Royal Commission into Victoria's Mental Health System

The Commission will be aware that a Royal Commission has been established in Victoria to inquire into, and make recommendations regarding, Victoria's mental health system as specified in the Royal Commission's Terms of Reference. Forensicare made a written submission to the Royal Commission submitted on 5 July 2019 and we consider the matters addressed in this submission are relevant to the Commission's draft report. Accordingly, we attach this submission and adopt it as part of our submission to the Commission at Annexure A. The remainder of this submission will address the Commission's Requests for Information relevant to Forensicare's service context (as described in paragraph 1 above).

4. Productivity Commission's Draft Inquiry Report

4.1. Justice System Reform

4.1.1 Demand for hospital-based forensic mental health care

The landscape of Victoria's mental health and justice systems has transformed over the past three decades. As the health service system has grappled with the mainstreaming of mental health services, strong population growth and increasing incidence of drug and alcohol misuse has resulted in increased demand and a more complex consumer cohort requiring forensic

mental health services. Research suggests 50 per cent of people with mental illness also identify as having addiction issues.[3]

Over the past 10 years, Victoria's prison population has increased by 82 per cent, more than tripling the general adult population growth of 24 per cent for the same period. Recent criminal justice reforms in Victoria in response to individual acts of violence have increased pressure on the prison system with a significant growth in remand prisoner numbers[4]. Many of these prisoners also have mental health issues; between December 2017 and December 2018 alone, there was almost a 12 per cent increase in the number of prisoners with diagnosed mental health issues[5]. Mental illness among offenders can also remain undiagnosed affecting estimates of true service demand, access to treatment and continued risk of reoffending.

This demand on forensic mental health services by the growing prison population has not been matched by planning and strategic investment in hospital services that enable safe and effective mental health treatment for prisoners when they need it, consistent with the principle that those in prison should have access to the same level of treatment that those in the community can access. Figure 1 illustrates, that whilst the Victorian population has increased by 37 per cent and the rate of prisoners (per 100,000) has almost doubled since TEH opened in 2000, the rate of TEH beds has not increased at a corresponding rate. In addition, the number of forensic patients has been steadily increasing over time (as illustrated in Figure 2), which, given the indefinite nature of these orders, places increased pressure on demand at TEH.

Whilst Forensicare has significantly grown in its presence in Victoria's prison system in response to the increasing demand for mental health treatment, these prison services are not a substitute for hospital care and therefore do not adequately address the demand for hospital treatment at TEH. This is because treatment pathways and care in the prison environment is necessarily limited due to:

- the inability to provide some forms of voluntary treatment safely in a prison environment; and
- the fact the MH Act does not permit compulsory treatment in a prison setting.

[3] Victorian Government Submission, Royal Commission into Victoria's Mental Health System, 2019. Research shows that almost 75 per cent of Forensicare's TEH and community patient groups have comorbid substance use disorders (Ogloff et al., 2004; Ogloff et al., 2015).

[4] State of Victoria Sentencing Advisory Council, *Victoria's Prison Population 2005 to 2016*, 2016.

[5] Justice Health, *Mental Health Diagnosis: number of people with distinct conditions 31/12/2017 and 31/12/2018*; Raw data provided via email, 7 October, 2019.

Figure 1. Prisoner numbers (per 100,000) and TEH beds (per 10,000), 2000 - 2018[6]

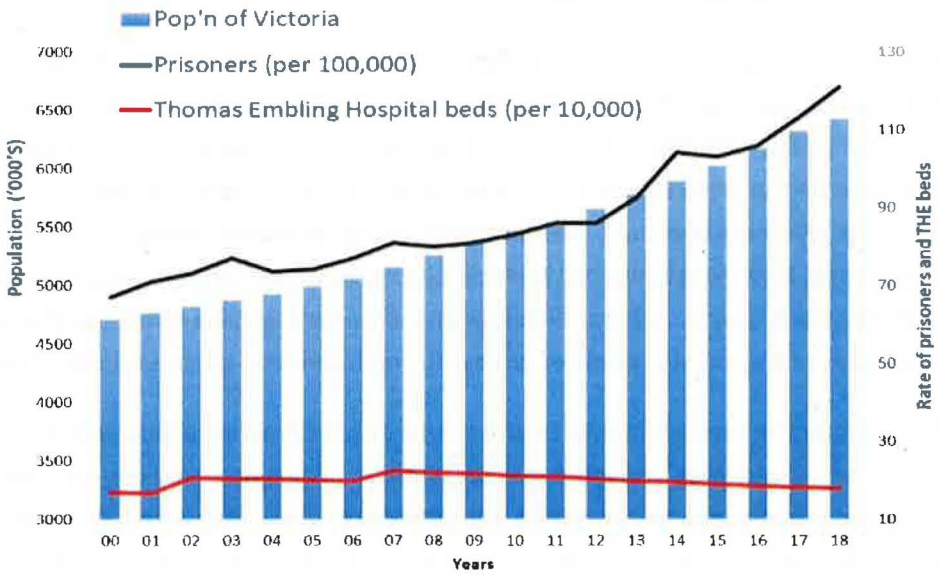
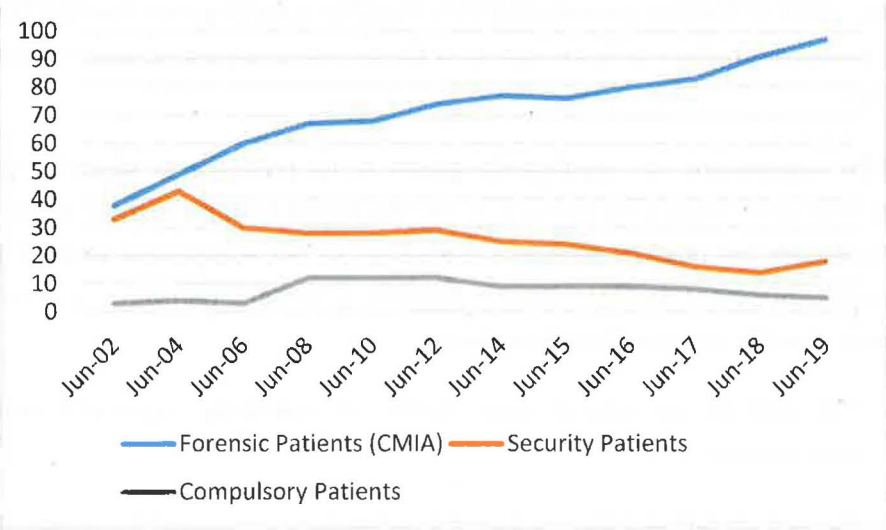


Figure 2. Numbers of patients in Thomas Embling Hospital, by patient type[7]



[6] Based on the capacity of 116 beds at Thomas Embling Hospital during that time.

[7] Based on the capacity of 116 beds at Thomas Embling Hospital up to June 2018 and 126 beds at June 2019.

Case study 1 *illustrating the need to provide mentally ill prisoners with hospital treatment*

A 20 year old man was charged with the attempted murder of his father. It was his first time in prison. He had been living with his parents and younger sister at the time of the offence. He had performed well in secondary school but dropped out of university during his second year due to increasing problems of drug use, especially cannabis and methamphetamine (**ice**).

He became socially isolated because of his increasing mistrustfulness of family members and friends and also became increasingly paranoid that he was being subjected to scientific experimentation. He became convinced that his family members were part of a conspiracy against him and that in fact his father was not really his father but an imposter who was a secret agent transmitting his thoughts via satellite back to the CIA. These delusions led to the offence where he stabbed his father with a kitchen knife believing that he was about to be liquidated by him.

On reception into prison he was assessed as having a first onset psychosis requiring intensive psychiatric treatment and ongoing support to recover from his illness. He was intensely frightened and incorporated prison authorities and mental health staff into his delusions. He contemplated suicide to prevent being tortured by his tormentors. Attempts by staff to work collaboratively with him on a voluntary basis within the prison were unsuccessful. He was recommended for compulsory treatment under the MH Act and was transferred to Thomas Embling Hospital on a secure treatment order.

To be treated safely and effectively, he required hospital treatment which allowed:

- repeated enforced injection with antipsychotic medication;
- 24-hour monitoring of physical health and safety, including regular physical observations given the potential side effects of the medication to have life threatening adverse effects;
- establishment of a trusted therapeutic relationship with specialist psychiatrist medical and nursing staff;
- intensive 24 hour a day psychiatric nursing care in a setting designed to support him and help him feel safe
- carefully supported and facilitated contact with his family; and
- as his psychotic symptoms gradually improved, regular access to allied health staff including occupational therapist, psychologist and social worker who can support him to meet some of his early recovery needs.

The treatment needs of the person described in this case study require treatment in a hospital setting – not a prison – to ensure their needs can be safely met in a therapeutic environment in accordance with the provisions of the MH Act, in the same way they would be able to access such treatment if they were a member of the community.

Case study 2 *illustrating the need to provide mentally ill prisoners with hospital treatment*

A young man with no pre-existing mental illness, was housed in lockdown[8] for several months in a regional prison. He had a history of assaults. Around a week before his release from prison, the primary mental health service provider in the prison became concerned that he was psychotic and assigned him a P1 rating[9]. He arrived at the Melbourne Assessment Prison 5 days before his release date.

He was housed in muirhead cell[10] for the duration of the 5 days. He proved very difficult to assess but presented as guarded and disorganised. Once he was identified as being a possible candidate for being placed on an inpatient assessment order (**IAO**) under the MH Act, he was assessed by:

- a psychiatric registrar
- the forensic clinical specialist of the receiving area mental health service; and
- a consultant psychiatrist.

It was determined that he was most likely psychotic and would need to be placed on an IAO on his day of release. There is no capacity at TEH to receive him on an IAO.

On the day of his release Ambulance Victoria and Victoria Police attend to transport him to an area mental health service. Due to the inability to safely gain his co-operation to transport him, he is placed under anaesthetic.

On arrival at hospital, early blood testing reveals that his Na+ and Crea are both very high and he is febrile. He is admitted to ICU and undergoes other testing and examination to rule out encephalitis. Subsequent investigations were largely normal, and his biochemistry returned to normal over several days. He was able to be extubated 2-3 days later.

It was determined that he had been dehydrated - likely the result of undetected poor oral intake in prison due to his mental illness. He was able to be discharged within a week to the care of his family.

This case represents the risks inherent where hospital treatment for mentally unwell prisoners is delayed. If he had been treated earlier in hospital, his dehydration and associated complications could have been prevented.

[8] 23 hour confinement of prisoners to their cell.

[9] Rating scale used in Victorian prisons to describe both the severity of a person's mental health condition and the intensity of mental healthcare a person requires, with P1 being the most severe/acute rating.

[10] A muirhead cell (also known as a safe cell) is a single cell that complies with the Cell and Fire Safety Guidelines, and is Building Design Review Project (BDRP) compliant. These cells are conducive to minimising self-harm.

In an attempt to predict current and future demand for hospital based forensic mental health services, substantial modelling work has been carried out by the Victorian Department of Health and Human Services, in consultation with Justice Health and Forensicare, which is set out in the following table:

Thomas Embling Cohort	Required capacity 2018	Current* capacity	Required capacity 2021	Required capacity 2026	Required capacity 2031	Required capacity 2036
	BEDS	BEDS	BEDS	BEDS	BEDS	BEDS
Forensic Patients	101	107	102**	109	117	125
Security Patients	77	27	99	116	125	134
Civil Patients[11]	11	2	12	14	15	16
Total Beds	**189**	**136**	**213**	**239**	**257**	**275**

*As at 14 January 2020.

** The modelling takes into account the increased capacity and potential efficiencies in more flexible treatment settings which are better geared towards patient needs, and ultimately patient progression.

Information Request 16.2 – Appropriate Treatment

The Productivity Commission is seeking further information about those held in correctional facilities who are eligible for forensic mental healthcare, but are unable to access it due to capacity constraints. In particular, we are seeking information about the likely costs and benefits to the wider community from increasing access to forensic mental healthcare.

If demand for forensic mental health hospital treatment continues to exceed supply, this will place the mental health system under increasing strain. In particular, this will continue to exacerbate the negative health and wellbeing outcomes for this vulnerable cohort and further compound the systemic mental health issues in Victoria. Further delays in alleviating this mismatch will only increase the total investment required in future years.

As outlined in paragraphs 2.1 and 4.1.1, there are inherent limitations associated with treatment pathways and care in the prison environment and custodial mental health units are therefore not a substitute for hospital care where indicated. If a prisoner's mental illness is not adequately treated during their period of custody, this can have adverse effects on their health and wellbeing and in turn, their rehabilitation and ability to successfully reintegrate into the community, reach their potential, have purpose and meaning in their life and contribute to the lives of others.

Benefits from increasing access to forensic mental healthcare

Upholding the principal of equivalency of care, individuals in the criminal justice system should have access to mental health care equivalent to that which would be available to them in the community. Forensicare considers timely access to forensic mental health services consistent with an individual's

[11] The Civil Patients admitted to Thomas Embling Hospital as at 23 January 2020 were not admitted directly to TEH from the community, they were initially Security Patient's whose legal status was changed to a compulsory patient under the MH Act at the conclusion of their sentence or period of remand.

clinical need, including hospital based care where indicated, has cumulative benefits for both the individual and the broader community, including:

1. **Improved mental health of forensic mental health consumers**

Access to specialist forensic mental health treatment consistent with clinical need and when required will improve the health and wellbeing of individuals experiencing mental illness whilst in custody.

2. **Improved mental health when released from prison, which helps facilitate successful transition to, and productive participation in, the community and reduce the likelihood of reoffending**

Mental health is a key driver of economic participation and productivity in Australia, and consequently has the potential to impact incomes and living standards and social engagement and connectedness in the wider community. Australians in good mental health are more likely to be employed, and when employed, are less likely to be absent from work and more productive while at work[12]. Employment also enables social inclusion in the wider community and is an important way that people with a mental illness can meaningfully participate in the wider community[13]. Consequently, improving the mental health and wellbeing of those in custody through timely access to forensic mental health care consistent with clinical need, including hospital care where indicated, will promote successful transition and re-integration to the community, including social and economic participation.

3. **Decreased length of stay in TEH due to being able to access treatment when required**

If prisoners require mental health treatment in a hospital setting and are unable to access, or are delayed in accessing, treatment at TEH, they will be more unwell upon admission and it will take longer for them to respond to treatment once admitted to TEH[14]. Increased acuity of patients can also result in increased risk of suicide and/or self-harm or harm to others. Consequently, access to hospital-based forensic mental health treatment when required will contribute to decreased length of stay due to admissions occurring before the individual's acuity has an opportunity to increase due to no treatment whilst waiting for access.

4. **Minimisation of avoidable emergency department presentations and hospitalisations of individuals following their release from prison**

The inability to access hospital treatment prior to release from prison also exacerbates the strain on Victoria's mental health system as this increasingly results in individuals upon release from prison being taken to an emergency department for assessment and treatment. It is also relatively common for a person on remand to leave prison to attend court, and then be released directly from court into the community without any transition to appropriate care. We understand this creates considerable problems and risks issues for area mental health services who may not be equipped to manage this. Consequently, accessing appropriate treatment whilst in custody will better minimise the need for

[12] KPMG & Mental Health Australia. (2018). *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*

[13] J. Pepper, R. Perkins, (2003) Social Inclusion and Recovery – A Model for Mental Health Practice, Bailliere Tindall

[14] Forensicare – Quality of Care Report, 2014-15

presentations at emergency departments as well as release without appropriate referral to community services.

5. Increased community safety

Although the vast majority of people with mental illnesses do not offend or become violent, people with serious mental illnesses are three times more likely to engage in offending and four times as likely to commit violent offences compared to other Victorians[15].

Evidence indicates that forensic mental health treatment in a hospital setting that provides specialist treatment and rehabilitation (for example TEH) as opposed to the services provided in a prison setting (e.g. through the custodial mental health units run by Forensicare in the prison setting) are more effective in reducing reoffending[16]. Consequently, Forensicare believes that the increase in the number of forensic consumers is linked to the current lack of capacity of the public mental health system. This lack of capacity escalates the severity of mental illness, forensic (offending) risk and in turn community safety.

Costs of increasing access to forensic mental health care

1. Investment in Infrastructure

Investment in infrastructure that is fit for purpose and facilitates delivery of best practice models of care to forensic consumers. For provision of forensic mental health services, building design needs to contemplate provision of services tailored to both the severity of mental illness of consumers and the security risk they pose to others.

2. Investment in workforce

Forensic mental health is a recognised area of specialisation within psychiatry, psychology, mental health nursing and, increasingly, occupational therapy and social work. In Victoria, very few mental health professionals across the disciplines receive specialist training in forensic mental health. As such, the workforce as a whole is poorly equipped to deal with issues related to mental illness and offending. Consequently, investment is required in training mental health professionals to obtain the requisite expertise to work with forensic mental health consumers.

4.1.2. Transition from prison to the community

With an increasingly high proportion of prisoners on remand in Victoria due to criminal justice reforms, the timing of release from prison is often uncertain. It is relatively common for a person on remand to leave prison to attend court, and then be released directly from court into the community. This makes it difficult to plan, and have appropriate supports in place, to support their effective transition and reintegration into the community.

[15] Short, T., Thomas, S. D. M., Luebbers, S., Mullen, P. E. & Ogloff, J. R. P. (2013). A case-linkage study of crime victimisation in schizophrenia-spectrum disorders over a period of deinstitutionalisation. BMC Psychiatry, 13, 66

[16] Appendix 2 of the Victorian Branch of the Royal Australian & New Zealand College of Psychiatrists, Formal Submission, Royal Commission into Victoria's Mental Health System, "Offence Prevention through Enhanced Mental Health Care and Better Mental Health"

Effective and coordinated discharge planning is essential for continuity of health care between prison and the community, and is necessary for successful transition and reintegration. To achieve this a system wide approach is required. The mental health and broader health and justice system needs to be better integrated, with service development and design based on need.[17]

Information Request 16.1 – Transition support for those with mental illness released from correctional facilities

The Productivity Commission is seeking further information on transition support for individuals with mental illness released from correctional facilities (on parole or not) that link them to relevant community services. This includes information on the benefits of transition support and the extent of transition support that should be provided.

The time of highest risk for consumers is during the transition from security and support in secure settings to increased independence and responsibility in the community[18]. As transition to community from correctional facilities necessarily requires collaboration and engagement with multiple service providers, including area mental health services, disability services, non-government organisations, NDIS, agencies working in the criminal justice system, Community Corrections, to ensure safe and effective transition, a system wide response is required.

Discharge from secure correctional or forensic mental health facilities for forensic consumers can be a particular challenge, especially, for consumers with high profile offences. The lack of adequate accommodation, support resources and linkages with general mental health and health services can adversely impact on discharge and continuity of care, resulting in extended inpatient stays beyond what is clinically necessary.

Continuity of care is essential for maintaining any health improvements achieved by people in prison, which will go to enhancing community safety and meaningful reintegration into community. Where care is not continued, individuals quickly lose any health gains they made in prison within a few months of release, which affects not only the individual, but the entire community. Seamless integration with community services is key for ensuring continuity of care is achieved. Judicious sharing of health information between service providers is critical to achieving this.

It is important to highlight that almost all consumers admitted to secure forensic mental health services suffer from serious mental illness, often in combination with other disorders (such as substance misuse, personality disorder and/or cognitive impairment). As outlined in paragraph 4.1.1 above, research indicates 50% of people with mental illness also identify as having addiction issues[19]

[17] Victorian Ombudsman, (2015) Investigation into the rehabilitation and reintegration of prisoners in Victoria,

[18] Appendix 2 of the Victorian Branch of the Royal Australian & New Zealand College of Psychiatrists, Formal Submission, Royal Commission into Victoria's Mental Health System, "Offence Prevention through Enhanced Mental Health Care and Better Mental Health"

[19] Victorian Government Submission, Royal Commission into Victoria's Mental Health System, 2019. Research shows that almost 75 per cent of Forensicare's TEH and community patient groups have comorbid substance use disorders (Ogloff et al., 2004; Ogloff et al., 2015).

and substance abuse in forensic mental health consumers is an important risk factor for violence and re-offending.[20]

The complexity of needs among this cohort has also contributed to system challenges not only in provision of appropriate treatment but also in adequate discharge planning and ultimate discharge from secure facilities. Consequently, Forensicare considers investment in alcohol and other drug therapeutic programs that are integrated with mental health treatment is required to more adequately address those experiencing mental illness who also have addiction issues.

[20] Ogloff, James R. et. al., (2015) "Co-occurring mental illness, substance abuse disorders and anti-social personality disorder among clients of forensic mental health services," Psychiatric Rehabilitation Journal, Vol. 38 (1), pp. 16 – 23; Pickard, H., and Fazel, S. (2013). Substance abuse as a risk factor for violence in mental illness: some implications for forensic psychiatric practice and clinical ethics. Current opinion in psychiatry, 26(4), 349–354.

Annexure A

Forensicare's formal submission to the Royal Commission into Victoria's Mental Health System submitted on 5 July 2019

Forensicare – Royal Commission into Victoria's Mental Health System Formal Submission

Overview

Vision

As the only agency in Victoria that provides clinical forensic mental health services that span all components of the mental health and criminal justice sectors, Forensicare has a unique perspective to share.

Our vision for Victoria's mental health system is that it:

- delivers humane, consumer-focused forensic mental health care to **all** forensic consumers[1], that is respectful of consumer rights, supportive of recovery and provided in the least restrictive way;
- promotes a whole of system approach that meets the needs of forensic consumers with multiple and complex needs across all stages of their recovery[2] journey;
- invests in prevention and early intervention to decrease demand for forensic mental health services;
- is grounded in a sound evidence base that recognises personal experience as legitimate evidence and addresses consumers' mental health and offending issues;
- ensures the safety of consumers and the broader community;
- ensures ongoing development of a specialist workforce; and
- fosters innovation through investing in research and evaluation.

Submission Context

Forensicare acknowledges the contribution of consumers, their families and carers.

Some patients at Thomas Embling Hospital (TEH) are transferred from the prison system as security patients under the *Mental Health Act* 2014 (Vic) for a period of treatment before subsequently returning to the prison system upon completion of that treatment. However, a large proportion of the patients at TEH (82%) have been found not guilty or unfit to plead on the grounds of mental impairment and ordered by a court to be detained for inpatient care and treatment. The average period of inpatient care and treatment is 6-8 years, during which these patients participate in an intensive rehabilitation program, which includes a slow, graduated program of leave in the community prior to the patient's ultimate supervised discharge into the community upon order by a court. Once discharged into the community, patients continue to receive compulsory care and treatment from community mental health services until ultimately discharged from this obligation by a court. The issues faced by patients and consumers within the forensic mental health system are often more pronounced than those experienced by people in the general mental health system.

[1] Forensic consumer(patient/client) refers to those people who have experienced a mental disorder, who have a history of criminal offending or are at risk of offending and who come into contact with the criminal justice system. (Mental disorders include organic brain disorder, ABI, personality, intellectual disorders.)

[2] Recovery refers to a contemporary approach to mental health care based on individualised care that focuses on strengths, hope, consumer choice and inclusion.

While there have been ongoing efforts made to attend to the pressures on the mental health system by services and the Victorian Government, there remain inequities, inconsistencies and gaps in the system which need addressing. In 2017-18, only 1.16% of Victorians received clinical mental health care[3] - the lowest level within Australia. Considered in the context of Victoria's above average population growth, (average growth rate of 1.81% over the last eight years)[4], Victoria's mental health system has not kept pace on a per capita population growth basis. Victoria has one of the lowest mental health bed bases nationally, resulting in major acute psychiatric units continually operating at or above 95% capacity. This means individuals experience longer waiting times to access services and face higher thresholds for access which has a flow-on effect to other parts of the system.[5] The access problem is accentuated for females as male bed pressures affect their access to treatment.

Community mental health services are overburdened, and not equipped to effectively support forensic consumers. The consequently shorter episodes of care compromise consumer outcomes. Shorter episodes of care for forensic consumers tend to result in them cycling between acute settings and crisis (inpatient, prison and the community). The lack of access for consumers to long-term secure forensic beds (including medium and low security options to allow people to "progress" through the system) is a barrier to recovery. Female forensic patients in particular spend longer time in TEH units and overall hospital stays because of a lack of stepped transition points, e.g., Sub-acute unit.

Although the vast majority of people with mental illnesses do not offend or become violent, people with serious mental illnesses are three times more likely to engage in offending and four times as likely to commit violent offences compared to other Victorians.[6] The opportunities for early identification and remediation of offending issues are often lost due to resource constraints and lack of relevant training in the wider mental health sector. Once in the mental health – or forensic mental health – systems, opportunities are still limited for addressing an individual's broader offending issues, again due to resource constraints and pressures to move people through the system quickly to accommodate the never-ending list of people with more acute needs.

The forensic mental health system is increasingly complex. Challenges with service integration are compounded by an increasing number of touch points. Moreover, consumers with complex needs – including personality pathology, substance misuse and cognitive impairment – are at greater risk of offending and destructive behaviour when undergoing treatment, hospitalisation or incarceration.[7] As a result of these challenges with service delivery, people are becoming more unwell and as a result of their mental health and offending issues being unaddressed, are more likely to come into contact with the criminal justice system. Community mental health care must be enhanced, supported, properly funded and better coordinated to ensure improved access to essential services, particularly for vulnerable communities. Victoria's mental health system requires significant increases in all types of services including acute, residential and forensic beds to meet

[3]Victorian State Government, Department of Health and Human Services, (2018) Victoria's Mental Health Services Annual Report 2017-18, , Victoria, Author

[4] Population of Victoria 2019

[5] Victorian Auditor-General's Office, (2019) - Access to Mental Health Services, Victorian Author

[6] Short, T., Thomas, S. D. M., Luebbers, S., Mullen, P. E. & Ogloff, J. R. P. (2013). A case-linkage study of crime victimisation in schizophrenia-spectrum disorders over a period of deinstitutionalisation. BMC Psychiatry, 13, 66

[6] Short, T., Thomas, S., Mullen, P. & Ogloff, J. R. P. (2013). Comparing violence in schizophrenia patients with and without comorbid substance-use disorders to community controls. Acta Psychiatrica Scandinavica, 128, 4, 306–313. DOI: 10.1111/acps.12066

[7] Ogloff, J. R. P., Talevski, D., Lemphers, A., Simmons, M., & Wood, M. (2015). Co-occurring mental illness, substance use disorders, and antisocial personality disorder among clients of forensic mental health services. Psychiatric Rehabilitation Journal, 38, 1, 16–23; Ogloff, J. R. P. Lemphers, A., & Dwyer, C. (2004). Dual Diagnosis in an Australian forensic psychiatric hospital: Prevalence and implications for services, Behavioral Sciences and the Law, 22, 543-562.

the critical shortage in service availability. While community mental health service expansion is imperative, this cannot be at the expense of overdue, needed bed-based support.

Who we are

The Victorian Institute of Forensic Mental Health, known as Forensicare, is the state-wide specialist provider of forensic mental health services in Victoria. Forensicare is a statutory body established in 1998 under the *Mental Health Act 1986* and continued under the *Mental Health Act 2014*. The Minister for Mental Health is the Minister responsible for Forensicare and the forensic mental health services provided. Forensicare operates under the *Mental Health Act 2014* in terms of its treatment of consumers, however, Forensicare also has obligations under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* in respect of consumers placed on supervision orders under that Act.

What we do

Our services deliver a range of forensic mental health programs targeted at consumers with varied needs at different stages of recovery; from assessment, early intervention and prevention, inpatient care, rehabilitation and community transition support[8]. As required by the *Mental Health Act 2014*, we also are responsible for research, education and training in forensic mental health.

These services are delivered through:

- Thomas Embling Hospital: a 136[9] bed secure forensic mental health hospital that provides acute and continuing care in separate male and female units and a mixed gender rehabilitation unit;
- Prison Mental Health Services: a 141 bed specialised forensic mental health service with programs and outpatient services located across Melbourne Assessment Prison, Dame Phyllis Frost Centre, Metropolitan Remand Centre, Port Phillip Prison, Ravenhall Correctional Centre and regional prisons; and
- Community Forensic Mental Health Service: the service delivery arm of Forensicare's outpatient and community based programs is located in Clifton Hill. Services are evidence-based and include effectively assessing, treating and managing high risk consumers aimed at improving outcomes for individuals and contributing to increased community safety.

We work in partnership with Swinburne University of Technology through the Centre for Forensic Behavioural Science (CFBS) to deliver a comprehensive forensic mental health research program, specialist training and ongoing professional education. [10]

Forensic mental health demand

Sadly, it is not uncommon for some people to have the first opportunity to access mental health assessment and services when they enter the justice system. Currently:

- 1 in 5 Victorians experience some form of mental illness;
- 3 per cent of Victorians experience a severe mental illness;
- 2 in 5 prisoners are assessed as having mental health treatment needs; and

[8] Full details on the range of Forensicare services can be found here: Annual Report 2017-18

[9] Current capacity is 128 beds due to Forensicare's inability to open the additional beds as a consequence of a shortage of mental health nurses across the sector.

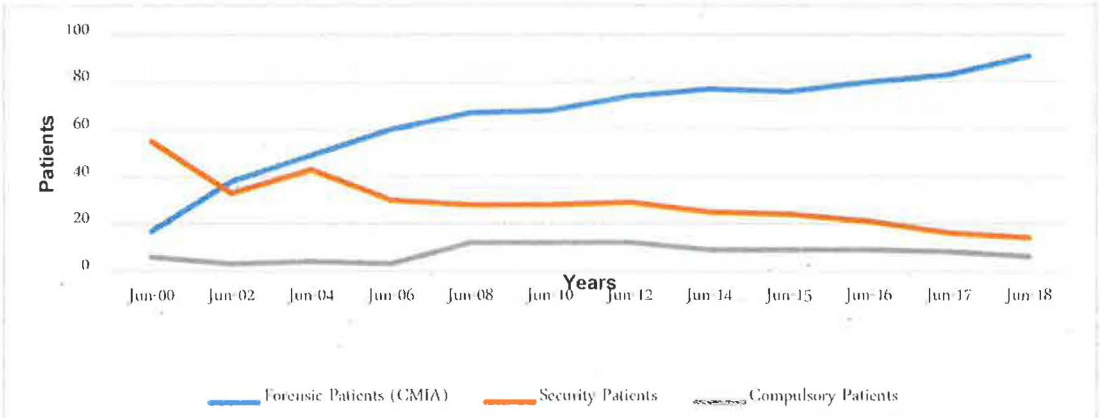
[10] Full details on CFBS can be found here: http://www.swinburne.edu.au/research/forensic-behavioural-science/

- the prevalence of mental illness is 3 times higher in the prison population.[11]

An Australian population-based data linkage study of adults in their 20s and 30s found that one in three (32%) of those with a psychiatric illness had been arrested during a ten-year period, and the first arrest often occurred before their first contact with mental health services.[12] Furthermore, approximately two in five prison entrants (40%) and people discharged from prison (37%) reported a previous diagnosis of a mental health disorder, including alcohol and other drug (AOD) use disorders, with prisoners ten to fifteen times more likely to have a psychotic disorder.[13]

Public perception of the interrelationship between mental illness and offending is disproportionate to the actual risks posed, with the majority of individuals living with a mental illness never offending.[14] Nevertheless, local and international evidence indicates that serious mental illness is a significant risk factor for offending.[15] We believe that the increase in the number of forensic consumers is linked to the current lack of capacity of the public mental health system. This lack of capacity escalates the severity of mental illness, forensic (offending) risk and in turn community safety.

The Victorian prison population continues to grow[16] placing an unprecedented demand on forensic mental health services, this impact may not have been factored into modelling and projections. Forensic patients in TEH have an increasingly long duration of stay[17] with a lack of alternative placement options. In general, as the number of forensic consumers increases, unless the overall number of beds available changes, the number of beds available for security and civil consumers reduces, as illustrated in the below graph. Despite taking measures to increase patient flow, Forensicare no longer has the capacity to adequately support the rest of the mental health system in managing complex forensic consumers in the community.



[11] Australian Institute of Health and Welfare (2018). The health of Australia's prisoners 2018. Cat. no. PHE 246. Canberra: AIHW

[12] Morgan, et al. (2013). A whole-of-population study of the prevalence and patterns of criminal offending in people with schizophrenia and other mental illness. Psychological Medicine, 43(9):1869-80.

[13] J.Ogloff, Good mental health care in prisons must begin and end in the community, The Conversation, 24 April 2015.

[14] Wallace, et al. (1998). Serious criminal offending and mental disorder: Case linkage study. British Journal of Psychiatry, 172:477-84.

[15] Short, et al. (2013). Comparing violence in schizophrenia patients with and without comorbid substance use-disorders to community controls. Acta Psychiatrica Scandinavica, 128(4):306-313

[16] A. Freiberg and S. Ross (1999), Sentencing Reform and Penal Change: The Victorian Experience (The Federation Press); Australian Bureau of Statistics (2017), Prisoners in Australia, Cat. No. 4517.0

[17] Forensicare, (2018) Yanith Bilang Quality Account 2017- 2018, pg 50.

If prisoners are not provided with adequate care this carries considerable human rights risks. The United Nations Basic Principles for the Treatment of Prisoners and Victoria's Charter of Human Rights and Responsibilities both speak to the right of prisoners to humane treatment when deprived of liberty.[18] Involuntary treatment cannot be provided in prisons, and there are significant wait times for prisoners to be transferred from prison to TEH to receive this treatment[19]. Due to the lack of available forensic mental health beds, more must be done for individuals with a mental illness while in prison to lessen the risk to the individual and the community. If a prisoner's mental illness is not treated during their imprisonment, this can have adverse effects on their health and wellbeing and in turn, their rehabilitation and ability to effectively reintegrate into the community.[20] The challenge of how to deliver to people in prison and detention an equivalent[21] level of care (to that received by the general community) is a complex issue that warrants specific consideration by the Royal Commission.

A world-leading mental health system should provide access to appropriate and effective treatment for all Victorians. To achieve this an imperative must be placed on growing the mental health workforce to keep pace with the required growth of mental health services. Forensicare has a significant role to play in a reformed system not only in providing services for those in contact or at risk of contact with the criminal justice system but in further building the capacity of both health and justice services to respond to the mental health needs of the community with a focus on prevention and early intervention.

[18] *The Victorian Charter of Human Rights and Responsibilities Act 2006*

[19] Victorian Ombudsman,(2015) Investigation into the rehabilitation and reintegration of prisoners in Victoria September 2015, Victorian Ombudsman, Victorian Government.

[20] J.Ogloff,(2015) Good mental health care in prisons must begin and end in the community, The Conversation, 24 April

[21] Niveau G. (2007). Relevance and limits of the principle of "equivalence of care" in prison medicine. *Journal of medical ethics*, *33*(10), 610–613. doi:10.1136/jme.2006.018077

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

Key recommendations:

- invest in awareness initiatives guided by trauma-informed principles that humanise people and address the myths and stigma associated with mental illness for forensic consumers;
- ensure stigma for forensic consumers is addressed in a way that avoids further stigmatisation of consumers, their carers and families; and
- prioritise and value the voices of those with lived experience, including their contribution to interventions and service design.

Forensicare's consumers and consumer consultants were key contributors to the following response.

People with a mental illness who have offended are a highly stigmatised and marginalised group in the community. Consumers of Forensicare often speak about the double stigma by virtue of their mental illness which is compounded again by their offending. This stigma arises from community-held misconceptions of mental illness and offending and often leads to discrimination, limiting the ability of consumers to reach their full recovery potential. Practically, this means forensic consumers face difficulties in accessing basic psychosocial services, such as housing and employment.[22] Double stigma (mental illness and offending) and triple stigma (mental illness, AOD use and offending) have a significant impact on a person's capacity to recover and achieve social inclusion.[23]

Consumers of Forensicare, more often than not, encounter temporary and sometimes permanent restrictions when trying to obtain housing, employment, education, and other aspects of community involvement and support due to stigma and discrimination. Additionally, consumers of Forensicare reported difficulties in forming and sustaining relationships due to stigma, leading to further social isolation. The impact of stigma can lead to poor health outcomes, unsuccessful reintegration and ultimately a potential increase in recidivism.[24] Forensicare provides a range of individual and group therapeutic programs to explore and overcome the challenges of stigma for forensic consumers.

While there has been a concerted effort over recent years to increase awareness, and reduce the stigma associated with anxiety and depression, there is still significant stigma associated with other more complex mental illness diagnoses, such as schizophrenia and personality disorders. Negative media coverage emphasising the relationship between mental illness and offending contributes to discrimination. Currently, community discourse regarding the impact of mental illness focuses heavily on suicide or homicide. This discourse needs to be broadened to incorporate the day-to-day experiences and challenges that people living with a mental illness face including the impact of stigma and the role of the community in being part of recovery. Particular care is required when addressing stigma for forensic consumers in order to minimise the risk of further stigmatising this vulnerable population.

In reflecting on their own experiences, members of the Forensicare Community Consumer Advisory Group (CAG) reinforced the importance of education about mental illness being a focus within

[22] W. Pogorzelski, N. Wolff, C. Blitz; (2005); Behavioural Health Problems, Ex-offender Re-entry Policies, and the "Second Chance Act" Public Health Consequences of Imprisonment. 2005;95:1718–1724.

[23] Forensicare Consumer Consultations for submission to the Royal Commission in Victoria's Mental Health System.

[24] Moore, K. E., Stuewig, J. B., & Tangney, J. P. (2016). THE EFFECT OF STIGMA ON CRIMINAL OFFENDERS' FUNCTIONING: A LONGITUDINAL MEDIATIONAL MODEL. Deviant behavior, 37(2), 196–218. doi:10.1080/01639625.2014.1004035

schools and supporting the implementation of mental health first aid courses for staff and students. Through investment in awareness-raising initiatives stigma can be reduced, providing opportunity for individuals, carers and family members to identify early warning signs of potential mental illness. One way to address stigma faced by forensic consumers may be to reframe the narrative to acknowledge people are battling against incredible odds to achieve recovery. The community needs champions of change who have a lived experience of mental illness.

Forensicare has a strong commitment to growing our lived experience workforce. The work of our CAG and Consumer Consultants have been recognised for their outstanding contributions to both Forensicare and the wider mental health sector.

The Royal Commission has an opportunity to highlight the needs of forensic consumers, their families and carers and build better community understanding of the challenges facing those with a mental illness who come into contact with the criminal justice system.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

Key recommendations:

- strengthen the opportunity for early therapeutic intervention through diversion when individuals encounter the criminal justice system; and
- deliver evidence-based services for youth forensic consumers.

A robust forensic mental health system needs to focus on early intervention, justice reinvestment and frontline holistic support.[25] To improve the health outcomes for individuals with a mental illness and reduce the risks of violence and offending, an early intervention framework targeted at forensic clients that begins in the youth mental health system and traverses adult mental health systems is required. Community-based diversion programs which divert people away from crime, prosecution and custody and link to appropriate support programs are more effective in reducing recidivism and more cost effective than detention.[26]
There are several programs connected to Forensicare that we consider are working well. Mental Health Court Liaison Services have emerged in Australia as a key part of the response to the over-representation of people with mental illness in the criminal justice system.[27] The Community Forensic Mental Health Service (CFMHS) provides the Mental Health Advice and Response Service (MHARS) which enables clinical services to intervene early with individuals in the criminal justice process.

Additionally, the Forensic Serious Offender Consultation Service (F-SOCS) is a unique mental health service working with the criminal justice sector. F-SOCS provides forensic mental health assessments and facilitates access to the mental health sector for eligible offenders supervised by community correctional services. This program works to identify those who are assessed as posing a high risk of further serious violent and/or sexual offending. The program targets clients who are either currently not engaged with Area Mental Health Services (AMHS) or where engagement is problematic.

The Victorian Fixated Threat Assessment Centre (VFTAC) is a joint initiative delivered in partnership with Victoria Police. It provides a structured and coordinated approach to respond to serious threats of violence posed by people with complex needs including mental illness and alcohol and other drug issues, by intervening early to help prevent violence. This model provides a good example of how partnerships between the justice and health systems can deliver enhanced outcomes for the individual and the community.

Forensicare also operates the Problem Behaviour Program (PBP) which aims to reduce the risk of violence and offending behaviours in those who have a mental illness who have recently engaged in, or are at risk of engaging in, one or more 'problem behaviours'. An evaluation of the PBP[28] in 2015 showed 66% of clients who attended the program for assessment did not have subsequent charges during the follow-up period. For those that did, this had significantly reduced to an average of 2.5 charges in the two years after PBP contact, compared to an average of 4.9 charges in the two years prior to PBP contact.

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[25] Institute of Public Policy Research (2011); Redesigning Justice: Reducing Crime through Justice; T.Lanning, I. Loader, R.Muir, London.
[26] H.Wilson; R.Hodge; The effect of youth diversion programs on recidivism: A Meta-Analytic Review; International Association for Correctional and Forensic Psychology; May 2013, Vol 40, pg 497-518
[27] Davidson, F., Heffernan, E., Greenberg, D., Butler, T., & Burgess, P. (2016). A Critical Review of Mental Health Court Liaison Services in Australia: A first national survey. *Psychiatry, Psychology and Law*, 1-14. doi: 10.1080/13218719.2016.1155509
[28] Evaluation of the Problematic Behaviour Program (2015) Forensicare

The Forensic Clinical Specialist model effectively builds the capacity of mainstream mental health services to identify and treat those at risk of contact with the criminal justice system due to their mental illness. Forensic Clinical Specialists can also provide a central coordination point for those released from prison who require referral to mental health services. There is an opportunity to expand this, which would reduce the number of people released from prison with no follow up to a mental health service upon their transition to the community. Building on the tiered approach delivered through the Forensic Clinical Specialist Program, supported by Forensicare, would ensure AMHS are better equipped to respond to the forensic needs of their consumers.

There are improvements required in order to strengthen the opportunities for early therapeutic intervention.

Traditionally, assessing and managing risk of violence and offending have been viewed as the domain of specialist forensic mental health services (such as Forensicare), rather than general services. While specialist forensic mental health services are available in some mental health catchments, these services are not consistently available and typically become involved only after a person has offended. As a result, there is growing recognition that general mental health services have a critical role to play in managing the risks of violence among consumers.[29] To this end, following on from a review of sentinel events in which consumers of mental health services committed homicide, or were themselves murdered, Queensland Health has developed a tiered approach to risk assessment and management of mental health consumers.[30]

The prevalence of mental illness is higher among young people engaged in the justice system compared to those who are not, and is higher again among young people in residential detention.[31] Despite experiencing a higher prevalence of mental illness, young people connected with the justice system are far less likely to have accessed mental health services.[32] While young adults under 25 years of age make up a relatively small percentage of the prison population, their rate of recidivism is higher, and the impact of that cycle can be significant for community safety.[33] As part of a comprehensive approach to early intervention, there is a need for an increased investment in specialist youth mental health services[34], underpinned by a whole of system approach across both justice and health systems. Provision of a range of detention based and community forensic mental health evidence based interventions for young people provides an opportunity to both address the emergence of mental illness and offending risks.

Creating a system which responds well to early identifiers of mental illness will result in a system of voluntary therapeutic involvement having a positive effect, whereby people can be actively involved in designing interventions which work for them and being supported in implementing them.

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[29] Fraser et al (2014). Early Intervention to Reduce Violence and Offending Outcomes in Young People with Mental Disorders. *Early Intervention in Psychiatry: EI of Nearly Everything for Better Mental Health*, First Edition

[30] Burnett, P., & Ogloff, J. R. P. (2016). When Mental Health Care Meets Risk: A Queensland Sentinel Events Review into Homicide and Public Sector Mental Health Services. Report prepared for the Department of Health, Queensland.

[31] Kinner, S.A., et al., (2014). Complex health needs in the youth justice system: a survey of community-based and custodial offenders. J Adolesc Health. 54(5): p. 521-6. 4

[32] Liebenberg, L. and M. Ungar, (2014). A comparison of service use among youth involved with juvenile justice and mental health. Children and Youth Services Review. 39: p. 117-122

[33] Sentencing Advisory Council, (2016) Reoffending by Children and Young People in Victoria; Author

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

3. What is already working well and what can be done better to prevent suicide?

Key recommendations:

- suicide prevention models need to be multidisciplinary, collaborative and consumer-centric and involve a combination of psychosocial and clinical interventions;
- suicide intervention models must maintain a recovery focus that is responsive and tailored to the person's long-term needs;
- models need to ensure families and carers are central to the design and delivery of postvention support;
- self-harm and suicide risk must be embedded within treatment planning for forensic consumers; and
- investment in specialist research to address the absence of evidence-based models of care for the prevention of suicide.

There are very few examples of what is working well currently to prevent suicide in forensic settings[35]. Forensicare seeks to apply best practice approaches to suicide prevention based on available evidence, however, more could be done with greater resources. This demonstrates an urgent need for continued research and development of suicide prevention risk assessments, models and programs.

The rates of suicide and self-harm are significantly greater for those living with mental illness.[36] For patients with a history of self-harm, the ratio of death by suicide is 4.3 when compared to those with no history of self-harm.[37] Suicide is a leading cause of death in Australian prisons[38]. Self-harm rates are known to be higher in inpatient hospital settings than in the community or general medical settings [39]. The significant rate of self-harm and suicide within these facilities suggest that security and restricted regimes alone are not protective against suicidal behaviour.

Self-harm and suicidal behaviours present significant challenges to the treatment journey for both the consumer and the staff treating them. Despite the commitment to recovery-based treatment and support, concerns exist over balancing the safety of consumers and staff, often limiting treatment and consumer outcomes.

Critical to responding to the risk of self-harm and suicide is establishing a robust and evidence based approach. Despite significant clinical and academic research endeavours to understand the assessment of suicide risk, an evidence based model and approach to suicide prevention continues to elude the mental health sector worldwide. The multidimensional and complex nature of suicidal ideation and behaviour is further compounded in forensic consumers with serious mental illness as a result of their significant comorbidities.

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[35] Martin, M. S., Dorken, S. K., Colman, I., McKenzie, K., & Simpson, A. I. (2014). The incidence and prediction of self-injury among sentenced prisoners. Canadian journal of psychiatry. Revue canadienne de psychiatrie, 59(5), 259–267. doi:10.1177/070674371405900505

[36] Bradvik L. (2018). Suicide Risk and Mental Disorders. Int J Environ Res Public Health. 2018 Sep:15(9):2028. doi 10.3390/ijerph15092028.

[37] The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: England, Northern Ireland, Scotland, Wales. October 2018. University of Manchester.

[38] Australian Institute of Health and Welfare 2019. The health of Australia's prisoners 2018. Cat. no. PHE 246. Canberra: AIHW.

[39] Walsh, G., Sara, G., Ryan, C.J., & Large, M. (2015). Meta-analysis of suicide rates among psychiatric in-patients. Acta Psychiatrica Scandinavica, 131, 174-184

Notwithstanding the absence of evidence-based assessment options, there are a number of well documented risk factors, triggers and contributors to self-harm in individuals with mental illness (specifically those in the forensic mental health sector), namely:

- A higher level of clinical complexity such as 'treatment resistance'.[40]
- Multiple comorbidities (particularly personality disorders and substance use disorders).[41] Research has estimated that the prevalence of dual diagnosis is high among people in prison, ranging from 18% to 56%.[42]
- Adverse childhood experiences (e.g. child abuse, significant trauma, family violence).[43]
- Head injury (e.g. extended loss of consciousness, acquired or traumatic brain injury).[44]

Investment in specialist research focused on suicide prevention for forensic consumers is essential to inform treatment approaches more broadly. This research must attend to the journey of mental illness, self-harm and suicide and seek to understand the antecedents and consequences, options and opportunities for prevention, early intervention, treatment and recovery. Families and carers must also play a key role in the design and delivery of models designed to both prevent suicide and provide postvention support to individuals.

A psychosocial lens needs to be applied when considering suicide risk so that all the factors impacting an individual and their mental health and wellbeing are understood and addressed.[45] Consideration of race, religion, ethnicity, social class, physical ability, sexual orientation and gender identity and how these might shape a person's behaviour and experiences is also important. The importance of a person-centred, recovery-focused approach to suicide prevention should not be underestimated.

It is also important to be cognisant that risk factors are indicators only and not to assume that suicide in a person with one risk factor is less likely than suicide in another person with several risk factors. The research supports using risk factors for suicide to identify populations at increased risk, not individuals at risk. It is not possible to reliably predict whether a person is likely to take their own life.[46]

There is now strong evidence that suicide prevention is most effective when delivered through an integrated systems approach, where accountability for working towards zero suicides is shared across all of the portfolios that have a role to play[47]. While suicide prevention needs to be led by

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[40] Wimberley T, MacCabe JH, Laursen TM, Sorensen HJ, Astrup A, Horsdal HT, Gasse C, Stövring. (2017). Mortality and Self-Harm in Association with Clozapine in Treatment-Resistance Schizophrenia. Am J Psychiatry. October 2017;174(10):990-998. doi: 10.1176/appi.ajp.2017.16091097

[41] Bradvik L. (2018). Suicide Risk and Mental Disorders. Int J Environ Res Public Health. 2018 Sep:15(9):2028. doi 10.3390/ijerph15092028.

[42] Young JT, Heffernan E, Borschmann R, Ogloff JRP, Spittal MJ, Kouyoumdjian FG, Preen DB, Butler A, Brophy L, Crilly J, Kinner SA. (2018). Dual diagnosis of mental illness and substance use disorder and injury in adults recently released from prison: a prospective cohort study. 2018 May;3(5): 237-248. doi: 10.1016/S2468-2667(18)20052-5

[43] University of South Australia. (2017). Trauma-Informed Approaches in Forensic Mental Health.

[44] Sariaslan A, Lichtenstein P, Larsson H, Fazel S. (2016). Triggers for Violent Criminality in Patients with Psychotic Disorders. JAMA Psychiatry 2016 August;73(8)796-803. doi:10.1001/jamapsychiatry.2016.1349

[45] Blackdog Institute (2016); An evidence-based systems approach to suicide prevention: guidance on planning commissioning and monitoring; NHMRC Centre of Research Excellence in Suicide Prevention, Blackdog Institute (Australia)

[46] Large M, Kaneson M, Myles N, Myles H, Gunaratne P, Ryan C (2016) Meta-Analysis of Longitudinal Cohort Studies of Suicide Risk Assessment among Psychiatric Patients: Heterogeneity in Results and Lack of Improvement over Time. PLoS ONE 11(6): e0156322. https://doi.org/10.1371/journal.pone.0156322

[47] Blackdog Institute (2016); An evidence-based systems approach to suicide prevention: guidance on planning commissioning and monitoring; NHMRC Centre of Research Excellence in Suicide Prevention, Blackdog Institute (Australia)

health, the justice, housing, employment, disability, education and social services portfolios all need to embed suicide prevention into their approaches and systems.

The fifth national mental health and suicide prevention plan (the Fifth Plan)[48] commits all governments to a systems-based approach by adopting a combination of the World Health Organisation's elements of an effective systems-based approach to preventing suicide. Forensicare supports the plan to establish a national universal approach across the eight target areas outlined in the Fifth Plan.

Forensicare plays a role in both the assessment and crisis response in some prisons across Victoria. However, there is an opportunity to review and strengthen the role of Forensicare in increasing the understanding of what is effective and ensuring it is available to all people in the criminal justice system.

[48] National Mental Health Commission, 2018: Monitoring mental health and suicide prevention reform: Fifth National Mental Health and Suicide Prevention Plan, 2018. Published by: National Mental Health Commission, Sydney

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

Key recommendations:

- develop a forensic mental health service framework as a specialist component of the mental health framework;
- reinforce system integration, collaboration and information sharing; and
- increase the availability of forensic beds across a spectrum of security levels.

Currently, the system is reactive because of a lack of system and strategic planning, with little planning involvement of stakeholders. This has led to a system which seeks additional services after the need has been highlighted and unmet for some time.[49] In the 1990s, as clinical mental health systems transitioned from provision by the Victorian Government to provision by public health services there was a comprehensive framework which described how the service system was expected to operate and, in particular, the links between the different components of the system and the transitions which would be expected between those components. These components included community care, inpatient treatment, secure extended care units, community care units, and the forensic mental health system. All of these components of the mental health system have changed over time. There is currently no clear framework describing how each of these components is expected to operate or interact with each other[50].

The Victorian Government has an obligation (through the Department of Health and Human Services) to clearly describe how each component of the system should operate, the outcomes each component is expected to achieve for consumers, and how consumers should move or transfer between components of the system. The lack of clear service system design produces poor outcomes for consumers and makes it more difficult for the providers of clinical mental health services to operate effectively together.[51]

Forensicare supports the development of a forensic mental health service framework based on sound in-depth projection analysis, considering population growth, current and emerging trends, and models of care. Improving the experience and outcomes of people living with mental illness must be based on the principles of recovery and the involvement of consumers in service design and delivery. Best practice identifies that these frameworks should be developed in consultation with consumers, carers, and service providers. There is a wealth of literature which emphasises the importance of commissioning services in consultation with these groups.[52]

A whole of system approach is required to meet the needs of all forensic consumers. There is currently poor integration of care between services (particularly between prisons, the community, alcohol and other drug services, mental health services and the justice system). Service providers report dual diagnosis is now the expectation rather than the exception. The prevalence of alcohol and other drug issues for those with a mental illness is well documented, however underreported[53], and consumers continue to report difficulties with the lack of integration

[49] Victorian Auditor –General's Office. (2019). Access to Mental Health Services.

[50] ibid

[51] ibid

[52] Schwartzkoff J. & Sturgess, G.L. (2015) Commissioning and Contracting for Better Mental Health Outcomes. Research report by Rooftop Social for Mental Health Australia

[53] N. Zoe Hilton, Shari A. McKee, Elke Ham, Michelle Green & Lauren Wright (2018) Co-Occurring Mental Illness and Substance Use Disorders in Canadian Forensic Inpatients: Underdiagnosis and Implications for Treatment Planning, International Journal of Forensic Mental Health, 17:2, 145-153, DOI: 10.1080/14999013.2018.1451416

between services. Substance abuse in forensic mental health consumers is an important risk factor for violence and re-offending[54] and forensic mental health services must take into account the effect that co-occurring disorders have on consumers' functioning and offending. Mental Health Services must address substance disorders to help ensure recovery from the mental illness and to reduce the likelihood of offending.[55]

Additionally, there is a clear link between homelessness and health, with homeless people having higher rates of mental illness, alcohol and other drug use disorders, chronic conditions and imprisonment[56]. Prison entrants are around 66 times more likely than the general population to be homeless.[57] Forensicare staff and consumers reported a significant challenge with finding suitable accommodation for people post release from prison. Due to a lack of comprehensive assessment and discharge planning, many prisoners without family or community support leave prison without any post-release support, including housing assistance, material aid and other services.

With an increasingly high proportion of prisoners on remand the timing of release from prison is often uncertain[58]. It is relatively common for a person on remand to leave prison to attend court, and then be released directly from court into the community. We understand this creates considerable problems and risks issues for AMHS who may not be equipped to manage this. The Community Integration Program provided by Forensicare only operates in some prisons. This program could be expanded to support the successful transition of people released from prison who require mental health follow up.

Further work is required at all points of the care continuum, in particular effective and coordinated discharge planning is essential for continuity of health care between prison and the community, and is necessary for a successful transition. The mental health and broader health and justice system needs to be better integrated, with service development and design based on need[59]. Electronic health information is stored on a multitude of different platforms and systems do not communicate with each other. The review of hospital safety and quality assurance in Victoria report[60] identified the importance of overhauling the way in which data and information is shared across the health system.

As detailed at the beginning of this submission there is a lack of access for consumers to long-term secure forensic beds, including medium and low security options. This prevents consumers from progressing through the system, resulting in some people with mental illness being released from prison without treatment. Furthermore, Forensicare no longer has capacity to provide services through TEH for non-forensic (civil) consumers with complex needs who are no longer able to be managed by AMHS.

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[54] Pickard, H., & Fazel, S. (2013). Substance abuse as a risk factor for violence in mental illness: some implications for forensic psychiatric practice and clinical ethics. *Current opinion in psychiatry*, *26*(4), 349–354. doi:10.1097/YCO.0b013e328361e798

[55] Ogloff, J. R. P., Talevski, D., Lemphers, A., Wood, M., & Simmons, M. (2015). Co-occurring mental illness, substance use disorders, and antisocial personality disorder among clients of forensic mental health services. *Psychiatric Rehabilitation Journal, 38*(1), 16-23

[56] *Homelessness, drug use and offending*. (2008) Crime facts info no. 168. Canberra: Australian Institute of Criminology.

[57] Australian Institute of Health and Welfare 2019. The health of Australia's prisoners 2018. Cat. no. PHE 246. Canberra: AIHW

[58] ibid

[59] Victorian Ombudsman, (2015) Investigation into the rehabilitation and reintegration of prisoners in Victoria.

[60] State of Victoria. (2016). Review of Hospital Safety and Quality Assurance in Victoria.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

Key recommendations:

- increase the options and availability of forensic mental health services for women;
- deliver culturally safe and community-led services for Aboriginal and Torres Strait Islander people;
- increase the range of options for forensic consumers with a cognitive impairment or disability;
- build capacity for specialist and general services to meet the needs of an aging forensic mental health population;
- respond to the needs of diverse communities, including the LGBTIQ+ community and those from culturally and linguistically diverse backgrounds;
- increase access to forensic mental health services for remote and rural communities and increase investment in line with the growth of prison populations; and
- deliver integrated forensic mental health services across mental health and homelessness services.

Determinants of mental health and mental illness include not only individual attributes, but also social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions, and community social supports.[61] There is a clear link between disadvantage and imprisonment with over half of Victoria's prisoners coming from just six percent of postcodes[62]. Prisoners are far less likely to have finished school, have higher rates of mental illness and acquired brain injury. [63]The average prisoner was unemployed at the time of committing the offence and has a history of substance abuse, with over 40 per cent homeless upon release.[64]

Between 2008 and 2013 the number of women imprisoned in Victoria increased by more than double the male population.[65] Women in prison were more likely to be single parents, and to be socioeconomically disadvantaged than those in the community.[66] Female consumers in secure forensic mental health services are more likely to have history of sexual, physical and/or emotional abuse when compared with male patients. A standardised approach to forensic mental health service provision does not adequately meet the needs of female consumers[67]. There is an urgent need for appropriate step-down options including secure mental health rehabilitation services for women. The pressures on male forensic beds have a direct impact on the movement of female

[61] World Health Organisation(WHO) (2013) Mental Health Action Plan 2013-2014, WHO document production services, Geneva, Switzerland.

[62] Victorian Ombudsman, (2015) Investigation into the rehabilitation and reintegration of prisoners in Victoria

[63] ibid

[64] ibid

[65] ibid

[66] Australian Institute of Health and Welfare. (2018). The Health of Australia's prisoners.

[67] CG,Long B, Fulton, CR, Hollin; The development of a 'best practice' service for women in a medium-secure psychiatric setting: treatment components and evaluation (2008). Clinical Psychology Psychotherapy. 2008 Sep-Oct;15(5):304-19. doi: 10.1002/cpp.591.

consumers throughout the forensic mental health system. System design and evaluation must consider and be responsive to gender.

Aboriginal and Torres Strait Islander people already face significant disadvantage. They are overrepresented at all levels of the criminal justice system and their rate of imprisonment is growing at a faster rate than anywhere else in the nation[68]. Despite Aboriginal and Torres Strait Islander people making up only 0.7 per cent of Victoria's population, they represent nearly 8 per cent of prisoners. The most significant contributing factor of Aboriginal and Torres Strait Islander people being overrepresented in the criminal justice system stems from their disadvantage and unequal position in the wider society.[69] Aboriginal and Torres Strait Islander people face the added complexity of intergenerational trauma caused by colonisation and invasion[70] . They experience additional barriers to accessing services such as discrimination, lack of culturally safe services, distrust of services and physical barriers (such as remote and rural locations).

In 2018, 6.89 % of patients admitted to TEH identified as Aboriginal and Torres Strait Islander[71]. Forensicare recognises that Aboriginal and Torres Strait Islander views on mental health and social and emotional wellbeing are very different to those of non-Aboriginal Australians. Therefore, development and implementation of culturally safe environments and culturally responsive mental health care is a Forensicare priority. As an example, in conjunction with Wurundjeri Elders, local Aboriginal community members and Aboriginal patients, the Bunjil Waa-Wein Fire Pit has been created at TEH and the Boon-Gim Ngaga Social and Emotional Wellbeing Assessment implemented. Concerted efforts are required to develop community driven, holistic culturally safe forensic mental health services for those who identify as Aboriginal or Torres Strait Islander.

People with intellectual disability, acquired and traumatic brain injury and cognitive impairment are overrepresented in the criminal justice system. A recent study estimated that 42 per cent of male and 33 per cent of female prisoners show evidence of an acquired brain injury (ABI). [72] There is no consistent process to identify, assess or support this group of vulnerable prisoners. Due to the complexity of their presentation, there is a lack of available services both within prison and in the community.[73] There is an urgent need for a range of suitable secure options for forensic consumers with a cognitive impairment or disability and investment in systematic screening and assessment processes.

Although elderly people make up a relatively small proportion of the forensic mental health consumer population, these numbers are increasing. The needs of this group require the availability of age-appropriate services which can meet the changing physical and psychological health needs of an aging population both within prison and the community.[74]

Australians living in rural and remote areas generally experience poorer health and welfare outcomes than people living in metropolitan areas.[75] The geographical challenges associated with providing forensic mental health services to rural and regional areas continues to require consideration and expanded solutions. Additionally, mental health investment needs to meet the needs of population growth, particularly in areas with an increasing prison population. Without

[68] Victorian Ombudsman, (2015) Investigation into the rehabilitation and reintegration of prisoners in Victoria

[69] Burra Lotjpa Dunguludja; Victorian Aboriginal Justice Agreement, Phase 4: A partnership between the Victorian Government and Aboriginal Community

[70] Cunneen C, Tauri J, 2016, Indigenous Criminology, Bristol Policy Press, United Kingdom

[71] Forensicare Annual Report (2018) Forensicare Annual Report 2017-18

[72] Synapse. (2019). Brain Injury and the justice system.

[73] Victorian Ombudsman, (2015) Investigation into the rehabilitation and reintegration of prisoners in Victoria

[74] Natarajan, M., & Mulvana, S. (2017). New horizons: Forensic mental health services for older people. BJPsych Advances, 23(1), 44-53. doi:10.1192/apt.bp.113.012021

[75] Australian Institute of Health and Welfare, (2017), Rural and remote health

investment in effective treatment both in and out of prison in these areas people will continue to experience worse outcomes.

The mental health of lesbian, gay, bisexual, transgender, intersex and other sexuality, sex and gender diverse (LGBTI+) people is among the poorest in the country, including experiencing the highest rate of suicidality of any population in Australia.[76] The elevated risk of mental illness and suicidality among LGBTI+ people is not due to sexuality, sex or gender identity in and of themselves, but rather due to discrimination and exclusion as key determinants of health.[77] There is a need to further understand the needs of this population in the context of forensic mental health service delivery and prioritise inclusive initiatives to address discrimination.

Over a quarter of a million first-generation adult Australians from culturally and linguistically diverse backgrounds are estimated to experience some form of mental disorder in a 12-month period, based on the findings of the National Survey of Mental Health and Wellbeing.[78] People in prison who were born overseas or whose first language is not English face added challenges during imprisonment, such as additional isolation, discrimination and marginalisation.[79] Further research is required to understand the relationship between trauma, mental illness and criminal offending in culturally and linguistically diverse populations.

Access to appropriate housing is a key contributor to recovery with a strong relationship between homelessness, mental illness and low-level offending.[80] More than half (54%) of people discharged from prison expected to be homeless, or didn't know where they would stay, once released. About 1 in 3 (33%) prison entrants reported they were homeless (including staying in short-term or emergency accommodation) during the 4 weeks before prison.[81] It is vital for the successful community reintegration of people with a mental illness that they have access to stable accommodation.

[76] Rosenstreich, G. (2013) LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance. Sydney

[77] ibid

[78] Australian Bureau of Statistics. (1998b). 1997 Mental health and wellbeing profile of adults, Australia. Australian Government Publishing Service, Canberra

[79] Australian Institute of Health and Welfare. (2018). The Health of Australia's prisoners.

[80] Somers JM, Rezansoff SN, Moniruzzaman A, Palepu A, Patterson M (2013) Housing First Reduces Re-offending among Formerly Homeless Adults with Mental Disorders: Results of a Randomized Controlled Trial. PLoS ONE 8(9): e72946. https://doi.org/10.1371/journal.pone.0072946

[81] Australian Institute of Health and Welfare, (2018), The Health of Australia's prisoners.

6. What are the needs of family members and carers and what can be done better to support them?

Key recommendations:

- family members and carers should be recognised as a key part of the treatment pathway across all aspects of the system including prisons;
- family members and carers need the systems and support to ensure the mental health system adequately supports their loved ones; and
- carer payments should adequately compensate for the time required to provide care to consumers with complex needs.

Family and carers of consumers and family care advocates were key contributors to the following response. Family members and carers of consumers have identified the need for a greater recognition of the impact of caring for a loved one with mental illness. Mental illness often has a ripple on effect on families, with family members and carers likely to be affected in different ways. Families and carers take on the day-to-day care of their loved one often with little training or support, or acknowledgement of their own needs and mental health. Carers report intense levels of guilt in putting their own needs first and at times, not being able to respond to the person experiencing mental illness. Where there are negative outcomes for the person experiencing mental illness, carers often assume responsibility and have limited support options for themselves. Additionally, carers often carry the responsibility of caring not only for the person suffering mental illness but also other siblings, partners, parents and extended family members. The care responsibility can impact family functioning and the needs of all the members in the family. Carer guilt is often exacerbated by the inability to meet the needs of other family members.

Family members and carers aren't often identified and engaged at first contact (and in an ongoing way) in assessment, treatment, care and recovery. They also don't have clear access to information about their rights and responsibilities in relation to their loved ones' care. Research has shown that healthcare professionals in forensic psychiatric care have less contact with family members than healthcare professionals in other psychiatric care contexts have with family members.[82]

Carers are often utilised as though they have expertise, however this is not adequately recognised as expertise. Carers have highlighted the need for open communication between themselves and services so that they are all informed about early warning signs, increasing the opportunity for early intervention and support.

Forensicare has a commitment to supporting families and carers across the range of our services. Currently Forensicare currently employs a family and carer advocate at the Ravenhall Correctional Centre as part of its Ballerrt Yeram-Boo-ee forensic mental health service. There is an opportunity for investment in further resources to extend this important role to other prisons.

Forensic mental health is multifaceted and extremely complex, with families and carers often experiencing increased stigma. As a result of complexities, families can experience difficulty in maintaining family relationships. This is further compounded by enforced separation between consumers and their families, the geographical distance between the institution and the family home, the security routines, and the organisational and cultural characteristics of forensic psychiatric care units. Family members and carers feel as though they aren't provided with the support they need to navigate the systems designed to support their loved ones. They describe the

[82] Horberg U, Benzein E, Erlingsson C and Syren S. (2015). Engaging with families is a challenge: beliefs among healthcare professionals in forensic psychiatric care. *Nursing research and practice*, 2015, doi: 1155/2015/843717

systems as complex - this is particularly evident for families and carers navigating both the mental health and justice systems.

In 2015 there was an estimated 2.8 million informal carers in Australia, of which 240,000 (8.6%) were mental health carers. According to a report commissioned by Mind Australia[83] it would cost $13.2 billion to replace all the caring tasks currently provided by mental health carers with formal mental health funded services. Carers have discussed the economic stresses adding to the impact of carer burnout. Carers want to find the best level of care for their loved one and often sacrifice significant amounts of their own income to fund private treatments. Due to care responsibilities and a poor response from the service system, carers are often unable to engage with the workforce or must do so in a casual capacity. Carers highlighted that even when they are engaged in work, carers leave is limited, their care responsibilities are not well understood, and the increased level of stress reduces their ability to effectively engage in work. Carer payments need to adequately compensate for the time required to support consumers with complex mental health needs.

[83] Mind Australia (2017) The economic value of informal mental health caring in Australia: summary report

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

Key recommendations:

- develop and implement a workforce development strategy to ensure the growth and sustainability of a specialist forensic mental health workforce;
- develop the capacity and expertise of community mental health teams to ensure the needs of complex forensic consumers can be met in the community;
- invest in programs to ensure the health and safety of the mental health workforce; and
- develop strategies to grow and support the peer workforce recognising the expertise of lived experience.

Health services need to be equipped to support the growth of the workforce. This requires a whole of workforce approach that needs to consider skills and capabilities of the workers, appropriate remuneration, career pathways, and training and development.

Currently in Victoria, there are over 5,000 people working in mental health, primarily in roles such as psychiatry, mental health nursing, social work, psychology and occupational therapy, and increasingly, lived experience workers (both consumers and carers) and other allied health professionals (such as speech pathologists).[84]

Mental Health Nurses are the largest single profession in the Victorian mental health system. The Health Workforce 2025 (HW 2025) report[85], released in March 2012, identified a likely continuation of workforce shortages across the Health Sector with the most significant shortages in the nursing discipline. According to the National Health Workforce Dataset (NHWDS) 2011, there were 161,471 Registered Nurses and 37,154 Enrolled Nurses actively working in nursing in Australia. Of these, only 8.2% (13,252) and 6.5% (2,443) respectively identified their principle area of practice as mental health. Further, an ageing mental health nurse workforce contributes to the current workforce shortage. About 3 in 5 mental health nurses (58.8%) were aged 45 and above in 2016; a third (32.7%) were aged 55 and older and 1 in 20 (5.2%) were aged 65 and over. The prediction is a shortfall of approximately 109,000 nurses by 2025. Further data highlights a critical shortage across Mental Health Nurses.

Forensicare, as a result of rapid service expansion, has experienced firsthand the impact of workforce shortages, including delay in the opening of critically required new services. For example, Forensicare's Apsley Unit was not open immediately after commissioning due to a shortage of appropriately skilled staff such as nurses, clinicians and psychologists with endorsement in both clinical and forensic psychology. In the past 12 months, Forensicare has recruited an additional 265 staff to the organisation. A workforce development strategy which incorporates the forensic mental health workforce is required to meet the growing demand.

Forensic mental health is a recognised area of specialisation within psychiatry, psychology, mental health nursing and, increasingly, occupational therapy and social work. Very few mental health professionals across the disciplines receive specialist training in forensic mental health. As such, the workforce as a whole is poorly equipped to deal with issues related to mental illness and offending. Investment is required in training mental health professionals to obtain the requisite expertise to work with forensic mental health consumers.

As one of the largest employers of a specialist forensic mental health workforce, Forensicare has an opportunity to play a leading role in investing and developing workforce for the broader mental

[84] Victorian Auditor –General's Office. (2019). Access to Mental Health Services.
[85] Health Workforce Australia. (2012). Health Workforce 2025 Doctors, Nurses and Midwives Volume 1.

health system. Forensicare works in partnership with several educational institutions to offer a range of graduate opportunities and traineeships. These initiatives could be expanded and formalised in a similar way to the Royal Women's Hospital Postgraduate Midwifery Program.[86]

Factors outlined in the Victorian Auditor-General's Office (VAGO) report[87] which may contribute to recruitment and retention include:

- insufficient supply;
- skills shortages;
- risks to safety and wellbeing;
- a lack of development opportunities; and
- inadequate undergraduate and other training opportunities.

There are a number of key strategies to effective recruitment, retention, and professional development support:

- increasing graduate intake[88] and creation of an industry-based careers website promoting forensic mental health as a profession could be successful in attracting and recruiting a skilled workforce;
- reviewing the enterprise bargaining agreement (including wage comparisons across organisations);
- creating joint appointments to allow for research and clinical work;
- delivering appropriate and effective clinical supervision;
- improving opportunities and incentives for staff development; and
- designing new and innovative solutions to respond to workforce shortages

Workplace aggression in healthcare is a major work health and safety concern. Evidence suggests that levels of workplace aggression remain high and continue to have a concerning impact on the workforce's physical and mental health and wellbeing. People in the healthcare profession are at higher risk of being confronted with violence and aggression from patients and relatives in the workplace, with significantly higher prevalence rates in forensic mental health settings.[89] Forensicare alongside the Centre for Forensic Behavioural Science plays a leading role in understanding the assessment and management aggression and violence in mental health services. More can be done to build and share this knowledge across community mental health services who are working with high levels of aggression and violence. To capitalise on this expertise, the creation of a statewide psychiatric intensive care unit at Forensicare should be part of a statewide master plan.

Building resilience, which involves a process of positive adaptation to stress and adversity, may assist in retention of mental health workers as this would equip mental health workers with the capacity to cope in a challenging environment.[90]

The stigma experienced by staff working in forensic mental health settings must be further explored to understand how this might impact workforce wellbeing. Stigma is discussed in more

[86] The Royal Women's Hospital (Victoria) Midwifery Program

[87] Victorian Auditor–General's Office. (2019). Access to Mental Health Services.

[88] Forensicare's graduate program has demonstrated a high retention rate of (81-92%) over the past 8 years.

[89] Hills D, Lam L, Hills S. (2018). Workplace aggression experiences and responses of Victorian nurses, midwives and care personnel. Collegian 25(2018)575-582

[90] Foster K, Roche M, Delgado C, Cuzzillo C, Giandinoto JA, Furness T. (2018). Resilience and mental health nursing: An integrated review of international literature. International Journal of Mental Health Nursing. October 2018;28(1);71-85

detail in Question 1 and this issue is particularly relevant in the context of the lived experience workforce.

There is growing evidence that a peer workforce is a key element of any effective and comprehensive forensic mental health workforce.[91] Further work is required to ensure these roles are appropriately remunerated and provided with the opportunity for career progression. Employing people with a lived experience in peer worker roles to support consumers and carers can drive a range of important benefits.

- Those who are living well with mental illness can represent a sense of hope that is often missing, particularly in long stay environments such as TEH.
- Peer workers know what it's like to experience mental illness and can listen to and understand personal recovery stories with consumers and carers.
- Peer workers in a Forensic Mental Health setting can offer consumers and carers advice, practical support and empathetic understanding.
- Peer work can be an important pathway for Forensicare consumers and carers to enter or re-enter the workforce.
- A peer workforce could impact positively on reducing seclusion and use of restraint.
- Peer workers could improve consumer and carer experience of care.

[91] Byrne L. (2014). A grounded theory study of lived experience mental health practitioners within the wider workforce. Unpublished doctoral thesis. Central Queensland University, Rockhampton, Australia

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

Key recommendations:

- increase opportunities for forensic consumers to participate in targeted education and vocational programs;
- ensure forensic consumers have access to specialised employment and support services; and
- National Disability Insurance Agency (NDIA) must consider the needs of forensic consumers.

Mental health is a key driver of economic participation and productivity in Australia, and hence has the potential to impact incomes and living standards and social engagement and connectedness. Improved population mental health can help to reduce costs to the economy over the long term.[92] Through delivery of an effective mental health system individuals with a mental illness should have access to the services they require for full economic and social participation. Consumers within the forensic mental health system in Victoria are socially and economically marginalised and experience high levels of unemployment. Their low rate of participation in the labour force is not a phenomenon restricted to Victoria, but is reported[93] worldwide.

It is well known that lower levels of education are associated with poorer health, with forensic consumers more likely to have lower levels of educational attainment when compared to the general community. Lower levels of educational attainment are associated with poorer employment opportunities and outcomes, and unemployment is a risk factor for incarceration and for reoffending post-release.[94] Education is a recognised social determinant of health, with evidence also demonstrating lower levels of education associated with poorer health. [95] Studies confirm the negative consequences of unemployment, including the loss of purpose, structure, roles and status and a sense of identity which employment brings.

Mental health clinicians and Forensicare consumers report that consumers experience great difficulty in finding employment due to stigma and discrimination. People being discharged from a forensic mental health inpatient facility are particularly disadvantaged due to the double stigma of mental illness and offending.[96]

Improving the social and economic participation of people with mental illness, particularly those with complex forensic histories cannot be achieved by one agency or service. It necessitates the consideration of services and supports, both within the healthcare and broader social services sector. [97] The introduction of vocational education and training programs as part of prisoner rehabilitation offers opportunities to build capacity for recovery and reduce the risk of offending.[98] Expansion of these opportunities has implications for the TAFE workforce and may need to be accompanied by additional support and training.

Employment enables social inclusion in the wider community and is an important way that people with a mental illness can meaningfully participate in the wider community.[99] To maximise the

[92] Productivity Commission. (2019). The Social and Economic Benefits of Improving Mental Health.
[93] 1 G. Waghorn, C. Lloyd, (2005) The Employment of People with Mental Illness, University of Queensland
[94] Australian Institute of Health and Welfare. (2018). The Health of Australia's prisoners.
[95] Mitrou et al. (2014). Gaps in Indigenous disadvantage not closing: a census cohort study of social determinants of health in Australia, Canada, and New Zealand from 1981–2006. BMC Public Health, 14:201
[96] G. Waghorn, C. Lloyd, The Employment of People with Mental Illness, University of Queensland, 2005
[97] Productivity Commission. (2019). The Social and Economic Benefits of Improving Mental Health.
[98] Australian Institute of Criminology. (2008). Reducing recidivism through vocational education and training programs.
[99] J. Pepper, R. Perkins, (2003) Social Inclusion and Recovery – A Model for Mental Health Practice, Bailliere Tindall

opportunities for people in the forensic mental health system to participate in the workforce, consumers must be able to access education and training programs that are specifically designed to meet their needs.[100] There needs to be a significant increase in employment and recruitment agencies specialising in assisting people with mental illness gain employment. Agencies need to acknowledge the special needs and requirements and increased length of time required to find suitable employment options for people with mental illness and offending histories. The incentive for generalist employment services is commercial and linked to the successful employment of easy to place candidates. Forensic consumers can experience difficulty in sourcing employment placement. The Individual Placement Support (IPS) is an effective employment model, which should be further considered. The model centres on participants' preferences and tailors unique, individualised responses to a person's goals and interests.[101]

In line with Forensicare's commitment to recovery orientated practice, consumers are encouraged to be involved in a variety of roles within the organisation to support social inclusion and community re-integration. These opportunities need to be readily available across the mental health and justice systems and should be targeted toward the needs of forensic consumers. In line with national consumer standards these positions, even in prison, need to be remunerated for their expertise and time. Employing people with a lived experience in peer worker roles to support others brings a tremendous range of benefits for those receiving support, peer workers themselves and for the mental health system as a whole. Strong evidence now suggests that employing peer workers, or experts by experience as they are commonly known, has a positive impact on the quality of services and client outcomes.[102]

The introduction of the National Disability Insurance Scheme (NDIS) is failing those with severe mental illness and risks creating significant gaps in support services.[103] A University of Sydney report[104] warns problems with the NDIS's handling of serious mental illness could leave many without proper support. The report found that people with a psychosocial disability are having significant difficulty accessing the scheme.

There are a number of additional challenges for forensic clients currently associated with the NDIS, including[105]:

- the NDIA has yet to establish a clear position in relation to forensic consumers;
- there is a need for collaboration between the federal and state governments to develop pathways for forensic consumers; and
- availability of alternative psychosocial support for consumers who are not eligible for NDIA funding.

[100] Forensicare. (2011). Submission to Family and Community Development Committee. Workforce participation by people with a mental illness – issues faced by the forensic mental health system in Victoria.
[101] KPMG & Mental Health Australia. (2018). *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform.*
[102] State of New South Wales (2016) Employer's guide to implementing a peer workforce
[103] Knaus C. (2018). NDIS failing people with severe mental health issues, new report warns. Available: https://www.theguardian.com/australia-news/2018/jan/29/ndis-failing-people-with-severe-mental-health-issues-new-report-warns
[104] University of Sydney. (2018). Mind the Gap: The National Disability Insurance Scheme and psychosocial disability. Available: http://sydney.edu.au/health-sciences/documents/mind-the-gap.pdf
[105] ibid

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

Victoria needs a mental health system that:

- delivers availability of humane, consumer-focused forensic mental health care that is respectful of consumer rights, supportive of recovery and provided in the least restrictive way;
- delivers a whole of system approach that meets the needs of consumers with multiple and complex needs;
- invests in prevention and early intervention to decrease demand for forensic mental health services;
- delivers gender appropriate services;
- delivers a sustainable specialist workforce recognising the significant expertise of peer workers; and
- invests in innovation, evaluation and research.

One common challenge for forensic mental health services relates to accessing secure inpatient acute and rehabilitation beds, for forensic consumers. In general, as the number of forensic consumers increases, unless the overall number of beds available changes, the number of beds available for security and civil consumers reduces. Furthermore, for forensic consumers who are often rehabilitated through the hospital system back to the community through various tiers of security, a clear care pathway is needed. It is well understood that to avoid blockages in the system specialist forensic rehabilitation beds are required in lower security settings[106] to which high security consumers can be moved when high security is no longer needed. In turn, low security services need to be augmented by appropriate accommodation and community support to enable discharge. This investment in accommodation options is especially important for those with long-term psychotic conditions to enable treatment in the least restrictive way. At times impacting upon this are the tensions between consumer recovery and public safety.

In the absence of additional forensic mental health beds, the immediate issue to consider is how to ensure forensic consumers in prison receive appropriate mental health treatment in a timely manner. Noting that the principle of equivalency[107] should underpin system improvements to prison mental health care, balanced against the evidence that treatment in a hospital setting, as opposed to a correctional facility, is more successful at reducing recidivism.[108] There are significant waiting times for prisoners awaiting a bed in TEH in order to receive treatment. Lack of access to non-voluntary specialist mental health treatment in prisons has ignited a debate on whether involuntary care should occur in prison, and it is the view of Forensicare that the Royal Commission should consider this issue.

The system should incorporate a stepped care model which has been widely applied as a system planning tool to the population generally. This would enable delivery of broad services to prisoners across the spectrum of need. This model should include:

- universal services for all prisoners to promote mental health;
- primary mental health care for prisoners with mild to moderate symptoms;

[106] Lurigio, A. J., & Swartz, J. A. (2000). Changing the contours of the criminal justice system to meet the needs of persons with serious mental illness. In J. Horney (Ed.), NIJ 2000 Series: Policies, processes, and decisions of the criminal justice system (Vol. 3, pp. 45-108). Washington, DC: National Institute of Justice

[107] Principle 9 of the United Nations' Basic Principles for the Treatment of Prisoners provides that prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation

[108] Fazel S, Fimińska Z, Cocks C, Coid J. Patient outcomes following discharge from secure psychiatric hospitals: systematic review and meta-analysis. *Br J Psychiatry*. 2016;208(1):17–25. doi:10.1192/bjp.bp.114.149997

- specialist mental health services for prisoners with more severe symptoms; and
- access to specialist mental health beds available across correctional settings.

The provision of services in prisons needs to align more closely with obligations under the *Mental Health Act 2014*. As an example, the role of the Chief Psychiatrist could provide further oversight of forensic mental health services provided within prisons which would ensure appropriate quality safeguards for these services.

Discharge from secure correctional or forensic mental health facilities for forensic consumers can be a particular challenge, especially, for consumers with high profile offences. The lack of adequate accommodation, support resources and linkages with general mental health and health services can adversely impact on discharge and continuity of care, resulting in extended inpatient stays beyond what is clinically necessary.

Continuity of care is essential for maintaining any health improvements achieved by people in prison, which will go to enhancing community safety. Many people quickly lose any health gains they made in prison within a few months of release, which affects not only the individual, but the entire community.[109] Seamless integration with community services is key for ensuring continuity of care is achieved. Appropriate sharing of health information between service providers is critical to achieving this.

It is important to highlight that almost all consumers admitted to secure forensic mental health services suffer from serious mental illness, often in combination with other disorders (such as substance misuse, personality disorder and/or cognitive impairment). The complexity of needs among this cohort has also contributed to system challenges not only in provision of appropriate treatment but also in adequate discharge planning and ultimate discharge from secure facilities.[110]

To improve the health outcomes for individuals with a mental illness and reduce the risks of violence and offending, an early intervention framework that begins in youth and traverses adult mental health systems is required. Opportunities for diversion into treatment instead of prison need to be prioritised, to ensure the assessment and care of forensic consumers is balanced by their right to justice and the rights of the community. There should be a focus on the diversion of minor offenders early in their contact with the criminal justice system with a particular focus on those with cognitive impairment.

Despite recognition of the specific needs of women across the spectrum of forensic mental health services, they do not have the same options as men for a staged transition through security levels to support recovery and community integration. More can be done to provide gender appropriate services to female forensic consumers both in within prison and the community.[111]

There is a need for the development and implementation of a clear workforce development strategy with a focus on recruiting to regional and rural areas where prisons are often based, and overcoming the burnout that can be associated with managing high caseloads of complex consumers in stressful environments. We emphasise the need to develop a specialist forensic community mental health workforce, building on the forensic clinical specialist model embedded across area mental health services, with Forensicare playing a key role in the coordination of forensic clinical specialists through continued education and training. Specialist forensic teams

[109] Kouyoumdjian FG, Cheng SY, Fung K, et al. The health care utilization of people in prison and after prison release: A population-based cohort study in Ontario, Canada. PLoS One. 2018;13(8):e0201592. Published 2018 Aug 3. doi:10.1371/journal.pone.0201592

[110] Victorian Ombudsman; (2018) Investigation into the imprisonment of a woman found unfit to found unfit to stand trial, Victorian Ombudsman.

[111] Women's Mental Health Network Victoria Inc. Position Statement Sensitivity and Safety for Women in Adult Inpatient Forensic Mental Health Services

must be a core component of a system that meets the needs of forensic consumers. These teams would also be positioned to provide in-reach services to prisons.

Finally, the importance of ongoing investment into innovation and research must be considered as a vital component of the mental health system. Forensic mental health services need to be sustainable, evidence-driven and innovative. Forensicare can strengthen its leadership role across the mental health system into the criminal justice system investing in the areas of research, innovation, training and evaluation. This would enable development and trial of tools, interventions and best practice models to support the provision of world leading forensic mental health services across Victoria.

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

Key recommendations:

- invest in innovation, evaluation and research to:
  - ensure best practice research outcomes are translated into practice;
  - increase investment for the Centre for Forensic Behavioural Science (CFBS);
  - embed research and evaluation into budgets prospectively for new services and programs; and
  - ensure evaluation frameworks and the systems put in place to support evaluation efforts are reflective of the dynamic nature of the system and the consumer population;
- conduct detailed, in-depth system planning to ensure a joined up, integrated government approach for the provision of forensic mental health care;
- consider critical infrastructure opportunities, including the expansion of services into growth corridors especially those with high concentration of correctional facilities;
- invest in a high quality, secure communication and data systems to enable safe, rapid exchange of clinical information; and
- invest in building the mental health workforce to meet demand.

The World Health Organisation's Mental Health Action Plan (2013–2020)[112] emphasises that "evidence and research are critical ingredients for appropriate mental health policy, planning and evaluation". Similarly, Targeting Zero, the review of hospital safety and quality assurance in Victoria[113] notes the importance of research and relationships between health services, researchers, and universities.[114]

In Victoria, a much stronger focus and commitment to research, data and outcome measurement is needed to drive continuous improvements across the service system. There is a significant need to develop a close interface between research/evaluation, quality and safety, and health information management across all Forensicare services. All too often, a tension exists between research and practice in clinical services, and forensic mental health services are typically no different.

Forensicare is mandated (under the *Mental Health Act 2014*) to provide research, training and professional education, specifically "to conduct research in the fields of forensic mental health, forensic health, forensic behavioural science and associated fields" and to "promote continuous improvements and innovations in the provision of forensic mental health and related services in Victoria".[115] Within Forensicare, however, there is a critical nexus between science and practice – with each informing the other to ensure excellence and evidence-based practice. A key focus of the Centre for Forensic Behavioural Science (CFBS) is to transfer academic and clinical excellence into practice in the health, community services and criminal justice sectors. Areas of research into aggression, violence and forensic mental health have applications across a wide range of services including corrections, youth justice, police and health services.[116]

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[112] World Health Organisation. (2013). Mental health action plan 2013-2020.

[113] State of Victoria. (2016). Review of Hospital Safety and Quality Assurance in Victoria.

[114] Centre for Forensic Behaviour Science, (2017) Annual Research Report

[115] Mental Health Act 2014 s.330(g) and s.330(h)

[116] Ogloff, J. & Thomas, S. (2014). Training police to better respond to people with mental illness. The Conversation, 4 March 1-3.

Ongoing research in forensic behavioural science and forensic mental health is critical due to the highly specialised nature, as well as the rapidly emerging knowledge, in the field. As an example, while Forensicare, in partnership with the CFBS, has an impressive track record of publication and presentation of research outcomes, there is often a disconnect between this activity and the direct dissemination of outcomes to practice. There is a need for increased funding to further expand this work and build capacity to embed translational research through workforce design. Funding for joint clinical and research positions would be an attractive recruitment/retention strategy for the workforce but would also ensure support for translational research.[117]

Forensicare believes there needs to be forward planning based on sound in-depth projection analysis, taking into account population growth, current and emerging trends and growth areas. A whole of system view combining the mental health and forensic mental health system across all providers is required. There is currently no clear framework describing how each of the system components is expected to operate or interact with each other.

Forensicare believes in the importance of partnering with consumers, carers and family members, and the workforce in planning for system reform understanding there is not one solution. There is a wealth of literature which emphasises the importance of commissioning services in consultation with consumers, carers and families. [118,119]

In order to support long term improvements to Victoria's mental health system, the funding disparity between Victoria and all other states needs to be addressed. Additionally, investment must be aligned to state wide population data ensuring additional services are imbedded in areas with higher numbers of correctional and forensic facilities.

Services need to be able to securely and appropriately exchange clinical information regarding consumers to enable effective transfer and continuity of care. This will ultimately lead to a more integrated mental health system. The communication systems between prisons and community services are prohibitive, exacerbating the tyranny of distance experienced by them; increasing risk and subsequent stress on practitioners. Forensicare faces additional challenges as it is a health service operating within a correctional framework. The inclusion of prison episodes of care into the Client Management Interface (CMI) would substantially improve continuity of mental health care. Forensicare is working with both the Department of Health and Human Services and Department of Justice and Community Safety to explore this.

There must be significant improvement in the way data is collected, analysed and shared so the community is better informed about health services and health services receive better information about their performance.[120] Services must have access to accurate and current data in order to understand and respond to changes in population and service demand.

Finally, as discussed in Question 7, the Health Workforce 2025 (HW 2025) report[121], released in March 2012, identified a likely continuation of workforce shortages across the health sector. It is evident that without a significant investment in the growth and development of a specialist mental health workforce, any proposed reform to the service system will not succeed.

[117] Forensicare (2018) Forensicare's Research Strategy 2018–2020

[118] Ministry of Health. (2015). A Guide to the Commissioning Framework for Mental Health and Addiction, New Zealand.

[119] Schwartzkoff J. & Sturgess, G.L. (2015) Commissioning and Contracting for Better Mental Health Outcomes. Research report by Rooftop Social for Mental Health Australia

[120] State of Victoria. (2016). Review of Hospital Safety and Quality Assurance in Victoria.

[121] Health Workforce Australia. (2012). Health Workforce 2025 Doctors, Nurses and Midwives Volume 1.