Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR DANIEL HORNBY SULLIVAN

I, Dr Daniel Hornby Sullivan, Executive Director of Clinical Services, of Thomas Embling Hospital, Locked Bag 10, Yarra Bend Road, Fairfield VIC 3078, say as follows:

BACKGROUND

1 My full name and title, together with postnominals, is as follows: Dr Daniel Hornby Sullivan, MBBS, MBioeth, MHlthMedLaw, MMgmt, AFRACMA, FRCPsych, FRANZCP.

2 I am a Consultant Forensic Psychiatrist and Executive Director of Clinical Services at the Victorian Institute of Forensic Mental Health (**Forensicare**).

3 My key responsibilities as Executive Director of Clinical Services include:

(a) Oversight of clinical standards and service provision;

(b) Management of the medical workforce; and

(c) The statutory duties of the Authorised Psychiatrist under the *Mental Health Act 2014* (Vic) (**MHA**).

4 Prior to my current role, I was:

(a) Acting Clinical Director of Forensicare (March-June 2016);

(b) Assistant Clinical Director (Community Operations) of Forensicare (2005 and 2017);

(c) Clinical Consultant to Care Plan Assessments Victoria as part of the Multiple & Complex Needs Initiative (2005 to 2007); and

(d) Consultant Psychiatrist at Forensicare (2004 onwards).

5 My professional qualifications include:

(a) Bachelor of Medicine, Bachelor of Surgery, University of Melbourne (1994);

(b) Master of Bioethics, Monash University (1998);

(c) Master of Health & Medical Law, University of Melbourne (2000);

(d) Member of Royal College of Psychiatrists, South London & Maudsley NHS Trust; Institute of Psychiatry, London, UK (2002);

(e) Fellow of Royal Australian and New Zealand College of Psychiatrists (2004);

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

(f) Associate Fellow of Royal Australasian College of Medical Administrators (2012);

(g) Fellow of Royal College of Psychiatrists (UK) (2016);

(h) Master of Management – International Masters for Health Leadership, McGill University, Montreal, Canada (2019); and

(i) Member, Australian Institute of Company Directors (2019).

Attached to this statement and marked **DS-1** is a brief curriculum vitae.

6 I make this statement in my personal capacity and, to the extent relevant, I am also authorised by the Forensicare to make this statement on its behalf.

7 The opinions and views expressed in my evidence are my own.

8 I give this evidence from facts which I believe to be true and correct, and which are within my own knowledge, unless otherwise stated. Where I refer to a document, I have read that document before signing this witness statement.

9 In this statement, I use the term "justice-involved person(s)" to describe people who are charged with offences, detained in prisons or otherwise become involved with the justice system.[1]

10 I also use the term "mental disorder" as opposed to "mental illness". The term mental disorder is more inclusive, as often a narrow focus on mental illness by the criminal justice system artificially excludes a number of people because they have a different form of mental disorder, such as personality disorder, intellectual disability, acquired brain injury or cognitive impairment. It is important to recognise that these groups of consumers have the same set of treatment needs and require similar psychosocial supports for their treatment needs. Forensic mental health has a predominant focus on mental illness, but cannot arbitrarily ignore the needs of those with comorbid conditions which come to the attention of mental health staff in prison,[2] are referred in the community, and are evident in hospital. This broad overarching term reflects common therapeutic needs rather than the more artificial definition used to determine whether certain people are eligible, and others are ineligible for access to public mental health services.

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1 Bedell, P. S., So, M., Morse, D. S., Kinner, S. A., Ferguson, W. J., & Spaulding, A. C. (2019). Corrections for Academic Medicine: The Importance of Using Person-First Language for Individuals Who Have Experienced Incarceration. *Academic Medicine*, 94(2), 172-175.

2 Tyler, N., Miles, H. L., Karadag, B., & Rogers, G. (2019). An updated picture of the mental health needs of male and female prisoners in the UK: prevalence, comorbidity, and gender differences. *Social psychiatry and psychiatric epidemiology*, 54(9), 1143-1152.

MENTAL DISORDERS AND OFFENDING

Correlations between mental disorders and offending

11 There are several different ways to consider the correlation between mental disorders and offending. The majority of people living with mental disorders do not offend. Indeed, mental disorder is a risk factor for being a victim of offending.[3] However, if one takes a cohort of people living with mental disorders, an increased prevalence of offending can be observed when compared to the general population. Similarly, in a cohort of people that offend, an increased prevalence of mental disorder can be observed.

12 The nature of offences committed by those that live with mental disorders is broad ranging. There may be an increased range of offences associated with poverty; but violent offending is of most concern to the field of forensic mental health. Psychotic illness is most strongly associated with offending of all types.[4]

13 Intellectual disability and cognitive impairment, comorbid with other mental disorders, are also linked to a broad range of offences. Psychotic illnesses and some personality disorders are associated with violent crimes, particularly when accompanied by substance abuse.[5]

14 The peak of offending occurs in young adult years, with a persistent reducing minority that continue to offend at older ages; the peak incidence of many mental disorders is not dissimilar. The distribution of offending justifies a focus on indicated early intervention for young people, to reduce the likelihood of offending.[6]

15 Some older justice-involved persons have committed historical sexual offences; or committed offences related to age related cognitive impairment. The relevance of older age in forensic mental health is in ensuring services for older offenders are appropriate.[7]

16 In forensic mental health, access to treatment is defined by clinical need and urgency as opposed to criminal offending profile. The primary treatment needs remain that of people with psychotic illnesses – many compounded by substance use disorders – who are not engaged effectively in treatment. It should be noted in terms of access, that those on custodial supervision orders (**CSOs**) for mental illness under the *Crimes (Mental*

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3 Dean, K., Laursen, T. M., Pedersen, C. B., Webb, R. T., Mortensen, P. B., & Agerbo, E. (2018). Risk of being subjected to crime, including violent crime, after onset of mental illness: a Danish national registry study using police data. *JAMA psychiatry*, 75(7), 689-696.

4 Yee, N., Matheson, S., Korobanova, D., Large, M., Nielssen, O., Carr, V., & Dean, K. (2020). A meta-analysis of the relationship between psychosis and any type of criminal offending, in both men and women. *Schizophrenia Research* <https://doi.org/10.1016/j.schres.2020.04.009>.

5 Fazel S, Långström N, Hjern A, Grann M, Lichtenstein P. Schizophrenia, substance abuse, and violent crime. *JAMA.* 2009;301(19):2016-2023. doi:10.1001/jama.2009.675.

6 Fraser R, Purcell R, Sullivan D. 'Early intervention in forensic mental health'; in A Rosen, P Byrne (eds.) *Early Intervention in Psychiatry* (London: Wiley-Blackwell, 2014).

7 Trotter, C., & Baidawi, S. (2015). Older prisoners: Challenges for inmates and prison management. *Australian & New Zealand Journal of Criminology*, 48(2), 200-218.

Impairment and Unfitness to the Tried) Act 1997 (Vic) (**CMIA**) are only treated in Thomas Embling Hospital (**TEH**); and Corrections Victoria mandates that justice-involved persons requiring compulsory treatment may only be treated in TEH.

Research findings on the relationship between mental disorders and offending

17 There is a broad range of research available that addresses the relationship between mental disorders and offending. Over the last decade, research in this field has increased and is far more robust as a result of epidemiological techniques. In particular, capacity for data linkage helps to define the relationships between various mental disorders and offending.

18 For instance, Professor Seena Fazel (Oxford University) has engaged in a body of research collaborations with Scandinavian researchers, using a comprehensive set of information and linked databases. This research robustly maps out relationships between several types of mental disorders and offending, through systematic reviews, meta-analysis, and exploring international datasets. In summary, several mental disorder diagnoses are associated with clearly increased offending risk, although the escalated risk is frequently mediated through substance use.[8]

19 Australian research in this field has been generally less prominent than overseas studies due to reduced capacity for large scale data linkage. Nonetheless, a number of researchers have performed important work and research in this field. I refer the Royal Commission to:

(a) Professor Paul Mullen (Professor Emeritus, Monash University), who has for many years explored an astonishingly varied range of topics, including for example, phenomenology of mental disorders, epidemiology of mentally disordered offending, and associations of childhood sexual abuse;

(b) Professor Jim Ogloff AM (University Distinguished Professor, Swinburne University), whose research program has ranged widely and focussed particularly on mentally disordered offenders in secure settings;

(c) Professor Stuart Kinner (Head of the Justice Health Unit, University of Melbourne) whose extensive research focusses on the physical health needs of justice-involved persons both in prison and in the community, with a strong public health focus;

(d) Professor Tony Butler (Professor and Program Head, Justice Health Research Program) whose research similarly addresses the health of prisoners; and

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8 See <https://fazel.org>.

(e) Associate Professor Ed Heffernan (Queensland Centre for Mental Health Research), who has published significant research on Indigenous mental health and prisoner health.

20 Increasingly, government agencies are producing publicly accessible data which is useful to analyse correlations between offending and mental disorder. Demographic and offence-type data about prisoners is compiled by the Australian Bureau of Statistics (**ABS**),[9] and the Australian Institute of Health and Welfare (**AIHW**) produces regular information on the health – including mental health – of prisoners.[10] At a state level, the NSW Bureau of Crime Statistics and Research (**BOCSAR**) has been influential in exploring hypotheses about offending (including mental health correlations),[11] and more recently the Crime Statistics Agency Victoria[12] has joined the Sentencing Advisory Council to offer local data in Victoria that is predominantly focussed on offending rather than mental health. However, the most effective tool to determine the correlation between mental disorders and offending – and thus target policy and programs – remains data linkage. More effective data linkage will assist in determining where best to focus interventions and public policy.

The role of risk and predictive tools in predicting violent offending

21 Forensicare uses a suite of risk assessment tools which increase the reliability of risk protection. These tools are validated in particular populations (such as youths, family violence and sexual offending in men, by way of example) and for the determination of the likelihood of particular outcomes such as violence or sexual reoffending. The tools used by Forensicare have been validated, in some cases, by research on local cohorts.[13] Among the most frequently used tools are the HCR-20 V3,[14] the START,[15] and the DASA.[16]

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9 <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2019~Main%20Features~Prisoner%20characteristics,%20Australia~4>.

10 <https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/contents/table-of-contents>.

11 <https://www.bocsar.nsw.gov.au/Pages/Search.aspx?k=mental#Default=%7B%22k%22%3A%22mental%22%2C%22r%22%3A%5B%7B%22n%22%3A%22DJContentTags%22%2C%22t%22%3A%5B%22%5C%22%C7%82%C7%824d656e74616c204865616c7468%5C%22%22%5D%2C%22o%22%3A%22OR%22%2C%22k%22%3Afalse%2C%22m%22%3A%7B%22%5C%22%C7%82%C7%824d656e74616c204865616c7468%5C%22%22%3A%22Mental%20Health%22%7D%7D%5D%7D>.

12 <https://www.crimestatistics.vic.gov.au/>.

13 See e.g. Reeves, S. G., Ogloff, J. R., & Simmons, M. (2018). The predictive validity of the Static-99, Static-99R, and Static-2002/R: Which one to use?. *Sexual Abuse*, 30(8), 887-907; Raymond, B. C., McEwan, T. E., Davis, M. R., Reeves, S. G., & Ogloff, J. R. (2020). Investigating the predictive validity of Static-99/99R scores in a sample of older sexual offenders. *Psychiatry, Psychology and Law*, 1-15.

14 Douglas, K. S., Hart, S. D., Webster, C. D., Belfrage, H., Guy, L. S., & Wilson, C. M. (2014). Historical-clinical-risk management-20, version 3 (HCR-20V3): development and overview. *International Journal of Forensic Mental Health*, 13(2), 93-108.

15 Webster, C. D., Martin, M. L., Brink, J., Nicholls, T. L., & Middleton, C. (2004). *Short-term assessment of risk and treatability (START)*. BC Mental Health & Addiction Services.

16 Chu, C. M., Daffern, M., & Ogloff, J. R. (2013). Predicting aggression in acute inpatient psychiatric setting using BVC, DASA, and HCR-20 Clinical scale. *The Journal of Forensic Psychiatry & Psychology*, 24(2), 269-285.

22 The use of validated and reliable risk prediction tools by appropriately trained clinicians increases the probability that a person assessed as having a high risk of reoffending is in fact at such risk. For clinicians, the utility of these tools is to enable triage and prioritise the treatment of certain people over others. With that said, risk prediction is of diminishing utility with the passage of time after the completion of the risk assessment.

23 There are significant constraints on the use of risk assessment tools which reduce their long-term utility in predicting future violence.[17] Therefore, it is important to rely on tools that have a sound evidence base, while recognising the limits of their application and also ensuring that risk assessment reliably informs management and resource allocation.

24 I note that it is also important to validate risk assessment tools in in the Australian context where these risk assessment tools have not yet been validated here. The Centre for Forensic Behavioural Science has commenced investigation into these issues.[18]

Community discourse around the relationship between mental disorders and offending

25 Justice-involved people with a mental illness are highly stigmatised and marginalised. At Forensicare, our consumers often speak about double stigma – mental and offending. Stigma springs from community misconceptions about mental illness and offending and may lead to discrimination. This may impact upon the recovery of consumers for instance affecting employment or inclusion in the community.[19]

26 Specifically, in my opinion, the criminal justice response to drug use and substance use, and the relationship of such use with mental illness, negatively impacts community discourse. In particular, I think there is a lack of understanding of sentencing rules, and how drug use and mental illness may be factored into sentencing. This discourse is often harmful to consumers. Both mental health and justice systems do not provide sufficient support to consumers who experience mental disorders that are caused or exacerbated by drug use. Further, the mental health system is generally not effectively integrated with substance use services. Poor access to such services, and stigma in the context of seeking help from these services, is associated with relapses and reoffending. Nevertheless, there is little evidence that compulsory substance use treatment is linked to sustained abstinence. It is likely that novel models of substance use intervention, beginning in prison and sustained into the community, are needed. For instance, evidence supporting Drug Courts in Victoria is strong, and may help justice-involved persons to address significant risk factors for further offending.[20] Furthermore, increasing use of

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17 Douglas, T., Pugh, J., Singh, I., Savulescu, J., & Fazel, S. (2017). Risk assessment tools in criminal justice and forensic psychiatry: the need for better data. *European Psychiatry*, 42, 134-137.

18 <https://catalystconsortium.com/wp-content/uploads/2020/02/Aus-RATED-Document-Final.pdf>.

19 Harris, S., Farnworth, L., & Mynard, L. (2020). Experiences of disclosure for vocational occupations by forensic mental health consumers. *Journal of Vocational Rehabilitation*, (Preprint), 1-11.

20 KPMG, Evaluation of the Drug Court of Victoria: Final Report to the Magistrates' Court of Victoria, 18 December 2014.

long-acting injectable opiate substitution treatments such as buprenorphine may reduce the risk of overdose in the first month after release from prison, and result in improved opportunity for engagement in treatment.[21]

27 The media may post information which is inflammatory or leads community members to make inferences about drug use or mental illness as causative factors in offending. There are Melbourne-based projects to improve media reporting on the association between mental disorders and offending, which will hopefully have a positive impact on the community discourse.[22]

CHANGES OVER TIME

Trends and changes in approaches to diversion, bail and parole law and practice in Victoria that have impacted young people and adults living with mental disorders

28 In recent years there have been significant changes in bail and parole laws, and new developments in opportunities for diversion. Most changes have been restrictive and have followed high profile cases which have led to reviews of current practices.[23] From a forensic mental health perspective, involvement in the justice system can be helpful when there is a therapeutic jurisprudence framework to engage consumers in interventions which move them towards recovery and away from offending.

29 In my opinion, *diversion* programs, when effectively implemented, can have significant positive impact on mental health for justice-involved persons, and address risk factors for reoffending. Through diversion programs, courts can make orders that provide incentives targeted at the therapeutic needs of justice-involved persons. In circumstances where justice-involved persons participate successfully in the diversion programs, potential sanctions imposed on them are reduced or waived.

30 Such court diversion programs should be accompanied by legislation that provides for a full range of diversion options and do not set an extremely high threshold for admission. Currently in Victoria, diversion programs are targeted at lower level and first time offending, provided the prosecution and defence agree to an adjournment of the proceeding to enable the person to participate in the diversion program.[24]

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21 Haight, B. R., Learned, S. M., Laffont, C. M., Fudala, P. J., Zhao, Y., Garofalo, A. S., ... & Andersen, J. L. (2019). Efficacy and safety of a monthly buprenorphine depot injection for opioid use disorder: a multicentre, randomised, double-blind, placebo-controlled, phase 3 trial. *The Lancet*, 393(10173), 778-790.

22 <https://mspgh.unimelb.edu.au/centres-institutes/centre-for-mental-health/news-and-events/phd-confirmation-seminar-mitigating-the-impact-of-the-media>.

23 The Callinan Review of 2013: <https://www.corrections.vic.gov.au/publications-manuals-and-statistics/review-of-the-parole-system-in-victoria>; the Harper Review into supervision of serious sexual offenders in 2015: <https://www.justice.vic.gov.au/justice-system/corrections-prisons-and-parole/review-of-post-sentence-supervision-scheme-for>; and the Coghlan Bail Review of 2017: <https://engage.vic.gov.au/bailreview>.

24 Section 59, *Criminal Procedure Act 2009*; Davidson, F., Heffernan, E., Hamilton, B., Greenberg, D., Butler, T., & Burgess, P. (2019). Benchmarking Australian mental health court liaison services–results from the first national study. *The Journal of Forensic Psychiatry & Psychology*, 30(5), 729-743.

31 For example, a comparison with NSW is apposite: there, section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) permits a Magistrate, at the commencement or at any time during the course of a proceeding, to make certain orders (to adjourn the proceedings, to grant the defendant bail or to make any other appropriate order) if it appears to the Magistrate that the defendant is, or was at the time of the alleged commission of the offence to which the proceedings relate, cognitively impaired, suffering from mental disorders or suffering from a medical condition for which treatment is available in a mental health facility. Such an order can effectively divert a person into therapeutic programs which may serve to address the issues which are associated with offending.

32 In my observation some of the most effective diversion programs have been implemented in the Drug Court. I note that the Drug Court has implemented significant and effective front-end services that have demonstrated improved outcomes for participants.[25]

33 Other effective diversion programs exist in the youth justice system. However, these become unavailable at the age of 18.

34 For justice-involved persons on *bail* there are effective programs which exist in some Melbourne courts: the Assessment and Referral Court (**ARC**) and Court Integrated Services Program (**CISP**). These assist justice-involved persons who comply with the programs while on bail to address mental health, psychosocial and practical issues.

35 ARC and CISP are both run out of the Melbourne Magistrates' Court, and are tailored to people with unmet therapeutic and social needs, including (but not limited to) housing, substance use issues, and needs related to cognitive impairment. The purpose of ARC and CISP is to engage people in therapeutic interventions prior to sentencing. The therapeutic interventions are coordinated by court affiliated services. These programs are effective: linkage to services addressing these needs not only significantly improves the quality of life of participants, it may also reduce risk of further offending. Although this is not a primary focus of treatment, it possibly could be.[26]

36 Such therapeutic programs are not expensive; however, a range of services is required to meet the wide range of very specific needs of justice-involved persons. Further, court staff who manage referrals to programs require specific skills in identifying individual needs and referring to the most appropriate programs. The benefits of these programs

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[25] KPMG, Evaluation of the Drug Court of Victoria: Final Report to the Magistrates' Court of Victoria, 18 December 2014.

[26] Chesser, B., & Smith, K. H. (2016). The Assessment and Referral Court List program in the Magistrates Court of Victoria: An Australian study of recidivism. *International Journal of Law, Crime and Justice*, 45, 141-151.

are available only in a few locations and could help Victorians better if they were available in more locations, especially large Victorian regional centres.

37 Parole is also an effective opportunity for mental health and other services to assist justice-involved persons. Parolees are bonded to services, and services are correspondingly bonded to them to ensure that their needs are met. In my experience, recent parole changes have precluded this conditional release for many justice-involved persons. Media-led public opinion against parole has impacted negatively on those who are motivated not to offend and for whom parole might offer effective support during a period of reintegration.

38 For those with mental disorder, parole offers an opportunity to return to the community with a coordinated support package involving treatment programs and supervision. Although there is limited data about people with mental disorder who receive parole, return to the community with conditions and supervision aligns with a recovery model and enables coordinated multi-agency planning with Community Corrections Service oversight and coordination. Parole is most likely to enable solid linkage to mental health and drug and alcohol services, as well as other agencies which can assist with the other needs for effective reintegration: housing, education and training, employment, living skills, and connection to family and community. However, the current integration between the Adult Parole Board (**APB**) and prison clinicians is limited, which reduces opportunities for aligned release planning. Better information-sharing between the APB and clinicians based in prison would potentially increase the likelihood that treatment goals could better prepare justice-involved persons for release.

Trends and changes in sentencing law and practice in Victoria that have impacted young people and adults living with mental disorders

39 Trends and changes in sentencing law and practice in Victoria appear to have been influenced by political and media pressures, generally to increase the lengths of sentences and to ensure that sentences are served in prison rather than in the community. As a result of these pressures, sentences and restrictions for justice-involved persons have increased significantly, and there has been a marked growth in the number of justice-involved persons.

40 Research suggests that the way in which community attitudes are represented and relied upon to seek more punitive responses is out of step with actual community attitudes. For example, research carried out under the auspices of the Sentence Advisory Council in 2018 suggested that community attitudes with respect to sentencing are generally more in line with current sentencing practices.[27] While the public generally believes judges are

[27] <https://www.sentencingcouncil.vic.gov.au/publications/public-opinion-about-sentencing-research-overview>.

too lenient, when provided with outlines or summaries of matters, community members tend to consider a sentence to be reasonable.

41 Advocacy on behalf of vulnerable cohorts of justice-involved persons is required to ensure that their rehabilitation and treatment needs are taken into account upon sentencing. I consider that policy must ensure the availability of treatment interventions for those likely to benefit from them. Furthermore, the judiciary requires contemporary information, whether through Corrections Victoria, expert evidence, or education through the Judicial College of Victoria, to understand therapeutic options available to those being sentenced, and their suitability.[28]

Trends and changes in recidivism rates for young people and adults living with mental disorders in the criminal justice system

42 In the last decade or more, there has been a profound increase in rates of incarceration compared with the rate of population growth in Victoria.[29] This applies to both young people and adults. Also notable is that for people with mental disorders, reductions in funding to essential services has, it would appear, reduced access to mental health and social services. It is access to these services which may assist to reduce the rate of incarceration. Comorbidity between mental disorder (including personality disorder) and substance use is associated with increased recidivism rates.[30]

43 Recidivism cycles can be reduced in the future through effective post-release support including social support[31] and mental health follow-up.[32]

44 There should be a range of opportunities for support that are in place proactively and can be easily accessed by those in need. To implement such opportunities, it is important that resources are targeted where they are needed, particularly to the groups of consumers that require a greater therapeutic input and are most vulnerable.

45 By way of example, in my experience dealing with justice-involved women, I have noticed that women are generally engaged in offending that results in shorter periods in prison. As a result of coming in and out of prison frequently, women are often destabilised because they are constantly disconnected from the community while in prison, and then struggle to engage with a broad range of support services while in the community. As a

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28 *Graeske v The Queen* [2015] VSCA 229, at 10.

29 <https://www.corrections.vic.gov.au/annual-prisoner-statistical-profile-2006-07-to-2018-19>.

30 O'Driscoll, C., Larney, S., Indig, D., & Basson, J. (2012). The impact of personality disorders, substance use and other mental illness on re-offending. *Journal of Forensic Psychiatry & Psychology*, 23(3), 382-391.

31 Green, B., Denton, M., Heffernan, E., Russell, B., Stapleton, L., & Waterson, E. (2016). From custody to community: Outcomes of community-based support for mentally ill prisoners. *Psychiatry, psychology and law*, 23(5), 798-808.

32 Jarrett, M., Thornicroft, G., Forrester, A., Harty, M., Senior, J., King, C., ... & Shaw, J. (2012). Continuity of care for recently released prisoners with mental illness: a pilot randomised controlled trial testing the feasibility of a critical time intervention. *Epidemiology and Psychiatric Sciences*, 21(2), 187-193.

result, justice-involved women may be caught in a vicious circle marked by loss of community supports each time they reoffend. In order to avoid this destructive and fruitless process, it is necessary to provide more support and to introduce a range of mental health, alcohol and drug treatment, psychosocial and practical interventions that can consistently and proactively be provided.

Representation of young people and adults living with a mental disorder in the criminal justice system and in prisons and youth justice centres

46 For *young people* in contact with the criminal justice system, there are strong correlations with:

> "*socioeconomic disadvantage, intergenerational trauma and grief, childhood abuse, exposure to criminal activity committed by parents or siblings, disrupted education, high levels of disability, cognitive impairment, language and communication delays, high levels of mental health concern, drug and alcohol disorders and fetal alcohol syndrome disorder, high levels of family conflict, unstable accommodation and homelessness.*"[33]

47 Staggeringly, the Armytage-Ogloff report identified a 30-fold increased rate of contact with public mental health services preceding young people's contact with the criminal justice system.[34]

48 Research undertaken by Professors Pamela Snow and Martine Powell also suggests that a substantial minority of young people experiencing the justice or correctional system have intellectual disabilities or language disorders,[35] but that there are limited opportunities for early recognition of these risk factors for offending, or opportunities to intervene appropriately when these conditions are detected. This research finding is strongly associated with the young people not remaining in education and, as a result, generally leads to profound social disadvantage. These markers of social disadvantage warrant a psychosocial response from mental health, child protection and education services. It is important to consider the needs of young people through therapeutic and rehabilitative lenses rather than as a criminal justice problem, as these young people too frequently end up in the adult criminal justice system.

49 For children and young people with mental disorders, focussed services addressing special age-specific needs are necessary. In particular, there is no appropriate service available for those subject to the CMIA who are under the age of 18. These young people need to be looked after by a service focussed on age-specific needs related to mental

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33 Armytage, P., & Ogloff, J. (2017). Youth justice review and strategy: Meeting needs and reducing offending.

34 Ibid., 157.

35 Snow, P. C., & Powell, M. B. (2011). Oral language competence in incarcerated young offenders: Links with offending severity. *International Journal of Speech-Language Pathology*, 13(6), 480-489.

disorder and cognitive impairment, rather than in a custodial setting. The service should have residential and community elements to reduce disconnection from a young person's community. The extension of the CMIA to young people is meaningless without appropriate therapeutic services.[36]

50 In my experience dealing with *adults* who have interacted with the criminal justice system, it has often been difficult to separate out the impacts of mental disorders, cognitive impairment and substance use. In Victorian prisons, there is a substantial minority of justice-involved persons with cognitive impairment, but it is thought that the major contributor is substance use.[37] However, cognitive impairment *simpliciter* is not considered a mental illness which falls under the responsibility of area mental health services (**AMHS**). Furthermore, there is no organised screening on reception, or soon after reception, for cognitive impairment. It is also difficult for these consumers to access other community services such as housing and employment due to stigmatisation associated with criminal justice contact, drug use and mental disorder. This simply reinforces a cycle of reoffending for consumers with mental disorders.

51 The representation of people with mental disorders is markedly increased in the criminal justice system and in particular in prisons. For instance an Australian data linkage study showed that 1/3 of people with psychiatric illness had been arrested over a 10-year period.[38] The AIHW in its annual publication on the health of prisoners noted in 2018 that about two in five in prison acknowledged having been told they had a mental health condition by a health practitioner.[39]

52 Sadly, it can also be said that the criminal justice system may hold some benefits for people with mental disorders because it enforces abstinence from alcohol and drugs, and offers some stability with access to medical treatment, accommodation and food.[40] I consider this a reflection on the dearth of services and stable accommodation options available to marginalised people in Victorian communities.

53 The reasons for over-representation of mentally disordered people in the criminal justice system are hard to map to single issues, but will reflect:

(a) difficulties in remaining linked to mental health services due to the limited capacity of the mental health system;

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36 K Morton, A Deacon & D Sullivan (2018). 'The Extension of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 to the Children's Court: Opportunities and Shortfalls.' 26(3) *Psychiatry, Psychology and Law*, 375-384.

37 Jackson, M. (2011). *Acquired brain injury in the Victorian prison system*. Department of Justice.

38 Morgan, V. A., Morgan, F., Valuri, G., Ferrante, A., Castle, D., & Jablensky, A. (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), 1869-1880.

39 Australian Institute of Health and Welfare. (2019). *The health of Australia's prisoners 2018*. Canberra: AIHW, 39.

40 Ibid., 33-4.

(b) changes to bail, sentencing and parole laws; and

(c) the psychosocial disadvantage associated with mental disorder.

The impacts of increased prison populations on the delivery of Victoria's forensic mental health services

54 In the last decade, I have observed that prisons have been overwhelmed by demand. This demand has resulted in a government focus on building prisons. With more people in prison, many of whom have mental health needs, this has served to divert the focus of Forensicare from the need to treat consumers living with mental disorders in hospitals and in the community. I strongly believe that prisons are not a therapeutic place for consumers with mental disorders.

55 The principle of equivalence is described in the *National Statement of Principles for Forensic Mental Health* and reflects that people in prison should receive the same level of service as people living in the community, including people with mental disorders.[41]

56 In order to optimise the delivery of forensic mental health services for justice-involved persons, I consider that the government must focus on providing forensic mental health beds across multiple levels of security[42] in therapeutic hospital settings and in the community, rather than prisons. If consumers are treated in a dedicated mental health setting, they will obtain more appropriate and dignified treatment with greater prospects of improvements and recovery. This could involve treatment in general mental health settings rather than specialist forensic mental health services (if security needs can be addressed appropriately). However, the focus on forensic mental health provision also includes addressing risk factors associated with offending, and this would therefore be preferable for justice-involved persons. This would require a small number of low and medium secure units distributed regionally, but with oversight and model of care aligned with forensic mental health services.

57 If public health services were resourced to provide the level of support needed for people exiting prisons or for people at risk of offending who have mental disorders, there would almost certainly be a reduced number of people with mental disorders in prisons. Unfortunately, however, stigma related to mental health, substance use and offending compounds the inaccessibility and inadequate bed numbers of available community mental health services. Ideally, services would involve proactive linkage to community mental health services prior to exit from prison, addressing not only mental health but the extensive range of psychosocial needs of justice-involved persons.[43]

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41 <https://www.aihw.gov.au/getmedia/e615a500-d412-4b0b-84f7-fe0b7fb00f5f/National-Forensic-Mental-Health-Principles.pdf.aspx>.

42 See Kennedy, H. G. (2002). Therapeutic uses of security: mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment*, 8(6), 433-443.

43 See footnotes 31 and 32 above.

BEST PRACTICE IN FORENSIC MENTAL HEALTH TREATMENT

58 Some of the key principles, characteristics and components of contemporary best practice in forensic mental health treatment are as follows:

(a) *Care equivalency*: Timely access to assessment and care that is equivalent to community standards and provided in an environment appropriate to the safety and security needs of the consumer and staff. All consumers have the right of respect for individual human worth, dignity, impartiality and privacy regardless of their offending history or status as a forensic patient.

(b) *Comprehensive and flexible service delivery*: A stepped care approach committed to ensuring consumers receive the right services at the right time in the right place. Safe and secure services that are responsive to complex consumer needs including the assessment and treatment of mental illness and comorbid offending behaviours and substance misuse.

(c) *Recovery-oriented, person-centred approach*: Recovery focused care that supports consumers in self-determination, self-management, personal growth, empowerment, choice and meaningful social engagement. Providing care that is person-centred and considers trauma, diversity and culture along with "offender recovery" - attending to the consumers' life story and the meaning of offending within it. Established clinical pathways provide consistency in care while allowing for individual care needs.

(d) *Collaborative and integrated partnerships*: Fostering community connections across health, community and justice sectors, with the common goal of ensuring a seamless approach to mental health care as consumers move across services/systems. Consumers successfully reintegrate into the community with the range of supports and services needed to achieve a meaningful and fulfilling life.

(e) *Evidence based care*: Established international leaders in undertaking and translating research into clinical practice and disseminating this to build knowledge and capacity across the health, community and justice sectors locally and internationally.

59 Forensicare is in the process of renewing its model of care based on these principles and underpinned by philosophies of recovery, person-centred care, and trauma informed practices. In addition, the principles of forensic mental health are informed by the Risk-Needs-Responsivity model.[44] The model is being further informed by an advisory panel of external experts and key stakeholders in mental health, justice, forensic psychiatry,

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[44] <https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-en.aspx>.

lived experience and research to ensure that the renewed model of care is best practice, contemporary and responsive to the needs of consumers, carers, staff and the broader community.

60 Victoria's forensic mental health services seek to remain engaged in national and international developments which provide opportunity to implement innovative and best practices. This includes ensuring linkage with colleagues nationally and internationally through: the Council of Australian Forensic Mental Health Service Leaders (**CAFMHSL**); professional bodies such as the RANZCP Faculty of Forensic Psychiatry and the Australian College of Mental Health Nurses; participation in national and international conferences; maintaining current knowledge through professional journals; and recruitment from overseas, which brings fresh ideas and practices.

61 From my training experience and professional linkages, I am aware that in the UK, there are a number of inpatient settings that have administered very effective long-term treatment. For instance, there are several medium and low secure settings tailored to the needs of consumers with personality disorders or cognitive impairment. Settings that provide a concentration of super-specialised skills would come at a high cost, which may not be justified in Victoria which has a smaller proportion of consumers in need of those services. However, we could seek to develop an appropriate framework which better meets the needs of specific groups. Among these are Aboriginal and Torres Strait Islander people, elderly people, people with cognitive impairment and neurodevelopmental disorders, and women.

62 For instance, Canada[45] and New Zealand[46] have developed innovative, co-designed models of care in both prisons and forensic mental health services to address the needs of indigenous populations in a culturally-appropriate manner.

63 Forensic mental health services in Victoria lack the inpatient beds to provide effective support to AMHSs in providing effective treatment for their consumers who have challenging behaviours. Sufficient beds would enable AMHS consumers who pose a high and continuing risk of aggression to be managed in an appropriate setting with staff who have specialised skills in the management of challenging behaviours. This does not only require high security settings, as many consumers with complex and challenging behaviours can be safely managed in medium and low secure settings. With adequate bed resources, Forensicare could offer far more assistance to AMHSs in managing aggressive and challenging consumers.

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45 Perdacher, E., Kavanagh, D., & Sheffield, J. (2019). Well-being and mental health interventions for Indigenous people in prison: systematic review. *BJPsych open*, 5(6).

46 Simpson, A. I., & Penney, S. R. (2011). The recovery paradigm in forensic mental health services.

Optimal governance arrangements

64 Currently Victoria has a complicated system with multiple providers of mental health services commissioned through two Departments, and with a range of governance requirements, multiple KPIs and reporting requirements, different models of care, and different electronic medical record systems. The system is correspondingly difficult for consumers to navigate. Carers of these people also struggle to understand the complexity of the system or to advocate effectively.[47]

65 I consider that forensic mental health services should be aligned with other mental health agencies, but exist as a discrete and separate agency with unified governance across the state; across community hospital and prison services; and across all levels of security. The focus should be on ensuring those consumers who have mental health disorders and are involved in the criminal justice system have the same level of care and access to health care as those in the community do – across both physical and mental health issues – and that their care is staged, and integrated no matter where they are treated.

66 Rather than focussing on having a single location provide all care to a forensic consumer, we need to develop a range of hospital settings that provide different kinds of care appropriate to various stages of treatment, and with different levels of security and support. A focus on forensic services as consisting only of hospitals with secure perimeter walls around them is out of step with the rest of the mental health system, where there is a focus on a community care provision with step up and step-down acute services. Consumers could then be placed into a setting which is appropriate to their security needs but not overly restrictive. Ideally this would also enable community linkage close to the location where they will, in future, live. This is particularly useful for those consumers with severe mental illness in prison, who would benefit from pre-release planning in a mental health setting to enable smooth and integrated transition back to the community at the end of a custodial sentence.

67 Development of the forensic mental health system should also provide a basis to develop therapeutic capacity with low and medium levels of security in regional areas, with centralised governance, capacity development and support across the system. There are significant advantages to having a single forensic mental health service covering a range of settings across Victoria, with a unitary governance structure, information management and service delivery model. This would aid in workforce and capacity development, data collection and research, and efficiency.

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[47] See e.g. Mary K Pershall (2018). *Gorgeous Girl*. Melbourne, VIC: Penguin.

FORENSICARE OPERATIONS AND CAPACITY TO MEET DEMAND

68 Forensicare delivers a range of forensic mental health programs in a secure hospital setting, as well as in prisons and in the community. These programs are targeted at consumers with varied needs at different stages of recovery; from assessment, early intervention and prevention, inpatient care, rehabilitation and community support. These services are delivered through:

(a) TEH: a 136-bed secure forensic mental health hospital that provides acute and continuing care in separate male and female units and a mixed gender rehabilitation unit;

(b) Prison Mental Health Services: 141 places located in specialised forensic mental health services at the Melbourne Assessment Hospital, Dame Phyllis Frost Centre, Port Phillip Prison, and Ravenhall Correctional Centre; along with associated programs and outpatient services, also at the Metropolitan Remand Centre and almost all regional prisons; and

(c) Community Forensic Mental Health Service: the service delivery arm of Forensicare's outpatient and community-based programs. These services are evidence-based and include effectively assessing, treating and managing high risk consumers aimed at improving outcomes for consumers and contributing to increase community safety. They include specialist programs such as the Problem Behaviour Program, the non-custodial supervision order (**NCSO**) program, the court-based Mental Health Advice and Response Service, and the Forensic Clinical Specialist Program coordination.

Changes in the scope of Forensicare's services over time

69 In hospital settings, the establishment of Forensicare consolidated a small number of units into the TEH. The unanticipated growth of the Victorian prison system has for several years placed an increasing demand on forensic mental health services. There is now little capacity to assess and manage a broad range of conditions in TEH, with almost all consumer admissions having a primary diagnosis of psychotic illness. Furthermore, consumers who would benefit from a prolonged hospital stay are returned to prison due to demand constraints. Finally, TEH now has little capacity to admit consumers from AMHSs due to its position as the sole provider of compulsory mental health services to the correctional system, and the need to prioritise that cohort. Aspects of the design of the TEH no longer meet contemporary standards and reduce Forensicare's ability to provide effective and appropriate services to some consumers.

70 Prison mental health services have increasingly been the priority for government. In my view, we are unable to provide services in prison as effectively and safely as we do in the therapeutic setting of hospital. I consider that it would also be more humane to meet the

needs of consumers with mental disorder if we could transfer them out of prison into mental health beds. This, along with linkage through to community-based services would likely more effectively reduce risks of reoffending.

71 Community forensic mental health services are provided across several programs. The main concern is that it remains difficult to meet the needs of AMHSs for support with their forensic patients and those with challenging behaviours. This reflects shortfalls in capacity and centralisation of services. The forensic clinical specialist scheme has made a significant positive impact, but its benefits vary across services.

The differences between compulsory, security and forensic patients

72 Consumers at TEH fall within one of three categories:

(a) Forensic patients who, under the CMIA, are on custodial orders or are temporarily apprehended from the community whilst on non-custodial orders, or who are specifically remanded to TEH pending findings under the CMIA. Forensic patients are persons found not guilty by reason of mental impairment or have been determined as unfit to stand trial, or pending those findings and where necessary have been remanded to TEH rather than prison.

(b) Security patients are transferred from prison under secure treatment orders (pursuant to section 275 of the MHA) in order to be treated at a designated AMHS for mental illness. Corrections Victoria requirements mean that TEH is the only facility considered able securely to meet the needs of security patients in Victoria;

(c) Compulsory patients are civil patients under the MHA. Of the few compulsory patients at TEH, most are consumers who were initially transferred from prison under a secure treatment order but whose correctional sentence has since expired. In those circumstances the security patient status lapses. However, where the consumer still meets the criteria under the MHA and is too aggressive or violent to be managed by an AMHS, they are occasionally placed on an inpatient compulsory treatment order under the MHA and detained at TEH for treatment past the expiry of their secure treatment order. Additionally, compulsory patients are on occasion admitted directly from an AMHS where the AMHS is unable to safely manage them. However, scarcity of beds at TEH means that it is only in exceptional circumstances that such consumers become admitted. They will often remain for several years due to lack of capacity of AMHSs to manage them once improved. As a result, it is important to secure long term and secure care in appropriate community mental health services in circumstances where compulsory patients do not require the level of security that TEH offers.

73 As I understand it, there are two main circumstances in which a person can simultaneously have more than one legal status under the MHA and the CMIA:

(a) Firstly, where a person is on remand in prison under the CMIA, and they are transferred from prison to TEH as a security patient for treatment prior to the resolution of their legal / mental impairment matters. In those circumstances, they would be subject to a remand order under the CMIA (whilst simultaneously being subject to a secure treatment order under the MHA).

(b) The second, and anecdotally more common, is where a person is on a NCSO under the CMIA and being treated in the community by AMHS under the supervision of Forensicare, but is simultaneously placed on a compulsory treatment order under the MHA. In circumstances where a person requires a period of compulsory treatment in the community, then despite the existence of the NCSO under the CMIA, the compulsory treatment orders under the MHA have a role to play in assisting the AMHS to ensure the person receives appropriate and necessary treatment, both community-based and inpatient-based (in a mental health facility other than TEH).

74 Neither of these circumstances cause Forensicare any particular practical concerns in ensuring that person receives treatment.

75 It is recognised by the courts that there is some overlap between the CMIA and the MHA, and they can be used simultaneously where required and where restrictions on a person's liberty are kept to the minimum necessary.

76 Due to bed shortages, TEH has had to delay the admission of some consumers from prison who are liable to custodial supervision under the CMIA. This is because, once these consumers occupy a bed, the bed is generally occupied for many years and TEH does not have the capacity to discharge such consumers.

77 The treatment needs of compulsory, security and forensic patients are managed differently. Despite the fact that TEH provides individualised treatment plans for all consumers, security patients are almost all managed only in acute units and returned to prisons thereafter, with a small number to sub-acute units if detained for longer periods of treatment. On the other hand, compulsory and forensic patients can progress into sub-acute or community facilities when appropriate for their treatment needs. Further, security patients have no entitlement to off-campus leave, while compulsory clients can have leave if approved by their authorising psychiatrists.

Demand for TEH, prison mental health services and Forensicare's Community Forensic Mental Health Service

78 Forensicare is currently unable effectively to meet current demand for services at TEH. This means the following:

(a) Justice-involved persons requiring compulsory treatment are often delayed for days or weeks prior to transfer and admission into hospital, during which time they are subject to custodial circumstances rather than therapeutic hospital-based care;

(b) Justice-involved persons who are awaiting transfer to TEH as a CSO under the CMIA can remain in prison for months or years prior to admission into hospital, due to bed availability constraints; and

(c) Civil patients who may benefit from treatment at TEH are almost all unable to obtain access to beds due to necessary prioritisation of justice-involved persons.

79 Prison mental health services are able to initiate and provide access to most treatment.[48] However, for many people, this treatment is less holistic than the treatment that would otherwise be administered in a therapeutic environment such as a secure hospital. It is a struggle to provide treatment across the entire state of Victoria, and effective treatment that meets the need, without access to greater number of treatment settings.

80 In respect of TEH, the three aspects that impact on Forensicare's ability to meet demand are:

(a) An inability to transfer consumers in a timely fashion from prison to hospital.

(b) Little capacity to treat consumers for the duration of treatment that is indicated. In respect of prison mental health services, Forensicare's focus has developed within resource constraints, to provide shorter term interventions as opposed to longer term sustained treatments which can be provided if a person is transferred to a hospital setting. More prolonged and sustained interventions increase the likelihood of recovery and are most likely to optimise functioning before return to the community.

(c) An inability to meet the demands of certain parts of the population. For example, those with acquired brain injuries or neuropsychiatric disorders do not necessarily qualify for forensic mental health services under the CMIA. Further, the physical setting is not appropriate for elderly consumers. Finally, women cannot have the full range of security needs met in single gender environments.

[48] Currently clozapine cannot safely be initiated in prison settings.

81 Forensicare has a high level of experience in forensic mental health services in the community. Community mental health services, however, are organised and administered through piecemeal funding and service provision. This has resulted in niche services being developed in the community, which can be very effective but are not sufficient to provide state-wide, consistent and long-term support for consumers with mental disorders and forensic mental health needs. Instead, it would be more effective if lower level security forensic services were provided regionally. Ultimately, there must be a centralised oversight of forensic mental health treatments that can be provided over a long duration of time, if possible in conjunction with the AMHS, so that consumers can have continuity of support and care as their needs increase and decrease at times.

FORENSICARE SERVICES IN PRISONS

Justice Health

82 There are two different government departments responsible for managing forensic mental healthcare – the Department of Justice and Community Safety (**DJCS**), and the Department of Health and Human Services (**DHHS**) – each with different scope of service provision. I consider that the current arrangements for the provision of mental health services are complicated and confusing. For example, a reception into prison involves mental health services provided by several different agencies and with different models of care.

83 Currently in correctional settings, physical health, mental health and allied mental health care, substance use interventions and other therapeutic interventions are provided by a range of separate agencies. The responsibility for providing particular elements of treatment is sometimes unclear, notwithstanding that the overall governance in prisons is overseen by Justice Health, a business unit of DJCS. Having multiple separate providers is also confusing for consumers and leaves them uncertain who is responsible for their treatment. I consider that better outcomes would be achieved through a joined-up trajectory delivered by a more integrated system. A more integrated system without an array of service providers would benefit justice-involved persons – by providing clarity around their treatment, clear lines of responsibility and better treatment coordination. This would likely improve outcomes.

84 The coordination of care as justice-involved persons enter the community provides a sharp disjunction between previous care in prison and the availability and access of subsequent care in the community. Re-entry into the community is often linked to increased mortality and diminished access to essential services.[49] Most critically, lack of

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[49] Cutcher, Z., Degenhardt, L., Alati, R., & Kinner, S. A. (2014). Poor health and social outcomes for ex-prisoners with a history of mental disorder: a longitudinal study. *Australian and New Zealand Journal of Public Health*, 38(5), 424-429.

accommodation is the norm and this impacts upon engagement with community mental health services and other linkages.[50] Rigid geographic catchments for services are detrimental to engagement with mental health services for recently-released justice-involved persons, and could be reconsidered for them, to prioritise their needs over administrative protocols. Consequently, consideration of integrated care in prison that then follows people back into the community will lead to better outcomes for justice-involved persons.

85 By way of example, the NSW Ministry of Health oversees the provision of all health care services in prisons through the Justice Health and Forensic Mental Health Network, which enables smoother linkage with health services on release from prison.[51]

The sharing of Forensicare patient information with other health service or correctional providers

86 Each AMHS utilises separate medical records, including Forensicare. Efficient transfer of clinical information where necessary is vital to ensuring adequate continuity of care. Accepted clinical practice dictates that, where there is a chain of contact between a person and different clinicians, each clinician in the chain ensures that the next clinician who sees the person is handed over the relevant information. As a designated mental health service, Forensicare is subject to section 346 of the MHA*,* which prescribes the circumstances in which it can disclose health information. For example, Forensicare routinely shares information to other mental health services upon referral of an individual for continuity of care.

87 An area for improvement arises with respect to access to clinical records created in prison. A platform known as “JCare” is used exclusively in the prison system for the recording of prisoner health information and is owned by Justice Health, part of the DJCS. Forensicare employees who work in the prison system must use JCare to record the health, medical and treatment history of each prisoner who receives forensic mental health services in prison. Access to JCare and to the clinical records contained in JCare is heavily restricted by DJCS for privacy and security reasons, and because of the sensitive nature of the information stored on the system.

88 Information sharing could be improved by developing a unified, password protected information technology platform that allowed compartmentalised access which could be accessed, at some restricted level, when necessary by mental health services. Audit trails

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50 Cutcher, Z., Degenhardt, L., Alati, R., & Kinner, S. A. (2014). Poor health and social outcomes for ex-prisoners with a history of mental disorder: a longitudinal study. *Australian and New Zealand Journal of Public Health*, 38(5), 424-429.

51 Private prisons may however be subject to different arrangements.

could protect the system from abuse. This would enable treatment providers to consider the treatment as distinct episodes of care but within a continuous care trajectory.

Prisoner access to mental health services

89 All prisoners upon entry into the prison system undertake mental health screening in accordance with prison standards as part of the standard 'reception assessment'. These assessments are of necessity rapid and time-pressured, but use skilled senior staff and some evidence-based tools to standardise assessment.

90 These reception assessments are carried out at Melbourne Assessment Prison, Melbourne Remand Centre, Ravenhall Correctional Centre and Dame Phyllis Frost Centre. At reception, all prisoners go through a screening process that includes a general assessment by a prison officer, a medical assessment by the general health service and a psychiatric assessment undertaken by a Forensicare-employed mental health clinician.

91 The reception psychiatric assessment is intended to operate as a screening to ascertain risk, rather than a comprehensive mental health assessment. The overarching purpose of the psychiatric assessment is to determine the prisoner's:

(a) current mental state;

(b) any immediate needs for care; and

(c) current risk of suicide and self-harm;

to make any appropriate recommendations for their placement.

92 The assessment is undertaken using a locally developed structured assessment tool, the Mental Health Intake Screening Assessment (**MHISA**) based on the Jail Screening Assessment Tool, an instrument internationally validated for detection of mental illness and suicide risk in comparable settings.[52]

93 Reception assessments are largely based on the incoming prisoners' current presentation, but collateral information sources are also used. Information sources include the client management interface, commonly known as the CMI (the statewide mental health database accessible by all public health services who are subject to the MHA), JCare, PIMS, E Justice, the Corrections Victoria reception assessment, and medical information from the Victoria Police Custodial Health Service.

94 When a person is recepted into custody, any previous care episode in the AMHS ends. Assessments usually need to be completed without the benefit of information from a

[52] Ogloff, J., Davis, M., Rivers, G., & Ross, S. (2007). The identification of mental disorders in the criminal justice system.

current medical record or treating practitioners. These are obtained subsequently with the consent of the justice-involved person.

Services available in prisons for people presenting with mild or moderate mental disorders

95 I do not have a current list of providers that offer services in prisons for people presenting with mental disorders. The Royal Commission may be able to obtain this information from Justice Health. Forensicare is considered a secondary provider of mental health care, and provides services which differ from prison to prison, but include:

(a) Outpatient assessment and treatment through consultant psychiatrists and registrars;

(b) Outpatient assessment and treatment through nurse practitioners and nursing staff;

(c) Outreach assessment by nursing staff;

(d) The Mobile Forensic Mental Health Service, providing individual assessment and treatment, and small group brief interventions; and

(e) Occupational therapy, psychology and social work input in the metropolitan prisons.

96 Mild and moderate disorders predominantly involve adjustment disorders, mood and anxiety disorders. The prevalence of these disorders increases in prison compared to the community.[53]

97 It is my understanding that primary mental health care is currently provided by contracted healthcare providers – currently Correct Care Australasia (and St Vincent's Health at Port Phillip Prison). In practice, there is no clear systematic delineation between the healthcare provided by Forensicare and primary providers for mild and moderate mental disorders. This relies instead on local implicit or explicit culture related to initiation and follow-up of treatment. It is difficult to determine how the care of mild and moderate mental disorders could be effectively apportioned between different treatment providers without disadvantaging some consumers if they attended 'the wrong provider'.

[53] Butler, T., Andrews, G., Allnutt, S., Sakashita, C., Smith, N. E., & Basson, J. (2006). Mental disorders in Australian prisoners: a comparison with a community sample. *Australian & New Zealand Journal of Psychiatry*, 40(3), 272-276.

Prisoners' right to access necessary and desirable care and treatment within or outside correctional settings

98 Prisoners have a right to access appropriate treatment. However, the *Corrections Act 1986* (Vic) does not, nor should it, provide any guidance about standards of clinical services.

99 In general, it is right and appropriate to aim for equivalent access by those in prison to physical and mental health care. For justice-involved persons, the systems and procedures that provide services and access to those services may be difficult to access if the person is not aware of the range of services available. Rather, they are reliant on requests being directed to the right provider in a timely fashion. It may also be difficult to navigate the complex process especially if the prisoner has difficulties writing or is from a culturally and linguistically diverse background. Justice-involved persons frequently move between locations, due to classification and placement issues, meaning that they may not get the benefit of full uninterrupted courses of treatment or the development of effective relationships with providers.

100 There remains a disjunction between the timely access of justice-involved persons to physical health treatment outside prison, and the profound delays in availability of mental health care. This can only be remedied by the provision of sufficient beds to meet demand, or a change in policy to enable mental health care for at least some justice-involved persons to be provided in AMHSs – which has a range or ramifications for security.

101 However, there is increasing acceptance of, and infrastructure for, the provision or telehealth services using videoconferencing platforms. This leads to the possibility that large unmet needs such as psychological interventions for distress and trauma could be provided by clinicians external to prison. This would require access to the JCare platform for clinical documentation purposes.

Forensicare's provision of preventative mental health services

102 There are general mental health outpatient services provided at most prisons by consultant psychiatrists, psychiatry registrars and nurse practitioners. Forensicare also provides mental health services such as wellbeing services and brief interventions in some prisons (the Metropolitan Remand Centre, Barwon, Karrenga and Marngoneet, with in-reach to the Melbourne Assessment Prison). In these prisons there is a significant proportion of high prevalence mental disorder such as anxiety, depression and adjustment disorders. These interventions are provided through the Mobile Forensic Mental Health Service (**MFMHS**). These programs are not specifically preventative, but are focussed on improving wellbeing and fostering resilience.

103 The MFMHS provides group and individual intervention to clients with a wide range of high prevalence conditions, including depression, anxiety, borderline personality disorder, adjustment disorder and trauma, as well as psychoeducation programs for people with chronic mental illness. It provides a service to a small number of high complex clients with multiple diagnoses. Some of its most needed work is in providing short term self-soothing skills to individuals with emotional dysregulation, who otherwise do very poorly in custody.

Prisoners' access to psychological services, other than through Forensicare

104 Prisoners can access psychological services through a range of different providers. There are some specific offence-related services offered by the Forensic Intervention Service of Corrections Victoria. General distress related services, brief counselling interventions and more specialised services in relation to sexual assault, gambling, and drugs or other addictions are delivered by a range of different providers that are contracted by Justice Health.

105 Problems that arise when consumers with mental disorders deal with different providers at once are described in paragraph 82 above. Additionally, I have observed that (sometimes) these providers do not communicate amongst themselves about the type of therapeutic interventions that they are each providing to a consumer, which means the care may be inconsistent or disjointed. Some services contribute to the JCare electronic record and some do not. Thus a clinician may not be aware of other clinical input being provided to a justice-involved person and thus may not have the opportunity to coordinate input.

The role and future of specialist mental health custodial management facilities in Victoria's prisons

106 There has been better access to mental health services in prison since the advent of more specialist mental health custodial management units and services across prisons. The opening of Ravenhall Correctional Centre has increased the presence of Forensicare in prisons, with 141 places clustered in mental health settings in prisons. While the men and women in prison are not compulsorily treated, they have access to a multi-disciplinary team, allowing for assessment and intervention for a range of mental illnesses as well as specialised units focussed on complex and challenging behaviour and complex transition.

107 Preliminary analysis has suggested that the group who most benefit are likely the moderately unwell group who are recommended for compulsory treatment, but who improve sufficiently that this recommendation can be withdrawn. There remain, however, a group of significantly unwell men who require transfer to TEH, who do not demonstrate meaningful improvement from specialist mental health services in correctional settings, which cannot provide the same level of care as a hospital setting.

108 A focus on improving access to mental health interventions in prison has been welcomed. However, access to hospital beds remains essential for the small group of men and women who become acutely mentally unwell, or enter custody in this state. While we should be seeking to provide comprehensive care and specialist services to justice-involved persons, and some at Ravenhall Correctional Centre access good quality care through this approach, my view is that it would be more effective and would likely lead to better outcomes if services for acutely or chronically unwell justice-involved persons were provided in hospital or other health settings.

109 Most mentally unwell justice-involved persons engage in treatment without compulsion. I have observed that a number of mentally unwell consumers treated in the custodial mental health service at Ravenhall Correctional Centre who have initially refused treatment will subsequently engage voluntarily in treatment in prison. This results in not requiring involuntary treatment through transfer to hospital, and is beneficial to their engagement and recovery.

110 It is difficult to demonstrate the impact of the provision of these specialist services at Ravenhall Correctional Centre due to the confounding factors:

(a) a shift from correctional service designed for a sentenced population to a population of predominantly remandees; and

(b) the rapid growth in size of Ravenhall Correctional Centre.

Transfer and access from prison health services for forensic patients

111 It is generally the case that those requiring compulsory treatment are held at the Ravenhall Correctional Centre, and less frequently at the Melbourne Assessment Prison prior to a bed becoming available at TEH. Current wait times in the first five months of 2020 have ranged up to eight weeks, with an average of under two weeks. The wait time has reduced significantly since Apsley Unit opened in April 2019, but the factor which continues to delay transfer is the insufficient bed capacity at TEH. There is also a small delay which relates to the administrative processes within Corrections Victoria which precede transfer.

112 Given these demand constraints, high priority consumers are prioritised according to urgency of clinical need. Forensicare has introduced the DUNDRUM toolkit, a suite of structured professional judgment tools. Of these the DUNDRUM-2 provides an objective rating of urgency that assists Forensicare to compare prisoners in multiple locations and

identify those with the most pressing need for bed access.[54] Priority for transfer to TEH is therefore based on the clinical state and severity of a person's mental disorder.

113 In order not to reduce the number of beds available at TEH, there have been occasions in recent years where Forensicare has had to ask the court to delay making CSOs under the CMIA. Individuals under CSOs occupy beds for several years until discharge. In addition, Forensicare has no power to discharge consumers on CSOs; this is a decision made by the courts. Consequently, insufficient bed capacity has increasingly constrained the number of beds available to all prisoners in Victoria, who cannot be treated for mental disorder in any other facility. The wait for admission has in recent years exceeded a year, although a small recent increase in bed numbers has enabled us to admit all awaiting a CSO by May 2020.

114 Since opening the Apsley Unit in April 2019, the wait times for beds have reduced significantly. Bed access in the Apsley Unit is targeted towards a stay of no longer than 30 days, in which case consumers return to prison or are transferred to another acute unit at TEH. This approach has enabled us to provide a more rapid throughput of consumers that require forensic mental health services. The Apsley unit is a male-only unit, so there is no equivalent capacity to provide such rapid access to women. Delays in admitting women to TEH from prison have so far been less significant than delays for men.

115 The Apsley beds are used in part for those justice-involved persons who experience recurrent admissions and whose treatment would otherwise cease when they enter prison. Of course, ideally they would be treated in a hospital setting for a longer period of time, to consolidate treatment and thus reduce the risk of relapse, and thereby reduce risk of offending and further incarceration.

116 There are consequences for prisoners, prison staff and Forensicare staff when beds are not readily available for those who need them most. It has been observed that delays in transferring a person from prison to hospital has escalated the risk of self-harm. It has also been observed that the delay in treating acute psychosis is linked to poorer longer-term outcomes.[55] In addition, those who recurrently commence and then cease anti-psychotic and other psychotropic medications have poorer longer-term outcomes.[56] Finally, it is distressing for our consumers and the staff involved in providing care, when there is a delay in accessing beds and there is no treatment available.

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[54] Flynn, G., O'Neill, C., & Kennedy, H. G. (2011). DUNDRUM-2: Prospective validation of a structured professional judgment instrument assessing priority for admission from the waiting list for a Forensic Mental Health Hospital. *BMC Research Notes*, 4(1), 230.

[55] Harrigan, S. M., McGorry, P. D., & Krstev, H. (2003). Does treatment delay in first-episode psychosis really matter?. *Psychological medicine*, 33(1), 97-110.

[56] See e.g., Berk, M., Kapczinski, F., Andreazza, A. C., Dean, O. M., Giorlando, F., Maes, M., ... & Magalhães, P. V. S. (2011). Pathways underlying neuroprogression in bipolar disorder: focus on inflammation, oxidative stress and neurotrophic factors. *Neuroscience & biobehavioral reviews*, 35(3), 804-817.

117 Systems and processes for the transfer of consumers with mental disorders from prison to TEH can be improved by increasing access to beds to meet the incoming demands, in addition to increased access to beds across different levels of security that are tailored to consumers with different mental health needs. For example, a small number of elderly consumers and people with neuropsychiatric disorders, including cognitive impairment, are by necessity placed into acute mental health settings along with others experiencing severe psychosis, which is distressing for them and exposes them to risk through their vulnerability. I consider that for specific cohorts, placement in alternative settings may enable more effective treatment without compromising the need to manage a consumer in an appropriate level of security.

118 The availability of the women's unit is important because it enables the admission of women into an appropriate and safe setting, particularly in circumstances of trauma backgrounds associated with domestic violence or sexual assault. However there are limited options to manage women in appropriate settings at lower levels of security, in TEH and in the community.

Prisoner discharge from correctional settings to emergency departments under MHA assessment orders

119 Justice-involved persons with mental disorders should be treated in mental health settings. Unfortunately, due to shortfalls in bed capacity, such treatment is not always possible for all justice-involved persons who have mental disorders. Firstly, if AMHSs had sufficient bed capacity, mentally unwell consumers might be diverted from the custodial system and treated there. Furthermore, if Forensicare had sufficient bed capacity, it would be able to ensure that before the expiration of their sentences, mentally unwell prisoners could be admitted to TEH to ensure that at the expiration of the time in custody they would be linked straightforwardly to the appropriate catchment AMHS. This would also enable TEH staff to prepare for return to the community by ensuring appropriate linkage to supports, accommodation and other practical needs.

120 Justice-involved persons with serious mental disorders during the period of remand and awaiting sentencing can currently only be treated compulsorily at TEH. In other jurisdictions, those with lower level offences can be transferred from prison for compulsory treatment in general community mental health services. If this is adequately resourced and there are sufficient levels of security, access to treatment might be increased.

121 In circumstances where such a person in prison is unexpectedly granted bail or is sentenced to time already served, there is no time or opportunity for Forensicare to arrange ongoing services in the community. Because Forensicare cannot anticipate a putative release or transfer date, planning for ongoing treatment is challenging.

122 The most effective – and least restrictive – course of action for sentenced justice-involved persons would be to transfer them for voluntary treatment at the relevant AMHS at the expiration of their time in custody. However, because of the demand for AMHS services, it cannot be anticipated that the person will receive these services. Furthermore, the stigma of justice system involvement may reduce the likelihood that they attend services or are accepted for them.

123 Ideally, the involvement of the relevant AMHS Forensic Clinical Specialist prior to release ensures that the AMHS is able to ensure follow-up in the most appropriate way for the consumer and the AMHS. If this is not able to occur, the only other way to ensure that a justice-involved person experiencing serious mental illness will be reviewed by an AMHS upon their release, is to make an Inpatient Assessment Order under the MHA. Otherwise, there is a significant possibility that these consumers will not attend or obtain the treatment that they require. However, it is my view that where a person is released on an Inpatient Assessment Order, they should be transferred to a direct entry point into an AMHS and not to an emergency department. When there is sufficient concern in prison that a person may require compulsory treatment on their release, Forensicare's duty of care is only sufficiently discharged by ensuring that the justice-involved person is transferred to an AHMS, which can then address the needs of the person according to their own resources and need to prioritise cases.

124 An Inpatient Assessment Order is the first step to initiating compulsory mental health treatment, as such an order authorises the assessment of a consumer in order to confirm whether the consumer needs compulsory mental health treatment. The practitioner making the Assessment Order can determine whether the assessment of the consumer can occur in the community or whether the consumer needs to be taken to a designated mental health service for this assessment.

Differences in service delivery for male and female prisoners

125 Service delivery for male and female prisoners differs significantly. By way of background:

(a) Female justice-involved persons have markedly increased rates of trauma histories including physical, sexual and emotional abuse, family violence victimisation, and child protection involvement. There is marked comorbidity with mental illness, including elevated rates of cognitive impairment, personality disorder and serious substance use disorders.

(b) There is a different profile of contact with the criminal justice system – women tend to serve shorter sentences on a repeat basis which results in a revolving cycle of recurrent incarceration. This has an impact in terms of continuous connection and disconnection with mental health services, support services, and

accommodation; the lack of continuity of care contributes to chaotic and unstable community lives.

126 Forensicare provides reception mental health screening by experienced mental health nurses, consultant psychiatrist outpatient clinics, and nurse practitioner clinics. In addition, the Marrmak Unit provides bed-based services which are provided by a large multidisciplinary team and includes specialised psychological interventions for personality disorder. Forensicare's provision of forensic mental health services within Dame Phyllis Frost Centre's (**DPFC's**) Marrmak Unit is in my opinion effective in diagnosing and treating women with mental disorders on a voluntary basis. It provides timely access to services.

127 At DPFC, there are inefficiencies of care provision. Women are seen by multiple clinicians from different organisations in their first week after reception. In contrast, the waiting time to see psychologists is often over six months. Furthermore, the DPFC outpatient psychiatrist clinic sees large numbers of women with features of complex trauma and personality disorder, family violence victimization and transgenerational trauma. These features correlate strongly with substance use disorders. It is impossible in the current system to deliver timely and sufficient evidence-based treatment for this population.

128 What is needed is a personality disorder treatment team or unit in DPFC, able to deliver individual and group interventions. A high quality service would also extend into the community with the capacity to commission and access coordinated care. The workforce for such a unit requires specialist skills and a dedicated model of care. This might also benefit the correctional system by – over time – reducing the number of women detained long-term in management units.

129 There are significant demands for community support services for this vulnerable population when released into the community. However, these services are provided within a complex system of multiple service providers and it can be very difficult to plan treatment holistically and ensure the various services provided to the justice-involved women are integrated. Also, there is a chasm between what services are available in prison and what is then available in the community upon release. It is especially difficult to link prisoners with Mental Health Community Support Services upon release in the circumstances of short sentences, when there is little notice of release, or where Community Correction Orders are not linked to therapeutic interventions.

130 The Marrmak Unit allows timely access. In the year from June 2019 to June 2020, 179 of 183 women were admitted within one week of referral. If it were possible to change anything to improve the quality of services at the Marrmak Unit, I would focus on improving integration across the myriad services available in the DPFC, and integration

with community services to enable continuation of provision of services in the community, including continuity of a longer term course of care and treatment.

131 The waitlist for transfer from DPFC to TEH has been more recently measured in days rather than weeks. However, there are very few, currently only three acute beds available for transfers from DPFC in the whole of TEH.

CLINICAL OVERSIGHT OF MENTAL HEALTH SERVICE QUALITY AND SAFETY IN PRISON SETTINGS

132 There is significant complexity in the oversight of service provision, quality and safety in mental health in the prison system given:

(a) The overlap of departmental responsibility for prison health services between DJCS and the DHHS;

(b) Justice Health sets the policy and standards for health care in prisons and monitors provision of health services in accordance with the Justice Health Quality Framework;

(c) As Forensicare is a designated mental health service, all Forensicare services provided outside of the prison setting are overseen by the DHHS. This can contribute to a lack of clarity regarding roles and responsibilities and reporting requirements;

(d) The multiplicity of service providers in the prison, and no doubt varying KPIs;

(e) A model involving division into primary and secondary mental health akin to the relationship between general practice and specialist services in the community, that does not translate well into the prison system. The boundary between the two is unclear and inconsistently applied across different prisons; and

(f) It is not difficult to observe how the above leads to confusion and lack of clarity when navigating the system, and challenges the provision of demonstrably consistent and effective care.

133 In addition to the Justice Health framework, there are a number of other health standards and policies that apply to Forensicare's services that are delivered in correctional settings, including:

(a) International treaties such as the Optional Protocol to the Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (**OPCAT**), which aims to prevent the mistreatment of consumers in detention;

(b) National principles such as the National Statement of Principles for Forensic Mental Health, which "aim to provide cohesion and credibility so that optimal

diagnosis, treatment and rehabilitation can be provided to clients of forensic mental health services"; and

(c) Quality and safety regulations such as the National Safety and Quality Health Service Standards, which aims to protect the public from harm and to improve the quality of health service provision (**National Standards**).

There is currently a triennial program of accreditation under the National Standards. I understand that state departments are responsible for forensic mental health and have an obligation under the Australian Health Ministers Advisory Council (**AHMAC**) to adhere to The National Statement of Principles for Forensic Mental Health and OPCAT. I am aware that OPCAT has been the subject of Ombudsman reviews, and is the subject of a current review of any setting in which people may be detained.

134 In circumstances where adverse clinical incidents occur, there are a various means by which these clinical incidents are reported and monitored, such as:

(a) Sentinel events which are the subject of Safer Care Victoria governance and oversight;

(b) Riskman, which is Forensicare's incident reporting system. Riskman is a mandated part of our accreditation and part of our agreement with the Mental Health Branch of DHHS;

(c) Local measures overseen by a small Quality Team, which aim to improve complaint and incident reporting;

(d) Forensicare's Quality Team oversees the resolution of incident reviews through the Serious Incident Review Committee, and reports to the Executive Best Care Committee (an executive committee of Forensicare that reports to the Forensicare Board);

(e) Serious incidents are reported in summary form and are the subject of KPIs that are reported to the Forensicare Board;

(f) Serious incidents in prisons, such as deaths in custody, are reported through the Justice Assurance and Review Office (**JARO**), which is DJCS's independent incident reporting office;

(g) Although there is reporting to the Office of the Chief Psychiatrist for serious clinical incidents, breaches of the MHA and sexual offences committed at TEH, it is less clear that this relates to incidents occurring in prison. However, the Office of the Chief Psychiatrist is notified by Forensicare of deaths in prison of justice-involved persons who are under treatment or have recently been seen by Forensicare; and

(h) Via coronial involvement following any death in custody.

135 It is not uncommon for incidents to be the subject several incident reviews. For example, a suicide can often be the subject of a JARO review, an internal review and a coronial inquest, and may also prompt the involvement of the Office of the Chief Psychiatrist and Safer Care Victoria.

136 As described in paragraph 134 and 135 above, there is currently an overlap in regulatory oversight between Safer Care Victoria and the Office of the Chief Psychiatrist. There should be one regulator only, or if there are two regulators for different aspects of the role there should be clear role division mapped out within DHHS and only one regulator involved in any one function.

137 While recognising that this is a complex issue, I consider that the Chief Psychiatrist should have some degree of oversight and powers in relation to mental health care and treatment delivered in all settings (such as prisons, communities, hospitals and youth detention). Oversight and powers would ensure that the rights of all mental health consumers are protected in the same way. Mental health services require a degree of consistency to function in mental health services and consumers should not be deprived of that consistency and oversight. If the Chief Psychiatrist is provided such oversight, I consider that the scope of its powers should ensure that the standards of mental health care administered in Victoria, including within prisons, fit within the MHA and its principles.

TRANSITIONS

Risks for people living with mental disorders when they transition between services, including between the courts, remand centres, prisons and upon exit from custody

138 People transitioning between services as part of moves within the justice system face significant risks. Each transition is risky because information may be lost or cannot be accessed easily. All the various sectors of health and human services have their own data systems. So, for example, the health system and the housing systems are not joined. In addition, courts, prisons, custody centres, remand centres and youth justice systems each use different data systems, and as a result, much information is not readily accessible across systems.

139 This model relies on the clinical practice of timely provision of information by clinicians during handover and transfer, as explained above. In urgent circumstances, this system is not beyond breakdown. This creates risk for adequate continuity of care. As consumers interact with various parts of the justice and health systems, the current information transfer practice is vulnerable to gaps whereby the receiving service or care providers may not have all of the relevant information to ensure comprehensive and integrated service provision.

140 It is particularly frustrating for consumers who are transitioning between services, whose journey may be fragmented. In some cases, there are discontinuities of care or periods of unanticipated disengagement with some services because these consumers are required to take further steps to provide, retrieve or collect that information.

141 By way of example, where justice-involved persons are entering custody, they or their receiving clinicians are required to obtain information from a range of resources that are not always responsive, or responsive in a timely fashion. This is a particular risk for consumers leaving prison, particularly those with physical and substance use issues because they may not engage with mental health services upon release.[57] See also the reasoning described in paragraph 49 above.

142 In addition, I note that the transition from youth mental health services to adult mental health services in custody does not have a defined pathway except when a justice-involved person is transferred from a youth detention facility directly to adult prison during an adult sentence.

Housing, alcohol and other drugs (AOD) and mental health requirements of people leaving custody

143 I consider that consumers with housing, AOD and mental health requirements leaving custody can best be supported through transition planning that commences prior to a person's release from prison, or is otherwise supported through community corrections services. This requires a period of time of notification of bail or release to enable the planning process and connection with housing, welfare and social services and community health services. Information-sharing between these services provides the information necessary for them to provide interventions in a timely manner upon the release of a justice-involved person.

144 Consumers with comorbid AOD and mental health issues would be more effectively assisted with mutual information transfer, liaison between correctional and community health services, and notice to ensure planning of transfer between these services. If Forensicare knew in advance when a justice-involved person was expected to be released, our staff could assist the justice-involved person to plan their transition into the community services. However all too frequently there is limited time for Forensicare clinicians to communicate with support services. As a result, justice-involved persons may be released without confirmed acceptance into a support program; this reduces the likelihood of successful transition and engagement.

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57 Cutcher, Z., Degenhardt, L., Alati, R., & Kinner, S. A. (2014). Poor health and social outcomes for ex-prisoners with a history of mental disorder: a longitudinal study. *Australian and New Zealand Journal of Public Health*, 38(5), 424-429.

145 Communication systems between prisons, health and community services can certainly be improved to facilitate continuity of care on release. Improvements can be made by providing each other with sufficient notification to allow for adequate planning. Ideally, all involved services should communicate with each from entry to prison, during a sentence and in planning for release if this is not a prolonged period. This would enable recommencement of a linkage or of an intervention without once more going through an onerous intake assessment process.

The operation of Forensicare's Community Integration Program

146 The Community Integration Program (**CIP**) began in 2010. It was originally run out of the Community Forensic Mental Health Service and supported Forensicare consumers leaving TEH or prison. CIP was split into two services in 2018. Of these, the CIP now supports those leaving prison and is now under the management of the Prison Directorate of Forensicare. CIP is designed to provide short-term pre-release work, over 6-8 weeks, and short-term assertive community outreach, for 6 weeks. It runs out of Melbourne Assessment Prison, the Metropolitan Remand Centre, DPFC and Ravenhall Correctional Centre. The primary goal of CIP is to facilitate linkage of prisoners with serious mental illness (**SMI**) and ongoing treatment needs to a treatment service in the community after they leave prison.

AMHS relationships with, and treatment responsibilities for, registered consumers who are incarcerated for brief periods of time

147 AMHS relationships with, and treatment responsibilities for, registered consumers can be maintained even though they are incarcerated for brief periods. Since 2017, Forensicare has operated an "Early AMHS notification" system across the four prison reception sites, in liaison with the state Forensic Clinical Specialists (**FCS**). On reception into custody, when the CMI check identifies a current or recent client of an AMHS, the relevant FCS is notified by Forensicare that their client is in custody. This serves as the first point of contact between the AMHS and their detained patient. Case managers and FCSs are encouraged to attend prison to review their clients.

148 Challenges arise as clients make their way through multiple prisons – a single point contact from Forensicare for AMHSs is the ideal solution. Ravenhall Correctional Centre has an AMHS coordinator position, but this would ideally be a state-wide position, aligned with the prison CIP.

149 With that said, justice-involved persons are often transferred to prisons that are distant from their homes and communities. In these circumstances, it may be possible to use telehealth or videoconferencing to maintain a service relationship for the consumer, but

also for AMHSs to liaise effectively with prison-based services prior to discharge. However, if the person will not return to the catchment area, this may be fruitless.

150 Administratively, AMHSs could keep in contact with a category of 'inactive' clients that remain on AMHS books. That way, they could maintain an ongoing responsibility and relationship could easily be rekindled when that person ultimately returns to their home or community, or is otherwise supported during a transfer to a different service. This proposal ensures that consumers have continuity and do not need to commence a completely new episode of care. Nevertheless, it is not straightforward for services to maintain input to clients who are not engaged with them, and this may not be easily imposed on an unwilling person. It is also not particularly helpful if the consumer will not be discharged to the same catchment; those who are incarcerated experience marked instability of accommodation and may not return to the same area.

FORENSICARE'S INPATIENT MODEL OF CARE

The current model of care underpinning delivery of inpatient services at Thomas Embling hospital

151 Forensicare is in the process of drafting a formal Model of Care, which is anticipated to be complete late in 2020. The core aspects of this is set out in 58 above.

152 It is paramount for Forensicare's model to incorporate human right principles that underpin the MHA. It is also necessary for the model to address the specialised nature of forensic mental health services to ensure that not only is there effective treatment of mental health problems, but also addressing offending behaviour. Finalising an episode of care involves developing linkage to other services (including but not limited to AMHSs, primary care, and psychosocial support services) to ensure that consumers with mental disorders, once treated, can return to meaningful lives in the community with reduced risk of offending where this is associated with mental disorder.

153 There are challenges in providing this model of care to consumers with mental disorders in prisons. Firstly, contact with consumers is episodic and it is often the case that consumers are moved between prisons without knowledge or oversight by Forensicare. This may interrupt the development of a therapeutic relationships with Forensicare clinicians, increase the risk of discontinuation of treatment, or interrupt the planned titration of medication. Finally, for justice-involved persons engaged in psychological interventions, this may prevent their completion of a multisession intervention.

Forensicare's provision of inpatient treatment and support for AMHS consumers

154 There is certainly a place for Forensicare to have a role in providing inpatient treatment and support for AMHS consumers in the future, though certain points must be made about

the capability building that would be required. I have observed that it is often difficult for AMHSs to provide intensive and sustained treatment with the necessary level of security for a small number of consumers. This is where Forensicare may help, through admission of civil patients to TEH. It is necessary that there be prior agreement that when stabilised, the consumer returns to the care of the AMHS, lest consumers be inappropriately stranded in a secure setting for protracted periods of time.

155 It is clear that AMHSs have a high caseload of consumers with challenging and complex behaviours which might benefit from an episode of forensic mental health care. It is often difficult for AMHSs to manage these caseloads alone due to resource constraints. An integrated service model, similar to the model adopted in the UK, would work well in Victoria because of the size of our population. If such a model is adopted, then medium secure units would be most appropriate for treating consumers with mental disorders, as consumers could move between forensic and community services.

156 I consider that inpatient treatment and support could most effectively be provided by a low or medium secure unit governed by Forensicare. Such a unit would be operated and staffed by Forensicare and rely on its Model of Care. It would admit consumers from AMHS to conditions of security separate from TEH, and provide extended forensic mental health input for months or a few years, until the consumer could safely return to the community. The other population who would benefit from such a unit would be forensic patients stepping down from TEH to a lower level of security enabling better community access.

157 An alternative model would include low and medium secure units which are overseen separately to AMHS as a state-wide network of beds that involve both AMHS and Forensicare, or for Forensicare to run a medium secure unit separate from TEH. This could provide treatment informed by forensic mental health expertise over the necessary extended duration of time.

Forensicare services for consumers with a mental disorder and intellectual disability or cognitive impairment

158 Forensicare provides dual disability services and outpatient consultative services that are commissioned by the Disability Forensic Assessment and Treatment Service. In prison, the needs of people with mental disorder tend to be met straightforwardly through Forensicare's mental health service, but there is no specialist service addressing needs specific to cognitive impairment except at two specific correctional locations.

159 For people with intellectual disability who are not linked to mental health services, forensic treatment is outside the scope of Forensicare's funding arrangements. The advent of the NDIS has significantly disrupted service provision, which is frequently provided on an

individual basis by not-for-profit or government organisations. There is limited input from state and public disability services, which may disadvantage justice-involved persons with mental disorders as they return to the community.

160 For people who are not recognised under the *Disability Act 2006* (Vic), but are otherwise cognitively impaired, there are significant service gaps, particularly for those with acquired brain injury and autism spectrum disorders. These conditions may not satisfy MHA criteria for compulsory treatment but require inpatient or secure residential treatment for extended periods of time. I am aware that this is available through some specialist units located in AMHSs, but these may be difficult to access and have limited resources. In an attempt to control their behaviour, justice-involved persons with severe autism spectrum disorders end up managed in highly restrictive and onerous management regimes that distress them and are in no way therapeutic. The appropriate environment is not available at TEH and there are limited options within the mental health system to provide appropriate interventions.[58]

COMMUNITY-BASED FORENSIC SERVICES

Improving the effectiveness of forensic clinical specialist roles

161 Forensic clinical specialist roles could function more effectively in the future through consideration of the various roles they already perform in the community setting. There is some variation in service models for the forensic clinical specialist roles between different AMHSs.

162 Currently, forensic clinical specialists may be utilised in the community setting to provide comprehensive risk assessments and formulations to guide treatment planning. AMHSs might benefit from developing capacity for offence-specific psychological interventions provided by the forensic clinical specialists within AMHSs or with support from Forensicare, which may reduce the risk of offending.

163 Where an AMHS forensic specialist has connections with prison services, they may attend case management meetings or be involved in considerations of recommendations for how to manage a consumer's return the community after exiting custody, and then be a part of establishing the linkages to enable this.

164 If there were sufficient resourcing for forensic clinical specialists within AMHSs, these specialists could provide management for a small case load.

[58] <https://www.ombudsman.vic.gov.au/our-impact/investigation-reports/investigation-into-the-imprisonment-of-a-woman-found-unfit-to-stand-trial/>.

Forensicare's secondary consultation and capacity building role for health and related sectors

165 Forensicare provides some secondary consultation through specialist programs within the Community Forensic Mental Health Service. These consultations cannot replace the need for adequately resourced service models and bed capacity in the mental health system, which can accommodate the needs of consumers who exhibit challenging or risky behaviours and who might benefit from forensic mental health input.

YOUTH FORENSIC MENTAL HEALTH SERVICES

166 Broadly speaking, the special needs of children and young people should be developed through a specialist forensic mental health service that has the capacity to treat children and young people across a range of settings, not just in detention settings. Youth who are subject to CMIA orders or those with developmental disorders may benefit from alternative settings. Timely interventions in the context of mental disorders and without the stigma of a detention setting have the potential to reduce the risk of offending.

167 This kind of service would be best provided by a youth service with sufficient capability, and linkages to a range of community support services which enable effective reintegration. I consider that a forensic specialist mental health service which is one element of a holistic and broad youth-focussed mental health service is preferable to a separate and specialised youth justice mental health service.

SUPPORTING CONSUMERS WITH VERY COMPLEX NEEDS

Secure extended care (SECU) model response to consumers with very complex treatment and support needs

168 There is an important role for SECU services in Victoria's future mental health service system. However, in my opinion, the current SECU model and facilities are now increasingly out of step with the needs of the population who access those services. This is because the units are not in fact secure to the extent required for the relevant consumer cohort and do not clearly provide extended care to the length of duration required. There is little data available to explore the functioning of SECUs in Victoria.

169 Further, SECU beds are managed by AMHSs. It can be very difficult to access SECU beds for forensic patients who require that level of containment. There are also not enough SECU facilities to meet demand. Finally, the model of care is not clear and there is no clear capacity to address offending behaviour in SECUs.

170 It is possible that some SECUs or other facilities that provide a secure setting outside of a prison could be managed through the forensic mental health system. It would be more

effective to administer those beds and facilities centrally rather than some administered by forensic mental health and others by AMHSs. We should ensure that the services provided within these facilities are provided in a manner that is consistent with one overarching model of care provided across the AMHSs, forensic and community services.

171 Consumers could be treated in a secure setting better suited to their needs but not in a prison setting. Members of the wider community, not just justice-involved persons, could access these kinds of services in a secure setting to focus on reducing challenging behaviours or risk factors – a step up for those with recurrent ineffective admissions and whose disorder is causing issues in community – also a step down for those from TEH as they transition into the community.

Forensicare's Personality Disorder initiative

172 Forensicare is one of six Victorian health services that is funded for the Victorian Government's Personality Disorder Initiative (**PDI**). The initiative aims to build the expertise and capability of the AMHS workforce to access, treat and support consumers with severe personality disorders at high risk of suicide, self-harm or challenging behaviours.

173 Forensicare has a somewhat different cohort of consumers whose needs will be addressed by the PDI. Our current focus is on developing specific capacity within our workforce for more robust and evidence-based assessment of personality. In addition, we are trialling models of clinical supervision to increase the ability of our staff to identify and manage mechanisms of personality disorder which can be detrimental to the functioning of a team and can impact negatively on the care of consumers.

174 At this stage, it is difficult to assess whether the PDI has met its intended objectives, as the initiative has only been operational since late 2019 and has taken some months to develop a workable staffing model and identify priorities and methods of working. However, the PDI staff are enthused by the links to specialist supervision and professional development through Spectrum, and have identified service improvements which are likely to enhance the capacity of Forensicare to provide more effective assessment and management of consumers with personality disorder, particularly in long stay inpatient settings such as TEH.

175 This initiative could be strengthened in the future by developing specific models of care, similar to those like the Orygen model, which is specific for age-related personality disorders or the onset of psychotic disorders. In addition, the PDI could be further strengthened by implementing training across the entire workforce and then targeting prison and community correctional services to ensure that consumers with personality

disorders receive appropriate interventions at all stages of their interaction with services. Similar models in the UK have shown promise.[59]

Forensicare's Problem Behaviour program

176 Forensicare's Problem Behaviour Program is meeting its intended objectives, subject to its relatively circumscribed scope. The program coalesced from several dedicated clinics targeted at the needs of consumers with specific offending behaviours. The program provides psychological and psychiatric consultation, assessment and treatment for adult consumers with a range of problem behaviours associated with offending, especially when services are not available elsewhere. Consumers do not need to have offended but must be at risk of this. The problem behaviours include, but are not limited to serious physical violence; threats to kill or harm others; stalking; sexual offending; paedophilia; collection and possession of child pornography; fire-setting; and querulance.

177 The objectives of the program are to provide comprehensive assessment and treatment for consumers whose problem behaviours place them at risk of offending. In doing so, the program aims to improve the wellbeing of consumers and to reduce their risk of offending. Evaluation has demonstrated reduction of subsequent offending in those who engage with treatment, compared to those who do not. With that said, the program's capacity to provide treatment at the intensity and duration required is limited by the offering of services in its central Melbourne location only. At present, there are resource limitations and other difficulties in providing the services in a regional setting.

178 The program could be strengthened by increased capacity to provide interventions in regional areas.

The delivery of Victorian Fixated Threat Assessment Centre model

179 The Victorian Fixated Threat Assessment Centre (**VFTAC**) began under the auspices of the DHHS in conjunction with Victoria Police. Other services involved include NorthWestern Mental Health and Monash Health. It was developed due to the recognition that mental disorder affects a significant proportion of those with grievances and who may pose a risk to individuals or the community. VFTAC seeks to identify and assess individuals who may have a mental disorder and who pose a threat to public safety due to their risk of engaging in potentially violent behaviours arising from fixation or grievances; and facilitate effective interventions by police, mental health services and other relevant agencies and, through these measures, prevent these individuals from progressing to violent action.

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59 Campbell, C., & Craissati, J. (Eds.). (2018). *Managing personality disordered offenders: A pathways approach.* Oxford University Press, USA.

180 The most significant challenge in delivery of the VFTAC model relates to resource constraints on AMHS, which may reduce their capacity to take on for treatment consumers who do not at first glance appear as acutely needing services than other consumers they are managing. The model is also more challenging to implement in regional areas due to resources available to AMHS.

FORENSIC MENTAL HEALTH OUTCOMES

Assessing forensic mental health outcomes and approaches

181 Forensicare employs a variety of tools to measure, assess and disseminate mental health outcomes to improve services. Forensicare reports on a suite of data required by all mental health services, such as the HONOS, BASIS and Focus of Care.

182 From 2020, Forensicare will be participating in the YES consumer experience survey.

183 In addition, Forensicare reports internally against a suite of KPIs, including for example: measures of proportions of security patients with an extended length of stay or who require readmission to hospital after return to prison; percentage of forensic patients who have received an annual physical examination; and number of patient-to-patient aggression incidents.

184 Forensicare's current approach could be improved by using information technology more effectively to extract data automatically from existing information to provide operational data, and to increase autopopulation of forms for communication about consumers both externally and related to patient care.

Public reporting of Forensicare's clinical, consumer experience and quality and safety

185 Forensicare is enthusiastic about more detailed public reporting for all mental health services and considers this would enable transparency and improve connection of Forensicare to the broader mental health system. Ideally, public reporting would enable national benchmarking with comparison between all state forensic mental health services.

Integrating outcome data in a broader custodial health, forensic mental health and forensic disability outcomes framework

186 I consider that there is little utility in Forensicare outcomes-related data being integrated in a broader custodial health, forensic mental health and forensic disability outcomes framework. The needs of justice-involved persons and those with disability differ significantly and are not easily compared.

187 Many of the outcomes are not within Forensicare's power, as we do not have oversight or control over the management of prisons. As a result, it is not clear if outcome data would enable meaningful interpretation of Forensicare's quality and safety or not.

Sharing deidentified prisoner health, forensic mental health and forensic disability data

188 Linking deidentified prisoner health, forensic mental health and forensic disability data in a data registry to facilitate research has promise. I would support any form of data linkage so long as it provides robust privacy and data protections to consumers that require forensic mental health services. I consider that it is necessary to ensure a linkage across health and welfare data to improve the mental and physical health of all justice-involved persons. Organisations such as the Victorian Agency for Health Information or similar organisations could facilitate research linkages and information access and sharing, to enable better service planning to meet the needs of consumers and justice-involved persons.

SECLUSION AND RESTRAINT

189 Restrictive practices such as seclusion and restraint are well established. In Victoria, these practices have been declining because seclusion, as an intervention, is not a preferable way of dealing with consumers with mental disorders and may be traumatising.

190 With that said, there is a very small population of consumers who, due to recurrent assaults on others, variously associated with psychotic illness, personality disorder, cognitive impairment or experiences of trauma, require greater durations of seclusion to protect those consumers from themselves, and others from the consumers.

191 The use of seclusion and restraint when extremely prolonged may not be consistent with the principles in the MHA, which require among other things that persons receiving mental health services be provided with treatment and assessment in the least restrictive way possible, with the aim of bringing about the best therapeutic outcome and promoting recovery and full participation. However, in these very rare cases, release from seclusion poses a grave and unacceptable risk of serious harm to other consumers and staff.

192 In the UK, there are legislative options for long term segregation to reduce the distress to the consumer and to provide a stable and humane setting with more amenity than a seclusion suite, with the intention of allowing consumers to return to an inpatient unit in a graduated and safe way.[60] Longer term segregation under very limited circumstances for a very small population of consumers is necessary in order to avoid the implementation of repeated or prolonged episodes of seclusion which make it more difficult for consumers with mental disorders to return to units with others. Longer segregation for those requiring

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60 <https://www.cqc.org.uk/sites/default/files/20190412_briefguide-longtermsegregation.pdf>.

it can enable slow and careful reintroduction to wards with others, without unnecessarily escalating the risk of harm to others.

COMPULSORY TREATMENT

193 Different Australian jurisdictions provide compulsory treatment in a number of different settings, some of which are more effective than others. By way of example, New South Wales provides compulsory treatment in a specific prison hospital setting. This is in contrast to Victoria's MHA, which expressly precludes any compulsory treatment regime to individuals who are detained in prison (section 67). Prisoners can only receive compulsory treatment upon transfer to TEH under a secure treatment order. All mental health services provided in prison are provided on a voluntary basis.

194 I consider that compulsory treatment should not be provided in a prison setting. As described in paragraph 54 above, prison is not a therapeutic setting in which the opportunity for recovery from mental health conditions is maximised. Further, the oversight required for the safe administration of sedating medication is not provided within a prison setting. In my opinion, it is necessary to provide timely and effective services in mental health settings with appropriate oversight and monitoring to ensure that treatment is safe, humane and carried out in accordance with human rights principles.

195 Coronial inquests have repeatedly identified shortcomings in the care of mental health problems in custodial settings.[61] The Faculty of Forensic Psychiatry of the RANZCP has provided a position statement opposing compulsory treatment in prisons.[62] While this might seem an expedient way to address shortfalls in resourcing of the mental health system, it clearly increases the risks of deaths in custodial settings and has significant potential for abuse. The solution to ensuring justice-involved persons can receive appropriate and equivalent treatment for mental disorder when they cannot consent to it, is to provide it in the therapeutic setting of a hospital with the protections of the MHA and the standards of care applied to mental health services. To provide compulsory care in prisons places justice-involved persons at an unacceptable risk of mortality or morbidity, and is not equivalent to the protections afforded by the MHA.

INNOVATION AND REFORM

196 There are a range of reforms that could improve the interaction of, and outcomes for, young people and adults living with mental disorders with the criminal justice system.

197 For justice-involved persons, it is necessary to ensure:

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61 See, e.g., <http://www.coroners.justice.nsw.gov.au/Documents/DUNGAY%20David%20-%20Findings%20-%20v2.pdf>.

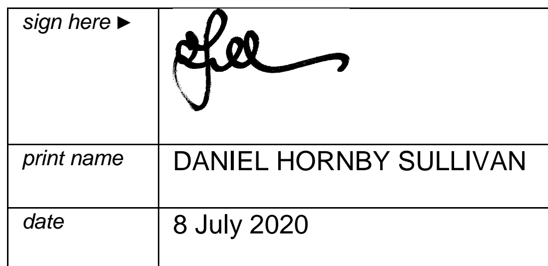
62 <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/involuntary-mental-health-treatment-in-custody>.

(a) Access to evidence-based treatments of appropriate intensity and length, which are provided in a place that maximises treatment effects and is suitable for their security needs. This includes, but is not limited to, mental health, alcohol and other drug, physical health and offence specific interventions;

(b) Information linkage that enables more effective treatment across multiple domains and services; and

(c) Use of data and reporting that maximises information available for individual service planning and outcome monitoring. That information should be available at all cross-sectors and stages of planning.

198 For victims of crime, some victim services available in correctional settings can often complicate the treatment of consumers when they have needs related to both offending and being a victim. As a result, reforms for victims should involve more rigorous screening upon entry into the criminal justice system, and treatment planning which recognises the preceding adverse experiences of the majority who enter the criminal justice system.



sign here ►	
print name	DANIEL HORNBY SULLIVAN
date	8 July 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT DS-1

This is the attachment marked 'DS-1' referred to in the witness statement of Dr Daniel Hornby Sullivan dated 8 July 2020.

Dr Danny Sullivan

MBBS MBioeth MHlthMedLaw MMgmt AFRACMA FRCPsych FRANZCP

Executive Director of Clinical Services, Victorian Institute of Forensic Mental Health (Forensicare)

Honorary Senior Fellow, University of Melbourne

Adjunct Research Fellow, Centre for Forensic Behavioural Sciences, Swinburne University

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Consultant Forensic Psychiatrist
Victorian Institute of Forensic Mental Health
Locked Bag 10, Fairfield 3068

Current positions

- *Executive Director of Clinical Services, Forensicare – clinical leadership and oversight of clinical governance of a dynamic and rapidly expanding public mental health service, with 136 hospital beds and 121 places in custodial prison settings.*
- *Academic appointments at University of Melbourne and Swinburne University: teaching, tutoring, research and consultancy.*
- *Private medico-legal practice: expert evidence & assessments in criminal, civil, coronial, regulatory and other jurisdictions; serious sex offender assessments; consultation on complex cases particularly involving neuropsychiatry and intellectual disability*

Qualifications

2019	Member, Australian Institute of Company Directors
2019	Master of Management – International Masters for Health Leadership, McGill University, Montreal, Canada
2016	Fellow of Royal College of Psychiatrists (UK) ("awarded as a mark of distinction")
2012	Associate Fellow of Royal Australasian College of Medical Administrators
2004	Fellow of Royal Australian and New Zealand College of Psychiatrists; accredited member, Forensic Faculty
2002	Member of Royal College of Psychiatrists, South London & Maudsley NHS Trust; Institute of Psychiatry, London UK
2000	Master of Health & Medical Law, University of Melbourne, Australia
1998	Master of Bioethics, Monash University, Australia
1994	Bachelor of Medicine, Bachelor of Surgery, University of Melbourne
1986	Victorian Certificate of Education, Scotch College, Melbourne (full government scholarship)

Academic and public appointments

2017 –	Member, Human Research Ethics Committee, Department of Justice and Community Safety.
2017 –	Complex Needs Panel, Bail Review, Department of Health and Human Services.
2016 – 2018	Tutor, International Masters for Health Leadership, McGill University, Montreal, Canada.
2016 –	Member, Forensic Evidence Working Group, Victorian Supreme Court.
2014 – 2016	Member, expert advisory committee, Enabling Justice Acquired Brain Injury Project
2014 –	Honorary Senior Fellow, Department of Psychiatry, University of Melbourne (teaching in Forensic Disability)
2014 –	Director, **ACSO** Board
2014 – 2017	Member, Corrections Victoria Intervention Accreditation Panel
2013 – 2014	Member, expert advisory committee, Victorian Law Reform Commission **CMIA review**
2011 – 2014	Foundation member, Faculty of Forensic Psychiatry, RANZCP; and committee member, Victorian branch
2011 –	*Journal of Law and Medicine* – section editor – Medical Issues
2011 –	Human Research Ethics Committee, Victorian Institute of Forensic Medicine
2010 – 2014	Department of Human Services: Therapeutic Treatment Board (Ministerial appointment; reappointed 2012)
2008-14, 17 –	Member, Clinical Advisory Group, Disability Forensic Assessment and Treatment Services (DFATS)
2008 – 2015	Adjunct Senior Lecturer, School of Psychology and Psychiatry, Monash University (teaching in: Forensic Behavioural Science, Law, Forensic Medicine and Psychological Medicine)
2009 – 2014	Visiting Lecturer, Deakin University School of Medicine, in Ethics, Law and Professional Development theme
2007 –	Victoria Police: Custodial Medicine Unit Advisory Board (2007-2010); Road Safety Fatality Review Panel (2008 -)
2006 – 2009	RANZCP – Ethical Practice Committee (national executive); Fellowship reaccreditation working group
2005 – 2008	Honorary Lecturer, Department of Psychological Medicine, Monash University
2005 – 2006	Victorian Branch Council member – RANZCP
2004 – 2011	Human Research Ethics Committee, Department of Human Services/Health; (Ministerial appointment)
2003 – 2013	Honorary Fellow, Department of Psychiatry, University of Melbourne
2003 – 2004	Editorial Board, Australian & New Zealand Journal of Psychiatry
2001 –	Peer reviewer, multiple journals
1996 – 1999	Chair, Patient Care Ethics Committee, Austin Repatriation Medical Centre

Previous employment - recent

2016 (Mar-Jun)	Acting Clinical Director, Forensicare, including planning of 8 bed secure intensive care unit and acute bed access review project
2005 – 2017	Assistant Clinical Director (Community Operations), Forensicare
2005 – 2007	Clinical Consultant, Care Plan Assessments Victoria – part of *Multiple & Complex Needs Initiative*
2004 – 2007	Consultant Psychiatrist, Forensicare: Community Forensic Mental Health Service; Thomas Embling Hospital; multiple prison clinics

Selected Publications (full list available on request)

B McSherry, R Darjee, & D Sullivan (2019). Post-sentence Detention and Supervision: The Role of Multi-agency Panels 27(1) *Journal of Law and Medicine*, 29-36.

K Morton, A Deacon & D Sullivan (2019). 'The Extension of *the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* to the Children's Court: Opportunities and Shortfalls.' 26(3) *Psychiatry, Psychology and Law* 375-384.

JRP Ogloff, J Ruffles, & D Sullivan (2018). *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System*. Unpublished Report, Centre for Forensic Behavioural Science, Swinburne University of Technology.

'Forensic Psychiatry' (book chapter); in Bloch et al. (eds.) *Foundations of Clinical Psychiatry* (Melbourne: MUP, 4th ed., 2017).

SM Shepherd & D Sullivan (2017). 'Covert and implicit influences on the interpretation of violence risk instruments.' 24(2) *Psychiatry, Psychology and Law* 292-301.

D Sullivan & A Deacon (2016). 'Solitary confinement – going down the rabbit hole' 24(1) *Journal of Law and Medicine* 20-34.

'Classification of personality disorders, clinical manifestations and treatment' (book chapter); in Gall & Payne-James (eds.) *Current Practice in Forensic Medicine* (London: Wiley-Blackwell, 2nd ed., 2016).

K O'Brien, DH Sullivan & M Daffern (2016) 'Integrating Individual and Group-based Offence-focussed Psychological Treatments: Towards a Model for Best Practice.' 23 (2) *Psychiatry, Psychology and Law* 1-19.

DH Sullivan, M McDonough (2015) 'Methamphetamine: Where will the stampede take us?' 23(2) *Journal of Law and Medicine* 41-49.

'Cultural considerations in psychiatric evidence' (chapter co-authored with IH Minas and S Minas); in I Freckelton & H Selby (eds.) *Expert Evidence* (Sydney, Thomson Reuters, 2015; previous version 2010).

'Early intervention in forensic mental health' (book chapter co-authored with Fraser R, Purcell R); in A Rosen, P Byrne (eds.) *Early Intervention in Psychiatry* (London: Wiley-Blackwell, 2014).

GN Baksheev, D Sullivan, et al. (2014). 'Characteristics of mentally disordered youth referred to a forensic satellite clinic for violence risk assessment: a case-control study.' 21 *Psychiatry, Psychology and Law* 1-12.

DH Sullivan, MA Rees (2014) 'Smoking bans in secure psychiatric hospitals and prisons.' 22(2) *Journal of Law and Medicine* 22-30.

'The forensic psychiatry specialty: from the birth to the subliming' (book chapter co-authored with PE Mullen); in S Bloch, S Green & J Holmes (eds.) *Psychiatry: Past, Present and Prospects* (Oxford, Oxford University Press, 2014)

'Ethical issues in Australian prisons'; in N Konrad, B Völlm & D Weisstub (eds.) *Ethical Issues in Prison Psychiatry* (Springer, 2013).

D Sullivan, T Roberton, M Daffern, & S Thomas (2013) *Building Capacity to Assist Adult Dual Disability Clients Access Effective Mental Health Services*. (Office of the Senior Practitioner, Melbourne).

D Sullivan (2013) 'Disorders, sublime menu: The DSM-5 '21(1) *Journal of Law and Medicine* 39-46.

'Forensic Psychiatry and Risk Assessment' (book chapter); in Castle D, Bassett D, King J & Gleason A (eds.) A Primer in Clinical Psychiatry (2nd ed., Sydney: Elsevier, 2013); (1st ed., Sydney: Elsevier, 2009).

'Managing the violent behaviours associated with the schizophrenic syndrome' (book chapter co-authored with Prof PE Mullen); in D Castle, D Copolov, T Wykes & K Mueser (eds.) *Pharmacological and Psychosocial Treatments in Schizophrenia* (3rd ed., London: Informa, 2012); (2nd ed., London: Informa, 2008).

DH Sullivan, PE Mullen (2012). 'Commentary: exploring hormonal influences on problem sexual behavior.' *Journal of the American Academy of Psychiatry and the Law* 40(4) 486-7.

R Purcell, R Fraser, C Greenwood-Smith, G Baksheev, J McCarthy, D Reid, A Lemphers, DH Sullivan (2012) 'Managing risks of violence in a youth mental health service: a service model description' 6(4) *Early Intervention in Psychiatry* 469-75.

A Smith & D Sullivan (2012) 'A new ball game: the UN CRPD and assumptions in care for people with dementia' 20(1) *Journal of Law and Medicine* 28-34.

'Mental Health and Patient Rights in Secure Settings' (book chapter co-authored with PE Mullen); in M Dudley, D Silove & F Gale (eds.) Mental Health and Human Rights (Sydney, Oxford University Press, 2012)

L Mileshkin & D Sullivan (2011) 'Access to expensive anti-cancer drugs'19(2) *Journal of Law and Medicine*

S Thomas, K Corkery-Lavender, M Daffern, D Sullivan & P Lau (2011) *Disability, mental health and medication: Implications for practice and policy*. (Office of the Senior Practitioner, Melbourne).

O Neilssen, J O'Dea, D Sullivan, M Rodriguez, D Bourget, M Large (2011) 'Child pornography offenders detected by surveillance of the Internet and by other methods' *21 Criminal Behaviour and Mental Health* 215-24.

'Culture and expert psychiatric evidence' (chapter co-authored with IH Minas and S Minas); in I Freckelton and H Selby (eds.) *Expert Evidence* (Sydney, Thomson Reuters, 2010).

'Hunger strike and food refusal' (book chapter co-authored with C Romilly); in S Wilson & I Cumming (eds.) Psychiatry in prisons (London: JKP, 2009).

R Hayes, M Barnett, DH Sullivan, O Neilssen, M Large, C Brown (2009) 'Justifications and Rationalizations for the Civil Commitment of Sex Offenders' 16(1) *Psychiatry Psychology and Law* 141-149.

DH Sullivan, M Chapman, PE Mullen (2008) 'Videoconferencing and Forensic Mental Health in Australia' 26:3 *Behavioral Sciences & the Law* 323-331.

'Forensic Psychiatry' (book chapter); in Fritzon K & Wilson P (eds.) *Forensic and Criminal Psychology: An Australasian Perspective* (Melbourne: McGraw Hill, 2008)

R Hayes, O Neilssen, D Sullivan, M Large, K Bayliff (2007) 'Earlier Intervention in Psychotic Illness' 14(1) *Psychiatry Psychology and Law* 35-44.

'Forensic Psychiatry' (book chapter co-authored with Prof Paul Mullen); in S Bloch and B Singh (eds.) *Foundations of Clinical Psychiatry* (Melbourne: MUP, 3rd edition, 2007).

Invited Editor, with Prof PE Mullen, of forensic special edition of the *Australian & New Zealand Journal of Psychiatry* (June 2006).

M Walterfang, M Fietz, M Fahey, D Sullivan, P Leane, D Lubman & D Velakoulis (2006) 'The Neuropsychiatry of Niemann-Pick Type C Disease in Adulthood' 18 *Journal of Neuropsychiatry and Clinical Neurosciences* 158-170.

DH Sullivan, PE Mullen, MT Pathé (2005) 'Legislation in Victoria on sexual offenders: issues for health professionals. 183 (6) *Medical Journal of Australia* 2005; 318-320.

D Sullivan, M Walterfang, D Velakoulis (2005) 'Bipolar Disorder & Niemann-Pick Disease Type C' 162:5 *American Journal of Psychiatry* 1021-1022.

Two chapters in T Brown & G Wilkinson (eds.) *Critical Reviews in Psychiatry* (Third edition) (London: Gaskell Press, 2005).

Presentations (full list here)

Presentations on a range of topics in the fields of sexual offending, substance use, mentally disordered offending, personality disorder, cognitive impairment, dual disability, expert evidence, neuropsychiatric syndromes, mass killing, and ethicolegal issues. Numerous keynote speeches and invited presentations, professional development and educational packages. Approximately 40 presentations per year.