Centre for Forensic Behavioural Science

Forensicare

Submission

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Parliamentry inquiry into mental health and suicide prevention

Prepared for the House Select Committee on Mental Health and Suicide Prevention

SWINBURNE UNIVERSITY OF TECHNOLOGY

The views expressed in this submission do not reflect the position of the Government of Victoria.

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We acknowledge the Traditional Owners of country throughout Australia and recognise their continuing connection to land, waters and culture. We pay our respects to their Elders past, present and emerging.

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Centre for Forensic Behavioural Science, Swinburne University of Technology

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Executive Summary and Recommendations

This joint submission is made by Forensicare (Victorian Institute of Forensic Mental Health) and the Centre for Forensic Behavioural Science (CFBS), Swinburne University of Technology. The CFBS and Forensicare have unique expertise in with working with people within the justice-system to improve mental health and offending outcomes. Although this submission focusses on services and issues arising in Victoria, the issues noted are typically consistent across all Australian jurisdictions.

Throughout this submission we refer to prisoners (sentenced and remand), offenders in the community (those on parole or on community corrections orders) and former offenders (those who have completed a sentence related to an offence) collectively as justice-involved individuals.

People involved with the justice system are at a heightened risk of experiencing mental health issues and engaging in suicide and self-harm compared to the general population. The Royal Commission into Victoria's Mental Health System (RCiVMHS, 2021) recently provided a comprehensive review of the treatment of people with mental illness within the justice system. The findings of the Royal Commission were briefly restated in this submission. Subsequently, we drew upon the suicide prevention frameworks relevant to justice populations to understand the gaps in suicide prevention for people in custody, people released from prison, and people who have a community-based order.

The RCiVMHS (2021) highlighted the criminalisation, lack of appropriate services, and poor continuity of care experienced by justice-involved people with mental illness. The Royal Commission was particularly concerned with how commonly people with mental illness were arrested for minor crimes within the context of mental health episodes and remanded (i.e., denied bail) either because of the difficulties they experience with lifestyle instability or because they could not have access to the mental health treatment that they require in the community. The Royal Commission found that people with mental illness were overrepresented among the remand population, as two-thirds of remandees are diagnosed with a serious mental illness. While there are no publicly available data on mental health service usage in Victorian prisons, Forensicare expressed concern regarding the shortage of beds within the state's forensic mental health hospital (Thomas Embling Hospital). As compulsory treatment cannot be delivered in the prison setting, an adequate number of forensic mental health beds are required to accommodate the demand for admission of prisoners requiring involuntary mental health care. The lack of adequate secure mental health beds leads to large numbers of prisoners waiting for prolonged periods, often whilst unmedicated, for admission to hospital. Further, even if individuals were to experience improvement in their mental health within a prison setting, they may experience a marked decline upon release due to poor continuity of care. The lack of support of people with a serious mental illness may result in them becoming trapped in the net of the justice system due to the criminalisation of their behaviour while unwell, and the limited access to appropriate mental health treatment in the community.

The Black Dog Institute (Ridani et al., 2016) provided an overview of an evidence-based

systems approach to suicide prevention involving nine suicide prevention strategies for the general population. Drawing upon these guidelines, as well as the Victorian Suicide Prevention Framework 2016-2025 and the Correctional Suicide Prevention Framework, the suicide prevention initiatives in Victoria were reviewed, and recommendations were suggested. The Correctional Suicide Prevention Framework provides guidance regarding the assessment and identification of risk, crisis care, means reduction, and training of staff as a way to prevent suicides. While this follows international best-practice among correctional services, individuals in prisons do not have access to the same level of aftercare services, psychosocial interventions, and programs that enhance mental health literacy and help-seeking as people in the community.

Community Corrections Services staff have a different duty of care for the people they supervise compared to custodial staff. With respect to the correctional environment, there is a significant but graduated duty of care and responsibility to prisoners and offenders placed on the State, with the State having greater obligations to protect people they hold in custody and a lesser requirement to intervene when offenders are under community supervision and free to access publicly available services. Community Corrections Services staff act as conduits, referring clients to the public health system if they are at risk of suicide. Offenders under community supervision have a heightened risk of suicide compared to others in the community (Skinner & Farrington, 2020; Spittal et al., 2014). Although released prisoners and people on community orders can access supports (e.g. HOPE) available to other members of the community, they require support and guidance in how to access such services. Greater investment in assertive outreach interventions for individuals released from prison is required. While the Community Integration Program (CIP) team and the Forensic Mental Health in Community Health (FMHiCH) program have been developed to attempt to bridge the gap between the prison and public health systems, neither of these programs adequately meets the needs of the individuals at risk of suicide. Greater investment in training for frontline staff and gatekeepers in the community and justice-specific entry points for psychosocial interventions may provide greater support to this population who is falling between the gaps in the Correctional and Victorian suicide prevention frameworks.

Recommendations

The following recommendations are made to improve the mental health support and suicide prevention initiatives for individuals involved with the justice system. Given the overlapping responsibilities and funding mechanisms of the Commonwealth and the states, we have identified recommendations to enhance practice rather than focussing on the level of government that should shoulder the responsibility for the recommendation:

The first four recommendations are drawn directly from the RCiVMHS.

1. To reduce the number of people with mental health issues being remanded, the RCiVMHS recommended expanding the Assessment and Referral Court (ARC) to 12 Magistrates Courts, which support people with mental health issues and cognitive impairments.

2. Increase the number of beds at the forensic mental health hospital available to provide compulsory treatment to people in prison who are acutely unwell and require hospitalisation.

3. Expand the existing community forensic mental health model to provide greater continuity of care for people in contact with or at risk of becoming in contact with the justice system.

4. Establish and enhance programs to support people as they transition from correctional to mainstream mental health settings.

5. The Commonwealth should provide funding for an initiative that would provide greater access to psychosocial interventions to reduce emotional dysregulation, distress, and suicidal behaviour among people in prison. This should include Medicare Benefits Scheme funding to prisoners. This would be equivalent to supports provided to people in the general community.

6. Improve aftercare support for individuals who have engaged in suicidal behaviour.

7. Trial peer listener programs to improve help-seeking behaviours of the whole prison population and enhance the mental health literacy of the 'listeners'.

8. Provide coordinated aftercare support programs for individuals released from prison who are at risk of suicide. These programs can draw upon the evidence-based Hospital-Outreach Post-Suicidal Engagement (Hope) initiatives in Victoria.

9. Provide training for GPs and frontline staff regarding additional considerations for risk assessment and management of people released from prison.

10. Greater consideration of justice-involved populations is needed within national and state-wide suicide prevention frameworks

11. Fund and facilitate collaboration with the mental health service to establish improved pathways to support people on community-based orders.

Background

This joint submission is made by Forensicare (Victorian Institute of Forensic Mental Health) and the Centre for Forensic Behavioural Science (CFBS), Swinburne University of Technology.

The Victoria Institute of Forensic Mental Health (Forensicare)

The Victorian Institute of Forensic Mental Health, known as Forensicare, is a statutory agency responsible for the provision of adult forensic mental health services in Victoria. Forensicare, which was established in 1997, is governed by a Board that is accountable to the Minister for Health. In addition to providing specialist clinical services through an inpatient and community program, Forensicare is mandated (under the Mental Health Act 2014) to provide research, training, and professional education.

Forensicare provides inpatient, prison-based services, and community services. These services are delivered through:

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

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

The Centre for Forensic Behavioural Science (CFBS)

The Centre for Forensic Behavioural Science, Swinburne University of Technology, provides academic and clinical excellence in forensic mental health research and practice. We bring together academics, clinicians, researchers and students from various disciplines, including psychology, psychiatry, nursing, social work, law, occupational therapy and epidemiology. Our research, consulting services and professional development and training programs have strengthened the field of forensic behavioural science in Australia and overseas.

A key focus of our work is to transfer academic and clinical excellence into practice in the health, community services and criminal justice sectors. Our aims include:

- understanding, predicting and reducing offending and violence by people with mental illness or problem behaviours

- improving the legal system through empirical research and policy analysis
- creating a vibrant culture of learning and research in the forensic mental health and behavioural science sectors.

A key focus of the Centre is to transfer academic and clinical excellence into practice in the health, community services and criminal justice sectors.

Overview of Justice Populations

Forensicare works with people in the justice and forensic mental health systems. This submission will specifically focus on mental health and suicide among individuals involved with the justice system who have been imprisoned and/or who are supervised by Community Correctional Services within Corrections Victoria while residing in the community.

Within the prison system, there are remandees (people who were denied bail) and sentenced prisoners. If an individual on remand is found guilty, they may receive a prison sentence, a community order, or 'time served,' which means that the time they spent on remand counts as their sentence and they are released without ongoing engagement with Corrections Victoria. People who reside in the community while being supervised by Corrections Victoria include those on parole and those who received a community-based sentence. It is important to remember that most people are only involved with the justice system for a short period of their life. For instance, more than 86% of people on a community corrections order and 50% of released prisoners do not have further justice-involvement within the two years after completing their sentences (Council of Australian Governments, 2021). When considering how to improve the mental health system in Australia, it is important to include people involved in the justice system as most of these people spend the majority of their lives in the community, but their involvement with the justice system may be leveraged to improve outcomes.

Terms of Reference to be Addressed in this Submission

This submission considers the terms of reference about which we have specialist knowledge and in which Forensicare has a role in the delivery of specialist forensic mental health services. In particular, we address the following terms of reference:

- The findings of the Royal Commission into Victoria's Mental Health System [in relation to Forensicare's work within the justice system]
- Emerging evidence-based approaches to effective early detection, diagnosis, treatment and recovery across the general population and at-risk groups, including drawing on international experience and directions
- Effective system-wide strategies for encouraging emotional resilience building, improving mental health literacy and capacity across the community, reducing stigma, increasing consumer understanding of the mental health services, and improving community engagement with mental health services.

Mental Health and Suicide Among Justice-Involved People

This submission considers the mental health and suicidal behaviour among individuals who are involved with the justice system. The findings and recommendations of the Royal Commission into Victoria's Mental Health System (RCiVMHS, 2021) will be discussed to provide a comprehensive overview of the state of mental health support available for people within the justice system and strategies for improvement. While the Royal Commission did mention a finding by the Victorian Ombudsman that 54% of people in prison had a history of suicide attempts or self-harm, it did not consider issues related to suicides within the justice system in detail. As such, this submission will consider the Black Dog Institute's (BDI; Ridani et al., 2016) recommendations of effective suicide prevention strategies before reviewing the suicide prevention frameworks relevant to people in the justice system. Following this, we will review current suicide prevention strategies in the justice system and make recommendations for how suicide prevention can be improved in this population.

Findings from the Royal Commission into Victoria's Mental Health System Relevant to Justice Populations

The Royal Commission into Victoria's Mental Health System (RCiVMHS, 2021) described the fractured relationship between the justice and mental health systems in Victoria. To read Forensicare's submission to the Royal Commission, please see attached. Below, the findings and recommendations related to Forensicare's work in the prison and community forensic mental health services will be discussed briefly.

According to the Royal Commission's Interim Report (RCiVMHS, 2019), 61% of people who enter the Victorian prison system have a mental health diagnosis, and 35% are referred to a prison mental health service. This proportion is similar to the number of people on Community Corrections Orders who receive a mental health treatment condition (RCiVMHS, 2021), highlighting that as at 30 June 2019, 56% of people subject to a Community Corrections Order had a mental health treatment rehabilitation condition.

Remand and Mental Illness

In the RCiVMHS report (2021), Forensicare, Victoria Police, and the Magistrates' Court commented on how the justice system had become a last resort option for mental health treatment for people who were unable to access services in the community. The report specifically noted that people with mental illnesses were disproportionately charged with minor offences, often within the context of mental health episodes, which the Fitzroy Legal Service described as 'a health issue is transformed into a criminal justice issue' (RCiVMHS, 2021, p. 365).

The Royal Commission highlighted key mental health issues specific to remandees. The Royal Commission (2021) described that due to changes to the bail laws in 2018, remand has become increasingly common, even for minor offences. From 2013 until 2020, the remand population grew from 18% to 38% of the prison system (RCiVMHS, 2021).

In 2020, 45% of remandees were released without receiving a prison sentence (RCiVMHS, 2021). People who are mentally unwell are more likely to be remanded, even for minor offences, as the instability in their mental health or lifestyle may affect their ability to comply with conditions. Two thirds of all people on remand have a serious mental illness, highlighting that they are disproportionately affected by the changes to the law (RCiVMHS, 2021). The Royal Commission described the practice of 'therapeutic remand,' in which people with a serious mental illness were remanded to receive the treatment that they would be unable to access in the community. It is important to acknowledge that while people may benefit from the mental health support in prison, imprisonment, even for a short period of time, increases the likelihood of future reoffending (Jonson, 2010). As such, people with a serious mental illness may be receiving much needed mental health treatment but are placed at the risk of becoming trapped within the criminal justice system.

Treatment for Serious Mental Illnesses in Prison

The large number of people with mental illnesses in prisons presents a burden on the mental health services that are available. The Royal Commission (2021) discussed the need to improve access to compulsory treatment for individuals in the prison system. While in prison, individuals with a serious mental illness cannot receive compulsory (involuntary) treatment under section 67 of the Mental Health Act and must be transferred to Thomas Embling Hospital (Victoria's forensic mental health hospital) as security patients as outlined in Part 11 of the Mental Health Act. The Royal Commission has reaffirmed that it is not appropriate for compulsory treatment to be provided in a prison setting in Victoria (RCiVMHS, 2021). However, in 2018-2019, men who were legally eligible for compulsory treatment had to wait 38 days, on average, to be admitted to the forensic mental health hospital, while women had to wait nine days (RCiVMHS, 2021). The lack of access due to the individual's lack of consent to necessary treatment while they are waiting to be transferred to the forensic mental health hospital is potentially harmful to individuals who are acutely unwell and may also put the safety of staff at risk. The Royal Commission has identified a lack of capacity at Thomas Embling Hospital as the cause of these delays and has made recommendations (Recommendation 38, RCiVMHS 2021) to significantly expand the capacity of Thomas Embling Hospital to address the shortage of available beds.

Continuity of Care of Mental Health Treatment

To improve continuity of care for individuals with mental illnesses as they transition from the justice health to the public health system, Forensicare established the Community Integration Program (CIP) team. The CIP team provides assertive case management prior to and after release with serious mental illnesses. However, Forensicare's (2019) submission to the Royal Commission noted that the program only has the capacity to support 35 clients at a time, which is less than 0.5% of the prison system. This is despite research suggesting that upon release from prison, 26% of people reported being distressed about mental health issues (Australian Institute of Health and Welfare [AIHW], 2018).

A further barrier to ensuring continuity of care, even if an individual were to be referred to CIP, is the unpredictability of discharge dates and lack of community support. A significant proportion of remandees are released without receiving a sentence of imprisonment (RCiVMHS, 2021). Individuals are typically released on bail, often without any warning, making it difficult for services to develop transition plans.

Individuals who are released from prison without ongoing Corrections Victoria engagement (e.g., received 'time served' or completed their sentence in prison) have no ongoing requirement to engage in community forensic mental health services. As such, if they are not motivated to engage in release planning, they will have to navigate the transition from the justice to the public health system on their own.

Recommendations

The Royal Commission made recommendations to improve the mental health care of people involved with the justice system. We echo all the recommendations and specifically highlight the following:

1. To reduce the number of people with mental health issues being remanded, the commission recommended expanding the Assessment and Referral Court (ARC) to 12 Magistrates Courts, which support people with mental health issues and cognitive impairments.
2. Increase the number of beds at the forensic mental health hospital that is available to provide compulsory treatment to people in prison who are acutely unwell.
3. Expand the existing community forensic model to provide greater continuity of care for people in contact with or at risk of becoming in contact with the justice system
4. Establish programs to support people as they transition from correctional to mainstream mental health settings.

Relevant Suicide Prevention Frameworks

The Black Dog Institute's (BDI) Evidence-Based Systems Approach to Suicide Prevention

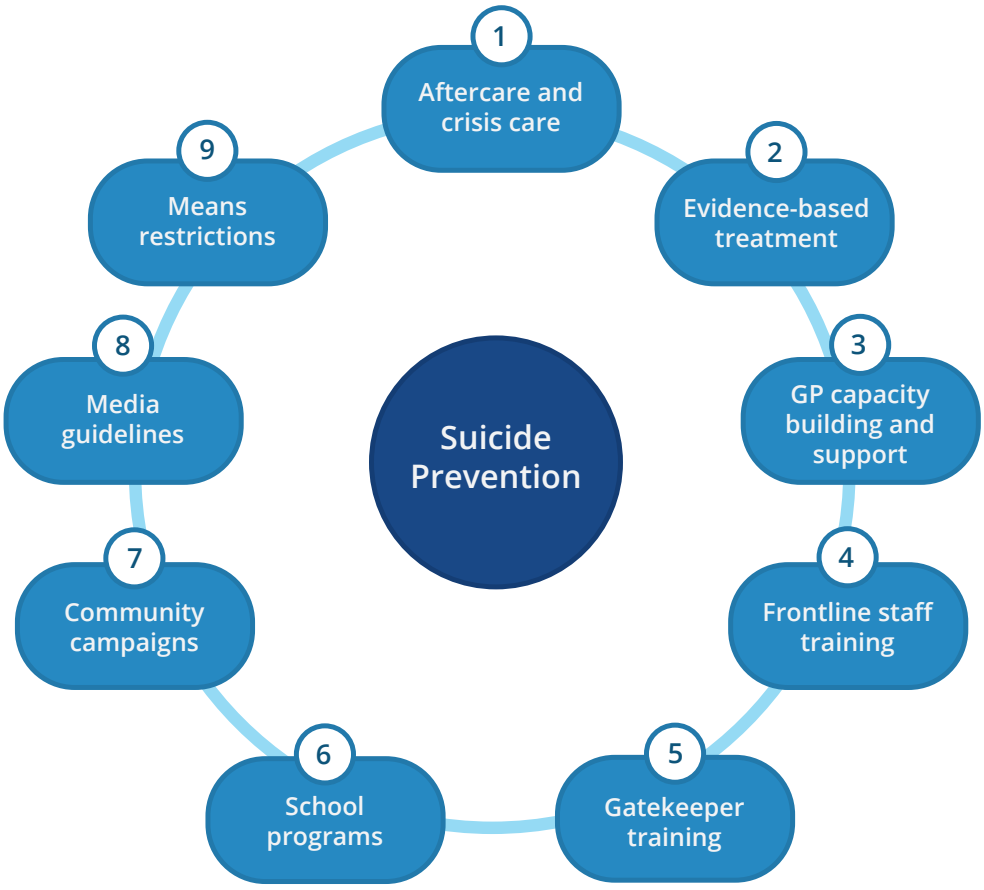
The BDI's systems approach to suicide prevention includes nine interventions that can be delivered at the individual level (strategies 1 to 5) and the population level (strategies 6 to 9; Ridani et al., 2016). The strategies are briefly described below (see Figure 1).

1. Provide continuity of care to individuals hospitalised for suicidal behaviour to reduce the likelihood of future attempts.
2. Psychosocial treatment (e.g., cognitive behaviour therapy or dialectical behaviour therapy) to reduce suicidal behaviour and ideation. Pharmacological treatment to help manage mental health symptoms.
3. Support GPs to develop the knowledge and skill to identify, assess, and provide brief intervention or referral services.
4. Increase frontline staff's confidence in assessing and managing risk, as well as referring to appropriate supports when necessary.
5. Identify local gatekeepers[1] (e.g., pharmacists, elders, clergy, teachers, counsellors, etc.), and increase mental health literacy and confidence in working with suicidal individuals.

1 BDI defines gatekeepers are those people who are likely to come into contact with at-risk individuals, and who might be influential in a suicidal person's decision to access care. They are naturally in a position to carry out informal observation of an individual, detect risk, and provide assistance. This includes frontline staff members such as police and emergency department staff.

6. Build mental health literacy, help-seeking behaviours, and teach students about warning signs and strategies to help peers.
7. Build mental health literacy and help-seeking behaviours while reducing stigma.
8. Adopt guidelines for responsible reporting of suicide deaths and attempts.
9. Restrict access to suicide means (e.g., firearms, toxic gases, jumping sites).

Figure 1. The Black Dog Institute's systems approach to suicide prevention (Ridani et al., 2016)



Ridani and colleagues (2016) made recommendations regarding which strategies should be prioritised based on the estimated reduction in suicide attempts and suicide deaths resulting from each strategy. Psychosocial intervention and coordinated or assertive aftercare programs were recommended given the estimated 8% and a 20% reduction in suicide attempts, respectively, as the result of these initiatives. Means restrictions, gatekeeper training, psychosocial treatment, and GP capacity building and support were also prioritised based on an estimated 4-6% reduction in suicide deaths.

Victorian Suicide Prevention Framework 2016–25

The Victorian Suicide Prevention Framework outlines five broad public health objectives with the aim of developing a whole-of-government approach for suicide prevention in the community. Notably, it mentions 'prisoners' as a vulnerable population but does not consider people involved in the justice system residing in the community as a vulnerable population.

Table 1. Victorian Suicide Prevention Framework

Domain	Objective	Target groups	Actions
Build resilience	Improve community and individual resilience	Whole population	• Enhance social cohesion • Foster a society inclusive of cultural and social identities • Safety and security of the environment • Access to healthcare • Reduce mental health stigma
		Student	• Focus on respectful relationships to enhance health and education outcomes while improving safety. • Safe Schools Coalition Victoria
Support vulnerable people	Improve identification and support to those at risk of suicide	Whole population	• Active monitoring of suicidal behaviour • Consultation with community groups regarding stressors
		LGBTI	• Develop specific mental health, school-programs, public health and stigma reduction interventions
		Aboriginal people	• Improve access to treatment for disengaged people
		Rural communities	• Programs for mental health, disaster recovery and community support.
		Family, friends and carers affected by suicide	• Services to involve family, friends, and carers in support of individuals at risk of suicide.
		Prisoners	• Continue to implement the Correctional suicide prevention framework
Care for suicidal person	Improve the response, treatment, and aftercare for individuals who engage in suicidal behaviours	People who engage in suicidal behaviour	• Provide assertive outreach support for individuals discharged from hospital following suicidal behaviour • Personal support in addition to mental health and medical care to ensure patients are supported during transitions in care. • Training for GPs, healthcare, and non-healthcare frontline staff (e.g., police)

The Correctional Suicide Prevention Framework

The Correctional Suicide Prevention Framework was developed in collaboration with Corrections Victoria, Justice Health and Forensicare, drawing upon international best-practice evidence to reduce suicide in prison settings (see Table 2). The framework is supported through workforce development, documentation and communication, monitoring and reporting, and research.

Table 2. Correctional Suicide Prevention Framework (adapted from Ogloff (2019) with permission).

Domain	Objective	Target groups	Actions
Universal strategy	Reduce access to the means of suicide, provide prisoner and offender education about suicide prevention and create a more supportive correctional environment	Whole prison population	• BDRP compliant cells • Provision of information at induction on suicide in prison and support available • Provision of information on how to refer other prisoners if concerned for a peer • Creating a more supportive correctional environment
		CCS	• Creating a more supportive correctional environment
Symptom identification	Know or be alert to high or imminent risk, adverse circumstances and potential tipping points, and provide support and care when vulnerability and exposure to risk is high	Whole prison population	• Assessment within 24 hours of initial reception • Observations throughout period in custody by custodial staff, other prisoners and external professionals
		Prisoners transferred from another prison	• Assessment within 24 hours of transfer
		Prisoners returned from court	• Assessment within 2 hours of return from court
		CCS	• Administration of Suicide and Self-harm Screening Checklist at induction and for offenders in Court who exhibit suicidal behaviour.
Treatment and support	Provide integrated professional care to manage suicidal behaviours, comprehensively treat and manage underlying conditions, improve wellbeing and assist recovery	Whole prison population	• Referral process • Assessment

Table 2. Correctional Suicide Prevention Framework (Continued)

Domain	Objective	Target groups	Actions
		Prisoners assessed as at immediate, significant or potential risk of suicide	• Mental health services • Risk Assessment Referral List and At Risk Register • Risk Management Plan • Coordination of prisoner management • Safe placement • Information sharing • Minimising opportunities to suicide • Transport • Acute intervention • Monitoring behaviours • Offending Behaviour Programs addressing adjustment to prison • Peer support • Re-assessment • Monitoring recovery
		CCS	• Referral to GP, community health services, or Area Mental Health Services. • Contacting mental health triage or 000 as required. • Monitoring behaviour and liaising with treatment professionals.
Ongoing care and support	Involve professionals, family, and friends to support offenders at the end of their order or prison term.	Prisoners	• Begin planning reintegration upon reception. • Refer prisons to transitional support services. • Create a prison discharge plan.
		CCS	• Refer offenders to community services.
Suicide incident management	Manage suicides and attempted suicides. Review incidents for enhancement.	Prison staff	• Detailed instructions regarding responses to incidents. • Corrections Victoria Internal Management Review • Corrections Victoria Formal Debrief • Justice Health death Review • Office of Correctional Services Review – Death Review • Coronial Inquest and Review
		CCS staff	• Detailed instructions regarding responses to incidents when offender attempted suicide and were either hospitalised or there was police involvement.

Table 2. Correctional Suicide Prevention Framework (Continued)

Domain	Objective	Target groups	Actions
Suicide incident impact management	Build strength, resilience, adaptation and coping skills to affected persons	Prisoners, staff, unduly affected by suicidal behaviour of a prisoner	• Critical Incident Support given to prisoners to assist in responding to grief and loss and their own elevated risk of suicide • Employee Assistance Program for prison staff
		CCS staff unduly affected by suicidal behaviour of an offender	• Employee Assistance Program for prison staff

Suicide Among Justice-Involved Individuals

It is difficult to ascertain the relationship between suicide and justice involvement (particularly beyond incarcerated individuals) in Australia due to limited research in the area and a preference for only researching individuals with a history of imprisonment, excluding individuals on community-based orders. However, research examining all suicides in the general population in England and Wales found that 36% of people who died from suicide in 2005 had been involved with the justice system at some point in their life (King et al., 2015). As such, despite the limited research, there appears to be a relationship between justice involvement and risk of suicide.

People in Custody

People within the prison system are at much greater risk for suicide relative to the general population (Fazel et al., 2016). The increased prevalence of suicide and self-harm within the prison system is theorised to be related to a combination of individual vulnerabilities, the prison environment, and the person's capacity to manage the stressors that they experience (Dear, 2008).

The Victorian Ombudsman (2015) found that more than half of all people in prison had a history of suicide attempts and self-harm, with remandees being at a heightened risk of suicide relative to sentenced prisoners (Austin et al., 2014; O'Driscoll et al., 2007). This is likely related to the significant number of stressors remandees face, including the challenge of adapting to a new prison environment. Additionally, during this heightened risk period, prison officers may not have had enough time to establish a relationship with the people in their care, which may negatively affect help-seeking behaviour and the identification of warning signs.

Within Victorian prisons, all staff are responsible for the identification of suicide risk.

As such, prison officers are provided with training to increase mental health literacy and their confidence and skill in assessing suicide risk. Mental health nurses are trained to assess suicide risk and develop management plans. There is a significant focus on means restrictions and crisis care by ensuring that cells do not have hanging points, and individuals who are acutely at risk of suicide are moved into safe cells, placed on an observation regime, and regularly assessed by mental health clinicians.

Gaps in suicide prevention strategies in prison

The Correctional Framework reiterates national strategy:

> *Suicide prevention in correctional settings is a shared responsibility: Suicide prevention is a shared responsibility across the broader community, prisoners, families and friends, health service providers, correctional staff and government agencies and departments (Australian Government Department of Health and Ageing 2008, p. 12)*

There is a risk that the recognition of shared responsibility contributes to confusion in responsibility, which was acknowledged by the Royal Commission report. There is a risk that this may also contribute to gaps in service delivery and supports in prison.

Within the prison system, while there is suicide prevention training for staff, there are no suicide aftercare services, and there are few evidence-based treatments provided directly to prisoners for prevention? prevent suicide and self-harm. The few psychosocial interventions that are available in Victoria are not system-wide, leaving many prisoners without the support they need. Moreover, whilst in custody, prisoners do not have access to the Medicare Benefits Scheme mental health care plan counselling. As aftercare programs and evidence-based treatments were prioritised strategies to reduce suicide attempts and/or deaths, it is important to consider ways to integrate these programs across the prison system.

Interventions tailored to forensic populations that enhance mental health literacy and help-seeking behaviour may be useful. While prisoners receive information regarding suicide upon reception into prison, this may not be sufficient to meaningfully increase understanding of mental health or a person's willingness to seek support. Both the Victorian Framework and the BDI's recommended strategies mention school programs as a strategy to enhance the mental health literacy and help-seeking behaviour of young people, as they are a group who are at an increased risk of suicide. As young people are required to attend school, school programs leverage this established linkage to reach a large number of potentially high-risk individuals. While the label of 'school program' may suggest that this strategy is not relevant to prison populations, prisons may be similar to schools in that they provide access to a high-risk population.

The use of peers to support prisoners' mental health has been used successfully within other jurisdictions. Within Canada and the UK, peer listener programs have been trialled to enhance help-seeking behaviour in prisons and build mental health literacy among a select group of prisoners. Peer listeners receive training on mental health literacy, communication skills, and what to do if suicide risk is identified.

Research suggests that the peer listener program increased help-seeking behaviour (Snow et al., 2002), resulted in a reduction in depressive and anxious symptoms (Davies et al., 1994; Hall & Gabor, 2004; Foster, 2011), and prisoners felt more comfortable opening up to listeners rather than prison officers because there was less of a power differential (Snow et al., 2006; Devilly et al., 2005). Additionally, the peer listeners noted that their confidence and skill in communicating and understanding mental health improved as a result of the program (Dhaliwal & Harrower, 2009; Foster, 2011). Due to the low number of suicides in a prison population, it can be difficult to determine the effect of interventions on suicides in prison. However, Hall and Gabor (2004) noted that in the years before the listener program was introduced in a Canadian prison, the suicide rate was 131 deaths per 100,000 (4 suicides in 5 years). During the program, the rate of suicides dropped to 66 per 100,000 (2 suicides in 2 years) but increased to 165 per 100,000 (2 suicides in 2 years) after the program's termination. These results provide tentative evidence that the peer listener program had a positive effect on suicide reduction.

Recommendations

The following recommendations are made to enhance suicide prevention within prison settings:

1. The Commonwealth should provide funding for an initiative that would provide greater access to psychosocial interventions to reduce emotional dysregulation, distress, and suicidal behaviour among people in prison. This should include Medicare Benefits Scheme funding to prisoners. This would be equivalent to supports provided to people in the general community.
2. Improved aftercare support for individuals who have engaged in self-harming and suicidal behaviour.
3. Trialling peer listener programs to improve help-seeking behaviours of the whole prison population and enhance the mental health literacy of the 'listeners'.

People Released from Prison

Individuals released from prison are at heightened risk of suicide, self-harm, and overdosing (AIHW, 2015; Borschmann et al., 2017a; Borschmann et al., 2017b; Forsyth et al., 2018; Karminia et al., 2007a; Karminia et al., 2007b; Spittal et al., 2014). Spittal and colleagues (2014) found that released prisoners were 5-14 times more likely to suicide than the general population. Individuals who were admitted to a prison psychiatric unit are at particularly high risk upon release, with the rate of suicide reaching 1,234 per 100,000 person-years in the first two weeks after release from prison, highlighting the critical need for continuity of care among this vulnerable population.

Although people who are released from prison are at heightened risk of suicide and self-harm, this population is noticeably absent from the Victorian Suicide Prevention Framework. Notably, however, the national suicide prevention strategy identifies people in contact with the justice system as vulnerable in the LIFE Framework. The Victorian framework only includes references to prisoners but does not consider justice-involved individuals who are residing in the community (i.e., outside of custody).

The Correctional suicide prevention framework provides some guidance regarding working with individuals released from prison. However, this is limited to those who received a parole or community corrections order following release, which means that people who received 'time served' or completed their full sentence have fallen through the gaps of current suicide prevention frameworks. As they are no longer justice-involved and not mandated to attend any treatment, they would be under the remit of Department of Health as voluntary clients. As confirmed by the Royal Commission's Recommendation 37, there is more work to be done on transition. Greater consideration is needed for how individuals released from prison without ongoing Corrections Victoria involvement can be supported to reduce their risk of suicide.

The Correctional suicide prevention framework primarily focuses on ensuring that justice-involved individuals in the community feel supported and that corrections staff have good mental health literacy, are skilled in suicide risk assessment, and refer to other services as required. Considering that individuals released from prison are at the greatest risk of suicide in the first month post-release (Spittal et al., 2014), case managers face a considerable challenge. They must try to identify suicide risk in people who they might have only just met, even though they are not mental health professionals.

Gaps in suicide prevention upon release from prison

Psychosocial interventions for suicide are not provided by Corrections Victoria or Forensicare for justice-involved people in the community. As such, justice-involved individuals must access mainstream suicide prevention initiatives, even though the Victorian framework does not include specific training for public health staff to help them engage effectively with this vulnerable population. Further, individuals released from prison have relatively low levels of engagement with mental health services (Thomas et al., 2016) and primary care providers (Young et al., 2015). Some of the reasons for this include: failing to meet program inclusion criteria due to justice-involvement, cost if accessing a private psychologist, practical concerns that make attending programs difficult (e.g., lack of access to mobile phones, transportation), stigma or other psychological barriers to help-seeking (Ballarat Community Health, 2020).

Coordinated aftercare support is also not a strategy that is listed in the Correctional Suicide Prevention Framework, despite being prioritised by the BDI (Ridani et al., 2016). Within Victoria, there has recently been significant investment in Hospital Outreach Post-suicidal Engagement (HOPE) initiatives to provide aftercare support for people released from hospital following suicidal behaviour. Considering the similarities in suicide risk factors between those released from prison (Pratt et al., 2010; van Dooren et al., 2013) and from the hospital (Irigoyen et al., 2019; Larkin et al., 2014) following suicidal behaviour, people released from prison may benefit from a similar intervention. An assertive outreach intervention that respectfully persists to help engage clients in treatment after release from prison may be particularly useful for this population, given the barriers to engagement and the high-risk period immediately preceding release from prison.

In Victoria, there are currently two services that have started to bridge the gap in mental health service provision for justice-involved individuals, but they would need to be adapted to provide coordinated aftercare support for suicide prevention.

The first is the Forensic Mental Health in Community Health (FMHiCH) program, which links individuals on community orders into mental health support with clinicians who have specialistic forensic training. The second is Forensicare's CIP program, which provides in-reach support to engage clients and establish a transition plan prior to release from prison. Neither program has provided training to the clinicians regarding suicide risk among released prisoners. Additionally, the FMHiCH program does not include assertive outreach, and the referral pathways are not set up to engage clients immediately upon release, during the highest risk period. While the CIP model may be best suited to suicide prevention, it can only support 0.5% of the prison system at a time.

Recommendations

The following recommendations are made to improve suicide prevention for people released from prison:

1. Train GPs and frontline health and social services staff regarding additional considerations for risk assessment and management of people released from prison.
2. Provide coordinated aftercare support programs for individuals released from prison who are at risk of suicide. These programs can draw upon the evidence-based Hospital-Outreach Post-Suicidal Engagement (Hope) initiatives in Victoria.

People on Community Corrections Orders

There are limited data on suicides among individuals who are on community corrections orders in Australia, as research has predominantly focused on individual who are, or have been, imprisoned. Research from the United Kingdom (UK) suggests that the annual rate of suicide for men on community orders was 143 per 100,000, which was approximately 10 times greater than the suicide rate in the general population (Phillips et al., 2018). King and colleagues' (2015) found that when examining all suicides in England and Wales in 2005, 13% of people who died by suicide were on or had been on a community corrections order in the 12-months prior. Despite the high rate of community corrections involvement among those who die from suicide (35%), there is relatively no investment in programs that leverage the established involvement with the justice system to link these typically difficult to engage (Thomas et al., 2016) populations in suicide prevention activities.

Similar to working with people on parole, corrections staff assess risk and can direct their clients to other supports as needed. The Correctional Suicide Prevention Framework recognises that the duty of care of Corrections Victoria differs depending on the intensity of the order (e.g., a lower duty of care in suspended orders relative to intensive community corrections orders). However, with respect to the correctional environment, there is a significant but graduated duty of care and responsibility to prisoners and offenders placed on the State, with the State having greater obligations to protect people they hold in custody and a lesser requirement to intervene when offenders are under community supervision and free to access publicly available services.

Gaps in suicide prevention among people on community orders

Drawing upon recommendations from the BDI's multisystemic approach to suicide prevention, there are clear gaps in the suicide prevention initiatives for people in the community. Despite being a high-risk population, there are no aftercare interventions or evidence-based treatment programs that have specific entry points for the high-risk individuals on community-based corrections orders. While justice-involved individuals can access many of the supports for the general population, the lack of justice-specific entry points disregards the heightened risk of the population and fails to leverage established service linkages to improve engagement among a difficult to reach group.

The Correctional Framework openly states:

As well as risks associated with imprisonment, the first few weeks immediately following release from prison is a time of high risk of suicide with this group at greater risk than the general population.

However, there is a lack of acknowledgement in the Victorian Framework, and the National Strategy, if there could be a greater focus on the needs of justice-involved individuals, given their heightened risk of self-harm and suicide. Unfortunately, there is a lack of acknowledgement of the heightened suicide risk among people involved with the justice system within Victorian and national suicide prevention frameworks. Under the Victorian Suicide Prevention Framework, the only justice-involved people mentioned are "prisoners" who are considered to be the responsibility of Corrections Victoria rather than the public health services. This conflicts with Commonwealth LIFE framework, which emphasises that suicide prevention is a shared responsibility across the broader community, families and friends, professional groups, and nongovernment and government agencies. As such, it is possible that health providers, including some GPs, frontline staff, or other professionals that come into contact with justice-involved individuals are aware of this high-risk population or have received training in how to best support them.

Recommendations

1. Consideration of justice-involved populations within national and state-wide suicide prevention frameworks

2. Collaboration with the mental health service to establish improved pathways to support people on community-based orders.

Conclusion

Justice-involved individuals experience significantly worse mental health and are at an increased risk for suicide and self-harm (RCiVMHS, 2021). As data from the Royal Commission show, the prison mental health system is supporting a large number of people who cannot access appropriate treatment in the community. Despite the potential short-term benefits of receiving appropriate treatment, due to poor continuity of care, treatment progress is often not retained after release from prison as people struggle to engage with public mental health services. As such, people become trapped in the criminal justice system.

The BDI was published before the Victorian Suicide Prevention Framework and the Correctional Suicide Prevention Framework. As such, there are now considerable gaps, in those prevention frameworks when compared to BDI's best-practice suicide prevention recommendations. There is an opportunity to update the prevention frameworks accordingly. Within the prison context, Corrections Victoria has a duty of care to ensure the safety of the people in their care. As such, significant effort is dedicated to crisis care, staff training, and removing access to means. In contrast, Corrections Victoria has a graduated and lower duty of care within the community context, with less control and fewer options for dealing with suicide prevention, as it is based on case management rather than full duty of care in a custodial environment. As such, individuals who are released from prison or who are on community-based orders have largely fallen through the cracks of two suicide prevention frameworks.

Across the justice system in Victoria – and across Australia more widely – there is limited access to evidence-based interventions, aftercare services, and programs to enhance mental health literacy and help-seeking behaviour. Greater investment in and expansion of the Forensic Mental Health in Community Health program and Community Integration Program may help to bridge the gaps in mental health and suicide prevention service provision. Additionally, leveraging the support of peer listeners may enhance help-seeking and mental health literacy among people in prison.

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