Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF DISTINGUISHED PROFESSOR JAMES ROBERT OGLOFF AM

I, Distinguished Professor James Robert Ogloff, Executive Director at the Victorian Institute of Forensic Mental Health, of Yarra Bend Road, Fairfield VIC 3078, say as follows:

1 I make this statement in my personal capacity but with authorisation from my employers, the Victorian Institute of Forensic Mental Health (**Forensicare**) and the Centre for Forensic Behavioural Science (**CFBS**)/Swinburne University of Technology (**SUT**).

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

BACKGROUND

3 My full name and title, together with postnominals, are as follows: Distinguished Professor James Robert Ogloff AM, B.A., M.A. (Clin. Psyc.), Juris Doctor, Ph.D., FCCP, FCFP, FAPS.

4 I have the following qualifications:

(a) Bachelor of Arts in Psychology;

(b) Master of Arts in Clinical Psychology;

(c) Juris Doctor with Distinction; and

(d) Ph.D in Psychology and Law, with specialised training in law/psychology, forensic psychology, and mental health policy.

5 I also hold Fellowships with the Canadian Psychological Association, the American Psychological Association, and the International Association of Applied Psychology.

6 My professional experience includes previously holding the following roles:

(a) Director, CFBS, Monash University;

(b) Foundational Professor of Clinical Forensic Psychology, Monash University;

(c) University Endowed Professor of Law and Forensic Psychology, Simon Fraser University (British Columbia, Canada);

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

(d) Director of Mental Health Services, Ministry of the Attorney General, Corrections Branch (British Columbia, Canada);

(e) Chair, Mental Health Review Panel, British Columbia Review Panel (British Columbia, Canada); and

(f) Consultant Forensic Psychologist, British Columbia Forensic Psychiatric Services Commission (British Columbia, Canada).

7 I have also served on a number of relevant boards and committees, including for example:

(a) Member of Forensic Mental Health Advisory Board (formerly Criminal Justice and Mental Health Systems' Planning and Strategic Coordination Board);

(b) Sessional member, Justice Health Ministerial Advisory Committee; and

(c) Member of Board of Directors, Justice Health and Forensic Mental Health Network, New South Wales (**NSW**) (2012 – 2015).

8 Attached to this statement and marked 'JO-1' is a copy of my Curriculum Vitae.

9 The roles I currently hold include the following:

(a) Executive Director of Psychological Services and Research, Forensicare; and

(b) University Distinguished Professor and Director of CFBS, SUT.

10 As Executive Director of Psychological Services and Research at Forensicare, my responsibilities include the following:

(a) overseeing the delivery of psychology services across Forensicare;

(b) overseeing the research program across Forensicare;

(c) member of the Executive Committee of Forensicare;

(d) assistance with the provision of vital service development advice; and

(e) psychological assessment of people accused of offending, offenders, forensic patients,[1] as well as secondary consultation and supervision of staff, students, and registrars in these areas.

11 As Director of CFBS, my responsibilities include the following:

(a) overseeing the operation of the research, education, training and consultation provided by the CFBS;

[1] A forensic patient is person detained or placed on a custodial supervision order under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).

(b) conducting research in forensic mental health and forensic behavioural science;

(c) overseeing courses and training programs in forensic mental health, forensic psychology, forensic psychiatry, forensic mental health nursing, and forensic behavioural science;

(d) supervising doctoral students and postdoctoral research fellows; and

(e) member of the Executive Committee, School of Health Sciences.

CFBS (OPERATED BY FORENSICARE AND SUT)

12 As noted in the Interim Report of the Royal Commission into Victoria's Mental Health System (**Royal Commission**) (p. 400), the CFBS is operated by Forensicare, in partnership with SUT. I was quoted in the Interim Report as explaining the direct benefits of this partnership:

> … the research undertaken by Forensicare and the Centre for Forensic Behaviour Science translates to service development and evaluation. Our work has transformed people's understanding in a number of areas relating to mental illness and offending. This work is used to continuously improve evaluation and intervention work within Forensicare and in the broader forensic mental health, justice and mental health fields. In short, it helps ensure better outcomes for our consumers and contributes to a safer Victorian community.[2]

Forensicare

13 As the state-wide forensic mental health service, Forensicare was initially established by an amendment to the *Mental Health Act 1986* (Vic). Forensicare is a statutory agency responsible for the provision of adult forensic mental health services in Victoria. Forensicare employs almost 800 staff members, 85% of whom are clinicians (444 nurses (of whom 389 are registered psychiatric nurses), 71 medical practitioners (39 forensic psychiatrists, 31 psychiatric residents, and one medical officer), 73 psychologists (a blend of clinical, forensic and clinical/forensic psychologists), 33 social workers, 28 occupational therapists, one art therapist, and one social welfare officer). The organisation also has professional placements across all of the disciplines.

14 Forensicare is governed by a Board of up to nine Directors who are appointed by the Governor in Council for 3-year terms on the recommendation of the Minister for Mental Health. The Board is responsible for establishing the strategic direction and governance framework of the organisation and monitoring compliance. Forensicare provides clinical services across three directorates: Prison Mental Health Service, Thomas Embling Hospital (**TEH**), and the Community Forensic Mental Health Service (**CFMHS**). The

[2] Victorian Institute of Forensic Mental Health, *Annual Report 2018-19*, August 2019, p. 36.

Prison Mental Health services provide forensic mental health services across all of the public and private prisons in Victoria. Mental health nurses screen all incoming prisoners for mental illness upon admission and a variety of services are then provided across the system. These include “bed-based” services as well as “out-patient” services within the prisons. The bed-based services include a 141 spaces across four Victorian prisons. Outpatient services, provided to prisoners residing in units other than the custodial mental health units, include psychiatry, mental health nursing and psychology sessions across most prisons, as well as the Mobile Forensic Mental Health Service at the Metropolitan Remand Centre. There are also 100 outpatient spaces available at Ravenhall Prison.

15 The TEH includes 136 beds configured across seven units in a high-secure precinct and low-secure unit. The units comprise an 8-bed psychiatric intensive care unit for prisoners requiring involuntary psychiatric care, two 17-bed male acute units, one 12-bed female acute unit, one 22-bed long stay male unit, a 24-bed mixed gender sub-acute unit, and a 20-bed mixed-gender rehabilitation unit. Male and female patients in the 16-bed low-secure unit are accommodated in independent living unit flats outside of the secure perimeter, but still confined within a wire mesh fence. The TEH provides the panoply of forensic mental health assessment and intervention services for the state, and includes prisoners transferred from prison for involuntary psychiatric care as well as forensic psychiatric patients.

16 The CFMHS includes a community treatment and transition team to help integrate prisoners living with mental illnesses back into the community and a similar service for forensic patients transitioning back into the community after discharge from the TEH. In addition, it operates a Problem Behaviour Program (**PBP**) that provides assessment and/or treatment to people in the criminal justice system – or at risk of entering the criminal justice system – as a result of their “problem behaviours” (e.g., sexual offending, stalking, threatening, fire-setting, violence). Clients are drawn both from the mental health system and the criminal justice system. The CFMHS also operates the Victoria Fixated Threat Assessment Centre in partnership with Victoria Police to help identify and manage fixated threateners and lone actor grievance fuelled violence perpetrators. The CFMHS also coordinates a clinical forensic specialist service for state-wide area mental health services for adults and youth. Finally, the CFMHS conducts the pre-trial and pre-sentence assessments for the courts as well as assessments for the parole board.

17 In addition to providing specialist clinical services through an inpatient and community program, Forensicare is mandated (under the *Mental Health Act 2014* (Vic) (MHA)) to provide research, training, and professional education. Specifically, the statutory functions and powers of Forensicare include the mandate “to conduct research in the fields of forensic mental health, forensic health, forensic behavioural science and associated fields” and to “promote continuous improvements and innovations in the

provision of forensic mental health and related services provided in Victoria" (MHA, s. 330(g) & s. 330(h)). Forensicare's mandate to conduct research is quite unique among forensic mental health services in Australia. All too often, a tension exists between research and practice in clinical services, and forensic mental health services are typically no different. Within Forensicare, however, there is a critical nexus between science and practice – with each informing the other to ensure excellence and evidence-based practice in our service. Ongoing research in forensic behavioural science and forensic mental health is critical owing to the highly specialised nature of the field and the rapidly emerging knowledge in the field.

SUT

18 SUT was founded as a technical college in 1908. It gained university status in 1992 (*Swinburne University of Technology Act 1992* (Vic)). The university has more than 23,000 students, including almost 4,000 graduate students. SUT is primarily located on a campus in Melbourne, but has satellite campuses in the state and one in Sarawak, Malaysia. The university is organised into three faculties: Business and Law; Health, Arts and Design; and Science, Engineering and Technology. The CFBS is located in the School of Health Sciences within the Faculty of Health, Arts and Design.

The CFBS

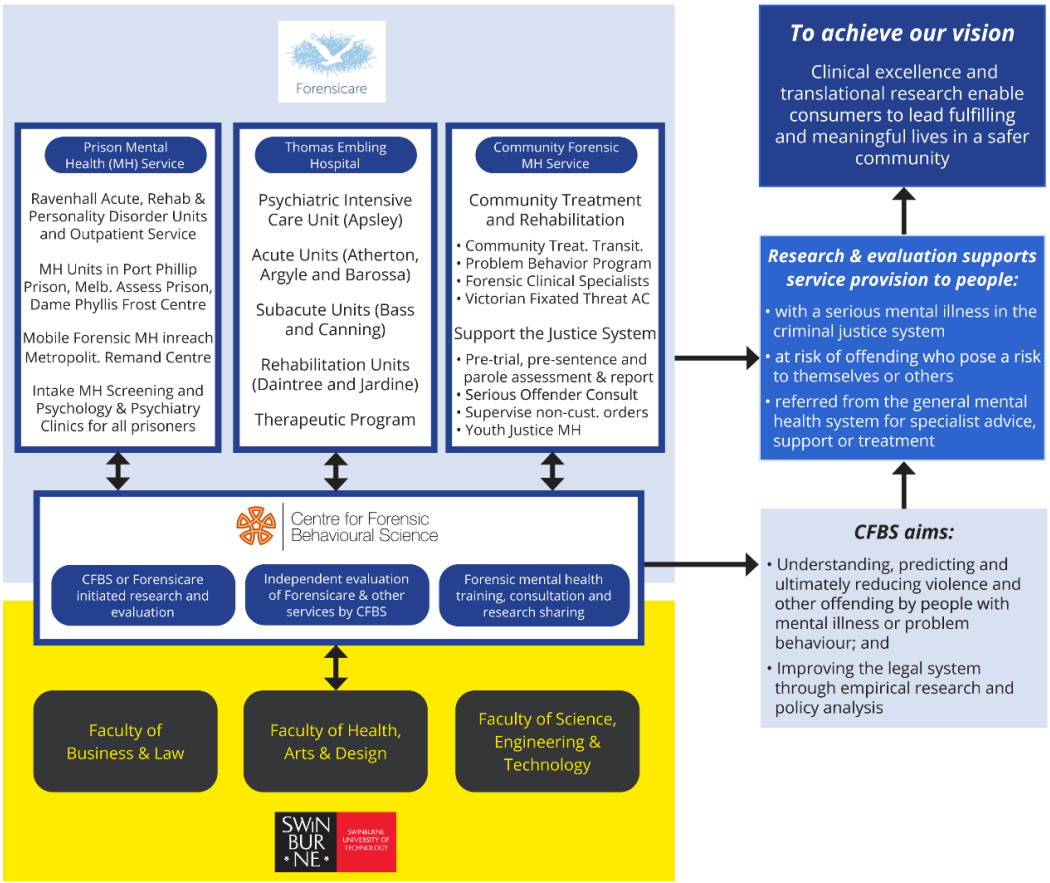
19 Despite the legislative mandate that Forensicare conduct research, Forensicare has traditionally received very little government funding to further this responsibility. From its inception, Forensicare has worked with a range of universities to develop a research capacity in forensic mental health and related fields. The relationships have ensured that Forensicare attracts academics and research funding to undertake research relevant to Forensicare's clinical work. The CFBS operates under the auspices of SUT in collaboration with Forensicare. The CFBS serves as the research arm of Forensicare, conducting independent research and facilitating the research enterprises of Forensicare, and as a research and teaching centre in the Faculty of Health, Arts and Design at SUT.

20 When I was appointed to my role at Forensicare in 2001, I worked closely with Professor Paul Mullen and Mr. Michael Burt, the inaugural CEO of Forensicare. They shared a vision to establish Forensicare as a centre for excellence in forensic mental health and they set out to do so. The establishment of the CFBS in 2006 allowed for the further development of academic and educational excellence in forensic mental health and forensic behavioural science. I have served as the Director of the CFBS since its inception.

21 Forensic behavioural science concerns the study of factors that underlie offending and human behaviour in the legal system. Forensic behavioural scientists are interested in

understanding how individual characteristics interact with the environment to produce criminal behaviour, and what might be done to prevent such behaviour in the future. Forensic behavioural science informs practice in the field of forensic mental health including the disciplines of psychology, psychiatry, mental health nursing, health sciences, social work, and occupational therapy. These professionals are responsible for the assessment and treatment of those who are, or have the propensity to become, mentally disordered, and whose behaviour has led, or could lead, to offending. More broadly, forensic behavioural science concerns the way in which people who offend are identified and managed by law enforcement, courts, and criminal justice systems. It includes both clinical and experimental approaches to understanding the legal system.

22 The diagram below, which I have prepared, depicts the relationships between the CFBS and Forensicare:



23 The CFBS operates both as a research centre within the Faculty of Health, Arts and Design at SUT and as the research, education, and training arm of Forensicare. The CFBS is comprised of researchers and clinicians with backgrounds in clinical and forensic psychology, forensic psychiatry, forensic mental health nursing, criminology, and law.

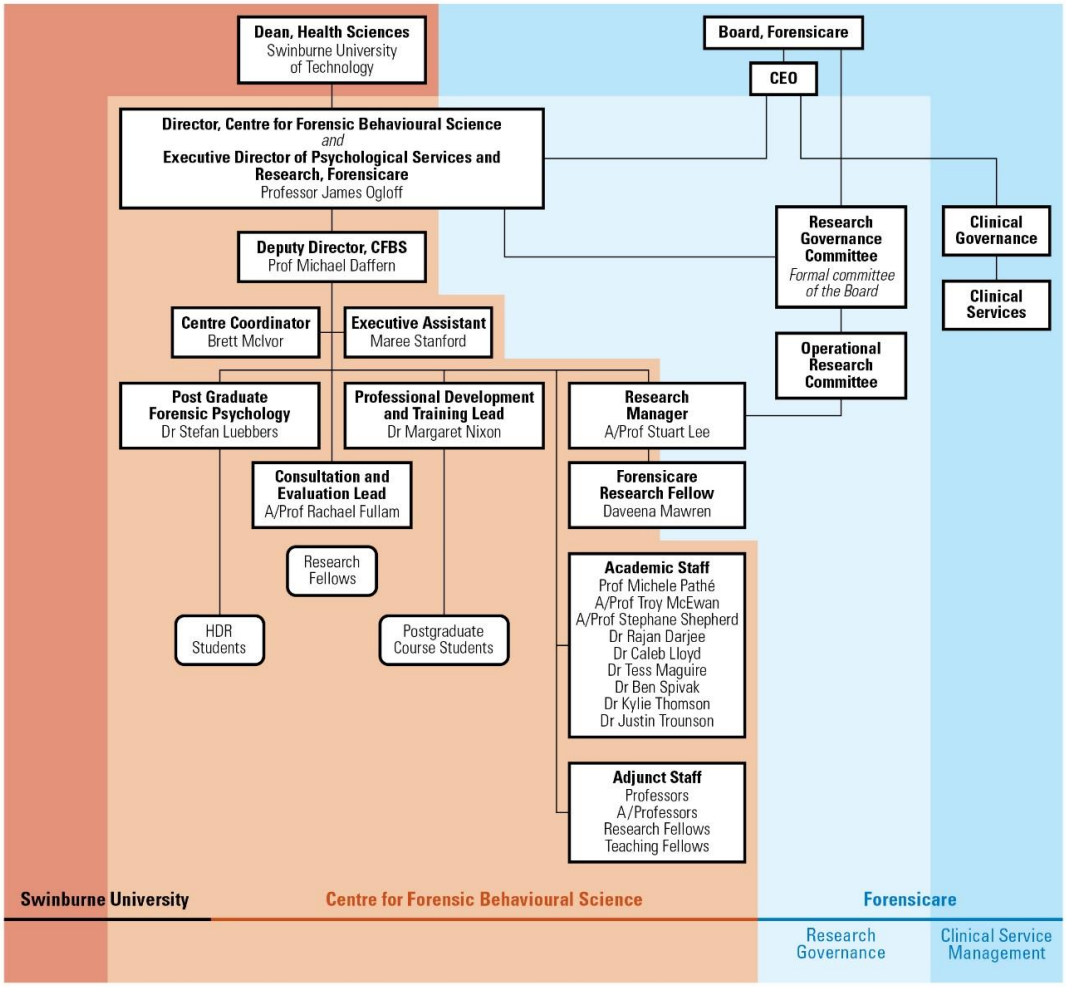
24 As noted in the figure above, the CFBS aims include:

(a) understanding, predicting, and ultimately reducing violence and other offending by people living with mental illness or problem behaviour; and

(b) improving the legal system through empirical research and policy analysis.

25 The figure below, which I have prepared, depicts the organisational structure of the CFBS and the relationship to SUT and Forensicare:

Forensicare and CFBS organisational arrangements



26 The progress and success of the CFBS is measured by both academic metrics and clinical service priorities. Academic monitoring includes the number and quality of publications, research grants and other funding awarded, impact and engagement, and student numbers and completions. The clinical service priorities are included to ensure that the CFBS satisfies the strategic research needs for Forensicare, including the need for translational research and service evaluation. There is a goal, as well, to increase the involvement of Forensicare staff members and consumers in research and to help ensure that the Forensicare culture continues to reinforce the importance of evidence-based

practice and continuing clinical excellence. More than 25 staff members from Forensicare, across all disciplines, have honorary appointments with the CFBS.

27 Beyond the research and evaluation roles of the CFBS, we play a unique role in Australia in education, professional training and development. Although there are pressures and limitations on the mental health workforce generally, there are many education providers in that space. For example, in Victoria alone, each university provides postgraduate training in clinical psychology, several more provide training in mental health nursing, occupational therapy, and social work. The state has three medical schools that train medical practitioners who may then choose to engage in specialised training in psychiatry. The CFBS, through SUT, is the only provider for postgraduate education and training in forensic mental health.

28 In respect of formal university training and courses, the CFBS operates two successful streams of post-graduate programs: forensic behavioural science and forensic psychology. The Graduate Program in Forensic Behavioural Science offers a range of courses in forensic mental health and forensic behavioural science that lead to seven possible degrees: 1) Graduate Certificate in Forensic Behavioural Science; 2) Graduate Diploma in Forensic Behavioural Science; 3) Masters of Forensic Behavioural Science; 4) Graduate Certificate in Forensic Mental Health Nursing; 5) Graduate Diploma in Forensic Mental Health Nursing; 6) Graduate Certificate in Forensic Psychiatry; and 7) Graduate Certificate in Specialist Forensic Assessment and Risk Management. Each of the courses comprise a unique blend of the 15 subjects offered by the CFBS:

(a) Core Skills in Forensic Practice;

(b) Fundamentals of Criminal Law Process;

(c) Working in Corrections and Youth Justice;

(d) Principles of Violence Risk Assessment and Management;

(e) Advanced Violence Risk Assessment and Management;

(f) Mental Disorder and Offending;

(g) Working with Difficult Personalities in the Forensic Context;

(h) Substance Misuse and Offending;

(i) Trauma and Offending;

(j) Development, Developmental Disability and Offending;

(k) Problem Behaviours 1 (violence, threats, intimate partner violence and fire-setting);

(l) Problem Behaviours 2 (stalking, abnormal complaining, and harmful sexual behaviours towards children and adults);

(m) Forensic Mental Health Nursing (restricted to nurses);

(n) Forensic Mental Health Nursing Practice (restricted to nurses); and

(o) Psychiatry in Forensic Contexts (restricted to psychiatrists).

29 These are full fee paying programs. More than 320 students enrol in the courses annually. Students are drawn from all of the mental health disciplines (i.e., nursing, psychology, psychiatry, social work, occupational therapy) as well as those who work in the broader sector. While most students are from Victoria, approximately one-third are from interstate, with growing numbers of overseas students. The courses are all conducted online, with a possible field school occurring once each semester.

30 Students can also enrol in a single subject to enhance their knowledge and skill in a particular topic.

31 The Graduate Program in Forensic Psychology provides training accredited by the Australian Psychology Accreditation Council leading to either a Graduate Diploma in Forensic Psychology or a Doctor of Psychology (Clinical and Forensic Psychology). The Graduate Diploma in Forensic Psychology is a part-time 2-year program that enables registered psychologists with endorsement in another area (e.g., clinical psychology, clinical neuropsychology) to undertake coursework and supervised clinical forensic placements to satisfy the requirements to be endorsed as a forensic psychologist. The Doctor of Psychology (Clinical and Forensic Psychology) is a 4-year program that provides clinical, research, and supervised placement training leading to endorsement as both a clinical psychologist and forensic psychologist. This program is unique in Australia. The intake for these courses combined is 8 to 9 students per year, with approximately 25 to 30 students in residence at any given time.

32 As part of its mandate for professional training and development, the CFBS offers a range of free and paid training opportunities. This work is carried out in a number of ways:

(a) seminar series;

(b) annual public lecture;

(c) training contracts with public and not-for-profit services seeking professional development in forensic mental health and forensic behavioural science; and

(d) fee-based training workshops.

The Future of the CFBS

33 Funding for the CFBS is an ongoing struggle, without ongoing government commitment to research funding. While basic funding is provided by SUT (ongoing staff costs, operating costs, equipment, and rent), supplemented by Forensicare (cross-appointed

staff, contribution to rent), most of the income is generated from research, consultation and training. As a result, most of the CFBS staff are funded on casual contracts, dependent upon income generated by research grants and contract research. This makes it exceedingly difficult to maintain a strategic research plan and to provide training necessary to enhance the Victorian mental health workforce's capacity in relevant areas. For example, at the present time, even the location of the CFBS is uncertain with a lack of space for accommodation at Forensicare. Space for the CFBS is being factored into the expansion and redevelopment plans for the TEH.

34 Going forward, I strongly endorse the recommendation made in the Interim Report to establish the Collaborative Centre for Mental Health and Wellbeing (**Collaborative Centre**). It was in the discussion of the Collaborative Centre that the CFBS and its role with Forensicare and SUT was used as an example of a partnership between clinical and academic organisations to help ensure excellence in forensic mental health. The CFBS also enjoys strong relationships with the Department of Justice and Community Safety (**DJCS**), having collaborated in research across many divisions of the Department: Corrections Victoria, Youth Justice, Court Services, and Justice Health.

35 It is my view that CFBS, considering its relationship with Forensicare and SUT, should be formally established as a partner or 'node' of the Collaborative Centre to further the important work in forensic mental health. Indeed, the aims of the Collaborative Centre to close the knowledge translation gap and to establish models for knowledge sharing are as important – if not more important – in forensic mental health than general mental health given the 'double stigma' people living with mental illness experience when they also come into contact with the criminal justice system. Working as part of the Collaborative Centre, the CFBS would continue to develop academic and clinical excellence in forensic mental health which drives best practice. Such a partnership would enable the shared vision of the CFBS and Forensicare as an innovation hub in forensic mental health and forensic behavioural science for Victoria and Australia.

36 In addition to the development of knowledge generation and translational research in forensic mental health, the education and training provided by the CFBS is a significant asset going forward as the state works to better equip the mental health workforce – and justice – to meet the needs of people living with mental illness who pose a risk of harm to others. There is an opportunity going forward for the CFBS and Forensicare to play a role in educating and supporting mental health professionals in risk assessment, risk management, and the secure care for people living with serious mental illnesses who are at risk for harmful behaviour to others.

MENTAL ILLNESS AND OFFENDING

In relation to offenders in the criminal justice system who are living with mental illness:

a. Impact of mental illness on the nature of offences committed

37 There has been extensive research in Victoria (including at CFBS) and internationally as to the relationship between mental illness and offending. The research has mostly been in relation to serious mental illnesses, as high prevalence disorders (for example, anxiety and depression) have weaker and more variable relationships with offending.

38 In particular, there was a series of studies initiated in the late 1990s by Professor Paul Mullen and later at CFBS that focussed on mental illness and offending. In 2004, for example, Wallace and colleagues[3] found that almost 22% of patients identified in the Victorian public mental health system with schizophrenia in five year cohorts from 1975-2000 have a history of offending at some point in their lives. Moreover, 8% of patients with schizophrenia in the sample had a criminal conviction for a violent offence.[4] Patients with schizophrenia were three to five times more likely than those in the community without schizophrenia to have convictions for general offending, and violent offending, respectively. These percentages increased three and four fold when the patients with schizophrenia also had a known substance abuse problem.

39 More recently, we extended the earlier work using a case-linkage design to compare patterns of violence and offending between 4,168 people in Victoria diagnosed with schizophrenia between 1995 and 2010 drawn from the public mental health register (**Consumer Group**), both with and without comorbid substance-use disorders, and a randomly selected community control group (**Community Group**) comprising 4,641 people who had never been diagnosed with schizophrenia.[5] To compare rates of offending between the Consumer Group and the Community Group, we obtained their criminal histories from Victoria Police and linked their police records with the data obtained from the public mental health register.

40 In summary, the study revealed that a significant majority of people living with serious mental illnesses (Consumer Group) did not commit any offences, but they were about 3.5 times more likely to commit non-violent offences and 4.5 times more likely to commit

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3 Wallace, C., Mullen P. E., & Burgess, P. (2004). Criminal offending in schizophrenia over a 25-year period marked by deinstitutionalization and increasing prevalence of comorbid substance use disorders. *American Journal of Psychiatry, 161*, 716-727.

4 *Ibid*.

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

violent offences as compared to the Community Group.[6] In particular, the study found that:

(a) 75% of people in the Consumer Group, as compared to more than 90% of people in the Community Group (noting that this percentage is naturally higher), did not commit any offences;

(b) 25% of people in the Consumer Group, as compared to 8.5 to 9% of people in the Community Group, have committed offences (whether violent or non-violent);

(c) 10% of people in the Consumer Group, as compared to 2.4% of people in the Community Group, have committed violent offences;

(d) 12% of people in the Consumer Group, as compared to 3.7% of people in the Community Group, have been convicted as the perpetrator of a family violence offence; and

(e) 10% of people in the Consumer Group, as compared to 3% of people in the Community Group, have been subject to a restraining order.

41 People living with mental illness are also more likely to be behaviourally dysfunctional and have comorbidities such as substance abuse, intellectual disabilities and personality disorders. The impacts of these comorbidities are discussed in paragraphs 52 to 62 below.

b. Impact of mental illness on violent offending

42 As noted previously (see paragraph 40), the vast majority of people with serious mental illness do not commit violent offences. Unfortunately, though, as a group, people living with serious mental illness are approximately three to five times more likely than others in the community to commit violent offending.

43 The CFBS previously considered all of the homicides committed over an eight year period in Victoria, and found approximately 9% of homicide offenders had been diagnosed with schizophrenia – which was significantly greater than the 0.7% rate in a control group of more than 4,000 people in Victoria.[7] When broken down by gender, approximately one in 5 women, and one in 10 men, who committed homicide were living with schizophrenia.[8]

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6 Violent offences include, for example, assault and more severe offences causing personal injury.

7 Bennett, D. J., Ogloff, J. R. P., Mullen, P. E., Thomas, S. D. M., Wallace, C., Short, T., (2011). Schizophrenia disorders, substance abuse and prior offending in a sequential series of 435 homicides. *Acta Psychiatrica Scandinavica, 124*, 226-233.

8 *Ibid*.; Bennett, D. J., Ogloff, J. R. P., Mullen, P. E., Thomas, S. D. (2012). A study of psychotic disorders among female homicide offenders. *Psychology, Crime and Law, 18,* 231-243.

44 Among the people living with schizophrenia who committed homicide, 87.5% of the women received their diagnosis of schizophrenia prior to the homicide offence and were not considered to be in the first episode of psychosis. For men, though, more than 40% committed homicide while they were very likely in the first episode of psychosis. Similar results have been found among homicide offenders with psychosis in NSW.[9]

45 The Australian research parallels findings from international studies. Douglas et al. (2009)[10] and Fazel et al. (2009),[11] investigated the relationship between psychosis and violence in comprehensive meta-analyses (a research method that combines and contrasts results from different studies). Results revealed a modest, yet statistically significant and clinically important relationship between psychosis and violence, even when controlling for moderating variables.

46 The studies I have considered, and those found in the literature, show a similar disproportion of offending – not just violent offending – among people living with serious mental illness (i.e., psychotic illnesses including schizophrenia).

47 In relation to the victims of violent offences committed by people living with a serious mental illness, a slightly higher proportion of victims are families and carers of such people. Acquaintances, as opposed to strangers, are also more likely to be victims. As people living with mental illness are less likely to have a spouse/partner,[12] they are therefore less likely to commit violence offences against a spouse or partner.

48 People living with mental illness are also more likely to be victimised and identified as potential victims, compared to people in the community who do not have diagnosed mental illnesses. I will discuss this further in paragraphs 102 – 104 when describing a study of victimisation in a cohort of people living with schizophrenia undertaken by the CFBS.

c. Impact of age on offending

49 The age of a person impacts both the types of offences committed by people living with mental illness and the likelihood of people with mental illnesses being victims of these offences. Generally speaking, the rate of offending increases during adolescence and

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9 Nielssen, O., & Large, M. (2010). Rates of homicide during the first episode of psychosis and after treatment: a systematic review and meta-analysis. *Schizophrenia bulletin, 36(4)*, 702-712.

10 Douglas, K. S., Guy, L. S., & Hart, S. D. (2009). Psychosis as a risk factor for violence to others: A meta-analysis. *Psychological Bulletin, 135(5)*, 679–706. https://doi.org/10.1037/a0016311

11 Fazel, S., Gulati, G., Linsell, L., Geddes, J. R., & Grann, M. (2009). Schizophrenia and violence: systematic review and meta-analysis. *PLoS Med, 6(8)*, e1000120.

12 Cross-cultural comparative research has found lower rates of marriage and higher rates of separation and divorce among persons with schizophrenia when compared with the general population (Cohen, A., Patel, V., Thara, R., & Gureje, O. (2008). Questioning an axiom: better prognosis for schizophrenia in the developing world?. Schizophrenia Bulletin, 34(2), 229-244; Thara R et al. Women with Schizophrenia and Broken Marriages - Doubly Disadvantaged? Part I: Patient Perspectives. International Journal of Social Psychiatry, 49, 225-232).

reduces during adulthood. Specifically, the likelihood and rate of offending increases rapidly among young people in the population from the onset of puberty to late adolescence or early adulthood, with a sharp decline thereafter, significantly reducing the likelihood of offending by the early to mid-thirties. This is known as the "age-crime curve" and it is among the most consistent findings in developmental criminology.[13]

50 In general, the general age crime curve also applies in relation to people living with mental illness – offending typically peaks in a person's late teens and early adulthood and then slowly declines. The probability of an individual commencing offending is low if the person has not committed an offence by the age of 35 years, but occasionally older people who develop mental illness have a later onset of offending behaviour.

51 The age-crime curve coincides with the onset of serious mental illness, including psychosis. Like adults, adolescents who offend have disproportionate rates of mental illness. As such, adolescent forensic mental health services are of critical importance for the well-being of young people who offend, and to help stabilise the symptoms of their mental illnesses so as to assist them in desistance.

d. Impact of substance use on offending

52 Substance use has a significant bearing on a person's likelihood of offending and is a problem in the broader criminal justice system. For example, a meta-analysis of more than 30 studies that investigated the relationship between substance misuse and offending revealed that drug-users were three to four times more likely than non-drug users to be convicted of offences.[14] The odds of offending were highest among users of free base cocaine and lowest among recreational drug users. This relationship held true across a range of offence types, including robbery, burglary, prostitution and shoplifting.

53 Through a series of studies, research at the CFBS has confirmed that comorbid mental illness and substance misuse significantly increases one's risk for offending and violence. In the program of research studies discussed in paragraphs 38, 39– 40, and 43 – 44, each study found that if a person with schizophrenia has comorbid substance use, the risk of offending and violent offending increases at least two-fold. For example, in the study of offending among more than 4,000 people living with schizophrenia, we found that members of the Consumer Group who also had a known substance abuse problem were three times as likely as those with schizophrenia alone to be convicted of a violent

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13 Farrington, D. P., Loeber, R., & Jolliffe, D. (2008). The age-crime curve in reported offending. In R. Loeber, D. P. Farrington, M. Stouthamer-Loeber, & H. R. White (Eds.), *Violence and serious theft: Development and prediction from childhood to adulthood* (p. 77–104). Routledge/Taylor & Francis Group.

14 Bennett, T., Holloway, K., & Farrington, D. (2008). The statistical association between drug misuse and crime: A meta-analysis. *Aggression and Violent Behavior, 13(2)*, 107-118. https://doi.org/10.1016/j.avb.2008.02.001.

offence, and more than eight times more likely than people in the Community Group to offence violently.[15]

54 Over time, alcohol has typically been the main substance used by people with comorbid mental illness and substance use.[16] Alcohol remains one of the drugs most strongly related to offending, by both people living with mental illnesses and those who do not experience mental illness.[17] They may also use other substances like cannabis, but these are less problematic compared to the alcohol use. Synthetic drugs like methamphetamine are increasingly problematic.

55 In two studies spanning almost 15 years, we have reliably found that approximately 75% of Forensicare's patients at TEH and the CFMHS have a diagnosed substance use disorder.[18] Such patients have worse outcomes overall – they have more extensive criminal histories, demonstrate a higher level of criminogenic risks and needs, are more likely to reoffend, and have poorer mental health outcomes than other patients.

56 The over-representation of mental health problems and mental illnesses among people with injecting drug use histories is well established. In a recent study of more than 300 people with injecting drug use histories preparing to be released from Victorian prisons, we found a disproportionate number of them had psychiatric histories, poor psychiatric well-being, increased rates of self-harm and suicide attempts, and substance misuse in the lead up to their offending.[19] There is an urgent need to more effectively address the comorbid mental health and substance misuse conditions of people in the criminal justice system.

57 A significant problem in the remediation of mental illness and substance misuse is the siloed service system. For example, people living in prisons – whether they are male or female – receive different services for mental disorders (including mental illness, psychological problems and crises, substance misuse, cognitive disability services) from different providers. It is difficult to envision a more fractionated and less efficient service provision model. While not as dire, matters in the community are still problematic. For

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15 *Supra* note 5.

16 Hunt, G. E., Large, M. M., Cleary, M., Lai, H. M. X., & Saunders, J. B. (2018). Prevalence of comorbid substance use in schizophrenia spectrum disorders in community and clinical settings, 1990–2017: Systematic review and meta-analysis. Drug and alcohol dependence, 191, 234-258.

17 Eggink, E., de Waal, M. M., & Goudriaan, A. E. (2019). Criminal offending and associated factors in dual diagnosis patients. Psychiatry research, 273, 355-362.

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

19 Cossar, R., Stoové, M., Kinner, S. A., Dietze, P., Aitken, C., Curtis, M., Kirwan, A., & Ogloff, J. R. P. (2018). The associations of poor psychiatric well-being among incarcerated men with injecting drug use histories in Victoria, Australia. Health & Justice, 6, 1, 1 – 8. doi: 10.1186/s40352-018-0059-4.

example, CFMHS's consumers have to go to a different provider for treatment of substance use disorders. There needs to be more dual diagnosis services that provide integrated treatment for both mental illness and substance use disorders. A jurisdiction that has made advances in this area is Florida, United States of America. Their integrated mental health and substance abuse services have been evaluated and encompass having drug courts and community interventions.

e. Impact of intellectual disability or cognitive impairment on offending

58 As with mental illness, there is a significant disproportion of people with intellectual disability in the criminal justice system. Although results of studies are variable, given the varying definitions of 'intellectual disability,' 'cognitive impairment,' and 'acquired brain injury,' it is estimated that up to 10% – 12% of people in prisons have IQ scores lower than 70, with many more (perhaps one-third) having borderline intellectual disability, with IQ scores between 70 and 80.[20] By comparison, only 2% to 3% of people in the general community would have IQ scores at or below 70, and approximately 10% would have scores at or below 80.

59 In two recent epidemiological studies conducted with the CFBS and collaborators, we investigated more than 2,000 persons with intellectual disability and have found that people with both an intellectual disability and a mental illness were approximately three times as likely to be charged with criminal offences, compared to those with an intellectual disability alone, and to people in the general community.[21]

60 Most recently, we have investigated the incidence of overlapping histories of criminal offending and victimisation, and the contribution that gender and dual disability had on risk.[22] We found that approximately 10% of people with intellectual disability had a history of both criminal offending and victimisation. Females with intellectual disability were more likely to have been victims than males. Most male and female offenders also had histories of victimisation. Dual disability was associated with an increased likelihood of criminal offending and victimisation.

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20 Baldry, E., Clarence, M., Dowse, L., & Trollor, J. (2013). Reducing vulnerability to harm in adults with cognitive disabilities in the Australian Criminal Justice System. *Journal of Policy and Practice in Intellectual Disabilities, 10(3)*, 222-229.

21 Fogden, B., Thomas, S., Daffern, M. & Ogloff, J. (2016). Crime and victimisation in people with intellectual disability: A case linkage study. *BMC Psychiatry, 16*, 170. DOI: 10.1186/s12888-016-0869-7; Nixon, M., Thomas, S. D. M., Daffern, M., & Ogloff, J. R. P. (2017). Estimating the risk of crime and victimisation in people with intellectual disability: A data linkage study. *Social Psychiatry and Psychiatric Epidemiology,* https://doi.org/10.1007/s00127-017-1371-3; Thomas, S. D. M., Daffern, M. D., Nixon, M. & Ogloff, J. R. P. (2019). Crime and victimization among people with intellectual disability with and without comorbid mental illness. Journal of Applied Research in Intellectual Disabilities, 32, 5, 1088-1095. DOI: 10.1111/jar.12598.

22 Nixon, M., Thomas, S. D. M., Ogloff, J. R. P., Daffern, M. D. & Luebbers, S. (in press). Co-occurrence of victimisation and offending histories among people with intellectual disabilities. *Journal of Intellectual Disability Research*.

f. Impact of personality disorder on offending

61 As I have noted thus far, mental illness, intellectual disability and substance misuse are all found disproportionately among people in the criminal justice system, and each have a moderate relationship to an increased risk of offending (individually and collectively). In comparison, however, personality disorder – and in particular antisocial personality disorder (**ASPD**) and psychopathy – have a more dramatic impact than any of the other factors on a person's likelihood of offending.[23]

62 Given the increased rates of offending among people with co-occurring mental illness, substance misuse, and ASPD, particular attention should be paid to this group. Contemporary approaches to offender rehabilitation shows that highly structured, cognitive-based approaches, with a focus on short-term reward, has some promise for successfully intervening with offenders who have been diagnosed with ASPD.[24] Moreover, assertive community treatment, using cognitive behaviour therapy (**CBT**), with case management has been shown to have a positive effect.[25] Therefore, it is important that offenders be assessed for the presence of ASPD, particularly given the high prevalence of the disorder. People with ASPD and co-occurring disorders should then be monitored and treatment approaches need to be structured (CBT as recommended by the NICE guidelines – see footnote 25). Nondirective approaches involving dynamic therapies are unlikely to be successful with this population.

g. Impact of access to treatment on offending

63 Psychiatric treatment is a central pillar of the care required, both to help stabilise symptoms of mental illness, and to increase community safety. I am part of a research group (with funding from the NSW government) that considered a large cohort of people living with serious mental illnesses. We found that psychiatric treatment lowers their likelihood of offending, but that this likelihood increases once the people were disengaged from treatment post-incarceration or hospitalisation.[26] In addition, we found that there was

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

24 Ogloff, J. R. P., & Wood, M. (2010). The treatment of psychopathy: Clinical nihilism or steps in the right direction? In L. Malatesti & J. McMillan (Eds.), *Responsibility and psychopathy: interfacing law, psychiatry and philosophy* (pp. 155 – 181). Oxford: Oxford University Press; Polaschek, D. L. L., & Skeem, J. L. (2018). Treatment of adults and juveniles with psychopathy. In C. J. Patrick (Ed.), *Handbook of psychopathy* (p. 710–731). The Guilford Press.

25 Frisman, L. K., Mueser, K. T., Covell, N. H., Lin, H.-J., Crocker, A., Drake, R. E., & Essock, S. M. (2009). Use of integrated dual disorder treatment via assertive community treatment versus clinical case management for persons with co-occurring disorders and antisocial personality disorder. Journal of Nervous and Mental Disease, 197, 822–828; NICE Antisocial personality disorder: prevention and management clinical guideline [CG77] January 2009 Last updated: 27 March 2013 http://dx.doi.org/10.1097/NMD.0b013e3181beac52; https://www.nice.org.uk/guidance/cg77/chapter/1-Guidance#treatment-and-management-of-antisocial-personality-disorder-and-related-and-comorbid-disorders.

26 Adily, A., Albalawi, O., Kariminia, A., Wand, H., Zohora Chowdhury, N., Allnutt, S., Schofield, P., Sara, G., Ogloff, J. R. P., O'Driscoll, C., Greenberg, D., Grant, L., & Butler, T. (2020). Early contact with mental health

a threefold increase in the risk of re-offending for those who disengaged from treatment compared to those who did not. More than two-thirds of the people who re-offended did so within one year of leaving treatment. People with a history of violent offending, substance-related psychosis, and those who were born outside of Australia have a higher chance of re-offending and returning to prison.[27]

64 Although necessary, however, psychiatric treatment is not sufficient in reducing the risk of offending. Rather, interventions must also address the factors that relate to offending in order to significantly decrease the likelihood of offending, while increasing community safety. Indeed, the same the same risk factors exist in people with mental illnesses who offend, and those who offend but do not have a mental illness.

Developments in research findings on the relationship between mental illness and offending

65 The major developments in research findings on the relationship between mental illness and offending over the past thirty-years have been the identification of:

(a) three groups of people living with mental illness who commit offences;

(b) criminogenic factors; and

(c) the importance of criminogenic factors in helping to understand and intervene in offending risk and violence among people living with mental illness who commit offences.

66 During the 1970s to 1980s, there was a strong belief among researchers that mental illness and offending were not related. This has been a vexed area as there was both an effort to destigmatise mental illness, and a need to warn family members and carers of people with mental illness that they are most at risk of being victims of offending by these people.

67 In Victoria, the process of deinstitutionalisation from psychiatric hospitals commenced after 1975 and was completed by the late 1990s. The TEH is the only public psychiatric hospital left. Deinstitutionalisation was partly built on the premise that people living with mental illness are no more likely to offend than people without mental illness.

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services after an offence and re-offending in those diagnosed with psychosis. *JAMA Psychiatry* doi: 10.1001/jamapsychiatry.2020.1255.

[27] Hwang, Y., Albalawi, O., Adily, A., Hudson, M., Wand, H., Kariminia, A., O'Driscoll, C., Allnutt, S., Grant, L., Sara, G., Ogloff, J. R. P., Greenberg, D., & Butler, T. (2020). Disengagement from mental health treatment and re-offending in those with psychosis: A multi-state model of linked data. *Social Psychiatry and Psychiatric Epidemiology*. doi: 10.1007/s00127-020-01873-1.

68 Research in the last 15 to 20 years has investigated the nature and extent of the relationship between mental illness and offending – this research is what changed people's perspectives on the relationship dramatically. As noted above in the individual studies considered, the vast majority of people with mental illnesses – even those living with the most serious low prevalence disorders such as schizophrenia – are not charged or convicted of offending and, in particular, violent offending.[28] A consideration of the research that has investigated the relationship between mental illness and offending shows that there are three groups of people living with mental illness who commit offences:[29]

(a) The smallest group of people are those who **offend because of their mental illness** (in other words, they would not offend but for the mental illness) (**Group 1**). Typically, people experiencing psychotic symptoms engage in offending behaviour as a result of the psychosis (e.g., typically delusional thinking). Some of the people in this group may be found not guilty of offences because of mental impairment, given the direct relationship that exists between mental illness and the offending. Although the offending of people in this group is driven by the symptoms of mental illness, they may still be affected by other complexities, including substance misuse, personality dysfunction, or cognitive impairment. Nonetheless, the serious mental illness, and the symptoms it produces, are the driving factor leading to the offending for people in this group. The fact that the offending behaviour committed by so few people is causally related to their offending behaviour is surprising to people. Indeed, many – perhaps most – people tend to assume that if someone is living with mental illness and offends, the offending is somehow caused by the mental illness.

(b) The largest group of people are those who **offend as a result of the sequelae of mental illness** (that is, those whose pathway to offending parallels their pathway to social disadvantage during which the mental illness is concurrent with the offending) (**Group 2**). These people may have had comorbid mental illness when they were young; this is where Professor Patrick McGorry's seminal research in relation to first episode psychosis is relevant.[30] For example, a young person may start to be socially disenfranchised while still in school, leave school,

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28 *Supra* notes 3, 4, 5 and related text – showing that typically 75% of people living with schizophrenia are never convicted of any offence, and 92% are never convicted of violent offences.

29 Hodgins, S., & Muller-Isberner, R. (2004). Preventing crime by people with schizophrenic disorders: The role of psychiatric services. British Journal of Psychiaty, 185, 245-250; Ogloff, J. R. P. (2009) Managing offenders with psychiatric disorders in general psychiatric services. In Michael G. Gelder, Nancy C. Andreasen, Juan J. López-Ibor Jr., y John R. Geddes (eds). *New Oxford textbook of psychiatry (2nd edition)*. Oxford, UK: Oxford University Press; Thompson, L., & Darjee, R. (2009). Associations between psychiatric disorder and offending. Michael G. Gelder, Nancy C. Andreasen, Juan J. López-Ibor Jr., y John R. Geddes (eds). *New Oxford Textbook of Psychiatry, Second Edition.*,Oxford, UK: Oxford University Press.

30 Yung, A. R., & McGorry, P. D. (1996). The prodromal phase of first-episode psychosis: past and current conceptualizations. *Schizophrenia Bulletin, 22(2)*, 353-370.

lose friends, have disaccord with family members and therefore spiral downward socially. In that downward spiral, there is also an increased likelihood of substance use and exposure to criminal elements. Relevantly, there is no evidence that people who have support systems, and whose families have a higher socio-economic status, do not develop mental illness and spiral downward socially. Of course, many more people experience higher prevalence disorders, such as mood disorders or anxiety disorders, where the link to offending is even more tenuous.

(c) The final group of people are those who **offend despite the mental illness**. These people typically have early onset offending and tend to persistently offend irrespective of their mental state (in other words, mental illness is irrelevant to their offending) (**Group 3**). Group 3 is smaller than Group 2 but much larger compared to Group 1. The people in this group are largely living with serious personality disorders and have a high degree of social disengagement. They would not be affected by positive social support.

69 The mental health service system requirements for each group are different:

(a) **Group 1**: It is clear that identifying people living with mental illness and providing psychiatric care can reduce offending by people in Group 1. Queensland has been developing services in this regard and doing quite well among the Australian jurisdictions, as it has implemented recommendations in its service delivery model following the review by the Mental Health Sentinel Events Review Committee of fatal events involving people living with mental health issues (**Queensland Sentinel Review**).[31] In some countries like the Netherlands, people in Group 1 who do not have comorbid substance misuse disorders or personality disorders are not hospitalised in forensic mental health services, but rather are managed in the mainstream public mental health system. Indeed for such people, the effective management of symptoms of mental illness alone is often all that is needed to also assist them to manage their risk of future offending.

(b) **Group 2**: The people in Group 2 are likely to be part of a 'revolving door' system; if they are medicated and treated for their mental illness, there would be some remediation of offending but residual issues (for example, criminogenic factors, homelessness, substance use and social disadvantage) are likely to result in a higher likelihood of them re-offending. Interventions therefore cannot be merely in relation to mental illness because the social context of the people in Group 2 contaminates and perpetuates their propensity to offend.

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31 Burnett, P., & Ogloff, J. R. P. (2016). When Mental Health Care Meets Risk: A Queensland Sentinel Events Review into Homicide and Public Sector Mental Health Services. Report prepared for the Department of Health, Queensland. https://www.health.qld.gov.au/__data/assets/pdf_file/0026/443735/sentinel-events-2016.pdf

(c) **Group 3**: Even if the people in Group 3 are medicated and treated for their mental illness, they are no less likely to offend. Reducing their level of offending cannot be done easily through psychiatric treatment alone, which is generally irrelevant to their offending.

70 In relation to treatment for the people in Groups 2 and 3, while psychiatric treatment can help remediate symptoms of mental illness, there can only be meaningful change to their level of offending if broader issues affecting offending are addressed. The factors that have been found to relate to offending across all manner of offenders are the so-called "criminogenic factors" present in individuals. This concept is part of a contemporary, well accepted and supported theory of offending known as the Psychology of Criminal Conduct, which has spawned the Risk-Need-Responsivity Model, that was developed by Andrews and Bonta in the 1980s and it has been refined over time.[32] It is a theory concerned with individual differences and variability in criminal behaviour, making it a particularly useful guide for both assessing the risk of reoffending and planning rehabilitation attempts. This emphasises the complexity of criminal behaviour, thereby acknowledging the contributions of social context, biology, and psychopathology.

71 Criminogenic factors are dynamic (changeable) risk factors that have been found to relate directly to a risk for re-offending. They are therefore modifiable characteristics, whereby a change in the risk factor equates with a change in the risk of re-offending. These are factors that can affect patients with mental illness just as they can affect people with no mental illness who offend. There are eight overarching areas of criminogenic need, known as the 'central eight:' Criminal History; Education/Employment; Financial; Family/Marital; Accommodation; Antisocial Companions; Alcohol/Drug Problems; Emotional/Personality Problems; and Attitudes/Orientation. Examples include having friends who are criminals, developing pro-criminal attitudes, having an anti-social personality, having limited problem-solving skills, and having difficulties controlling anger and hostility.[33]

72 A broad range of research with people who offend, including people living with mental illness who offend, has shown that assessing and intervening with offenders to remediate the criminogenic needs – in addition to psychiatric treatment:

(a) can significantly reduce the likelihood of re-offending for the people in Group 2 where both mental illness and criminogenic needs were addressed; and

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32 Bonta, J., & Andrews, D. A. (2016). *The psychology of criminal conduct.* Taylor & Francis.

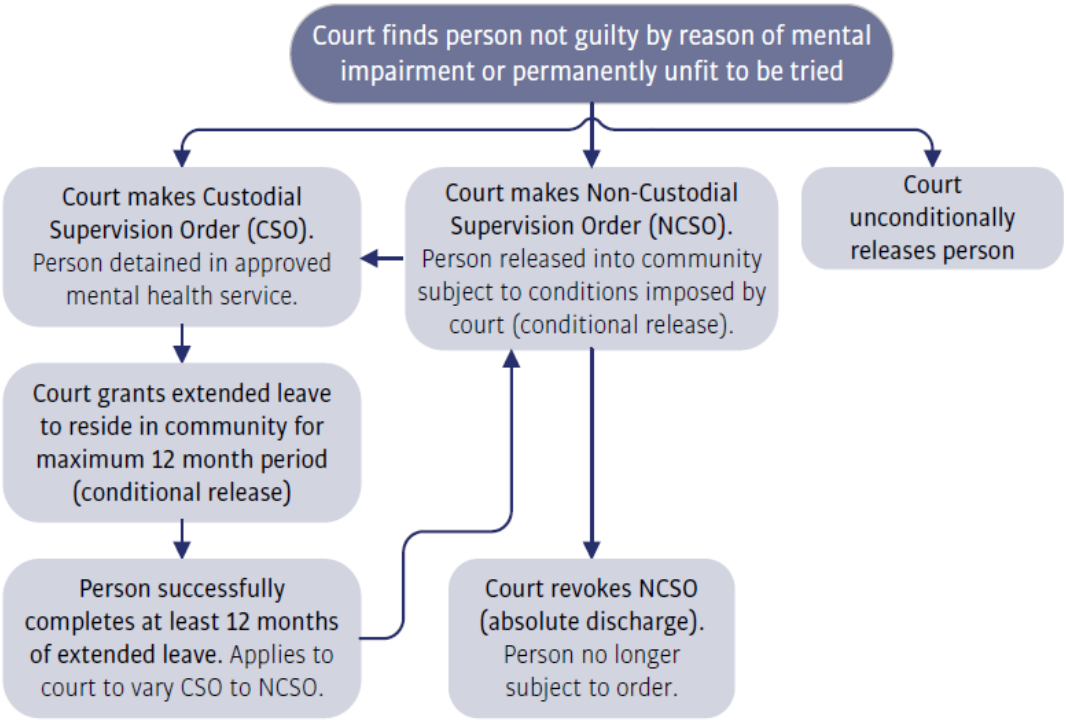
33 Ogloff, J. R. P., & Davis, M. R. (2004). Advances in offender assessment and rehabilitation: Contributions of the risk-needs-responsivity approach. *Psychology, Crime and Law, 10*, 229-242.

(b) are more likely to lead to positive outcomes for the people in Group 3 (including those living with serious personality disorders) when their treatment focussed on criminogenic needs.[34]

The efficacy of treatment and supervision among forensic patients

73 The overview of pathways under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) (**CMIA**) to conditional release and absolute discharge are depicted in the figure below:

CMIA Pathways to Conditional Release and Absolute Discharge



Source: Ruffles, Fullam, & Ogloff (2020, August), note 35, p. 1.

74 Forensic patients, including those who receive custodial treatment orders, typically fall within Group 1 and 2, with those falling in Group 3 being rarer. As such, our treatment addresses both mental health and criminogenic needs. As a group, forensic patients have done remarkably well following treatment and the CFBS found that their rate of re-offending is very low.

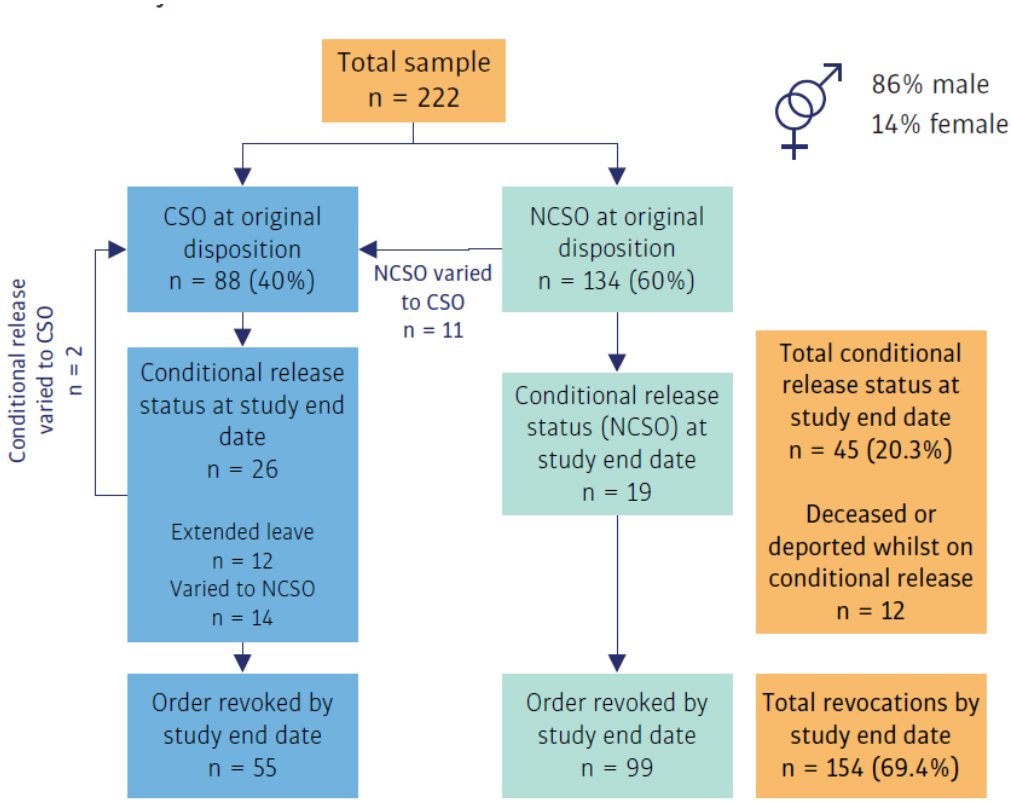
75 The CFBS and Forensicare have very recently completed an investigation of all 222 people placed on a supervision order (either a Custodial Supervision Order (**CSO**) or a

34 *Supra* notes 24 and 32 and related text.

Non-Custodial Supervision Order (**NCSO**)) under the CMIA in the first 18 years of the Act's operation (April 1998 to April 2016) who, between the imposition of the order and the end of December 2018, were subsequently granted community release.[35]

76 We collected data on all new criminal charges incurred by participants following release to the community. Criminal charges (rather than convictions) capture incidents that may ultimately be dealt with under mental health provisions, and are a better representation of offending and violent behaviour than convictions. To examine potential modifiers of reoffending outcomes, we collected data on the socio-demographic details of the population, mental health histories, and criminological characteristics of participants.

Pathways of All People Placed on a Supervision Order or a Non-Custodial Supervision Order Under the CMIA (April 1998 to April 2016)



Source: Ruffles, Fullam, & Ogloff (2020, August), note 32, p. 1.

77 The findings revealed that no person granted absolute discharge during the first 20 years of the CMIA's operation has been charged with a serious violent offence following absolute discharge. A total of 47 (21%) individuals were charged with an offence following

35 Ruffles, J., Fullam, R., & Ogloff, J. R. P. (2020, August). *Reoffending outcomes of people managed under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic). Prevention and Intervention Summary Report, Catalyst Consortium, Centre for Forensic Behavioural Science.

community release. 28 (13%) people were charged with a personal injury offence that did not constitute serious violence (most typically assault), and 19 people (9%) were charged with non-violent offences only. Only 10 (4.5%) participants were received into prison for any period of time following community release.

78 One (0.5%) participant was charged with a serious violent offence (recklessly cause serious injury); however, that offence was committed whilst on conditional release.

79 The factors that we identified that were related to re-offending were consistent with those discussed previously. Past criminal history was a significant predictor of both general and violent reoffending. A comorbid diagnosis of personality disorder increased the risk of general and violent reoffending. A comorbid diagnosis of substance use disorder also increased the risk of general and violent reoffending. Being under the influence of drugs or alcohol at the time of the index offence was also a significant predictor of reoffending.

80 Participants who committed a severe index offence (murder or attempted murder) leading to the initial CMIA finding were 3.14 times less likely to reoffend than those who committed less serious offences.

The efficacy of treatment among clients who exhibit 'problem behaviours'

81 Apart from forensic patients, Forensicare and the CFBS has also found that the PBP, which is operated by the CFMHS, is also effective at reducing clients' risks of reoffending.[36] The PBP works with clients who are identified as engaging in 'problem behaviours', such as uttering threats, stalking, violence, harmful sexual behaviour or fire-setting.[37] Such acts not only cause harm to others, but often to the client who commits them, and these people are often difficult for courts and services to understand or manage. While in many cases such conduct is also criminal, 'problem behaviour' encompasses actions that are prosecuted as well as those that never come before a court.

82 The PBP is a unique community-based service that provides assessment and treatment to individuals with high-risk problem behaviours (e.g., sexual offending, violence, threatening, stalking and fire-setting).[38] The PBP expands the scope of the traditional

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36 McCarthy, J., McGrail, J., McEwan, T., Ducat, L., Norton, J., & Ogloff, J. R. P. (2015). *Evaluation of the Problem Behaviour Program: A Community Based Program for the Assessment and Treatment of Problem Behaviours.* Melbourne, Victoria: Forensicare and Centre for Forensic Behavioural Science, Swinburne University of Technology.

37 Warren, L. J., MacKenzie, R., Mullen, P. E., & Ogloff, J. R. P. (2005). The problem behaviour model: The development of a stalkers clinic and a threateners clinic. *Behavioral Sciences and the Law, 23*, 387-397.

38 The Problem Behaviour Program model has been adopted by other forensic mental health services, including in the UK.

community forensic mental health service model beyond a focus on psychopathology to other psychosocial needs and offence reduction.

83 The PBP is underpinned by a framework that operates on two levels. At the organisational level, it is a model of service provision for clients who would otherwise find it difficult, if not impossible, to access interventions to ameliorate risks associated with their behaviour. In the individual case, the problem behaviour framework provides a way of conceptualising complex and potentially harmful behaviours so as to make them more understandable and manageable. Very importantly, rather than conceptualising the person as a 'problem person,' the focus of the assessment and intervention is non-judgment, focusing rather on the person's behaviour – with the assumption that with assistance, they will be able understand and better control their behaviour.

84 Reflecting a range of research into human behaviour, the problem behaviour framework takes a reductionist approach, assuming that complex human behaviours can be understood as the product of multiple contributory factors. In the broadest sense, individual factors such as personality attributes (attitudes, beliefs and values), interpersonal and other skills deficits, and, in many cases, psychopathology, interact with the social milieu and context(s) in which the behaviour occurs (criminogenic factors and related matters).[39] These types of factors may have developed over time and be present throughout the individual's life, or appear only in close proximity to the onset of the problem behaviour. In undertaking an assessment with an individual using this framework, the clinician is attempting to elicit evidence of personal and situational factors that may predispose the individual to the behaviour, precipitate its onset, and perpetuate it once it has begun. There is also an interest in identifying factors that may protect against the behaviour occurring or lead to desistence from the behaviour.

85 Interventions are mainly conducted individually by psychologists and psychiatrists, using contemporary approaches including Cognitive Behaviour Therapy, Schema Therapy, elements of Dialectical Behavioural Therapy, behavioural interventions, and other modalities.

86 The evaluation analysed offending patterns before and after contact with the PBP for 824 individuals who were assessed by the PBP between January 2006 and January 2011. Consistent with the referral criteria, the clients, as a group, were typically high risk of engaging in problem behaviours and many had not done well with other services (mental health and criminal justice). Clients were mostly male (89%) and were referred from justice and mental health services, private practitioners and self-referrals. The results were promising showing that two-thirds of clients did not reoffend after PBP contact. Clients had on average 4.9 offences prior to contact with the PBP and 2.5 following

39 *Supra* note 32, Bonta & Andrews (2016).

contact. For individuals who re-offended (33% of total), two-thirds had no change or a decrease in offence severity from their pre-referral offence. Clients completing treatment reoffended at significantly lower rates than other clients. Average time to re-offence for the treatment group (785 days) was significantly longer than for all other client groups. Contact with the PBP also resulted in more positive mental health outcomes for clients, with a significant reduction in the number of outpatient contacts following service provision.[40]

Understanding the interface between offending behaviour and mental illness

87 I believe that there is an opportunity to increase the understanding of the interface between offending behaviour and mental illness that would strengthen the response of area mental health services. Understanding the interface between risk of reoffending and deteriorating mental health requires close collaboration and shared decision making with Forensicare to support recovery outcomes. Relevantly, a group of psychiatrists and psychologists (including myself) have written an article on the role mental health providers can play in assessing and managing risk of offending and violent behaviour by people living with mental illness.[41]

Reliability of risk and predictive tools in predicting violent offending

88 Let me begin with a quotation that Professor Paul Mullen and I wrote in our chapter on the assessment and management of aggression for the Oxford Textbook of Psychiatry:

> We are not now and probably never will be in a position to be able to determine with certainty who will or will not engage in a violent act. Relying on a range of empirically supported risk factors, though, we can make a reasoned determination of the extent to which those we are assessing share the factors that have been found in others to relate to an increased level of risk.[42]

89 When the predictive validity of risk assessment by psychiatrists and psychologists was first formally investigated forty to fifty years ago (including both inpatient aggression and violence to the community), results revealed that they were not accurate. An early law review article, critiquing the assumption that psychiatrists could somehow determine

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40 McCarthy, J., McGrail, J., McEwan, T., Ducat, L., Norton, J., & Ogloff, J. R. P. (2015). *Evaluation of the Problem Behaviour Program: A Community Based Program for the Assessment and Treatment of Problem Behaviours.* Melbourne, Victoria: Forensicare and Centre for Forensic Behavioural Science, Swinburne University of Technology.

41 Allnutt, S., Ogloff, J. R. P., Adams, J., et al. (2013). Managing aggression and violence: The clinician's role in contemporary mental health care. Australian and New Zealand Journal of Psychiatry, 47, 8, 728 – 736; See also, *Supra* note 29; Mullen PE. (2006). Schizophrenia and violence: from correlations to preventive strategies. *Advances in Psychiatric Treatment, 12(4),* 239-48;

42 Mullen, P. E., Ogloff, J. R. P. (2009) Assessing and managing the risk of violence towards others. In Gelder, M., Lopez-Ibor, J. Andreasen, N., & Geddes, J. (Eds.). New Oxford textbook of psychiatry (2nd edition). Oxford University Press.

which patients would present a harm to other and, therefore, would meet criteria for involuntary hospitalisation, referred to the exercise as "flipping coins in the courtroom," since the accuracy rate of risk predictions was less than 50%.[43]

90 A great deal has been written on the prediction of risk for violence and offending over the past 40 years. Research shows that the prediction of risk is – and in my view always will be – imperfect. This is similar to prediction in all areas of social science and social services. It is clear that significant advances have been made and validated risk assessment measures since then and our risk assessment tools now have acceptable predictive validity when used as an adjunct to a comprehensive clinical evaluation completed by an experienced and qualified psychologist or psychiatrist. Research shows that the predictive accuracy of individual tools varies, and that the measures are typically more accurate at identifying which people are at low or moderate levels of risk of offending.[44]

91 The practice at Forensicare, which is consistent with the international literature, is not to use the measures alone, but as part of a comprehensive risk assessment. The goal of which is on risk management rather than risk prediction. It is accepted that risk assessment processes can produce both false positives and false negatives, and the degree of confidence in the assessment varies based upon a combination of factors, including the characteristics and history of the subject of the assessment and the context in which the assessment is being undertaken. Depending on the circumstances, clinicians tend to err towards false positives if the goal is to protect the public (such as when considering a person for release to the community, particularly without supervision), while greater tolerance for risk occurs when people are moving from one part of a service to another.

92 Over many years, we have undertaken the evaluation of risk assessment measures employed at Forensicare. Most recently, for example, we have undertaken an evaluation of the Historical Clinical Risk Management-20 (**HCR-20**) Version 3,[45] one of the most commonly used violence risk assessment tools amongst mental health professionals.[46] The sample comprised of 100 people with mental illnesses who were released from the TEH, either back to prison and then to the community for prisoner patients, or to the

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43 Ennis, B. J., & Litwack, T. R. (1974). Psychiatry and the presumption of expertise: Flipping coins in the courtroom. *California Law Review, 62*, 693-735.

44 Fazel, S., Singh, J. P., Doll, H., & Grann, M. (2012). Use of risk assessment instruments to predict violence and antisocial behaviour in 73 samples involving 24 827 people: Systematic review and meta-analysis. *British Medical Journal, 345*, e4692.; Singh, J. P., Grann, M., & Fazel, S. (2011). A comparative study of violence risk assessment tools: A systematic review and metaregression analysis of 68 studies involving 25,980 participants. *Clinical Psychology Review, 31(3)*, 499-513.

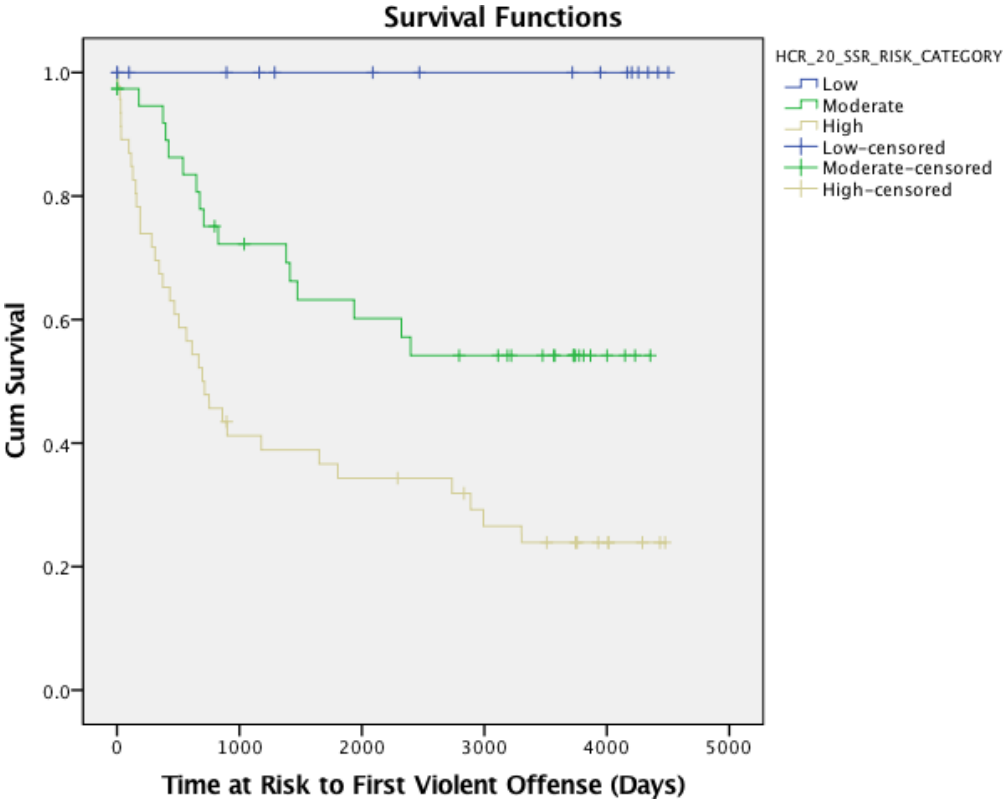
45 Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). *HCR-20 (Version 3): Assessing risk for violence - User Guide*. Burnaby, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.

46 Brookstein, D. M., Daffern, M., Ogloff, J. R., Campbell, R. E., & Chu, C. M. (2020). Predictive validity of the HCR-20V3 in a sample of Australian forensic psychiatric patients. *Psychiatry, Psychology and Law,* 1-18.

community for forensic patients (the sample comprised security patients (72%), involuntary patients (20%), and forensic patients (8%)). Recidivism data were sourced from official Victoria Police records. The overall predictive validity showed that the measure had large effect sizes for offending and violence, both when simple total scores were employed and when used clinically to produce clinically informed risk ratings (which were slightly more accurate).

93 The figure below shows the 'survival curves' for the clinicians' structured, or clinically informed risk ratings, for the HCR-20 and time to first violent offence. The top left of the figure represents the point at which people were released to the community (either directly from hospital or from prison), as individuals within the three groups (low risk, moderate risk, and high risk) began to be charged with new violent offences, the line began to fall. No participants rated as low risk of violence were charged with a violent offence over the entire follow-up period. Conversely, approximately 1/5 people in the high risk group were not charged with a violent offence over the evaluation period. These results are favourable and compare well with international investigations.

Survival Analyses of HCR-20 Structured Risk Ratings and Time to First Violent Offence



Source: Brookstein, Daffern, Ogloff, Campbell, & Chu (2020), note 46, at p. 11.

94 Unfortunately, to my knowledge, area mental health services in Victoria do not routinely employ empirically validated risk assessment measures in their work, but most if not all have internal protocols (un-validated) to assess violent offending risk.

Tools currently used by Forensicare in assessing violent offending risk

95 Forensicare employs a broad suite of assessment measures, including measures designed and validated to measure the risk of inpatient aggression, risk of violence, and a host of other matters. For example, two tools used by Forensicare to assess inpatient aggression and violent offending risk include the following:

(a) The Dynamic Appraisal of Situational Aggression (DASA)[47] identifies whether a person who is an inpatient is likely to be aggressive within a short period of time (i.e., within 24 hours). Developed in the TEH in 2006, this tool is now widely used internationally and has been identified by the National Health Service of United Kingdom (**UK**) as being best practice. Forensicare nurses administer the measure daily in acute units and research shows that it can help identify patients in the hospital who have elevated levels of risk for inpatient aggression.[48] Research has found that the measure has acceptable predictive validity and has been able to assist nurses reduce the level of inpatient aggression and need for seclusion.[49]

(b) As discussed previously, the HCR-20[50] is among the most commonly used, and widely validated assessment measures for the risk of violence. It is designed to measures a person's risk over time based on both the person's history (for example, age, personality disorder, employment, education, attitudes towards violence, substance use and criminal history) and current presentation (for example, impulsiveness). It also takes into account factors to be taken into account when planning for release to the community. Forensicare uses this tool comprehensively at TEH. In addition to international use, the HCR-20 is employed by all forensic mental health services throughout Australia and New Zealand, as well as many correctional services.

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47 Ogloff, J. R. P., & Daffern, M. (2006). The Dynamic Appraisal of Situational Aggression: An instrument to assess risk for imminent aggression in psychiatric inpatients. *Behavioral Sciences and the Law, 24*, 799-813.

48 *Ibid.*

49 For example, Maguire, T., Daffern, M., Bowe, S. J., & McKenna, B. (2017). Predicting aggressive behaviour in acute forensic mental health units: A re-examination of the dynamic appraisal of situational aggression's predictive validity. *International Journal of Mental Health Nursing, 26(5),* 472-481; Maguire, T., Daffern, M., Bowe, S. J., & McKenna, B. (2018). Risk assessment and subsequent nursing interventions in a forensic mental health inpatient setting: associations and impact on aggressive behaviour. *Journal of Clinical Nursing, 27(5-6)*, e971-e983.

50 *Supra* notes 45, 46 and related text.

(c) Importantly, the HCR-20 is completed and reviewed six-monthly, and the results feed into recommendations made in annual forensic patient reviews, and during hearings at court to consider varying or discharging orders. As noted in the review of forensic patients above,[51] few discharged patients have been charged with violent offending, which concords well with the HCR-20 validation results.

(d) This tool is also used in Queensland's public mental health system, following the implementation of the Queensland Sentinel Review referred to above.[52]

Community discourse around the relationship between mental illness and offending

96 Much of the community discourse around the relationship between mental illness and offending remains shameful. Very often when there is a violent incident involving persons living with mental illness, there is instantly a public outcry over mental illness and people may question why such persons are not in secure facilities. Newspaper headlines, media posts and the public discourse tend to sensationalise the matter and demonise the accused.

97 The community discourse is very difficult to change. I am not aware of anywhere in the world that has done well in achieving a balanced discourse. While there have been efforts in Victoria to change this discourse (for example, Herald Sun has visited TEH to have a greater understanding of our services, and CFBS has done some research looking at media reporting of mental illness and policing), there have not been further steps forward. In my experience, non-governmental organisations and advocacy groups have understandably tried to side-step this area. Unless society can deal with mental health issues in a measured way, it will be difficult or impossible to change the community discourse.

98 The discourse needs to shift from people living with mental illnesses are dangerous, unpredictable, and should be in institutions to better reflect the reality of the situation, as conveyed in the research findings discussed above. That is, the vast majority of people living with mental illness are not violent and do not offend. However, as a result of some forms of mental illness and related factors (e.g., substance misuse, disorganisation, lack of support), a small number of people living with mental illness engage in harmful behaviours. With proper assessment and intervention, however, most of these risks can be managed.

99 We would do a great disservice to the public and families if we communicate to them that there is no relationship between mental illness and offending. This strategy inevitably backfires and is disingenuous based on research and experience. I have done interviews

51 *Supra* note 35 and related text.

52 *Supra* note 31 and related text.

and talks to community and professional groups to communicate this relationship, and have often been met with a degree of disdain (sometimes literally receiving hate mail from those who considered that I was disparaging or stigmatising people living with mental health). That was certainly not my intention; indeed, I have spent my professional life working in this field to advocate for enhanced mental health services for people living with mental illnesses who are at risk of coming into the criminal justice system. Rather, what I am seeking to do is to communicate to the public that most people living with mental illness do not offend and do not behave violently, but they have an increased risk of doing so in certain circumstances. Moreover, family and carers should be educated about potential risk factors or triggers for individuals so as to help identify and ultimately prevent harm.

100 Relevantly, through the Queensland Sentinel Review, we found that family members of people living with mental illness were often unaware of the risks that such people may pose because of their mental illness.[53] There is a need to work with family members to help them understand these risks, as they are most likely to be the victims of violent offending. This is also relevant in the context of COVID-19 when people are restricted in their movement, with little opportunity for time away from one another.

101 In addition, to achieve a more balanced discourse, there is a need to better equip clinicians and the broader community with the ability to recognise risks of violence. For example, any clinician can provide a reliable list of suicide risk factors, but clinicians are unlikely able to provide a list of violence risk factors unless they are forensically trained. Again, Queensland has tried to establish a minimum competence among mental health professionals to identify the risks of harm to others posed by some people living with mental illnesses.

MENTAL ILLNESS AND VICTIMISATION

The increased likelihood of people who are living with mental illness being victims of crime

102 It is important to recognise that people living with mental illnesses are generally at greater risk of victimisation.

103 Some of our research has investigated victimisation among people who are living with mental illnesses. For example, using a similar methodology in which we have explored rates and likelihood of offending among people with schizophrenia, we have explored victimisation experiences.[54]

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53 *Supra* note 31 and related text.

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

104 Compared to community controls, people living with schizophrenia were significantly more likely to have a record of violent and sexually violent victimisation, but were slightly less likely to have an official record of victimisation overall – particularly for property offences. This is likely because people living with schizophrenia are more likely vulnerable for personal offences and, as they typically are less well-off, are less likely to be subject to property crimes. Taken together, we have found that people living with schizophrenia are particularly vulnerable to violent crime victimisation. The risks of victimisation were greatest among people living with schizophrenia who have criminal offending histories themselves, and who experience substance misuse.

105 As noted above, the findings for people with intellectual disabilities are generally similar to those living with mental illness, with higher rates of victimisation.[55]

OVER-REPRESENTATION OF YOUNG PEOPLE AND ADULTS LIVING WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

106 There is an overrepresentation of people living with mental illness in the criminal justice system. This finding is well-accepted and established in Australia.[56] The CFBS has done a lot of research in this area over many years, including assisting the Victoria Police with preparing the data for their submission to the Royal Commission. In particular, in a research study conducted a few years ago in collaboration with Victoria Police,[57] the CFBS took a random sample of more than 600 people coming into police custody and tested them for mental health illness. We found that more than half of police cell detainees had previously had contact with public mental health services at some point during their lives. One in three were in treatment for mental disorders at the time of being arrested, with half treated within the public mental health system (approximately 17%) and half by primary care services and local doctors or psychologists. The prevalence of diagnosed psychiatric illnesses upon admission was high with 10% suffering psychosis and another 10% suffering an affective illness. Substance abuse was present for the majority, most notably seen in the one in five who required medical management of substance withdrawal while in police detention.

107 Half of those found to be experiencing psychiatric symptoms in police cells were not receiving treatment in the community at the time of their arrest. Victoria Police did not access the mental health system for their psychiatric history during their intake process, and roughly half of the men who were receiving mental health care admitted that to the

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55 *Supra* note 22 and related text.

56 Ogloff, J. R. P., Davis, M. R., Rivers, G., Ross, S. (2007). The identification of mental disorders in the criminal justice system. *Trends and Issues in Crime and Criminal Justice. 334*, Australian Institute of Criminology, Canberra, Australia. https://www.aic.gov.au/sites/default/files/2020-05/tandi334.pdf

57 Ogloff, J.R.P., Warren, L.J., Tye, C., Blaher, F. & Thomas, S.D.M. (2010) Psychiatric symptoms and histories among people detained in police cells. *Social Psychiatry and Psychiatric Epidemiology, 46, 9*, 871-880

police – the other half did not. Finally, the people with mental illness at the time of reception were no more likely than other people being detained to have been charged with personal injury offences. Opportunities exist, therefore, for diverting at least some of the people living with mental illnesses back into mental health services.

108 We also investigated the mental health screening outcomes for all male prisoners received into custody in Victoria in 2009 (n = 4229).[58] The results showed that, overall, 19% of all prisoners were suffering from a mental illness, and another 20% had a history of psychiatric illness that required ongoing care. Even by then, fewer than 1% were transferred to the TEH for further assessment and treatment, despite the 19% being currently unwell and requiring more acute psychiatric care.

109 There is a high demand for mental health services in prison, and a very high demand for mental health services when people exit prison. There is also poor integration of people exiting prison, and who are living with a mental illness, back into the community. As noted previously, this is a great shame since engagement with mental health care upon release from prison can not only assist people with their mental health, but it leads to decreased rates of offending.[59] As those findings show, people are more likely to deteriorate very rapidly in their mental state and re-offend before they get mental health care if not engaged with mental health services.

110 Although it is well-accepted that people with mental illnesses are over-represented in the criminal justice system, the cause for this is unknown. Certainly, in Victoria, little systematic analysis of the factors that contribute to the over-representation have not been systematically investigated. It is tempting to infer that the reduction in psychiatric beds and the concurrent rise in the number of people in prisons has caused the misrepresentation (this is known as transinstitutionalisation). Although the transinstitutionalisation hypothesis has led to a great deal of debate, it has been characterised by little in the way of resolution. After reviewing the arguments supporting and refuting the transinstitutionalisation hypothesis, Prins perceptively cautions that.[60]

111 At the very least, policymakers and researchers should treat the transinstitutionalisation hypothesis with caution and not as a presupposition. Failure to approach this issue with the nuance it requires may unwittingly imply expensive interventions that will benefit only a fraction of the population at issue. For the large remainder of people living with severe mental illness in jails and prisons, other causes of their involvement with the criminal justice system should not be ignored. In this regard, shifts in philosophy and ideology

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58 Schilders, M. & Ogloff, J. R. P. (2014). Review of point-of-reception mental health screening outcomes in an Australian Prison, *Journal of Forensic Psychiatry and Psychology, 25, 4*, 480 – 494

59 *Supra* note 26 and related text.

60 Prins, S. J. (2011). Does transinstitutionalization explain the overrepresentation of people with serious mental illnesses in the criminal justice system?. *Community Mental Health Journal, 47(6)*, 716-722, at p. 722..

behind the concept of deinstitutionalisation are still relevant. For the majority of this group, the key to staying out of hospitals, jails, and prisons may be a place to live, a job or some income support, a meaningful relationship or social network, quality healthcare, or linkage to treatment instead of frequent arrest for substance use disorders—fundamental needs that can best be redressed in the community, not psychiatric or correctional institutions.

112 In the two studies of cohorts of people living with schizophrenia identified in 5 year blocks, initially between 1975 and 1995 (the period of deinstitutionalisation) and then between 1975 and 2010, Mullen colleagues in the CFBS[61] explored offending rates by people with schizophrenia over time and compared this to the rates by people in the community without such diagnoses. They found that while the rate of offending increased over time (particularly between 1975 and 2005) among people with schizophrenia, the rate was similar to the community sample. Moreover, co-morbid substance misuse, which was higher and grew among people living with schizophrenia, helped explain the rise in offending rates.

113 Future research is required to understand the factors that are empirically related to the misrepresentation of people with mental illnesses in the criminal justice system.

Addressing the overrepresentation of people living with mental illness in the criminal justice system

Interfaces between mental illness and the criminal justice system

114 There is a need to consider the interfaces between mental illness and the criminal justice system, to address the overrepresentation of people living with mental illness in the criminal justice system. People often only think about prisons when considering mental illness and offending, but there are opportunities for intervention along the whole criminal justice system. The system starts with police contact and encompasses issues of diversion, bail, remand, sentencing, parole and re-integration to community. Reform of the mental health system requires that consideration of mental illness and the criminal justice system must consider each point along the justice journey and how better leverage off of criminal justice interfaces to meet individual's mental health needs. This would essentially adopt a position where criminal justice contact could be considered a public health opportunity.

115 A positive example of intervention at an interface between mental illness and the criminal justice system occurs in Queensland where the forensic mental health service and police have a service in the central police command centre in which a police inspector and senior psychiatric nurse monitor police 'jobs' or contacts in Queensland. If a frontline police member is called, the senior psychiatric nurse can quickly access mental health data so

61 *Supra* notes 3 & 5 and related text.

that the police are aware of the mental health history of the relevant person by the time they arrive at the scene.

116 Victoria should also have a system to more readily identify people living with a mental health illness as they enter the criminal justice system, and to intervene appropriately. There is no need to wait to address mental health needs until a person is taken into custody in police cells or remanded into custody. For example, a provider of prison mental health services (such as Forensicare) can check the mental health records and be aware of a person's contact with the public mental health system by the time the person enters prison. In 2008, Forensicare proposed a similar model where mental health information could be shared on an as-need basis in a central state-wide system.

Early identification

117 In Victoria, every youth entering the youth justice system is screened for mental illness, comorbid disability and other relevant health conditions. This screening takes place too late, as the young person is already in the system. There are opportunities for the education system and other public service agencies to enable much earlier identification of youths living with mental illness and who have a propensity to offend.

118 Relevantly, Penny Armytage and I published a report dated July 2017 on our independent review of Victoria's youth justice system.[62] The report showed that approximately one-third of young people had a history of contact with the public mental health system, with many having been hospitalised. As part of our review, Ms Armytage and I met with a Deputy Secretary of the Department of Education and Training to enquire how youths who engage in violent behaviour are handled. I was shocked to find out that youths who are expelled from school due to violent behaviour are typically not directed to the mental health system. Other examples exist of opportunities to identify young people and engage with them in a preventative manner to reduce the likelihood of them both offending and deteriorating psychiatrically.

119 The Embedded Youth Outreach Program (**EYOP**), which the CFBS is currently evaluating for Victoria Police, is an example of a program that seeks to identify young people living with mental illness and who have a propensity to offend. The EYOP is funded by Victoria Police and delivered in partnership with a youth support specialist, Youth Support and Advocacy Service. Under the EYOP, a police officer and a youth worker are paired up in two high-need areas (which have a dearth of services) to provide an after-hours secondary response to young people coming into contact with police. Where appropriate, the youth worker would intervene and seek to link up the young people with service providers who can assist in addressing the underlying welfare needs and criminogenic

62 https://www.justice.vic.gov.au/justice-system/youth-justice/youth-justice-review-and-strategy-meeting-needs-and-reducing-offending.

factors that drive contact with police. While the evaluation process is at preliminary stage, the initial results of the EYOP are positive. In the absence of the EYOP, there are limited options available to police to link up a young person to service providers. The gap is what the service providers would do for the young people.

120 Understandably, the mental health system focusses on assessing and treating mental illnesses; however, as I have noted, there are opportunities for mental health services to increase their competence in identifying and providing appropriate services for people who are at risk of harm to others. I have previously mentioned the Queensland Sentinel Review. That review found, similarly, that mental health services in Queensland were focussed on treating mental illness and not the person's likelihood of offending. The review identified opportunities to enhance services to better address this shortcoming. Following the Queensland Sentinel Review, there were three key changes to the service delivery system:

(a) staff in public mental health services receive training for violent offending;

(b) staff who have expertise in forensic mental health are embedded in the mental health services (forensic outreach teams); and

(c) the provider of forensic mental health service (Queensland equivalent of Forensicare) provided secondary assessments and assisted in managing the highest risk individuals.

121 Such a model could work well in Victoria as we move forward with mental health reform. While the Forensic Clinical Specialists have some capacity, community-based forensic mental health teams that provide in-reach to area mental health services can be of much greater use to the services in helping to identify and manage forensic issues among the consumer group who would benefit from – or require – such services. Indeed, most forensic psychiatric patients were patients of public mental health services prior to engaging in acts that lead to them being made forensic patients. This highlights opportunities for prevention in the broader mental health system.

SENTENCING FOR PEOPLE WITH MENTAL ILLNESS

122 Along with the rapid rise in prisoner numbers over many years, the number of people living with mental illness in the criminal justice system has increased rapidly as well. Given the high percentage of people coming into custody who are living with mental illness (see paragraphs 106 – 109 above), it would be desirable to have more community and diversion orders to facilitate treatment for mental illness.

123 There are more therapeutic options in sentencing than what is available in Victoria, where there are only a few options other than using mental illness as a mitigating factor. There are two main ways in which mental impairment or mental illness can be taken into account

by the courts when dealing with a criminal matter. First, as an important part of an offender's personal circumstances, mental impairment constitutes one of many factors a court is required to take into account when sentencing an offender. In *R v Verdins* (2007) 16 VR 269 (**Verdins**), the Court of Appeal stated that mental impairment is relevant to sentencing in at least five ways. Mental impairment can:

(a) reduce the offender's moral culpability for the offence – this could affect the weight given to just punishment and denunciation as purposes of sentencing;

(b) influence the type of sentence that can be imposed and the conditions in which the sentence could be served;

(c) reduce the weight given to deterrence as a purpose of sentencing – this would depend on the nature and severity of the mental impairment and how this impairment affected the mental capacity of the offender at the time of the offence and at the time of sentencing;

(d) increase the hardship experienced by an offender in prison if they suffer from mental impairment at the time of sentencing; and

(e) justify a less severe sentence where there is a serious risk that imprisonment could have a significant adverse effect on the offender's mental health.

124 The court may consider the Verdins principles when sentencing an offender who has a mental impairment at the time of the offence and/or at the time of sentencing. For mental impairment to be a relevant consideration in sentencing, there is no need for the offender to have a diagnosable mental illness or for the illness/impairment to be of a particular level of severity. Although Verdins is now commonly used in sentencing decisions to mitigate sentences, there are still limited treatment options for people with mental illnesses both in the community and in prisons. This is true in prisons particularly for people with higher-prevalence disorders.

125 Secondly, some sentencing orders are only available if an offender has a mental illness. In particular, a court may impose a court secure treatment order which allows a person to be compulsorily detained and treated in a designated mental health service (*Sentencing Act 1991* (Vic), s 94A) provided the court is satisfied that an offender has a mental illness and requires mental health treatment to prevent serious deterioration in their health or serious harm to the offender or another person (among other factors). The order is restricted to cases where imprisonment would have been imposed had the offender not had a mental illness and where the court is satisfied that no other less restrictive option is available for the person to receive the necessary treatment. Additionally, the court cannot sentence a person to a court secure treatment order for a period longer than the term of imprisonment the court would otherwise have imposed. Although I do not have access to sentencing data regarding this option – nor do I know if

such exists – to my knowledge this sentencing option is rarely used. If services were available, the court secure treatment order would provide another sentencing option for courts. At the present time, however, realistically, there is no availability at the TEH to accommodate such persons, given competing demands for scare beds.

126 A final way in which mental impairment or mental illness may be taken into account by the court concerns the situation where a person's mental impairment is at a level that it impacts on their ability to take part in the normal criminal process or renders them incapable of having the capacity to be criminally responsible for their actions; that is, where the mental impairment impairs a person's capacity to stand trial or provides a defence to the charge. People found permanently unfit to be tried or not guilty by reason of impairment proceed down a specialised judicial pathway that is governed by the CMIA.

127 Under the CMIA, the court can declare a person liable to supervision under either a CSO or a NCSO. For people with a mental illness (as opposed to those found unfit to be tried or not guilty by reason of mental impairment on the basis of an intellectual disability or cognitive impairment), a CSO requires that a person be committed to custody in a mental health service, namely TEH. For those placed on a NCSO, a person is required to reside in the community under supervision and conditions imposed by the court. Those with a mental illness are supervised by Forensicare's CFMHS. In deciding whether to impose a CSO or NCSO, a court is required to apply the principle that "restrictions on a person's freedom and personal autonomy should be kept to the minimum consistent with the safety of the community" (CMIA, s 39(1)). The court must also have regard to:

(a) whether the person is likely to endanger themselves or another person if released (because of their mental impairment);

(b) the need to protect people from such danger;

(c) the nature of the person's mental impairment or other condition or disability;

(d) the relationship between the impairment, condition or disability and the offending conduct; and

(e) whether there are adequate resources available for the treatment and support of the person in the community.

128 Both orders are for an indefinite period. It should also be noted that the dispositional options in the CMIA apply to indictable offences heard in the Supreme Court, County Court and Children's Court. They cannot be imposed in matters heard in the Magistrates' Court. As such, these options are limited and used under limited circumstances.

129 As noted, some of the current options are also underutilised. This may be because of the lack of capacity at facilities like TEH (which is unable to accommodate all forensic patients, let alone people subject to other orders). Through my role on the Forensic

Mental Health Advisory Board, I am aware that even though some judges and magistrates are proactive in terms of wanting to make diversion orders, they are concerned about where to divert people living with mental illness. There is a need to have a service system that is capable of underpinning the making of diversion orders, such that judges and magistrates have some confidence that there will be remediation.

130 As compared to Victoria, the legal systems in other jurisdictions take a different approach and are more effectively using dispositions that are able to facilitate treatment for mental illness. For example, in the UK, diversion due to mental illness is possible before people are charged (although this does not occur often) and at the time of bail, remand or sentencing. The trend there is that they have fewer forensic patients and a higher number of people getting their equivalent of hospital orders which allow for the provision of mental health care (without determination of whether or not these people are criminally responsible). In contrast, the position in Victoria is that people living with mental illness are convicted before they can be considered for diversion at the time of remand or sentencing. While advances have been made in sentencing for people living with mental illnesses, and those found not guilty because of mental impairment, few mechanisms exist for the diversion of people living with mental illnesses.

BEST PRACTICE IN FORENSIC MENTAL HEALTH TREATMENT

Contemporary best practice in forensic mental health treatment

131 In my experience, one of the fundamental principles of contemporary best practice in forensic mental health treatment is that the mental health system needs to recognise that forensic mental health goes beyond providing mental health care to people who offend. Forensic mental health is a highly specialised area that considers issues such as the prevalence of mental health and offending, and why people living with mental illness might offend. As I have noted in this statement, there are opportunities for prevention and early intervention. As it now stands, the bulk of forensic mental health services in Victoria are provided to people who are already in custody in prison or who have committed an offence for which they have been found not guilty because of mental impairment.

132 Mental health systems that work best are systems which they can engender specialties; they do not work well if forensic mental health is subsumed by the general mental health system. The forensic mental health system should be operating within a larger framework but have responsibility for forensic mental health services. It would address criminogenic needs in addition to mental health and related needs (for example, attitudes and other criminogenic needs), so as to cater for the complex needs of people living with mental illness who have a propensity to offend.

133 I am not aware of anywhere in the world where a higher level of forensic mental health in the general mental health system has been effective. I note that a State-wide Integrated

Forensic Mental Health Services Model was trialled in Queensland and it had significant problems.[63]

Current Justice Health arrangements

134 Justice Health was established as a business unit of the DJCS in the mid-2000s. I have been in the Justice Health Ministerial Advisory Committee since its inception, and I served on the Corrections Health Board previously. There can be no doubt that the number and range of services for prisoners living with mental illnesses has increased over the past 10 years.

135 Unfortunately, however, I consider that the current arrangements for contracting, delivery and oversight of mental health services in prisons is the wrong approach.

136 In my view, it is fundamentally the wrong model that Justice Health, a business unit of DJCS, is essentially responsible for the health of prisoners. I believe that this responsibility should lie with the Department of Health and Human Services (**DHHS**) and not the DJCS, as DHHS is in a better position to identify and meet health needs. Justice Health should be under the oversight of DHHS and be operated like a health service. I believe that this is the only way that:

(a) equivalency in services between justice and the wider community can be guaranteed; and

(b) health and mental health service planning and delivery within the criminal justice system is integrated with the wider community health and mental health systems.

137 I believe that this should be the case both for adult and youth justice health services.

138 Indeed, many jurisdictions in the world (including Australian states, the UK and most Canadian jurisdictions) have moved the responsibility for health arrangements in prisons from the government's justice portfolio to the health portfolio. For example, over time following the deinstitutionalisation of NSW health services, it moved its Justice Health and forensic mental health services back under its health portfolio. Today, NSW's Justice Health and Forensic Mental Health Network is legally a local health district (as a state-wide service), with the same requirements for governance as other local health districts but provides state-wide services. It is statutorily required to comply with various reporting requirements (for example, governance requirements in relation to its Board of Directors),

63 Ogloff, J. R. P., Seccombe, C. E., & Thomson, K. (2018). Options paper for a Statewide Integrated Forensic Mental Health Services Model in Queensland. Unpublished Report prepared for Queensland Health. https://www.health.qld.gov.au/__data/assets/pdf_file/0029/726068/Implementation-Progress-Report-June-2018.pdf

which promotes transparency and accountability. In comparison, Justice Health only has an advisory committee and is not subject to the similar reporting requirements.

139 While we have seen extraordinary growth in demand for forensic mental health services in Victoria, broadly, the appreciable growth has occurred mostly in prison-based services. At the same time, there has been a very small increase in the growth in the TEH and the CFMHS. For example, 15 years ago, the bed-based mental health services in prisons were limited to 16 spaces at the Melbourne Assessment Prison (**MAP**) and 20 at Port Phillip Prison, and TEH had 100 beds. Today there are 141 spaces in the bed-based services in prisons (a four-fold increase) and 136 beds at TEH (a 1/3rd increase). While the provision of extra services in prisons is welcome – and something I advocated for over many years – a systems wide perspective is required.

DEMAND FOR FORENSICARE SERVICES

Ability of Forensicare to meet current demand for services

140 The foreword to the Royal Commission's Interim Report stated that:

"Once admired as the most progressive in our nation, the state's mental health system has catastrophically failed to live up to expectations. Past ambitions have not been realised or upheld, and the system is woefully unprepared for current and future mental health challenges."

141 Of course, the forensic mental health system exists, largely, within the public mental health system and has been affected by many of the inadequacies of the broader mental health system. As the longest-serving member of the Forensicare Executive, I have seen the early promise of Forensicare and the erosion of service capacity. While I still see excellent work done at Forensicare on a daily basis – as is true in the broader mental health system – the gradual depletion of resources has altered and limited available services and capacity. For example, beginning as early as 2006, Forensicare began to advocate for increased resources in the face of growing demand.

TEH

142 Planned in the late 1990s and opened in 2000, the capacity at TEH has not kept up with:

(a) the growth in the general Victorian population;

(b) the growth in the Victorian prison population; and

(c) the growth in the population of forensic patients.

143 At the time TEH opened, the prison population was about 3,000. The hospital was built with a capacity of 100 beds, out of which 31 beds were for occupied by forensic patients

and the rest of the beds were for prisoners and those in the general mental health system who required a period of secure hospitalisation.

144 Today, the prison population is approaching 8000. TEH now has 136 beds, out of which approximately 80 beds are occupied by male forensic patients and 10 beds are for female forensic patients. As such, the capacity for prisoners has reduced (from 69 to 46 beds), but the prison population has almost tripled (from 3,000 to 8,000). There is little capacity to take in security patients,[64] and no capacity to take in patients with very complex needs from area mental health services. As Dr. Sullivan notes in his witness statement, the Apsley Unit, opened recently, has alleviated some of the pressure to admit security patients, although they have a short length of stay and there are still limits on the capacity of the hospital to meet the demand for services.

145 In addition, the Victorian population has increased by about 1.5 million since TEH first opened. In comparison, the rate of beds at TEH has actually decreased; the service demand cannot be over-stated.

146 Since 2006, Forensicare has been lobbying, with supporting data, for increased capacity for service delivery at TEH. TEH currently only has capacity to cater for those who are most unwell and very limited capacity to provide services for people living with mental illnesses other than schizophrenia. When TEH first opened, 75% of the patients had schizophrenia and the rest had other mental illnesses. Today, over 96% of patients at TEH have schizophrenia. Other consequences of TEH's lack of capacity include the following:

(a) the length of stay of patients has reduced dramatically;

(b) there is no capacity to bring people in for observation or follow-up treatment; and

(c) the high security unit has a high turnover – security patients stay at the unit for a period of 3 weeks for intensive treatment and are sent back to prison. As Dr. Sullivan noted in his witness statement, it is often a case of sending back the least unwell person to prison. This does not afford an appropriate standard of care over the long-term.

147 Finally, it is important to consider the rate of forensic beds in Victoria compared to other Australian jurisdictions and with overseas jurisdictions with populations, and legal histories/systems similar to Victoria. I prepared the following diagram as part of my work reviewing national and international forensic mental health services (unpublished).

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64 A security patient is a person who is placed on either a secure treatment order under the *Mental Health Act 2014* (Vic) or on a court secure treatment order under the *Sentencing Act 1991* (Vic) and detained in Thomas Embling Hospital (prisoners transferred to Thomas Embling Hospital typically return to prison once treated).

Forensic Mental Health Beds – Australia & International (Dec 2019)

	WA	SA	VIC	NSW	QLD	TAS	ACT	NT
Pop'n (millions)	2.64	1.71	6.15	7.70	4.90	.52	.40	.25
Beds	30	40	116 136 (2019)	238	90	35	25	30
Rate per 100,000	1.13	2.34	1.89 2.14 (2019)	2.99	1.84	6.73	6.25	12.0

	New Zealand	British Columbia	Scotland	Ireland
Pop'n (millions)	4.7	4.8	5.2	4.7
Beds	238	190	534	94[1] 170 (2020)
Rate per 100,000	5.06	3.96	10.27	2 3.62 (2020)

1. These are medium and high secure forensic psychiatric patient beds; prisoners with mental illnesses are hospitalised in general mental health hospitals; a new hospital is under construction that will have 170 beds

148 As the information above shows, by comparison, Victoria has a lower rate of forensic beds than all of the international comparator jurisdictions. Within Australia, Western Australia and Queensland continue to be underserviced. In Queensland, though, for example, most forensic patients are managed in area mental health services (both in the community and in hospital). In Western Australia, most forensic patients on a custodial order are detained in prison. Victoria has among the lowest number of beds per capita among like jurisdictions. Noting that these jurisdictions have a similar population size to Victoria, Scotland has more than 500 beds and British Columbia has approximately 280 beds, with a plan to expand service. New Zealand has between 350 and 400 beds for a smaller population size as compared to Victoria. It is interesting to note that even if all of the bed-based services in prisons (141) were added to the TEH capacity (136), the total would still be lower than all like international jurisdictions.

Prison mental health services

149 Prison mental health service comprise of inpatient services (bed-based mental health services in prisoners) and outpatient services (mental health services in general custodial units).

150 In contrast to the TEH, the DJCS, led by Justice Health and Corrections Victoria, has done a remarkable job of increasing the capacity of bed-based mental health services in prisons (see paragraph 139). As noted previously, 15 years ago, there were only 16

spaces in the mental health unit of the MAP, and 20 'psychosocial rehabilitation' spaces at Port Phillip Prison, and there were no dedicated bed-based services for women in prisons. Today, there are bed-based mental health services in MAP, Port Philip Prison, Ravenhall Correctional Centre, as well as the Marrmak Unit at Dame Phyllis Frost Centre which provides dedicated services for women.

151 In relation to outpatient services, there is limited capacity for Forensicare's prison mental health services to meet the needs of prisoners with higher prevalence disorders. This would not be equivalent to the community standard of mental health care.

CFMHS

152 There are a range of services provided by the CFMHS. In relation to services provided at Courts, most of these services are run by the CFMHS and some services are run by area mental health services). These services are of limited scope – the CFMHS conducts assessments and make recommendations but has limited capacity to provide secondary consultations to patients from area mental health services or to implement recommendations.

Differences in service delivery for male and female prisoners

153 Service delivery for female prisoners is better than that for male prisoners, with a much higher rate of bed-based services.

154 Outside of prisons, however, service delivery in the forensic mental health system for female patients is much worse than that for male patients – there are only 12 dedicated beds for women in Victoria and there is a lack of economies of scale to provide female patients with the same access to services as male patients. Importantly, the number of dedicated beds for women has just grown by two beds (from 10 to 12), but this is the only growth in 20 years. Women in the TEH do not enjoy equivalence of care and placement options as males. Forensicare has been advocating for a 'women's precinct' for many years.

155 Relevantly, there are a few mixed-gender units at TEH but this is now not seen as appropriate in psychiatry.[65] Some female patients have also indicated that they do not wish to be in a mixed-gender unit. As such, it has been Forensicare's priority to have a dedicated precinct for female patients at TEH.

SUPPORTING CONSUMERS WITH COMPLEX NEEDS

65 Kulkarni, J., Gavrilidis, E., Lee, S., Van Rheenen, T. E., Grigg, J., Hayes, E., & Worsley, R. (2014). Establishing female-only areas in psychiatry wards to improve safety and quality of care for women. *Australasian Psychiatry, 22(6)*, 551-556.

Drivers of the diminished capacity for Forensicare to provide treatment and support for consumers from area mental health services

156 From its inception, the target population of the TEH included 'people with a serious mental health disorder in mainstream mental health services who are in a danger to their carers or the community.'[66] Initial admission criteria for the TEH included the provision of inpatient accommodation to involuntary patients who were not subject to forensic or sentencing orders, as follows:

> there is capacity to provide short-term admissions to non-forensic clients who are mentally ill and who have been receiving treatment with general mental health services.[67]

As such, clients of general mental health services who present with significant difficulties which manifest in self-harm, and/or harm to others (including staff and potentially to the community), may be referred to Forensicare for advice on matters of assessment, treatment and risk management.

157 The TEH opened in April 2000 with 65 beds initially, becoming fully operational with 100 beds by the end of 2002. For the first ten years of operation, between 3% and 13% of patients admitted to the hospital were involuntary patients transferred from other hospitals.[68]

158 The table on the following page, which I prepared for the Royal Commission based upon data provided in successive Forensicare annual reports, provides the percentage of involuntary patients admitted to the TEH as a percentage of the total number of patients admitted in each fiscal year during the first 10 years of operation. Beginning in the late 2000s, the capacity of the hospital became increasingly limited and ultimately non-forensic involuntary patients ceased to be admitted, except under unusual circumstances. TEH still has a small group of involuntary patients, but they are prisoners who were transferred to the hospital as security patients under the MHA who require ongoing involuntary treatment after their sentence expires and become involuntary patients under the MHA. Unfortunately, however, the capacity to assist the broader area mental health services by admitting complex and challenging patients for assessment and intervention has been lost.

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66 Forensicare – Victoria's Forensic Mental Health Service (March 1999), p. 6.

67 *Ibid* at p. 30

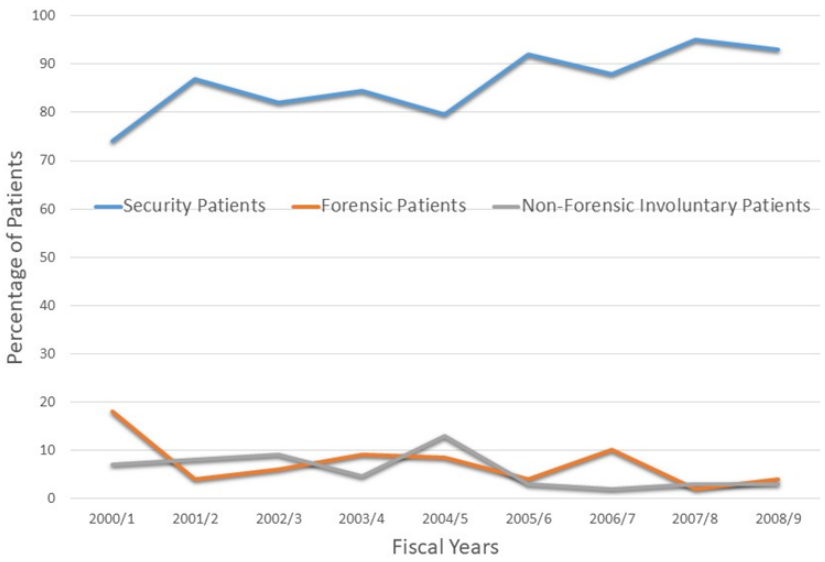
68 Victorian Institute of Mental Health Annual Reports 2000/2001 to 2009/2010.

Percentage of Involuntary Patients Transferred to TEH from Other Hospitals during the First 10 Years of Operation

Fiscal year	Percentage
2000/1	7%
2001/2	8%
2002/3	9%
2003/4	4.5
2004/5	13%
2005/6	3%
2006/7	2%
2007/8	3%
2008/9	3%
2009/10	3%

159 The figure below, which I prepared for this Royal Commission, shows the percentage of prisoners at TEH between 2001/2002 and 2008/2009 by legal status on admission. Security patients are prisoners transferred to the TEH under the MHA. Forensic patients are those admitted under the CMIA. Non-forensic involuntary patients include patients transferred to TEH from other area mental health services under the MHA.

Percentage of Patients Admitted to TEH by Legal Status



160 There is a need for Forensicare to provide a high level of care to consumers who have very complex needs and are behaviourally challenged. The TEH would be an opportune place to accommodate them – as it was planned to do, and did, for the first 10 years of its inception.

Changes required to the SECU model of care, governance or system safeguards

161 There is scope for Forensicare to interface with Secure Extended Care Units (**SECUs**) in providing services to consumers with very complex treatment and support needs. There have been discussions over the past year that it would be ideal to have a SECU in TEH, being the only public forensic mental health hospital. The advantage of a forensic mental health hospital is that it has secure perimeters, allowing safe movement of consumers within the hospital. Also, while TEH's facilities are relatively tired, it has good services such as Technical and Further Education courses, a swimming pool and a gym. In comparison, the current SECUs are not well-designed for long-term stay and do not have such facilities. As such, consistent with the principle of least restriction under the MHA, consumers currently at SECUs may benefit if they are in a SECU in TEH instead.

The role of forensic clinical specialists in area mental health services

162 Forensicare coordinates the Forensic Clinical Specialist Program (**FCSP**), which allocates a forensic clinical specialist, being a senior forensic mental health clinician, to each area mental health service. The CFBS runs a suite of courses in forensic mental health that are attended by the forensic clinical specialists (see paragraph 28).

163 The role of the forensic clinical specialists is to improve the expertise and capacity of the workforce in the area mental health services to optimally assess and manage offending and problem behaviours by:

(a) improving clinical outcomes for vulnerable consumers with mental health and offending treatment needs;

(b) reducing consumer contact with the justice system;

(c) improving management of offence-related risk;

(d) improving worker safety and reducing violence and aggression in the workplace

(e) improve coordination and referral pathways between specialist mental health services and correctional services;

(f) focussing on vulnerable individuals released from custody in need of mental health follow-up; and

(g) enhancing local oversight of consumers subject to Non-Custodial Supervision Orders under the CMIA.

164 From my experience interacting with and teaching the Forensic Clinical Specialists since their inception, many become highly experienced but all typically lament the inability to meaningfully address all of the needs in their home services. Although the current model has begun to bridge a gap in services, it has not filled that gap. Only with expanded services, can the broader needs of the area mental health service and their consumers with forensic histories and contact be met.

Challenge associated with effective performance of the role of forensic clinical specialists

165 The challenge associated with effective performance of the role of forensic clinical specialists is that there is largely only one forensic clinical specialist for an entire area mental health service. To my knowledge, Forensicare had no role in the plan for this service, and I presume the limited resources are due to funding constraints. While the forensic clinical specialist might be able to provide some services such as secondary consultations and training, it is important to expand the FCSP such that it can be a conduit between Forensicare and the area mental health services. For example, Queensland's forensic mental health service has a team which is integrated with each area mental health service and can provide various roles.

Increasing the effectiveness of forensic clinical specialists

166 Perhaps the best way to enhance the forensic clinical specialists is to expand on the capacity of Forensicare's community forensic mental health services to better support area mental health services and the people they support living with mental illnesses. There are two broad areas of need for community forensic mental health services. The first (community forensic outreach service) pertains to the broad needs area mental health services have managing people living with mental illnesses who require specialist forensic services and the second (forensic assertive community treatment) pertains to people living with mental illnesses who are transitioning back to the community from a period of time in prison – either on remand or after serving a sentence. I will briefly address potential service models to meet both of these areas of need.

167 Community forensic outreach services (**CFOS**) provide specialist forensic input to community and inpatient mental health services. An example of such services comes from Queensland's community forensic mental health service. In Queensland, the service utilises a consultation-liaison model to assist with assessment and management of complex clients who have committed, or are at risk of committing an offence or those engaged in problematic and high concern behaviours towards others.

168 There are three CFOS teams across Queensland based in Brisbane, Townsville and Cairns. Each team provides services to area mental health services on a regional basis. CFOS operate as multidisciplinary teams. The target group includes consumers 18 years

and over, at risk of, or who have committed offences, or at risk of such behaviour as noted. Consumers include both voluntary and involuntary consumers.

169 CFOS program components are: multidisciplinary, outreach consultation liaison services including specialist advice, risk assessment, threat assessment, fire setting assessment, second psychiatric opinion, review of management plans, training and education, outreach clinics for reviews of patients, and time limited co-case management. The CFOS team also provides specialised forensic risk assessments at the request of AMHSs. These assessments are conducted for the purposes of assisting in the determination of the patient's current risk profile, formulation of risk mitigation and management strategies, and making recommendations to a patient's care plan.

170 Regarding people living with mental illnesses who are transitioning back to the community from a period of time in prison, international best practice shows that intensive rehabilitation services work very well for ex-prisoners living with mental illness. Like assertive community treatment, forensic assertive community treatment (**FACT**) teams have developed as an adaptation of the assertive community treatment model are designed to serve justice-involved adults with serious mental illness.[69] A range of evaluations exist that show that FACT teams can reduce offending and incarceration, reduce hospitalisation, and promote engagement in outpatient mental health services. These services, together with area mental health services, provide shared care to ex-prisoners when they re-enter the community, and the area mental health services eventually take over the care for them.

171 In addition to the adult services, there has been a more limited youth forensic clinical specialist service. With far fewer resources than those dedicated to adults, the youth service is also severely limited.

OUTCOMES

172 The outcomes of Forensicare's forensic patients are generally very good, particularly the forensic patient group. For example, forensic patients who are under non-custodial orders under the CMIA usually have their orders discharged. As a group, they also tend to have a low rate of re-offending and an extremely low rate of violent offending (see paragraphs 7373 – 81).

173 In stark contrast to forensic patients, security patients tend to have high rates of re-offending over time (e.g., 50% violent reoffending).[70] This is because, as discussed in

69 Lamberti, J. S., Weisman, R. L., Cerulli, C., Williams, G. C., Jacobowitz, D. B., Mueser, K. T., ... & Caine, E. D. (2017). A randomized controlled trial of the Rochester forensic assertive community treatment model. *Psychiatric services, 68(10)*, 1016-1024.

70 Brookstein, D. M., Daffern, M., Ogloff, J. R., Campbell, R. E., & Chu, C. M. (2020). Predictive validity of the HCR-20V3 in a sample of Australian forensic psychiatric patients. *Psychiatry, Psychology and Law*, 1-18.

paragraph 69, some patients have complex needs that include both mental health needs and criminogenic needs. The focus of the care of most security patients is a comprehensive assessment and then stabilisation of the symptoms of the mental illness as rapidly as practicable to return them to prison. Although Forensicare has not systematically investigated the outcomes of security patients over time, anecdotally, the experience of our clinical staff members is that security patients do not have adequate time to recover meaningfully from the mental illness before they return to prison. As Dr. Sullivan has noted in his witness statement, Forensicare is under considerable pressure to move security patients through the TEH as rapidly as possible given the chronic bed shortage and unmet needs. Interestingly, jurisdictions like Scotland and the UK have longer lengths of stay, often keeping security patients in forensic mental health hospitals until their sentences expire. With our very low rate of beds, that is simply not possible in Victoria, except with a small group of complex and high risk security patients who require ongoing involuntary treatment in the TEH after their sentences expire. There are often no other options for the appropriate accommodation of security patients in area mental health services.

174 Another example of demonstrated good outcomes for Forensicare consumers comes from the PBP as discussed above (see paragraphs 81 – 86). The PBP expanded within the last five years following increased funding provided following the Complex Adult Victorian Sex Offender Management Review Panel (commonly known as the 'Harper Review') to provide advice on the legislative and governance models under the Victorian *Serious Sex Offenders (Detention and Supervision) Act 2009*.[71] The CFBS and Forensicare are working on an updated evaluation of the PBP.

YOUTH FORENSIC MENTAL HEALTH SERVICES

175 There should be a state-wide specialist forensic mental health service for children and young people, because of the same reasons for a specialist service for adults. Contemporary developmental psychology and psychiatry increasingly extend youth to 25 years of age. In particular, specialised forensic mental health expertise is required to understand the needs of youths (noting that a high percentage of Forensicare's patients are youths and are in prisons, TEH or the CFMHS).

176 A specialist forensic mental health service for children and young people can be either part of a broader service system, or a standalone service on its own. My view is that the best model is to integrate it with the adult specialist forensic service for efficiencies (for example, a forensic mental health service with a youth division), as children and young

[71] Advice on the legislative and governance models under the Serious Sex Offenders (Detention and Supervision) Act 2009 (Vic), Complex Adult Victim Sex Offender Management Review Panel, (November 2015).https://www.justice.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2020/06/fb/b3d672e6b/cavsom-harper-report.pdf

people are likely to also require the services as young adults and later. There must also be good communication and dialogue with the adult specialist system. With adequate expertise in child and adolescent forensic mental health, it is important to ensure continuity care across the age spectrum. All too often, youth are 'cut off' from services as they reach adulthood. I have personally assessed and worked with youth who go from being supported by child protection to having a lack of services.

COMPULSORY TREATMENT

177 I echo the comments of my colleague, Dr. Danny Sullivan in asserting that compulsory treatment is most effective and most appropriate in hospital settings. The purposes of sentencing do not include the involuntary treatment of mental illness. The purpose of prisons is not to treat complex mental illness involuntarily.

178 When I was Director of Mental Health Services in British Columbia, Canada, we gazetted a mental health unit in a custodial setting (the equivalent of the MAP). This was done prior to the construction of an expanded forensic psychiatric hospital in British Columbia when there was a dearth of capacity for secure beds in the forensic and general mental health system. In the end, the experience was negative. Medical and nursing staff felt compromised in forcibly medicating people in the context of incarceration. Consumers reported experiencing involuntary treatment as a form of punishment. Following a review, the unit was de-gazetted. While there is doubtless a need for greater capacity for involuntary mental health treatment for security patients in Victoria, expediency ought not be a reason to jeopardise treatment and risk an affront on human rights.

INNOVATION AND REFORM

179 A system that much better integrates forensic issues with mental health would be most effective in improving the interaction of, and outcomes for, people living with mental illness with the justice system. Integration does not, however, mean being subsumed into the mental health system. Rather, stronger ties and formal service system relationships must be fostered. The Collaborative Centre model will facilitate and foster such relationships.

180 As I have previously discussed, mental illness and comorbidities such as substance use and personality disorder can impact a person's likelihood of offending. The goal would be to have an integrated service across the criminal justice system that has better interfaces with services addressing mental illness and each of these comorbidities. People living with mental illness who offend should not be treated differently in terms of their mental health needs. It is also a waste of resources if people with mental illness are not identified and provided treatment earlier, and end up having to spend years in forensic mental health facilities. Not to mention the damage and harm caused to victims, families, and of course to those living with mental illness who offend and harm others.

181 Given the length of stay in hospital for forensic patients, each forensic patient displaces a minimum of 15 to 25 security patients, depending upon length of stay. As such, prevention and early intervention not only lead to better practice, but can also contribute to a more efficient service system.

sign here ► 

print name JAMES ROBERT OGLOFF

date 5.8.2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT JO-1

This is the attachment marked 'JO-1' referred to in the witness statement of Distinguished Professor James Robert Ogloff dated 5 August 2020.

CURRICULUM VITAE

JAMES R. P. OGLOFF AM

B.A., M.A. (Clin. Psyc.), *Juris Doctor, Ph.D., FCCP, FCFP, FAPS*

University Distinguished Professor of Forensic Behavioural Science and Director,

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Swinburne University of Technology

Executive Director of Psychological Services and Research

Victorian Institute of Forensic Mental Health (Forensicare)

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Citizenship: Australian and Canadian

CURRENT APPOINTMENTS:

Swinburne University of Technology

- 2013 – present Director, Centre for Forensic Behavioural Science
- 2020 – present University Distinguished Professor of Forensic Behavioural Science
- 2013 – 2020 Foundation Professor of Forensic Behavioural Science

Victorian Institute of Forensic Mental Health (Forensicare)

- 2018 – present Executive Director of Psychological Services and Research
- 2001 – 2018 Director of Psychological Services
- 2014 – 2018 Director of Research
- 2009 – 2011 Principal Advisor, Service Development and Forensic Operations
- 2009 – 2017 Acting CEO (for periods of 2-3 weeks intermittently)

PREVIOUS APPOINTMENTS:

Monash University

- 2006 – 2012 Director, Centre for Forensic Behavioural Science
- 2001 – 2012 Foundation Professor of Clinical Forensic Psychology
- 2001 – 2007 Member, International Institute of Forensic Studies, Faculty of Law

Simon Fraser University (British Columbia, Canada)

- 1999 - 2001 University Endowed Professor of Law and Forensic Psychology
- 1990; 1993; 1997 Assistant/Associate/Professor of Psychology
- 1992 – 2001 Director, Program in Law and Forensic Psychology
- 1992 – 1997 Associate Chair, Department of Psychology
- 1992 – 1996 Associate Member, School of Criminology

University of British Columbia

- 1994 – 2001 Adjunct Professor of Law

Ministry of the Attorney General, British Columbia, Corrections Branch

- 1998 – 2001 Director of Mental Health Services

British Columbia Review Panel

- 1992 – 2001 Chair, Mental Health Review Panel (*B.C. Mental Health Act)*

British Columbia Forensic Psychiatric Services Commission

- 1994 – 2001 Consultant Forensic Psychologist
- 1990 – 1999 Research and Policy Consultant

Other Academic Appointments

- 1996 Visiting Professor, Department of Mental Health Law and Policy, Florida Mental Health Institute, University of South Florida
- 1996-2001 Adjunct Professor of Psychology, University of Manitoba, Canada

LICENSURE AND COLLEGE MEMBERSHIP:

- 1991 – 2003 Registered Psychologist, B.C. College of Psychologists (#1022)
- 2001 – Present Registered Psychologist, Psychology Board of Australia (#PSY001124563) Endorsed as a clinical psychologist and forensic psychologist
- 2002 – Present College of Clinical Psychologists, Australian Psychological Society
- 2002 – Present College of Forensic Psychologists, Australian Psychological Society

EDUCATION:

University of Nebraska, Lincoln

- 1986 – 1990 Ph.D. Psychology and Law, with specialized training in law/psychology, forensic psychology, and mental health policy, University of Nebraska Law and Psychology Program

  Dissertation: *A Comparison of Insanity Defense Standards on Juror Decision Making*, Supervisor – Dr. Gary B. Melton

University of Nebraska College of Law, Lincoln

- 1986 – 1989 Juris Doctor, With Distinction
  Class Rank: 4th out of 169

University of Saskatchewan

- 1984 – 1986 Master of Arts in Clinical Psychology

  Thesis: *Electrodermal and Cardiovascular Indicants of a Coping Response in Psychopaths*, Supervisor – Dr. Stephen C. P. Wong

University of Calgary

- 1980 – 1984 Bachelor of Arts in Psychology

  Thesis: *Eyewitness Testimony and Hypnosis: No Enhancement and No Bias*
  Supervisor – Dr. H. L. Radtke

HONOURS AND AWARDS:

2020	University Distinguished Professor, Swinburne University of Technology
2019	Vice-Chancellor's 2019 Research Excellence Award, Swinburne University of Technology
2019	University of Nebraska-Lincoln LawPsychology Distinguished Alumni Award
2019	Award for Swinburne Outstanding Researcher, Swinburne University of Technology
2018	Award for Distinguished Contributions to Psychology and Law (American Psychology-Law Society)
2015	Member in the General Division of the Order of Australia (AM) for significant service to education and to the law as a forensic psychologist, as an academic, researcher and practitioner.
2013	Distinguished Alumni Award, University of Saskatchewan, Saskatoon, Saskatchewan
2012	Donald Andrews Career Contribution Award for Criminal Justice Psychology, Canadian Psychological Association
2009	Australian Psychological Society College of Forensic Psychologists Distinguished Contributions Award
2005	Elected a Fellow of the Australian Psychological Society
2005	Award for Outstanding Teaching and Mentoring (American Psychology-Law Society)
2003	Elected a Fellow of the Canadian Psychological Association
2001	R. G. Myers Memorial Lecture (Monash University and Australian and New Zealand Association of Psychology, Psychiatry and Law (ANZAPPL))
2000	Kenneth G. Grey Lecture (invited lecture for distinguished contributions to law and psychiatry), Canadian Psychiatric Association
1997	Elected a Fellow of the American Psychological Association
1996	Canadian Council of Professional Psychology Programs Award for Excellence in Professional Training
1995	Saleem Shah Award from the American Psychology Law Society (Div. 41 of APA) and the American Academy of Forensic Psychology in honour of early career excellence in research in law and psychology.
1992	CPA Committee of Young Psychologists Awards; Travel Scholarship to attend the XXV International Congress of Psychology in Brussels
1990 - 1991	APLS/Div. 41 American Psychological Association Dissertation Award (1st Place)
1990	Recipient of University of Nebraska-Lincoln Parents' Association "Award for Contributions to Students."
1990 - 1992	SSHRC Postdoctoral Fellowship (declined)
1989	1st Place Grad. Student Presentation Award, Great Plains Psychology Conference
1987 - 1990	SSHRC Doctoral Fellowship
1986 - 1988	Scholarships held at the University of Nebraska College of Law: Lane Scholarship, Holt Scholarship, and Devoe Scholarship
1985 - 1987	Saskatchewan Health Research Board Training Fellowship

RESEARCH GRANTS/CONTRACTS AWARDED:

2020	Department of Youth Justice, Queensland Government ($202,170.00 with M. Daffern, K. Thomson, R. Darjee, S. Luebbers & S. Reeves) 'Review of Adolescent Sexual Offending Services'
2019 – 20	Court Services Victoria ($675,512 with P. Reddy, T. McEwan, B. Batagol, K. Gelb & B. Spivak) 'Evaluation of Magistrates' Court of Victoria Family Violence Reforms'
2019	Australian Research Council ($482,366 with J. Clough & D. Meyer) 'Understanding and responding to online child sexual exploitation offenders'
2019	Australian Institute of Criminology ($160,000 with M. Henshaw, R. Darjee, & J. Clough) 'Preventing repeat child exploitation material offending: A two-tiered psychological intervention approach'
2018 – 2020	Correctional Service of Canada ($150,000 with J. Trounson, J. Pfeifer) 'Advanced mental strength training for correctional officers'

2018 – 2019	Victorian Institute of Forensic Mental Health ($147,099 with J. Trounson) 'Evaluation of the Boon-Gim Ngaga (deep understanding) social emotional and wellbeing assessment package'
2018	Department of Justice and Regulation, Victoria ($189,000 with S. Luebbers, M. Daffern, K. Thomson, A. Dunne, N. Papalia) 'Revision of Adolescent Violence Intervention Program (AVIP) and development of high intensity violence intervention program'
2018	Department of Home Affairs, Commonwealth of Australia ($120,045 with T. McEwan, M. Daffern) 'Validation of national tools' Catalyst Consortium - Australian Consortium for Research Excellence in Reducing Persistent Violence and Sexual Offending'
2017 – 2021	Department of Justice and Regulation, Victoria, and Victorian Institute of Forensic Mental Health ($2,200,000 with M. Daffern, R. Fullam, T. McEwan, C. Lloyd, S. Luebbers, S. Shepherd, M. Nixon)
2017- 2018	Department of Justice and Regulation, Victoria ($78,750 with C. Lloyd, M. Daffern, C. Trotter, N. Wilson, K. Thomson) 'Reintegration assessment package: Evaluation, Revision and Enhancement of Existing reintegration planning practices'
2017 – 2018	Swinburne Research Development Grant Scheme ($9,940 with S. Shepherd, T. Anthony, E. Marchetti, J. Trounson, Victorian Aboriginal Legal Service) 'The consideration of culture in pre-sentence reports'
2017	Swinburne Research Development Grant Scheme ($9,944 with C. Lloyd, M. Daffern) 'Which risk factors may "flag" imminent violence? Exploring 'real time' risk assessment to improve correctional practice'
2017 – 2022	Victorian Institute of Forensic Mental Health ($848,502 with M. Nixon, R. Fullam) 'Evaluation of the Forensic Mental Health (FMH) Services at Ravenhall Prison
2016 - 2017	Legal Services Board of Victoria ($63,000 with B. Spivak) 'Effective Judicial Supervision of Offender Rehabilitation'
2016 – 2017	Swinburne Indigenous Small Grants Scheme ($4,000 with S. Shepherd) 'The Relevance of Aboriginality in Sentencing: Reducing Inequality Before the Law or Undermining Individualised Justice?'
2016 – 2017	Department of Justice and Regulation, Victoria ($267,437 with M. Daffern, K. Thomson, A. Day, C. Lloyd) 'Evaluation of programs for serious violent offenders'
2016 - 2017	Department of Justice and Regulation, Victoria ($257,752 with M. Daffern, C. Trotter, A. Day) 'Evaluation of the Corrections Victoria case management model for serious sex offenders'
2016 – 2017	Department of Justice and Regulation, Victoria ($173,222 with M. Daffern, D. Shea, G. Klepfisz) 'Validation of the Violence Risk Scale (VRS) and the Violence Risk Scale – Screening Version (VRS-SV) in a Victorian offender sample'
2016	Victorian Institute of Forensic Mental Health ($114,623 with R. Fullam, M. Sellars) 'Evaluation of the new Forensic Mental Health operating model, Ravenhall Prison'
2016	Macedon Ranges Medicare Local with Victoria Police ($509,907 with T. McEwan) 'Improving the Health and Safety of Family Violence Victims via Evidence-Based Policing'
2016 – 2021	Australian Research Council linkage grant with University of Melbourne & Crime Stoppers Victoria ($115,000 with J. Stanley & A. March) 'Building an Integrated System for Australian Bushfire Prevention
2015-2016	Department of Justice and Regulation, Victoria ($165,113 with J. Pfeifer, J. Hiller, J. Skues, R. Fullam, M. Nixon) 'Evaluation of the Smoke Free Prisons Project'
2015	Department of Justice and Regulation, Victoria ($19,699 with M. Daffer, D. Shea) 'Scoping exercise for the Violence Risk Scale (VRS) validation'
2015 – 2018	Victorian Institute of Forensic Mental Health ($229,525 with R. Fullam, L. DeBortoli, J. Norton) 'Evaluation of the Mobile Forensic Mental Health Service (MFMHS)
2015-2016	Criminology Research Council ($58,467 with S. Shepherd, Y. Paradies, & J. Pfeifer) 'Aboriginal Offenders with Cognitive Impairment: Is This the Highest Risk Group?'
2014 - 2017	Australian Research Council ($538,000 with J. Pfeifer, M. Daffern, J. Skues, A. Oliva, R. Owen, D. Roach) 'Enhancing Wellbeing and Resilience within Prisons: A Psycho-Educational Approach for the Missing Middle'

2014 – 2015	Australian Institute of Criminology ($61,178 with S. Shepherd & S. Luebbers) 'The Relationship between Mental Illness and Offending among Australian Young Offenders'
2014	Mental Health Commission ($260,000 with T. Butler, S. Allnutt, P. Schofield, G. Sara, A. Kariminia, D. Owens, L. Grant, & D. Weatherburn) 'The relationship between mental illness and offending in New South Wales'
2012 - 2015	National Health and Medical Research Council ($956,020 with M. Stoove, S. Kinner. T. Butler, P. Dietze & C. Aitken) 'A Prospective Cohort Study of Ex-Prisoners with a History of Injecting Drug Use: Examining Health Service Utilisation, Physical and Mental Health and Blood Borne Virus Trajectories'
2012	Department of Human Services, Victoria ($175,000 with M. Daffern, M. Dolan) 'Evaluation and Redevelopment of the Youth Justice Program for Violence Reduction'
2011 - 2014	Australian Research Council linkage grant ($230,444 with J. Clough, R. Monteleone) 'Asking the Right Questions: Improving Juror Comprehension of Instructions'
2010 - 2012	Justice Health, Department of Justice, Victoria ($225,000 with S. Thomas) 'Koori Prisoner Mental Health and Cognitive Function Study'
2010 – 2014	Australian Research Council discovery grant ($554,000 with P. Mullen, T. McEwan, R. MacKenzie) 'Recognising, Assessing and Managing High Risk Stalking Behaviour: An Evidence-Based Approach'
2010 – 2013	Australian Research Council discovery grant ($440,000 with M. Dolan, R. Fullam) 'Understanding the Nature and Characteristics of Youth Violence in Australia'
2009 – 2011	Australian Research Council linkage grant with Victoria Police and the Department of Human Services ($171,969 with S. Thomas, M. Daffern, P. Mullen, L. Webber, & A. Dickinson) "Intellectual Disability, Victimization, Challenging Behaviour and Offending"
2009 – 2010	Criminology Research Council ($43,652 with P. Mullen & M. Cutajar) 'Child Sexual Abuse and Subsequent Offending and Victimisation: A 45 Year Follow Up Study'
2007 – 2011	Australian Research Council linkage grant with Victoria Police ($980,000) with S. Thomas, P. Mullen, T. Martin, J. Clough, A. Dickinson, K. Lay, J. Pfeifer). "Police Responses to the Interface with Mental Disorder" (Project PRIMeD)
2007	Department of Immigration and Citizenship ($69,000 with P. Mullen, S. Thomas, E. Colucci) "An Evaluation of the Suicide and Self Harm Protocols and Procedures"
2006-2009	Australian Research Council ($222,000 with B. McSherry, J. Crichton, T. Hadjistavropoulos, L. Thomson). "Confidentiality in Therapeutic Relationships: Developing Guidelines for Mental Health Professionals"
2006-2009	Australian Research Council ($467,000 with D. Tait, J. Goodman-Delahunty, J. Kyd, J. Joran, G. Brawn, G. Battye, C. Lennard, D. Jones, A. Wallace, & R. Regshauge). "Juries and Interactive Visual Evidence: Impacts on Deliberation Processes and Outcomes"
2006 – 2007	Corrections Victoria ($183,000 with S. Thomas, M. Daffern, S. Wong) "An Evaluation of the Corrections Victoria Violence Intervention Program"
2006	Department of Human Services ($70,600 with T. Dalton, V. Marziano, R. Campbell, N. Warden) Treatment Program for 15 – 18 Year Old Sex Alleged Sexual Offenders
2006	Criminology Research Council ($50,000 with P. Mullen, S. Ross) "Identification of Mental Illness in the Criminal Justice System"
2005	Criminology Research Council ($14,500 with A. Carroll) "An Investigation into Serious Violence Associated with Motor Vehicle Use: Is 'Road Rage' a Valid and Useful Construct?"
2003	Monash University Small Grants ($40,000 with P. Mullen). "Risk for Violence among Forensic Psychiatric Patients in Australia"
2003-2005	Australian Research Council linkage grant ($220,000 with S. Lancaster and S. Thomas). "An Examination of Pathways to and from Juvenile Justice"
2000 - 2001	Ministry of Attorney General, BC Corrections Branch ($24,000) "The Prevalence of Mental Illness in a Population of Offenders under Community Supervision"
2000 - 2001	William and Ada Isabelle Steel Fund, SFU ($18,000) "Prevalence of FAS/FAE Among Pretrial Jail Inmates"
2000	Mental Health Services, BC Ministry of Health ($69,000) "Dually Diagnosed Offenders Alternative Treatment Program"
1999 - 2002	SSHRC Research Grant ($116,000) "The Impact of Jurors' Incomprehension of Judicial

	Instructions on Verdict: Evaluation of the Interactive Jury Deliberation Model"
1999 - 2001	Mental Health Services, BC Ministry of Health ($328,000) "Dually Diagnosed Offenders Alternative Treatment Program"
1998 - 2000	Canadian Foundation for Innovation ($175,000) "Forensic Mental Health Research and Training Network"
1998 - 2000	William and Ada Isabelle Steel Fund, SFU ($12,000) "Addressing the Needs of Mentally Ill Offenders with Substance Abuse Disorder"
1997-1998	President's Research Grant, SFU ($20,000) "Increasing jurors' comprehension of judicial instructions"
1997 - 1999	SSHRC Small Research Grant ($4,999) "Screening for Inpatient Risk of Harm to Others"
1996 - 1997	Law School Admission Council ($21,200) "Review of the Empirical Research Literature on Legal Education."
1995 - 1997	Law Foundation of British Columbia ($88,000) "Judicial Instructions and the Jury"
1995 - 1997	B.C. Health Research Foundation ($76,000; with I. Grant, B. Ledwidge, & C. Webster) "An investigation of civil commitment in British Columbia"
1995	Department of Justice ($5,000, contract) "The Treatment of High Risk Offenders: A Literature Review and Analysis"
1994 - 1997	SSHRC Research Grant ($90,000) "Increasing Juror Comprehension of Judicial Instructions: A Comparison of Alternative Strategies."
1994 - 1995	SSHRC Small Research Grant ($4,618) "A Comparison of Pre and Post Bill C-30 Insanity Defence Standards in Canada"
1993	Correctional Services of Canada ($26,757, contract) "Literature Review on Evaluating Anger Management Programming"
1993	Department of Justice ($9,969; with R. Roesch) "Study of the Impact of Bill C-30 on Remands on Assessments of Fitness to Stand Trial and Criminal Responsibility."
1992 - 1993	BC. Ombudsman ($3,000) "Mentally Ill Individuals' Self-Advocacy Programs Literature Survey"
1992 - 1994	Health and Welfare Canada Research Grant ($182,408) "An Evaluation of two Treatment Programs for Assaultive Husbands."
1992 - 1995	SSHRC Research Grant ($126,000; with R. Roesch and R. Corrado) "The Impact of Mental Disorder on Legal Competencies and Pretrial Release Decisions: Implications for Public Policy."
1991 - 1994	SSHRC Research Grant ($73,856) "A Comparison of Current and Proposed Insanity Defence Standards in Canada"
1991 - 1993	Department of Justice ($75,000; with R. Roesch & M. Moretti) "A Study of the Impact of Changes in Release Procedures for Defendants found NGRI"
1991 - 1992	B.C. Ministry of Solicitor General ($29,500; with R. Roesch) "A Survey of Domestic Violence"
1991 - 1992	SSHRC Law and Social Issues Grant ($9,200; with 3 co-investigators) "Judicial Decisions, Legal Norms and Professional Compliance in Schools: Development of a Research Agenda"
1991 - 1992	SSHRC Small Research Grant ($4,000; with Dr. M. Moretti) "Automatic and Controlled Processing in Adolescent and Adult Offenders and Non-Offenders"
1991	Department of Justice ($11,255; contract) "The Insanity Defence in British Columbia"
1990 - 1992	SFU President's Research Grant ($4,992) "A Comparison of the Impact of Canadian Insanity Defence Standards on Mock Jurors' Decision-Making"

CLINICAL, SERVICE, AND CONSULTING EXPERIENCE OVERVIEW:

- Since November 2001, my duties as Director of Psychological Services in the Victorian Institute of Forensic Mental Health (Forensicare) have included psychological assessment and treatment of offenders and forensic patients, as well as secondary consultation and supervision of staff and students in these areas.
- Examiner for the Victorian Transport Accident Commission, conducting personal injury assessments
- Clinical and forensic psychologist in a variety of settings both as a training psychologist and as a registered psychologist since 1984 (e.g., community mental health centre, university hospital, university psychology clinic, forensic clinic, secure forensic hospitals, jails and prisons).

- Clinical and forensic psychologist in private practice and with the British Columbia Psychiatric Services Commission from 1990 – 2001 conducting court ordered assessments of forensic patients and helping develop, implement, and evaluate programs for mentally ill offenders.
- Given expert opinion evidence at all levels of court in Canada, Victoria (Australia) and at some trial courts in Australia, New Zealand, Indonesia and the United States in the areas of forensic mental health, criminal offending, sexual offending, violent offending, the prediction of violence and risk, death penalty, jury behaviour and jury decision making.
- Consultant to the Attorney General of British Columbia regarding high profile difficult cases.
- Chaired government task forces exploring such matters as the assessment and treatment of sexual offenders and the provision of mental health services in jails and prisons.

RECENT CONSULTATIONS:

• March 2018	Provision of expert advice to Queensland Corrections on offender management frameworks and assessment tools (KPMG)
• February 2018	Review of the operation of the Forensic Disability Act 2011, and consideration of Queensland's forensic disability service system (Department of Communities, Child Safety and Disability Services, Queensland)
• August 2016 – August 2017	Reviewed the Victorian Statutory Youth Justice System (Department of Health and Human Services and Department of Justice and Regulation, Victoria)
• July 2016	Development of guidelines for responding to difficult client behaviours (Transport Accident Commission)
• 2014	Specialist consultation regarding the parole system reform project (Department of Justice, Victoria)
• February 2014	Review of suicides that occurred in Victorian prisons in 2013 (Department of Justice, Victoria)
• August 2012	Review of CCS Supervision of Offenders Charged with Murder Whilst on Parole (Department of Justice, Victoria)
• March 2011	The effect of the disclosure of a sex offender's identity on re-offending and re-habilitation (Department of Justice, Victoria)
• October 2009	The psychology of firesetting (Victorian Bushfires Royal Commission)
• February 2008	Review of the mental health and psychosocial needs of prisoners detained in restrictive environments (Department of Justice, Victoria)
• April 2008	Training and research consultancy for Singapore Prison Service regarding development of program for youth and adult offenders
• 2007	Consultation to the Department of Immigration and Citizenship regarding an evaluation of the suicide and self-harm protocols and procedures
• December 2007	Consultation on offender rehabilitation framework at Singapore Prison Service
• May 2007	Assessment of three members of the Bali 9 for court; evidence presented to the court in Denpasar
• October 2006	Assessment and classification of tools and procedures at the Hakea Prison for the Office of the Inspector of Custodial Services, Western Australia
• 2003 – present	Supervision of psychologists with the Forensic Mental Health Service, Tasmania
• February 2006	HMDP Visiting Expert, Department of Health, Singapore
• 2005, 2006	Department of Corrective Services, Western Australia. Review of two cases for the Attorney General
• 2005, 2006	Review of cases for Department of Human Services, Child Protection, Victoria
• 2005-2006	New Zealand Correction preparation of expert evidence for Court of Appeal

COURSES TAUGHT:

Introduction to Psychology	Juries and Jury Decision Making
Forensic Psychology	Criminal Forensic Assessment
Civil Forensic Assessment	Child and Family Law and Psychology
Mental Health Law and Policy	Introduction to Personality

Law and Psychology
Law and Psychiatry
The Psychology of Litigation
Undergraduate and Graduate Directed Studies
Ethics and Professional Responsibility
Social Psychology
Issues in Psychology
Abnormal Psychology

STUDENTS SUPERVISED:

Ph.D. Dissertations/Doctor of Psychology Theses Supervised

Arran Rose, Assessing the Mental Health of Multicultural Prisoner Populations: A Cross-Cultural Comparison with Culturally and Linguistically Diverse, Indigenous Australian and English-Speaking Background Groups of Prisoners (2020)

Ryan Veal, Construct and Predictive Validity of the Psychopathy Checklist: Screening Version in a Violent Offender Population in Australia (2020)

Mateja Popovic, *Co-Occurring Mental Disorders and Behavioural Distrubance among Male Prisoners* (2020)

Ahona Guha, *An Epidemiological Investigation into Long-Term Health Care Utilisation and Rates of Premature Mortality in Child Sex Abuse Survivors* (2019)

Ming Wai Tam, *Presentence Reports and Sentencing Comments: Description and Comparison of Psychiatric and Psychological Reports and their Use in Sentencing Decisions* (2018)

Angela Sorotos, *Characteristics of Australian Internet Sexual Offenders: An Examination of Psychological, Offence Specific and Treatment Factors in Internet, Contact and Dual Sexual Offenders* (2018)

Nina Papalia, *Long-Term Offending and Re-Victimisation Patterns Among Child Sexual Abuse Victims: The Role of Abuse Characteristics and Co-Occurring Psychopathology* (2017)

Gregg Shinkfield, *Measuring the Progress and Outcome of Forensic Mental Health Patients* (2017)

Marie Henshaw, *The Demographic, Mental Health and Offending Characteristics of Online Child Pornography Offenders: A comparison with Contact-Only and Dual Sexual Offenders* (2017)

Ben Spivak, *Asking the Right Questions: Examining the Utility of Fact-Based Directors Utilising a Simulated Trial Paradigm* (2016)

Dan Shea, *Stalking Recidivism and Risk Assessment* (2015)

Emily Mann*, Revictimisation in a sample of 2759 victims of child sexual abuse: A 44 year follow-up study* (2014)

Lillian de Bortoli, *Child Removal in Child Protection Practise: Comparing Structured Professional Judgement and Actuarial Risk Assessment Instruments* (2014)

Lauren Ducat, *Risks and Determinants of Firesetting Behaviour: Characteristics, Psychiatric Morbidity and Recidivism* (2013)

Terri Roberton, *Emotion Regulation and Aggression* (2013)

Stephane Shepherd, *Assessing the Utility and Validity of Adolescent Violence Risk Approaches in an Australian Young Offender Population* (2013)

Diana Talevski, *Patterns of Substance Use in Offenders Court-Referred for Pre-Sentence Evaluation: Associations with Mental Disorder and Offending Behaviour* (2013)

Simon Vincenzi, *Intimate Partner Violence: Conservative Masculine Attitudes, Personality and Romantic Attachment Style* (2013)

Gennady Baksheev, *The Prevalence of Psychiatric Disorders In Police Cells: Service Provision Implications and Associations with Criminal Victimisation* (2011)

David Curnow, *Predicting the Risk of 'White Collar' Offending: Assessing the Interaction of Work Environment and Offender Characteristics* (2011)

Irina Elliott, *Procedural Justice in Contacts with Police: The Perspective of Victims With and Without Mental Disorder* (2011)

Murray Ferguson, *Major Mental Illness, Substance Abuse and Antisocial Personality: Implications for Mental Health and Criminal Justice Outcomes in a Mentally Ill Offender Population* (2011)

Joel Godfredson, *Police Encounters with People Experiencing Mental Illness* (2011)

Dragana Kesic, *Use of Force on and by Police* (2011)

Joyce Lee, *The Effects of Inpatient Aggression and Work Stress on Psychological Well-being: A Comparison between Forensic and General Psychiatric Nursing* (2011)

Tamsin Short, *The Relationship between Substance Use, Mental Illness and Criminal Offending Across a 40 Year Period* (2011)
Chi Meng Chu, *The Predictive Accuracy of Static and Dynamic Measures for Assessing Risk of Inpatient Aggression in a Secure Psychiatric Hospital* (2010)
Dominic Doyle, *Australia's Preventive Detention Laws: An Analysis of Risk Assessment Practices and Characteristics of Sex Offenders* (2010)
Debra Bennett, *An Investigation of 435 Sequential Homicides in Victoria: The Implication of Psychosis, Motive for Offending, Substance Abuse and Gender* (2010)
Michael Davis, *Of Broken Legs and Smoking Guns: Structured Professional Judgement and Violence Risk Assessment* (2010)
Kate McGregor, *Psychopathy, Violence, and Violent Victimisation in Schizophrenia* (2010)
Bronwyn McKeon, *The Role of Offender Typology on Perceptions of Stalking: Community and Police Perspectives* (2010)
Janet Ruffles, *The Management of Forensic Patients in Victoria: The More Things Change, the More they Stay the Same* (2010)
Cindy Wall, *The Psychological Consequences of Work Injury: The Influence of Personality, Workers' Compensation, and Perceptions of Justice* (2010)
Melisa Wood, *Characteristics of Mentally Disordered Offenders who Engage in Persistent and Versatile Violent Behaviours: An Examination of Axis I and II Comorbidity, Psychopathy, and Offender Typologies* (2010)
Margaret-Christine Cutajar, *Impact of Child Sexual Abuse on Subsequent Psychiatric Morbidity and Fatal Self-Harm: A Historical Cohort Study* (2009)
Joanne Griffith, *Substance Use and Personality Characteristics of Mentally Ill Offenders* (2009)
Stefan Luebbers, *Crime, Young People and Emotion: The Role of Emotional Intelligence in Young Adult Offending* (2009)
Lisa Warren, *The Characteristics of Those Who Utter Threats to Kill and the Association Between Threats and Physical Violence* (2009)
Troy McEwan, *Assessing Risk in Stalking Situations* (2008)
Elizabeth Najdovski-Terziovski, *Enhancing Judicial Communications with the Jury* (2008)
Rachel Campbell, *Antisocial Personality Disorder, Psychopathy, and the Assessment of Risk for Violence in an Australian Mentally Disordered Population* (2007)
Narelle Warden, *Child Pornography and the Internet: The Relationship between Accessing and Downloading and Contact Child Sex Offences* (2007)
Peter Enticott, *Impulsivity, Inhibitory Control and Aggression among Violent Offenders* (2006)
Anita Goh, *Inhibitory Control, Impulsivity, and Anger among Young Adult Offenders in a Maximum Security Prison* (2006)
Rachel MacKenzie, The Systematic Assessment of Stalkers (2006)David R. Lyon, *An Examination of Police Investigational Files for Criminal Harassment (Stalking): Implications for Case Management* (2005)
Michael Daffern, *A functional analysis of psychiatric inpatient aggression* (2004)
Daryl Ternowski, *Sex Offender Treatment: An Evaluation of the Stave Lake Correctional Centre Sex Offender Treatment Program* (2004)
Andrew Welsh, *Sentencing With Aboriginal Offenders: Progressive Reforms or Maintaining the Status Quo*? (2004)
V. Gordon Rose, *Social Cognition and Section 12 of the Canada Evidence Act: Can Jurors "Properly" use Criminal Record Evidence* (2003)
Sonia Chopra, *Juror Stress: Sources, Severity and Solutions* (2002)
Lynda Murdoch, *Psychological Distress and Substance Abuse in Law Students: The Role of Moral Orientation and Interpersonal Style* (2002)
Kevin S. Douglas, *Making Structured Clinical Decisions about Violence Risk: Reliability and Validity of the HCR-20 Violence Risk Assessment Scheme* (2001)
Tonia L. Nicholls, *Violence Risk Assessments with Female NCRMD Acquittees: Validity and Reliability of the HCR-20 and PCL:SV* (2001)
Marcus K. Rogers, *A Social Learning Theory and Moral Disengagement Analysis of Criminal Computer Behaviour: An exploration study* (2001)
Lindsey A. Jack, *Psychopathy, Risk/Need Factors, and Psychiatric Symptoms in High- Risk Youth:*

Relationships between Variables and Their Link to Recidivism (2000)

Lynne E. Sullivan, *Malingering and Head Injury on Neuropsychological Instruments: A Meta-Analytic Review* (2000)

Marie A. Achille, *Attitudes Toward, and Interest in, Assisted Suicide in a Population with Amyotrphic Lateral Sclerosis and Their Caregivers* (1999)

Kelly Frame, *Cognitive Processes Underlying Pretrial Publicity Effects on Jurors* (1999)

Karen C. Whittemore, *Releasing the Mentally Disordered Offender: Disposition Decisions for Individuals found Unfit to Stand Trial and Not Criminally Responsible* (1999)

Maureen C. Olley, *The Utility of the Test of Charter Comprehension for Ensuring the Protection of Accuseds' Rights at the Time of Arrest* (1998)

Sandra C. A. Vermeulen, *Legal Knowledge and Decision-Making in Adolescents: Plea Decisions and Competency to Waive Charter Rights* (1997)

Elizabeth D. Bannerman, *Female Police Officers: The Relationship between Social Support, Interactional Style, and Occupational Stress and Strain* (1996)

Masters Theses Supervised

Marie A. Achille, *Euthanasia Decisions: Influence of Method Employed, Person Involved and Situational Considerations* (1994).

Lisa K. Brown, *Mental Health Screening in Jail: The Predictive Validity of a Symptom Level Instrument* (1996).

Kevin S. Douglas, *Assessing the Risk of Violence among Psychiatric Patients: A Comparison of the HCR-20 and the PCL:SV* (1996).

Murray Ferguson, *Predicting Recidivism in an Australian Mentally Disordered Offender Population with and without Comorbid Substance Abuse* (2004).

Lindsey A. Jack, *Factors Affecting the Referral of Young Offenders for Medical and Psychological Assessment Under the YOA* (1995).

David R. Lyon, *The Characteristics of Stalkers in British Columbia: A Statistical Comparison of Persons Charged with Criminal Harassment and Persons Charged with Other Criminal Code Offences* (1997).

Andrea McEachran, *The Predictive Validity of the PCL:YV and the SAVRY in a Population of Adolescent Offenders* (2001).

Tonia L. Nicholls, *Risk Assessments with Female and Male Civil Psychiatric Patients: Utility of the HCR-20 and PCL:SV* (1997).

Maureen C. Olley, *Competency to Understand Charter Cautions: A Preliminary Investigation* (1993).

V. Gordon Rose, *The Incomprehensibility of Jury Instructions: A Method and an Example* (1998).

Gina M. Vincent, *Criminal Responsibility After Bill C-30: Factors Predicting Acquittal and Lengths of Confinement in British Columbia* (1999).

Andrew Welsh, *Aboriginal Peoples and the Criminal Justice System: Differences in Full Parole Release Rates between Aboriginal and Non-Aboriginal Offenders* (1999).

Karen E. Whittemore, *An Investigation of Competency to Participate in Legal Proceedings in Canada* (1995).

Honours Theses Supervised

Georgia Bekiou, *The Biasing Effects of Incriminating and Exculpating Pretrial Publicity on Guilt Attributions* (1994).

Shirley B. Chau, *Mass Media and Heuristics: Elements of Distortion in the Perception of an Increase in Adolescent Homicide* (1993).

Margaret Clingwall (Pfoh), *Violent Offenders: Cognitive Processing and Automaticity* (1993).

Kevin S. Douglas, *Public Opinion of Property Bias and Inequity in Criminal Code Maximum Sentences* (1994).

Jennifer Honeyman, *Capital Punishment: Arguments for Life and Death* (1994).

Ken P. Kroeker, *Lifespan Assessment of the Elements of Biopsychosocial Functioning in the Homeless* (1994).

Olga Nikonova, *Jurors' Perceptions of Child Witnesses: The Impact of Judicial Warning* (2000).

Heather Rhodes, *Juvenile Ageism: The Forgotten Discrimination* (1994).

Randy T. Salekin, *The Effects of Emotionality on Jury Decision-Making* (1993).

Kerry Smith, *Is Knowledge Dangerous? A Comparison of Adolescent Offender and Non- Offenders' Knowledge of the Young Offenders Act* (1991).

Karen E. Whittemore, *Factors That Influence Jury Decision Making: Disposition Instructions and the*

Accused's Mental State at the Time of the Trial (1992).

Hannah Woolhouse, Risk and Need in a Victorian Sample of Juvenile Offenders: The Influence of Child Protection Services Involvement (2004).

GOVERNMENT COMMITTEES AND TASK FORCES:

Australia

2019 – 2021	Member, Expert Advisory Committee, Royal Commission into Victoria's Mental Health System
2018 – Present	Youth Justice Advisory Committee, Department of Justice and Regulation, Victoria
2016 – Present	Member of Forensic Mental Health Advisory Board (formerly Criminal Justice and Mental Health Systems' Planning and Strategic Coordination Board)
2016 – Present	Member, Juvenile Justice Advisory Committee, NSW
2015 - Present	Member of Therapeutic Treatment Board (Department of Health and Human Services)
2015 - 2016	Member of Criminal Justice and Mental Health Systems' Planning and Strategic Coordination Board (Department of Justice and Regulation, Victoria)
2015 – present	Director, Well-Being and the Law Foundation (not for profit foundation for mental health and wellbeing of members of the legal profession and law students)
2014 – present	Sessional member, Justice Health Ministerial Advisory Committee
2012 – 2014	Member of Board of Directors, Justice Health and Forensic Mental Health Network, NSW
2012 – 2015	Independent Member, Corrections Monitoring and Review Steering Committee (Department of Justice, Victoria)
2009 – 2011	Expert Advisory Group on Suicide and Self Harm Prevention (Department of Human Services, Victoria)
2009 – 2011	Reference Group on Victorian Ombudsman Review into Policing Mentally Ill People in Crisis situations
2002 - Present	Expert Participant, Australian Forensic Reference Group, Victoria Police (State Intelligence Management Division Operations, Behavioural Analysis Unit)
2002 - 2007	Member, Corrections Health Board, Corrections Victoria
2002 - 2004	Specialist Advisory Group on offender programs and rehabilitation, Corrections Victoria
2003 - 2005	ACT Corrective Services Program Advisory Group
2003	Expert Panel to Inform the Development of Research and 'What Works' with Young Adult Offenders in Prisons, Department of Justice, Victoria

Canada

2000 - 2001	B.C. Provincial Task Force on the Assessment, Treatment and Management of Sexual Offender Services (Chair)
1999 - 2001	B.C. Provincial Consultation Group on Fetal Alcohol Syndrome
1999 - 2001	B.C. Provincial Task Force on Mental Illness and Substance Abuse
1999 - 2001	National Advisory Committee on Risk Assessment Training, National Parole Board of Canada.
1998 - 2001	B.C. Provincial Mentally Disordered Offender Committee
1991 - 2001	Steering Committee and Management Committee of the Surrey Pretrial Mental Health Program.

DEPARTMENT AND UNIVERSITY SERVICE (MONASH UNIVERSITY):

2002 – 2007; 2010-2011	Director, Doctor of Psychology (Clinical) Program
2002-Present	Coordinator, Clinical Forensic Specialisation, Doctor of Psychology (Clinical) course
2003 – 2007	Director, Monash University Clinical Psychology Centre
2005 - Present	Member, Consortium on Research in Corrections, Monash University
2002-2004	Member, School Research Committee, School of Psychology, Psychiatry and Psychological Medicine

2002-2003 Deputy Chair, Doctor of Psychology (Clinical)/Doctor of Psychology (Neuropsychology) Boards of Studies

DEPARTMENT AND UNIVERSITY SERVICE (SIMON FRASER UNIVERSITY):

1999 - 2001 Vice-Chair, Senate of Simon Fraser University
1999 - 2001 Chair, University Research Ethics Review Committee
1999 - 2001 Member, Senate Committee on Agenda and Rules
1997 - 2001 Member of the Senate, Simon Fraser University
1996 - 2001 Member, University Board on Student Discipline
1994 - 1999 Member, University Research Ethics Review Committee
1990 - 2001 Member, Clinical Program Faculty, Department of Psychology
1990/91; 1993-2001 Member, Department Tenure Committee, Department of Psychology
1997 - 1998 Chair, Senate Committee on Undergraduate Studies
1997 - 1998 Member, Senate Committee on Academic Planning
1996 - 1997 Member, ad-hoc Committee on Planning Priorities
1992 - 1997 Chair, Appointments Planning Committee, Department of Psychology
1992 - 1994 Chair, Standing Committee on Academic Discipline
1991 - 1992 Member, Undergraduate Studies Committee
1990 - 1991 Member, Standing Committee on Academic Discipline

PROFESSIONAL ASSOCIATION MEMBERSHIPS:

American Psychological Association

1997 – Present Fellow
2001 - 2004 Council Member, Council of Representatives, Representing Division 41 (American Psychology Law Society)(resigned due to relocation to Australia)
1999 - 2001 Member, Committee on Legal Issues
1999 Member, Steering Committee; APA/ABA Conference on Psychological Expertise and Criminal Justice
1990-1997 Member

American Psychology-Law Society (APA Division 41)

1997 – present Fellow
2018 – 2021 Member, Committee on Fellows
1997 - 2000 President (President Elect: 1997-98; President: 1998-99; Past President: 1999-2000)
1994 - 1997 Treasurer
1991 - 1993 Member, Panel on Training
1991 - 1992 Program Co-Chair, 1992 APLS Mid-Year Conference
1990 - 1994 Chair, Committee on Careers and Training
1989 - 1990 Chair, Graduate Student Division
1988 - 1990 Student Rep. and Student Editor of the Division Newsletter

Australian and New Zealand Association of Psychiatry, Psychology, and Law

2007 – 2012 President
2003 – 2007 President, Victorian Branch
2002 - 2003 Committee Member, Victoria Branch
2003 – present Secretary, National Organization

Australian Psychological Society

2007 – present Fellow
2002 – 2005 Member

Australian Psychological Society, College of Forensic Psychologists

2009 – 2011 Chair, College of Forensic Psychologists (Victorian Branch)
2008 – 2009 Convenor, Forensic Psychology Conference
2004 – 2008 Chair, College of Forensic Psychologists (national body and Victorian Branch)
2003- 2004 Committee Member, Victorian Branch

Australian Psychological Society Clinical College

2002 – present Member

Canadian Psychological Association

2003 – present Fellow
2002 Chair, Committee on Fellows and Awards
1999 - 2001 President (President Elect: 1999-2000; President: 2000-2001; Past President: 2001-2002)
1996 - 2002 Chair, Committee on Legal Affairs
1994 - 2000 Chair, Committee on Ethics
1998 - 2001 Member, Accreditation Panel for Doctoral Programs and Internships
1995 - 1997 Member, Professional Affairs Committee
1994 - 1995 Chair, Nomination Committees
1994 - 1999 Scientist/Practitioner Director, Board of Directors
1993 - 1994 Member, Committee on Ethics
1990 – 2003 Member

Canadian Bar Association; B.C. Branch (1990-2001)

Canadian Law and Society Association

1994 Law and Psychology Convener

College of Psychologists of British Columbia (Registration #1022)

1995 Inspector of Ethics Complaints
1993 - 1994 Member, Regulatory Committee

International Academy of Law and Mental Health

1991 - 1992 Congress Program Planning Committee Member
2002 - 2003 Scientific Committee Member, 2003 Congress

International Association of Applied Psychologists

2009 – present Member
2006 – 2008 President of the Division of Psychology and Law

International Association of Forensic Mental Health Services

2003 – Present Member
2004 – 2005 Member, Scientific Committee 2005 Conference and Member, Organizing Committee 2005 Conference

International Association for Correctional and Forensic Psychology

2017 – present Member
International Corrections and Prisons Association

2016 – present Member

International Union of Psychological Science

2002 - 2004 Delegate representing Canadian psychologists

Society for Police and Criminal Psychology

2015 – present Member

EDITORIAL AND REVIEW ACTIVITY:

Associate Editor, Criminal Justice and Behavior (2018 – present)

Editor, *International Journal of Forensic Mental Health* (2005-2008)

International Editor, *Behavioral Sciences and the Law* (2003- Present)

Associate Editor, *Law and Human Behavior* (1996-2000); Adversary Forum Editor, *Law and Human Behavior* (1993-1996).

Guest Editor, *Behavioral Sciences and the Law*, *International Journal of Law and Psychiatry, Law and Human Behavior, Police Practice and Research*.

Member of the Editorial Board, *Behavioral Science and Law; Canadian Psychology; Corrections Law Reporter; Criminal Justice and Behavior; Empirical and Applied Criminal Justice Research; Forensic Reports* (1991-93)*; International Journal of Law & Psychiatry* (1992-1996)*; International Journal of Forensic Psychology; International Journal of Forensic Mental Health; Journal of Behavioral Health Services and Research; Journal of Mental Health Administration* (1995-1997)*; Law & Human Behavior* (1990-1996; 2001-2007); *Mental Health Law Reporter; Psychology, Public Policy, and Law.*

Member of the Editorial Board of the APLS book series, *Perspectives in Psychology and Law.*
Action Editor, *American Psychologist* (ad hoc).

Editorial Consultant, *American Journal of Psychiatry; Behavioral Sciences and the Law*; *Canadian Journal of Behavioural Sciences; Canadian Journal of Education; Canadian Psychology; Criminal Justice and Behavior; Ethics and Behavior; International Journal of Law and Psychiatry; Journal of Mental Health Administration; Journal of Social Issues; Law and Policy; Psychiatry, Psychology, and Law; University of Toronto Press*.
Member and Symposium Editor, *Nebraska Law Review* (1988-1990).
Grant Reviewer for the Australian Research Council; National Health and Medical Research Council of Australia; Medical Research Council of Canada; Health & Welfare Canada; National Health Research and Development Program (NHRDP); Social Sciences and Humanities Research Council of Canada; National Science Foundation, USA.

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