The Justice System and Mental Health

A review of the literature

A report for the Australian Government National Mental Health Commission

Prepared by:

A/Prof Kimberlie Dean¹,²
Mr Vaughan Parsons¹
Ms Natalia Yee¹,²
Dr Toby Mackinnon¹
Dr David Chaplow¹
Dr Karin Lines¹

¹Justice Health and Forensic Mental Health Network, NSW
²School of Psychiatry, University of New South Wales

August 2013
Contents

Summary ................................................................................................................................................. 4

1. Background ........................................................................................................................................ 5

1.1. What do we know about the occurrence of mental health problems among those in
contact with the criminal justice system? .............................................................................................. 5

1.2. Is there an association between the presence of mental illness and risk of offending
behaviour? ............................................................................................................................................. 8

1.3. Principles and concepts relevant to consideration of the approach taken to
addressing mental health problems among those in contact with the criminal justice
system ................................................................................................................................................ 10

1.3.1. The principle of equivalence of care ......................................................................................... 10

1.3.2. The public health implications of prison health ....................................................................... 11

1.3.3. Acknowledging the complexity of health problems .................................................................... 12

1.3.4. ‘Care and treatment, not punishment’ – the principle of diversion and the
potential impact of deinstitutionalisation ............................................................................................. 14

1.3.5. Respecting difference but not discriminating; the particular case of Indigenous
Australian prisoners ................................................................................................................................. 15

1.4. Description of approach taken to literature review ......................................................................... 19

2. Reducing contact with the criminal justice system for those with mental health
problems – preventative approaches ..................................................................................................... 21

2.1. Preventing offending behaviour and criminal justice system contact for those with
mental illness (primary prevention) ......................................................................................................... 21

2.1.1. The impact of mental health interventions on risk of offending or contact with
the criminal justice system .................................................................................................................. 21

2.1.2. Early intervention for psychosis and offending behaviour ...................................................... 23

2.1.3. Interventions for those with complex needs and risks, including development of
inter-agency co-operative arrangements .............................................................................................. 24

2.2. Reducing re-offending and repeat contact with the criminal justice system for
mentally disordered offenders (secondary prevention) ......................................................................... 26

2.2.1. The mental health needs of individuals in contact with the police ........................................ 26
2.2.2. Preventing criminal justice system involvement for those with mental illness for those in contact with the police .......................................................... 28

2.2.3. Preventing reoffending or repeat CJS contact – approaches to secondary prevention beyond police contact .............................................................. 30

3. Court diversion approaches .......................................................................................................................... 33

3.1. Court diversion and liaison models in Australian jurisdictions .............................................................. 33

3.2. Evaluating the effectiveness of court diversion ...................................................................................... 35

4. Approaches to providing in-prison care and after-care for those incarcerated mentally disordered offenders .......................................................................................................................... 37

4.1. Prisoner rehabilitation – principles and practices in Australia – and the relevance for those with mental illness .......................................................................................................................... 37

4.2. Assessment and management of mental illness in custody .................................................................... 40

4.2.1. Mental health screening ......................................................................................................................... 40

4.2.2. Within-prison mental healthcare models in Australia ........................................................................ 41

4.2.3. Evaluations of within-prison models of mental health care .............................................................. 43

4.3. What happens post-release? ................................................................................................................... 45

4.3.1. Why is the post-release period important? .......................................................................................... 45

4.3.2. The current picture of post-release mental health care provision and attempts at interventions to improve ‘through-care’ ........................................................................................................... 46

5. Victims with mental health problems in contact with the criminal justice system ......................... 48

5.1. Evidence supporting the notion that those with mental illness are at elevated risk of victimisation .................................................................................................................................................. 48

5.2. Interventions to reduce risk of victimisation and barriers to accessing justice ............................ 50

Conclusions ................................................................................................................................................ 51

References .................................................................................................................................................. 54
Summary

Those with mental illness are known to be over-represented among those in contact with the criminal justice system. The extent to which the reasons for this are understood and effective approaches are taken to address the problem is the subject of the literature review presented in this document. The review is intended to provide a targeted overview and discussion of key issues that relating to ‘the Justice System and Mental Health’. The discussion is supported by drawing upon national and international research findings and other relevant source material. As a background to the review, key research evidence related to the prevalence of mental illness among offenders and the association between mental illness and risk of offending is presented in addition to an overview of several relevant principles and concepts including: ‘the principle of equivalence of care’, ‘public health implications of prison health’, ‘acknowledging the complexity of health problems’, ‘the principle of diversion’, and ‘respecting difference but not discriminating’. The framework adopted for the body of the literature review reflects the offender journey taken and focuses on the following key periods: i) the period before or early in the course of contact with the criminal justice system, in order to examine preventative approaches, ii) the period of interaction with the court system, with an emphasis on court diversion approaches for those with mental health needs, and, iii) the period of incarceration and release back into the community, in order to examine the evidence to support provision of in-reach mental health services community-based support services to assist offenders to transition back into the community. The review ends with a consideration of the oft-neglected risk of becoming a victim of crime and violence which is faced by those with mental illness and the difficulties experienced for those victimised in accessing justice. Concluding remarks are made based on emerging gaps in either existing research evidence or in the apparent implementation of evidence-supported approaches.
1. Background

1.1. What do we know about the occurrence of mental health problems among those in contact with the criminal justice system?

It has long been observed that those individuals in contact with the criminal justice system (CJS) are more likely to suffer from mental ill health than those in the general population. This observation has been repeatedly confirmed by the results of studies estimating the prevalence of mental disorder in this population both in Australia and internationally over the past several decades.

A recent systematic review and meta-analysis of 109 prison studies conducted in 24 countries reported that the pooled prevalence of major depression among prisoners was 10% (14.1% for females) while the pooled prevalence for psychosis was 3.6% for males (3.9% for females) [1], rates much higher than found in the general population. In Australia, results from the 2012 National Prisoner Health survey [2], indicate that over 38% of prison entrants report having a history of mental ill health and 21% report current use of mental health medication. Rates in this survey were higher among female prisoners and lower among those identifying as indigenous. For younger offenders, the prevalence of mental illness is particularly worrying. A 2009 NSW survey of young people in custody (juvenile detention) found the majority (87%) had at least one mental health disorder and of this group, almost three-quarters (73%) had two or more mental health disorders. In addition, the survey found females were significantly more likely to have a mental health disorder (in particular, mood disorders, anxiety disorders and behavioural disorders) compared to males. Indigenous young people were significantly more likely to have a mental health disorder compared to their non-Indigenous counterparts (particularly with respect to a substance use disorder or attention or behavioural disorders) [3].

While elevated rates of mental disorder are consistently found in studies of prisoners, the magnitude of the excess risk varies considerably – by diagnosis, by location, by gender, by
While the 2012 Australian National Prisoner Health survey relied on self-report information, the NSW Inmate Mental Health Survey conducted in 2001 utilised a structured diagnostic interview approach (using the Composite International Diagnostic Interview or CIDI). In this survey, 43% of those screened had at least one of the following current diagnoses: psychosis, anxiety disorder, or affective disorder [4]. Posttraumatic stress disorder was found to be the most common individual disorder, diagnosed in 26% of reception and 21% of sentenced prisoners. When the same instrument was used in a community sample in Australia as part of the 1997 National Mental Health and Wellbeing survey and compared to the inmate sample, substantially more psychiatric morbidity was detected among the latter even after accounting for sociodemographic differences [5]. Odds of psychotic symptoms were almost 12 times higher in the prison sample; substance use disorder over 11 times higher and personality disorder were almost 9 times higher.

Studies conducted in different jurisdictions across Australia indicate that the disproportionate burden of mental illness suffered by prisoners is a consistent finding across Australia despite differences in incarceration rates, legal frameworks and correctional and health system processes. In addition to NSW, state-specific surveys of mental ill health in prisoners have been published on data obtained from prisoners in a variety of locations, including in the ACT [6], Victoria [7] and Queensland [8].

While it is clear that the prevalence of mental ill health is strikingly higher among prisoners than those in the general population, a finding which is consistent across jurisdictions and across countries, much less is known about those in contact with other components of the justice system. There has quite rightly been an emphasis on describing the extent and nature of mental health need among prisoners, justifying the need for appropriate mental health service provision, but there is now also a need to consider those in contact with police, probation, and parole services if appropriate interventions and services are to be developed for these groups. It is also of note that evidence to date has been almost entirely in the form of prevalence studies, providing a cross-sectional snapshot of mental health need. Very little is known about the longitudinal course of mental illness among offenders,
research that would inform development of interventions and service delivery models – what kind of intervention is needed when in the course of justice system contact?
1.2. Is there an association between the presence of mental illness and risk of offending behaviour?

The national and international prisoner mental health surveys confirming an excess burden of mental ill health concur with the findings of other studies exploring links between mental illness and offending behaviour, including studies of individuals known to have mental illness and studies of unselected cross-sectional and population cohort samples. An example of the former is a Victorian study of individuals diagnosed with schizophrenia over a 30 year period who were linked to criminal records data and compared to a control sample from the general population [9]. Those with schizophrenia were more likely to be found guilty of an offence, including a violent offence, and in this study the association was not entirely explained by the co-occurrence of substance misuse problems. In a whole of population data-linkage study conducted in WA, those with psychiatric illness had a period prevalence of arrest of 32.1% (prevalence for schizophrenia was 38.7%), with the average annual arrest rate appearing to increase over time (1985-1996) for those with mental illnesses other than schizophrenia while arrest rates dropped for those without illness [10]. Interestingly this study also reported that for the majority of offenders with psychiatric illness, first arrest preceded first contact with mental health services.

Irrespective of study methodology or setting, the vast majority of studies in the field of forensic mental health confirm an association between the presence of mental illness and risk of offending. That there is an association is no longer in doubt but less well understood is what explains the association and to what extent mental illness itself is a causal factor. Many researchers have identified factors such as socio-demographic disadvantage and co-occurring substance misuse problems which can explain much of the association between mental illness and offending; the question is to what extent such factors are confounding or giving rise to an apparent association versus explaining how mental illness causally impacts on offending risk [11, 12]. These questions are actively debated in the literature and are not simply of academic interest since to have any impact on reducing offending and contact
with the justice system for those with mental illness causal factors should be targets for intervention – i.e. if mental illness itself causes an increased risk of violence and other offending then adequately treating mental illness should have not only mental health benefits but should reduce risk.

In appraising the literature it is also important to distinguish absolute from relative risks of offending among those with mental illness, particularly given the problem of stigma associated with mental illness and the impact of media reporting of studies and of individual high-profile cases which tend to emphasise the dangerousness of individuals diagnosed with serious mental illness. The vast majority of those with mental illness do not pose a risk of violence or other offending and, indeed, the vast majority of such behaviour occurring in the community is not committed by individuals with mental illness. In a systematic review and meta-analysis of studies examining the association between schizophrenia and violence, population attributable risk fractions reported in six studies were all below 10% [13] – meaning that less than 10% of violence in the community could be potentially explained or caused by schizophrenia.

On balance, the current evidence indicates that mental illness is associated with an increased risk of offending and an increased risk of contact with the criminal justice system. This reality necessitates taking a preventative approach which includes identifying those at risk and then acting to reduce such risk, an approach which is arguably in the interests of the individual, community, and as others have argued, in the interests of stigma reduction [14]. The current evidence also justifies taking an evidence-based approach to challenging the stigmatising views of the mentally ill presented in the media and held in the general population.
1.3. Principles and concepts relevant to consideration of the approach taken to addressing mental health problems among those in contact with the criminal justice system

In considering the current evidence relevant to the topic of ‘the Justice System and Mental Health’, it is important to reflect on a number of relevant principles and concepts which shape the nature of the problem and frame the approaches taken to address it.

1.3.1. The principle of equivalence of care

The principle of ‘equivalence of care’ refers to the notion that those individuals in contact with the criminal justice system, prisoners in particular, should receive the same level and quality of health care as they would have access to in the community. This principle has guided the evolution of health care provision, including mental health care provision, to prisoners in various jurisdictions and has, in recent times, been formally adopted by some. The ‘Basic principles for the treatment of prisoners’ resolution was adopted by the United Nations General Assembly in 1990 with one of the 11 principles describing a right to equivalence of care — ‘Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation’ [15]. In line with protection of other related human rights for prisoners, the principle of equivalence in this context supports the notion that discrimination on the grounds of legal situation cannot be used to justify denial of rights. In Australia prisoners sentenced to long period can have their voting rights removed, perhaps indicating some reluctance locally to fully embrace the notion that prisoners should not be denied rights on the basis of their legal status.

In the UK, the principle of equivalence of care has been formally enshrined in documents governing healthcare arrangements for prisoners for well over a decade and predated the transition from prison service to National Health Service responsibility for prison healthcare in 2003 [16, 17]. In this context equivalence was considered relevant to ‘policy, standards and delivery’. Despite formal adoption of the equivalence of care principle in some
jurisdictions, minimum standards for healthcare provision to prisoners are rarely formally set or monitored. This is a trend internationally.

In Australia one of the barriers to formal national adoption of the principle of care equivalence is the fact that prison services and healthcare provision within prisons is the responsibility of states and territories. There is currently no national organisation tasked with setting standards and monitoring the quality of healthcare provision to prisoners and others in contact with the criminal justice system. Arrangements for healthcare provision vary between jurisdictions and, while the Australian Institute of Health and Welfare co-ordinates a national census of prisoner health which provides an internationally unique picture of the state of health of Australian prisoners, there is no national approach to setting and monitoring adherence to standards of healthcare provision. In addition, prisoners in Australian states and territories are not entitled to access the federally administered Medicare insurance system which inevitably limits the extent to which access to healthcare is equivalent to that available in the community.

Challenges to the principle of care equivalence have focused on the barriers to full implementation of the principle and on the fact that the striking level and complexity of health need presented by those coming in contact with the criminal justice system necessitates more than an ‘equivalent’ level of healthcare provision [18]. Barriers to provision of equivalent care include the limitations inherent in delivering healthcare in an environment which by its nature and culture is not designed to facilitate healthcare delivery. A focus on the extent to which prison healthcare provision is equivalent in terms of process rather than outcomes has also been raised as a concern in light of these challenges to the principle [19].

1.3.2. The public health implications of prison health

Prisoners come from the community and will, in nearly all cases, return to the community – an obvious fact which is often lost in the discourse surrounding prisoner health. Given the
high level of morbidity and the poor history of community healthcare access for most prisoners, a period in prison can and should be seen as an opportunity to identify health needs and provide appropriate treatment which may well have positive public health impacts [20]. The impact on the individual, their families and the wider community is likely to be significant. This point is most easily made when considering the case of infectious diseases but the principle can also apply to chronic diseases including mental ill health.

The extent to which identification of mental health need and provision of appropriate treatment for those in contact with the justice system improves the health of the community as a whole is essentially unknown but the potential is clear. One of the implications of such a potential is that improving the mental health of offenders may well also have economic benefits – a notion which is again untested. The public health implications of improving offender health rely on continuity of care between the justice system and the community, particularly given the often chronic nature of mental illness. There would seem to be limited benefit in adequately addressing mental ill health among prisoners only to release prisoners without ongoing treatment and support in the community with the inevitable risk of deterioration.

1.3.3. Acknowledging the complexity of health problems

It is generally recognised that when individuals with a mental illness come into contact with the criminal justice system the health needs they present are very often complex – both in terms of the increased risk of co-occurring health disorders, both mental and physical, and the typical pattern of poor prior health service utilisation. The co-occurring disorders may include dual diagnoses (i.e. additional substance use disorders), additional mental health and personality disorders, cognitive disability and a range of physical health disorders including infectious diseases and/or chronic conditions such as diabetes.

While there remains an overall paucity of research examining the nature and extent of health complexity for those with mental illness in contact with the criminal justice system, it
is well recognised that a high proportion of mentally disordered offenders have at least a coexisting substance use disorder [21]. A cross sectional study in metropolitan Victoria identified a third of police detainees, for example, as having a dual-diagnosis [22]. Significant mental health co-morbidity was identified in the 2001 NSW Inmate Mental Health survey with 945 diagnoses (of psychotic symptoms, affective disorder or anxiety disorder) recorded for 624 individuals [2]. As noted earlier, mental illness co-morbidity was also identified as a particular problem in the NSW survey of young people in custody [3]. With regard to evidence of poor health service utilisation prior to incarceration, the most recent Australian prisoner health survey report notes that 39% of prison entrants needed to see a health professional in the community during the prior 12 months and did not [2].

Those in contact with the criminal justice system are also well known to have high rates of cognitive disability [23-26]. A recent prison cohort and data-linkage study based in NSW [27] identified 1463 individuals with a cognitive disability who had contact with the criminal justice system. Of those, 66% were found to have complex needs which included having an additional substance use disorder and/or additional mental health diagnoses.

Complexity of healthcare needs may well be the norm for those in contact with the criminal justice system, a notion which has clear implications for the development of effective and appropriate interventions and service delivery models. As noted earlier, it is also a notion which challenges the appropriateness of the principle of care ‘equivalence’. The development of forensic mental health services in most Western settings and, secure inpatient forensic units in particular, reflects an acknowledgement that ‘more than equivalent’ levels of mental health care may be needed to effectively assess and manage mentally disordered offenders. Such services are of course focused most often on individuals with severe mental illnesses who have committed serious violence offences and present significant ongoing risks.
1.3.4. ‘Care and treatment, not punishment’ – the principle of diversion and the potential impact of deinstitutionalisation

In various jurisdictions around the world measures aimed at diverting individuals with mental illnesses away from the criminal justice system and into mental health and substance misuse treatment services have been developed. These measures are aimed at least in part at preventing the ‘criminalization of the mentally ill’. The criminalization hypothesis refers to the tendency to view the mentally ill as ‘offenders’, a view which is potentially manifest in the practice of placing them in the criminal justice system rather than the mental health system [28]. A consequence is the shifting of responsibility for the provision of basic mental health care services to the criminal justice system [29]. Diversion measures are aimed at therapeutic jurisprudence and operate on the premise that the mentally ill offend because of illness and therefore require treatment rather than criminal sanctions [30, 31].

In addition to the notion of criminalisation of the mentally ill, in recent decades, deinstitutionalisation, particularly in the West, appears to be another factor potentially contributing to the over-representation of people with mental illness in the criminal justice system. In what is known as the Penrose hypothesis [32], it was initially believed that there exists an inverse relationship between prison and psychiatric hospital populations. In other words, fewer psychiatric beds is expected to lead to an increase of mentally ill individuals being arrested and incarcerated [33]. The closing of psychiatric institutions and the lack of community-based mental health services to take on the challenge of meeting mental health need in the community has arguably served to make prisons and jails de facto mental health treatment facilities [34]. In the US, it has been reported that the number of seriously mentally ill individuals in jails and prisons far exceeds the number treated in psychiatric inpatient units [35]. Fuller-Torrey comments that ‘jails and prisons are replacing public mental hospitals as the primary purveyors of public psychiatric services for individuals with serious mental illnesses in the United States’. The term ‘transinstitutionalisation’ has been proposed to describe this apparent interdependence between psychiatric hospital capacity and the burden of mental ill health in the criminal justice system [36]. However, critics of
the concept have argued that the transinstitutionalisation hypothesis is too simplistic as it does not take into account other factors and trends that might give rise to increasing incarceration rates [37-39]. Stricter civil commitment criteria, inadequate access to mental health treatment in the community, and a belief by law enforcement officers that deviant behaviour is better dealt with by the criminal justice system are some other reasons likely to have contributed to the channelling of the mentally ill to prisons [33].

Deinstitutionalization in Australia began later than the US but there has been a similar decrease of bed numbers in both jurisdictions [40]. Direct evidence of a causal link between deinstitutionalisation and rising incarceration rates among the mentally ill has, however, been lacking. In a Victorian case-control study, for example, the increase in rates of criminal conviction over the 25-year period following deinstitutionalisation was found to be the same among those with schizophrenia and community controls, suggesting that the rise of incarceration among the mentally ill reflects factors other than the effects of deinstitutionalisation [41].

1.3.5. Respecting difference but not discriminating; the particular case of Indigenous Australian prisoners

The rate of incarceration for Indigenous Australians is significantly higher than non-Indigenous Australians across all Australian jurisdictions. As at 30 June 2012, there were 7,979 prisoners in Australia who identified as Indigenous, representing 27% of the total prisoner population [42]. The rate of incarceration for Indigenous Australians was 1,914 per 100,000 compared to 129 per 100,000 for non-Indigenous Australians, an extraordinary relative risk of almost 15. Western Australia recorded the highest rate of incarceration for Indigenous Australians compared to non-Indigenous Australians (20 times higher) and Tasmania reported the lowest rate of incarceration compared to non-Indigenous Australians (4 times higher). Indigenous prisoners represented 84% of the prisoner population in the Northern Territory and only 8% of the prisoner population in Victoria. Since 2002, an increase in the rate of incarceration has been observed for both Indigenous and non-
Indigenous Australians (1,262 per 100,000 and 123 per 100,000 respectively). These figures represent some of the worst relative incarceration rates seen for any minority population in the Western world.

Interestingly, as reflected in previous prisoner health surveys, the latest 2012 National Prisoner Health survey [2] found that Indigenous prisoners were less likely to report a history of mental health disorder (29%) compared to non-Indigenous prisoners (43%), less likely to be taking medication for a mental health disorder (13% and 26% respectively) and less likely to report very high distress on reception (20% and 38% respectively). Indigenous prisoners were less likely to report a history of self-harm (13% compared to 18%) or recent thoughts of self-harm (5% compared to 14%). While these figures appear to suggest Indigenous prisoners are less likely to suffer mental health problems compared to non-Indigenous prisoners, caution should be exercised when interpreting these data, particularly given that community-based studies indicate an elevated risk of mental disorder for Indigenous Australians. The prevalence of mental disorders among Indigenous Australians has been estimated to represent 15.5% of the total burden of disease in the community and, furthermore, compared to their non-Indigenous counterparts, Indigenous Australians are reported to be twice as likely to be hospitalised for a mental disorder [43]. The relatively low rates of self-reported mental health problems among Indigenous prisoners entering prison may reflect a reluctance to report previous mental health problems and/or a history of poor engagement with health services for mental health problems whilst in the community. It is also acknowledged that Indigenous prisoners, along with others at particular socio-economic disadvantage are more often incarcerated for relatively short periods for minor offending, one of the consequences of which is a more limited opportunity to have their mental health needs identified and addressed.

The 2009 NSW Young People in Custody Health Survey found that while there was no significant difference in the prevalence of mood, anxiety, alcohol abuse or attention disorders between Indigenous and non-Indigenous younger offenders, there was a higher prevalence of substance use disorder and attention or behavioural disorder observed in Indigenous young offenders compared to non-Indigenous young offenders [3].
A retrospective data linkage study also conducted in NSW estimated the overall and cause specific mortality for Indigenous prisoners (N= 9353) during and post incarceration for the period 1988-2002 [44]. The data revealed that the risk of death among Indigenous males was 4.8 times and among Indigenous females 12.6 times that of NSW residents. Of particular note, the study identified cardiovascular disease as the leading cause of death in Indigenous men and mental and behavioural disorders in Indigenous women, with the risk of death being greatest following release from prison. The study found 17% of male and 23% of female deaths were attributed to mental and behavioural disorders, most notably in response to a drug overdose.

As noted earlier, a period of incarceration can provide an important opportunity for individuals to access and receive healthcare services, including treatment. This is, of course, of particular importance for those with a prior history of poor health care contact in the community. When changes to mental health whilst in prison were assessed in the Australian national prison survey, Indigenous prisoners appeared to benefit to a greater extent than non-Indigenous prisoners (66% of the former reported that their mental health was either a lot better or a little better compared with 37% of the latter) [2].

A number of dedicated programs have been established to provide culturally specific or sensitive general health and mental health care to Indigenous prisoners in order to improve access and utilisation. These include the training and employment of Aboriginal health workers in prison health clinics and in-reach consultation and treatment provided by visiting Aboriginal health services ordinarily based in the community. However, the available evidence suggests that these programs are not always sufficiently embedded within prison healthcare service provision across all Australian jurisdictions, and where they are available, they appear to be under-utilised by Indigenous prisoners [45].

It is clear that the patterns of mental health need and service use for Indigenous Australians in the community and in prison, and the underlying factors giving rise to such patterns, are
highly complex. Current evidence is insufficient to inform service development and given
the extraordinary incarceration rates and known extremes of disadvantage faced by
Indigenous Australians, gathering vital evidence and testing interventions and service
changes is an important priority.
1.4. Description of approach taken to literature review

This review is focused on providing an overview of literature relevant to considering what we know about mental ill health among those in contact with the criminal justice system and what strategies have been developed to address the problem. We have taken the ‘journey of an offender’ as the basis of the structural framework for the review:

- Considering the offender or potential offender with mental health problems before or early in the course of contact with the criminal justice system
  
  *(see section 2)*

- Considering the mentally ill offender in contact with the courts
  
  *(see section 3)*

- Considering the mentally ill offender in prison and facing release back to the community
  
  *(see section 4)*

We have also included a section focused on an area of the ‘justice and mental health’ discourse which has been largely ignored until relatively recently – the extent to which victims of crime and violence are mentally ill and the nature of their experience of accessing or attempting to access justice *(see section 5)*.

Given the breadth of the field under review, a systematic review methodology has not been adopted but an attempt is made to present relevant research findings, from national and international sources, intended to provide an overview of the current understanding of both the extent of the problem and the attempts made to address it. We also aim to identify key gaps in current understanding.

It should be noted that, while highly relevant to the topic of mental health within the criminal justice system, a specific focus on the role of substance misuse or interventions
targeting substances misuse among offenders is not included. It is mentioned where relevant or illustrative but a specific review of this area is considered outside the scope of the current review. Similarly, we have deliberately focused on evidence directly relevant to those mentally disordered offenders in contact primarily with the criminal justice system rather than predominantly in contact with mental health services – i.e. we have not focused our review on forensic mental health services and systems except to note models of care and evidence where relevant.

In the course of preparing the review, a representative from the literature review team (VP) took our plans to a forensic patient users forum held within the Justice Health & Forensic Mental Health Network, NSW, for informal feedback.
2. Reducing contact with the criminal justice system for those with mental health problems – preventative approaches

There has been limited emphasis on developing and evaluating either primary or secondary prevention strategies intended to reduce offending behaviour and criminal justice system contact for those with mental illnesses. Reducing reoffending is the holy grail of criminal justice system interventions but rarely has mental ill health been a focus or consideration in studies with this outcome in mind. Although early identification and early intervention are well established concepts driving models for mental health care in the community, particularly for psychosis, they have not been extended to include those in contact or at risk of being in contact with the criminal justice system.

2.1. Preventing offending behaviour and criminal justice system contact for those with mental illness (primary prevention)

Studies of interventions aimed at improving outcomes for individuals with mental illness only infrequently include offending behaviour or criminal justice system contact as outcomes of interest and even fewer describe interventions specifically intended to address such outcomes. As a result, we know very little about what primary preventative strategies might work – is the answer simply effective mental health treatment universally applied or are specific interventions targeted to those at particular risk required?

2.1.1. The impact of mental health interventions on risk of offending or contact with the criminal justice system

The following describes the findings of some of the few mental health intervention studies which have included offending behaviour and/or criminal justice system contact as outcomes of interest:
• **Models of community mental health care – e.g. assertive community care**

A UK randomised controlled trial of intensive case management compared to standard community mental health care for individuals with chronic and severe mental illness did not find that the intervention had any effect on reducing violence [46]. Authors of this study noted that of those previous RCT studies of assertive community care conducted in the US, seven included time in jail or number of legal contacts in their list of outcome measures but only two reported any benefit [47, 48]. A modified version of the assertive community care model for mentally disordered offenders has, however, been developed and evaluated in the US (termed Forensic Assertive Community Treatment) – a discussion of the evidence gathered on FACT is included within the section on reducing reoffending (see 2.2.2).

• **Involuntary community treatment**

A one-year randomised trial of the effectiveness of outpatient commitment was conducted in the US in which subjects with psychotic or major mood disorders and a history of hospital recidivism were randomly assigned to release or court-ordered treatment after discharge from involuntary inpatient admission [49]. A significantly lower incidence of violent behaviour occurred in subjects with at least 6 months outpatient commitment while lowest risk of violence was associated with extended outpatient commitment combined with regular out-patient services, adherence to prescribed medications and no substance misuse. A Cochrane systematic review of compulsory community and involuntary outpatient treatment for those with severe mental disorders was published in 2011 [50]. Only two RCTs were identified, both based in the US, and the conclusion of the review was that there is currently little evidence of benefit with regard to any of the main health outcomes assessed by these studies. There was some evidence that those receiving compulsory care were less likely to be victimised but the impact on likelihood of arrest was low (number need to treat was estimated to be 238 to prevent one arrest).

• **Psychopharmacological studies**

A number of studies have examined the impact of psychopharmacological agents on the occurrence of violence among those with severe mental illness, often with an
emphasis on trying to establish whether particular agents are more efficacious in this regard than others [51-53]. Some advantage associated with prescribing atypical antipsychotic agents such as olanzapine and clozapine (the treatment of choice for treatment-resistant cases of schizophrenia) has been documented, but overall the evidence is limited.

- **Psychological interventions**
  Group and individual psychological interventions targeting risk of violence or other offending behaviour have been evaluated in the criminal justice system context but not routinely with specific reference to their efficacy for those with mental illness. One randomised controlled trial of cognitive behavioural therapy compared to social-activity therapy, delivered to a sample of individuals with a diagnosis of schizophrenia and history of violence, found a benefit for violence and risk management [54]. In another RCT involving mentally disordered offenders in a medium secure inpatient setting, a group intervention (Reasoning and Rehabilitation) was found to have some positive impact on a range of antisocial behaviours although drop-out from treatment was a considerable problem [55].

### 2.1.2. Early intervention for psychosis and offending behaviour

As noted earlier, an approach to the care and treatment of those with severe mental illnesses such as schizophrenia which focuses on early identification and early intervention has been well established in the community for some time, albeit not without controversy as to overall effectiveness particularly in the longer term and with regard to success in reducing duration of untreated illness. While a range of health, social and economic outcomes of such an approach have been evaluated, little thought has been given to the potential impact on preventing offending behaviour and contact with the criminal justice system. One study recently linked an RCT of assertive community management for early psychosis (the Danish OPUS study) with criminal records and found that, although the intervention had benefits for health and social outcomes, the intervention did not reduce risk of criminal conviction, including for violent offending [56]. Thus, there currently is little
evidence to support the notion that current best practice for early psychosis translates into a reduction in offending, perhaps indicating that a targeted rather than universal approach is needed, that intervention needs to be offered even earlier than currently offered (in the quoted study many had already offended prior to recruitment to the study) and/or that the intervention needs to be specifically focused on reducing criminality. In this context it is important to note that there is emerging evidence to support the notion that risk of violence for those with serious illness might well be greatest early in the phase of illness [57], particularly prior to treatment.

2.1.3. Interventions for those with complex needs and risks, including development of inter-agency co-operative arrangements

Beyond the early phases of severe mental illness, another area of mental health service focus which has potential to have an impact on risk of criminal justice system contact is in developing services for those with complex and chronic mental health needs, many of whom may well have indicated potential propensity to offend. An example of such an approach is the Multiple and Complex Needs Initiative (MCNI) in Victoria [58]. The focus of the service is on providing time-limited intensive case management support to individuals with complex psychosocial needs and is targeted specifically at those with established mental illness, intellectual impairment, acquired brain injury or substance use disorder and those considered to present a serious risk of harm to themselves or others. The initiative focuses on developing individually tailored care plans and those involved in delivering on the initiative’s goals are tasked with brokering care arrangements, with funding tied to the individuals requiring care. Such an approach is welcome given the typically fractured nature of services involved with persons presenting with complex needs and the tendency of individual services to reject such persons on the basis of their levels of complexity and their need for multiagency support.

Inter-agency working to support individuals with complex needs and risks is clearly important but very often lacking. Communication between different agencies is often poor
and clarity around responsibilities and the nature of co-working is often limited. In many jurisdictions in Australia and elsewhere formal arrangements for inter-agency working for high risk or high needs groups are in place. In the UK such an approach has developed further than in other settings with the emergence of Multiagency Public Protection Panels (MAPPP) underpinned by statutory arrangements (MAPPA) [59]. MAPPPs are designed to provide an effective interagency forum for criminal justice and mental health agencies, and others where relevant, to develop and implement practical strategies to manage and monitor high risk offenders in the community. There are, however, predictable challenges to the effective operation of such panels given the different professional values, attitudes and expectations that exist between agencies [59]. Specifically, there have been difficulties encountered with respect to the assessment, measurement and management of risk, issues regarding information sharing and confidentiality, and concerns about accountability. An audit undertaken during 2001-2003 of the clinical demands and resource requirements of a MAPPP held in a south London catchment area found that a lack of co-operation from offenders with mental health services coupled with reliance on limited clinical resources presented significant ongoing challenges [60]. No formal evaluation of the impact of formal inter-agency co-operation arrangements on re-offending or other relevant outcomes has yet been published.
2.2. Reducing re-offending and repeat contact with the criminal justice system for mentally disordered offenders (secondary prevention)

If there is little evidence to support strategies to prevent those with known mental health problems from engaging in offending behaviour and coming into contact with the criminal justice system in the first place, what about for those already in contact? How can a potential trajectory within the criminal justice system be avoided and repeat offending behaviour prevented? A review of the evidence and examples of models of practice in this area includes consideration of approaches to identifying the mental health needs of those presenting to the criminal justice system with offending behaviour but without prior contact or adequate treatment from mental health services previously. We know that mentally disordered offenders often have contact with the criminal justice system prior to mental health services [10].

Few studies have rigorously assessed the impact of mental disorder on risk of recidivism. In a recent systematic review and meta-analysis of studies focused on re-offending among those with psychotic disorders, a significantly increased risk of repeat offending when compared to those without psychiatric disorder was reported [61]. No association was found when the comparison groups included those with other psychiatric disorders indicating that risk of re-offending may not be limited to those with psychosis. Despite the limited evidence regarding the role of mental disorder in elevating risk of recidivism, reducing repeat contact with the criminal justice system for those with mental disorder is clearly an aim of the principle of diversion. Again there is little evidence to support the long-term success of diversionary mechanisms – once diverted from the criminal justice to the mental health system, what is the subsequent risk of a return to the former?

2.2.1. The mental health needs of individuals in contact with the police

Although the police service represents the first level of criminal justice system contact and thus an opportunity to identify mental health needs, divert individuals to appropriate
mental health services, and potentially reduce future offending and criminal justice system contact, the focus of services and research in this area has been on the courts and prisons rather than on police.

Conservative estimates suggest that up to 10% of police contacts with the community involve individuals whose contact is driven primarily by a deterioration in their mental state [62], while the true prevalence of mental health need is likely to be much higher if mental ill health, including cognitive disability, organic disorders and substance use disorders, is considered as a potential contributing factor to a police contact, or indeed if a history of such problems is known [63, 64]. While the prevalence of mental ill health among those in contact with the police is likely to be elevated, rates are known to be particularly high among those in contact under particular circumstances. For example, a study from Victoria examining rates of mental health conditions among those subject to police use of force reported that 38% were known to have a history of mental disorder, with a particular overrepresentation in the estimated prevalence of both psychosis and schizophrenia [65] compared to what would be expected in the community. An earlier case linkage study in Victoria that examined the prior psychiatric histories and offending behaviours of individuals who had been fatally shot by police from November 1982 to February 2007 found a significant overrepresentation of mental disorders. In particular, the study estimated rates of psychosis and schizophrenia to be 11.3 and 17.3 fold higher than estimated rates in the general population [66].

In the UK, figures released by the Independent Police Complaints Commission (IPCC) [67] indicated that almost half of the 15 deaths in police custody occurring during 2012-2013, were known to have had mental health concerns. The report also revealed that 64 individuals had committed suicide within days of release from police custody. Mental ill health was identified as a contributory factor in two-thirds of these cases. In the report, the Chair of the IPCC acknowledged the need to do more to enhance the capacity of frontline agencies to respond to and manage individuals experiencing acute mental illness in community.
A study conducted recently in NSW focused on the mental ill health of frequent presenters to police during 2005 [68]. For the purposes of the study, mental health frequent presenters were defined as persons who had three or more contacts with police for a mental health related event (an event involving use of mental health legislation). Researchers found that there were a total 18,672 mental health related events in which police were involved over the 12 month period of observation, representing 13,500 individuals. Of the total number of mental health frequent presenters (n=1010) identified, males and females were almost equally represented (56.5% males) and approximately 14% of mental health related events involved individuals with an indigenous background. Interestingly, approximately 80% of mental health frequent presenters were also known to police as a Person of Interest (POI) and 64% known to have been a victim of crime, indicating the complex overlapping picture of offending, victimisation and mental health events involving police. The focus of police involvement in mental health events is typically to arrange diversion of individuals identified by police as having mental health needs, to support mental health staff in their role undertaking assessments or to transport individuals to appropriate mental health services.

The extent to which individuals can become frequent mental health presenters to police, for whatever reason or reasons, implies a potential failure of mental health services to manage risk and prevent ongoing criminal justice system contact.

2.2.2. Preventing criminal justice system involvement for those with mental illness for those in contact with the police

The focus of mental health service interventions (providing assessment, treatment and diversion) within the context of the criminal justice system has been on the court system and prison environment whilst there are few settings in which services are dedicated to providing such input to the police, despite the potential opportunities for early intervention.
Approaches focused on improving the mental health skills of police officers have been more widely adopted, with Crisis Intervention Teams (CITs) being established in a number of settings [69]. The Memphis CIT model is particularly well known and is based on specialist training for police officers who may be called upon to intervene with individuals who present with mental health needs (training includes skills in problem solving, de-escalation and negotiation, and in identifying the need for diversion) [63]. Like many models of care in this field, there has been little in the way of rigorous evaluation of the effectiveness of CITs (and certainly no RCTs) but there is some indication that the intervention is associated with a reduction in arrest rates, use of force in the management of behaviourally disturbed individuals and economic savings [70]. A not dissimilar model has been trialled in NSW – the NSW Police Mental Health Intervention Team (MHIT) program. An independent evaluation of the program found that police officers receiving training reported an increase in knowledge and understanding of mental health problems, had a preference for utilising de-escalation techniques when managing crises and felt more confident operating in crisis situations [71]. The Birmingham model represents an extension of the CIT approach in which the active involvement of mental health professionals or specially trained civilian police employees is incorporated into responses to individuals with mental health needs in contact with the police, particular those with acute needs [72]. The UK government recently announced that similar schemes will be piloted across four sites in England commencing in 2013 [73]. The ‘street triage scheme’ will see the model extended to involve mental health nurses patrolling the streets with police officers.

In Victoria, a trial of the interagency Police, Ambulance and Clinical Early Response (PACER) model was undertaken in 2007 [74]. A key focus of the PACER model was to provide primary first responders, either police or ambulance, with the option of requesting a secondary responder unit (PACER unit) to assist in managing psychiatric emergencies. The PACER unit comprised a senior mental health clinician and police officer who were able to provide on-site, and telephone, support and advice to primary responders. Following an assessment by the PACER unit, a decision is made to either transport an individual to an emergency department, mental health facility, police station or private address. Follow up support in the community is then be arranged if necessary. An inter-agency response also
means that information held by each agency with respect to individuals experiencing a mental health emergency can be accessed and used in the decision making process. Despite a number positive findings identified following an independent evaluation, the trial was ceased in 2011 on the grounds that the model did not represent significant value for money, particularly in relation to the efficient use of a senior mental health clinician. Further, it was reported that approximately half of all PACER responses were made in the context of welfare concerns rather than mental health needs [74]. The latter finding highlights the importance of considering the full range of support potentially required by those with mental illness coming in contact with the police.

2.2.3. Preventing reoffending or repeat CJS contact – approaches to secondary prevention beyond police contact

Although court-directed community sentences and post-release conditions can include mental health treatment and supervision components, the impact of these on re-offending has been little studied. For those diverted from court or prison to forensic mental health services, however, there is some evidence that assertive community treatment, including formal supervision, can reduce re-offending rates.

A study in the UK focused on those offenders who are diverted to the forensic mental health system [75] found that longer inpatient admissions and greater supervision restrictions on discharge reduced reoffending for those released from medium secure care. A similar retrospective study conducted in NSW, examining the rate of reoffending, conditional release revocation and psychiatric hospital admission for 197 forensic patients conditionally or unconditionally released into the community from 1990 to 2010 following a prior Not Guilty due to Mental Illness (NGMI) verdict for an index offence [76], concluded that re-offending rates for this group were reassuring low (less than 5% reconviction rate for violence over an average of 8 years follow-up). Formal supervision in the community allowing for early re-admission where required was identified as being an important element in preventing re-offending, ultimately leading to reoffending outcomes which
appear to be better than those seen for mentally disordered prisoners released into the community.

The Forensic Assertive Community Treatment (FACT) model is an emerging model which specifically aims to prevent the arrest and incarceration of mentally ill adults [77]. Although very similar to the standard ACT model, the developers of the model envisioned FACT to differ in terms of the legal leverage component provided by having a probation officer as part of the team and a supervised residential treatment component. An RCT of FACT conducted recently in California found that at 12 months (and at 24 month follow-up), FACT participants had fewer jail bookings, greater outpatient contacts, and fewer hospital days than did those receiving treatment as usual [78]. FACT participants also had a higher probability of avoiding jail, although once jailed, the number of jail days did not differ between groups. Increased outpatient costs resulting from FACT outpatient services were partially offset by decreased inpatient and jail costs.

There has been some evaluation of the effectiveness of probation and parole practices, including supervision and mandated interventions, in reducing recidivism for offenders with mental illness. In a discussion paper reviewing this literature, researchers reported that mental health-trained probation and parole caseworkers with specialist caseloads were more effective than generalist caseworkers in linking probationers with treatment services in the community, improving their well-being and reducing their risk of probation violation and recidivism [79]. They concluded that specialist probation and parole caseworkers play an important role in improving the health and criminal outcomes of probationers with mental illness. Further, a national survey in the US of supervision practices, case management style and enforcement strategies identified five core characteristics of specialty probation and parole caseworkers for offenders with mental illness [80]. These included having: i) exclusive mental health caseloads, ii) small caseloads, iii) received mental health training and skills development for caseworkers, iv) a primary focus on intervening early and facilitating access to treatment and services, and v) use of advanced problem solving strategies, particularly to support medication adherence. Other researchers underscore the importance of maintaining adherence to psychiatric medication as critical in
reducing offenders risk of future incarceration, while also recognising the practical challenges that this can often present [81]. However, while specially trained caseworkers have been found to reduce the risk of violation among parolees with mental illness, it is unclear the extent to which they are effective in reducing the longer-term risk of reoffending among probationers with mental illness [79].
3. Court diversion approaches

With regard to the principle of diversion of individuals with mental health needs from the criminal justice system to the mental health system so that they might receive treatment rather than punishment (see 1.3.4.), the main focus of implementation of the principle has been the court system.

Court diversion programs and mental health courts first started in the US and Canada in the late 1990s following a rise in deinstitutionalization [82]. Run by a multidisciplinary team (typically judges, lawyers, psychiatrists, psychologists, case workers, and social workers) and using a problem-solving approach, mental health courts are usually reserved for summary to moderately serious offences. Individuals who chose to participate in this diversion procedure are required to comply with an individually tailored case management plan designed by the team. Key elements of mental health courts include mental health screening and assessment, mandated treatment as a condition of participation, regular court or judicial supervision, use of sanction and rewards, and voluntary participation [83]. Unlike the US and Canada, the UK primarily utilises court-based mental health diversion or liaison services rather than having a distinct mental health court [84]. The former are mental health services which provide input to an ordinary court - undertaking mental health assessments, giving advice to the courts and diverting individuals to mental health services where appropriate.

3.1. Court diversion and liaison models in Australian jurisdictions

Australia is still in its infancy in terms of having diversion programs and mental health courts for mentally ill offenders. Each Australian jurisdiction has its own approach to court diversion and/or liaison for mentally ill offenders; the nature of such programs is dictated by the state’s or territory’s mental health and criminal justice systems and supporting legislative frameworks.
The Magistrates Court Diversion Program established in South Australia in 1991 was the first diversion scheme in Australia. It is a court directed diversion program. Similar to this is the Hobart Mental Health Diversion List, which is a diversion program which commenced operations in the Magistrates Court of Tasmania in 2007. Both Tasmania’s and South Australia’s diversion programs are based on the US mental health court model whereby a problem-solving approach is adopted and there is collaboration between mental health professionals and judiciary officers. The main difference between the two states is that while South Australia diverts people with intellectual disability (ID), Tasmania would only do so if the individual with intellectual disability has a mental illness as the primary diagnosis [85]. Initially Victoria did not have a mental health court and was operating a mental health court liaison service. However, in 2010 the Victorian government developed the new ‘Assessment and Referral Court List’ (the List) which operates according to similar principles as the South Australian and Tasmanian mental health courts. Queensland also has a mental health court although it is unique altogether from the other Australian jurisdictions. The Mental Health Court of Queensland commenced in 2002 and is a specialist court that primarily determines issues of fitness to plea and criminal responsibility. The Court considers both mental illness and intellectual disability issues [86].

Mental health court liaison services are the other main type of diversion program operating in Australian states, namely NSW (started in 2002) and Victoria (started in 1994). These services are similar to those which dominate in the UK. Rather than being court mandated and having direct judiciary supervision of offenders, court liaison services are integrated into the local courts and are typically provided by forensic mental health teams acting in an advisory role to the courts. Services may include undertaking mental health assessments and court reports, provision of clinical and case management services, and diversion/linkage to other service providers including community or prison-based mental health [87].
3.2. Evaluating the effectiveness of court diversion

Although promising results have been obtained, the evaluation of mental health courts and diversion programs remains limited [83, 88]. One reason for this is related to how success is defined. Should success be measured in terms of program completion, reoffending rates, or levels of engagement with treatment or services [89]? In a recent review of 21 publications evaluating either pre-booking diversion, jail-based diversion, court-based diversion, and mental health courts in the US, it was found that diversion programs for the mentally ill have limited impact on reducing reoffending but were associated with reduced prison time for offenders with mental illness [31]. The need to conduct further research to identify program-specific and participant-specific factors to determine who is helped by diversion was identified. The efficacy of court diversion programs in England and Wales remains largely unknown because poor data collection has prevented rigorous evaluations to be undertaken [90].

More locally, a recent review of Tasmania’s court diversion program revealed a reduction in offending in the post-program period [91]. An evaluation of the NSW court liaison services also reported some positive findings: clients of the statewide service experienced a decline in their offending frequency following their index court appearance compared to a control group and to a group of individuals receiving supervised bonds [92]. A discussion paper was recently published in NSW that presented a series of case studies in order to describe the long-term costs associated with frequent contact with the criminal justice system for people with mental health disorders and cognitive impairment [93]. It was estimated that government costs to provide criminal justice and human services (such as police, courts, corrections, health, housing and financial support services), could be as high as $1 million per person annually. In addition, the paper presented a series of cost-benefit analyses of early support and diversion initiatives targeting people with mental health disorders or cognitive impairment and estimated that for every dollar spent on these initiatives, between $1.40 and $2.40 could be saved in government expenses over the longer term.
Critics have argued that mental health courts and diversion programs provide interventions to only a selected few and can be expensive way of intervening [94, 95]. Even for the few who meet eligibility criteria, diversion programs can only offer potential access to resources at the level available in the community [85]. In many cases, community resources are limited and not always readily available or indeed suited specifically to the needs of offenders. It is also possible for participants to be simply sent back to treatment that has already failed them. Some have also questioned the wisdom of diversion programs which offer at best short-term, non-specific brief interventions such as motivational interviewing while many offer diversion only and provide no direct treatment at all [82, 96].

Given the high over-representation of Indigenous people with mental illness in the criminal justice system, efforts to establish partnerships with local Aboriginal communities are needed to ensure that diversion programs in Australia are culturally appropriate. Thus far there is a dearth of information on Indigenous participation in diversion programs [97] which is suspected to be relatively poor. In a review of the South Australian Magistrates Court Diversion program, Indigenous offenders comprised only 3.5% of engaged offenders [98]. Low rates of participation have also been reported in drug diversion programs [99]. Poor Indigenous participation in diversion programs is clearly not in keeping with the high rate of arrests and incarceration reported for this group.
4. Approaches to providing in-prison care and after-care for those incarcerated mentally disordered offenders

Beyond mental health liaison and diversion applied to those in contact with the courts, providing mental health assessment and treatment for mentally disordered offenders has been focused on prisoners. The evidence to support the need to provide mental health care in prisons has been established by the widespread reports of elevated rates of mental disorder amongst prisoners (see section 1.1) and is supported by the principle of care equivalence (see section 1.3.1). The glaring gap in provision and evidence is the vital link between mental health care provided in prison and on release in the community – so called ‘after-care’ or ‘through-care’.

4.1. Prisoner rehabilitation – principles and practices in Australia – and the relevance for those with mental illness

In Australia, offender rehabilitation programs embedded within and provided by criminal justice systems are well established. Each Australian jurisdiction has its own range of offender-focused programs that are informed by the ‘What Works’ literature. However, it was only in 2004 (updated in 2011) that an overview of the different custody-based offender rehabilitation programs in the country was undertaken [100, 101]. There are great similarities across the different jurisdictions in terms of the underlying principles governing offender rehabilitation and the nature of interventions offered. Most offending-focused programs in Australia are dedicated to reducing the risk of recidivism, especially sexual and violent re-offending. In all jurisdictions, there are sex offender and violent offender programs. Programs targeting general recidivism and focused on core issues including the development of socio-cognitive skills and reduction of drug and alcohol use also exist. Alongside these are non-offence-focused programs that aim to promote overall rehabilitation and reintegration into the community and include educational and vocational programs [101]. Offender rehabilitation programs in Australia are informed by best practice internationally and informed by evidence-based research where available. The Risk-Need-
Responsivity (RNR) model is perhaps the most influential model that has been used to guide the assessment and treatment of offenders [102, 103]. It is also the main model used to theoretically inform the offender treatment literature [104].

Briefly, the three core principles of the RNR model are the:

- **Risk principle** - matching the level of service to the offender’s risk of re-offending
- **Need principle** - assessing criminogenic needs and targeting them in treatment
- **Responsivity principle** - maximizing the offender’s ability to learn from a rehabilitative intervention by providing cognitive behavioural focused treatment and tailoring the intervention to the learning style, motivation, abilities and strengths of the offender

Despite having a focus on criminogenic needs, the ‘what works’ principles of offender rehabilitation can still apply to mentally ill individuals in custody [100], although there is little evidence to support its effectiveness for this group and limited clarity regarding what alterations might be needed to accommodate those with mental health needs and impairments. Established international programs such as the drug and alcohol Counselling, Referral, Advice, and Throughcare (CARAT) service and Dangerous and Severe Personality Disorder (DSPD) services in the UK, and sex and violence reduction programs in Canada recognize that the best institutional mental health care can have only limited utility if after release from custody, one’s risk of reoffending or return to substance use is not addressed [105]. In Australia, the Compulsory Drug Treatment Correctional Centre (NSW) for repeat offenders with substance use issues and ‘Marngoneet’ (Victoria) for intensive treatment of sexual and violent male offenders are examples of purpose-built units for offender rehabilitation. While offence-focused programs addressing ‘offending’ for the mentally ill offender arguably only shifts the individual’s status from a mentally ill offender to a mentally ill patient. The risk that the patient status is dismissed and psychiatric needs are neglected further increase if antisociality dominates the clinical picture [106]. It is of note that in many Australian jurisdictions, the practice of legally excluding personality disorder sufferers explicitly from longer term involuntary care and from diversion on the basis of being found...
not guilty by reason of mental illness or unfit to plead persists. One consequence is a ‘message’ that these sort of mental health and behavioural problems are not those that the mental health service needs to or should deal with. Recently in the UK, the ‘Personality Disorder - no longer a diagnosis of exclusion’ document [107] has attempted to begin to redress this disparity, one which is not well supported by evidence, while recent reform of mental health legislation has also reflected a change in approach.
4.2. Assessment and management of mental illness in custody

The over-representation of serious mental illness in prisons is well-recognised. However, much mental health need still goes undetected and untreated in prison [Offender Health Research Network (OHRN), 2009]. Providing effective mental health care in custody remains a challenge as prisons are often perceived as anti-therapeutic and not designed as places to comprehensively deal with the needs of mentally ill offenders [108]. Unlike specific offence-focused programs, a review of the current international and local literature seems to suggest that the management of mental health needs in custody largely involves general and broad ‘in-house’ services delivered via prison in-reach primary and mental health multidisciplinary teams or visiting mental health professionals. Typically, such services involve screening of new prison entrants for physical and mental illness, substance misuse problems, and risk of self-harm, and subsequent follow-up for psychotropic prescribing, counseling, and psychiatric consultation [109].

4.2.1. Mental health screening

Screening of new prisoners for the presence of known prior and unknown mental health need is a common practice and of significant potential but has been little studied. There are no consistent models or guidelines for prison mental health screening. Different jurisdictions tend to use different approaches. In recent times screening tools developed and tested for use specifically in prisons have appeared. A recent New Zealand study tested the Brief Jail Mental Health Screening (BJMHS) and English Mental Health Screen (EMHS) tools for new prison entrants and found the tools to be useful in identifying psychosis and in identifying those likely to require urgent or semi-urgent psychiatric intervention [110]. Given the rate of false positives resulting from use of the tools, the authors of the study suggested that a second stage screening process entailing a brief triage interview be used for those who screen positive. Correctional Services in Canada recently implemented a Computerised Mental Health Intake Screening System (CoMHISS), which involves a 45-minute computerised interview typically administered within 14 days of reception to
facilitate timely referrals to other services [111]. The interview uses two psychological measures of distress and an additional ADHD and cognitive screening component. An iterative classification tree (ICT) methodology is used to interpret the screening outcome. The potential benefits of effective screening with prompt access to treatment are multiple and include: guarding against adverse outcomes (e.g. suicide and self-harm), improving prognosis of those who are acutely unwell, reducing prison disturbance (as a result of better management of psychiatric symptoms), and fostering initial engagement with mental healthcare among new entrants with a mental illness [112]. However, evidence suggests that the majority of psychiatric disorders are likely to be missed during initial screening; routine screening in the UK has been shown to identify only about 23-33% of prisoners with serious mental illness [113]. For those whose illness is not identified, the stress of incarceration can subsequently lead to worsening of symptoms or development of additional morbidity [114].

Models of mental health care provision in prisons vary from those where external health providers provide occasional out-patient style clinics to local prison services to those where the healthcare providers are embedded in the prison environment on a full-time basis providing in-reach services (analogous to community mental health team models outside hospital) and sometimes hospital-type care (analogous to inpatient psychiatric care). Healthcare providers may be employed by the prison service, employed by the publically-funded health service or by a private provider contracted by the state. It is fair to say that there has been very little research, beyond providing descriptions of health needs, models of care and audits of provision in particular settings, to support the efficacy of any specific models of mental health service provision to prisoners.

4.2.2. Within-prison mental healthcare models in Australia

Levy [18] provides a detailed description of the models for provision of mental healthcare to prisoners across the various jurisdictions in Australia and in the context of international trends. A wide range of approaches have evolved, both in terms of the funding and
management arrangements, and in terms of the models of provision. Many of the states and territories have also adopted a range of approaches depending on local circumstances, with more remote prison facilities often reliant on local or ‘fly in fly out’ healthcare professionals providing occasional care while the larger metropolitan-based prisons have full-time in-reach mental health provision. The ‘prison hospital wing’ concept which has long been the focus of debate nationally and internationally is also in operation in Australian jurisdictions both with and without the ability to provide healthcare with the support of mental health legislation. Some have seen the former as challenging the notion of equivalence of care since no such model of care operates in the community [16] while others have opposed the development of the latter on the grounds that prison hospitals intended to function as community psychiatric hospitals are essentially unable to do so.

Mental health needs of prisoners are addressed by the individual Australian states or territories which govern their own mental health funding and the nature of service provision such as whether services are to be provided by corrective or health departments, outsourced to a third party, or a combination of these [115]. Across all Australian jurisdictions, mental health services to individuals coming into contact with the criminal justice system are commonly provided by the health sector, sometimes in partnership with the criminal justice system (for example, Justice Health and Forensic Mental Health Network (JH&FMHN) in New South Wales, Forensicare in Victoria, the State Forensic Mental Health Service (SFMHS) in Western Australia). Within the custodial environment, there may be dedicated prison clinics, prison hospital wings or gazetted hospitals staffed by mental health professionals and within the non-custodial environment, there are specialised facilities such as secure inpatient psychiatric hospitals or units some of which are gazetted under the respective state’s mental health legislation (generally forming a forensic mental health system or service). The Mental Health Screening Unit (MHSU) at the Metropolitan Reception and Remand Centre (MRRC), NSW, is an example of a prison in-reach service (which also has some of the properties of the ‘hospital wing in prison’) for those with mental health issues or who pose a risk to themselves or others [116]. Inmates presenting with mental health issues at reception screening are seen by the Risk Assessment and Intervention Team (RAIT) and thereafter referred to the MHSU if necessary. Patients remain in the MHSU until a diagnosis is made and a management plan is established following multidisciplinary consultations with psychiatrists, GPs, psychologists, welfare officers. Several
discharge pathways are available from the MHSU. For example, patients can be transferred to a gazetted mental health facility for involuntary treatment, back into the main jail, or be diverted from the local court if the patient had been remanded for summary offences.

### 4.2.3. Evaluations of within-prison models of mental health care

Few evaluations have been undertaken to determine the effectiveness of prison in-reach and other mental health services. It has been argued by some that these services are based on limited and idiosyncratic models of care [117] based on the potential of small and poorly resourced teams [118]. The National Evaluation of Prison Mental Health In-Reach report [119] a survey of in-reach services in the UK, found that while in-reach team leaders supported the idea of in-reach services, they also thought that these services were poorly resourced and implemented. Furthermore, in line with criticism focused on court diversion/liaison services most clinical activity for in-reach teams is focused on assessment and liaison/support rather than face-to-face intervention. Some newly developed in-reach teams have strayed from providing specific targeted interventions for serious mental illnesses to broad primary mental health care [117]. According to the principles of equivalence, mentally ill offenders in custody should receive a standard of care equivalent to that available in the community. On this basis there have been attempts to replicate a functional community mental health service in prison and to implement established models of community care such as Assertive Community Treatment (ACT), although such efforts have been met with difficulties [120].

Prison in-reach services in the UK in both adult and juvenile settings operate on a generic community mental health treatment model rather than any specialist models and, even so, the aim of community equivalence is arguably yet to be met [121]. Concerns have been raised about the significant number of people in the criminal justice system still receiving little or no care [122]. Prison clinics are often unable to cope with influx of prisoners with complex health needs, and often rely on prisoners to self-report of health conditions. Therefore, only those who present with overt and salient psychiatric symptoms or request mental health treatment would likely receive attention from prison clinic staff [123]. For many though, prison represents an opportunity for intervention and treatment and often is the only
setting in which an offender might be able to establish contact with mental health services [124].

The development of in-reach teams has reportedly been associated with a reduction in the stigma associated with mental illness for prisoners and at least the opportunity for establishing continuity of care after release [119]. Regardless, the need to provide a seamless and integrated service for mentally ill offenders from prison and into the community cannot be emphasised enough given that the vast majority of incarcerated individuals will be eventually released into the community where ongoing stability of mental health will be dependent on provision of appropriate ongoing support [125].
4.3. What happens post-release?

The complex needs of prisoners can make it difficult for them to reintegrate into the community; add to this the challenge of achieving any continuity of mental healthcare on return to the community. There is limited benefit in capitalising on mental health treatment achievements in prison only for these to be lost on release due to a lack of continuity in care or ability to link prison to community services.

4.3.1. Why is the post-release period important?

On release from prison, the first 72 hours are known to be a critical period for people at risk of drug overdose and the first 2 weeks are critical for relapse into substance use and reoffending [126]. Numerous prison studies have shown that the period immediately post-release is also associated with high rates of suicide [127] with the following factors being found to be predictive of particularly high risk of post-release suicide: age over 25 years old, released from a local prison, prior history of substance misuse and self-harm, having a psychiatric diagnosis, and needing community mental health follow-up [128].

In the local context, a recent large-scale retrospective cohort study involving 85 203 adult inmates in NSW found that 86% of suicides among inmates occurred after release and that men had a higher suicide rate than women (129 vs 56 per 100 000 person years) both in prison and after release (135 vs 82 per 100 000 person years) [129]. The suicide rate in men in the 2 weeks after release was 3.87 (95% CI, 2.26–6.65) times higher than the rate after 6 months. However, men who received psychiatric admission to the prison hospital had a three-fold higher risk of suicide than non-admitted men both in prison and after release, thus highlighting the role of mental illness in increasing risk of self-harm and the urgent need to target mental health needs among those released into the community. Drug-related mortality in men was 9.30 (95% CI, 7.80–11.10) times higher, and in women was 6.42 (95% CI, 3.88–10.62) times higher, in the 2 weeks after release than after 6 months. Ninety-seven percent of mortality due to drug overdose occurred after release. A recent
meta-analysis of six prison systems globally found that the risk of drug-related death remains elevated for at least 4 weeks after release from prison [130].

4.3.2. The current picture of post-release mental health care provision and attempts at interventions to improve ‘through-care’

The vast majority of Australian prisoners are released into the community and this includes those with mental health issues. The post-release management of these offenders varies by jurisdiction although, in general terms individuals can be released into the community with formal conditions imposed (e.g. parole or intensive supervision orders) or unconditionally [131]. Undeniably, however, there is an absence of continuity of care in the form of pre-release planning and post-release support in Australia and this results in suboptimal reintegration of offenders into the community [131]. Similar findings have been reported in UK studies [132, 133]. Following release, less than a quarter of prisoners with a psychotic illness in the UK will receive an appointment from a mental health professional [134].

In 2007, a randomised controlled trial was piloted in the UK that sought to examine whether implementation of a new Critical Time Intervention (CTI) program was effective in linking individuals with severe mental illness with appropriate health and social care services, including mental health services upon their release from prison [135]. Outcome measures were then compared with those in the treatment as usual control group. A key focus of the CTI program was the provision of a prison-based CTI manager whose primary responsibility was to support and empower mentally ill prisoners to identify their own support needs and to assist them in establishing and engaging with appropriate agencies prior to their release. The program required CTI managers to perform a range of case management duties both pre- and post-release. This included accompanying individuals to appointments in the community and discussing ongoing support needs. The results found that at follow up, individuals in the CTI program were more likely to be receiving medication and maintaining active engagement with services in their local community (in particular their local primary healthcare provider) than those who were in the TAU group. The CTI manager played a critical role in providing interim
support for individuals in the community until local community mental health team involvement could be reinstated.

It must be noted also that post-release programs and community integration efforts for offenders generally only benefit those who are still in contact the criminal justice system (i.e. under formal supervision orders). Those individuals released from custody without formal post-release supervision often have to rely on the goodwill of non-government and faith-based organisations for welfare and other services [131] (e.g. the Community Restorative Centre (CRC) in NSW which is a community organisation providing post-release support to prisoners, ex-prisoners, and their families). In addition to a deterioration in mental health status following release from prison without through-care established, re-offending is a potential risk.

In 2002, a roundtable discussion was held at the Australian Institute of Criminology to discuss the provision of post-release services to prisoners. Various stakeholders attended and the international literature was also drawn upon. The general consensus of the discussion was that research into ‘through-care’ – referring to treatment and services that commence in custody and continue after release into the community - in Australia pales in comparison to that found in North America and the United Kingdom. The group also identified numerous barriers to the integration of prisoners into the community and acknowledged that there needs to be a collaborative effort [131]. Essentially the conclusion of the discussion was that best outcomes are when factors predisposing a person to criminal activity (criminogenic needs) are addressed and when physical and social needs are appropriately supported via interagency collaborations, both in prison and post-release [136].
5. Victims with mental health problems in contact with the criminal justice system

The risk of harm individuals with mental illness might pose to others as perpetrators of crime and violence has been emphasised at the expense of the recognition that individuals with mental illness are also vulnerable to becoming victims. This is borne out by the following: the number of research studies focused on mentally ill perpetrators compared to those focused on mentally ill victims; the lack of awareness of risk of victimisation for patients by mental health clinicians and clinical services as well as the absence of interventions designed to identify and reduce such risk; the lack of support for victims with mental ill health in their attempts to access justice; and the unbalanced focus of media reporting on perpetration compared to victimisation risks. The potential consequences of this disparity of focus include a likely increase in the stigma associated with mental illness, inequity in access to justice for victims with mental illness and a negative impact on mental health and wellbeing resulting from the trauma of victimisation.

5.1. Evidence supporting the notion that those with mental illness are at elevated risk of victimisation

In 2008, a review of US violence perpetration and victimisation studies was published with the startling conclusion that ‘victimization [for those with serious mental illness] is a greater public health concern than perpetration’ [137]. This review identified 31 perpetration studies and only 10 victimisation studies. In two of the three identified studies which examined both perpetration and victimisation risks, the latter were found to be substantially greater. Compared to victimisation rates in the general population, individuals with mental ill health do appear to be at considerably increased risk, although the evidence for this comes largely from the US and the UK. The British Crime Survey conducted in 2009/10 included for the first time a question about disability, including disability due to mental disorder. The odds of being a victim of violence in the previous year were found to be three times higher for those with mental disorder compared to those without disorder.
A recent review of domestic violence studies also identified mental illness, particularly depression, anxiety and PTSD, as being strongly associated with victimisation experiences [139]. It must be noted that there have been few longitudinal studies of the relationship between mental illness and risk of victimisation and it is very likely that causal relationships extend in both directions in a complex manner (i.e. that victimisation increases risk of subsequent mental ill health and that mental ill health in turn increases vulnerability to victimisation), particularly for those experiencing chronic or repeated victimisation. In one longitudinal population-based birth cohort study in the UK, mental disorder was certainly confirmed to increase risk of subsequent crime victimisation [140]. Operating in the other direction, there is increasing evidence to indicate that trauma and abuse suffered early in life can increase later risk of the onset of serious mental illness [141].

There have been few studies of victimisation vulnerability among those with mental illness conducted in Australia. The recent Australian National Survey of Psychotic Illness, a study which included individuals with psychotic illnesses receiving treatment from services (public or NGO) in seven catchment sites across the country, found that 38.6% had been victimised during the year prior to the survey [142]. Almost a quarter reported being a victim of assault, a figure which is dramatically higher than found in general population surveys where rates of around 5% are more typical. A Victorian case linkage study compared official records of victimisation for those with schizophrenia-spectrum disorder to a comparison group from the general population and found an increased risk for violent and sexually violent victimisation for the former [143]. The Dunedin study in New Zealand has also published findings related to victimisation and mental illness, concluding that ‘Mentally disordered young adults tend to experience more violent victimization in the community than those without a mental disorder’. In Australia, we do not currently have data from a population-based source which can address questions related to the relative prevalence of victimisation experiences for those with mental illness, the nature of such experiences, the consequences of victimisation, or the outcomes for those seeking justice, and this is sorely needed if the problem is to be addressed.
5.2. Interventions to reduce risk of victimisation and barriers to accessing justice

With regard to interventions and their impact on risk and/or outcomes of victimisation for those with mental illness, there have been very few studies internationally. A reduction in victimisation was noted as a secondary outcome in an RCT of outpatient commitment conducted in the US [144]. A trial of specialist psychological advocacy for women who experience domestic violence or abuse has been established in the UK [145] but results awaited. This clearly represents an area which has been lacking in research evidence to date.

Finally, the potential barriers to accessing justice for victims with mental illness have been little recognised within the criminal justice system where, unlike for accused individuals, there is no established system for recognition of mental illness or support for navigating the system. We do not know whether outcomes for those who do report being the victim of crime or violence differ by the mental health status of reporting victims. To what extent are victims or witnesses with mental ill health regarded as ‘unreliable’ as regards giving evidence to the police and courts? Qualitative research and survey findings give some indication that ‘access to justice issues’ are very real for those with mental illness. A survey conducted in the UK by the mental health charity MIND reported in 2007 that 30% of those who had been victimised told no-one of their experiences [146]. Following the survey, MIND developed a ‘mental health toolkit’ for prosecutors and advocates to inform the way in which individuals with mental distress are dealt with by the courts when they present as victims and witnesses [147].
Conclusions

Those with mental ill health in contact with the criminal justice system represent a strikingly disadvantaged group in society; one whose health and other needs have often been neglected despite their levels of morbidity. This is reflected in the relative paucity of rigorous research underpinning our understanding of the nature of the problem and our responses to it. The field of justice and mental health has not received the prioritisation justified by the level of need and the extent of discrimination experienced - in terms of the body of research, clinical and service development, and policy work devoted to it both locally and internationally. This review, while unable to provide a systematic account of the relevant literature across all relevant topics, highlights both the broad scope of the field and the limited nature of the evidence base that currently exists.

The field is plagued by a number of complexities in addition to the lack of prioritisation given to research and intervention/service development. Researchers, clinicians, justice employees, and policy makers are by necessity working across different fields and systems (legal, health and criminal justice), with differing approaches, priorities and frameworks. The specific nature of these also varies by jurisdiction, both across States and Territories in Australia and between different countries internationally.

There are, however, a number of emerging themes and ideas which can be drawn from the review, limited by the evidence base which in many cases is insufficient to support any firm recommendations – other than the clear need for more research and a greater overall focus on the field. The following are a collection of concluding remarks informed by the review process.

1. There is a need to develop and agree standards for mental health care provision and outcomes for mentally disordered offenders and to prioritise areas for further research and evaluation. In Australia, this would benefit from consideration of the development of a national body to take responsibility for driving improvements in
the field and for reducing disparity between jurisdictions. There needs to be a consensus developed around whether the principle of ‘equivalence of care’ is sufficient to meet the needs of mentally disordered offenders or whether cost-effective outcomes can be achieved through interventions and service delivery models which take explicit account of health need complexity.

2. Overall, research to date has focused on prevalence studies, descriptive and comparative studies of models of care, and evaluations of interventions that are often of limited rigour. There is a need for longitudinal studies to understand the complex relationships between mental ill health, service contact, offending and justice system contact, over time, and a need for rigorous testing of interventions and service-delivery models with evaluation of the long term impact on health and offending outcomes a priority. There is also a need for causally-informative research to extend the forensic mental health research field beyond confirmation of the statistical association between mental illness and offending to an understanding of the underlying causal mechanisms which might be targets for intervention.

3. While a large number of prevalence studies have established the clear need for mental health assessment and treatment for those in custody and before the courts, there has been a lack of focus on the needs of mentally ill offenders in the community, both before or in the early stages of justice system contact and following release or initial court diversion. Most offenders will spend the majority of their lives in the community where their mental ill health and risk of offending will have greatest impact on themselves and others, and where interventions are likely to have the greatest and most sustained impact. Early identification (both of mental illness among offenders and of risk of offending among the mentally ill) and intervention is needed, as is a greater focus on establishing successful models of through-care.

4. If interventions and service delivery models are to be effective they need to be targeted and specialist in their approach. Evidence to date indicates that mental health driven interventions need to address criminogenic need specifically if they are
to have an impact on offending and criminal justice system contact rather than universal provision of best-practice mental health care. The same is true for criminal justice driven interventions – they need to have a specific mental health focus if they are to be effective for mentally disordered offenders.

5. A greater recognition of the risk of victimisation that exists for individuals with mental illness is justified, as is the discrimination faced by those with mental illness who attempt to access justice. More research is needed, particularly locally in Australia, to understand the extent and impact of the problem and to evaluate approaches to reducing risk and improving justice system experiences.

6. Specific subgroups among those offenders with mental illness should be the focus of research and evidence-informed service development including those of Indigenous background, female prisoners and young people in contact with the Justice System.
References

34. Stephey, M.J., Decriminalizing mental illness, in Time. 2007.


Independent Police Complaints Commission, IPCC publishes annual deaths during or following police contact for 2-12/13 - mental health a key factor. 2013, Independent Police Complaints Commission: London.


Zammitt, A., Disability and the courts, O.o.P. Advocate, Editor. 2004: Victoria


146. MIND, Another assault: Mind’s campaign for equal access to justice for people with mental health problems. 2007.