ACT Government | Canberra Health Services

Forensic Mental Health Services

Model of Care

November 2019

VERSION CONTROL

VERSION	DATE	AUTHORED BY	MODIFICATIONS
0.1	December 2018	Matt Ferriman	Commenced development of draft documentation
1.0	April 2019	Matt Ferriman	Released document for comment.
1.4	May 2019	Matt Ferriman	Incorporating feedback from Project Reference Group
1.5	May 2019	Matt Ferriman	Edits
1.7	June 2019	Matt Ferriman	Incorporation of comments from Corporate Governance Committee member
2.0	June 2019	Matt Ferriman	Draft for external consultation
2.3	August/Sept 2019	Matt Ferriman	Draft for merging and incorporating comments/changes
2.6	October 2019	Matt Ferriman	Merged document for Corporate Governance.

RELEASE OF DOCUMENT

VERSION	ISSUE DATE	ISSUED TO	REASON FOR ISSUE
1.0	11/04/19	Project Reference Group	Initial draft for comment
1.4	16/05/19	Project Reference Group	Follow up draft for comments after significant decisions
1.5	3/06/19	Corporate Governance Committee	Clearance for further dissemination and consultation
2.0	26/06/19	Executive Director, internal/external stakeholders	Consultation with internal/external stakeholders
2.6	26/10/19	JHS Clinical and Operational Directors	For submission to Corporate Governance Committee for endorsement.

ENDORSEMENT HISTORY

VERSION	DATE	Endorsed By
2.6	4/11/19	MHJHSADS Corporate Governance Committee

Abbreviations

ACAT	ACT Civil and Administrative Tribunal
AA	Advance Agreement
ACD	Advance Consent Direction
ACT	Australian Capital Territory
ACMHS	Adult Community Mental Health Services
ACTCS	ACT Corrective Services
ADS	Alcohol and Drug Service
AHPRA	Australian Health Practitioner Regulation Agency
AHS	Aboriginal Health Service
AIHW	Australian Institute of Health and Welfare
AMC	Alexander Maconochie Centre
AMHU	Adult Mental Health Unit
AOD	Alcohol and other drugs
BYJC	Bimberi Youth Justice Centre
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Service
CHS	Canberra Health Services
CRO	Conditional Release Order
CYPS	Child and Youth Protection Services
DMHU	Dhulwa Mental Health Unit
ED	Emergency Department
FoCIS	Forensic Consultation and Intervention Service
FMHS	Forensic Mental Health Services
FPTO	Forensic Psychiatric Treatment Order
GP	General Practitioner
JHS	Justice Health Services
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer +
MDT	Multidisciplinary Team
MHCALS	Mental Health Court Assessment and Liaison Service
MHS	Mental Health Service
MAJICeR	Mental Health Alcohol and Drug, & Justice Health Integrative Care Electronic Record
MHJHADS	Mental Health, Justice Health and Alcohol & Drug Services
MoC	Model of Care
MOU	Memorandum of Understanding
NDIA	National Disability Insurance Agency
NICE	National Institute for Health and Care Excellence
OPMHS	Older Persons Mental Health Service
PTO	Psychiatric Treatment Order
TAC	Threat Assessment Centre

Contents

Executive Summary

Forensic mental health services have been developed with a number of core purposes. These include treating individuals with mental illness or disorders who pose or posed risks to others as a result of their illness; providing specialist advice and working collaboratively with other health professionals regarding people at risk of harming others to reduce risk and the need for secure care; providing expert advice to the criminal justice system to reduce risk for the community and people with mental illness or disorder; and other services such as training and development of research. They are 'low volume high cost' services and tend to work intensively with a small number of people with more complex needs. This results in higher care costs per occasion of service, and requires clear service goals and highly trained staff.

The Australian Capital Territory (ACT) Forensic Mental Health Service (FMHS) is a core component of the Justice Health Services (JHS) program within Mental Health Justice Health Alcohol and Drug Services (MHJHADS), a division of Canberra Health Services (CHS). It is the only provider of public forensic mental health services in the ACT, providing mental health care across the lifespan and across a range of settings, including adolescent and adult custodial and community settings.

The FMHS provides specialist expertise to other mental health services (including general community mental health and inpatient services) and interagency partners (including police, the courts, and custodial centres) regarding the treatment of people experiencing mental illness/disorder and at high risk of offending, or those already in the criminal justice system. The FMH service elements form critical components of the pathways a person with mental illness or disorder may take when they come into contact with the criminal justice system, and can be a key contributor to the reduction of risk for those people who may offend due to their mental illness.

The following FMHS Model of Care (MoC) is aimed at a range of people, clinicians and other services who engage with the FMHS and details the service elements, their roles, and how they can support people with mental illness or disorder, and services working with this cohort. The MoC aims for increased effectiveness in the identification and treatment of mental illness/disorder across settings and the reduction of delays or gaps in service provision resulting in improved outcomes for people and carers. The MoC acknowledges the complexities of providing this care in restrictive settings or contexts and commits FMHS to collaboration with various services working at the interface of the mental health and criminal justice systems.

Section 1 - Background

Forensic Mental Health Service Context

International and Australian research has identified an increased prevalence of mental illness and disorder 1,[i] among people at all stages of the criminal justice process (e.g., pre-arrest, police cells, courts, and prisons)[ii]. Consequently, specialised mental health services have been developed in order to address the significant mental health issues in this population and support the organisations tasked with managing the criminal justice process.

Put simply, *forensic* means related to, or associated with, legal issues. Forensic mental health services typically provide assessment and treatment of people with a mental illness or disorder and a history of offending, or those who are at risk of offending.

The ACT FMHS is the specialist provider of custodial and community forensic mental health services in the ACT. The service provides mental health assessment and treatment services for people across the lifespan who have come into contact with the criminal justice system, or those identified as being at high risk of serious offending behaviour. This includes the provision of services to people in various settings (e.g., ACT Courts, correctional centres, community centres) and under a variety of conditions, including *forensic patients.* 2

The FMHS also provides specialist expertise to other mental health services (including general community mental health and inpatient services) and interagency partners (including police, the courts, and custodial centres) regarding the treatment of people with mental illness and disorder and the interaction between the mental health and criminal justice systems.

The FMHS is a service function within the larger Justice Health Service program. Figure 1 outlines the current JHS structure.

---

1 The *National Standards for Mental Health Services 2010* define mental illness as:

"A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders...or the International Classification of Diseases. These classification systems apply to a wide range of mental disorders...In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system and there is a separate, but linked, national strategy. Similarly, dementia is treated primarily in aged care settings. Both are considered important in terms of their co-morbidity with mental illness." (p 37)

2 In the ACT section 127 of the *Mental Health Act 2015 (ACT)* defines a *forensic patient* as:

"a person in relation to whom a forensic mental health order may be made or is in force"

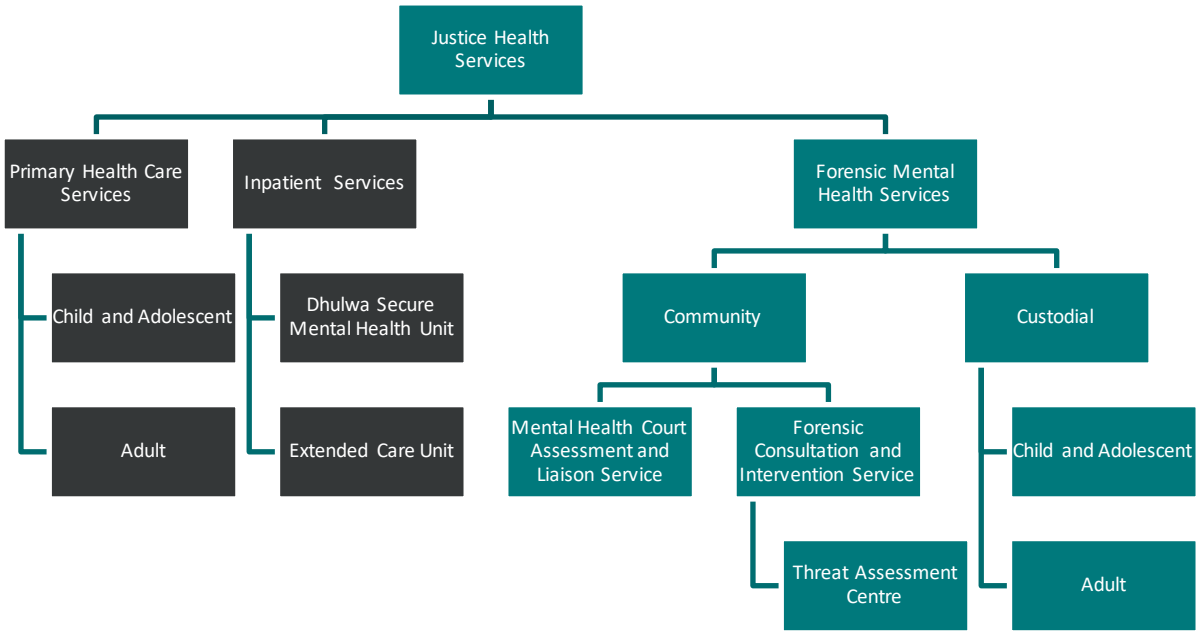

Figure 1. Organisational structure of the Justice Health Services.

Within JHS the FMHS has a community and custodial stream with four distinguishable service components as follows:

- Community Forensic Mental Health Services
    - Mental Health Court Assessment and Liaison Service (MHCALS)
    - Forensic Consultation and Intervention Service (FoCIS)
- Custodial Mental Health Services (MHS)
    - Custodial MHS – Child and Adolescent (CA)
    - Custodial MHS – Adult

These service components form part of a mental health care pathway including community, custodial, and secure inpatient settings. The integration and close collaboration of services minimises administrative delays at the interfaces between service elements and supports the reduction of risks within our community through the provision of targeted, evidence-based clinical interventions for people at various stages of the criminal justice system.

All FMHS teams also provide evidence-based interventions in collaboration with other MHJHADS services such as community mental health teams, acute hospital-based services, and Alcohol & Drug Services (ADS), in order to provide the best possible care for people engaged with the service.

Purpose of the Model of Care

In recent years there have been a number of changes in the landscape of the ACT criminal justice system, organisational structures, and the needs of the ACT community. Accordingly, the remit of the FMHS MoC project was to plot and review the existing service design against domestic and international best practice, identify issues and shortcomings of the existing model and develop a MoC that addressed these areas for improvement, with clarification of service purpose, service provision, and service sustainability.

As a result, the MoC was designed with the following goals:

1. Improved service delivery effectively targeting consumer and carer needs across various settings
2. Removal of gaps in the clinical pathway for people with mental illness in the criminal justice system
3. Increased standardisation of care practices
4. Improved support of other services (e.g., community MHS, prison GP care, ACT Corrections, etc) in their care of people with mental illness or disorder
5. The service is able to undertake meaningful research with consumers and other agencies
6. FMHS is considered a desirable place to work and able to successfully attract and retain staff
7. Identification of future service directions and development opportunities.

Section 2 – Principles of care

The Definition, Vision and Principles of Care below reflect the nature of the services delivered by the FMHS and the principles required to best meet the needs of people experiencing mental illness or disorder, intra- and interagency partners, and the ACT community. They are underpinned by national frameworks including the *Fifth National Mental Health and Suicide Prevention Plan 2017*[iii], the *National Statement of Principles for Forensic Mental Health 2006*[iv], the *National Framework for Recovery-Oriented Mental Health Services 2013*[v], the *National Safety and Quality Health Service Standards 2012*[vi], and the *National Standards for Mental Health Services 2010*[vii].

Additionally, the Principles are underpinned by ACT definitions, expectations and frameworks such as the *ACT Charter of Rights for People who Experience Mental Health Issues*[viii], the MHJHADS *Governance Framework 2015*, and legislation including the *Mental Health Act 2015*[ix], *Human Rights Act 2004*[x], *Corrections Management Act 2007*[xi], *Crimes Act 1900 (ACT)*[xii] and the *Criminal Code 2002 (ACT)*[xiii].

Mental illness and disorder

In the ACT, the *Mental Health Act 2015* provides definitions of mental illness and disorder. For the purpose of the *Mental Health Act 2015* and this model of care ***mental illness*** is defined as "a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person in one or more areas of their thought, mood, volition, perception, orientation or memory. It has one or more of the following symptoms: delusions, hallucinations, serious disorders of streams of thought, serious disorders of thought form, or serious disturbance of mood". [xiv] Examples of some of the most common mental illnesses that are impacted by the *Mental Health Act 2015* and this model of care are depression, anxiety-related disorders, schizophrenia, and bipolar disorders.

Under the *Mental Health Act 2015* and for the purpose of this model of care, *a* ***mental disorder*** is a "condition that is not a mental illness, but a disturbance or defect that substantially disables a person's perceptual interpretation, comprehension, reasoning, learning, judgement, memory, motivation or emotion. This may be caused by conditions including dementia (e.g., Alzheimer's disease), intellectual disability, acquired brain injury, other degenerative neurological conditions (e.g., Huntington's disease), eating disorders (e.g., anorexia nervosa), and personality disorders (e.g., borderline personality disorder)". [xv]

FMHS Vision

'Recovery-focused mental health care for healthier people and safer communities'

The vision statement reflects the significant role that a person's health and, specifically, their mental health has in determining likelihood of contact with the criminal justice system. It also highlights the

significant role that the FMHS plays in providing effective services to people, carers and other agencies in support of safer communities.

FMHS Principles of Care

1. *High quality, person-centred, recovery-oriented care*
2. *Timely and responsive service access and provision*
3. *Provision of a comprehensive service in which care pathways are integrated, multidisciplinary and evidence-based*
4. *Service provision is ethical, transparent, and accountable*
5. *Increased focus on quality improvement and research development and evaluation*
6. *Staff expertise is acknowledged and developed*

Principle 1. High quality, person-centred, recovery-oriented care

People in the criminal justice system with mental health issues are a highly stigmatised and marginalised group within our communities[xvi]. Within this group there are a number of particularly vulnerable populations, including Aboriginal and Torres Strait Islander peoples, children and adolescents, older persons, Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer + (LGBTIQ+) people, and people from culturally and linguistically diverse backgrounds. As such, it is key to the provision of the FMHS MoC that the service meets the specific care needs of an individual while taking into account the entirety of their biological, psychological, social, cultural, spiritual and contextual needs. This individualised care implies improved access to comprehensive and holistic biopsychosocial assessment and treatment, acknowledgement of the background, experiences, and wishes of the individual with respect to their assessment and treatment, regular review of progress, and the involvement of significant others in the treatment, support, and care of people accessing the service. This is further underpinned by the Principles of Recovery as per the *National Framework for Recovery-Oriented Mental Health Services 2013*[xvii].

Trauma informed care

Rates of childhood and adult trauma are high among incarcerated persons and are associated with the risk of developing mental health disorders[xviii]. Trauma-informed approaches are an integral part of recovery-oriented services[xix] and as such are embedded within the FMHS MoC. Trauma is a broad term and includes experiences of personal lived-experiences as well as cultural, inherited (intergenerational) history and collective trauma. All clinical practices and interventions within the FMHS are trauma-informed by:

- Being attentive and responsive to the impacts of trauma on mental health and recovery
- Ensuring policies and daily practices do not contribute to re-traumatisation or further harm

- Recognising that unresolved trauma may impact on a person's feelings of safety and trust. It may also lead to a reliance on harmful coping strategies, such as substance use or self-injurious behaviours
- Appreciating the complexity of recovery outcomes and the need for both evidence-based clinical interventions and support to overcome functional and other barriers in order to achieve better health
- Ensuring all FMHS staff are trained in trauma-informed practice.

Carers, guardians and Nominated Persons

In line with the *ACT Carers Strategy 2018-2028*[xx] the FMHS is committed to recognising and working with carers, guardians and Nominated Persons in the provision of person-centred care to the ACT community. This includes the provision of relevant education and training as needed to support carers in their roles, and information and referrals for further supports where needed.

The FMHS is committed to supporting the important statutory functions provided by individuals identified as Nominated Persons and their role in person-centred care. The FMHS will identify and work with people and Nominated Persons in respect to Advance Agreements (AAs) and Advance Consent Directions (ACDs) in line with the *Mental Health Act (2015)*[xxi] and the CHS *Advance Agreements, Advance Consent Directions, and Nominated Persons under the Mental Health Act 2015* operational guideline.[xxii]

Principle 2. Timely and responsive service access and provision

People experiencing mental illness or disorder in the criminal justice system are a marginalised group who often face significant difficulty in accessing and receiving timely and responsive treatment. In keeping with Standard 10.2 of the *National Standards for Mental Health Services 2010*[xxiii] and the ACT *Corrections Management Act 2007*[xxiv] the FMHS is committed to increasing service accessibility to a quality and standard available to other members of the community, and to meeting the needs of people experiencing mental illness or disorder and others in a timely manner.

Principle 3. Provision of a comprehensive service in which care pathways are integrated, multidisciplinary and evidence-based

According to the *National Statement of Principles for Forensic Mental Health Services 2006*[xxv], a comprehensive forensic mental health services should provide the following functions:

- Mental health promotion and prevention
- Assessment
- Management, including treatment and rehabilitation
- Coordination of care across settings, including pre-release planning and linking clients with general mental health and private mental health services
- Delivery of care in a culturally sensitive environment
- Facilitation of diversion to appropriate treatment settings
- Consultation, liaison and support to general mental health services, corrections and other bodies

- Provision of expert advice and reports as determined by individual State and Commonwealth requirements
- Other functions such as administration, research, education and training.

The provision of these services addresses the mental health needs of people at various stages of the mental health and criminal justice systems through primary, secondary, and tertiary health interventions. The FMHS is committed to the provision of a comprehensive range of multidisciplinary, evidence-based services in order to meet the variety of needs of people and services across the mental health and criminal justice systems.

The responsibility for addressing the needs of people in the criminal justice system with mental illness or disorder is a responsibility shared among the mental health, justice, and correctional systems. In order to provide effective interventions across the broad range of settings in which the FMHS operates, the service requires strong communication, links, and partnerships with general mental health services, government services, and community-managed organisations. Strong relationships among these services can support early intervention for those at risk of serious offending and ensures that treatment is provided in the most appropriate manner and setting.

Principle 4. Service provision is ethical, transparent, and accountable

FMHS acknowledges that many of the people for whom the service provides interventions have been charged and convicted of a range of offences. There are also a number of people referred to FMHS who have not committed an offence, however are at risk of offending due to significant mental health issues. In line with Principle 7 of the *National Statement of Principles for Forensic Mental Health 2006*[xxvi] and the *Human Rights Act (ACT) 2004*[xxvii], the service recognises that an individual's right to have their dignity, privacy, and individual human worth respected is not waived as a result of their individual circumstances, regardless of their history of offending behaviour. Further, their capacity and right to provide consent is not automatically forfeited as a result of their status as a detainee, their individual offending history, or their mental health condition.

Therefore, the service aims to provide mental health treatment only with the explicit informed consent of the person, except in circumstances where they are unable to give informed consent, or where there are legislative or ethical requirements for treatment. Where a person is unable to provide consent for treatment, treatment will be provided consistent with the principles and requirements of the *Mental Health Act 2015*[xxviii] (e.g., least-restrictive care). This includes the use of any established Advance Agreements or Advance Consent Directions, in consultation with a Nominated Person, or under other provisions for substitute decision-making outlined under other relevant legislation (e.g., *Guardianship and Management of Property Act 1991 [ACT]*[xxix]*).*

Principle 5. Increased focus on quality improvement and research development and evaluation

The provision of high quality services relies on the continual review and improvement of clinical services and the development of research investigating areas of need. In line with Principle 10 of the *National Statement of Principles for Forensic Mental Health 2006*[xxx], the services provided by the

FMHS will be subject to quality improvement processes. Performance outcomes will assist in identifying opportunities for addressing gaps or deficiencies, and opportunities for further improvement in service delivery.

The FMHS also has a significant role in the development of innovative research and evaluation programs that support service development and improved treatments and supports for people living with mental illnesses. The FMHS MoC is supported by the continued building of links with local universities and other research partners to investigate issues facing people experiencing mental illness or disorder both in custody and community settings.

Principle 6. Staff expertise is acknowledged and developed

In light of the specialist, complex, and often difficult nature of the clinical issues faced by staff working in FMHS settings, this workforce requires a high degree of professionalism and strong clinical leadership. It is also recognised that staff require appropriately specialised training and support in order to maintain a highly skilled workforce and reduce the risks to staff, people experiencing mental illness or disorder, and the community. This includes training in relation to diversity, provision of forensic mental health services, principles of care, and specific clinical interventions. The FMHS is committed to the ongoing support of staff to develop and maintain specialist knowledge and skills in forensic mental health settings. FMHS are committed to providing support, mentoring and training to other intra and interagency partners in support of their safe and appropriate engagement with those in need of these services. This includes training in relation to the principles of care in responding effectively to the clinical complexities of this cohort.

Diversity considerations inherent to FMHS Principles and Purpose

Aboriginal and Torres Strait Islander People

The historical and contemporary context and conditions in which Aboriginal and Torres Strait Islander Australians live have impacted significantly on the capacity of these communities to attain and sustain good health and wellbeing. Access to health services is an important contributor to good health and wellbeing, however there are often major barriers to accessing health services for Aboriginal and Torres Strait Islander peoples[xxxi]. The *Australian Medical Association Report Card on Indigenous Health 2018*[xxxii] reported that in the Australian mainstream health system there was evidence of inherent discrimination and poorer clinical outcomes for Aboriginal and Torres Strait Islander Australians in comparison to other Australians.

The *Royal Commission into Aboriginal Deaths in Custody report 1991*[xxxiii] highlighted the high rates of imprisonment of Aboriginal and Torres Strait Islander Australians in prison and the negative impact this has on people and their communities. As a result of this report, many changes to policy and practice have occurred. Nevertheless, Aboriginal and Torres Strait Islander Australians continue to be over-represented in the Australian justice system, including in the ACT justice system. As at 30 June 2018, Aboriginal and Torres Strait Islander prisoners made up approximately 28 percent of the total Australian prisoner population, yet comprised only two percent of the total Australian population aged 18 years and over[xxxiv]. In the ACT the number of Aboriginal and Torres Strait Islander

people is smaller compared with most other jurisdictions at 1.9 percent[xxxv], however the percentage of Aboriginal and Torres Strait Islander detainees in the ACT prison system has risen from 13.2 percent in 2009 to 22.4 percent in 2018, peaking at 23.8 percent in 2016[xxxvi].

Consistent with the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*[xxxvii], FMHS are committed to 'Closing the Gap' for health outcomes for Aboriginal and Torres Strait Islander people. FMHS is guided by principles that aim to improve access to high quality services that are free from racism and inequality, support individual and community partnership in decision-making (including in the criminal justice system), and improve social and emotional wellbeing and clinical outcomes for Aboriginal and Torres Strait Islander people requiring FMHS.

Consistent with the ACT *Aboriginal and Torres Strait Islander Agreement 2019-2028*[xxxviii], FMHS aim to deliver culturally safe, responsive and respectful services through partnering with Aboriginal and Torres Strait Islander Australians and their representative groups to improve access and cultural sensitivity of the service delivery environments.

Delivery of all FMHS services will be sensitive to the social and cultural beliefs, values and practices of Aboriginal and Torres Strait Islander people. Communication with Aboriginal and Torres Strait Islander people and carers will be in a language that they can understand, free from medical jargon and with use of interpreters where required. FMHS also recognise traditional and non-traditional Aboriginal and Torres Strait Islander family structures, elder mentoring, and healers. Specific improvements regarding these elements will be identified in consultation with the community and its representatives and included in policies and procedures as part of the MoC implementation process.

FMHS aims to develop and maintain effective working relationships with local community services including Winnunga Nimmityjah Aboriginal Health and Community Service (AHS)[xxxix], Gugan Gulwan Youth Aboriginal Corporation, the Aboriginal Legal Service, and the Ngunnawal Bush Healing Farm. Service integration, multi-agency intervention coordination, and information sharing practices will support the best outcomes for Aboriginal and Torres Strait Islander people accessing FMHS.

Culturally and Linguistically Diverse (CALD) Backgrounds

People from CALD backgrounds can experience a range of barriers to successfully accessing and navigating the health system. Some of these barriers include discrimination, social isolation, keeping a sense of cultural identity with the culture of origin, and language barriers in accessing mainstream services.

Refugees who migrate to Australia as a result of persecution in their country of origin may also be suffering from untreated psychological trauma. The complex interplay of these factors can impact a person's involvement with the criminal justice system.

As at 30 June 2018, 17 percent of adults in Australian prisons were born overseas, including many from culturally and linguistically diverse backgrounds[xl]. When considering the prisoner population in the ACT, 14 percent of people in custody in the ACT were born overseas, with many coming from culturally and linguistically diverse backgrounds[xli]. As such, there is a significant need for culturally appropriate and sensitive services.

The *ACT Multicultural Framework 2015-2020*[xlii] and *Towards Culturally Appropriate and Inclusive Services: A Co-ordinating Framework for ACT Health 2014-2018*[xliii] are the ACT-wide and ACT Health frameworks that aim to enhance ACT Health's response to cultural and linguistic diversity. These documents identify characteristics of a culturally competent health service. Consistent with these frameworks, the FMHS commits to the needs of people from CALD backgrounds being acknowledged across FMHS service elements to ensure that it has capacity to meet cultural, gender and spiritual needs of people and their families by developing and maintaining the linguistic and cultural competencies required of the health service.

Strategies to support this FMHS purpose include:

- Delivery of services that are sensitive to the diversity of social and cultural beliefs, values and practices of those from CALD backgrounds
- Recognising culture as a protective factor where a strong connection between culture and positive wellbeing exists. This includes acknowledgement of the influence culture has on explanatory models of mental illness/disorder, including its causes and the manner in which it presents
- Delivering services and information which are accessible in culturally safe and appropriate ways to people from CALD communities. This includes communicating with people in language that is easily understood, free from medical jargon, and with use of interpreters when required. It also includes increasing access to written materials in languages other than English
- Facilitating the participation of people from CALD backgrounds in feedback, service planning and improvement, including access to safe and responsive avenues for reporting on perceived discrimination where required
- Supporting ongoing training for staff to develop, maintain and improve their cultural competency and reinforce sensitive practice.

Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer + (LGBTIQ+)

People of diverse sexuality, sex and gender a more vulnerable to mental health issues and higher rates of suicide than other Australians[xliv]. Sexuality, sex and gender diversity is in itself not a causal factor for mental illness and disorder however the discrimination and exclusion that people who identify as LGBTIQ+ experience relates to higher rates of depression, suicidality, substance misuse, and psychological distress in this community[xlv].

FMHS aims to provide safe and supportive care for LGBTIQ+ people. The clinical team will be sensitive, interested and understanding of issues related to sexuality, sex and gender diversity. Delivery of services will take into consideration people's sexuality, sex and gender diversity in order to address specific mental health issues that have a high prevalence amongst LGBTIQ+ people. FMHS will promote inclusive language and practices, cultural competency and staff education in order to support LGBTIQ+ people. Furthermore, pursuant to the recommendations from a La Trobe (2012) national survey of the health and wellbeing of gay, lesbian, bisexual and transgender Australians[xlvi], FMHS will affirm and value diverse gender identities and sexual identities by promoting LGBTIQ+ inclusion and freedom from heterosexist discrimination.

Younger Australians

Research is increasingly identifying a significant impact of mental health disorders on young people with half and three quarters of disorders emerging by 14 and 24 years respectively. [xlvii,xlviii] These can have a range of long lasting impacts on the wellbeing, functioning, and development of young people, including future substance use, risk of self-harm or suicide, and social and academic functioning.

It has been well established in Australia and internationally that there is a high prevalence of mental health disorders in adolescents coming into contact with the criminal justice system. [xlix] Research investigating the prevalence of mental health issues in NSW identified that 87% of young detainees had at least one psychiatric disorder, 24% of males and 55% of females reported high psychological distress, and 8% of males and 23% of females attempted suicide. [l] Further research has identified that young offenders in Australia are more likely to die than their community counterparts at rates of 9 and 41 times for males and females respectively. [li]

FMHS is committed to supporting young people up to 25 years experiencing mental illness or disorder across both the youth and adult correctional systems. FMHS will continue to work collaboratively with the Child and Adolescent Mental Health Service (CAMHS) and other relevant health and justice services to identify and support the specific mental health and other needs of this vulnerable cohort of Australians.

Older Australians

The increasing age of Australians is placing an imperative on forensic mental health services to improve the understanding and management of issues of aging within the custodial and community forensic mental health consumer cohort. Issues associated with aging can place older aged persons at increased risk due to various mental health conditions and access to appropriate interventions aimed at managing the impact of these issues should be identified at the earliest possible stages.

FMHS is committed to supporting people experiencing mental illness or disorder who present with issues of aging and will continue to build collaborative relationships with the Older Persons Mental Health Services (OPMHS) and other relevant agencies and supports in order to best identify how to support people in their respective settings.

COMORBIDITY CONSIDERATIONS INHERENT TO THE FMHS MOC

Physical illness

Mental Health conditions are associated with lower life expectancy and a greater burden of physical disease. Factors affecting the higher burden of physical health concerns for people experiencing mental illness/disorder include barriers to accessing physical health care, issues with diet, exercise, and smoking, the direct impacts of chronic mental illness/disorder (for instance cognitive impairment due to schizophrenia), treatment-related complications (e.g., sedation, weight gain, insulin resistance) and non-adherence or inconsistent approaches to mental and physical health interventions.

The FMHS are committed to the physical health needs of people with mental illness or disorder in line with the *Fifth National Mental Health and Suicide Prevention Plan 2017*[lii], the *Equally Well Consensus Statement*[liii], and the CHS *Providing Physical Health Care Across MHJHADS* operational guideline[liv]. The FMHS recognise the importance of treating a person holistically, particularly in relation to improving the physical health of people experiencing mental illness/disorder by:

- Ensuring physical health is considered an integral part of all comprehensive assessment and recovery-planning processes
- Promoting access to quality physical healthcare through collaborative relationships with other health providers, particularly custodial health services and community-based GPs
- Considering the physical health impacts of proposed pharmacological treatments and thoroughly exploring alternatives or limiting use of such treatments wherever possible
- Promoting positive healthy lifestyle strategies, particularly those which may counteract or minimise any negative impacts of pharmacological treatments on physical health
- Addressing the social determinants of health as part of someone's health care.

Disability

As cited in the *Disability and Health Inequalities in Australia Research Summary 2012*[lv], people classified as having a disability have, on average, poorer mental health than their non-disabled peers. In line with the ACT Government *Disability Justice Strategy 2019-29*[lvi] and the *Disability Justice Strategy First Action Plan 2019-2023*[lvii], FMHS is committed to ensuring that people with a disability and a mental illness or disorder have equal access to the protection of the law, and will support implementation of the *Action Plan*. The FMHS recognise the importance of being an accessible service for people with disabilities, and are committed to working collaboratively with people, primary health care services, disability services, and the National Disability Insurance Agency (NDIA) to ensure FMHS clinical input is complementary to a package of care and support options for people with disabilities and mental illness or disorders.

Alcohol and Other Drug Use

The rate of alcohol and other drugs (AOD) use is higher in people involved with the justice system. Data published by the Australian Institute of Health and Welfare (AIHW) indicates that Australian prisoners reported significant alcohol and other drug use in the 12 months prior to incarceration,

with 39 percent reporting drinking alcohol at levels placing them at high risk of harm, while 67 percent reported using illicit drugs including methamphetamine, cannabis, and opioids[lviii].

The complexities of comorbid substance use and mental illness should not be further complicated by the separation of mental health and AOD services. The FMHS will work with people and alcohol and drugs services to address both areas of concern with the approach that substance use and mental illness are rarely mutually exclusive.

FMHS acknowledge the key issue of comorbidity and the critical importance of specifically addressing the needs of peoples with disorders of substance misuse as well as mental illness/disorder. This involves the use of de-stigmatising, evidence-based and integrated pathways to appropriate care and treatment.

The core skills of working with alcohol and other substance misuse and mental illness/disorder is to enhance motivation and engagement; identify risk factors; and develop relapse-prevention strategies, all of which are essential capabilities of the FMHS staff. More complex issues are addressed through consultation and collaborative work with other AOD services to ensure access to specialist intervention and integration of treatment efforts when required.

FMHS will have work practices and service delivery systems that ensure:

- Current and historical substance use will be identified as part of comprehensive mental health assessments
- Timely and evidence-based responses are provided to people identified as having issues with substance use
- Collaborative approaches to intervention, including partnerships with GPs, AOD nurses, and AOD services (including the CHS Alcohol and Drug Services [ADS]), both in custodial and community settings.

The *ACT Health Comorbidity Strategy 2012-2014*[lix] helps clarify the service level coordination when people identify with a combination of mental health needs and substance abuse. This is outlined in Table 1.

Table 1: Matrix of shared care arrangements between mental health and alcohol and drug services

	Severe Mental Illness	Moderate Mental Illness	Mild Mental Illness
Severe AOD problem	Joint treating team of Specialist MH and Specialist ADS	Joint treating team of Specialist MH and Specialist ADS OR Primarily ADS treating team inclusive of basic MH care from ADS with Specialist MH input and consult liaison	Primarily ADS treating team inclusive of basic MH care from ADS
Moderate AOD problem	Joint treating team of Specialist MH and Specialist ADS OR Primarily MH treating team inclusive of basic AOD care from MH with Specialist ADS input and consult liaison	Joint treating team of Specialist MH and Specialist ADS OR Primarily MH treating team inclusive of basic AOD care from MH with Specialist ADS input and consult liaison OR Primarily ADS treating team inclusive of basic MH care from ADS with Specialist MH input and consult liaison	Primarily ADS treating team inclusive of basic MH care from ADS
Mild AOD problem	Primarily MH treating team inclusive of basic AOD care from MH	Primarily MH treating team inclusive of basic AOD care from MH	Basic MH and AOD support services and self-help

Section 3 – Components of care

The FMHS MoC organises service delivery into two core operational streams, custodial and community operations (see figure 2). This allows for greater focus on the needs of these two related but different groups. The groups are then further organised into service components addressing specific consumer groups and needs within each of those specified areas. The specific service components are described briefly below.

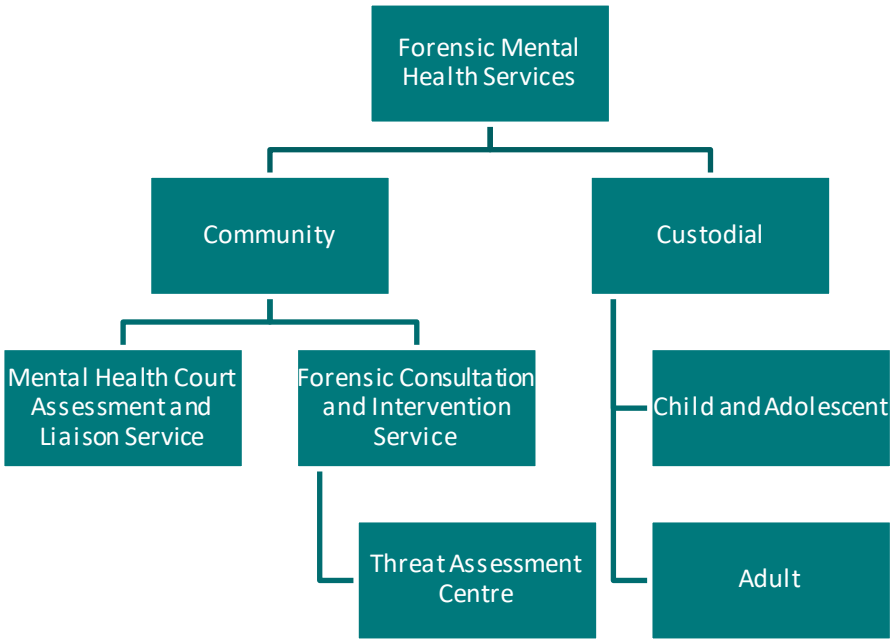

Figure 2. Organisational structure of the FMHS.

Mental Health Court Assessment and Liaison Service (MHCALS)

The MHCALS is a specialist ACT Courts-based mental health service that is often the first point of contact a person may have with the FMHS. The primary purpose of the MHCALS is the support of the ACT Court system and people presenting before the ACT Courts. MHCALS provides immediate assessment of people suspected of being acutely unwell and requiring diversion to acute inpatient services, and thorough assessment of people referred by the courts for consideration of their fitness to plead or be tried, criminal responsibility, or suitability for diversionary court settings.

Forensic Consultation and Intervention Service (FoCIS)

The FoCIS is an ACT-wide service for people with a mental illness or disorder who are already engaged with other MHJHADS mental health services. Access to FoCIS requires a referral from another MHJHADS mental health service. The FoCIS provides specialist consultation to MHJHADS mental health services regarding the safe and effective care of forensic and high-risk civil mental

health service consumers 3. It is a consultation-liaison service providing advice regarding the relationship between mental illness and offending risk, and recommendations regarding appropriate support and management strategies. Where indicated and where staff speciality and resources allow, the service may provide specialist interventions targeted at specific high-risk behaviours (i.e., fire-setting) in order to reduce the risk of offending.

The Threat Assessment Centre (TAC) is a specialist consultation service operated in collaboration with the ACT and National branches of the Australian Federal Police. The service was developed as part of a Coalition of Australian Governments and whole-of-ACT-government response to the management of the risk of grievance-fuelled violence. The service aims to identify people engaging in inappropriate and threatening behaviours and support further assessment and coordination of their mental health care to reduce potential risks to themselves and the community.

Custodial MHS – Child and Adolescent (CA)

The Custodial MHS - CA is a specialist multidisciplinary mental health service based at the Bimberi Youth Justice Centre (BYJC). The Custodial MHS may be the first contact a young person has with a mental health service and is therefore a key entry point to further services required upon their exit from custody. The Custodial MHS – CA is aimed at the early identification of mental illness and disorder in young people entering custody and the referral to or provision of high quality services in order to improve their mental health and wellbeing.

Custodial MHS – Adult

The Custodial MHS – Adult is a multidisciplinary mental health service based at the Alexander Maconochie Centre (AMC). For some people it may be the first contact they have had with a mental health service, for many others it is a service providing care as they transition through the criminal justice/custodial system, with care being transferred back to the community mental health services upon release. The Custodial MHS – Adult is aimed at the early identification of mental illness and disorder and provision of high quality psychiatric care.

3 High-risk civil mental health service consumers are those people who present with significant risks associated with possible offending behaviour, however are not subject to restrictions as a result of their mental health related offending (e.g., FPTOs, CROs).

Person Journey through an Integrated Forensic Mental Health Service

Journey 1.

John is a 45 year old man with a diagnosis of schizophrenia who has been receiving treatment from a local Canberra Health Services community mental health team. John was arrested by the police overnight and charged with a series of offences. The MHCALS clinician identifies John's name on the daily court list and attends the courts cells to offer him an assessment. John consents to the assessment and information being provided to the Magistrate regarding his current mental state.

During this assessment the clinician has concerns that John is unwell and may need immediate treatment for his mental illness. The clinician provides advice to the courts regarding John's current mental state and the Magistrate orders that he go to hospital for an assessment of his mental health needs. The MHCALS clinician provides information to the hospital regarding John's presentation.

After being seen at the emergency department, John is admitted to the Adult Mental Health Unit (AMHU) and receives treatment for his mental illness. After a period of treatment his mental state improves and he is returned to court to have his matter heard. The MHCALS clinician is advised by the hospital that John is returning to court and they liaise with the courts regarding the outcomes of his matter.

On this occasion, John is remanded to custody. The MHCALS clinician is aware of this outcome and facilitates a handover to the Custodial MHS at the Alexander Maconochie Centre (AMC). The Custodial MHS is then aware that John will be arriving at the centre and can prepare for his arrival.

Upon John's arrival at the AMC he is seen jointly by a nurse from the Custodial Health Service and a clinician from the Custodial MHS who identify his immediate physical and mental health needs while in custody. On the basis of this assessment John is allocated a clinical manager with the Custodial MHS who will liaise with John's community mental health team, arrange for him to see a psychiatrist while in custody and provide advice to ACT Corrective Services regarding any additional supports he may need to manage his illness while in custody. John's treatment as provided by the community mental health team is continued where possible while he is in custody, and the clinical manager works closely with his treating community team to support his transition back to the community if he leaves custody in the short term.

Four weeks later, John works with his solicitor who files an application for bail. John advises his clinical manager that he is applying for bail and the clinical manager liaises with his treating community mental health team to advise that he may be bailed from custody. At John's bail hearing he is bailed from court and returns home. The Custodial MHS monitor for the outcome of John's matter and upon learning that John was bailed, his Custodial MHS clinical manager provides a handover to John's community mental health team who agree to contact him and continue his care in the community.

Journey 2.

Ellie is a 26 year old woman with a diagnosis of bipolar disorder. She is engaged with a local community mental health team for treatment of her bipolar disorder. However while working with the community mental health team she becomes more unwell, believing that she has a romantic relationship with her neighbour, despite never having met him. Ellie begins monitoring her neighbour's whereabouts, following him to his work, and sending inappropriate letters and items to his home and workplace. Ellie's neighbour reports her behaviour to the police who liaise with her community clinical manager about what she's been doing, noting that they have received a complaint about her behaviour. They advised that they don't intend to charge Ellie yet, however if they receive further complaints about her behaviour they will likely have to charge her.

After speaking with the police, Ellie's community clinical manager is concerned that she is more unwell at present and that her behaviours are related to her illness as this is out of character for her. Her clinical manager makes a referral to the Forensic Consultation and Intervention Service (FoCIS) for further advice about how to manage Ellie's care and potential for stalking-related violence against her neighbour.

The FoCIS team consider the referral against their entry criteria and accept the referral from the community team. They contact the community clinical manager and arrange to meet with Ellie and her clinical manager for further assessment regarding her mental health and other needs that may be impacting on her current stalking behaviours. As part of this assessment the FoCIS use specialised structured professional judgement tools to make a risk assessment and formulation regarding Ellie's behaviour and recommendations for her care. FoCIS then provide the community mental health team with advice about elements of her current situation that are effecting her risk and ways in which her treatment can be supported, including through the use of medications, referral to other supports, and practical strategies for managing her risk, including crisis management plans.

On the basis of the feedback from FoCIS, Ellie's community mental health team work with her to review her current medications, engage her with additional support programs outside of her home, and develop a risk management plan including options for seeking support when she felt the thoughts about contacting or following her neighbour were worse. Over the coming weeks Ellie's mental health improve as a result of a change in her medication and an increase in her engagement with other external support services. Over this time she notices a decrease in her romantic thoughts and urgers to contact her neighbour. She continues to engage with the new services and the supports that had been recommended.

On the basis of the improvement in Ellie's mental health and a reduction in the risk of stalking, the FoCIS closes the referral from the community mental health team.

Journey 3.

Conrad is a 21 year old man who is in custody following a serious offence he committed while acutely psychotic. He is receiving ongoing treatment from the Custodial MHS for schizophrenia and is working with his clinical manager to manage his illness while in custody.

As part of his court matter the MHCALS is requested by the ACT Courts to provide a psychiatric opinion regarding his mental health at the time of the offence. Conrad is seen by the MHCALS psychiatrist who provides an opinion to the courts. On the basis of this opinion and a range of other

information, the courts find that Conrad is not guilty because of mental impairment. The matter is referred to the ACT Civil and Administrative Tribunal (ACAT) for them to make a mental health order in relation to the matter. The ACAT makes a mental health order and a Conditional Release Order (CRO) requiring Conrad to receive treatment at the Dhulwa Mental Health Unit (DMHU) until they are suitably satisfied that his risk of further offending has been mitigated by way of treatment and support.

On the basis of the CRO, Conrad's clinical manager at the Custodial MHS begins preparing for his care to be transitioned to the DMHU. Staff from the DMHU meet with Conrad at the prison and, along with his clinical manager, they provide him with information about what the service is and what to expect there. Conrad's clinical manager liaises further with the hospital and ensures that the hospital is aware of Conrad's current mental health treatment and any physical health needs he has. As a result of the effective communication between Conrad, his clinical manager, and the DMHU staff, Conrad's transition from custody to the hospital goes smoothly and his concerns regarding the move are allayed.

Over the course of Conrad's treatment in hospital his mental state improves significantly, he addresses his issues with substance use, and develops an in-depth understanding of his illness and how it can impact on his risk of further offending. In due course Conrad's treating team provide an update regarding his progress to the ACAT who subsequently determine that he is suitable to transition to the community. As part of his continued treatment Conrad is referred to both the general community mental health team for treatment, and the FoCIS for forensic specialist input. The FoCIS meets with Conrad prior to discharge and identify ways in which they can support his treating team in the community. Upon his discharge from hospital Conrad receives treatment from his community mental health team, with intermittent appointments with the FoCIS psychiatrist who provides advice back to the community team regarding Conrad's presentation, any factors that may increase his risk of further offending, and strategies for managing these risks.

Under the conditions of his CRO the FoCIS provide updates to the ACAT regarding his progress in the community and assessments of his risk of further offending. On the basis of this support the ACAT continue to support Conrad living in the community and he continues engaging with his treating team.

Journey 4.

Sam is a 15 year old female who was arrested by police and taken to the Bimberi Youth Justice Centre (BYJC). After arriving at BYJC she is seen by a Custodial MHS clinician for initial induction assessment. Sam tells the clinician that she has been experiencing low mood and anxiety over the last 12 months, and has recently been using cannabis and methamphetamine on occasion.

After returning to court on Monday Sam is remanded into custody. Upon returning to custody she is seen by the Custodial MHS who discuss with her options for treating her low mood and anxiety, and options for addressing her drug and alcohol use when she leaves custody. Sam is referred to a psychiatrist who prescribes her an anti-depressant medication, and she is referred to a clinician with the Custodial MHS to work on psychological and other strategies for managing her mood and anxiety.

Over the ensuing weeks Sam works with the psychiatrist and clinical manager to identify issues that have impacted on her mood and anxiety, and prepare a plan for accessing supports in the community. Sam is aware that she is applying for bail at an upcoming court hearing and advises her clinical manager of this. The clinical manager discusses with Sam about options for continuing treatment and Sam agrees to referrals being made to her local bulkbilling GP and Headspace for continued support regarding her low mood, anxiety, and recent drug use. The clinical manager also provides Sam with contact details for the Child and Adolescent Mental Health Service who may be able to provide additional support should her mental health deteriorate further following leaving custody.

On the day of the court matter, Sam is bailed to reside with her parents. The Custodial MHS clinical manager liaises with Sam's GP regarding her treatment and makes a referral to the local Headspace service. They also contact Sam's parents to discuss the referrals and Sam's needs now that she has returned home. Sam's parents agree to support her in accessing these treatments and will seek further support if required.

Community Forensic Mental Health Services

Mental Health Court Assessment and Liaison Service (MHCALS)

What does the service intend to achieve?

The Mental Health Court Assessment and Liaison Service (MHCALS) is a specialist mental health service developed in response to high rates of mental illness and disorder in people in court settings. The MHCALS aims to support of the ACT Court system and people presenting before the ACT Courts through the provision of high quality consultation and liaison regarding mental health issues in this setting.

The appropriate identification of people with mental illness or disorder allows for suitable treatments and supports to be made available, potentially reducing their risk of self-harm or harm from others, increasing their ability to engage with the criminal justice process, facilitating the justice system's consideration of appropriate sentencing options, and improving the criminal justice system outcomes for people with mental illnesses or disorders.

With the upcoming development of the Drug and Alcohol Court and Warrumbul Children's Court the policy model of therapeutic jurisprudence[4] is growing in the ACT. FMHS and MHCALS support the development of this model and will continue to work with the ACT Courts and other government and community-managed organisations to address the various psychosocial determinants of offending.

Who is the service for?

MHCALS provides a range of services to a number of stakeholders in the criminal justice system. First, MHCALS provides assessment and referral services for people of all ages who may have a mental health condition and require further assessment and treatment. The MHCALS is often the first point of contact with the mental health service for a person who may have a mental illness or disorder and is presenting before the ACT Courts.

MHCALS also provides liaison services for the ACT Courts in order to identify, assess, and where possible divert people with mental illness into appropriate mental health services. The MHCALS also provides advice and support back to other MHJHADS services in support of the people with mental illness or disorder and their health professionals.

What does the service do?

4 Therapeutic jurisprudence is a policy model that identifies the negative impacts that the criminal justice process can have on individuals and aims to holistically address the various determinants of offending in the administration of justice.

MHCALS provide a range of services to people and the ACT Courts, including assessment and referral for people with mental health issues, advice and reports to the ACT Courts regarding mental illness/disorder and suitable treatment and services. These services are provided across the range of court settings (including the court cells, Magistrates Court, Supreme Court, Drug and Alcohol Court, and Childrens' Courts). The service does not currently provide assessments in the police watch-house, which is serviced by the CHS Forensic Medicine Service.

Assessment and Referral

MHCALS both screens for and accepts referrals for individuals who may be presenting with mental illness or disorder in the court cells. Referrals are received from multiple sources including, for example, the Courts, police, and legal practitioners. Referrals are triaged and prioritised for assessment. For those people consenting to assessment and reporting to the courts, or those people displaying a lack of capacity for decision making or significant risk issues, advice is provided to the ACT Courts regarding appropriate follow up, including the need for immediate treatment and care, or referral options in the event they are remanded to custody or bailed to the community. MHCALS is supported by the input of psychiatry registrars and consultants who provide a multidisciplinary team review process in addressing an individuals' needs.

The MHCALS supports a person's continued treatment and care by making referrals to appropriate supports including, for example, the Custodial MHS, Access Mental Health, or community-managed organisations as needed. The service operates as an entry point to mental health care for people with mental illness or disorder coming into contact with the criminal justice system.

Advice and Reports

MHACLS provides specialist advice and reports to the ACT Courts in response to court orders and other referrals regarding a range of medicolegal issues. Depending on the source and topic of referral, MHCALS may provide assessment regarding an individual's fitness to plead, criminal responsibility, or their suitability for diversion to the Drug and Alcohol Court or the Warrumbul Children's Court. In this respect the MHCALS provides a key role in the ability of the criminal justice system to identify people's needs and develop appropriate sentencing options.

Person journey through MHCALS

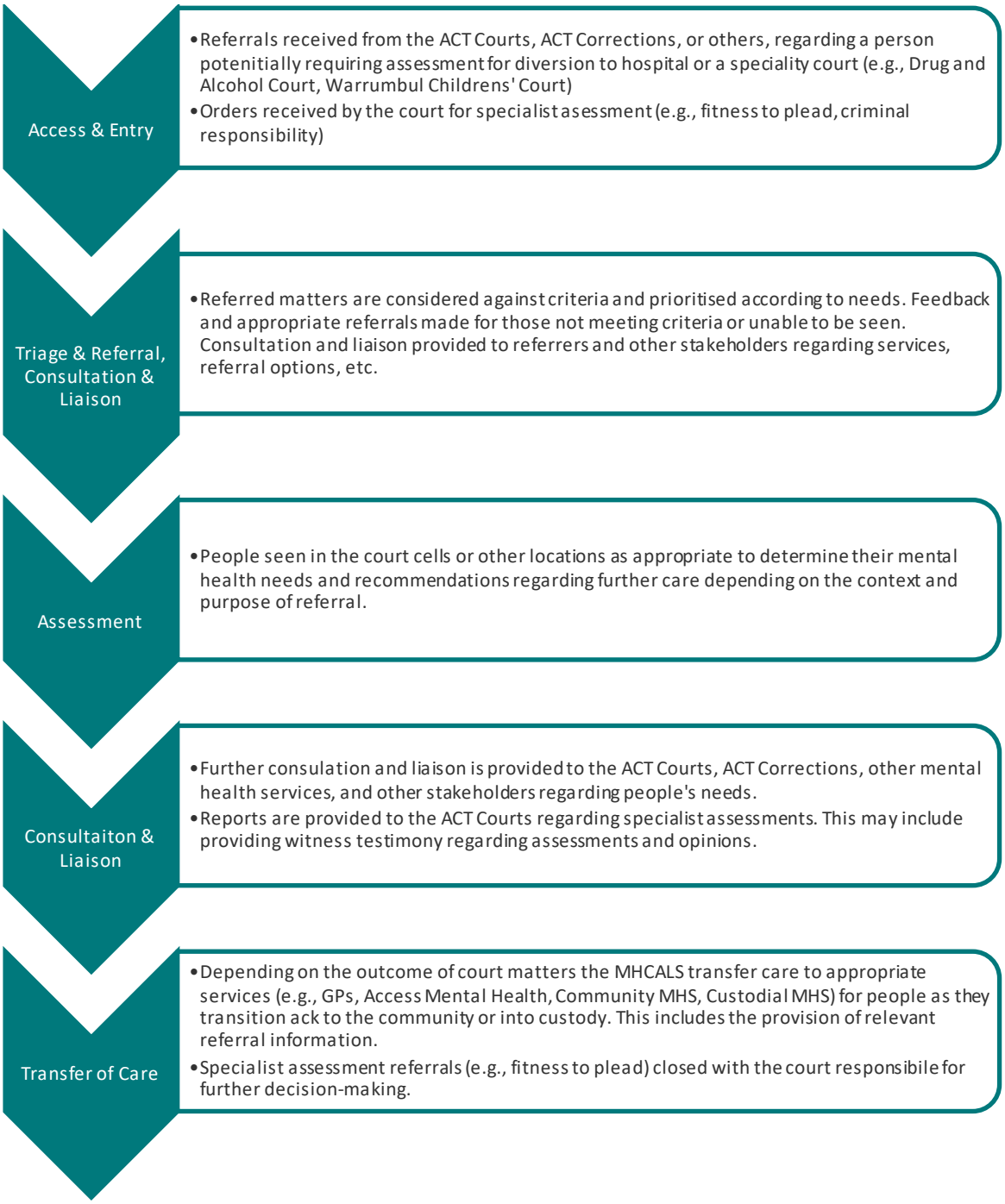

Figure 3. MHCALS person journey

Forensic Consultation and Intervention Service (FoCIS)

What does the service intend to achieve?

The interplay between mental illness and disorders and offending behaviour can be complex. The Forensic Consultation and Intervention Service (FoCIS) is a specialist multidisciplinary tertiary mental health service that aims to provide expert knowledge and skills to general mental health services regarding the interplay between mental illness/disorders and offending risk in support of their safe care of forensic and high-risk civil mental health service consumers. The service intends to reduce risks to people with mental illness/disorder, the communities, and the services supporting them by providing high quality advice and support.

Who is the service for?

FoCIS provides consultation liaison services to general mental health services regarding forensic and high-risk civil mental health service consumers[lx] of all ages. The service is targeted towards providing specialist consultation to services regarding people with mental illness or disorder who are at ***significant risk of causing serious injury or harm to others*** as a result of their mental illness or disorder.

In order for the FoCIS to accept a referral the referred person must be an active client of a child and adolescent, adult, or older persons community, custodial, or inpatient mental health service at the time of referral and for the duration of service. The FoCIS does not accept referrals for people not engaged with a MHJHADS mental health service.

Key referral criteria

In order to prioritise those people for whom there is a distinct need for specialist forensic mental health assessment and support, the following referral criteria have been developed (see Figure 3).

Referral:

1. The consumer person is an active ongoing consumer of a MHJHADS mental health service;

and

2. There are **behaviours and/or symptoms present within the past three months** that have resulted in or had the potential to result in **serious injury or harm to others** (either psychological or physical) as evident by one or more of the following:
    - **a.** Actual or attempted serious violence
    - **b.** The consumer has expressed increasing or recurrent violent ideation, fantasies, intent, and/or planning
    - **c.** Threats to harm others that are serious in nature and/or escalating in frequency or intensity
    - **d.** Stalking (repeated unwanted contact or communications)
    - **e.** Problematic sexual behaviors, fantasies or ideations
    - **f.** Fire setting
    - **g.** Fixation (an increasingly pathological preoccupation) with a person, cause, grievance or ideology that has the potential to result in serious harm (for example, school attacks, support for a terrorist or other extremist ideology);

or

3. High risk psychotic symptoms that have been unresponsive to treatment strategies, such as:
    - **a.** Delusional jealousy
    - **b.** Delusional misidentification of others
    - **c.** Command hallucinations to harm others
    - **d.** Threat/control override symptoms (delusions that others intend the person harm and that external drives are overriding their self-control);

or

4. There is a **history of serious harm** and **recent escalation** in dynamic risk factors or concerns about the adequacy of the current risk management plan;

or

5. The consumer is subject to a Conditional Release Order (CRO) or Forensic Psychiatric Treatment Order (FPTO) under the *Mental Health Act (2015)*.

Figure 4. Key referral criteria for FoCIS consultation liaison.

Exclusion criteria

A number of exclusion criteria have been identified that aim to ensure people with mental illnesses or disorders are not referred to FoCIS before there is a specific need for specialist consultation liaison. Referrals to FoCIS can delay a person's movement through their care journey and contribute to stigma and difficulties accessing other services. As such, these criteria aim to reduce these unintended consequences of referral and ensure the service is responsive to the needs of people at highest risk. The criteria are as below:

1. The referral relates to violence risk for a person who has not been assessed by a consultant psychiatrist for initial management of the identified risk and the multidisciplinary team has not attempted to implement initial violence risk management strategies.
2. The referral relates only to the immediate management of inpatient aggression.
3. The person is not an active client of a MHJHADS mental health service.

What does the service do?

Consultation liaison

FoCIS provides consultation regarding the relationship between mental illness and offending risk and provides recommendations to the treating team regarding appropriate intervention and management strategies in order to manage the risk of offending. Where required the service also provides recommendations to the ACAT regarding the management of mental health and forensic mental health orders.

Upon receipt of a referral the FoCIS multidisciplinary team will ascertain whether the referral meets the criteria before allocating the referral a priority level and clinician. The FoCIS clinician then makes contact with the treating team to identify and discuss any immediate issues of concern and provide them with initial recommendations regarding intervention options or supports. If indicated, the FoCIS clinician would then work with the treating team to arrange a time for further assessment with the referred person.

At the point of assessment the FoCIS clinician works with the person and their supports to develop an understanding of their current circumstances, allowing for further assessment using structured professional judgement tools to identify potential areas of concern and need. On the basis of this assessment the service provides the treating team with recommendations regarding treatments and supports that can assist them in the person's ongoing care. In some circumstances (i.e., where a forensic mental health or conditional release order is in place or risks are considered to be high) FoCIS will consider the need to maintain a time-limited period of regular assessment/consultation with the person and their treating team in order to support them in their ongoing treatment and care. Where indicated and where staff speciality and resources allow, the service may provide specialist interventions targeted at specific high-risk behaviours (i.e., fire-setting) in order to reduce the risk of offending.

Person journey through FoCIS

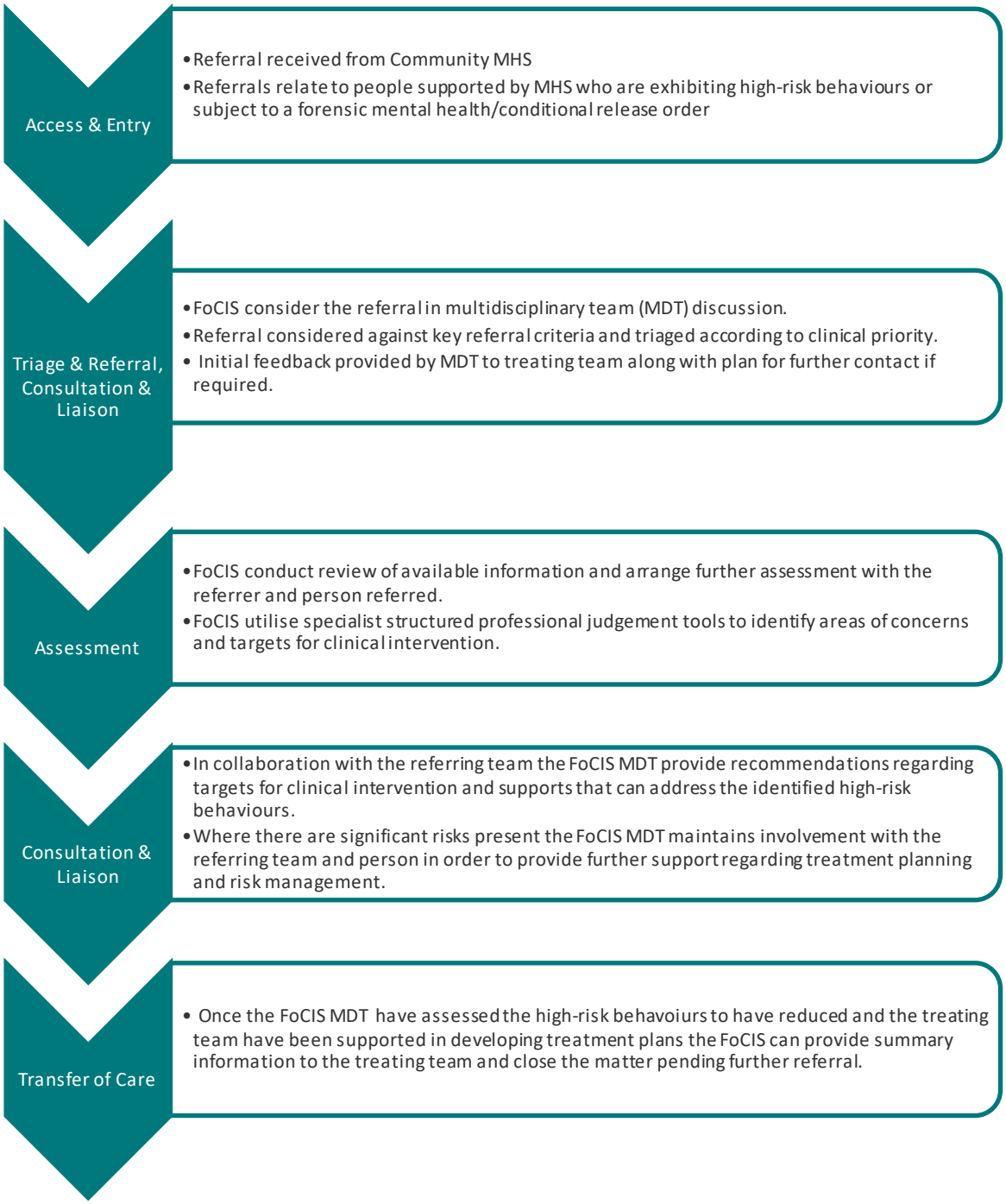

Figure 5. FoCIS person journey

Custodial Mental Health Services

Custodial Mental Health Service – Child and Adolescent

What does the service intend to achieve?

It has been well established both in Australia and internationally that there is a high prevalence of mental illness and disorders in young people coming into contact with the criminal justice system, and that there is a link between mental illness and disorder and offending rates[lxi,lxii]. The Custodial MHS – CA is a specialist multidisciplinary mental health service aimed at the early identification of mental illness and disorder in young people entering custody and the provision of or referral to high quality services in order to improve their mental health and wellbeing. The service aims to reduce the impacts of mental ill-health on young people in custody, with a view to supporting their transition back into the community and building their capacity for independent management of their health and social issues. The service also aims to build strong collaborative networks with intra and interagency partners, family, carers, and guardians in order to support young people's access to services, and ultimately reduce the risk of further offending by addressing the health and social determinants of offending.

Who is the service for?

The target population for the adolescent custodial mental health service is any young person detained in the Bimberi Youth Justice Centre who requires mental health assessment and/or treatment for a mental illness or disorder, or who present with risks of self-harm or suicide.

Key access criteria

Access to the Custodial MHS - CA is underpinned by the *National Standards of Mental Health Services 2010*[lxiii] and the *National Statement of Principles for Forensic Mental Health 2006*[lxiv], and required by legislation[lxv].

In order to ensure young people are accessing appropriates treatments, the Custodial MHS – CA prioritises people for care who are:

- In custody

and

- Experiencing a mental illness or disorder

and/or

- High risk of harm to self or others, or of misadventure.

What does the service do?

The service provides specialist mental health services for young people detained in the BYJC who require assessment and/or treatment for a mental illness or disorder. The service operates as a primary/secondary mental health service, receiving referrals from children and young people as well as various other sources in the BYJC and the broader health and criminal justice system.

In order to ensure the early identification of mental health needs of young people entering BYJC, the Custodial MHS - CA provides mental health screening for all young people entering custody. People identified as having a mental illness or disorder requiring treatment are referred for further assessment and interventions as indicated.

High standards of screening at point of entry is paramount so that:

- Young people with mental health needs are correctly identified, minimising the likelihood of young people 'falling through the cracks'
- Recommendations made to BYJC and CYPS regarding the mental health needs of detained young people can be tailored to the individual

The mental health needs of children and young people, especially those coming into contact with the criminal justice system, can often be complex and multifactorial and can include emerging issues regarding sexuality and gender identity, disability issues, and histories of significant trauma. Consequently, the Custodial MHS – CA provides assessment and intervention for the range of mental health disorders in custody, including high prevalence disorders such as depression and anxiety that are common in this population, as well as other present and emerging mental health issues.

Specific services include:

- Effective screening resulting in early identification of mental illness and disorder in young people detained in BYJC
- The provision of ongoing high quality, collaborative mental health assessment, treatment and care (including diversionary processes to inpatient care if required) for a range of mental health issues and the risk of suicide and self-harm
- Coordination and facilitation of pharmacological treatments, as well as continued monitoring of their efficacy and other effects
- The provision of various allied health interventions to address a range of mental health issues in custody. These include evidence based psychological strategies, psychoeducation, skills training and supportive interventions where indicated as part of a holistic biopsychosocial assessment and intervention plan
- The development and delivery of mental health psychoeducation and intervention individual and group programs that support the mental health of detained children and young people
- Preparation for transition to the community in support of continuity of care. This includes providing information and referrals to support access to a broad range of mental health services upon release from custody
- Health-focused reviews in response to BYJC custodial processes, such as segregation
- Education and training to key stakeholders regarding the mental health needs of young people who are detained in, or who are leaving, custodial settings
- Establishment of partnerships with government agencies and the community sector to assist in providing coordinated approaches to service delivery.

The mental health service works in close collaboration with the Custodial Health Service, who provide for the physical health needs of young people in BYJC. The service also works closely with the community Child and Adolescent Mental Health Services (CAMHS) and other major stakeholders including the BYJC, CYPS, and the families and carers of young people in custody.

Key exit criteria

The main criteria to indicate a suitable transition of a person out of the Custodial MHS – CA are:

1. The person is no longer in custody;

or

2. The person is not subject to a mental health order under the *Mental Health Act 2015*;

and

3. The person has recovered to the extent that frequent Custodial MHS – CA contact is no longer required;

and

4. The person has treatment and/or support structures external to the Custodial MHS – CA that are able to meet the young person's ongoing needs, and where relevant a clinical handover has been provided;

and

5. A recovery and discharge plan inclusive of information on how to re-access the Custodial MHS – CA in the future have been developed and communicated with the person, carer, guardian and/or Nominated Person;

or

6. Is voluntary and expresses a preference (including by way of an AA or ACD) to receive care via another service or receive no care at all. Every practical effort should be made to ensure the young person receives appropriate care including providing a comprehensive clinical handover to the preferred health practitioner (and other services) where these exist;

or

7. A person continues to have significant symptoms and functional impairment and/or require more frequent contact but whose needs can be adequately met by other services. In these cases it must be demonstrated that no further significant benefit is expected to be gained from specialist care over and above what can be expected in the primary care sector.

Young people who meet these criteria will be transitioned or considered for transition from the Custodial MHS – CA where appropriate. This not only increases the capacity of the Custodial MHS – CA to provide access pathways to new referrals, it also validates the autonomy and recovery journey of a person.

The Custodial MHS – CA works collaboratively with the young person, their family, carers, guardians, Nominated Persons, kinship carers and others involved in their care, ensuring that transition from the service is safe and successful. This process includes sharing information that will assist the young person's recovery into the future, such as relapse prevention strategies, and information regarding services available to them in custody and the community. The transition from the Custodial MHS – CA will be managed in a considered fashion and in consultation with the young person and their family, carers, and/or a Nominated Person where applicable. A clinical handover will be provided to nominated health professionals in the community upon release from BYJC.

Person journey through Custodial MHS – Child and Adolescent

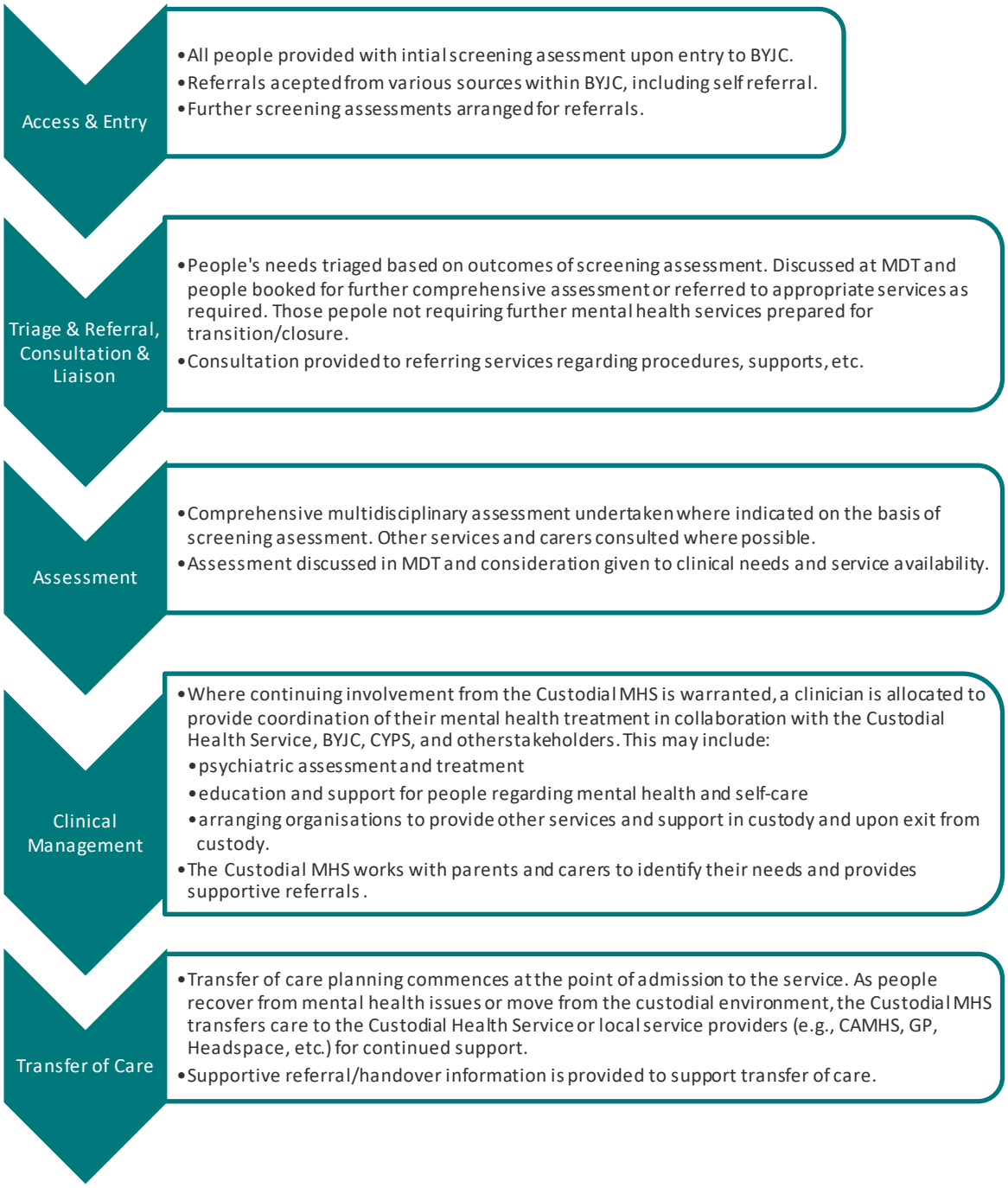

Figure 6. Custodial MHS – CA person journey

Custodial Mental Health Services – Adult

What does the service intend to achieve?

The Custodial MHS – Adult is a specialist multidisciplinary mental health service that aims for the early identification of mental illness in detainees and provision of evidence-based treatment and care or referral to appropriate services in order to improve the mental health and wellbeing of people while in custody. The service aims to reduce the impact of mental ill-health on detainees with a view to supporting their transition back to the community, and building their capacity for independent management of their health and social issues.

It is accepted that prison populations have rates of mental illness higher than those typically found in the community and that there are often multiple co-morbid issues that complicate assessment and treatment for this population, including physical health concerns, neurological deficits, drug and alcohol issues, and other psychosocial stressors. As such, the service also aims to build strong collaborative partnerships with intra and interagency partners in order to support detainee access to appropriate services and ultimately reduce the risk of further offending by addressing the health and social determinants of offending.

Who is the service for?

The target population for the Custodial MHS – Adult service is any person detained in an ACT adult correctional centre and who requires mental health assessment and/or *specialised* treatment for a mental illness or disorder. This includes people identified as being at increased risk of suicide.

Key access criteria

Access to the Custodial MHS – Adult is underpinned by the *National Standards of Mental Health Services 2010*[lxvi] and the *National Statement of Principles for Forensic Mental Health 2006*[lxvii], and required by legislation[lxviii].

In order to ensure detainees are accessing appropriates treatments, the Custodial MHS – Adult prioritises people for care who are:

- In custody

and

- Experiencing serious mental illness or mental disorder, including those on involuntary treatment orders (i.e., PTO, FPTO)

with

- Significant psychosocial functional impairment

and/or

- High risk of harm to self or others, or of misadventure

and have

- Complex needs and intervention requirements that cannot feasibly be provided by a GP.

What does the service do?

The service provides specialist mental health services to detainees in ACT adult correctional centres who require mental health assessment and/or specialised treatment for a mental illness or disorder. The service operates principally as a secondary mental health service, receiving referrals from the Custodial Health Service for people requiring specialised mental health support. However, the service also accepts referrals from a wide range of sources including detainees themselves, ACTCS, and the broader health and criminal justice system.

In order to best identify those people requiring specialised mental health services, the Custodial MHS – Adult screens every individual upon their entry to custody. The Custodial MHS – Adult identifies those people with mental health needs and refers them for appropriate supports and intervention as required.

High standards of screening at point of entry is paramount so that:

- People with mental health needs are correctly triaged and directed to the appropriate health care setting, minimising the likelihood of people 'falling through the cracks'
- Direct psychiatric care and clinical management can be targeted to those detainees with high needs, ensuring the Custodial MHS – Adult has the capacity for quality and assertive treatment for people with serious mental illness
- Recommendations made to ACTCS regarding the mental health needs of detainees can be tailored to the individual.

Following initial referral and screening, the Custodial MHS – Adult offers a range of clinical interventions that are presented based on the individual needs of the detainee and availability of staffing and other resources. These include (but are not limited to):

- Collaborative psychiatric treatment and care, for people requiring specialised mental health treatment, including diversionary processes to inpatient care if required
- Coordination and facilitation of pharmacological treatments, as well as continued monitoring of their efficacy and other effects
- The provision of various allied health interventions as required. These include evidence based psychological strategies, psychoeducation, skills training and supportive interventions where indicated as part of a holistic biopsychosocial assessment and intervention plan
- The development and delivery of mental health psychoeducation and intervention programs that support the mental health of detainees
- Effective consultation and liaison with the Custodial Health Service regarding the treatment of less severe mental illness/disorder not requiring specialised treatment
- Health-focused reviews in response to AMC custodial processes, such as segregation
- Preparation for transition to the community in support of continuity of care. This includes the effective liaison with custodial staff and other services to identify and support the transition of people into the community and facilitate continuity of care through access to a range of mental health services as required upon release from custody

- Education and training to key stakeholders regarding the mental health needs of people who are detained in or leaving custodial settings
- Establish partnerships with government agencies and the community sector to assist in providing coordinated approaches to service delivery.

The service works in close collaboration with the Custodial Health Service who support the physical health needs of detainees with severe mental illness, and provide initial care for people with less severe mental health needs. The service consults regularly with major stakeholders including ACTCS, the Adult Community Mental Health Services (ACMHS), community-managed organisations, and the families and carers of detainees.

Stepped care approach to care pathways

Whilst all detainees who experience mental health concerns should have timely access to high quality treatment and support, not all will require specialist mental health services. According to the National Institute for Health and Care Excellence (NICE) Guidelines *Mental Health of Adults in Contact with the Criminal Justice System 2011*[lxix] and *Common Mental Health Problems: Identification and Pathways to Care 2011*[lxx] all people should be able to access entry level mental health triage and primary health care. This is followed by a 'step up' for those with mild to moderate mental illness/disorder accessing primary health care services in combination with more structured psychological services. Higher steps on the care spectrum include specialist mental health service management for more severe and/or complex mental health presentations. A basic outline of this is shown in table 2 and the pathway a person's care takes is shown in figure 7.

The Custodial MHS – Adult also provides specialist mental health advice where requested from the Custodial Health Service, ACTCS, and other agencies for detainees not requiring referral for direct psychiatric care and clinical management from a specialist mental health service.

Table 2. Stepped care approach to care pathways

Focus of the intervention	Nature of the intervention	Role of Custodial MHS – Adult	Role of other services
STEP 5: Complex treatment-refractory and very marked functional impairment, such as self-neglect or a high risk of self-harm, requiring involuntary or inpatient care.	Inpatient care at AMHU or Dhulwa Secure Mental Health Unit depending on presentation and clinical needs.	Ongoing consultation with inpatient setting and ACTCS regarding treatment progress and transfer between settings.	Physical and mental health care needs managed by inpatient unit. ACTCS may provide security support depending on setting.
STEP 4: Complex treatment-refractory and very marked functional impairment, such as self-neglect or a high risk of self-harm.	Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, or inpatient care.	Custodial MHS – Adult direct psychiatric care and assertive clinical management. Collaborate on joint management planning with custodial agency.	Continued Primary Health or Winnunga Nimmityjah AHS for physical health care. Custodial MHS – Adult and ACTCS joint management plans.
STEP 3: Symptoms with an inadequate response to step 2 interventions or marked functional impairment.	Choice of a high-intensity psychological intervention or a drug treatment.	Custodial MHS – Adult direct psychiatric care and clinical management or other therapies. Collaborate on joint management planning with custodial agency	Continued Primary Health or Winnunga Nimityjah AHS for physical health care. Custodial MHS – Adult and ACTCS joint management plans.
STEP 2: Diagnosed Mental Illness that has not improved after education and active monitoring in primary care.	Low-intensity psychological interventions: individual non-facilitated self-help, individual guided self-help and psychoeducational groups.	Custodial MHS – Adult Psychiatrist consultation to primary health. Custodial MHS – Adult consultation to custodial agency.	Primary Health Practitioner consultation with Custodial MHS - Adult Psychiatrist. Winunga Nimmityjah AHS clinician consultation with Custodial MHS – Adult Psychiatrist. ACTCS therapeutic programs and psychological services for suitable participants.
STEP 1: All known and suspected presentations of mental health concern.	Identification and assessment; psychoeducation and treatment options; active monitoring.	Induction screening Assessment and response based on triage rating. Referral to appropriate supports	Primary Health induction assessment. Primary Health Practitioner treatment formulation first response to suspected mental illness. Winnunga Nimmityjah AHS Health practitioner treatment formulation first response to suspected mental illness.

			ACTCS therapeutic programs and psychological services for suitable participants.

Key exit criteria

The main criteria to indicate a suitable transition of a person out of the Custodial MHS – Adult are:

1. The person is no longer in custody;

or

2. The person is not subject to a mental health order under the *Mental Health Act 2015*;

and

3. The person has recovered to the extent that frequent Custodial MHS – Adult contact is no longer required;

and

4. The person has treatment and/or support structures external to the Custodial MHS – Adult able to meet the person's psychiatric needs (e.g., GP primary care), and where relevant a clinical handover has been provided;

and

5. A Recovery Plan and Discharge Plan inclusive of information on how to re-access the Custodial MHS – Adult in the future have been developed and communicated with the person, carer, guardian and/or Nominated Person where appropriate;

or

6. Is voluntary and expresses a preference (including by way of an AA or ACD) to receive care in another setting (e.g., GP primary care) or receive no care at all. Every practical effort should be made to ensure the person receives appropriate care including providing a comprehensive clinical handover to the preferred health practitioner (and other services) where these exist;

or

7. A person continues to have significant symptoms and functional impairment and/or require more frequent contact but whose needs can be adequately met by other services (e.g., GP primary care). In these cases it must be demonstrated that no further significant benefit is expected to be gained from specialist care over and above what can be expected in the primary care sector.

People who meet these criteria should be transitioned from the Custodial MHS – Adult wherever possible. This not only increases the capacity of the Custodial MHS – Adult to provide access pathways to new referrals, it also validates the autonomy and recovery journey of a person.

Given the significant psychosocial issues facing people leaving custody, continuity of mental health care upon leaving custody is important in providing detainees with the best possible opportunities for successful re-integration into the community. As such, the Custodial MHS – Adult is committed to providing supportive and thorough handover of care in line with CHS and MHJHADS clinical handover policies and procedures for detainees leaving custody with serious mental health issues.

The Custodial MHS – Adult works collaboratively with the person and others involved, ensuring that transition from the service is safe and successful. This process includes sharing information that will assist the person's recovery into the future, such as relapse prevention strategies and information on how to re-access the Custodial MHS – Adult, if required. The transition from the Custodial MHS – Adult will be managed in a considered fashion and in consultation with the person, their family, guardian, carers and/or Nominated Person where applicable. A clinical handover will be provided to the Custodial Health Service GPs and nursing staff, Winnunga Nimmityjah AHS, or to a nominated health professional in the community upon release from prison.

Person journey through Custodial MHS – Adult

Figure 7. Custodial MHS – Adult person journey

Section 4 - FMHS MOC Sustainability

Care delivery team

In order to effectively provide care to a wide variety of people across a range of diverse settings the ACT FMHS MoC requires the input and skills of a range of clinical and non-clinical staff including:

- Consultant psychiatrists
- Psychiatry registrars
- Nurses
- Psychologists
- Social workers
- Occupational therapists
- Co-morbidity clinicians
- Allied health assistants
- Peer specialists
- Carer consultants
- Administrators

Sector partnerships

The ACT FMHS MoC takes a whole of government approach to the support of people experiencing mental illness or disorder in contact with the criminal justice system. This model acknowledges the significant range of biopsychosocial determinants of good mental health, many of which fall outside the remit of mental health services. This includes access to accommodation, education, employment, and health needs.

Consequently, close collaboration and coordination with multiple interagency partners is a key feature of the FMHS MoC. The FMHS has developed close relationships with government agencies including ACTCS, CYPS, and Housing, and community-managed organisations. The FMHS works closely with these services to address the range of support needs identified by people. The inclusion of service partners, peak agencies and statutory bodies is part of any model of care in order to sustain optimum service delivery.

The FMHS acknowledges the pivotal role of other government and community-managed agencies in the support of people experiencing mental illness or disorder in custodial and community settings. Continued committed close linkages and collaborative partnerships with both internal and external stakeholders is essential to the implementation and sustainability of the FMHS MoC. The FMHS is a specialist service within a much broader mental health sectoral landscape and provides advice and support to other agencies regarding the management of the complex interaction between the health and criminal justice systems. However, the FMHS cannot achieve its aims without the close links it has made with community and government organisations and, likewise, services managing these interactions require the support and advice provided by the FMHS. Consequently, collaboration will be key a priority for the ongoing MoC, with various inter-agency meetings seen to be integral to the

effective functioning of the service and the sector in relation to this population. The FMHS is committed to continued engagement with our inter-agency partners in this respect.

However, FMHS accept that there is still more that can be achieved in this space, noting that relationships between services can be variable. Further, supports such as housing, education, employment, and health needs are still often out of reach of many people with mental illness or disorder. As such, FMHS aims to continue building on the relationships with other agencies and formalising these in MOUs where possible. The FMHS will also work to highlight specific areas of need within the sector (e.g., supported accommodation for people with complex needs or leaving custody) and work with government and community managed organisations to address these needs.

Culture

Staff wellbeing

The physical and psychosocial wellbeing of FMHS staff has a direct impact on workplace culture and quality customer service. Facilitating ways in which staff are able to focus on their personal wellbeing in the FMHS workplace follows the strategies outlined in the *ACT Health Staff Health and Wellbeing Action Plan 2016-2018*[lxxi], including:

- Providing resources to increase awareness of mental health conditions and self-care amongst mental health professionals
- Promoting peer support and wellbeing champions
- Having dedicated spaces for staff quiet time, break time and self-care time
- Providing opportunities for regular physical activity and providing healthy food and drink choices
- Including health and wellbeing on staff meeting agendas and promoting work health and safety
- Promoting a smoke free work environment and providing smoking cessation support and resources for staff
- Promoting access to Employee Assistance Programs (EAP) and supervision.

Additionally, FMHS endeavours to

- Actively address bullying and harassment in the workplace
- Ensure manageable workloads and clarity of roles, responsibilities and expectations
- Develop and appoint responsive and supportive managers
- Promote healthy work life balance.

The FMHS acknowledges the significant strain that can be placed on FMHS staff by the environments they work in and the complex clinical presentations they face in their day to day work. Consequently, the FMHS aims to support staff in their roles through the provision of clinical supervision and, where possible, sufficient support to access work roles outside of the custodial environment when needed.

Respect, equity and diversity

The FMHS is committed to upholding the provisions of the *ACT Government Respect, Equity and Diversity Framework 2010*[lxxii]. The FMHS is committed to providing a safe and harmonious work environment that enhances the achievements of both an individual's and the organisation's goals. It also upholds a culture in which diversity is respected and the contribution that people with diverse backgrounds, experience and skills make to the workplace is valued.

Governance and Leadership

Structured, consistent and embedded governance and leadership within FMHS is pivotal in implementing the FMHS MoC and for sustaining improvements. A focus on governance provides a framework which draws together initiatives, processes and systems and ways of working as described in the FMHS MoC, and therefore staff of all levels, including clinicians, managers, team leaders and medical staff retain responsibility for FMHS performance and quality service provision.

The FMHS has a tiered hierarchy of organisational governance regarding decision making and endorsement of service activities which aligns with the *Governance Framework for Mental Health, Justice Health and Alcohol and Drug Services 2018*. The specific roles and responsibilities of the FMHS staff within this governance structure are also detailed in individual position descriptions and duty statements.

Both the *Governance Framework for Mental Health, Justice Health and Alcohol and Drug Services 2018* and the *ACT Health Governance Framework 2018 – 2023*[lxxiii] highlight that clinical governance is the responsibility of each and every person who is involved in receiving or providing health services. The application of FMHS MoC principles of care is a key commitment for FMHS staff across all service components.

The FMHS Clinical and Operational Directors and the Senior Manager provide senior leadership to ensure service delivery is in line with the strategic direction, organisational accountability targets and corporate governance processes.

The FMHS Community and Custodial team managers have a direct role in supporting their staff and in overseeing daily operations. This role is pivotal in shaping the appropriate delivery of service functional components in line with priority access criteria and principles of care. Team managers also contribute significantly to an innovative and engaged workplace culture promoting shared and collaborative responsibility and driving continuous quality improvement.

Given the complex environments and clinical presentations and risks, the management team require strong leadership attributes and skills to support their staff in the FMHS workplace. This includes the ability to navigate interagency relationships where competing priorities present ethical and operational difficulties when providing good clinical care. The team managers are supported by senior clinical staff in the execution of the service goals and aims. This includes staff at the senior clinical nurse consultant and health professional officer levels. At the same time, all FMHS staff are developed and encouraged to show personal leadership within their workplace and are rewarded and recognised for displaying leadership in their approach to championing quality initiatives, best practice, multidisciplinary team work and governance.

The FMHS Medical staff support staff and the management team by providing clinical and academic leadership, ensuring clinical decision making and treatment remain in line with the FMHS principles of care, working towards achievement of quality clinical outcomes consistent with evidence based practice.

As part of an integrated FMHS the MDT forms a decision making body that will establish as a group the appropriate follow up requirements for a person or review and endorse any outcomes of the assessment and treatment. The MDT provides transparency and accountability for decision-making and also enhances practice by fostering learning opportunities, including interdisciplinary development within a supportive peer review environment. It also ensures a holistic view of current clinical demands and complexity which can highlight service delivery issues to management. MDTs are not defined by service location and instead can include a variety of clinical services involved in a person's care.

Based on an established commitment to equality and partnerships, opportunities are also provided to ensure people, their carers and other internal and external stakeholders are able to contribute to a range of activities which include the planning, development, implementation and evaluation of services.

Furthermore, MHJHADS Discipline Principals have an integral role within FMHS to advise on and promote professional standards, competency and professional development of FMHS staff.

The Chief Psychiatrist has a statutory function under the *Mental Health Act 2015 (ACT)* to oversee the provision of assessment, treatment, care and support for people subject to the Act, and to make recommendations about mental health service delivery. The Chief Psychiatrist is also responsible for setting out the functions of mental health officers, which may include FMHS staff.

Workforce Development

Continuing professional development and supervision provide benefits for MHJHADS in the maintenance of a motivated and effective workforce. The Australian Health Practitioner Regulation Agency (AHPRA) and other professional bodies overseeing the various disciplines have specific requirements for continuing professional development and supervision. Clinicians must adhere to these requirements in order to maintain their professional registration. The ACT Government has also supported the continued maintenance of clinical competence for health care workers not covered by AHPRA through endorsement of the *National Code of Conduct for Health Care Workers*[lxxiv].

The FMHS recognises the importance of professional development and supervision and will allocate adequate time and resources to ensure clinicians' needs in these areas are met, including ensuring linkages with other forensic mental health specialists and services that can support staff development.

Professional development – Training

The FMHS MoC promotes ongoing training and development for all staff, including clinical and peer supervision, clinical reviews and multidisciplinary team meetings where each staff member is

responsible for ensuring the best possible service is delivered in line with the *National Mental Health Practice Standards 2013*[lxxv].

All FMHS staff have an individual performance plan. This is developed in consultation with supervisors and supports their learning and professional development and ensure a skilled and competent workforce. The *National Health Workforce Innovation and Reform Strategic Framework 2015* emphasises the importance for services to develop an adaptable health workforce equipped with the requisite competencies and support that provides team based, inter-professional and collaborative models of care. The *National Statement of Principles for Forensic Mental Health 2006*[lxxvi] also acknowledges this requirement, highlighting the challenging nature of forensic mental service delivery and the need for appropriate training and support to maintain a highly skilled workforce. To this end, the FMHS acknowledges the need for FMHS staff to have specialist knowledge and skills in order to be able to fulfil the complex and difficult nature of the roles they occupy. As such the FMHS will provide staff with access to specialist training in areas such as risk assessment (e.g., HCR-20v3[lxxvii], Stalking Risk Profile[lxxviii], etc.) and interventions (e.g., problem behaviour interventions regarding fire-setting, etc.). Training in these areas are considered integral to the ability of the FMHS to be able to fulfil its role as a speciality consultation liaison service and will be prioritised.

Workforce growth, efficiency and productivity are supported by providing staff with appropriate access to professional development opportunities. FMHS staff will have regular access to clinical supervision, training, and multi-disciplinary and interprofessional learning in the workplace. Outside of registration requirements, continuing professional development is critical for keeping up to date with research and innovation in health care in order to equip the workforce to provide the highest quality health care.

Professional development – Supervision

Clinical supervision facilitates the professional and practice development of clinicians through a process that includes reflection, education and discussion. Clinical supervision enables FMHS clinicians to assume responsibility for the development of their knowledge, skills, competency, practice and professionalism. It supports professional standards of practice and quality of care within a clinical and professional governance framework. The effective use of clinical supervision is critical for providing efficient, effective and timely support to people with mental health issues and their carers and is a key part of staff professional development. Individual supervision and peer supervision will provide avenues for staff to access the specialist knowledge and guidance from supervisors and colleagues. Supervision is important in creating room for clinicians to examine and reflect on their own practice and to seek advice from and feel supported by their colleagues particularly when caring for complex, high-needs people. Supervision is also important for maintaining a clinician's wellbeing in what can be a demanding environment. This is particularly so for clinicians working in the forensic mental health field.

Teaching environment

MHJHADS has key partnerships with a number of teaching institutions including the University of Canberra, the Australian National University, and the Australian Catholic University and provides opportunities for undergraduate clinical placements and teaching to medical, nursing, and allied

health students. The FMHS offers placements for each of these disciplines and provides opportunities for students' learning across a range of settings.

MHJHADS also has the responsibility for providing post graduate training to clinicians across a range of disciplines. Our aim is to provide a setting where junior clinicians can learn from and be mentored by experienced practitioners and in turn become skilled practitioners of evidence-based care and be qualified to teach others.

The MHJHADS also provides entry level employment for nursing and allied health staff and has the responsibility to create work opportunities suitable to the staff at this stage of their career. MHJHADS values and nurtures entry level staff in effort to build and develop their experience and expertise for future succession into more senior roles.

Providing a quality learning experience takes an investment of time and resources. Adequate time, training and resources are allocated to supervisors and entry level clinicians in order to ensure they have a positive learning experience. AHPRA and other professional bodies that oversee the registration and training of health professionals have specific requirements regarding the training experiences, clinical supervision, and working environment that are adhered to in order to maintain accreditation and reputational status as a provider of high quality training.

Staff orientation

Orientation training packages should not just focus on familiarising new staff with the service components and work duties, instead FMHS should also orientate new staff to the principles of care and culture that underpin the FMHS MoC and support the provision of services to a highly marginalised and vulnerable population.

Embedding Research

The FMHS provides a rich setting in which to conduct mental health research in a real world setting. In line with the *National Statement of Principles of Forensic Mental Health 2006*[lxxix] and the FMHS MoC Principle 5, the FMHS is committed to ongoing research in collaboration with people with mental illness and disorder because:

- Ongoing research and innovation is vital to improving the lives of people with mental health issues
- Research projects have the capacity to enliven the service with new ideas and to assist staff with the maintenance of curiosity and life-long learning that is essential to providing good quality clinical care
- Research projects are a key part of training for many of the under graduate and post graduate students who have clinical placements within MHJHADS
- Ongoing research adds to the prestige of the organisation and assists in the recruitment and retention of a skilled workforce that is essential to providing excellence in clinical care.

Section 5 - FMHS MOC Evaluation

Accountability Indicators

JHS has an obligation to report to the ACT Legislative Assembly annually on its performance. Specific reporting indicators for 2018-19 are provided in Table 3.

Table 3: JHS Accountability Indicators

Indicator	Description
Proportion of detainees at the AMC with a completed health assessment within 24 hours of detention.	All detainees will, under Section 67 of the *Corrections Management ACT* 2007, undergo a health assessment within 24 hours of admission to the AMC.
Proportion of detainees in BYJC with a completed health assessment within 24 hours of detention.	All detainees will, under Section 160 of *the Children and Young People Act 2008*, undergo a health assessment within 24 hours of admission to the BYJC.
JHS community contacts (in the AMC, including FMHS and Custodial Health Service)	Community service contacts are occasions of service with or about the client resulting in a dated entry in the clinical file. Service contacts include both direct and indirect clinical contact, reported for all community mental health service units in the Justice Health program. Exclusions: Did Not Attend (DNAs).

Performance monitoring

The FMHS MoC intended changes and performance will be monitored via the following data, outlined in table 4.

Table 4: Data to be captured for monitoring service outcomes5

Service	Metric
MHCALS	• Number of persons triaged • Number of assessments conducted in the court cells, including demographic variables • Numbers of s309 recommendations made to ACT Courts • Number of people accepted for admission following s309 recommendation • Number of people referred for further care following assessment • Number of referrals received for medicolegal reports by type (i.e., Verdins, s331) • Number of assessments completed • Number of DNAs
FoCIS	• Number of referrals for consultation liaison • Number of accepted referrals • Number of assessments undertaken • Number of external service MDTs attended • Number of TAC referrals received • Number of TAC assessments completed (low/medium/high) • Number of TAC psychiatric assessments completed
Custodial MHS – CA	• Number of young people inducted to centre (100%) • Number of new referrals triaged and seen within triage guidelines (100%) • Number of care/recovery plans completed for clinically managed young people (100%) • Number of young people referred to external services upon release • Number of young people already linked with CAMHS prior to entry
Custodial MHS – Adult	• Number of detainees inducted to centre (100%) • Number of new referrals triaged and seen within triage guidelines (100%) • Number of 'At-Risk' referrals seen within 2 hours (100%) • Number of care/recovery plans completed for clinically managed detainees (100%) • Number of detainees referred to external services upon release • Number of detainees already linked with MHS prior to entry • Number of detainees on PTOs • Number of detainees on long acting injectable medications
Training and development	• Numbers of trainings provided across the ACT (including outcome measures)

5 Demographic variables relevant to service provision are monitored across services

	• Number of Quality Improvement and research projects being undertaken • Number of publications from service • Number of conference presentations by service

Section 6 – Future Directions

Future Opportunities

In the process of developing the FMHS MoC, there were a number of opportunities identified that were out of scope because they required more comprehensive investigation, analysis, consultation and work planning across different directorates and levels of government.

The main opportunities include:

1. Review and restructure of the Justice Health Service as a whole in order to streamline services and improve efficiencies
2. Further integration of primary physical care and mental health care services in line with broader environmental and group needs (i.e., child and adolescent health needs, adult health needs) rather than by physical versus mental health needs
3. Investigating greater collaboration between the ACT Courts and MHJHADS regarding the management of people with mental illness or disorder, including the possibility of a Mental Health List or Court, and increased involvement of the Court Liaison staff in diversion from the criminal justice system
4. Exploring options for outcome measures tailored to forensic settings
5. In line with interstate examples, exploration of options for shared Custodial MHS and ACT Corrective Services management of a mental health support unit in the AMC
6. The implementation of a MHJHADS service-wide risk assessment and management framework[6] that supports general community and inpatient mental health services in managing risk of violence.
7. The development of a Specialist Forensic Therapies Team.

6 See New South Wales' Clinical Risk Assessment and Management (CRAM) framework and the Queensland Health Violence Risk Assessment and Management (V-RAM) framework

Summary of main FMHS changes for MoC implementation

A number of elements of this model of care are already embedded in current practice in the wider FMHS, however specific changes to several functions will require implementation. These include:

1. Change of names for individual service elements to more accurately reflect the nature of the services provided by each arm of the service and reduce confusion regarding service roles.
2. Organisational restructure in order to align community and custodial services in two separate streams. This will require further clarification of roles descriptions and processes.
3. Development and broadening of the scope of the MHCALS to incorporate the Drug and Alcohol Court and Warrumbul Childrens' Court. This will include increased staffing and definition of roles, learning and development requirements, and interagency MOUs.
4. A significant shift of the FoCIS from a clinical management/consultation-liaison model to a more focused consultation-liaison model. This includes increased involvement of the FoCIS in the review of people subject to CROs and FPTOs in order to ensure they receive the most appropriate and least-restrictive care. This will require further definition of staffing roles, and learning and development plans to address specialist training needs. It will also require significant training to be provided to other stakeholders.
5. Consolidation of clinical pathways for people experiencing mental illness or disorder in the AMC. This will provide improved clarity for detainees and ACTCS regarding available services, and improve access to specialist mental health care for people with serious mental illness. This will require clarification of service and staffing roles within the team, clarification of staff learning and development requirements, policies and procedures, and interagency MOUs.
6. Consolidation clinical pathways for people experiencing mental illness or disorder in the BYJC. This will provide improved clarity for young people and BYJC/CYPS regarding available services. This will require clarification of service and staffing roles within the team, clarification of staff learning and development requirements, policies and procedures, and interagency MOUs.
7. The development of a quality improvement and research culture within the service. This includes the building of ongoing links with researchers and local and interstate colleagues.

[i] Department of Health. (2010). *National standards for mental health services.* Canberra: Commonwealth of Australia. Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf

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

[iii] Department of Health. (2017). Fifth national mental health and suicide prevention plan. Canberra: Commonwealth of Australia. Retrieved from http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf

[iv] Department of Health and Ageing. (2006). *National Statement of Principles for Forensic Mental Health.* Canberra: Commonwealth of Australia. Retrieved from https://www.aihw.gov.au/getmedia/e615a500-d412-4b0b-84f7-fe0b7fb00f5f/National-Forensic-Mental-Health-Principles.pdf.aspx

[v] Department of Health and Ageing. (2013). *A national framework for recorvery oriented mental health services.* Canberra: Commonwealth of Australia. Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf

[vi] Australian Commission on Safety and Quality in Health Care. (2012). *National Safety and Quality Health Service Standards.* Sydney: ACSQHC. Retrieved 2019, from https://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf

[vii] Department of Health. (2010). *National standards for mental health services.* Canberra: Commonwealth of Australia. Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf

[viii] ACT Health. (n.d.). *The ACT charter of rights for people who experience mental health issues.* Canberra: ACT Government. Retrieved from https://www.health.act.gov.au/sites/default/files/2018-09/ACT%20Charter%20of%20Rights%20for%20people%20who%20experience%20mental%20health%20issues.pdf

[ix] *Mental Health Act 2015* (ACT) (Austrl.).

[x] *Human Rights Act 2004* (ACT) (Austrl.).

[xi] *Corrections Management Act 2007* (ACT) s53. (Austrl.).

[xii] *Crimes Act 1900* (ACT) (Austrl.).

[xiii] *Criminal Code 2002* (ACT) (Austl.).

[xiv] Department of Health (2016). *The plain language guide for the Mental Health Act 2015 (Australian Capital Territory), February 2016.* Canberra: ACT Government. Retrieved from

https://www.health.act.gov.au/sites/default/files/2018-11/Plain%20Language%20Guide_MH%20ACT_0.pdf

[xv] Ibid.

[xvi] Department of Health and Ageing. (2006). *National Statement of Principles for Forensic Mental Health*. Canberra: Commonwealth of Australia. Retrieved from https://www.aihw.gov.au/getmedia/e615a500-d412-4b0b-84f7-fe0b7fb00f5f/National-Forensic-Mental-Health-Principles.pdf.aspx

[xvii] Department of Health and Ageing. (2013). *A national framework for recorvery oriented mental health services.* Canberra: Commonwealth of Australia. Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf

[xviii] Wolff, N. & Shi, J. (2012). Childhood and adult trauma experiences to incarcerated persons and their relationship to adult behavioural problems and treatment. *International Journal of Environmental Research and Public Health, 9,* 1908-1926.

[xix] Department of Health and Ageing. (2013). *A national framework for recorvery oriented mental health services.* Canberra: Commonwealth of Australia. Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf

[xx] ACT Government (2018). *ACT Carers Strategy 2018-2028.* Canberra: ACT Government. Retrieved from https://www.communityservices.act.gov.au/__data/assets/pdf_file/0006/1263732/2018-2028-ACT-Carers-Strategy-First-Three-Year-Action-Plan-Designer-Version.pdf

[xxi] *Mental Health Act 2015* (ACT) (Austrl.).

[xxii] Canberra Health Services (2018). *Advance Agreements, Advance Consent Directions, and Nominated Persons under the Mental Health Act 2015.* Canberra: ACT Government.

[xxiii] Department of Health. (2010). *National standards for mental health services.* Canberra: Commonwealth of Australia. Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf

[xxiv] *Corrections Management Act 2007* (ACT) s53. (Austrl.).

[xxv] Department of Health and Ageing. (2006). *National Statement of Principles for Forensic Mental Health*. Canberra: Commonwealth of Australia. Retrieved from https://www.aihw.gov.au/getmedia/e615a500-d412-4b0b-84f7-fe0b7fb00f5f/National-Forensic-Mental-Health-Principles.pdf.aspx

[xxvi] Ibid.

[xxvii] *Human Rights Act 2004* (ACT) (Austrl.).

[xxviii] *Mental Health Act 2015* (ACT) (Austrl.).

[xxix] *Guardianship and Management of Property Act 1991* (ACT) (Austrl.)

[xxx] Ibid.

[xxxi] Australian Institute of Health and Welfare (2016). *Australia's health 2016*. Australia's Health Series no.15. Cat. No. AUS 199. Canberra: AIHW.

[xxxii] Australian Medical Association (22 Nov 2018) *Report Card on Indigenous Health – Rebuilding the Closing the Gap Health Strategy: and a review of the 2016 and 2017 AMA Indigenous Health Report Card Recommendations*. Canberra: AMA.

[xxxiii] Commonwealth, Royal Commission into Aboriginal Deaths in Custody (RCIADIC), *National Report* (1991) vol 1. Retrieved from http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol1/

[xxxiv] Australian Bureau of Statistics. (2018). *Prisoners in Australia, 2018.* Cat. No. 4517.0. Canberra: Commonwealth of Australia. Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2018~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20prisoner%20characteristics%20~13

[xxxv] Australian Bureau of Statitics. (2016). *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*. Cat. No. 3238.0.55.001. Canberra: Commonwealth of Australia. Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001

[xxxvi] Australian Bureau of Statistics. (2018). *Prisoners in Australia, 2018.* Cat. No. 4517.0. Canberra: Commonwealth of Australia.

[xxxvii] Australian Government (2013). *National Aboriginal and Torres Strait Islander health plan 2013-2023.* Canberra: Australian Government.

[xxxviii] ACT Community Services Directorate (2019). ACT Aboriginal and Torres Strait Islander agreement 2019-2028. Canberra: ACT Government. Retrieved from https://www.communityservices.act.gov.au/atsia/agreement-2019-2028

[xxxix] ACT Government (2018). *Memorandum of understanding between Australian Capital Territory and Winnunga Nimmityjah Aboriginal Health and Community Services Ltd for the delivery of coordinated helaht care services to Aboriginal and Torres Strait Islander detainees in Alexander Maconochie Centre.* Canberra: ACT Government.

[xl] Australian Government (2013). *National Aboriginal and Torres Strait Islander health plan 2013-2023.* Canberra: Australian Government.

[xli] Ibid.

[xlii] ACT Community Services Directorate (2014). *ACT Multicultural framework 2015-2020.* Canberra: ACT Government.

[xliii] ACT Health (2014). *Towards Culturally Appropriate and Inclusive Services: A Co-ordinating Framework for ACT Health 2014-2018*. Canberra: ACT Government.

[xliv] Corboz J, Dowsett G, Mitchell A, Couch M, Agius P, & Pitts M 2008. *Feeling Queer and Blue: A Review of the Literature on Depression and Related Issues Among Gay, Lesbian, Bisexual and Other Homosexually Active People*. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

[xlv] Suicide Prevention Australia 2009. *Suicide and self-harm among Gay, Lesbian, Bisexual and Transgender communities*. Sydney: Australia.

[xlvi] Leonard W, Pitts M, Mitchell A, Lyons A, Smith A, Patel S, Couch M, & Barrett A 2012. *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians.* Monograph Series Number 86. Melbourne: The Australian Research Centre in Sex, Health &

Society, La Trobe University.

[xlvii] McGorry, P. D., Goldstone, S. D., Parker, A. G., Rickwood, D. J., & Hickie, I. B. (2014) Cultures for mental health care of young people: an Australian blueprint for reform. *The Lancet Psychiatry*, *1*(7), 559-568.

[xlviii] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R. & Walters, E. E. (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in Natoinal Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593-602.

[xlix] Kasinathan, J. (2015). Predictors of rapid reincarceration in mentally ill young offenders. *Australasian Psychiatry, 23*(5), 550-555.

[l] Indig, D., Vecchiato, C., Haysom, L., R, Carter, J., Champion, U., . . . Muir, P. (2011). *2009 NSW young people in custody health survey: Full report.* Sydney: Justice Health and Juvenile Justice.

[li] Coffey, C., Veit, F., Wolfe, R., Cini, E., & Patton, G. C. (2003). Mortality in young offenders: retrospective cohort study. *BMJ, 326*(7398), 1064.

[lii] Department of Health. (2017). Fifth national mental health and suicide prevention plan. Canberra: Commonwealth of Australia. Retrieved from http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf

[liii] National Mental Health Commission (2016). *Equally Well consensus statement: Improving the physical health and wellbeing of people living with mental illness in Australia.* Sydney: NMHC.

[liv] Canberra Health Services (2019). *Providing physical health care across MHJHADS operational guideline.* Canberra: Canberra Health Services.

[lv] Kavanagh, Anne. & Krnjacki, Lauren. & Kelly, Monica. & Victorian Health Promotion Foundation issuing body. (2012). *Disability and health inequalities in Australia : research summary : addressing the social and economic determinants of mental and physical health*. Carlton South, VIC : Victorian Health Promotion Foundation

[lvi] ACT Government (2019). *Disability justice strategy 2019-2029: A strategy to address unequal access to justice in the ACT.* Canberra: ACT Government.

[lvii] ACT Government (2019). Disability justice strategy first action plan 2019-2023. Canberra: ACT Government Retrieved from https://www.communityservices.act.gov.au/disability_act/disability-justice-strategy/first-action-plan-2019-2023

[lviii] Australian Institute of Health and Welfare (2015). *The health of Australia's prisoners.* Cat. No. PHE 207. Canberra: AIHW.

[lix] ACT Health (2012). *ACT Comorbidity (Mental Health and Alcohol, Tobacco or Other Drug Problems) Strategy 2012-2014*. Canberra: ACT Government.

[lx] Department of Health and Ageing. (2006). *National Statement of Principles for Forensic Mental Health*. Canberra: Commonwealth of Australia. Retrieved from https://www.aihw.gov.au/getmedia/e615a500-d412-4b0b-84f7-fe0b7fb00f5f/National-Forensic-Mental-Health-Principles.pdf.aspx

[lxi] Kasinathan, J. (2015). Predictors of rapid reincarceration in mentally ill young offenders. *Australasian Psychiatry, 23*(5), 550-555.

[lxii] Penner, E. K., Roesch, R., & Viljoen, J. L. (2011). Young offenders in custody: An international comparison of mental health services. *Internation Journal of Forensic Mental Health, 10*, 215-235.

[lxiii] Department of Health. (2010). *National standards for mental health services.* Canberra: Commonwealth of Australia. Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf

[lxiv] Department of Health and Ageing. (2006). *National Statement of Principles for Forensic Mental Health*. Canberra: Commonwealth of Australia. Retrieved from https://www.aihw.gov.au/getmedia/e615a500-d412-4b0b-84f7-fe0b7fb00f5f/National-Forensic-Mental-Health-Principles.pdf.aspx

[lxv] *Children and Young People Act 2008* (ACT) ss. 160-161 (Austrl.).

[lxvi] Department of Health. (2010). *National standards for mental health services.* Canberra: Commonwealth of Australia. Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf

[lxvii] Department of Health and Ageing. (2006). *National Statement of Principles for Forensic Mental Health*. Canberra: Commonwealth of Australia. Retrieved from https://www.aihw.gov.au/getmedia/e615a500-d412-4b0b-84f7-fe0b7fb00f5f/National-Forensic-Mental-Health-Principles.pdf.aspx

[lxviii] *Corrections Management Act 2007* (ACT) s. 68 (Austrl.).

[lxix] National Institute for Health and Care Excellence (2017). *Mental health of adults in contact with the criminal justice system*. London: NICE. Retrieved from https://www.nice.org.uk/guidance/ng66/resources/mental-health-of-adults-in-contact-with-the-criminal-justice-system-pdf-1837577120965

[lxx] National Institute for Health and Care Excellence (2011). *Common Mental Health Problems: identification and pathways to care*. Clinical Guideline. UK. Retrieved from https://www.nice.org.uk/guidance/CG123/chapter/1-Guidance#stepped-care

[lxxi] ACT Health (2016). *ACT Health Staff Health and Wellbeing Action Plan 2016-2018.* Canberra: ACT Government.

[lxxii] ACT Government (2010). *Respect, equity and diversity framework*. Canberra: ACT Chief Minister's Department. Retrieved from https://www.cmtedd.act.gov.au/__data/assets/pdf_file/0007/205576/redframework2.pdf

[lxxiii] ACT Health (2018). *ACT Health Governance Framework 2018-2023*. Canberra: ACT Government: Canberra. Retrieved from https://www.health.act.gov.au/sites/default/files/2019-02/ACT%20Health%20Governance%20Framework%202018-2023.pdf

[lxxiv] Australian Health Ministers Advisory Council (2014). *The National Code of Conduct for health care workers.* Melbourne: AHMAC.

[lxxv] Victorian Government Department of Health (2013). *National practice standards for the mental health workforce.* Melbourne: Victorian Government.

[lxxvi] Department of Health and Ageing. (2006). *National Statement of Principles for Forensic Mental Health*. Canberra: Commonwealth of Australia. Retrieved from https://www.aihw.gov.au/getmedia/e615a500-d412-4b0b-84f7-fe0b7fb00f5f/National-Forensic-Mental-Health-Principles.pdf.aspx

[lxxvii] Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). *HCR-20V3: Assessing risk of violence – User guide*. Burnaby, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.

[lxxviii] MacKenzie, R.D., McEwan, T.E., Pathé, M.T., James, D.V., Ogloff, J.R.P., & Mullen, P.E. (2009). *The Stalking Risk Profile. Guidelines for assessing and managing stalkers.* StalkInc. & the Centre for Forensic Behavioural Science, Monash University.

[lxxix] Department of Health and Ageing. (2006). *National Statement of Principles for Forensic Mental Health*. Canberra: Commonwealth of Australia. Retrieved from https://www.aihw.gov.au/getmedia/e615a500-d412-4b0b-84f7-fe0b7fb00f5f/National-Forensic-Mental-Health-Principles.pdf.aspx

ACKNOWLEDGMENT OF COUNTRY

ACT Health acknowledges the Traditional Custodians of the land, the Ngunnawal people. ACT Health respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. ACT Health also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

ACCESSIBILITY

If you have difficulty reading a standard printed document and would like an alternative format, please phone 13 22 81.

If English is not your first language and you need the Translating and Interpreting Service (TIS), please call 13 14 50.

For further accessibility information, visit: www.health.act.gov.au/accessibility

www.health.act.gov.au | Phone: 132281