The Identification of Mental Disorders in the Criminal Justice System

Criminology Research Council Consultancy

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EXECUTIVE SUMMARY

Incontrovertible evidence now exists to show that the prevalence of mental disorder among those in the criminal justice system (prisoners, offenders on community orders and accused on remand) is significantly greater than is found in the general population. Despite the prevalence of mentally disordered people in the criminal justice system, and the potential consequences of failing to adequately address the issues, few services exist either in prisons or in the community to help identify and prevent these people from entering or remaining in the criminal justice system. This consultancy paper provides an overview of the mechanisms by which persons with mental illnesses are identified across the criminal justice system in Australia. The paper comprises several components. First, a literature review is provided regarding the prevalence of mental disorders across the criminal justice system as well as the various screening measures described in the international literature. Based upon detailed interviews and correspondence with key contact people in the Australian criminal justice system, we then provide an overview of current practice identifying mental disorder across police, correctional services, and the courts in all jurisdictions. Finally, we provide a fiscal analysis of the most promising approaches and make recommendations for further development in this area.

The results of the literature review show that the prevalence rates of a wide variety of mental disorders are disproportionately high in the criminal justice system. It has been found that rates of the major mental illnesses, such as schizophrenia and depression, are between three and five times higher than that expected in the general community. Not only are large numbers of prisoners suffering from mental illness, even larger numbers of mentally disordered offenders are being remanded prior to trial. The number of offenders with mental illnesses has also increased substantially during the process of deinstitutionalization. It must be noted, though, that the increase in the number of mentally ill people in the criminal justice system may be as much or more a product of the increase in the use of substances by people with mental illnesses as it is due to the deinstitutionalisation of mentally ill patients.

Unfortunately, research shows that a relatively poor job is done adequately identifying the needs of mentally disordered offenders prior to the time they enter the criminal justice system (indeed, it has been said, perhaps facetiously, that any need for a forensic psychiatric system arises from a failure of the mainstream mental health system).

Police services are generally the first point of contact with the criminal justice system for most people, and police officers have essentially three choices when they are faced with

an individual who is behaving irrationally. They can attempt to informally resolve the issue, contact a crisis team, take the person to a hospital, or arrest them. The increased prevalence of mentally disorder in gaols suggests that, at least in the past, arrest has been the predominant option. Furthermore, police have traditionally viewed their interactions with mentally ill people as a problematic and undesirable part of their duties. Accordingly, several models have been developed for policing those with mental health issues. These include various combinations of police officer training and the involvement of mental health clinicians and each proposed model has its advantages and disadvantages. Unfortunately, there has been little testing or validation of such approaches in the Australian context.

The increased prevalence of mental disorder in the criminal justice system indicates that identifying such disorders is of paramount importance. Nonetheless, it is not possible to conduct a comprehensive mental health assessment with every person who comes into contact with the police, the courts, or the correctional system. Thus, screening is vital to identify those that do require a comprehensive evaluation. The aims of screening are to identify mentally disordered offenders and provide necessary treatment, prevent violent and disruptive incidents in institutions, allocate resources to those with the greatest or most immediate need, and reduce the cycle of admissions to the criminal justice system. Screening processes should aim to minimise the number of “false negatives” (failing to identify an actually mentally disordered person), even at the expense of making “false positives (those identified as possibly being mentally disordered who are not).

Formal structured methods for screening are likely to be more accurate than those based upon unstructured opinion. Indeed, despite the reticence of decision-makers to utilise formal instruments, there is over 50 years of research indicating their superiority across a wide range of predictive tasks. Several formal screening tools have been developed for identifying mentally disordered offenders. The most well known include the Referral Decision Scale, the Brief Jail Mental Health Screen, and the Jail Screening Assessment Tool. Validation data for all three tools is promising.

In regard to the identification of mental disorder within the Australian criminal justice system, our experience as a research team conducting interviews across the country was powerful. At virtually every meeting, many participants were meeting one another for the first time, indicating the general disconnect between the various services in many jurisdictions. Further, it was clear that substantial difficulty is experienced by services outside of the capital cities in each jurisdiction.

Despite mental illness being a health issue, Australian police agencies are left in the unenviable position of being the first point of contact with mentally disordered individuals. This is particularly so during the after hours period. There was considerable heterogeneity in screening practices across Australian police services. Each service acknowledged the increased need for training of officers in this area. No jurisdictions have structured screening devices for identifying individuals likely to have a mental disorder at the time of initial contact. Nonetheless, identification and screening for mental disorder generally takes place in the watch house. In some jurisdictions nurses conduct the screening and in others this is performed by police officers. Generally there is liaison with health staff where appropriate, especially in the major cities. Some jurisdictions have no formal screening process. Communication of mental disorder information with health and correctional services appears to be frustrating – with more restrictions seemingly placed on police gaining information than providing it.

Formalised court liaison programs/services appear to exist in most Australian states. Some services are particularly well-developed and staffed. Such services would appear to be an integral part of the court system with services expanding along with the target groups they serve. These services are usually provided by forensic mental health and are predominantly staffed by psychiatric nurses. Such services show great promise for identifying individuals before the courts who are mentally ill or who require services.

There are now a variety of diversion programs that have been developed internationally which are aimed at early identification of risks and needs for persons arrested by police. The goals of these diversion programs include screening persons arrested for a range of risks and needs (including mental illness) and linking them with appropriate services. This program model raises the question of whether screening should be done by police, or whether it is better to use specialised assessment and referral services.

Unsurprisingly, screening is most extensive within the incarcerated population in remand centres. In most jurisdictions the mental health screening forms part of a larger health screening and is generally completed by nurses. Nonetheless, there is considerable heterogeneity in approach. Systematic screening tools specifically developed for mental illness screening were described in some jurisdictions. Such tools take approximately 20 minutes to administer. Following admission to the correctional facility, no jurisdictions have any formal ongoing assessment or screening service that monitors prisoners' mental health status. Nonetheless, several jurisdictions do conduct re-assessments as required and suicide risk assessment is an understandable key focus.

Australian community corrections services generally employ the services of officers with post-secondary education that are expected to identify mental health concerns of the offenders they are supervising. Nonetheless, forensic mental health services are also utilised in virtually all of the states to work with community corrections – to varying capacities.

Juvenile justice services appear to have a greater focus on detailed assessments of health in general, including mental health issues. Formal screening tools are not prevalent, although this appears to be due to the greater focus on clinical assessment.

While the use of formal screening tools appears to be the exception rather than the rule in the Australian criminal justice system, the dominant view in the literature is that they are the most appropriate approach to the task. Accordingly fiscal analyses are presented regarding the most promising tool for police custody screening and remand/sentenced prisoners.

Recommendations:

1. Continued attention is required to be focussed on understanding the reasons for the disproportionate prevalence of mentally ill people in the criminal justice system.

2. This report should be referred to the national conferences of relevant agency heads for consideration and action: Police Senior Officers' Group, Court Administrators and Corrections Administrators (including Juvenile Justice Administrators).

3. At present, screening for mental illness goes on at a number of points in the criminal justice system. However, information collected at one point in the system is not always made available to staff at a later stage. Systems should be developed within jurisdictions for routine data sharing between criminal justice agencies on suspected or diagnosed mental illnesses.

4. Police are often the first point of contact for mentally ill people entering the criminal justice system. Police require adequate training to assist them in determining, in the first instance, whether an individual may be mentally disordered.

5. All accused being taken into police custody following arrest should undergo a mental health screen. Where possible and feasible such screening should be conducted by a nurse or mental health professional using a structured and standardised approach,

such as the Jail Screening Assessment Tool. Where it is not possible for practical reasons to routinely screen all people in these circumstances, alternative mechanisms should be put in place. Such mechanisms could include screening by police, using measures that do not require administration by a health professional, or it may be possible to have mental health staff from agencies such as forensic mental health services conduct screenings on an as-need basis.

6. Court liaison programmes have been met with considerable success and support and should be developed further. In these programs, mental health professionals (e.g., psychiatric nurses or psychologists) assist the courts by conducting assessments, obtaining information about prior contract with mental health services, and by connecting those people with mental illnesses coming before the courts with mental health services.

7. When remanded into custody, or when sentenced, all accused and offenders (including adolescents) should be screened for mental illness by a mental health professional (e.g., psychiatric nurse). This is necessary given the prevalence of mentally ill people entering the prisons and the concomitant concerns they raise. Best practice suggests that systematic, standardized measures such as the Jail Screening Assessment Tool, rather than informal clinical judgment should be employed. As with admission to police lock-up, where such screening cannot practicably be conducted by a mental health professional, alternative mechanisms should be put into place.

8. Given that relapses in mental illnesses can contribute to detioration and ultimately re-offending, information about an offenders' mental health needs should be shared with parole authorities so that appropriate conditions may be attached to parole to help ensure that offenders receive mental health services when released from custody.

9. Research is required in Australia to explore the validity of screening tools that are administered by justice staff and not mental health professionals.

10. Given the significant concerns and difficulties that were identified nation-wide regarding the prevalence of mentally ill people in the justice system, and the relative dearth of services available to them, ongoing dialogue would be beneficial between mental health and justice to identify issues and to develop solutions.

LITERATURE REVIEW

Incontrovertible evidence now exists to show that the prevalence of mental disorder among those in the criminal justice system (prisoners, offenders on community orders and accused on remand) is significantly greater than is found in the general population. Despite the prevalence of mentally disordered people in the criminal justice system, and the potential consequences of failing to adequately address the issues, few services exist either in prisons or in the community to help identify and prevent these people from entering or remaining in the criminal justice system. In this consultancy paper we review the prevalence of mental disorders across the criminal justice system as well as various screening measures described in the international literature. We then provide an overview of current practice identifying mental disorder across police and correctional services in all Australian jurisdictions. Finally, we provide a fiscal analysis of the most promising approaches and make recommendations for further development in this area.

THE PREVALENCE OF MENTAL DISORDERS IN THE CRIMINAL JUSTICE SYSTEM

There is a general perception shared by correctional health care administrators and correctional mental health professionals that the number of persons with mental illness entering gaols has increased over the years. Sixty-nine percent of gaol administrators responding to the survey prepared by Torrey and his colleagues (1992) reported that the number of persons with mental illness who were entering gaol had increased over the course of 10 years. Moreover, a number of commentators claim that the proportion of mentally disordered gaol inmates is increasing (Teplin, 1983; Torrey et al., 1992). Upon reviewing the relevant literature Teplin (1983) concluded that "research literature, albeit methodologically flawed, offers at least modest support for the contention that the mentally ill are (now) being processed through the criminal justice system" (p. 54).

The contention that the mentally ill are entering gaols in increasing numbers is not accepted by all, however (Monahan, Caldiera, & Friedlander, 1979). It has been proposed that it is simply heightened awareness among professionals and the public of the problem of mentally ill in the gaols that has resulted in the perception that they are entering in increasing numbers (Ogloff, 2002). In a recent study investigating the criminal offence history of every person in Victoria with schizophrenia in the public mental health registry in five year cohorts from 1975 to 1995, Wallace, Mullen, and Burgess (2004) found that there was no subsequent increase in offence rate by year for those with schizophrenia, while the offence rate for the matched comparison group of people in the community without a mental illness increased significantly over the period. This is particularly

interesting since during that time the process of deinstitutionalisation was completed in Victoria. Indeed, there are no more psychiatric hospitals in Victoria (except for a 100 bed secure forensic psychiatric hospital).

Considerable research now exists to show that the prevalence of mental disorder among those in the criminal justice system (prisoners and offenders or accused on community orders) is *significantly* greater than is found in the general population. It is simplistic to believe that the over-representation of mentally ill people in the criminal justice system is simply the result of deinstitutionalisation. Instead, the reasons behind the apparent increase are complex and this has a significant bearing on what should be done to respond to the problem.

A number of contributing factors have been identified that help explain the high numbers of people with mental illnesses in the criminal justice system. Considerable concern has been raised about the capacity of community-based mental health services to address the needs of mentally ill offenders. Community-based mental health services work best for those who have reasonable connections and support within the community. Unfortunately, offenders (especially imprisoned offenders) tend to be poorly integrated into the community (Makkai & McGregor 2003) and have poor access to a range of support services including accommodation, income support, health and mental health (Baldry 2003; Travis & Waul 2003). While the presence of mentally ill people in the criminal justice system presents challenges and raises concerns, the fact is that the justice system provides an opportunity to identify and deliver treatment to people who are otherwise likely to remain outside the reach of services. As such, it has been suggested that justice mental health services present an opportunity for identifying those with mental illnesses and making services available to them that would otherwise be non-existent (see Ogloff, 2002).

A further complication that helps explain the prevalence of mentally ill people in the criminal justice system pertains to the fundamental change in offending populations over the past decade with respect to the spread of drug dependency. It is arguable whether this has partially supplanted the alcohol dependency that has traditionally characterised offender populations. There are two important consequences of this. The first is there has been an increase in the rate of some forms of drug-related mental illness (mainly associated with cannabis and amphetamine dependency) (Roxburgh, Degenhardt, Larance & Copeland, 2005). The second is that the conjunction of mental illness and drug dependency further limits offenders' access to treatment. Again, the significance of this is that the justice system provides an opportunity to deliver the kind of specialised

assessment and treatment services that are required by this population (Ogloff, Lemphers, & Dwyer, 2004).

The increase in the representation of mentally ill people in custody needs to be seen as being driven by the same socio-political forces that are responsible for the general increase in imprisonment rates. Garland (2001) identifies a series of changes in late modern communities that are associated with a decline in traditional "penal-welfare" approaches and the rise of punitive sanctions and expressive justice. The key change is that offenders who in the past were at the margins of custody (especially non-violent, recidivist and drug dependent offenders) are now routinely imprisoned, and average periods of imprisonment have increased. Mentally ill offenders are particularly vulnerable to these changes.

Estimating the prevalence of mental disorder in the criminal justice system is a somewhat inexact practice as the population is inconsistently defined and markedly heterogeneous (Cohen & Eastman, 1997, 2000; Harris & Rice, 1997; Rice & Harris, 1997). Differences may exist on the basis of age, gender, diagnosis, or culture. Further, being classified a *mentally ill offender* requires that several interacting criteria be met[1]. The mental disorder limb of such criteria requires a diagnosis by a mental health professional, a practice that requires the exercise of professional clinical judgment. Despite contemporary improvements in psychiatric nosology (e.g., American Psychiatric Association, 1994, 2000; World Health Organisation, 1992), the reliability of such diagnoses in actual clinical settings remains relatively unknown (Harris & Rice, 1997; Regier, Kaelber, Roper, Rae, & Sartorius, 1994). In addition, contact with the criminal justice system is, to a considerable extent, a product of the attitudes and practices of law enforcement agencies and legal institutions, which can differ markedly across jurisdictions (Drewett & Sheperdson, 1995; Harris & Rice, 1997). Therefore, research regarding the prevalence of mentally disordered offenders is likely to refer to a truncated sample of such individuals. This caveat must be kept in mind when reviewing the literature.

In addition, any consideration of prevalence rates within the criminal justice system must take into account the increasing population within gaols and prisons. The greater number of inmates over the past 20 years has certainly included a concomitant increase in the number of mentally disordered offenders. However, the proportion of mentally disordered inmates within this larger population is also likely to have increased. Ogloff (2002) reviewed population data for prison inmates and psychiatric patients in Canada and the

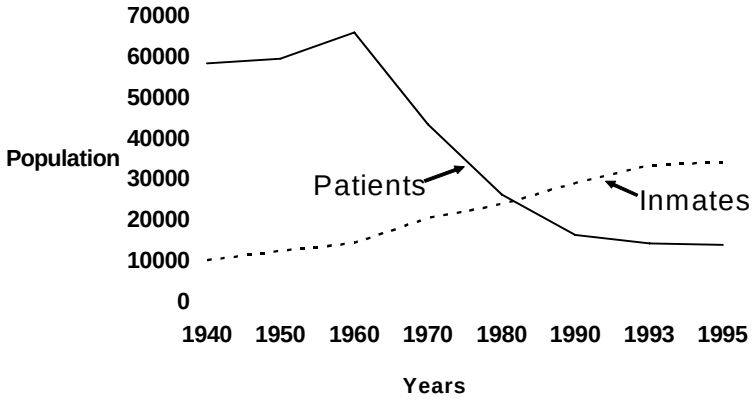
[1] Drewett and Sheperdson (1995) note that the term describes a legal category of persons in the United Kingdom, and cite the Home Office circular (66/90) and the Mental Health Act (1983).

United States from the years 1940 to 1995. He showed that as the population of psychiatric patients was dramatically reduced following deinstitutionalization, the number of prison inmates more than tripled. Similar results were found in Canada and the United States (see Figure 1 and Figure 2).

Ogloff acknowledged that these figures did not indicate causality, and thus stopped short of declaring that deinstitutionalization had caused the "criminalisation" of the mentally ill (see Teplin, 1983, 1991; Torrey, 1992). Nevertheless, he noted, "there can be little doubt that some of the people who might otherwise be detained in psychiatric hospitals are making their way into the criminal justice system." (p. 5). In many ways the question of causality is quite irrelevant. The fact is that the current levels of incarceration of mentally ill persons are the product of current mental health and criminal justice policies. In that sense, one isn't really concerned with whether deinstitutionalisation was the original cause.

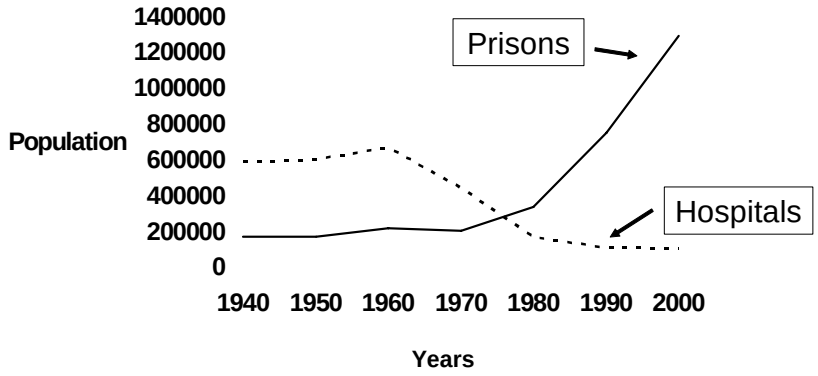
Gunn (2000) reported strikingly similar results for prisoners and psychiatric patients in England and Wales for the much shorter period of 1982-1997. Thus, this inverse relationship would appear to be a near-universal phenomenon[2] that would affect the number of mentally ill people having subsequent contact with the criminal justice system.

Figure 1. Populations of Psychiatric Hospitals and Prisons in Canada (1940-1995)



[2] In Britain this inverse relationship between psychiatric hospital beds and prisoners is referred to as "Penrose's law," after concepts described by Penrose (1939; see Gunn, 2000, for discussion).

Figure 2. Populations of Psychiatric Hospitals and Prisons in the United States (1940-2000)



Despite the aforementioned caveats and limitations, considerable literature does exist regarding the prevalence of mental disorder in the criminal justice system. This includes several recent studies across a range of countries, including Australia (Herrman, McGorry, Mills, & Singh, 1991; Mullen, Holmquist, & Ogloff, 2003; Ogloff, Barry-Walsh, & Davis, in preparation),[3] New Zealand (Brinded, Simpson, Laidlaw, Fairley, & Malcolm, 2001), Canada (Ogloff, 1996; Roesch, 1995), Ireland (Duffy, Linehan & Kennedy, 2006; Wright, Duffy, Curtin, Linehan, Monks, & Kennedy, 2006) and the United Kingdom (Brabbins & Travers, 1994; Brooke, Taylor, Gunn, & Maden, 1996; Howard & Christopherson, 2003). Notably, these studies show a consistently higher prevalence of mental illness in the criminal justice system than that found in the general population.

PREVALENCE OF MENTAL ILLNESSES IN CUSTODY

Gaols and Prisons

Several gross estimates of mental disorder among prisoners are reported in the literature. Mullen, Holmquist, and Ogloff (2003) conducted an extensive review of existing

[3] Ogloff (2002) compared the incarceration rates of Canada (110 per 100,000), Australia (110), the United Kingdom (125) and the United States (680). Despite the vast distance between Canada and Australia, the countries share many historical and contemporary similarities. The incarceration rates in both countries are virtually the same and they are somewhat lower than English rates and dramatically lower than American rates. There are many other similarities between the two countries with respect to public mental health and criminal law. As such data obtained from Canada and Australia may be particularly useful for comparative purposes.

Australian epidemiological data, collating data sets to arrive at composite prevalence data, as part of the forensic mental health scoping study. They concluded “that the prevalence of major mental illness among male prisoners is significantly greater than in the general population in the community” (p. 2). They reported that 13.5% of male prisoners, and 20% of female prisoners, had reported having prior psychiatric admissions(s). In regard to prisoners who reported having had a prior psychiatric assessment, these figures were a very large 40% and 50% respectively. These findings are astounding if one compares them to the general population. While comparable data are not readily available, it is safe to say that far fewer than 13.5% (1 out of 7) of men and 20% (1 out of 5) of women in the general populations have been admitted to hospital for psychiatric reasons. In the general population, fewer than 1% of adults are admitted to a hospital for mental health problems in any year (Australian Bureau of Statistics 1998). Moreover, certainly less than 40% (1 out of 2.5) of men and 50% (1 out of 2) of women in the general population ever receive a psychiatric or psychological assessment.

These results indicate not only that the prevalence of mental disorder is high, but that the proportion of those with mental illness is larger among the smaller population of female prisoners than it is for male prisoners (see also Walsh, 2003, for similar conclusions regarding mentally ill females in New South Wales). This is further supported by Brinded and colleagues (2000), who investigated New Zealand prisoners in what has been described as “one of the most well conducted studies on the prevalence of mental illnesses among inmates ever published.” (Ogloff, 2002, p. 7). They interviewed all female and male remand prisoners in New Zealand, as well as all female and 18% of male sentenced prisoners, with an overall completion rate of almost 80%. They found that, compared to sentenced male prisoners, females had a greater prevalence of mental disorder, particularly major depression and posttraumatic stress disorder, which were both twice as prevalent.

In an attempt to compare the relative number of people in the gaols and prisons who are mentally ill with those who are in psychiatric hospitals, Ogloff (2002) extrapolated from existing data concerning the prevalence of inmates with major mental illnesses in gaols and prisons. Figures 3, 4, and 5 depict the proportion of prisoners with major mental illnesses in Canada, Australia, and the United States. For comparative purposes, the figures also show the estimated number of patients detained in psychiatric hospitals.

Figure 3. Comparison of Mentally Ill Prisoners and Patients in Psychiatric Hospitals in Canada

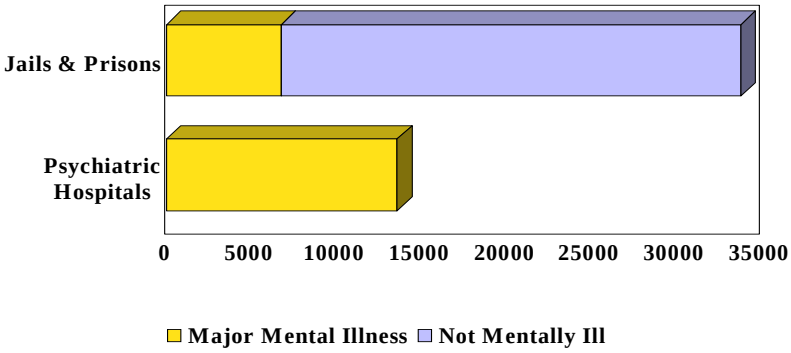


Figure 4. Comparison of Mentally Ill Prisoners and Patients in Psychiatric Hospitals in Australia

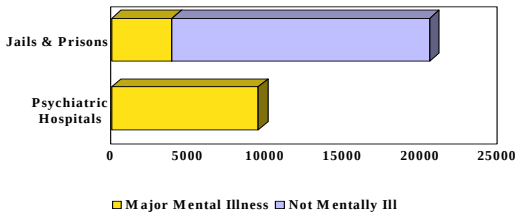
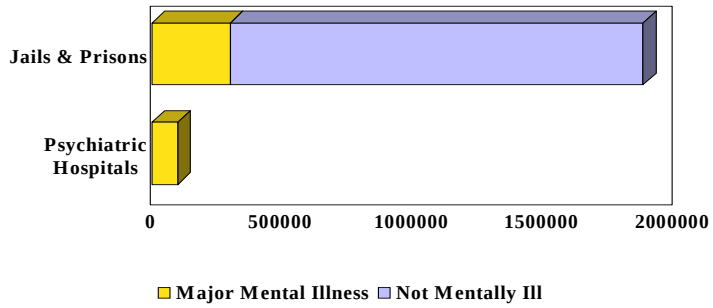


Figure 5. Comparison of Mentally Ill Prisoners and Patients in Psychiatric Hospitals in the United States[4]



Remand Prisoners

One consistent finding in the literature has been a high level of mental illness among remand prisoners and, when compared, a higher prevalence of mental illness for remand prisoners than for sentenced prisoners. Prins (1995) reviewed numerous studies and concluded that one third of the population of British prisoners required psychiatric treatment, but that this number would be higher among those on remand. Similarly, in Brinded and colleagues' (2001) New Zealand study, the male remand population had higher rates than the male sentenced sample for all categories of mental disorder that were studied. Additionally, Brooke and colleagues (1996) investigated 750 British remand prisoners (9.4% of unconvicted male prisoners) in England and Wales, by means of semi-structured interview and case-note review. They found that 63% of their sample could be diagnosed as having at least one ICD-10 mental disorder. Substance misuse disorders were the highest category (38%), however neurotic illnesses (26%), personality disorders (11%), and psychosis (5%) were quite prevalent[5].

Parsons, Walker, and Grubin (2001) investigated mental illness among 382 female remand prisoners in the United Kingdom. They found that 59% had at least one *current* mental disorder (*excluding* substance use disorders), including a large 11% with psychotic disorders. When substance dependence was included in the analysis the level

[4] Figures 1-5 are reprinted from Ogloff, J. R. P. (2002). Identifying and accommodating the needs of mentally ill people in gaols and prisons. *Psychiatry, Psychology, and Law,* 9, 1-33. Reprinted here by permission of the author.

[5] Due to considerable co-morbidity, it was impossible to gain a gross estimate of non-substance abuse disorders from the results of this study. Indeed, where 63% of the sample was identified as having at least one disorder, adding the individual totals for each disorder equalled 84.4%.

of current mental illness rose to 76%. Lifetime prevalence of mental disorders was 68% (not including substance dependence) and 81% (including substance dependence). Therefore, the higher prevalence of mental disorder among female inmates would appear to exist among the remand population as well.

Overall, these results indicate that not only are large numbers of prisoners suffering from mental illness, even larger numbers of mentally disordered offenders are being remanded prior to trial. The following section will be a more fine-grained analysis of the prevalence of particular mental disorders.

PREVALENCE OF SPECIFIC MENTAL ILLNESSES

Schizophrenia and Psychotic Illnesses

The results from various studies indicate that the prevalence of schizophrenia and other psychotic disorders is much higher within the criminal justice system than the general population. The Australian national forensic scoping study that was discussed above estimated that "up to 8% of male and 14% of females in… (Australian) prisons have a major mental disorder with psychotic features" (Mullen et al., 2003, p. 17). In regard to schizophrenia itself, Mullen and colleagues estimated that the prevalence was between 2-5% for prisoners, and was likely to be similar for those on community orders.

The estimates of Mullen and colleagues (2003) appear relatively consistent with the literature available from other countries. Nevertheless, the estimates for psychotic illnesses are somewhat higher. Mullen and colleagues acknowledge this in their manuscript, and suggest that meta-analyses of psychotic illnesses are predominantly concerned with schizophrenia, rather than the wider range of psychotic disorders.

The particular meta-analysis that Mullen and colleagues (2003) referred to was published in *The Lancet* (Fazel & Danesh, 2002). Using data from 49 world-wide studies of psychotic illness (19,011 prisoners), Fazel and Danesh reported an overall prevalence rate of 4% of prisoners having psychotic illnesses. When this was broken down, 4% of male detainees and 3% of male sentenced prisoners were diagnosed with psychotic illnesses (as the preceding discussion would suggest). There was some variability across studies, some (but not all) of which was explained by differences between research that used validated diagnostic procedures (3.5%) and those that did not (4.3%). Studies from the USA also showed higher prevalence rates than elsewhere (4.5% *c.f.* 3.3%). As may

also be expected from the previous discussion, psychosis among female prisoners was slightly higher than that in males (4.0% *c.f.* 3.7%).

As Mullen and colleagues (2003) suggested, the psychosis section of Fazel and Danesh's meta-analysis was chiefly concerned with schizophrenia. Thus, their findings are certainly consistent with those provided by Mullen and colleagues. The results are also consistent with a Canadian study by Roesch (1995),[6] which estimated that 4.9% of admissions to the Vancouver Pre-trial Services Centre were diagnosed with schizophrenic disorders. Additionally, the New Zealand study by Brinded and colleagues (2001) found prevalence rates for schizophrenia and related disorders *within the last month* to be 4.2% for women, 3.4% for remanded men, and 2.2% for sentenced men. The results are therefore relatively consistent across settings (see Table 1). Considering that the estimated *lifetime* prevalence rate for the general population is up to 1% (American Psychiatric Association, 1994, 2000), it is clear that the current (i.e., within the past month) incidence of schizophrenia among prisoners is many times higher.

Table 1: *Comparison of Prevalence Rates for Schizophrenia and Psychotic Disorders*

Country/Study	Male	Female	Total
Worldwide*	3.7%	4%	4%
Australia (schizophrenia)**	-	-	2% - 5%
Australia (psychotic, including schizophrenia)**	8%	14%	-
New Zealand (in last month) ^	2.2%-3.4%	4.2%	-
Canada (pretrial) ^	-	-	4.9%
General population (lifetime)^^	-	-	0.3%-1.0%

Note. *Fazel & Danesh (2002); **Mullen et al. (2003); ***Brinded et al. (2001); ^Roesch (1995); ^^Ogloff (2002).

Major Depression

Fazel and Danesh (2002) analysed 31 studies involving major depression (10529 prisoners) and found higher rates among females (12%) than males (10%). Somewhat surprisingly, the rates for male sentenced prisoners (11%) were higher than those on remand (9%), but this counterintuitive result did not hold for females (13% remand, 10% sentenced). Marked heterogeneity existed between the studies, particularly for those

[6] It should be acknowledged that the Canadian study by Roesch (1995) was one of the studies included in Fazel and Danesh's (2002) meta-analysis. The results are provided separately here to indicate the congruence between Canadian data and that from elsewhere.

involving males, where rates of depression were as low as 5% and as high as 14% in some individual studies.

The study by Roesch (1995) found a similar prevalence of 10.1% for major affective disorders, and a further 7.1% for dysthymic disorders (VPSC). Ogloff (1996) found that 15.7% of admissions to the Surrey Pre-trial Services Centre were diagnosed with major depression. Brinded and colleagues' (2001) New Zealand data indicated a point prevalence for major depression of 11.1% for women, 10.7% for remanded men, and 5.9% for sentenced men.

The Mullen and colleagues (2003) study estimated that depressive disorders in Australian prisons were somewhat lower, approximately 5% in males and 7% in females. They acknowledged that these estimates (based in part on "severe" total scores on the Beck Depression Inventory-II) were perhaps pertaining to a more restricted range of affective disorders than that described by Fazel and Danesh (2002). They also surmised that their estimates did not take account of the "chronically miserable who…are relatively common in prisons" (p. 27).

Nevertheless, the figures from this range of studies are considerably higher than what would be expected in the general population (see Table 2). The point prevalence of major depression is estimated to be 5-9% for females and 2-3% for males (American Psychiatric Association, 2000). The meta-analytic results of Fazel and Danesh (2002) are 2-3 times higher.

Table 2: *Comparison of Prevalence Rates for Major Depression*

Country/Study	Male	Female	Total
Worldwide*	10%	12%	5-14%
Australia**	5%	7%	-
New Zealand (in last month)***	5.9%-10.7%	11.1%	-
Canada (pretrial – major depression)	-	-	10.1%^-15.7%^^
Canada (pretrial – dysthymia) ^^	-	-	7.1%
General population^^^	2-3%	5-9%	-

Note. *Fazel & Danesh (2002); **Mullen et al. (2003); ***Brinded et al. (2001); ^Roesch (1995); ^^Ogloff (1996); ^^^American Psychiatric Association (2000).

Substance Use Disorders

While not often thought of as "mental disorders" in popular parlance, substance abuse disorders are a very important consideration in any discussion of mental disorder within the criminal justice system. The recent proliferation of high potency amphetamine-based substances has led to presentations that are often indistinguishable from major mental illness. Thus, they cause considerable diagnostic problems. Furthermore, substance use disorders are among the most prevalent "mental disorders" in the criminal justice system.[7] Roesch (1995) found that 85.9% of admissions to the Vancouver Pre-trial Services Centre in Canada received a substance use disorder diagnosis (77.6% alcohol abuse/dependence, 63.7% drug use disorders). Ogloff (1996) reported a prevalence of 60.9% of admissions to a similar correctional centre (Surrey Pre-trial Services Centre). Alcohol disorders were the most prevalent in Ogloff's study (24%), followed by cannabis (16.5%) and cocaine (10.2%). Polydrug use disorders were relatively common (15%).

Brinded and colleagues' (2001) study of New Zealand inmates also found high rates of substance-related disorders. Lifetime rates of alcohol abuse and dependence (39% and 35.6% respectively) and cannabis abuse (32.2%) were quite prevalent among remanded men. Among sentenced men substance use was also high (alcohol abuse, 40.6%; alcohol dependence, 35.3%; cannabis abuse, 33.2%).

It is also important to note that co-morbidity in the criminal justice system is perhaps the rule rather than the exception. This has been highlighted by recent research on dual diagnosis (Ogloff, Lemphers, & Dwyer, 2003). Ogloff and colleagues conducted structured interviews (using the structured clinical interview for DSM-IV substance use disorders) of all patients in a secure forensic psychiatric hospital in Victoria, Australia (including mentally disordered offenders, forensic psychiatric patients, involuntarily committed patients, and those on hospital treatment orders). Results showed that 74% "met the criteria for a substance abuse or dependence disorder at some time in their lives," while 12% met the stricter criteria for a current disorder (i.e., within the past month). This lower percentage is partly explained by the fact that the majority of patients had been in hospital or prison for longer than one month, thereby not having access to alcohol or illicit drugs.

The prevalence of dual diagnosis was highest among the offenders in the sample who were involuntarily hospitalised and transferred to the secure psychiatric hospital from

[7] Substance use disorders are included among the mental disorders included in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR, 2000).

prison. Fully 100% of remanded offenders met the criteria for a lifetime diagnosis and 29% met current criteria for substance abuse or dependence. Additionally, 92% of sentenced offenders met lifetime criteria.

Particularly concerning in the study by Ogloff and colleagues was the fact that only 8% (of the entire sample) had formal diagnoses of co-morbidity noted in their clinical files. This indicates that substance use disorders, while highly prevalent, do not seem to be as frequently noted by mental health staff as other illnesses such as psychosis. Such clinical practices are particularly problematic, as co-occurring substance abuse and schizophrenia is a potent risk factor for future violence.

RISK FACTORS FOR THE DEVELOPMENT OF MENTAL DISORDER

It is perhaps prudent at this stage to briefly examine the potential risk factors for developing a mental disorder amongst those who have contact with the criminal justice system. A useful overview of this topic was provided by Singleton, Meltzer, Gatward, Coid, & Deasy (1998) who conducted a study of psychiatric morbidity among prisoners in England and Wales. They examined a range of information regarding life events and suggested that some may be considered risk factors for the development of a mental illness. They wisely noted that these were not necessarily the *causes* of mental illness, adding that without information regarding the onset of illness in their sample, some factors may be the result of a mental disorder. Nevertheless, they divided these risk factors into five main areas: childhood factors, living arrangements, stressful life events, victimization during prison, and intellectual functioning.

Singleton and colleagues (1998) used multiple logistic regression, a form of multivariate statistical analysis, to examine the individual contribution of each of their potential risk factors for particular mental disorders. In regard to psychotic disorders, attendance at a special school had an odds ratio of 1.65 with subsequent psychosis. Those living alone had twice the odds of psychosis than couples with children. Being unemployed also increased the odds of a psychotic disorder (odds ratio = 1.71). In regard to stressful life events, sexual abuse (thrice the odds), experiencing bullying (twice the odds), homelessness, and the stillbirth of a child were all independently associated with psychotic disorders. Finally, lower scores on a screening test of intellectual functioning called the “Quick Test” increased the odds of psychosis.

In regard to “neurotic” disorders, Singleton and colleagues (1998) reported no association with childhood circumstances or living arrangements. Stressful life events were

significantly related to neurosis, such as sexual abuse, having a spouse die, or having a stressful event in the previous six months. Nevertheless, the biggest association with neurotic psychopathology was the number of stressful events experienced. Experiencing 3-4 stressful events had an odds ratio of 2.35, with the odds increasing with each event experienced. Prisoners who reported “11 or more events had an adjusted odds ratio of 18.27” (p. 279). Unsurprisingly, victimization in prison was also related to neurosis, more so for violent threats than stolen property.

These “risk factors” provide useful information about some of the life events experienced by mentally disordered offenders in the British prison system. It is clear however, as acknowledged by Singleton and colleagues (1998), that many of these areas can be envisaged as the results of mental illness. For example, unemployment and homelessness are perhaps classic indications of the social withdrawal characteristic of many people with schizophrenia and other psychotic disorders. Nevertheless, perhaps the real value of these results is that they underscore the substantial difficulties that mentally disordered offenders have experienced in their lives, and thus highlight the need for appropriate mental health care within correctional services. It is important to note that many of the risk factors for mental illness are also risk factors for offending and imprisonment (Bonta, Law, & Hanson, 1998).

SERVICE UTILISATION PATTERNS FOR MENTALLY DISORDERED OFFENDERS

Prior to Incarceration

In the excellent and comprehensive New Zealand study reviewed above that was conducted by Brinded and colleagues (2001; Simpson, Brinded, Laidlaw, Fairley, & Malcolm, 1999), 58.2% of female inmates, 56.4% of remanded males, and 68.8% of sentenced males reported that they had received *no* treatment prior to entering prison. Most who had received treatment had attended a primary and community agency (21.6%, 20.4%, and 14.8% respectively). Prior specialist outpatient (9.9%, 7.8%, and 6.4%) and inpatient treatment usage (9.9%, 15.3%, 9.9%) was quite a bit lower (Simpson et al., 1999).

Singleton and colleagues (1998), in the aforementioned study of psychiatric morbidity among prisoners in England and Wales, found somewhat similar levels of prior “help for mental or emotional problems in the year before coming to prison” (p. 228). The fact that they looked at the year prior to prison should caution any direct comparison with the results of Simpson and colleagues (1999) and Brinded and colleagues (2001). Women

were twice as likely to have received help (40% of both remand and sentenced prisoners). Males were considerably lower (21% remand and 18% sentenced). The most common professional help was provided by GPs or family doctors (approximately two-thirds). Singleton and colleagues noted, perhaps unsurprisingly, that those with a mental disorder had higher rates of service usage prior to prison. This was particularly so for those with a psychotic disorder (65% male remand, 58% male sentenced, 79% female remand, 83% female sentenced). Despite the higher rates of those receiving treatment than the non-mentally disordered, the large number of people with psychotic illnesses who were not being treated prior to committing offences is a somewhat alarming statistic.

In Victoria, Australia, a stratified sample of approximately 500 offenders were surveyed concerning their mental health history and assessed to determine mental health problems and illnesses (Ogloff et al., in prep). The offenders were asked if they had ever been assessed or received treatment by a psychiatrist or a doctor for an emotional or mental health problem. Overall, about half (51.4%) of prisoners responded in the affirmative. Of those prisoners who had received treatment or assessment for an emotional or mental health problem, about a third had been admitted to a psychiatric unit or ward in a hospital as a result. This suggests that around one in six or seven prisoners would have experienced admission to a psychiatric unit or ward. The similarity in percentage across groups is rather striking.

During Incarceration

In regard to those receiving treatment while in prison, Brinded and colleagues (2001) reported varied results for different categories of mental disorder. Those with a lifetime diagnosis of bipolar disorder were most likely to be receiving treatment in the prison (80.8%) followed by obsessive-compulsive disorder (55.3%), major depression (46.4%), and posttraumatic stress disorder (41.4%). Of concern, only 37% of those with schizophrenia, or a related disorder, were in receipt of treatment at the time; although Brinded and colleagues acknowledged that the researchers did not ask prisoners if they had refused treatment that had been offered. Therefore, these figures may exaggerate the concern somewhat. Nevertheless, these do appear to be of some concern and indicate that the treatment opportunities for prisoners with major mental illnesses may be less than optimal.

In the England and Wales prisoner study, Singleton and colleagues (1998) reported that a smaller proportion of people were receiving help for mental health problems in prison than they were outside. Nevertheless, the pattern of service usage remained relatively similar,

with two-thirds receiving help for mental health problems from the prison doctor. The results showed that more women than men were utilising services, and violent offenders more so than property or drug offenders. Offenders with psychotic disorders were most likely to receive some form of help for emotional problems, however, the numbers were still quite low (47% male remand; 47% male sentenced; 50% female remand; 69% female sentenced). It should be noted that these figures include all forms of helping professional, from the prison doctor (the most utilised) to the chaplain or probation officer. When analyses were restricted to psychiatric health professionals the level of service usage among those with psychosis dropped even further (25% male remand, 35% male sentenced; 38% female remand; 59% female sentenced). Therefore, while not quite at the levels reported by Brinded and colleagues (2001) for New Zealand, the figures are alarmingly low, further suggesting that treatment opportunities in prison for prisoners with major mental illnesses may be less than optimal.

In the Australian study, Ogloff et al. (in prep.) found that 15% of prisoners surveyed were receiving psychiatric medication while incarcerated. The figure was highest for female prisoners (25.3%) versus male prisoners (11.8%) who reported taking current medication. The most common form of psychiatric medication that prisoners reported taking was anti-depressants. Apart from medication, around 40% of respondents reported having received support, counselling or treatment for a mental health problem from a psychologist while incarcerated.

Within the population of prisoners with a mental illness, there is a small group of offenders with an array of disorders or disabilities that demand a grossly disproportionate portion of the resources. While relatively little research has been conducted with this group, preliminary research in Victoria suggests that some 250 people with “multiple and complex needs” (i.e., mental illness, substance abuse, brain injury, intellectual disability, functional impairment, absence of social supports, disruptive or dysfunctional behaviour, violence to self, and absence of living skills) absorb 56 million dollars in resources annually (Department of Human Services, 2003). The vast majority of these people are either in the criminal justice system or have a history of such contact. Such a profile of cases led to the development of a unique legislative initiative to attempt to deal more effectively and more efficiently with this group (Human Services (Complex Needs) Act, 2003). As the legislation has been implemented, the majority of patients identified with complex and multiple needs have offence histories. The primary policy problem with this group is not that their disabilities are not known, but that the combination of problems precludes effective treatment and support interventions – both when in the criminal justice system and when in the general community.

Taken together, existing information suggests that in general a relatively poor job is done adequately identifying the needs of mentally disordered offenders prior to the time they enter the criminal justice system (indeed, it has been said that any need for a forensic psychiatric system arises from a failure of the mainstream mental health system). Indeed, by default, the justice system becomes the repository of many of those that fall through the gaps in the mainstream mental health system, but then isn't organised or resourced to identify or respond to them.

MODELS FOR POLICE RESPONSES TO MENTAL DISORDER

Police services are typically the first point of contact with the criminal justice system for most people, including those suffering from a mental disorder. Two common law principles anchor police involvement: a) protection of the public, and b) protection of disabled citizens or parens patriae (Teplin, 2000). Accordingly, police officers have essentially four choices when they are faced with an individual who is behaving irrationally. They can attempt to informally resolve the issue, contact the crisis assessment and treatment team (or equivalent), take the person to a hospital, or arrest them. The increased prevalence of mentally disorder in gaols would suggest that, at least in the past, arrest has been a predominant option. This is particularly problematic for those people with mental illnesses who are arrested and detained without bail (i.e., when either a serious offence has occurred, the person has a history of breaching bail, or has no social supports). For example, Teplin (1984; see also Teplin, 2000) reported data from the United States involving 506 people considered to be suspects in a crime. Of these, 30 (6%) showed signs of a mental disorder. Nonetheless, 47 percent of these 30 people were subsequently arrested, compared with only 28 percent of the 476 people who did not show overt signs of mental disorder.

Police have traditionally viewed their interactions with mentally ill people as a problematic and undesirable part of their duties. For example, the Police Association submissions to State Parliamentary and Senate Select Committees inquiring into mental health issues (Burgess 2005; Carroll 2005) argued that police are required to fill gaps in the mental health system, that the overly burdensome role police have been forced to bear in relation to mental health needs to be ameliorated, and there needs to be mandatory liaison between police and mental health practitioners.

One of the key issues in policing in recent years has been how to prevent the lethal use of force by police when dealing with violent mentally ill people. The Victorian Office of Police Integrity review (Office of Police Integrity, 2005) identified a range of problems,

including a lack of effective risk management, a culture in which self-assessment, review and improvement are given insufficient attention, and a diminution of essential police training to accommodate other organisational priorities. The OPI recommended that the "Memphis Model" (which will be discussed later in this report) was not suitable for implementation in Victoria, and called instead for more attention to developing "arrangements designed specifically for Victorian circumstances." (p.39). The OPI also noted that the protocols between Victoria Police and DHS "do not appear to be well understood" by police or mental health professionals.

The Drug Use Monitoring Australia (DUMA) research by the Australian Institute of Criminology provides a picture of the prevalence of mental disorder in people arrested by police (Schulte et al., 2005). The DUMA survey is conducted at selected police stations in Queensland, New South Wales, South Australia and Western Australia[8]. Interviewers ask arrestees whether they have ever been a psychiatric in-patient and the month and year of last admission. The proportion of arrestees reporting an admission in the last year has been fairly stable nationally at 5-6%. In the last part of 2004 they also administered the Kessler Psychological Distress Scale to arrestees. Thirty percent of arrestees scored "very high" (30 – 50) compared with 4% of the general population in the National Health Survey.

In regard to current approaches to policing those with mental health issues, the literature suggests several models. Shoobridge (2006) reported that New South Wales will soon have nine Psychiatric Emergency Care (PEC) units for people presenting to emergency departments with mental illness. A trial indicated that police involvement in transporting persons with mental disorder was substantially reduced due to this system (indeed, Shoobridge described the "total removal" of this need during the trial, p. 18).

Several policing models have been employed in the Unites States. As the name suggests, the training model involves training all police officers in mental health issues. Conversely, the expertise model involves teams of police officers and non-sworn mental health clinicians. Finally, there is what is commonly known as the Memphis model. This involves crisis intervention teams or "first responder" teams comprised of police with specialist mental health training. They liaise directly with mental health services, with whom they have a no-refusal agreement (Shoobridge, 2006).

Of the three models, the training model is considered easy to implement, but crisis management skills are reportedly difficult to maintain in the long-term. The expertise

[8] A Victorian site will be added to this research in the near future.

model, while intuitively sensible, has been associated with more police cost and slower response times. Conversely, the Memphis model is associated with decreased waiting time for police, reduced police injury, and subsequent improvements in medication compliance. It is also considered the most cost effective and is now considered “best practice” in the literature (Dupont & Cochran, 2000; Shoobridge, 2006). There are also additional models which involve mental health clinicians responding with police on an ad-hoc basis at the scene. Lamb, Weinberger, and DeCuir (2002) suggested that such an approach reduces unnecessary arrests. Additionally, Shoobridge (2006) indicated that such models facilitate greater liaison between police and mental health, as well as a carefully controlled sharing of relevant information. Nonetheless, she expressed caution in merely adopting these models in Australia without due consideration of the local context.

SCREENING FOR MENTAL DISORDER IN THE CRIMINAL JUSTICE SYSTEM

As can be readily appreciated from the preceding discussion, the increased prevalence of mental disorder in the criminal justice system indicates that identifying such disorders is of paramount importance. It is clearly not fiscally possible, nor particularly desirable, to conduct a comprehensive mental health assessment with every person who comes into contact with the police, the courts, or the correctional system. As such, screening is vital to identify those that do require a comprehensive evaluation. However, the literature indicates, even to this day, that mental health screening within such services has been quite ineffective (Birmingham, Mason, & Grubin, 1997; Birmingham & Mullee, 2005; Gavin, Parsons, & Grubin, 2003). Indeed, British data has estimated that 75% of men and 66% of women with major mental disorders are missed by some screening processes (Gavin et al., 2003; Parsons, Walker, & Grubin, 2001). This is clearly unacceptable and improved means of screening are definitely required. In this section we describe the overall goals of screening and discuss and evaluate several of the notable screening tools described in the scientific and scholarly literature.

Goals of Screening for Mental Disorder

There are several aims involved in screening for mental disorders in the criminal justice system. These were summarised by Nicholls, Roesch, Olley, Ogloff, and Hemphill (2005), who cogently noted the following

(1) to identify Mentally Disordered Inmates (MDIs) and provide necessary treatment/intervention in an expedient fashion, thus improving their well-being; (2) prevent

violent (i.e., against self and others) and disruptive incidents in correctional institutions; (3) allocate limited resources to those with the greatest or most immediate need; and (4) reduce the cycle of admissions to criminal justice, health and social welfare systems (p. 2).

It is perhaps worth noting that screening tools should be designed to sacrifice specificity for the sake of sensitivity. For example, it is better to have several “false positives” (those identified as possibly being mentally disordered who are not) in order to avoid a small number of “false negatives” (failing to identify an actually mentally disordered person).

Screening Tools and Instruments

Before discussing the individual screening tools described in the literature, it is perhaps worth noting that clinicians and other decision makers have historically been reticent to use structured or actuarial schemes for most predictive tasks (see Grove & Meehl, 1996). Nonetheless, formal methods of prediction and assessment have been found to be superior to those made solely on the basis of the assessor’s clinical judgment. A meta-analysis by Grove, Zald, Lebow, Snitz, & Nelson (2000) analysed 136 studies with 617 comparisons between mechanical actuarial prediction and subjective clinical prediction. These included a wide range of criterion variables, including diagnosis of congenital heart disease, academic performance in university, length of hospitalisation, personality characteristics, and 11 studies involving recidivism, assaultive behaviour, juvenile delinquency, or parole/probation success. Of the 136 studies, 64 favoured the actuary, 64 showed equal results, and eight favoured the clinician. Formal schemes offer several advantages. They promote reliability and validity and offer reasonably transparent decision making. Conversely, clinical judgment, while inherently flexible and attentive to idiographic features, can be unreliable and often lacks transparency. The results of the meta-analysis of Grove et al. (2000) suggest that predictive validity is also compromised. It would therefore be prudent to consider the use of a formal scheme for the task of screening for mental disorder.

Several formal screening tools have been described in the literature. It should be noted that the development of such tools is often very difficult, essentially because it is often difficult to recruit control subjects (i.e., those with no history of mental illness or symptomatology; see Schechter & Lebovitch, 2005 for discussion of this issue). In this review we will focus upon the most well known actuarial and structured tools.

Referral Decision Scale *(RDS; Teplin & Swartz, 1989).* The RDS is a 15 item tool comprised of three scales: schizophrenia, manic-depressive illness, and major depression. It was developed because most clinical tools, such as personality inventories, are too lengthy for assessing large numbers of inmates, as well as the paucity of mental health professionals in some correctional services, the poor reading skills of some inmates, and the lack of demonstrated validity for many clinical tools in gaol settings (Teplin & Swartz, 1989). The RDS items were derived from a larger tool known as the Diagnostic Interview Schedule (Robins, Helzer, Croughan, & Ratcliff, 1981).

Each of the RDS scales is comprised of five items. Cut off scores are two for the depression and schizophrenia scales and three for the bipolar/mania scale. When compared to subsequent assessments the RDS has reported respectable validity. Nonetheless, Hart, Roesch, Corrado, and Cox (1993) described unacceptably large numbers of false positive errors when using the RDS. They reported that altering the cut off score for the depression scale somewhat improved its predictive efficiency.

The RDS was used in the prisoner health study conducted in Victoria in 2003; however, it produced an extraordinary number of false-positives (e.g., indicating that as many as 40% of prisoners had symptoms of schizophrenia). Only by adjusting the cut scores were the data made useful for estimating the actual percentage of prisoners with symptoms of major mental illnesses (Ogloff et al., 2004).

The Brief Jail Mental Health Screen *(BJMHS; Steadman, Scott, Osher, Agnese, & Robbins, 2005).* The BJMHS is a briefer revision of the RDS that uses a single composite scale rather than the three scales on the RDS. This was reportedly because the various RDS scales were not particularly discriminative. The BJMHS consists of eight items and takes a mere 2.5 minutes to complete. Steadman and colleagues reported that when compared to data from the Structured Clinical Interview for DSM-IV (SCID), the new tool correctly classified 73.5 percent of males but only 61.6 percent of females (with high false negative rates in females – that is missing those women with actual mental illness).

The Jail Screening Assessment Tool *(JSAT; Nicholls et al., 2005).* The JSAT differs from the previously mentioned tools in that it is not an “actuarial” tool (i.e., it does not utilise cut scores for identifying people requiring further assessment). Rather, the JSAT is an example of structured professional judgment, a decision-making approach in which professional judgment is guided by a formal, standardised structure (Douglas, Ogloff, & Hart, 2003). The JSAT is also unique in that it involves screening inmates for violence and victimisation as well as self-harm, suicide, and mental disorder. It takes

approximately 20 minutes to complete and does require training and clinical expertise. Validation data reported by Nicholls and colleagues indicated that the JSAT has a very high degree of validity. Indeed, 100 percent of those identified as having psychotic illnesses, obsessive compulsive illnesses, or suicide risk, were subsequently referred to a mental health program.

It is important to note that in addition to screening for mental illnesses, *per se*, the screening instruments and approaches employed should be sensitive to the presence of related mental disorders (e.g., acquired brain injury).

SCREENING FOR MENTAL DISORDER IN THE AUSTRALIAN CRIMINAL JUSTICE SYSTEM: INFORMATION FROM ACROSS THE COUNTRY

Beyond reviewing the relevant literature and identifying existing tools for identifying mentally ill people in the criminal justice system, a large focus of this consultancy was to obtain systematic information from the states regarding current practice. In this section, we detail the procedure we employed to obtain information about the ways in which people with mental disorders are identified in the criminal justice system throughout Australia.

The experience of conducting the meetings and interviews across the country was powerful. Very often participants identified a plethora of issues that extended well and truly beyond the consultancy. At virtually every meeting we convened, many participants were meeting one another for the first time. This speaks volumes about the general disconnect present within government agencies in many jurisdictions. While this might be more understandable in the larger jurisdictions, we found it just as likely in less populated states.

INTERVIEWS AND MATERIALS

As part of the consultancy process, contact was made with key contact people in the criminal justice system in each of the states and territories of Australia. The process was an involved and ongoing one. Initially, a meeting was held with the CRC Consultancy Group for this project (see Appendix A). The Consultancy Group consisted of members from each of the Australian states and territories as well as some CRC staff. Group members were initially asked which agencies and individuals in their states should be contacted. Group members were then contacted individually to assist with identification and contact with people in their jurisdictions. Many of the members also facilitated the in-person meetings that were held in all of the states.

As part of the initial process of the project, a letter was circulated by the Chairman of the Criminology Research Council to the heads of jurisdictions and relevant department secretaries/directors. A three page summary of the project, developed by the project team, accompanied the letter. Although the exact constituency of agencies consulted in the course of the project varied across the states and territories, core services were identified in each jurisdiction. This involved contact with police services, corrections (prisons and community), forensic mental health, juvenile justice (in some states), and the court system. Overall the response was very positive. Face-to-face meetings with contact

people from each service were conducted in each of the six states and telephone interviews were held with each of the territories. Individuals were then followed-up to obtain specific information as required. These interviews, and ongoing discussions, provided a rich pool of qualitative information which illuminated the broad trends in mental disorder screening across the jurisdictions – as well as key differences.

The information provided below is based upon the interviews and collateral documentation graciously provided by the contact people in each service. Although we initially expected to be able to provide tables detailing the approached used by various agencies across states, this proved impossible. Some agencies refused to participate in the project outright. Many others agreed only to participate if the information provided was not specifically linked back to their agencies. We realised that to obtain the richest and most complete information it was necessary to assure participants that we would present the material obtained in the consultation in a broad manner, identifying trends and differences without naming each particular service. In the end, while unable to detail the circumstances in each state explicitly, we believe we obtained more complete and frank information than would have otherwise been the case. Thus, the information we obtained enables us to provide an overview of approaches (or lack thereof) to mental disorder identification and screening within justice agencies across Australia without singling out any particular service. We felt that this was the most appropriate use of the information provided while ensuring the confidentiality of the agencies interviewed specifically.

DATA LIMITATIONS

In regard to corrective services, contact was made with people from each of the eight jurisdictions. However, one corrective service indicated that while they were using screening tools they acknowledged that these had been identified as being inadequate. Thus, they were in the process of reviewing their practices in order to replace what they perceived to be an inadequate instrument with one that would be more satisfactory. Accordingly, we chose to leave this service out of the review due to the changing nature of their policy. Nonetheless, it is positive that reviews had been made regarding the adequacy of their screening process. In regard to police services, it must be acknowledged that we were unable to make contact with appropriate contact people in one jurisdiction. Furthermore, we were unable to obtain information from juvenile justice services in one jurisdiction as the process they required us to complete in order to interview senior staff was not feasible given the time and resource constraints of the project. Given the nature of juvenile justice services we understood this reluctance. Regardless of the limitations on the data, the trends presented below can still be

considered reflective of mental disorder screening and identification within the Australian criminal justice system.

RESULTS AND TRENDS

Before discussing the trends and themes identified across the various components of the criminal justice system, it is perhaps worth noting one particular issue that was of considerable concern across most jurisdictions and services. The interviews indicated that substantial difficulty is often experienced by services outside of the capital cities. While this was particularly notable in the geographically larger jurisdictions, such concern was reflected across the country. Similarly, some jurisdictions described the further difficulty of providing appropriate services to indigenous offenders and arrestees.

We will now discuss the results across each component of the Australian criminal justice system.

POLICE SERVICES

An overarching theme of most police services' views on mental disorder was that this is a health issue rather than a police issue per se. Nonetheless, police are left in the unenviable position of being the first point of contact with mentally disordered individuals, especially as mental health crisis teams are often understaffed and under-resourced, particularly during the after hours period. Moreover, understandably, mental health crisis and assessment teams often will not respond to a situation whether their members could be put in danger. Furthermore, the definition of mental illness used in health services is quite narrow, leaving police services with the frustration of identifying a person whom health services do not admit for treatment. Co-morbid substance abuse and mental illness (as well as brain injury, intellectual impairment, etc.) was also identified as a frequently encountered presentation that poses additional diagnostic and logistical problems.

There was considerable heterogeneity in screening practices across the various police services in Australia. Nonetheless, five of the seven services described having formal memoranda of understanding between police services and health/mental health services. In each jurisdiction, the police reported that they took the issue of mental disorder very seriously, with formalised procedures developed for interactions between police and

mentally disordered offenders.[9] It was estimated by one service that 50% of high risk incidents that come to police attention involve mental illness. Another noted that calls regarding people with mental illness increased by approximately 10% each year. Accordingly, each service also noted the increased need for training of police officers in the basic features of mental illness. This was generally accompanied by an acknowledgement that more training would be required in the future. It would seem that police officers on the street would be able to identify people with psychotic illnesses characterised by overt positive symptoms.

Police struggle with mechanisms to identify mental disorder in the people with whom they come into contact. Considerable frustration was commonly expressed regarding the lack of perceived services police had to deal with people officers identify as being mentally disordered. Part of the concern comes from the fact the when the police see someone who appears mentally disordered, the causes of the person's disorientation can be varied (e.g., mental illness, substance abuse or intoxication, broad mental disorder such as acquired brain injury, and difficult behaviour). If the disturbance is not attributed to mental illness, as defined by the states' mental health acts, there is very little that police can do for the individual. In one state, police noted that even when they try to identify mental illness in the people with whom they come into contact, they are criticised by mental health practitioners about the propriety of the police forming any judgment that an individual may be mentally ill.

In no jurisdiction did police officers have any structured screening device upon which they could rely to assist them to determine whether individuals likely have a mental disorder, broadly defined. Police officers must rely upon their experience and limited training to try to determine whether individuals are mentally ill. Given the unstructured nature of the process by which police can identify if one is mentally disordered, their capacity is affected by the level of training they have in the area of mental disorder. While it is beyond the scope of this consultancy to explore the training that police officers receive, the topic was covered in each of the interviews with police. The level of formal training provided to police regarding mental illness varied quite noticeably around the country. In most jurisdictions, police receive very little training (as few as three hours) dedicated to mental illness and the identification thereof.

Unsurprisingly, given the difficulties for the police trying to identify mental illness in people with whom they come into contact, identification and screening for mental disorder

[9] While memoranda of agreement and other protocols between police and mental health were common, it was commonly acknowledged that the documents are not well understood by police or simply do not, in practice, meet the needs of the police in their work (see Office of Police Integrity, 2005).

generally takes place in the police lockup or watch house. One jurisdiction indicated that this screening process was conducted by general health or psychiatric nurses as part of the health screen. The screening assessment tool that they used was considerably detailed.

Detailed screening was not limited to the use of nurses, as one jurisdiction reported that police officers screen everyone in their lockups. Generally there is liaison with health staff where appropriate, especially in the major cities. Two jurisdictions reported conducting no formal screening for mental disorder; although, access to mental health services/medical practitioners is sought when indicated. A further two jurisdictions reported that some questions pertaining to mental disorder are included in a broader health questionnaire administered by general health nurses.

Despite most jurisdictions adopting formal memoranda of understanding with mental health, and three identifying themselves with the previously mentioned “Memphis model,” communication of mental disorder information with health and correctional services appears to be frustrating – with more restrictions seemingly placed on police gaining information than providing it. Due to privacy concerns by health and mental health services, police in virtually every jurisdiction expressed concern that they are unable to obtain mental health information about individuals that they perceive is vital to identifying their mental illnesses. Some communication has been facilitated by means of ad-hoc agreements rather than official policy. It was pointed out by some that such arrangements are often contingent on personal contacts made between the police and mental health services.

COURT SERVICES

Through the course of the interviews it was determined that formalised court liaison programs/services exist in most states in Australia. Some services are particularly well-developed with a large number of staff who cover many lower courts (i.e., 20). Court liaison services would appear to be an integral part of the court system with services expanding along with the target groups they serve. These services are usually provided by forensic mental health and are usually staffed by psychiatric nurses although psychologists work in some jurisdictions. One service reported conducting “proactive checks” against the mental health register to determine if they should be aware of particular court attendees that may require their services. Such services show great promise for identifying individuals before the courts who are mentally ill or who require services.

There are now a variety of programs that have been developed internationally which are aimed at early identification of risks and needs for persons arrested by police. One example of such a program at a local Australian level is the CREDIT/Bail Support Program (Alberti, King, Hales, & Swan, 2004) that operates in Victoria. This program operates at nine Magistrates Courts across Victoria in order to provide a range of services to offenders on bail with alcohol and other drug problems (Department of Human Services, 2005).

The goals of these diversion programs include screening persons arrested for a range of risks and needs (including mental illness) and linking them with treatment and support services. This program model raises the question of whether screening should be done by police, or whether it is better to use specialised assessment and referral services. Research conducted in Brisbane found that police receive little training in how to deal with mentally disordered offenders and do not see much value in acquiring this kind of knowledge or expertise (Ebert, 2005). Ebert's recommendation is that responsibility for assessment and intervention needs to be vested in trained service providers.

CORRECTIVE SERVICES AND FORENSIC MENTAL HEALTH

Unsurprisingly, screening is most extensive within the incarcerated population in remand centres. In most jurisdictions the mental health screening forms part of a larger health screening and the screening is generally completed by health nurses. There are typically a limited number of questions asked of prison detainees (e.g., past suicide/self-harm, have they seen a mental health professional in the past, do they have mental health problems). Nonetheless, there is considerable heterogeneity in approach.

In a few jurisdictions, specific mental health assessments are conducted in addition to the general health screening. This approach reflects best-practice in the literature (Nicholls et al., 2005; Ogloff, 2002). Most corrective services that have separate mental health screening reported that the screening was conducted by staff from forensic mental health services, although this was not uniform. Admissions through remand assessment services ranged from averages of two to 40 each day depending on the jurisdiction. Screening is conducted by varying disciplines: psychiatric nurses (mostly), psychologists, general nurses, and counsellors. Systematic screening tools specifically developed for mental illness screening were described by two jurisdictions. Each reported that the instruments take approximately 20 minutes to administer.

Following admission to the correctional facility, developing mental illnesses are generally identified by corrections officers, nurses, or by self-report. No jurisdictions have any ongoing assessment or screening service that monitors prisoners' mental health status. Nonetheless, several jurisdictions do conduct re-assessments as required. Understandably, suicide risk assessment was a key focus within correctional environments. Training of correctional officers in regard to mental health issues was variable – in form, content, and duration.

COMMUNITY CORRECTIONS

Discussion with community corrections services indicated that most employ the services of officers with post-secondary education and that they are expected to identify mental health concerns of the offenders they are supervising. In some jurisdictions psychologists are employed by community corrections, though their background and qualifications are variable (i.e., whether they are clinical psychologists). Nonetheless, forensic mental health services are also utilised in virtually all of the states to work with community corrections – to varying capacities. In the geographically larger states, and the Northern Territory, there was an expressed difficulty in providing mental health services in regional areas. The difficulty of providing appropriate services to indigenous offenders was also reported by many states.

JUVENILE JUSTICE SERVICES

What was notable by the participating juvenile justice services was the greater focus on detailed assessments of health in general, including mental health issues. This greater assessment focus is essentially because there are fewer clients. Indeed, one service reported that health assessments are conducted for up to an hour. Ongoing monitoring is arguably more sensitive in juvenile justice because a case management approach is utilised in most jurisdictions.

Formal screening tools were mentioned by just two services, one of which is due to discontinue its use. This does not indicate that the services are not being thorough. Indeed, the dearth of formal screening tools in juvenile justice appears to be due to the greater focus on clinical assessment. One service also reported that they were not proponents of a "one size fits all" approach and when mental illness is suspected, clinicians are free to choose psychological tests and assessment procedures that they feel are appropriate to the individual case. This does not speak to the need to conduct screening of all offenders, not just those about whom the staff have some concern.

FISCAL ANALYSES OF PRISON AND POLICE LOCK-UP MENTAL HEALTH SCREENING

The preceding review indicated that the use of formal screening tools is the exception rather than the rule in the Australian criminal justice system. It is our view, and the dominant view in the literature, that formal screening tools are the most appropriate method for obtaining reliable and valid results from mental illness screening. This is certainly true in the case of screening in prisons, juvenile justice, police lock-ups and perhaps court liaison. As such, we now provide an economic analysis of the two most complete approaches uncovered by the review. These are the screening processes used within Victorian police lockups by custodial nurses (Appendix B) and by psychiatric nurses from the Victorian Institute of Forensic Mental Health (Forensicare) for Corrections Victoria at the Melbourne Assessment Prison (Appendix C) and that used. It should be noted that the Forensicare tool was based upon the gold standard identified in our literature review – the JSAT (Nicholls et al., 2005)(Appendix D). Accordingly, it takes roughly the same amount of time to complete (20 minutes on average). Thus, the fiscal analysis for the Forensicare tool would also apply to implementation of the JSAT. The measure used in Victorian police lock-ups includes both health and mental health components. The mental health components are also very similar to the JSAT (although briefer and with no Brief Psychiatric Rating Scale which forms part of the JSAT). The time it takes to complete the mental health section is approximately 10 minutes in addition to general health screening that takes place during the same process.

The cost of conducting mental health screening in prisons and police lock-ups are analysed below. The costs are based on the Victorian costs; however, in institutions with too few assessments to employ mental health screeners on a full time or casual basis, the individual costs of screening would be greater.

Mental Health Screening at an Assessment Prison

The number of people being admitted per day for mental health assessment in assessment prisons – on average is estimated in Table 1 by multiplying the number of visits per day in Victoria (this number has established by Forensicare as 15 per day) and then weighting this figure for each state by:

- the population in each state as a percentage of Victoria's population; and
- taking into consideration the level of imprisonment in each state as compared to Victoria (i.e. the % of population imprisoned as a proportion of the % of population imprisoned in Victoria).

Table 3: State and national estimates for the number of people being admitted per day for mental health assessment in assessment prisons– on average

State	Population '000 (a)	Population as a % of Victoria's population (b) = (a)/4972.8 x100	People Imprisoned (with or without sentence) (c)	% of population Imprisoned (d) = (c)/(a) x100	% of population imprisoned as a proportion of the % of population imprisoned in Victoria (e) = (d)/0.07% x100	Estimated number of people being admitted *per day* for mental health assessment – on average (f) = 15 x (b) x (e)/10,000
NSW	6,731.3	135.4%	9,329	0.14%	200%	**40.6**
Victoria	4,972.8	100%	3,624	0.07%	100%	**15.0**
South Australia	1,534.3	30.9%	1,485	0.1%	142.9%	**6.6**
Queensland	3,882.0	78.1%	5,240	0.13%	185.7%	**21.8**
Tasmania	482.1	9.7%	447	0.09%	128.6%	**1.9**
Western Australia	1,982.2	39.9%	3,169	0.16%	228.6%	**13.7**
NT	199.9	4%	717	0.36%	514.3%	**3.1**
ACT	324	6.5%	556	0.17%	242.9%	**2.4**
Total for all states and territories	20,111.3	404.4%	24,171	0.12%		**105**

Source: (a) ABS, (2006), Australian Year Book, Canberra; (c) ABS, (2005), Prisoners in Australia, Cat.No.4517.0, Canberra

All population and relevant imprisonment statistics are based on 2004 figures provided by the ABS, which are the most up to date currently available.

Mental health screening assessments at the 'Melbourne Assessment Prison' take approximately 20 minutes to conduct. This would mean that roughly 15 admissions could be processed per day by a registered psychiatric nurse (RPN-2). This calculation allows for time to attend meetings, wait for prisoners, etc. The midrange salary for this position is given as $48,292.07 translating into an hourly rate of $24.37. The number of psychiatric nurses required to undertake these assessments in each of the states - assuming that

this model is adopted across Australia - and corresponding daily and annual costs is given in Table 4.

The model is based on the assumption that rates of mental illness in arrestee populations are constant across jurisdictions. The calculations would need to vary should evidence suggest otherwise.

Table 4: State and national estimates for the number of psychiatric nurses required to undertake mental health screening in an assessment prison (excluding Sunday)

State	Estimated number of people being admitted *per day* for mental health assessment – on average (f)	Number of nursing staff required per day to undertake mental health screening (g) = (f)/15	Hours required per day to process mental health screening in an assessment prison (h) = (f) x 20/60	Daily cost of providing mental health screening in an assessment prison (i) = (h) x $24.37	Annual cost of providing mental health screening in an assessment prison (j) = (i) x 313[10]
NSW	**40.6**	2.7	13.5	$329.97	$103,280.55
Victoria	**15.0**	1.0	5.0	$121.85	$38,139.05
South Australia	**6.6**	0.4	2.2	$53.80	$16,840.72
Queensland	**21.8**	1.5	7.3	$176.72	$55,313.71
Tasmania	**1.9**	0.1	0.6	$15.20	$4,757.54
Western Australia	**13.7**	0.9	4.6	$111.14	$34,787.16
NT	**3.1**	0.2	1.0	$25.07	$7,845.97
ACT	**2.4**	0.2	0.8	$19.24	$6,021.58
Total for all states and territories	**105**	**7.0**	**35.0**	**$852.99**	**$266,986.28**

Besides a daily cost of *$853* and an annual cost of *$266,986* - there would also be a one-off training and materials cost of $5,000 where nurses are registered psychiatric nurses (1 day training required) or a cost of $10,000 where nurses are not psychiatric nurses (2 days training required). Training would be up to 30 nurses and would be likely to occur in each State. This would create a total one-off cost in the vicinity of *$40,000* to *$80,000*.

[10] Annual figures in Table 2 exclude Sundays, (i.e., the desk for this assessment activity is closed).

Mental Health Screening at a Police Lock-Up

The number of people being admitted per day for mental health assessment in police lock ups – on average is estimated in Table 5 by establishing that there are 7.8 visits in per day in Victoria (as established with discussions with Victoria Police) and then weighting this figure for each state by:

- the population in each state as a percentage of Victoria's population; and
- taking into consideration the level of imprisonment in each state as compared to Victoria (i.e. the % of population imprisoned as a proportion of the % of population imprisoned in Victoria).

Table 5: State and national estimates for the number of people being admitted per day for mental health assessment in police lock-ups – on average

State	**population as a % of Victoria's population** **(b)**[11]	**% of population imprisoned as a proportion of the % of population imprisoned in Victoria** **(e)**[12]	**Estimated number of people being admitted *per day* for mental health assessment** **(k) = 7.8 x (b) x (e)/10,000**
NSW	135.4%	200%	**21.1**
Victoria	100%	100%	**7.8**
South Australia	30.9%	142.9%	**3.4**
Queensland	78.1%	185.7%	**11.3**
Tasmania	9.7%	128.6%	**1.0**
Western Australia	39.9%	228.6%	**7.1**
NT	4%	514.3%	**1.6**
ACT	6.5%	242.9%	**1.2**
Total for all states and territories	**404.4%**		**54.6**

Source: (a) ABS, (2006), Australian Year Book, Canberra; (c) ABS, (2005), Prisoners in Australia, Cat.No.4517.0, Canberra

[11] See Table 1 column (e) for calculation.
[12] See Table 1 column (e) for calculation.

CONCLUSIONS AND RECOMMENDATIONS

Given the prevalence of people with mental illnesses and mental disorders in the criminal justice system, there is an urgent need to ensure that mechanisms exist throughout the criminal justice system to accurately identify those people with mental illnesses. Only by properly identifying people with mental illnesses can appropriate services ultimately be delivered to them. Also, where appropriate and available, diversion from the criminal justice system to the mental health system is only possible if mentally ill people are properly identified in the criminal justice system.

Despite the efforts that are being made to identify mentally ill people at various junctures in the criminal justice system in Australia, considerably more needs to be done before there can be any assurance that people with mental illnesses are being properly identified. It is still the case that in most states police – with very limited training – are left to make decisions about whether the people with whom they come into contact have a mental illness, mental disorder, or otherwise. Even when taken into custody, many people do not receive a systematic screen to determine if they are mentally ill while they are in police lock-up. It is still the case that a minority of courts have any capacity to reasonably identify accused who may have mental illnesses. Generally speaking, when incarcerated in prisons – both adults and adolescents – are more likely to be properly screened and assessed for mental illness.

Even with the best screening and identification processes possible, the prevalence of mentally ill people entering and remaining in the criminal justice system will remain disproportionately high so long as we lack effective strategies to properly treat their mental illnesses. This includes treatment both while in custody and when in the community. Moreover, as appropriate, a great many people with mental illnesses who find themselves in the criminal justice system by default could and should be diverted to mental health services. In virtually every jurisdiction in Australia, considerable frustration was expressed by those in the criminal justice system about the inadequacy of general and specific (i.e., forensic) mental health services.

It is beyond the scope of this consultancy to comment on the plethora of complicated reasons for why so many people with mental illnesses are languishing on the margins of society and in the criminal justice system. The proper identification of people with mental illnesses in the criminal justice system is a necessary – but not sufficient – step in the journey toward rectifying the plight of mentally ill people in the justice system.

Based on the information contained in this report, we have identified a number of recommendations that flow from the literature review and in consideration of current practices in Australia. The recommendations are intentionally general in nature. Great diversity exists both within and among Australian jurisdictions. As such, a variety of approaches are ultimately required to address the difficulties pertaining to identifying people with mental illnesses in the criminal justice system.

Recommendations:

1. Continued attention is required to be focussed on understanding the reasons for the disproportionate prevalence of mentally ill people in the criminal justice system.

2. This report should be referred to the national conferences of relevant agency heads for consideration and action: Police Senior Officers' Group, Court Administrators and Corrections Administrators (including Juvenile Justice Administrators).

3. At present, screening for mental illness goes on at a number of points in the criminal justice system. However, information collected at one point in the system is not always made available to staff at a later stage. Systems should be developed within jurisdictions for routine data sharing between criminal justice agencies on suspected or diagnosed mental illnesses.

4. Police are often the first point of contact for mentally ill people entering the criminal justice system. Police require adequate training to assist them in determining, in the first instance, whether an individual may be mentally disordered.

5. All accused being taken into police custody following arrest should undergo a mental health screen. Where possible and feasible such screening should be conducted by a nurse or mental health professional using a structured and standardised approach, such as the Jail Screening Assessment Tool. Where it is not possible for practical reasons to routinely screen all people in these circumstances, alternative mechanisms should be put in place. Such mechanisms could include screening by police, using measures that do not require administration by a health professional, or it may be possible to have mental health staff from agencies such as forensic mental health services conduct screenings on an as-need basis.

6. Court liaison programmes have been met with considerable success and support and should be developed further. In these programs, mental health professionals (e.g.,

psychiatric nurses or psychologists) assist the courts by conducting assessments, obtaining information about prior contract with mental health services, and by connecting those people with mental illnesses coming before the courts with mental health services.

7. When remanded into custody, or when sentenced, all accused and offenders (including adolescents) should be screened for mental illness by a mental health professional (e.g., psychiatric nurse). This is necessary given the prevalence of mentally ill people entering the prisons and the concomitant concerns they raise. Best practice suggests that systematic, standardized measures such as the Jail Screening Assessment Tool, rather than informal clinical judgment should be employed. As with admission to police lock-up, where such screening cannot practicably be conducted by a mental health professional, alternative mechanisms should be put into place.

8. Given that relapses in mental illnesses can contribute to detioration and ultimately re-offending, information about an offenders' mental health needs should be shared with parole authorities so that appropriate conditions may be attached to parole to help ensure that offenders receive mental health services when released from custody.

9. Research is required in Australia to explore the validity of screening tools that are administered by justice staff and not mental health professionals.

10. Given the significant concerns and difficulties that were identified nation-wide regarding the prevalence of mentally ill people in the justice system, and the relative dearth of services available to them, ongoing dialogue would be beneficial between mental health and justice to identify issues and to develop solutions.

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APPENDIX A: CRC ADVISORY GROUP AND INDIVIDUALS CONSULTED

The project team would like to acknowledge the assistance of the CRC Advisory Group, whose advice and direction enabled us to establish contact with many of the appropriate professionals in each jurisdiction. Many Advisory Group members also facilitated state visits by providing meeting space and refreshments. Advisory Group members included:

Mr Damon Muller – Criminology Research Council
Dr Russell Smith – Australian Institute of Criminology
Mr David Ware – Corrections Victoria
Ms Wendy Murray – Western Australia Department of Corrective Services
Ms Joy Wundersitz – South Australia Office of Crime Statistics and Research
Mr Alan van Zyl – Northern Territory Department of Justice
Mr Sean Moysey – Australian Capital Territory Department of Justice and Community Safety
Mr Mark Pathé – Queensland Department of Justice and Attorney General
Mr Terry Byrnes - National Centre for Crime and Justice Statistics
Mr. Lloyd Babb – New South Wales Attorney General's Department
Mr. Jonathon Rees – Tasmania Department of Corrections

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Senior Sergeant Craig Rolls – NSW Police
Mr Craig Smith – NSW District Court
Dr John Basson – NSW Chief Psychiatrist
Professor David Greenberg – Justice Health NSW
Dr Murray Mackay - Justice Health NSW
Mr Max Saxby – NSW Department of Corrective Services
Ms Laura Wells – NSW Attorney General's Department
Judge D Price – Local Court of NSW

Northern Territory

Ms Julie Jenkins – NT Corrections Health
Mr Terry Barker – NT Department of Health and Community Services
Superintendent Sean Parnell – NT Police
Senior Sergeant Danny Bacon – NT Police
Superintendent Murray Taylor – NT Police
Chief Justice Brian Martin – NT Supreme Court

Queensland

Ms Michelle Denton - Queensland Forensic Mental Health Service
Dr Ed Heffernan - Queensland Forensic Mental Health Service
Dr Mark Rallings – QLD Corrective Services
Ms Georgia Sakrzewski – QLD Corrective Services
Mr Bob Greene – QLD Community Forensic Mental Health Service
Mr Robert Pedley – QLD Prison Mental Health Service
Mr David Thompson – QLD Legal Aid
Mr Andrew Kennedy – QLD Legal Aid
Mr Jim Gibney – QLD Legal Aid
Mr Phil Macey – QLD Homeless Persons Court Liaison Service
Acting Senior Sergeant Kyle Gould – QLD Police
Dr Superintendent Grant Pitman – QLD Police
Mr Neil Hanson – QLD Supreme Court
Mr Rob White – QLD Magistrates' Court

Mr Paul Marschke – QLD Supreme Court
Chief Judge PM Wolfe – QLD District Court
Ms Linda Apelt – QLD Department of Communities
Ms Kim Tually – QLD Department of Communities

South Australia

Chief Inspector Oleh Cybulka – SA Police Service
Assistant Commissioner Bryan Fahy – SA Police Service
Chief Superintendent Silvio Amoroso – SA Police Service
Mr John Forward – SA Prison Health
Ms Sue King – SA Magistrates' Court Diversion Program
Ms Anna D'Alessandro – SA Magistrates' Court Diversion Program
Ms Nancy Rogers – SA Department of Families and Communities
Mr Don Colton – SA Department of Families and Communities
Ms Julie Gunn – SA Department of Families and Communities
Chief Justice John Doyle – SA Supreme Court

Tasmania

Ms Kay Cuellar – Tasmania Department of Corrections
Ms Rachel Aalders – Tasmania Prison Service
Mr Graeme Braber – Tasmania Prison Service
Ms Gergia Burbury – Tasmania Department of Justice
Mr Colin Baldwin – Tasmania Probation Services
Commander Peter Edwards – Tasmania Police
Inspector Mark Mewiss – Tasmania Police
Ms Helen Jessup – Youth Justice Tasmania

Victoria

Mr Michael Pruscino – Corrections Victoria
Ms Sylvia Killich – Corrections Victoria
Ms Frankie Boardman – Corrections Victoria
Ms Leanne Sargent – Victoria Police
Ms Robyn Babbel – Juvenile Justice Victoria
Ms Jan Noblett – Juvenile Justice Victoria
Ms Karlyn Chettleburgh - Victorian Institute of Forensic Mental Health

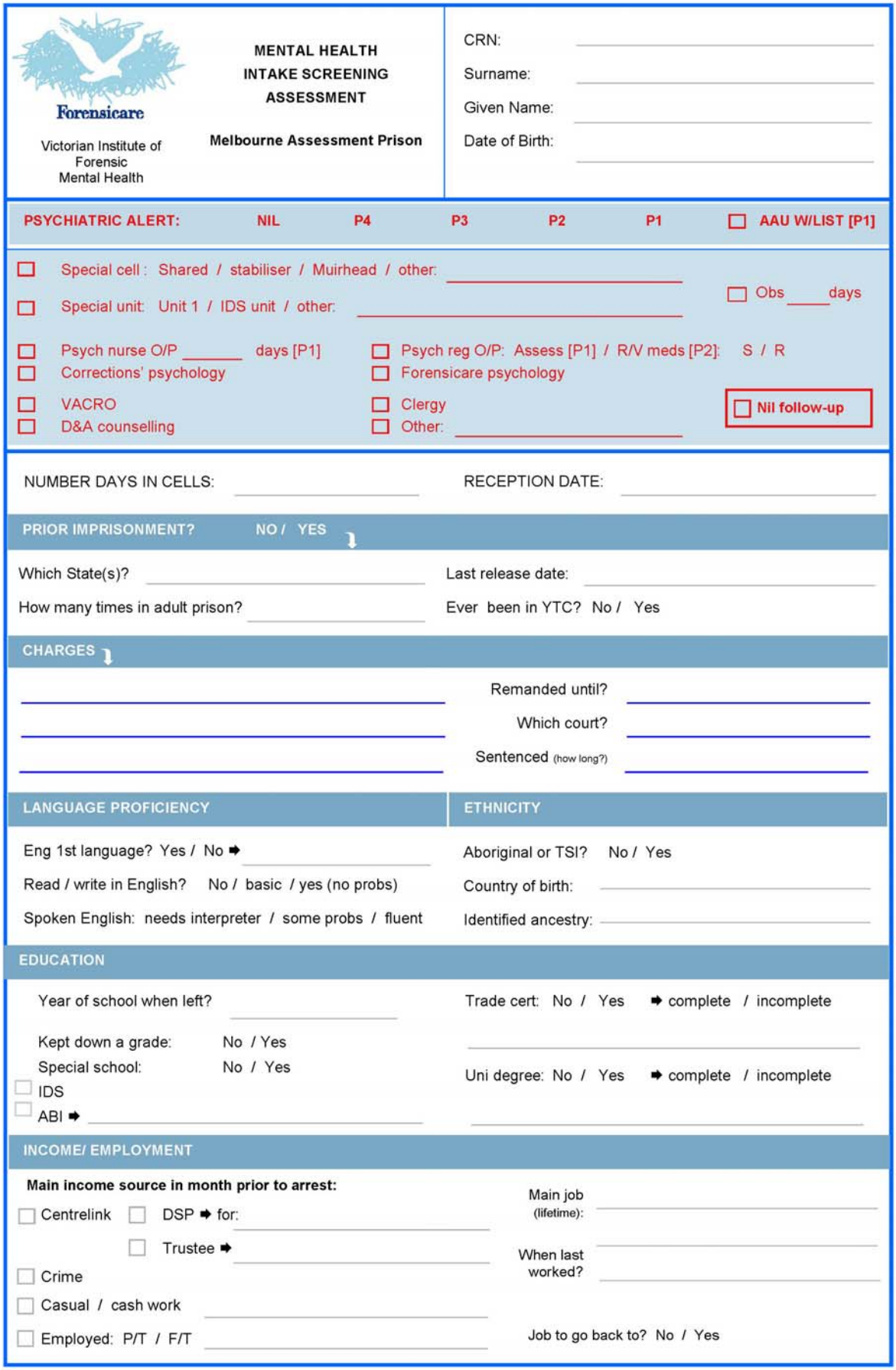
Chief Judge Michael Rozenes – County Court of Victoria
Ms Marilyn Heard – County Court of Victoria
Ms Vivienne Macgillivray – Supreme Court of Victoria
Chief Magistrate Ian Gray – Magistrates' Court Victoria

Western Australia

Dr Adam Brett – WA Community Forensic Mental Health Services
Ms Kati Kraszlan – WA Office of Inspector of Custodial Services
Mr Mark Jessop – WA Department of Corrective Services
Mr Kevin Parsons – WA Kimberley/Pilbara Court Services
Dr Jacqui Joseph-Bowen – WA Police
Ms Frances Mott – WA Police
Ms Tilli Prowse – WA Department of Corrective Services
Ms Ann Highfield – WA Department of Corrective Services
Ms Jackie Tang – WA Department of Justice

We would also like to note our extra special thanks to Chief Inspector Oleh Cybulka of the SA Police Service who graciously shared his years of research on policing and mental illness with us.

APPENDIX B: FORENSICARE MENTAL HEALTH SCREENING INSTRUMENT



Forensicare

Victorian Institute of Forensic Mental Health

MENTAL HEALTH INTAKE SCREENING ASSESSMENT

Melbourne Assessment Prison

CRN: _____

Surname: _____

Given Name: _____

Date of Birth: _____

PSYCHIATRIC ALERT: NIL P4 P3 P2 P1 ☐ AAU W/LIST [P1]

☐ Special cell : Shared / stabiliser / Muirhead / other: _____

☐ Special unit: Unit 1 / IDS unit / other: _____

☐ Obs ____ days

☐ Psych nurse O/P _____ days [P1]

☐ Corrections' psychology

☐ Psych reg O/P: Assess [P1] / R/V meds [P2]: S / R

☐ Forensicare psychology

☐ VACRO

☐ D&A counselling

☐ Clergy

☐ Other: _____

☐ **Nil follow-up**

NUMBER DAYS IN CELLS: _____ RECEPTION DATE: _____

PRIOR IMPRISONMENT? NO / YES

Which State(s)? _____ Last release date: _____

How many times in adult prison? _____ Ever been in YTC? No / Yes

CHARGES

_____ Remanded until? _____

_____ Which court? _____

_____ Sentenced (how long?) _____

LANGUAGE PROFICIENCY

Eng 1st language? Yes / No ➡ _____

Read / write in English? No / basic / yes (no probs)

Spoken English: needs interpreter / some probs / fluent

ETHNICITY

Aboriginal or TSI? No / Yes

Country of birth: _____

Identified ancestry: _____

EDUCATION

Year of school when left? _____

Kept down a grade: No / Yes

Special school: No / Yes

☐ IDS

☐ ABI ➡ _____

Trade cert: No / Yes ➡ complete / incomplete

_____

Uni degree: No / Yes ➡ complete / incomplete

_____

INCOME/ EMPLOYMENT

Main income source in month prior to arrest:

☐ Centrelink ☐ DSP ➡ for: _____

☐ Trustee ➡ _____

☐ Crime

☐ Casual / cash work _____

☐ Employed: P/T / F/T _____

Main job (lifetime): _____

When last worked? _____

Job to go back to? No / Yes

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SOCIAL NETWORK

Single / current girlfriend / partner / wife ⬇

Yes ➡ How long been together? _____

- ☐ Seems stable
- ☐ Uncertain status currently
- ☐ On the rocks (imminent separation)

Have children? No / Yes ⬇

How many? _____ Ages? _____

Seeing them? ⬇

- ☐ At home, no problems
- ☐ Regular access
- ☐ Access problems
- ☐ No contact; no problem
- ☐ Child(ren) in care

Supports

Expecting a visit? No / Yes

➡ who? _____

Have a support network?

- ☐ Identifies a close other
- ☐ Acquaintances only
- ☐ "A loner"

➡ Notes: _____

HOUSING PRE-ARREST

- ☐ Homeless ➡ how long? _____
- ☐ Boarding house/ special accom/ emergency accom
- ☐ Living with parents/ girlfriend / friends
- ☐ Housing Commission/ private rental
- ☐ Own home/ mortgage
- ☐ Other: _____

Suburb/town where slept most in week before arrest: _____

Home to go back to? No / Yes ➡ _____

DRUG USE

Past month:	Ave use (daily / weekly)	Last use	Prior problem use	When?
THC			☐ THC	
Alcohol			☐ Alcohol	
Opiates			☐ Opiates	
Bup / m'done			☐ Bup / m'done	
Amphet / ice			☐ Amphet / ice	
Mush / LSD			☐ Mush / LSD	
Solvents			☐ Solvents	
Pills (BZD)			☐ Pills (BZD)	

Current withdrawal Sx _____

PSYCHIATRIC HISTORY? NO / YES ⬇

Ever been on...

Ψ meds: No / Yes ➡ _____

Depot Rx: No / Yes ➡ _____

CTO: No / Yes ➡ _____

AMHS I/P: No / Yes ➡ _____

Any Ψ care: No / Yes ➡ _____

Diagnoses: _____

Current meds: _____

Where treated: _____

Family history: No / Yes ➡ Bipolar / schizophrenia / depression / alcohol ➡ biol parent / full-sib / half-sib

_____

MAP PSYCHIATRIC NURSING ASSESSMENT - RECEPTION

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MENTAL STATE ON RECEPTION

CRN: _____

Surname: _____

Given Name: _____

Date of Birth: _____

[Mark applicable box & circle relevant Sx]

	Definitely present	Perhaps	No		
1. Disorientation	☐	☐	☐	Lack of comprehension, of situations or communications. Confusion regarding place or time. Place:	Time:
2. Somatic concerns	☐	☐	☐	Concern over physical health, whether realistic or not	
3. Reported anxiety	☐	☐	☐	Reported apprehension, tension, fear, panic or worry	
4. Reported depression	☐	☐	☐	Sadness, anhedonia and preoccupation with depressing topics, hopelessness, loss of self-esteem	
5. Guilt	☐	☐	☐	Statements indicating over-concern or remorse for past behaviour	
6. Suspiciousness	☐	☐	☐	Expressed or apparent belief that others have acted maliciously or with discriminatory intent	
7. Grandiosity	☐	☐	☐	Exaggerated self-opinion, self-enhancing conviction of special abilities or powers, or identity as someone rich or famous	
8. Unusual thought content	☐	☐	☐	Unusual, odd, strange or bizarre thought content	
9. Hallucinations	☐	☐	☐	Reports of perceptual experiences in the absence of relevant external stimuli	
10. Conceptual disorganisation (FTD)	☐	☐	☐	Speech is confused, disconnected, vague, or disorganised (e.g. tangentiality, circumstantiality, sudden topic shifts, incoherence, derailment, blocking, neologisms, and other speech disorders)	
11. Tension	☐	☐	☐	Observable tension, nervousness and agitation	
12. Uncooperative ness	☐	☐	☐	Resistance or lack of willingness to cooperate with interview	
13. Hostility	☐	☐	☐	Hostile attitudes, including belligerence, threats, arguments, property destruction and fights	
14. Excitement	☐	☐	☐	Heightened emotional tone or increased emotional reactivity to interviewer or topics (e.g. increased intensity of facial expressions, voice tone, expressive gestures, or increase in speech quality and speed)	
15. Motor retardation	☐	☐	☐	Reduction in energy level (e.g. slowed movements and speech, reduced body tone and spontaneous body movements)	
16. Blunted affect	☐	☐	☐	Restricted range in emotional expressiveness of face, voice and gestures	
17. Emotional withdrawal	☐	☐	☐	Deficiency in ability to relate emotionally during interview	
18. Self-neglect	☐	☐	☐	Hygiene, appearance or eating behaviour below usual expectations, below socially acceptable standards or life-threatening	
19. Bizarre behaviour	☐	☐	☐	Reports of behaviours which are odd, unusual or psychotically criminal	
19. Mannerisms and posturing	☐	☐	☐	Unusual and bizarre behaviour, stylized movements or acts, clearly uncomfortable/inappropriate postures	
20. Suicidality	☐	☐	☐	Expressed desire, intent or actions to harm or kill self **[see over]**	

MAP PSYCHIATRIC NURSING ASSESSMENT - RECEPTION

Draft vJan18

SUICIDE / SELF-HARM

Prior self harm: No / Yes ⬇

Details:

- ☐ Gunshot
- ☐ OD
- ☐ Hanging
- ☐ Slashing
- ☐ MVA
- ☐ Other

Family history: No / Yes ➡

Current self harm ⬇

- ☐ No ideation expressed
- ☐ Ideation; denies intent
- ☐ Some intent/ambivalence
- ☐ Clear intent

Comments/ protective factors

COMMENTS

INFORMATION AVAILABILITY / DISCLOSURE

RAPID check available prior to interview ? No / Yes ➡ **Prisoner informed of RAPID check:** N/A / No / Yes

Old files available prior to interview? No / yes / some ➡

Reception screening completed by:

Name: Signature: Date:

'RAPID' HISTORY: NO / YES ⬇

1: F00-09; 2: F10-19 except 2a: XX.5 or XX.7 3: F20-29; 4: F30-31.0 & 34; 5: F32-33.9 & 34.1-39; 6: F40-48; 7: F60-69; 8: Z91.5

- ☐ 'Organic' d/o (ABI, etc)[1]
- ☐ Drug & alcohol problem[2]
  - ☐ D or A psychosis[2a]
- ☐ Psychotic disorder[3]
- ☐ Bipolar / cyclothymia[4]
- ☐ Depressive disorder[5]
- ☐ Anxiety/ neurotic disorder[6]
- ☐ Personality disorder[7]
- ☐ Self-harm[8]

No. of admissions:

Date of last contact:

Last AMHS:

RAPID check completed by:

Name: Signature: Date:

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MAP PSYCHIATRIC NURSING ASSESSMENT - RECEPTION

APPENDIX C: HEALTH SCREENING (INCLUDING MENTAL HEALTH) USED IN VICTORIA POLICE LOCK-UPS

CONFIDENTIAL TREATMENT RECORD

PROFORMA 305

DETAILS OF PERSON EXAMINED

SURNAME:	M.N.I No:
GIVEN NAMES:	Date of Service _____/_____/_____
Date of Birth: _____/ _____/ _____ Gender: M ☑ F ☑	Date First Lodged _____/_____/_____
Aboriginal ☑ Torres Strait Islander ☑ Interpreter Y / N Country of Birth _____. Language_____ Cultural Background	Commenced Case _____ hrs Completed Case _____ hrs

EXPLANATION OF PATIENTS MEDICAL RIGHTS GIVEN : SIGNATURE OF NURSE

NURSE :	CNS Visits:	CMO Visits:	STATION:
Critical ☑ Urgent ☑ Routine ☑	Sentenced:	Remanded:	Postcode:

SERVICE: General Medical ☑ Drug Withdrawal ☑ Telephone Advice ☑ Psychiatric Assessment ☑ Attempt Suicide ☑ Arrange/ Verify/ Reorder Medications ☑	Consent for medical information obtained ☑

ADIS Outcome: Adis Screening ☑ Information/Advice Provided ☑ Referred to Other Program ☑ Will not take part in Program ☑ Accepted into a Treatment Service ☑ Not Applicable ☑	**Adis Episode**	
	CMU Database	

Medical /Surgical :

Hep B ☑ Hep C ☑ HIV ☑ Asthma ☑ Epilepsy ☑ Diabetes ☑ Allergies ☑ None Stated ☑

States current Treatment / Medications are:	***Medications confirmed by Doctor / Pharmacy*** ☑ or ☒
General Practitioner : ✉	☎
General Practitioner : ✉	☎
Local Pharmacy: ✉	☎

Psychiatric:

Psychiatrist ✉	☎
Community Mental Health	☎

Name **MNI**

Drug & Alcohol Use		
Drug Type : **Never Used** ☑ Heroin ☑ Amphetamine ☑ Benzodiazepine ☑ Cannabis ☑ Tobacco ☑		
Other ☑		
Amount: **=**		
Last time drugs used:		
Route : Inject ☑ Ingest☑ Smoke ☑ Other ☑		
Injection sites inspected (site and condition)		
Daily alcohol Use : (Type/amount) Beer ☑ Spirits ☑ Wine☑ Other ☑		
Alcohol W/D, AUDIT: AWS:	**Benzo W/D:**SBWS	**Opiate W/D:** SOWS

Methadone/Buprenorphine: ☑ ☒	Daily / Bi Daily	Dose
Last dosed:	Attended Detox program:	
Prescriber :	☎	
Dispensing Pharmacy:	☎	

Presenting Issues

Objective:

Temp:	Pulse:	BP:	Conscious State:

Name **MNI**

Mental State Assessment Indicators: please indicate all characteristics observed in your assessment

Appearance:
Normal ☑ Unremarkable ☑ Inappropriate dress ☑ Appears older than years ☑
Unusual gait ☑ Undernourished ☑ Obese ☑ Bizarre Colourful ☑ Unkempt ☑
Behaviour:
Calm ☑ Settled ☑ Psychomotor retardation ☑ Abnormal movements ☑ Self Confident ☑
Tense☑ Restless ☑ Agitated ☑ Lethargic ☑ Tremors ☑ Aggressive ☑ Disinhibition ☑ Distressed ☑
Interaction:
Cooperative ☑ Polite/accommodating ☑ Uncooperative ☑ Hostile ☑ Irritable ☑ Guarded ☑
Apathetic ☑ Passive ☑ Non responsive ☑ Little or no eye contact ☑ Suspicious ☑ Seductive ☑
Defensive ☑ Evasive ☑ Vague ☑ Manipulative ☑ Vengeful ☑ Provocative ☑ Accusatory ☑
Speech:
Normal tone& volume ☑ Soft ☑ Loud ☑ Even paced ☑ Expansive replies ☑
spontaneous conversation ☑ Overtalkative ☑ Fast/rapid ☑ Slow ☑
Monosyllabic ☑ Slurred ☑ Mute ☑ Incoherent ☑ Incomprehensible ☑
Mood:
Euthymic☑ Bright ☑ Cheerful ☑ Euphoric ☑ Elevated ☑ Depressed ☑ Unhappy ☑ Sad/Crying ☑
Hopelessness ☑ Irritable ☑ Angry ☑ Placid ☑ Anxious ☑ Fearful ☑
Affect:
Congruent ☑ Incongruent ☑ Flat ☑ Blunted ☑ Labile ☑ Reactive ☑
Thought Content:
Appropriate to topics/questions ☑ Obsessive ☑ Phobic ☑ Somatic concerns ☑ Bizarre ☑
Abusive ☑ Guilt ☑ Poor self worth ☑ Low self esteem ☑ Untruthful ☑ self harm ideas ☑
Remorseful ☑ No remorse ☑ Over self valued worth ☑ Delusions ☑ Paranoid themes ☑
Recurrent Ideas about suicide/homicide ☑ Grandiose ☑ Disjointed topics ☑
Thought Process:
Rational ☑ Lucid ☑ Irrational ☑ Relevant ☑ Fluent ☑ Slow ☑ Disjointed ☑ Distracted ☑
Delusional ☑ Thought Insertion ☑ Thought Broadcasting ☑ Poverty of thought ☑
Hallucinations:
None illicted ☑ Auditory ☑ Gustatory ☑ Visual ☑ Somatic ☑ Tactile ☑
Level of Concentration/Judgement:

	Attentive ☑ Mildly impaired ☑ Significantly impaired ☑ Fluctuating ☑ Distractible ☑
	Unable to pay attention ☑
Insight:	States they are/ or appears mentally well ☑ Recognises/states they maybe / are mentally unwell ☑
	Disagrees they may be mentally unwell ☑ Unable to offer an opinion ☑
Ability to understand his/her current situation:	
	Fully aware of reasons for this legal situation ☑ Does not understand his/her legal situation ☑
	Denial of circumstances ☑ Denial of wrong doing ☑ Blames outside factors/others ☑
	Manipulative ☑ Contriving ☑ Unable to offer an opinion ☑
Mental State Assessment Notes:	

Name **MNI**

Self Harm Assessment: Indicators

No Identified risk ☑	**First Timer** ☑	
Recent destructive behaviour ☑ Impulsive ☑ Anger management problems ☑		
Recent self harm injury ☑ Visible injuries ☑ Verbally expressing self harm ideas ☑		
Relationship Breakdown ☑ Unexpected outcome at court ☑ Protection issues ☑ Child protection Issues ☑		
Mental illness ☑ Documented(**substantiated**) self harm attempt/injuries ☑ Heavy illicit drug use ☑		
Other (describe)		

CMO Consultation:	*Doctor has been requested to visit Station and review : Medications and or Treatment* ☑

CMO Contact: Date:	**Time:**	**CMO Name:**
Script Faxed to CMO *Yes* o ***No*** o	Time hrs	Date: _____/_____/_____

Diagnosis

Alcohol W/D (F10.3) ☑	Opiate W/D (F11.3) ☑	Benzo W/D (F13.3) ☑	ICD 10 Code __ __ __ . __
Other Diagnosis			ICD 10 Code __ __ __ . __
Medical Priority: Yes No			

ADIS Episodes of Care

Registration. ***EPISODE PROGRAM*** = Normal. ***SERVICE TYPE*** = General Outpatient Withdrawal DHS Funded.

Source of Referral

- ☐ Police/Comm. Justice
- ☐ Self

Indigenous Status

- ☐ Aboriginal but not TSI
- ☐ TSI but not aboriginal
- ☐ Aboriginal and TSI
- ☐ Not aboriginal or TSI
- ☐ Not known

Source of Income

- ☐ Employed full time
- ☐ Employed part-time
- ☐ Home Duties
- ☐ Pensioner
- ☐ Retired
- ☐ Sickness benefits
- ☐ Self-employed
- ☐ Student
- ☐ Unemployed
- ☐ Other
- ☐ Unknown

Marital Status

- ☐ De Facto
- ☐ Divorced
- ☐ Married
- ☐ Never Married
- ☐ Separated

Living Arrangements

- ☑ Other (Prison inmates)

Accommodation

- ☑ Prison/detention centre

Current Legal Status

- ☐ Sentenced /Remand (Indicate **S** or **R** in box)

Relationship to user

- ☑ User

Drug Problems - DIAGNOSIS **Dependence (DSM-IV: Has evidence of a withdrawal syndrome)**

Principle Drug:	**Period of Abuse:** Yrs Months	
Other Drug #1	**#2**	**#3**
#4	**#5**	

Method of use	**Ingests**	**Injects**	**Smokes**	**Sniffs**	**Inhales**	**Other**	**Not stated**	

Injecting drug use:	Never injected	Unknown	yes, 3-12 mths ago	yes,<3mths ago	Yes, >12 mths ago		
Polydrug use:	Yes	No	Unknown	***Methadone:***	Yes	No	Unknown
Buprenorphine:	Yes	No	Unknown	***Naltrexone:***	Yes	No	Unknown

Name **MNI**

Treatment Plan

	Date		**Significant Goals Achieved? & Goal (indicate on Service / Contact Screen)**
☐ ITP Developed?	_____	☐	#1 _____
☐ ITP Reviewed?	_____	☐	#2 _____
☐ Discharge Plan?	_____	☐	#3 _____
		☐	#4 _____
		☐	#5 _____

Previous treatments

This Agency:	No ❒ Yes, in the last 12 mths ❒ Yes, over 12 mths ❒ Unknown ❒	
Other Agency	**Date**	Enter service Type; eg CCCC
1.		
2.		
3.		

Intervention

Management and Welfare Plan:

Medication:

Referrals to other Agencies:
Observations/ Monitoring Required:
Following risk Identified by **Watchouse** keeper **Sui1** ☐ **Sui 2** ☐ **Psych1** ☐ **Psych 2** ☐ **Med 1** ☐ **Med 2** ☐ **IDS** ☐

Signature of Nurse

APPENDIX D: JAIL SCREENING ASSESSMENT TOOL SCREENING FORM[13]

JAIL SCREENING ASSESSMENT TOOL (JSAT) – CODING FORM

Tonia L. Nicholls, Ronald Roesch, Maureen C. Olley, James R. P. Ogloff, & James F. Hemphill

Institution: | Place ID Label Here

ADMISSION DATE: Day Month Year | **SCREENING DATE:** (If different from admission) Day Month Year

IDENTIFYING INFORMATION

AGE: _____ years

ENGLISH: Fluent ☐ Yes ○ No
○ Moderate ○ Poor ○ None
First language: _____

ETHNIC/CULTURAL BACKGROUND:

☐ White
☐ Black
☐ North American Indian
☐ Métis
☐ Inuit
☐ Chinese
☐ Japanese
☐ Korean
☐ Filipino
☐ Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)
☐ South Asian (e.g., East Indian, Pakistani, Sri Lankan)
☐ West Asian (e.g., Afghan, Iranian)
☐ Arab
☐ Latin American
☐ Other: _____

LEGAL SITUATION

CURRENT STATUS:
☐ Remanded
☐ Sentenced _____ (length)
☐ Transferred
☐ Immigration Hold
Country of Origin: _____

CURRENT CHARGE(S): (Check all relevant)
☐ Offence against persons
☐ Offence against property
☐ Drug offence
☐ Sexual offence
☐ Driving offence
☐ Breach/Parole violation/Escape
○ Comments:

PREVIOUSLY INCARCERATED: ☐ Yes ○ No
☐ In past year
☐ In past 6 months
☐ In past month
Note any problems:

PREVIOUSLY SENTENCED: ☐ Yes ○ No
Longest sentence: _____

VIOLENCE ISSUES ☐ Yes ○ No

Past aggression/violence: ☐ Yes ○ No
Describe:

Violent incidents while incarcerated: ☐ Yes ○ No

Time since any aggression/violence: _____ (months/years ago)

Past violent offences: ☐ Yes ○ No
Type:

Institutional charges: ☐ Yes ○ No
Describe:

Current anger/aggression: ☐ Yes ○ No

MENTAL HEALTH TREATMENT ☐ Yes ○ No

Past Month	Lifetime		Past Month	Lifetime		
☐	☐	Assessment	☐	☐	Treatment – Correctional	
☐	☐	Assessment – Court Ordered	☐	☐	Treatment – Community	
			☐	☐	Treatment – Inpatient	☐ > 6 months
			☐	☐	Treatment – Court Ordered	☐ > 6 months
			☐	☐	Psychiatric Medications	☐ > 6 months
					Type:	

PAST HEAD INJURY: ☐ Yes ○ No
Describe:

SUICIDE/SELF-HARM ISSUES ☐ Yes ○ No

Number of past attempts: _____

Time since last attempt: _____ (months/years ago)

METHOD:
☐ Shooting ☐ Hanging/Asphyxiation
☐ Jumping ☐ Carbon monoxide
☐ Slashing ☐ Motor vehicle
☐ Overdose ☐ Other _____

WHILE INCARCERATED:
Past attempt while incarcerated: ☐ Yes ○ No

Number of past attempts: _____

Time since last attempt: _____ (months/years ago)

METHOD:
☐ Overdose ☐ Hanging/Asphyxiation
☐ Slashing ☐ Other _____

SELF-HARM ISSUES: ☐ Yes ○ No
Describe:

CURRENT LEVEL OF SUICIDALITY:
☐ None stated
☐ Ideation / No intent
☐ Some intent / Contracted / Referred
☐ Suicide concerns / Suicide watch recommended / Referred
☐ Intent / Suicide watch recommended / Referred

MANAGEMENT RECOMMENDATIONS

SUICIDE/SELF-HARM RISK: ☐ Not Evident ☐ Concerns ☐ High Risk
VIOLENCE RISK: ☐ Not Evident ☐ Concerns ☐ High Risk
VICTIMIZATION RISK: ☐ Not Evident ☐ Concerns ☐ High Risk

MENTAL HEALTH ISSUES: ☐ Yes ○ No
☐ Situational stress/depression
☐ Possible anxiety/mood disorder
☐ Hx of psychotic/bipolar disorder / Currently stable
☐ Possible recurrent psychotic symptoms
☐ Active current psychosis
☐ Intellectual disability / Brain damage
☐ Personality disorder traits
☐ Other concerns: _____

PLACEMENT RECOMMENDATIONS: ☐ Yes ○ No
☐ Regular unit / Monitor for mood changes
☐ Regular unit / Double-bunking for support
☐ Regular unit / Single-bunking
☐ PC unit
☐ MDO unit
☐ Segregation
☐ Suicide watch
☐ Stable/Quiet unit
☐ Other _____

REFERRALS: ☐ Yes ○ No
☐ Monitor / Reassess mental status
☐ Evaluate for counseling / Provide support
☐ Referred / Assess for medication
☐ Drug and alcohol assessment/counseling
☐ Other _____

☐ Translator required – Language:

COMMENTS/CLARIFICATION **Note: Relevant information must be documented in the CLINICAL NOTES section of the Health Care File.**

Signature:

This form is published in *Jail Screening Assessment Tool (JSAT): Guidelines for Mental Health Screening in Jails* (2005). For more information and/or permission to copy this form, please contact the Mental Health, Law, and Policy Institute at Simon Fraser University, Burnaby, BC, Canada, V5A 1S6 (E-mail: Roesch@sfu.ca). Revised August 1, 2006.

[13] The JSAT Screening Form is taken from the JSAT Manual. Readers are referred to the manual for details on the instrument. Nicholls, T. L., Roesch, R., Olley, M. C., Ogloff, J. R. P., & Hemphill, J. F. (2005). *Jail Screening Assessment Tool (JSAT): Guidelines for mental health screening in jails*. Burnaby, BC: Mental Health, Law, and Policy Institute, Simon Fraser University. Information available at www.sfu.ca/mhlpi.

SOCIAL BACKGROUND

MARITAL STATUS:
☐ Never legally married (Single)
☐ Married/Common-law partner
☐ Current girlfriend/boyfriend
☐ Separated/Divorced
☐ Widowed

RELATIONSHIP STABILITY:
☐ > 1 year
☐ < 1 year
○ Problems:

CHILDREN: ☐ Yes ○ No
Comments:

LIVING SITUATION:
☐ Owns home
☐ Rents
☐ Lives with family
☐ Hotel/with friends/no rent
☐ Institution (tx center, psych inpatient)
☐ Homeless
☐ In custody
☐ Other _____

FAMILY SUPPORT: ☐ Yes ○ No
☐ Frequent contact
☐ Some contact
○ Problems:

SOCIAL SUPPORT: ☐ Yes ○ No
☐ Friends/Acquaintances
☐ Mental Health Associations
☐ Spiritual Supports
☐ HIV/AIDS Organizations
☐ Veterans Affairs
☐ Other _____
○ Problems:

EDUCATION:
☐ Less than high school
☐ High school or equivalent
☐ Trades certificate/diploma
☐ Some college/university
☐ Completed college/university

FINANCIAL SUPPORT:
☐ Full-time employment
☐ Part-time employment
☐ Seasonal/unsteady
☐ Full-time student
☐ Part-time student
☐ Social Assistance (Welfare)
☐ Employment Insurance
☐ Disability
Mental Health ☐ Yes ○ No
☐ Criminal activity
☐ In custody
☐ No means of support
☐ Other _____

SUBSTANCE USE

☐ Yes ○ No

TOBACCO USE: ☐ Yes ○ No

	Use	Current Abuse	Long-term Severe Abuse	Past Abuse	
Alcohol					
Marijuana					IV use
Heroin					
Cocaine					
Methamphetamine					
Other					

Describe:

CURRENT METHADONE TREATMENT: ☐ Yes ○ No
☐ < 1 month ☐ Past
☐ < 1 year
☐ > 1 year

PAST SUBSTANCE ABUSE TREATMENT: ☐ Yes ○ No
☐ AA/NA ☐ Native healing
☐ Detox ☐ Correctional
☐ Recovery house ☐ Community counseling
☐ Treatment centre ☐ Other _____

MENTAL HEALTH STATUS (Based on BPRS Expanded Version 4.0)

COMMENTS:

Present	Possible	Absent		
☐	☐	○	1. Somatic Concerns	Concern over physical health, whether realistic or not
☐	☐	○	2. Anxiety	Reported apprehension, tension, fear, panic, or worry
☐	☐	○	3. Depression	Sadness, anhedonia, and preoccupation with depressing topics, hopelessness, loss of self-esteem
☐	☐	○	4. Suicidality	Expressed desire, intent, or actions to harm or kill self
☐	☐	○	5. Guilt	Statements indicating overconcern or remorse for past behavior
☐	☐	○	6. Hostility	Hostile attitudes or actions, including belligerence, threats, arguments, property destruction, and fights
☐	☐	○	7. Elevated Mood	Pervasive, sustained, and exaggerated feeling of well-being, euphoria, and optimism - out of proportion to circumstances
☐	☐	○	8. Grandiosity	Exaggerated self-opinion, self-enhancing conviction of special abilities or powers, or identity as someone rich or famous
☐	☐	○	9. Suspiciousness	Expressed or apparent belief that others have acted maliciously or with discriminatory intent
☐	☐	○	10. Hallucinations	Reports of perceptual experiences in the absence of relevant external stimuli
☐	☐	○	11. Unusual Thought Content	Unusual, odd, strange, or bizarre thought content
☐	☐	○	12. Bizarre Behavior	Reports of behaviors which are odd, unusual, or psychotically criminal
☐	☐	○	13. Self-Neglect	Hygiene, appearance, or eating behavior below usual expectations, below socially acceptable standards or life-threatening
☐	☐	○	14. Disorientation	Lack of comprehension of situations or communications. Confusion regarding person, place, or time
			Rate items 15-24 based on observed behavior or speech during the interview.	
☐	☐	○	15. Conceptual Disorganization	Speech is confused, disconnected, vague, or disorganized (e.g., tangentiality, circumstantiality, sudden topic shifts, incoherence, derailment, blocking, neologisms, and other speech disorders)
☐	☐	○	16. Blunted Affect	Restricted range in emotional expressiveness of face, voice, and gestures
☐	☐	○	17. Emotional	Deficiency in ability to relate emotionally during interview
☐	☐	○	18. Motor Retardation	Reduction in energy level (e.g., slowed movements and speech, reduced body tone and spontaneous body movements)
☐	☐	○	19. Tension	Observable tension, nervousness, and agitation
☐	☐	○	20. Uncooperativeness	Resistance and lack of willingness to cooperate with interview
☐	☐	○	21. Excitement	Heightened emotional tone or increased emotional reactivity to interviewer or topics (e.g., increased intensity of facial expressions, voice tone, expressive gestures, or increase in speech quantity and speed)
☐	☐	○	22. Distractibility	Speech and actions interrupted by stimuli unrelated to the interview
☐	☐	○	23. Motor Hyperactivity	Increase in energy level (e.g., more frequent movements and/or rapid speech)
☐	☐	○	24. Mannerisms and Posturing	Unusual and bizarre behavior, stylized movements or acts, or clearly uncomfortable/inappropriate postures