20 November 2008

Mr Jude Perera, MLA
Chairman
Family and Community Development Committee
Parliament House
Spring Street
EAST MELBOURNE  3002

Dear Mr Perera

Inquiries Into Supported Accommodation for Victorians with a Disability and Mental Illness

The Victorian Institute of Forensic Mental Health, known as Forensicare, welcomed the opportunity to prepare a submission for the inquiries being held by the Family and Community Development Committee.

I am pleased to be able to enclose a copy of our submission, which covers the specific issues confronting people with a mental illness in the criminal justice system attempting to secure supported accommodation following their release from Thomas Embling Hospital (our 118 bed inpatient facility) or prison. An electronic copy of our submission is also being forwarded to the office of the Family and Community Development Committee.

Should you require any further information on the issues detailed in our submission, please do not hesitate to contact me. We would be pleased to meet with the Committee, or individual members, at any time.

Yours sincerely,

MICHAEL BURT
Chief Executive Officer

Encl
SUBMISSION TO FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE – SUPPORTED ACCOMMODATION FOR VICTORIANS WITH A DISABILITY AND MENTAL ILLNESS

NOVEMBER 2008

FORENSIC MENTAL HEALTH – SECURING ACCOMMODATION FOR OFFENDERS WITH A MENTAL ILLNESS

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SUMMARY

This submission to the Family and Community Development Committee of the Victorian Parliament on Supported Accommodation for Victorians with a Disability and Mental Illness is made by the Victorian Institute of Forensic Mental Health. The submission has been prepared considering the terms of references received separately from the Legislative Council and the Legislative Assembly.

This response focuses on the plight of mentally ill offenders in obtaining appropriate and safe accommodation, either post release from prison or discharge from hospital, or during an ongoing period of community treatment and care. The issues surrounding lack of accommodation options are confronted by our clinical staff on a daily basis in the delivery of a specialist forensic mental health services.

The following terms of reference are addressed -

Legislative Council
2. the adequacy of the current number of places and care provided in community residential units, residential institutions, community care units, secure extended care units, prevention and recovery care facilities and other forms of supported accommodation.

3. the adequacy and appropriateness of care and accommodation provided in various government, private and community facilities that accommodate clients with a disability or mental illness because of insufficient places in the specialist system, and in particular including supported residential services, boarding houses, public hospital, nursing homes and SAAP funded services.

4. The impact on Victorian families of insufficient supported accommodation.

Legislative Assembly
(f) access and service issues for particular groups, including rural communities, culturally and linguistically diverse communities and indigenous Australians.

(g) the impact on families of the current service provision of accommodation.

In responding to Term of Reference (f) from the Legislative Assembly, this submission includes offenders with a mental illness as a ‘particular group’ within the wider mentally ill population.

Where relevant, recommendations are made to address the identified gaps in service delivery.

INTRODUCTION

The Victorian Institute of Forensic Mental Health, known as Forensicare, is a statutory agency that is responsible for the provision of adult forensic mental health services in Victoria. Forensicare, which was established in 1997, is governed by a ten
member Council that is accountable to the Minister for Mental Health. In addition to providing specialist clinical services through an inpatient and community program, Forensicare is mandated (under the Mental Health Act 1986) to provide research, training, professional education and services to victims.

The specialist clinical services provided by Forensicare include -

- Inpatient services - Thomas Embling Hospital, a 118 bed, secure inpatient hospital located in Fairfield,
- Prison services - within the prison system we provide a 16 bed Acute Assessment Unit for prisoners thought to be mentally ill, specialist clinics, outpatient services and a reception program at Melbourne Assessment Prison (the statewide reception prison for males); a 20 bed residential program, intensive outreach program and therapeutic day program for women at Dame Phyllis Frost Centre (the main prison for women in the state), and consultant psychiatrist services to the larger state managed prisons.
- Community services - within our Community program we provide four specialist programs - Community Forensic Mental Health Program, Court Services, a Problem Behaviour Program (for people with a range of 'problem behaviours' that have led, or may lead, to offending) and a Community Integration Program (supporting prisoners with a serious mental illness on their transition to the community).

Our patients and clients are primarily people with a serious mental illness who have offended and subsequently been sentenced by the courts to either imprisonment or ordered to receive inpatient or community treatment and care. A large proportion of the patients at Thomas Embling Hospital (58%) have been found not guilty or unfit to plead on the grounds of mental impairment and ordered by the court to be detained for care and treatment. Other Thomas Embling Hospital patients have been transferred from the prison system as an involuntary patient and are returned to the prison system when/if they regain their health.

Forensicare was established to achieve –

- improved quality of services in forensic mental health
- increased level of community safety
- better community awareness and understanding of mentally disordered offenders
- increased specialist skills and knowledge
- policy advice, service planning and research that contributes to the improved delivery of mental health services

**FORENSIC MENTAL HEALTH – A SPECIALIST MENTAL HEALTH FIELD**

Forensic mental health is a specialist area within the mental health field that provides care and treatment to people within the criminal justice system who have a serious mental illness. It addresses the special needs of mentally disordered offenders, the justice sector and the community, while providing effective assessment, treatment and management of forensic patients in appropriately secure settings.
Traditionally forensic psychiatry was concerned solely with providing long term containment for the ‘criminally insane’ and providing assessments and opinions to courts on an individual’s state of mind. In many jurisdictions, provision for the care, treatment and containment of serious offenders with a mental illness was grossly inadequate, and at times, inhumane.

There has however, been an almost total transformation of what has become known as forensic mental health services over the past two decades. The management and treatment of people with a mental disorder in the criminal justice system are now just as central to a forensic service as to any other mental health service. Forensic inpatient services are no longer primarily psychiatric prisons, but hospitals designed to provide quality care, rehabilitation and eventual reintegration into the community.

As with other mental health services, the forensic mental health system now provides a comprehensive range of services, ranging from secure inpatient facilities, to community oriented, community based services and court services (including providing assessments, and on occasion, advice on management). In summary, a modern forensic mental health service provides treatment and care to offenders and alleged offenders sent to a psychiatric hospital by the courts, to prisoners, to individuals for whom the courts have mandated psychiatric treatment and to patients deemed to present an imminent risk of serious offending.

**TERMS OF REFERENCE - RESPONSE**

As a specialist mental health provider, this submission will detail the special needs and difficulties faced by our patients and clients in securing secure extended care and community accommodation.

A response is provided to the following terms of reference.

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Secure extended care units

The Thomas Embling Hospital, a 118-bed secure forensic hospital, provides mental health inpatient services to people in the criminal justice system with a serious mental illness requiring inpatient treatment and care. The hospital provides statewide specialist treatment and containment for -:

- people found unfit to plead to an offence or not guilty on the grounds of mental impairment under the *Crimes (Mental Impairment and Unfitness to be Tried)*
- remanded or sentenced prisoners with a mental illness who require acute inpatient care, transferred from prisons under section 16 of the *Mental Health Act*.
offenders found guilty under the *Sentencing Act 1991* and detained involuntarily by order of the Supreme or County Courts

involuntary patients referred from area mental health services. These are patients who are unable to be managed within mainstream services, have challenging, assaultative behaviour, and are frequently non-compliant with treatment requirements.

Within the mental health system, Thomas Embling Hospital patients are regarded the most complex, difficult to treat and high risk patients in Victoria.

Since Thomas Embling Hospital opened in 2000 it has struggled to meet the demand for inpatient care and treatment from prisons, courts and the mental health sector. This demand has increased steadily, and prisoners requiring admission are now frequently required to wait in prison for up to a month, as are people ordered by courts to be detained in the hospital. Thomas Embling Hospital is now also unable to meet the demand from area mental health services for admission for patients who have become unmanageable in regional facilities.

This demand for admission is most frequently managed by a ‘juggling strategy’ – senior clinicians making difficult clinical decisions to identify the most ‘well’ of the patients who can be returned either to prison or an area mental health facility. In the case of discharge to area mental health services however, the lack of available secure inpatient or extended care beds effectively removes this as a discharge option. The flow-on effect is acute bed blockages in Thomas Embling Hospital, with patients unable to be admitted, or remaining as an inpatient for longer than is clinically indicated.

The admission of involuntary patients to Thomas Embling Hospital is usually regarded as a last resort placement. Requests for inpatient admissions frequently involve difficult patients, displaying non-compliant, assaultative behaviour, who require a contained environment, rather than an acute forensic inpatient bed. On admission, these patients consume a large proportion of the scarce resources within Thomas Embling Hospital and contribute to the ‘bed blockages’ that are experienced.

The diversion of this group of patients to a secure extended care program or some other suitable secure inpatient program would improve access to Thomas Embling Hospital for prisons, courts and area mental health services requiring high level specialist services. There are currently 103 Secure Extended Care Unit beds provided across Victoria by three metropolitan area mental health services. The development of additional secure beds for high risk, long stay patients who are not safe to return to the community will free up capacity in existing forensic and adult acute inpatient facilities.

Forensicare and area mental health services have lobbied for some years for additional secure beds. Aware of the pressing and steadily growing demand for mental health inpatient services, Government has provided funding for detailed planning to be undertaken for the development of a proposed new 120 bed medium secure mental health hospital. The proposed new facility, to be located on a site at the Heidelberg Repatriation Hospital, will provide 60 beds for forensic patients and 60 beds for civil
patients requiring secure care and treatment. While planning has been undertaken over the past 18 months, Government has yet to commit capital funding for the project. Given the pressures experienced within the forensic and general mental health systems due to limited (and ever-diminishing) bed availability, it is imperative that funding for this proposal be provided.

**Case Studies – the impact of inadequate availability of secure extended care beds**

**Patients remaining in Thomas Embling Hospital due to the lack of secure extended care beds in the community.**

C is a 53 year old man with a 15 year history of schizophrenia who has spent lengthy periods in hospital for his treatment resistant illness. His illness has progressively deteriorated over the years, despite intensive efforts through mainstream services, including a mobile support and treatment team, and prolonged placement in a community care unit with assertive supervision of medication compliance and psychosocial rehabilitation.

C developed an erotomanic delusional preoccupation with a young married woman whom he had met in a local park. He began to follow the woman to her home, often late at night and would present her with gifts of flowers, chocolates and other signs of his love for her. This caused the woman and her family considerable distress and they made contact with local mental health and police authorities. C was admitted as an involuntary patient (s.12, Mental Health Act 1986) to the acute inpatient unit of the relevant area mental health service. He repeatedly absconded and would visit the young woman at her home to continue to persuade her of his love and devotion to her.

C was eventually transferred to a secure extended care unit, from which he also eventually repeatedly absconded and resumed his activities towards the woman. She and her husband contacted the Office of the Chief Psychiatrist and Health Services Commissioner with complaints regarding C’s activities, stating that if he were not able to be effectively detained, she and her family would be forced to leave their home and move interstate. Although at no stage had C ever engaged in any acts of physical violence, a decision was made that he required containment in a more secure hospital setting and C was transferred to Thomas Embling Hospital. Since admission, he has been fully compliant with treatment, although his symptoms remain substantially unchanged. He is behaviourally well settled and finds being placed in a unit with other considerably more disturbed, and on occasion, violent, patients very distressing.

The clinical assessment is that he does not require the intensive high security environment of the Thomas Embling Hospital and he could be managed in a secure extended care unit, offering a level of security that could prevent him from absconding until his illness comes under satisfactory control. A vacancy in a secure extended care unit is currently not available. C remains in the high secure environment of Thomas Embling Hospital, preventing admission of other people whose illness and security concerns require this level of security.

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A patient who should be managed in Thomas Embling Hospital, but is unable be admitted due to a backlog of patients waiting discharge to a secure extended care unit.

E is a 36 year-old man with a long offending history, consisting of numerous thefts, burglaries, armed robberies (using a knife or syringe to procure money for drugs) and serious assault charges. He is well known to forensic mental health services and has had several prolonged admissions to Thomas Embling Hospital over the past ten years. E has strong antisocial traits and it is well recognised by treating staff that during periods of acute deterioration of illness, his intimidating and aggressive behaviour significantly diminishes as he becomes more disorganised and incapable of purposeful, exploitive activity. His psychotic symptoms generally respond reasonably well to treatment, although never fully resolve.

As E’s illness comes under control, he becomes extremely disruptive of the ward environment, standing over other vulnerable patients for money, cigarettes and sexual favours. On occasion, he has been seriously assaultive to patients and staff, including using implements such as pool cues and billiard balls in socks as weapons. He has been intractably non-compliant with assertive efforts to support and treat him in the community, despite the use of medication and community treatment orders.

E was recently brought by police to the emergency department of a general hospital for psychiatric assessment. He was in a severely psychotic state, having assaulted the proprietor of a boarding house. While in the emergency department, E was loud and abusive towards other patients, and required physical restraint by security staff to prevent further assault and damage to property. He was subsequently certified by the duty consultant psychiatrist. Given his past history and the difficulties experienced managing him (even in Thomas Embling Hospital), it was determined that he could not be safely managed in the psychiatric inpatient unit of the hospital. A referral for admission was then made to Thomas Embling Hospital. At that time, there was no bed available, and E required heavy sedation and mechanical restraint in the emergency department for over 24 hours until a bed could be made available at Thomas Embling Hospital. The bed was made available by the forced and inappropriate return of another patient to prison.

Recommendation

Additional secure inpatient accommodation is urgently required to meet the needs of people with a mental illness in both the forensic and general mental health systems. The inadequate levels of accommodation currently available work against people receiving the level of treatment and care they require in an environment that provides an appropriate level of security. The current level of accommodation does not accord with best practice standards and hinders successful rehabilitation and community integration.

It is recommended that Government commit to funding the proposed new 120 bed medium secure facility as a priority in the 2009-2010 State Budget.
Legislative Council –
3. the adequacy and appropriateness of care and accommodation provided in various government, private and community facilities that accommodate clients with a disability or mental illness because of insufficient places in the specialist system, and in particular including supported residential services, boarding houses, public hospital, nursing homes and SAAP funded services.

Legislative Assembly –
(f) access and service issues for particular groups, including rural communities, culturally and linguistically diverse communities and indigenous Australians.

Community care – supported accommodation

Area mental health service clinicians report great difficulty accessing suitable supported accommodation for people being discharged from a general mental health inpatient facility. For Forensicare, this difficulty becomes even more pronounced when people with a mental illness are being discharged from a prison or Thomas Embling Hospital. The stigma that is so frequently associated with a prison sentence or placement in a forensic mental health facility is, in itself, frequently a barrier to accessing suitable and supported accommodation. This creates serious problems for Forensicare’s patients and clients when they are attempting to secure accommodation, and is a major issue facing clinicians, patients and clients.

A large proportion of Thomas Embling Hospital patients (59%) are people who have been ordered by the courts to be detained in Thomas Embling Hospital under the Crimes (Mental Impairment and Unfit to be Tried) Act 1997 (known as ‘forensic patients’). These people remain as inpatients, on average, for 6-8 years, prior to beginning a slow, graduated program of leaves to the community. Access to stable accommodation is a vital element in achieving successful rehabilitation and community reintegration all people with a mental illness, and this is particularly so for forensic patients (because of the length of time they have been hospitalised in a secure facility) and others with a mental illness being released from Thomas Embling Hospital, prison or other parts of the criminal justice system.

In particular –

1. bail applications generally require an address to be stated to the Court in order for the application to be successful. There are minimal options for prisoners requiring accommodation to gain bail - mainstream accommodation services are generally unavailable for people as a condition of bail and only one bail hostel operates in Melbourne.

2. area mental health services in Victoria offer services on the basis of address. A smooth prison-community transition for a prisoner with a mental illness (ie where community mental health supports are in place prior to release), is vital for community reintegration to have a chance of being successful. This can only be facilitated if an address is established prior to release. An address that
cannot be arranged until late in the discharge process may lead, at the best, to a prisoner not receiving the optimum level of mental health service on release, or at the worst, not receiving services at all.

Lack of accommodation restricts the ability of area mental health services to engage with newly released prisoners, or newly discharged (or soon-to be discharged) forensic mental health patients and clients, and provide the ongoing care necessary to effectively treat their mental illness.

The graduated program of supported leaves available to forensic patients, (people found by courts ‘not guilty by reason of mental impairment’, generally for a serious offence) to assist their community reintegration, is highly dependent on the availability of suitable community accommodation. Participation in the leave program requires the support of the treating clinical team and the subsequent approval of the Forensic Leave Panel. Leaves are usually initially approved for day absences, leading to overnight and ultimately three day periods. A full graduated program is generally spread over 18 months – 2 years, prior to the forensic patient being considered by the court for supported discharge to the community.

The difficulties experienced in accessing appropriate accommodation for forensic patients on overnight leaves cannot be overstated. While treating clinicians will recommend and support a program of community leaves for a patient, a leave application will not be approved by the Forensic Leave Panel until appropriate accommodation is arranged that offers the level of individual support required. Long-stay forensic patients commencing overnight leaves generally require a high level of psychiatric rehabilitation and support, and ongoing monitoring of risk. Finding secure accommodation that offers this level of support (a level of support that usually diminishes over time), which will only be used 1 or 2 days a week, is a significant hurdle for clinicians and patients.

The accommodation issue can be a vicious circle for forensic patients – the Forensic Leave Panel may acknowledge the clinical appropriateness and timeliness of an application to participate in a program of overnight leaves, but will not approve the leave program until suitable accommodation is arranged. Community accommodation for forensic patients however, is so very limited, because of their offence and mental health histories and assessed need for rehabilitation and community support, that their ability to access suitable accommodation to achieve a successful transition to the community is severely restricted.

It is generally felt that the lack of appropriate accommodation options has resulted in some forensic patients remaining in Thomas Embling Hospital for considerably longer than has been clinically indicated. In many cases, the delay in discharge has been months, and in the worst case, years.

A large proportion of the accommodation available to people being discharged from Thomas Embling Hospital or prison is emergency housing. It is uncommon for this type of accommodation to make any special provision for
the housing of people with a mental illness, and in addition, it is usually located in high crime neighbourhoods. Close supervision of mentally unwell people in a low crime neighbourhood is vital not only to ensuring that they maintain a level of wellness that allows them to function in a social setting, but to reduce the likelihood of re-offending (both violent and non-violent).  

A lapse of sentence and subsequent discharge from hospital or prison on a weekend can be problematic in terms of ensuring continuity of care. Most accommodation services provide a reduced level of service on weekends, and without a housing worker to escort people with a mental illness newly discharged from a forensic hospital or prison, discharge planning can unravel quickly.

Waiting lists for public housing (even those ‘priority lists’ which operate in Victoria) mean that it is often not possible to discharge patients from hospital to public housing. This applies not only to ‘short term’ patients, but also long term patients whose discharge date may be 12 months away. The availability of public housing for this group would enable a smoother, safer transition back to the community, supported by forensic mental health staff.

Our clinical staff report that the lack of suitable and stable accommodation for our patients and clients is critical. In addition to having a significant, negative impact on the well-being and rehabilitation prospects of our patients and clients, the lack of supported accommodation works against achieving successful community integration, continuity of care and optimal health outcomes.

Levels of accommodation are required that provide a supportive environment which incorporates ongoing clinical care. Prisoners and others with a mental illness being discharged from a secure environment face particular problems in terms of community care. Connecting these people with assertive case management for 6-12 months following release from their custody is a pressing service need. Following their release, these people currently attract little in the way of community care, and most frequently fail to follow up any community care arrangements which may be put in place for them prior to their release.

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CASE STUDY – COMMUNITY INTEGRATION PROGRAM

Forensicare operates a Community Integration Program, located at two large metropolitan prisons for men, which assists identified prisoners and remandees with a serious mental illness in their transition to the community. People assisted by the program typically have psychotic illnesses (eg. schizophrenia) and co-existing serious health and social problems, including substance dependence, personality disorder, homelessness and poor community supports. The Community Integration Program commenced in 2005-2006.

In a two year period (to 30 June 2008) –

110 people had been referred to the Community Integration Program.

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1 Silver, E. Race, Neighborhood Disadvantage, and Violence Among Persons with Mental Disorders: The Importance of Contextural Measurement. Law and Human Behavior, 2000; 24(4):449-456
Of those people referred, 70 (64%) were homeless and in need of housing placement. Nearly all were placed in short term crisis housing following their release from prison.

Of the small group who did have pre-existing accommodation (most frequently those held on short-term remand), most were released to unstable and unsuitable housing, which had an associated negative impact on their psychosocial wellbeing.

Supported housing (crisis and transitional) agencies and rehabilitation services reported a history of difficulty working with clients of the Community Integration Program, and were often reluctant, or even refused, to work with them.

An audit of referrals to the Community Integration Program confirms the following profile – people referred have a history of poor engagement with service agencies, poor compliance with treatment and failure to complete court imposed orders, they are ‘revolving door clients’, both within the prison and mental health systems, who are considered to have a poor prognosis and poor prospects for rehabilitation.

Community Integration Program clients are less likely to be granted bail or parole because of poor or non-existent housing and supports and resultant difficulties in completing discharge planning. As a result, they spend longer in prison.

Implications of system shortages for clients of Community Integration Program –

Referrals to area mental health services and community supports are most frequently only finalised on the day of release. This not only removes any opportunity for essential release planning, but significantly impacts on the likelihood of the client engaging with the service/s.

Exposure to de-stabilising influences (drug use, threats) when placed in crisis housing, frequently leads to violent situations and a quick return to prior patterns of substance abuse.

Delays in being seen or being allocated a community support worker or clinician contributes to a cessation of treatment and relapse of illness.

Clients regularly leave the accommodation arranged with a loss to follow-up.

The audit found that clients who were able to be placed in stable and supported accommodation, with an address known in advance of their release date, had better outcomes. In these situations, timely referrals to community agencies provided an opportunity for clients to meet with workers and promoted engagement. These clients were more likely to remain engaged in treatment and better able to complete rehabilitation activities. They had greater levels of success in avoiding re-offending, relapse of illness and/or substance abuse, and achieving a successful transition to the community.

Recommendation

Specific accommodation pathways are required to provide the level of assistance necessary to support people with a mental illness being released from forensic mental
health care, whether a secure inpatient facility or prison. These accommodation services, which need to be located in low crime areas, should not only routinely offer a stable address to access area mental health services, but also provide services associated with bail conditions and bail hostels. Supervision of people accessing these services would ideally be provided by a combination of forensic mental health, health and housing workers.

The accommodation pathways available should also ideally provide a range of accommodation options that are able to be matched to individual need, ranging from single accommodation through to shared flats or houses.

The therapeutic/rehabilitation program supporting the accommodation would include ongoing clinical management, including assertive outreach case management, provided by Community Forensic Mental Health Service and/or area mental health services. The program would provide appropriate levels of support and monitoring of service users by specialist support staff, based on identified needs and risk factors.

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Primary carers of patients and clients of forensic mental health services most frequently have needs that are more complex than other carers in the mental health field. Within forensic mental health, most primary carers are family members, and in a large percentage of cases, a member of the family has been the victim of the crime committed by the patient/client\(^2\). The special needs of these carers are generally unacknowledged and the scarcity of appropriate accommodation for their family member following discharge from hospital or prison can greatly heighten an existing feeling of unease.

An almost unimaginably high level of family disruption occurs when a family member is seriously injured or killed by another member of the family. In these cases, mental illness adds an additional layer of complexity to an already difficult situation. The recovery process for families, both victims and offenders, is very long. Of the 69 patients currently detained in Thomas Embling Hospital on a determination of the courts under the Crimes (Mental Impairment and Unfitness to be Tried) Act (ie. those patients found not guilty on the grounds of their mental impairment), almost half committed an offence against a member of their family.

The very long-term trauma and grief that most frequently overtakes the lives of the families involved is profound and should not be underestimated. Carers need specific help in understanding and accepting the devastation that the offence can have on the

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remaining family members. They have often lived long-term with violent and unpredictable behaviour, and are fearful of the discharge of their family member. Without suitable accommodation, this fear is understandably heightened.

Not all carers in this category require specific services. It is the experience of Forensicare clinicians however, that a great proportion of carers and family members remain traumatised by the offence and mental illness for many years after the event. This is especially so in cases where children are involved. (In many cases children have been witness to violent acts perpetrated by a member of their family that has resulted in the death of a loved one.). The impending discharge of the offender and the paucity of suitable accommodation can further compound and significantly impact on what is frequently an already fragile relationship.