Royal Commission
into Family Violence

WITNESS STATEMENT OF DR MELISA HELEN WOOD

I, Melisa Helen Wood, forensic psychologist, of Thomas Embling Hospital, Yarra Bend Road in the State of Victoria, say as follows:

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

2. Forensicare and the Centre for Forensic Behavioural Science at the Swinburne University of Technology (**CFBS**) have made a joint Submission to the Royal Commission into Family Violence in May 2015 (**Submission**). I am informed and believe that the Submission has been produced to the public hearings as an attachment to the witness statement of Professor Ogloff. I refer to and adopt that Submission.

3. I have been asked to comment on several matters, some of which have also been canvassed in the Submission.

Current role

4. I am currently employed as a senior clinical and forensic psychologist at Forensicare where I have worked across a range of services since 2011. Most recently (January to June 2015), I worked on site with the Victoria Police Westgate Family Violence Team (**WGFVT**; located at Footscray Police Station) to provide support and advice to the police, assess risk of family violence perpetrators, and assist victims and perpetrators in receiving needed services. This work formed part of a pilot project which is a conjoint family violence initiative between Forensicare, CFBS, and Victoria Police, which I discuss further in my statement below.

5. I currently work on the Forensicare Problem Behaviour Program (the **Program**), which provides psychiatric and psychological consultation and treatment for people with a range of 'problem' (i.e., offending-related) behaviours, as outlined

below. I have previously worked in the sub-acute and continuing care units at the Thomas Embling Hospital providing psychological assessment and treatment services predominantly to persons with major mental illness who have committed serious crimes. A considerable proportion of clients and patients in both these roles have committed family violence offences.

Background and qualifications

6. Between 2003 and 2015, I have intermittently worked in a research capacity on a project basis for CFBS, with Professor James Ogloff AM, who is both the Director of Psychological Services at Forensicare and the Director of the Centre for Forensic Behavioural Science at Swinburne University of Technology. I currently hold an adjunct research fellow position with CFBS. My main areas of research and clinical interest and expertise include psychopathic personality disorder, violence and sexual risk assessment, "what works" in violent offender rehabilitation, and understanding the relationship between major mental illness, personality characteristics, and violent behaviour.

7. I have the following qualifications:

   7.1. Doctor of Psychology (Clinical; Forensic Specialisation); and

   7.2. Bachelor of Arts (Honours).

Forensicare

8. The Victorian Institute of Forensic Mental Health, known as Forensicare, is the state-wide specialist provider of forensic mental health services in Victoria. We are the only agency in Victoria that provides clinical services that span the mental health and justice sectors. As a result, Forensicare has a unique perspective on mental health and public safety issues and is able to provide specialist forensic mental health services that are tailored to meet the specific needs of both sectors.

9. Forensicare has a 116-bed secure hospital, together with comprehensive community based programs and prison services. Additionally, our specialist clinical staff support an active Research Program which results in an extensive list of publications each year.

10. Forensicare is governed by a Board of up to nine Directors that is accountable to the Minister for Mental Health.

11. Forensic mental health is a specialist area within the mental health system. It is required to meet the needs of mentally disordered offenders, the mental health and justice sectors and the community. We primarily focus on providing clinical services, which includes the effective assessment, treatment and management of forensic patients and clients and people with a mental illness who have offended or are at risk of offending. We also provide a comprehensive Research Program and specialist training and professional education for our staff and the broader mental health and associated fields.

12. Our clinical services include the following:

12.1. **Thomas Embling Hospital** - The hospital has 116 beds, spanning acute and continuing care, and includes a dedicated women's unit. Most patients are from the criminal justice system, either transferred from the prison system or ordered by the courts to be detained for psychiatric assessment and/or care and treatment. The hospital was purpose designed and built to further the delivery of advanced clinical programs. A comprehensive range of therapeutic programs are provided which are innovative and provided within a recovery framework.

12.2. **Community Forensic Mental Health Service** - a state-wide service providing assessment and multidisciplinary treatment to high risk clients referred from area mental health services, correctional providers, courts, the Adult Parole Board, Thomas Embling Hospital, our prison services, government agencies and private practitioners. The programs include the following:

- Community Forensic Mental Health Program;
- Problem Behaviour Program;
- Court Services Program;
- Community Integration Program; and
- Non-custodial Supervision Order Consultation and Liaison Program.

12.3. **Prison Services** - a comprehensive range of specialist mental health care including dedicated bed based units, is provided in the men's prison system at the Melbourne Assessment Unit, and at Dame Phyllis Frost Centre in the women's system. Other prison based services include a Mobile Forensic Mental Health Service based at Metropolitan Remand Centre, psychology

positions at Barwon Prison and Marngoneet Correctional Centre, and Psychiatric Registrar Clinics, Nurse Practitioners Clinics and visiting Consultant Psychiatry sessions at other publicly managed prisons. A Mobile Forensic Mental Health Unit operates from the Metropolitan Remand Centre.

Problem Behaviour Program

13. The Program provides psychiatric and psychological consultation and treatment for people with a range of 'problem' behaviours associated with offending and for whom services are not available elsewhere. The program is specifically directed at people known to have recently engaged in, or are at risk of engaging in, one or more 'problem behaviours'. Problem behaviours include the following:

    13.1. serious physical violence;

    13.2. threats to kill or harm others;

    13.3. stalking (repeated unwanted contact);

    13.4. sexual offending, including adult sexual assault and rape;

    13.5. paedophilia;

    13.6. collection and possession of child pornography, including internet child pornography;

    13.7. fire-setting;

    13.8. querulous (vexatious) complainants; and

    13.9. problem gambling associated with serious offending.

14. The Program provides Primary, Secondary and Tertiary Consultations, together with ongoing treatment.

15. I have been working on the Program for approximately four years. Through my work, I deal with a range of different types of offenders, including those who are perpetrators of family violence. The majority of clients are referred to us from community correctional services, either because they have been found unsuitable for standard correctional programs or because they require further intervention and support after they have completed correctional programs. While Corrections do tailor more intensive offender rehabilitation programs (usually on a group

basis) to offenders with higher levels of risk and need, they do not have sufficient resource capacity or forensic mental health expertise to provide individually-tailored interventions that specifically address the interplay of multiple complex needs (particularly mental illness, personality disorder, and substance use) and their relationship to the offending behaviour. For these offenders, multiple service involvement and long-term therapeutic interventions (usually on an individual basis) are often required.

Family violence and Forensicare

16. Family violence is pervasive in the community and this is reflected in the nature of the patients served by Forensicare. Depending upon the area of the service, between 30% to 50% of Forensicare clients have an index offence that includes family violence.

17. Forensicare and CFBS are presently working with Victoria Police and a Medicare Local in a specialist family violence initiative based at Footscray Police station. As outlined above, I have been working on-site with the Victoria Police Family Violence Team to clinically assess the risk of family violence perpetrators, and assist victims and perpetrators to connect with meaningful and appropriate services. This pilot project recently completed its trial phase and is now in the process of data analysis. There is hope that negotiations for funding a further project period will be successful.

Cohort of respondents to intervention orders

18. A large proportion of the respondents have issues associated with drug and alcohol abuse, and while mental health and personality problems are more difficult for police to accurately identify, they are also over-represented among family violence offenders. Indeed, the symptoms and characteristics of certain mental and personality disorders may be directly associated with violent behaviour for some individuals (for example, paranoid beliefs, misattributions of others' hostile intent, mood instability, poor behavioural controls, or limited empathic capacity).

19. Mental and personality disorders are not something that one can expect the police at the frontline to assess, as they do not have the necessary clinical training and expertise. The assessment needs to occur elsewhere using approved clinical techniques and practices.

Current WGFVT police response to family violence

20. Current Victoria Police protocols for assessing and managing risk in family violence case involve a two-step process. Relevant information is gathered by front-line responding officers in their assessment of the case as they attend the scene, which is then documented in the 'L17' narrative, and a checklist of identified risk factors is completed. The family violence teams then utilise this information to 'triage' each case according to the number of identified risk factors and the particular contextual factors of the case. This triage is completed using the Priority Attendance Process (**PAP**) which is an actuarial (mathematical) tool which categorises family violence incidents into the appropriate risk category according to a weighted risk score. In the current project, the role of the Forensicare clinician is to enhance the WGFVT's ability to prioritise, manage and refer high risk family violence cases by providing a more comprehensive and specialist risk assessment and management procedure, using an empirically validated risk assessment tool (the B-SAFER; described below). While the B-SAFER is designed for use by law enforcement officers, at present responding officers and family violence teams are not sufficiently resourced or trained to undertake this more comprehensive risk assessment procedure.

21. The PAP and L17 processes are guided by the Department of Human Services' (**DHS**) Common Risk Assessment Framework (**CRAF**). The CRAF is a guideline process for people working at the first point of contact for people who may be suffering from family violence. It allows frontline workers, such as healthcare or social services workers, to identify family violence and provides a framework for assessing how much attention the case requires. The CRAF is not, however, an empirically-validated risk assessment tool and has not been evidenced to predict recidivism or to successfully discriminate high risk cases.

22. The PAP comprises 20 risk factors which are derived from the CRAF and have been shown in the research literature to indicate the potential severity of family violence cases. The PAP applies a weighted system of these 20 items to derive an overall risk category. There is some opportunity for professional "override" of the risk category to account for additional contextual factors if the FVT member deems this necessary.

23. Using the PAP system, offenders frequently score in the high and very high risk categories due to the PAP having a very low threshold score, resulting in an over-identification of cases as "high risk". As a result a large number of cases are assessed as requiring a higher level of case prioritisation and resource allocation,

usually a face-to-face visit by the WGFVT to the victim and/or offender, as opposed to a less resource-intensive intervention, such as a follow-up phone call. If the perpetrator and the victim are still cohabiting, the WGFVT members will usually attempt to contact both parties, but if there is no contact between the victim and the perpetrator, the WGFVT will usually focus on the victim.

24. As the PAP identifies an overwhelming percentage of cases as high risk, part of the Forensicare clinician's role during the pilot project was to assist the police in differentiating genuinely high risk cases from those that are likely to be over-estimated as high risk using the low threshold of the PAP.

25. The PAP does not necessarily influence the criminal justice response to the perpetrator (i.e., whether or not charges will be laid), rather it influences how the WGFVT police allocate resources to ongoing involvement with the victim for the purpose of risk management. Importantly, those deemed "recidivist" offenders (defined by three or more family violence incidents in the previous 12 months) are automatically allocated for case management regardless of the PAP score.

26. The police then ensure that the orders are in place to protect the victim, as well as ensuring that Women's Health West (the local specialist family violence service) and other relevant services have been contacted as appropriate.

27. I understand that Victoria Police are currently planning to revise the L17 and PAP procedures to better capture risk-relevant information and ultimately streamline the frontline risk assessment process.

28. Ideally, a risk assessment procedure should consider the nature and severity of the violence that has occurred, and the contextual risk factors that likely contributed, in order to identify the most appropriate areas for risk-management interventions. Thus the risk assessment process should consider:

    28.1. What is the likelihood of further violence occurring?

    28.2. If further violence were to occur, what are the most likely contexts, scenarios or triggers in which violence may arise?

    28.3. What kind of violent behaviours are most likely to occur? Consider the nature, severity, and potential for life-threatening physical harm, and any indications that the severity of violence may escalate to life-threatening harm in future.

28.4. What is the risk of imminent violence? Are there indications of violence recurring in the very short term (hours or days) versus weeks or months.

29. Clearly, the capacity to complete such context-specific professional judgements of risk is reliant on the quality and content of information obtained. Ideally, police at the frontline could be trained to sensitively and reliably gather much more initial information to better inform the initial risk triage process, with more specialist risk assessments occurring at the second tier.

B-Safer Family Violence Structured Risk Assessment Tool

30. The purpose of my presence within the WGFVT was to provide a more structured and comprehensive professional risk assessment process using The Brief Spousal Assault Form for the Evaluation of Risk (**B-SAFER**), which is a structured professional judgement tool designed to assess risk of intimate-partner violence. While multiple risk assessment tools exist, the B-SAFER is the only empirically-validated structured professional judgement tool to assess risk in intimate partner violence at the policing/law enforcement stage, and can be used by non-clinical professionals (i.e. police members). There is no structural professional judgement tool designed to assess risk of targeted violence (risk toward a specific victim) in non-intimate family violence cases, or risk of non-physical forms of family violence (other than stalking). **Attached** to this statement and marked '**[Confidential MW-1]**' is a copy of Forensicare's 'Rating Sheet for B-Safer' form, which illustrates the types of case information and specific risk factors that are considered in a B-SAFER assessment. The form is commercial in confidence and I ask that the Royal Commission not make it public.

31. The B-SAFER stemmed from forensic psychology research into whether formally trained police officers' risk assessments in the context of intimate partner violence can be coded in an acceptable and reliable way. The tool is designed for police members to use, and considers both the perpetrator risk factors as well as victim vulnerability factors. The model was developed in Sweden, where the policing and legal systems and the family violence response system are relatively similar to the Victorian system. Part of the pilot program at WGFVT is aimed at validating the risk assessment tool in the Victorian context.

32. In practical terms, gathering information for the B-SAFER risk assessments involves a review of all police file materials (including criminal histories and narratives for both current and prior family violence incidents) followed by interviews with the victim and perpetrator (where they provide informed consent).

I usually interview the victim first which provides valuable information regarding the relationship context, their experience of family violence, and the presence of vulnerability factors that may complicate their exposure to risk.

33. I also attempt to interview the offender to identify the perpetrator risk factors and the level of psychosocial adjustment. Unfortunately, it is often difficult to interview the respondent, as they may have been remanded, changed their contact and residential details, or simply declined their consent to be interviewed. These barriers to the assessment become more worrisome in cases where the perpetrator remains in the community, and the collateral information indicates concerns for his mental state and potential risk to the victim. It often becomes necessary to complete the B-SAFER without directly interviewing the respondent, whilst recognising and emphasising the limitations this entails.

34. After completing the B-SAFER form I submit a two page report to the police, which summarises the case, the risk formulation, and relevant recommendations. The risk formulation is the identification of risk factors and their application to the specificities of the individual case, as well as the risk assessment outcome (overall risk category, likely risk scenarios, and whether there are indicators of risk of serious escalation or imminent risk).

35. The B-SAFER is unique compared to other violence risk assessment tools, in that it considers vulnerability factors related to the victim as well as offender risk factors. It is also able to consider other contextual and dynamic aspects of the victim-perpetrator relationship, such as whether the victim and offender have separated, whether there are indicators they may reunite in future, or whether there are children involved in the relationship. Consideration of these factors creates a broader picture of the issues associated with the victim and the perpetrator, and informs more appropriate and long term solutions.

36. One critical aspect of family violence risk assessments is that they are dynamic and time-limited in nature, considering the current circumstances of the case and the current context of the victim-perpetrator relationship in which violence has occurred. If the nature of the relationship changes, or there are changes to individual risk factors (such as mental state or patterns of substance use) then the risk must be re-assessed to account for these changes. Furthermore, it is emphasised that the B-SAFER and other risk assessments of family violence are assessing risk of targeted violence; that is, the risk of violence by the offender to a specific, identified victim (i.e. a current or former intimate partner). If the perpetrator enters a new relationship in future, the context of that relationship is

different and the new partner will bring his or her own characteristics to those relationship dynamics. Therefore, the risk associated with one intimate relationship will be different to the risks associated with future relationships for that perpetrator. In this circumstance, a new B-SAFER would need to be completed.

37. Part of the report I write for the police is recommendations for how best to manage the risk identified. As per the principles of risk, need, and responsivity, higher-risk cases require more intensive risk-management interventions. Recommended interventions are included for both the victim and the perpetrator. The recommendations for the victim are in relation to case management and support services and safety planning. The recommendations for the perpetrator may relate to the criminal justice response, such as appropriate risk-relevant conditions to bail and intervention orders, and also referral to treatment services to address relevant criminogenic needs. On occasion, I have also made recommendations to be respectfully submitted to the Court (via handover to the police prosecutor), particularly in cases where more comprehensive, specialist forensic mental health assessments are indicated and can only be arranged by the presiding Magistrate.

Police family violence risk assessment procedures generally

38. Due to the varying levels of triage and risk assessment protocols at different stages of criminal justice processing and service involvement, there are different interpretations of how risk is defined and what the "risk is" in a given case. For example, the responding officers may develop their own unstructured 'risk assessment' guided by their observations on the scene, while the PAP (completed later by the FVT) risk category may conflict with the original informant's views. Further, the PAP risk category may be different to that identified by the BSAFER. These different risk appraisals in the same case can create confusion if there are not specific protocols and language to determine which is ultimately "correct". Importantly, while the PAP is widely referred to as a "risk assessment", it has not been empirically validated to reliably predict recidivism or escalation in violence severity. As previously noted, its low scoring threshold results in considerable over-identification of cases as high risk, and thus is better conceptualised as a 'triage' or 'screening' assessment than a "risk assessment" per se.

39. There can also be varying agreement within each risk tool. Some of the PAP/L17 items are arbitrarily defined, and thus the accuracy of these risk assessments depends upon the experience, knowledge and personal views of the officer is who is completing the evaluation, as well as the quality of the information obtained by the front-line responding officers.

40. The B-SAFER partially overcomes this by providing specific definitions and the types of information to be considered for each variable. If frontline police were trained in asking more detailed questions of victims and perpetrators, it would inform the risk assessment process, and therefore the response to the family violence more fully. There must be a shared understanding of how to accurately assess and define risk.

41. In addition to identifying the simple *presence* of risk factors, their relevance should also be considered in terms of the specific case. For example, "weapon use" may be present in two cases but very contextually different between someone who grabs and holds a readily-accessible household item without entering physical proximity to the victim, versus someone who actually approaches and physically attacks the victim with a highly lethal weapon such as a knife. Allocating the same code for two very different types of assault or abuse leads to inaccurate risk assessments and formulations, and thus potentially inappropriate interventions.

42. Another issue arising from the multiple risk assessment procedures is that there is confusion in relation to the phrase 'risk assessment', as it appears unclear who is completing the risk assessment and at what point the risk assessment occurs. For example, some may view the front-line on-scene analysis and decision-making as a 'risk assessment' while others may consider it to be the 'PAP', and others still may view the risk assessment to be a more ongoing, fluid process over the course of police involvement with the case. In my view, the front-line responders should be considered to conduct a 'triage' assessment and to gather appropriate information for more specially trained members to complete the formal risk assessment process at the family violence team stage, using all available information on the overall case and an empirically-validated risk assessment tool.

43. The risk to the victim and the risk posed by a perpetrator are two halves of the same assessment process, as the risk exists in the context of the relationship. It is not specifically stated either way whether the L17 and PAP address the risk posed *to* the victim or the risk posed *by* the perpetrator. This can be very important as circumstances change and that can result in changing risk levels.

44. An effective assessment process should act as a pivot point:

    44.1. To identify the range and severity of needs in the individual case;

    44.2. To identify the most appropriate treatment services for intervention (in the community as well as in custody); and

44.3. To provide a baseline that can be reviewed at completion of treatment to allow for comparison and evaluation.

45. The tools used within this procedure should, wherever possible, be validated and consistent with approaches in other services that respond to family violence perpetrators (e.g., crisis services, substance abuse services, mental health services). Where these services do not actively use a risk assessment tool, being able to understand the results of family violence risk assessments used by specialist violence services would be ideal.

46. The L17 and PAP predominantly reflect the current violent incident, and do not adequately take into account the history or context of the relationship or the abuse when considering risk. There can be instances where one serious incident may result in an extremely high risk category, but a second incident concerning the same couple only a few days later may be less serious in nature (for example, verbal argument only), and is therefore assessed by the PAP as less concerning in risk. Thus the perpetrator can be changed from very high risk to low risk in a matter of days, because that second PAP score does not account for the overall context of the case. In contrast, the B-SAFER tool assesses the overall case to ensure previous behaviour is considered. There is clear benefit to assessing the whole circumstance rather than incident by incident.

Delay in Perpetrator Service Responses

47. The nature of the criminal justice system means that there are issues of delay which affect how well and how rapidly we are able to intervene with offenders. Police refer every male offender to the same community-based intervention program as a matter of course, which currently has a waitlist of at least six months. During that six month wait, the victim is often exposed to ongoing risk.

48. Other violence intervention programs such as correctional programs and the Problem Behaviour Program are currently unable to treat offenders with pending charges, for ethical reasons. There are ethical complications involving providing therapeutic treatment interventions when police matters have not yet been resolved. Potential issues of confidentiality, offence disclosure and subpoena of clinical records can have substantial impact on the therapeutic relationship and the ability to address risk in treatment directly. Only limited skills-based interventions (such as learning and practicing coping strategies) can be conducted during this phase, but even these interventions have limited accessibility. While treatment can be mandated by the Judge or Magistrate during sentencing, often

sentencing orders (both in custody and community) are of insufficient length for genuine treatment readiness to develop, and for progress to be sustained. Frustratingly, sometimes offenders are on remand for so long that by the time they are sentenced, they have served their time and are released without any forensic mental health assessment or treatment. There is a need to find alternative solutions to these issues, so that offenders with behavioural problems can be assessed and treated as early as possible to prevent further recidivism.

49. Ideally, when the police make an assessment in instances of high risk offenders, the officers would have a mechanism for immediate referral for a second-tier, comprehensive assessment by specialist forensic mental health services. This is especially important when identifying mental health issues, personality problems, and other areas of complex risk and need. Forensicare has the experience, the expertise and the knowledge to undertake these forensic mental health assessments, but we do not have the resources under our current funding model. Currently there is the possibility for the Court to order a Forensicare assessment to inform sentencing decisions (via a Pre-Sentence Court Report) however there are often substantial delays between the initial family violence incident and the sentencing hearing, and thus this does not assist the timely assessment and intervention of very high risk cases who remain at risk in the community. Further, an offender must have entered a plea of guilty before a Forensicare sentencing assessment can occur. If an offender doesn't enter a plea of guilty, or new charges are laid due to further offending, the Forensicare assessment and treatment process is further substantially delayed. Currently these Court assessments are funded for offenders in remand, but not for those on bail.

Information sharing

50. There is a clear lack of communication between support services, the police, corrections and government agencies about the needs of people who have experienced family violence. For example, Forensicare might identify an offender as high risk, but DHS may not, which would mean that the offender may still have access to his children. If different parts of the system are able to share information about risk assessments, this may inform the most appropriate services provided to victims and perpetrators of family violence.

51. Information sharing between police and corrections also requires improvement, as there is a limitation on the amount of accurate information the police or the family violence teams can obtain from corrections in terms of when a perpetrator is released from prison. A list is circulated by corrections listing which perpetrators

will be released per week or per month, but a specific release date is not provided. This can cause unnecessary stress and anxiety for the victim of the prisoner who is due to be released. There must be improvement in the provision of information from corrections to family violence services regarding when the associated offender is released, so that appropriate victim safety planning can occur.

Integration of services

52. There is also a need for improvements to integration and communication between mental health services, drug and alcohol services, and offence-specific program providers. The Sexual Offences and Child Abuse Investigation Teams (**SOCIT**) appear better able to integrate with other services very successfully, as through their work they have built relationships with child protection, family violence teams, CASA and Forensicare. Having multiple services available on one site is useful in assisting both victims and perpetrators of family violence.

53. Another model for integration is having a support service outreach worker placed within a mainstream service or entry point to assist people with multiple and complex needs. The current model of embedding a Forensicare psychologist at Footscray police station has proven successful to date, as has the Forensicare Court Liaison Service.

Recommendations

54. Based on my work with police, I can see the need for some changes in the way the system works to identify high risk offenders and protect high risk victims.

55. Improvements are required for training police officers in both risk assessment of, and responses to, family violence. Some police officers have an excellent grasp of the issues associated with family violence, usually though their experience in the job. Initiatives, such as the collaboration of Victoria Police, Forensicare, and the CFBS in the provision of specialist forensic mental health services to family violence teams should be explored and implemented as viable mechanisms for supporting and upskilling police in their work.

56. The response to family violence incidents is based on police resources. Frontline police have to respond to hundreds of calls per shift, and then complete the necessary paperwork for each incident at the end of the shift. The demand for police assistance is so great that sometimes family violence associated issues are not able to be prioritised. This means that tasks associated with following up

family violence matters, such as applying for intervention orders or pressing charges, may be delayed or overlooked.

57. The identification of any form of family violence should routinely require assessment for the presence and nature of other types of family violence. Identification of multiple types of violence within a family should lead to increased service provision to the family.

58. A consistent and comprehensive assessment procedure is required for identifying risk and treatment needs for family violence perpetrators who are subject to agencies including Victoria Police, court services, custody, community corrections, Forensicare and other relevant services.

59. There are clear service gaps for complex family violence offenders whose behaviour is caused by a range of factors including their attitudes and beliefs. Where complex, high risk offenders are identified at these gateway points, they could be referred to more intensive programs offered by specialist services that can cater to the increased level of risk and need. Forensicare would be in a position to provide enhanced services, should resources be made available.

Dr Melisa Helen Wood

Dated: 24/07/2015