Evaluation of the Problem Behaviour Program

A community based model for the assessment and treatment of problem behaviours.

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Centre for Forensic Behavioural Science

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Contents

PART 1: Describing Problem Behaviour Program (PBP) Clients

Key Findings

- In an analysis of all clients attending the PBP over a five year period to 2011, it was found that violence was the most common reason for referral to the PBP, accounting for 46% of overall referrals. Harmful sexual behaviour accounted for a further third of referrals and stalking for a quarter (with a number referred for multiple problem behaviours).
- More than 40% of referrals to the PBP came from Community Correctional Services, followed by Area Mental Health Services (30%) and self-referral (6%).
- The vast majority of PBP clients have had previous contact with the Victorian public mental health system (90%). PBP clients were diagnosed with a range of psychiatric disorders including psychotic disorders (28%), depressive disorders (15%) and paraphilias (13%). This suggests that, although not based on a typical forensic mental health service model, the PBP routinely provides assistance to mentally disordered offenders and others experiencing serious mental health difficulties.
- Individuals seen at the PBP have diverse offending histories. Nearly 20% were versatile offenders (index problem plus five or more offence types). Approximately a third (37.2%) of clients who had contact with the PBP were charged for a subsequent offence; this offending included violent offences (16%); breaching a legal order (3.6%); sexual assault (3.3%) and weapons offences (2.2%)
- Approximately 25% of clients seen for assessment at the PBP went on to receive individual treatment. However, 60% of clients recommended for treatment dropped out prior to commencement or satisfactory completion. This likely relates to the persistent and challenging nature of many clients' behaviours.
- 37.2% of all PBP clients (attending for either assessment only, or assessment plus treatment) reoffended within the follow-up period. Analyses separating rates of reoffending for assessment compared to assessment plus treatment are provided in Part 2.

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Background

The PBP is an internationally recognised community-based service that was established in 2004 and provides assessment and treatment to individuals with high-risk problem behaviours, including harmful sexual behaviours, violence, threatening, stalking and fire-setting. The PBP is a unique forensic mental health service in Australia as it expands the scope of the traditional community forensic mental health service model beyond a focus on psychopathology to other psychosocial needs. The PBP does not require clients to have a diagnosable mental disorder or current legal order to attend. Instead, clients are accepted to the PBP if they are engaging in a problematic behaviour that has the potential to cause harm to the community and to the client themselves. Clients of the PBP engage in a wide range of problem behaviours including harmful sexual behaviours such as rape, child molestation, internet child pornography use, exhibitionism, and actual or threatened violence. The PBP is the only service in Victoria to provide specialist assessment and treatment to stalkers, fire-setters and individuals engaging in unreasonable complaints.

In 2012 Forensicare committed to a comprehensive research evaluation of the program. This report is the first of a series investigating the operation of the PBP and its efficacy. *Part 1: Describing Problem Behaviour Program Clients* provides a summary of the clients who were referred to the PBP for assessment or assessment and treatment between January 2006 and January 2011. This is part of the first evaluation of the PBP since its inception and this report provides necessary descriptive information regarding referral sources, presenting problem behaviours, mental health diagnoses and history, criminal history, length and type of treatment received and general recidivism of PBP clients.

While the term 'problem behaviour' is used, it should be noted that individuals do not have to have *committed* a violent or other criminal act to be referred for treatment. For example, a number of individuals are taken on for treatment for violent or homicidal thoughts, making threats, problematic sexual thoughts or urges, or internet child pornography. The PBP plays a pivotal role in the assessment and treatment of client groups that are often unable to access treatment elsewhere, and whose behaviours impact on community safety. The results of this evaluation will inform service development to ensure the program is employing best practice in the assessment, treatment and management of problem behaviours, as well as meeting the needs of key stakeholders in reducing harm to victims, the community and clients.

Results

Referral information

During the five year period of the study, 824 individuals were assessed and/or treated at the Problem Behaviour Program. Figure 1 depicts the number of individuals seen by the PBP per year (note that 2011 is not represented as the study ended in January of that year by which time only 14 referrals had been made).

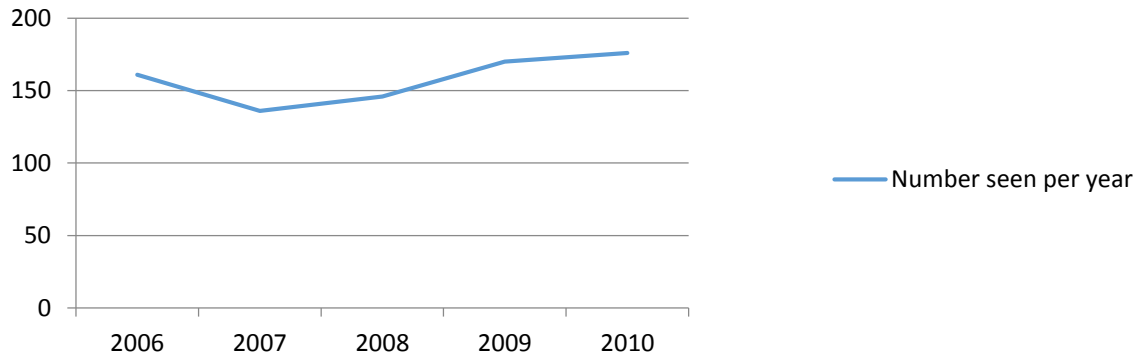


Figure 1. Number of individuals assessed per year at the PBP

Clients were on average 36.9 years old (range: 15-83; SD 12.7) at the time of the assessment or treatment episode with PBP. In total, 25 (3%) clients were 18 or under[i] at the time of PBP contact (15 years: 1; 16

years: 4; 17 years: 11; 18 years: 9). The vast majority were male (731, 88.7%; female 91, 11%) and did not self-identify as Aboriginal or Torres Strait Islander (774, 93.9%).

During the study period 610 (74%) clients were seen for an assessment only, while 214 (26%) were taken on for treatment. Figure 2 depicts the number of individuals either assessed or referred for treatment per year.

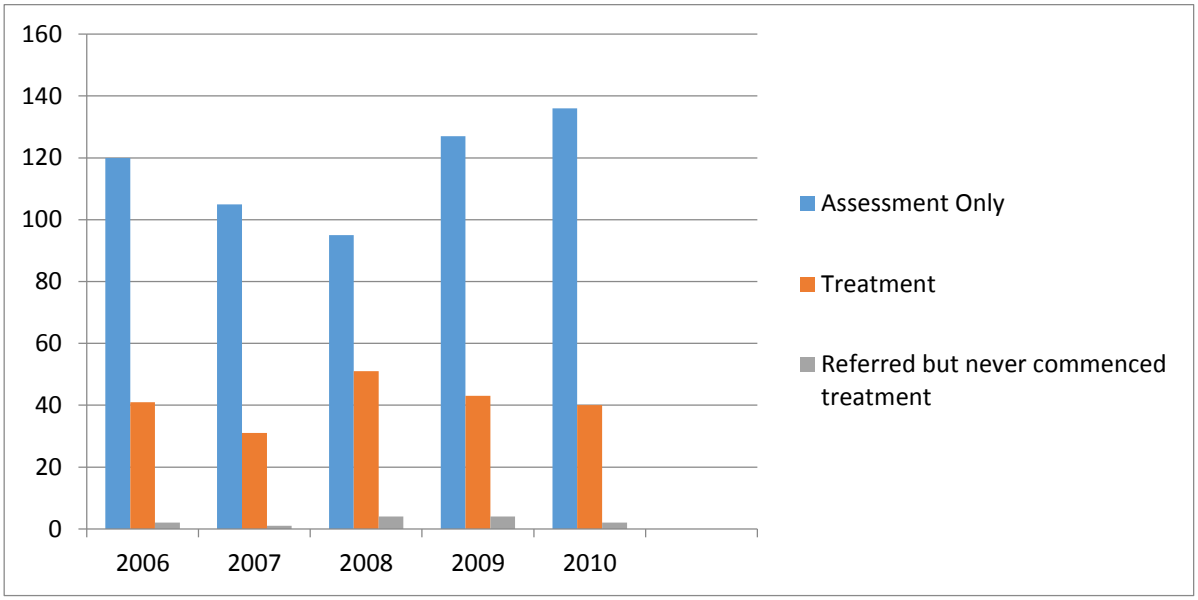


Figure 2. Number of individuals seen for assessment only compared with those taken on for treatment, or referred for treatment but never attended.

Referrals came from a range of services (depicted in Table 1.), although the majority were from community corrections services or Area Mental Health Services. A small number of individuals were referred from a number of other services, including Thomas Embling Hospital, the Adult Parole Board, Youth Criminal Justice Services, private psychological services, prisons, brain injury services, mental health court liaison service and legal services. The purpose of the referral was mainly primary consultation (627, 75.7%), secondary consultation (186, 22.5%) and tertiary consultation (12, 1.4%).

Table 1. Number of individuals referred by various sources

Type of service	**Number (%)**
Community Corrections Services	346 (41.8%)
Area mental health services- Inpatient	112 (13.5%)
Area mental health services- Outpatient	134 (16.2%)
Self-referral	53 (6.4%)
Youth mental health services	35 (4.2%)
Private psychiatric services	25 (3.0%)
DHS- child protection	20 (2.4%)
Other	26 (3.1%)
GP	13 (1.6%)
Other community health services	13 (1.6%)

Presenting problem behaviours

Violence was the most common referral reason (384, 46.6%), followed by harmful sexual behaviour (266, 32.3%), stalking (213, 25.8%), firesetting (52, 6.3%), and other, for instance gambling and persistent complainers (95, 11.4%). In understanding these figures, it is noted that a minority of the sample were referred for multiple problem behaviours (131, 15.9%). For referrals related to violence, specific referral reasons included: violent behaviour (236, 28.6%), violent or homicidal ideation (74, 9%) and threats (74, 9%). Specific harmful sexual behaviours included: problematic sexual behaviour (209, 25.4%), internet child pornography (24, 2.9%), and problematic sexual thoughts or fantasy (33, 4%).

Mental health information

Primary and secondary diagnoses made by PBP clinicians at the time of assessment are shown in Table 2. As these diagnoses were made between 2006 and 2011, they are reported here according to DSM-IV-TR Axis I and Axis II categories; however, DSM 5 no longer makes these distinctions.

Table 2. Primary and secondary diagnoses made by clinicians at time of assessment

Disorder	Primary Diagnosis in Assessment only group N (%)	Primary Diagnosis in Treatment group N (%)	Total Primary N (%)	Total Secondary N (%)
Axis I				
None	188 (30.5)	55 (25.7)	243 (29.3)	658 (79.5)
Psychotic disorders	202 (33.1)	30 (14)	232 (28)	6 (0.7)
Bipolar affective	28 (4.6)	6 (2.8)	34 (4.1)	5 (0.6)
Depressive	76 (12.5)	28 (13.1)	104 (12.6)	18 (2.2)
Anxiety	28 (4.6)	7 (3.3)	35 (4.2)	31 (3.7)
Paraphilia	16 (2.6)	63 (29.4)	79 (9.6)	27 (3.3)
Substance misuse	24 (3.9)	9 (4.2)	33 (4)	40 (4.8)
Developmental disorder	11 (1.8)	6 (2.8)	17 (2.1)	12 (1.4)
Cognitive disorder	22 (3.6)	2 (0.9)	24 (2.9)	17 (2.1)
Other (DID, eating, impulse, adjustment)	11 (1.8)	7 (3.3)	18 (2.2)	11 (1.3)
Mood NOS	4 (0.7)	1 (0.5)	5 (0.6)	3 (0.4)
Axis II				
None	10 (1.6)	2 (0.9)	670 (80.9)	807 (97.4)
Personality Disorder				
Paranoid	2 (0.3)	2 (0.9)	4 (0.5)	0
Schizoid/schizotypal	3 (0.5)	3 (1.4)	6 (0.7)	1 (.01)
Antisocial/Psychopathic	36 (5.9)	15 (7)	51 (6,1)	3 (0.4)
Borderline	28 (4.6)	10 (4.7)	39 (4.7)	7 (0.8)
Histrionic	1 (0.2)	0	1 (0.1)	1 (0.1)
Narcissistic	6 (1)	1 (0.5)	7 (0.8)	2 (0.2)
Other (avoidant, dependent, obsessive-compulsive)	23 (3.8)	11 (5.1)	34 (4.1)	4 (0.6)
Total Personality Disorder	**99 (16.3)**	**42 (19.6)**	**142 (17)**	**18 (2.2)**
Intellectual disability	13 (2.1)	3 (1.4)	16 (1.9)	2 (0.2)
Axis II traits				
Paranoid	0	2 (0.9)	2 (0.2)	1 (0.1)
Schizoid/schizotypal	0	4 (1.9)	4 (0.5)	1 (0.1)
Antisocial	5 (0.8)	8 (3.7)	13 (1.6)	3 (0.4)
Borderline	5 (0.8)	3 (1.4)	8 (1)	4 (0.5)
Histrionic	0	0	0	0
Narcissistic	1 (0.2)	1 (0.5)	2 (0.2)	3 (0.4)
Psychopathic	0	1 (0.5)	1 (0.1)	0
Other (avoidant, dependent, obsessive-compulsive)	6 (1)	10 (4.7)	17 (2.1)	2 (0.2)
Total Personality Disorder	17 (1.9)	29 (13.8)	47 (5.7)	14 (1.7)

A small number of individuals were diagnosed with 3-4 Axis I disorders at time of assessment; the majority of the third and fourth diagnoses related to developmental or substance use disorders. When individuals did not meet full criteria for a personality disorder but were exhibiting personality traits consistent with the personality disorders represented in Axis II of the DSM-IV-TR, clinicians recorded the presence of these traits only. These are also shown in Table 2.

Treatment clients

The length of the episode of treatment at the PBP ranged from 0 to 38 months (M = 7.29, SD = 7.76, median = 5 months). Of those who were taken on for treatment 63 (29.4%) completed the course of treatment, 19 (8.9%) were still in treatment at the time of the study collection, and the remainder did not complete treatment for a range of reasons. Refer to Figure 3 for the break-down. For those who dropped out of treatment the reasons were diverse: Failure to attend (68, 31.8%), being taken into custody (10, 4.7%), correctional order expiring (3, 1.4%), hospitalisation (1, 0.5%), and other reasons (9, 4.2%).

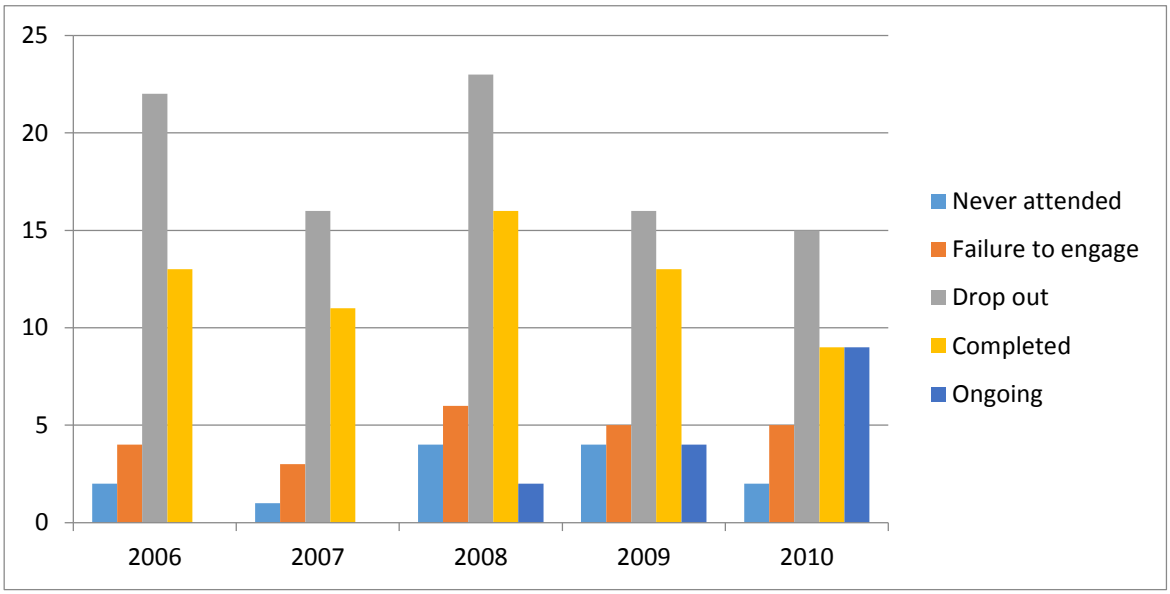


Figure 3. Treatment outcomes by year

Based on the referral question and outcome of the assessment a range of targets were identified as priorities for treatment. These were both offence-specific and offence-related targets. Many clinicians identified a number of targets; up to four were recorded for the purposes of this evaluation. Treatment targets by treatment clients are shown below in Table 3.

Table 3. Percentage of treatment clients by specific targets

	Target 1 N= 197 (%)	**Target 2 N= 182 (%)**	**Target 3 N = 138 (%)**	**Target 4 N= 71 (%)**
Offence-specific				
Cognitive distortions	60 (28)	22 (10.3)	14 (6.5)	4 (1.9)
Victim empathy	12 (5.6)	18 (8.4)	3 (1.4)	2 (0.9)
Fantasy work	28 (13.1)	14 (6.5)	6 (2.8)	5 (2.3)
Violence reduction	4 (1.9)	7 (3.3)	2 (0.9)	1 (0.5)
Antisocial attitudes	1 (0.5)	1 (0.5)	0	3 (1.4)
Risk management	16 (7.5)	19 (8.9)	22 (10.3)	9 (4.2)
Other	1 (0.5)	1 (0.5)	1 (0.5)	1 (0.5)
Offence-related				
Social skills	14 (7.1)	26 (14.3)	28 (20.3)	13 (18.3)
Emotion regulation	49 (22.9)	27 (12.6)	28 (13.1)	5 (2.3)
Prosocial relationships	3 (1.4)	3 (1.4)	7 (3.3)	6 (2.8)
Substance misuse	1 (0.5)	11 (5.1)	5 (2.3)	3 (1.4)
Coping skills	8 (3.7)	24 (11.2)	17 (7.9)	8 (3.7)
ADLs	0	5 (2.3)	2 (0.9)	3 (1.4)
Suicide	0	1 (0.5)	2 (0.9)	1 (0.5)
Other	0	3 (1.4)	1 (0.5)	7 (3.3)

Criminal History and Recidivism

Criminal history was obtained from Victoria Police's Law Enforcement Assistance Program (LEAP) for all individuals in the study, including offences committed two years prior to the study period (01.04.2004) and follow-up data for offences committed up to 30.06.2012. These data show that in addition to being referred for a diverse range of problem behaviours, individuals seen at the PBP had diverse offending histories. While 573 (69.5%) were not versatile offenders (index problem plus two or fewer offence types), a sizeable proportion were. 101 (12.3%) clients were moderately versatile (index problem plus 3-4 other offence types in history) and 150 (18.2%) were highly versatile (index problem plus five or more offence types). On average, clients had a mean of 12.5 (SD = 16.8; range 1 - 112) total charges and a mean of 2.5 (SD = 6; range 0 – 53) subsequent charges after the PBP contact. There were no significant differences in the number of offences committed by assessment or treatment clients.

More than one third (n= 299, 36.3%) of the individuals were charged for an offence after any contact with the PBP[ii]. Each individual's most serious offence committed after the index episode of contact was coded according to the Cormier Lang system (Quinsey, Rice, Harris, & Cormier, 2006). The most serious offences individuals reoffended with included violent offences (132, 16%), breaching a legal order (30, 3.6%), sexual assault (27, 3.3%), weapons offences (18, 2.2%), and a range of stalking, drugs, property damage, theft, deception, threats, bad public behaviour, possess child pornography and arson offences. Further detail on client recidivism can be found in Part 2 including analysis of subsequent offending comparing assessment only clients versus those who received assessment plus treatment.

Mental health system contacts

Information about lifetime contact with mental health services was collected from the Department of Health and Human Services. 744 (90.3%) individuals were registered on the statewide mental health database (known as RAPID) and had accessed a range of services across the lifespan, with outpatient contact being the most common. Types of services accessed are displayed in Table 4. When comparing lifetime registration between clients referred to the PBP by mental health services and those referred via legal channels, the former group were significantly more likely to have been registered with psychiatric services; although the proportion amongst those referred through legal services was also high (316, 82.7%).

Table 4. Type of lifetime mental health service contact

Type of service	Number (%)
Outpatient	710 (86.2)
Inpatient	390 (47.3)
CCU/ongoing care	418 (50.1)
Community Treatment Order	205 (24.9)
Crisis Assessment and Treatment Teams	361 (43.8)
Child/Adolescent	89 (10.8)

A comparative analysis was undertaken to compare the service usage of individuals who were only seen for an assessment to those referred for ongoing treatment. As shown in Table 5, assessment only clients were significantly more likely than treatment clients to have had all types of mental health contact (with the exception of mental health contact as children).

Table 5. Comparison of the type of contacts with MHS by treatment and assessment clients

Type of service	**Assessment only Number (%)**	**Treatment Number (%)**	χ^2
RAPID registered	535 (64.9)	209 (25.4)	17.92***
Outpatient	502 (60.9)	208 (25.2)	25.51***
Inpatient	316 (38.3)	74 (19)	18.82***
Community Treatment Order	180 (21.8)	25 (3)	26.94***
Child/Adolescent	66 (8)	23 (2.8)	0.001

*** $p < .001$

Of those registered on RAPID, 634 (76.9%) received an Axis I diagnosis, 305 (37%) received an Axis II Personality diagnosis and 46 (5.6%) received an Intellectual Disability diagnosis. Diagnostic information from RAPID showed that individuals have received a range of diagnoses across the lifespan (see Table 6). A large proportion had lifetime diagnoses of substance misuse (305, 37%). Despite the range of diagnoses received in adulthood, only 69 (8.6%) received some form of diagnosis in childhood. Personality disorder diagnoses (as recorded on RAPID) were predominantly of the antisocial (110, 13.3%), borderline (66, 8%) and unspecified (58, 7%) types, with a number receiving more than one personality disorder diagnosis over time (28, 3.4%).

Table 6. Lifetime Axis I diagnoses received by individuals

Most severe diagnosis ever received	N	(%)
None	200	(24.3)
Schizophrenia spectrum	218	(26.5)
Other Psychosis	34	(4.1)
Bipolar affective disorder	30	(3.6)
Depressive disorder	120	(14.6)
Anxiety Disorder	97	(11.8)
Eating Disorder	1	(0.1)
Paraphilias	72	(8.7)
Impulse control	5	(0.6)
Substance use disorder	33	(4.0)
Other	14	(1.7)

Conclusions

The Problem Behaviour Program was established in 2004 to fill a perceived gap in existing mental health and justice services. Clients of the PBP are those who often cannot access other services either because the nature of their behaviour means there are no available services (e.g., stalking, firesetting, internet child pornography); they have mental disorder that impacts on their ability to engage with other forensic services; their behaviour places them at risk of being excluded from mental health services and incurring legal penalties (e.g., threats/violence); or because they do not qualify for other services due to the absence of mental disorder. This first survey of PBP clients over a five year period between 2006 and 2011 showed that the largest single problem behaviour exhibited by PBP clients is violence, accounting for almost half of all referrals. Harmful sexual behaviour was present in one third of referrals, stalking in one quarter, and firesetting in six percent. Notably, one in six clients were referred with multiple different problem behaviours.

Nearly half of PBP referrals came from Community Corrections Services during the data collection period. One in twenty clients self-referred and one in four had no mental health diagnosis. These figures suggest that the PBP is meeting its stated purpose: to fill a gap by providing assistance to clients who engage in problem behaviours but due to the absence of a diagnosable mental disorder or current legal order, cannot access other services. Referrals to the PBP remained largely steady over the five year period of data collection, with a trend towards increasing referrals since 2007. It should be noted that since the end of the data collection period, the relationship between the PBP and Corrections Victoria has been formalised and Corrections clients now constitute an even larger proportion of the PBP workload than is represented in this report.

The majority of clients seen by the PBP have had contact with the public mental health system. Furthermore, approximately three quarters of clients were diagnosed with an Axis I psychiatric disorder and a quarter with an Axis II disorder. This highlights that whilst the single largest group of referrals come from the legal system, the PBP is responding to clients with major mental health difficulties. Given high rates of psychiatric disorder in PBP clients, there is a clear need for staff to have clinical training and skills in addition to specific forensic skills and training. It should be noted that the figures regarding the prevalence of personality disorder are likely to underestimate the true prevalence of those disorders amongst PBP clients, as personality disorders often go unrecorded on RAPID. Studies of clients referred to the PBP for stalking show that approximately 45% of this sub-group have identifiable personality disorder or problematic personality traits that contribute to their behaviour.

One quarter of clients assessed at the PBP were taken on for treatment. The target population for the PBP are those individuals whose problem behaviours place them at risk of engaging in offending behaviour. More specifically, they pose a high risk of harm to the community, their needs cannot be met elsewhere and they show some sign of willingness to engage in treatment and are likely to benefit from treatment. Of this group, approximately one third completed treatment as recommended, with the majority dropping out of treatment or treatment being terminated due to failure to engage. Those who dropped out did so for a range of reasons including simply failing to attend, ceasing attendance after the expiry of their legal order, being re-apprehended or being hospitalised. In the time since 2011 a range of strategies have been put in place to improve client attendance, including a text message service to remind clients of appointments and increased liaison with Community Corrections staff. Despite these efforts, treatment drop-out remains an area for further consideration and review. There are a range of issues that require additional attention including the effectiveness of current administrative procedures, closer consideration of suitability of clients for treatment, and routine exploration of issues related to the engagement of clients in treatment (e.g., motivation to engage).

A range of treatment targets were identified by clinicians, including both offence-specific (e.g., antisocial attitudes) and offence-related (e.g., emotion regulation) targets. Anecdotal recognition by clinicians of the need to address offence-related targets of interpersonal skills and emotion regulation has resulted in the establishment of group programs (e.g., the Handling Anger Wisely and Positive Relationships groups).

Perhaps one of the more interesting findings from this review of PBP clients is that approximately one quarter are versatile offenders who engage in a wide range of offences aside from those arising from the problem behaviours leading to referral. Moreover, almost 40% of PBP clients reoffended in the 2 – 6 year follow-up period. This reflects broader reoffending rates reported in the literature and indicates that while PBP clinicians clearly have a responsibility to understand and address the specific problem behaviours that led to referral, they also need to be mindful of the broader criminogenic needs of their clients.

[i] The PBP provides service to adults; however, over the time period of the study, decisions have on occasion been made to accept referrals pertaining to clients aged under 18. These exceptional cases have generally involved circumstances where the person in question was near the age of 18, and/or displayed problem behaviours directly and clearly within the scope of service of the program and with no alternative expert assessment options available.
[ii] 25 cases had no reoffending data available and were excluded from the denominator in these analyses

PART 2: Offending and mental health outcomes for individuals assessed and treated at the Problem Behaviour Program (PBP)

Key Findings

- The PBP is effective in reducing reoffending. Two-thirds of all clients who received assessment and/or treatment with the PBP did not receive any further charges after PBP contact. PBP clients had on average 4.9 offences prior to contact with the PBP; post PBP contact this dropped to 2.5 offences.
- For individuals who re-offended (33% of total), the average time to reoffence was just over one year (14.41 months). Of these, two-thirds had no change or decrease in offence severity from their pre-referral offence, and only one third (i.e., one ninth of the total sample) had an increase in severity of offence.
- Clients completing treatment reoffended at significantly lower rates than other clients. Average time to reoffence for the treatment group (785 days) was significantly longer than for the other client groups. A higher proportion of clients in the *treatment* group compared to the *failed to attend* group had a reduction in the severity of their reoffending.
- Contact with the PBP also resulted in more positive mental health outcomes for clients. Overall, there was a significant reduction in the number of outpatient contacts following service provision from the PBP.
- Even for those clients who were seen for *assessment* only, there was a significant reduction in inpatient admission, CATT contact and CTO status.
- There was no significant difference in inpatient contact for the other clients (*treatment* and *failed to attend* groups); this may be due to the more complex nature of these higher risk clients. Overall the *failed to attend* group continued to utilise mental health services at relatively the same level as prior to contact with the PBP, suggesting that assessment alone is not sufficient to result in positive mental health outcomes for many higher risk clients and they require specialist treatment.
- PBP treatment clients report high levels of satisfaction with the service. The majority of clients surveyed report that they have had a positive experience at the PBP and felt supported. More specifically, they reported that the PBP has helped them to understand their problem behaviour, reduce this behaviour, understand unhelpful thinking habits, and feel better.
- The very positive results for those who attended and completed treatment suggests that an increased focus of the work of PBP clinicians should be on engaging clients to the extent possible to retain them in treatment, including further exploration of the reasons that clients cease treatment prior to an agreed end and the kinds of barriers that exist that prevent successful completion.

Background

Part 2 of this Report looks in detail at the treatment and outcomes for PBP clients. The nature of the PBP makes it challenging to evaluate. By its very nature "successes" are cases in which risk is successfully managed and nothing happens. That is, there is no further instance of the problem behaviour and no further involvement with the criminal justice system. The current evaluation therefore examines the reoffence rates and mental health system contacts of PBP clients. Importantly the evaluation also sought feedback from clients about their experience of treatment at the PBP.

In the absence of the PBP, individuals who are at risk of engaging in complex criminal behaviour, but have not yet done so, would not be able to access specialist assessment and intervention unless or until they committed and were prosecuted for an offence. Even then, their access to correctional rehabilitation services may be hampered by the presence of mental disorder or by a lack of service specific to their behaviour. Acceptance into the PBP for many individuals is also often a first step towards establishing links with other key services such as mental health, community health, or other social services. "By taking a lead clinical role in the management and treatment of high-risk behaviours, the PBP strengthens referral pathways to those services that may have previously been apprehensive about taking on such clients" (McEwan et al., 2014, p. 363).

Treatment at the PBP is evidence-based, adhering to Andrews and Bonta's (2010) risk, needs and responsivity principles and using structured risk assessment to identify clients who present as moderate or high risk and so are appropriate for behaviour-specific treatment. The modality of treatment, although somewhat eclectic, is based on cognitive behaviour therapy and relapse-prevention approaches. Relevant risk factors (i.e., 'criminogenic needs') that may be pertinent treatment targets are identified from the risk assessment tools, supplemented with functional analyses of the problem behaviour. Treatment is oriented towards the cessation of the problem behaviour and the formulation is used to prioritise treatment targets and responsivity factors. This allows treatment plans to focus on the client's criminogenic needs, but also to be individualised and tailored to the context of the specific problem behaviours (McEwan et al ., 2014). Clients who attend for treatment at the PBP are deemed to have completed treatment once they have progressed in their treatment gaols to a satisfactory level, as agreed upon by both the clinician and client.

A typical assessment (primary consultation) lasts between two and six hours duration. This takes the form of a semi-structured interview, covering areas such as childhood, adolescence and adulthood, educational and employment history, relationship and sexual history, psychiatric and medical history, drug and alcohol use, and offense history. It is essential that corroborative history is obtained, including criminal history reports, police charge sheets and previous mental health assessment/reports. Further collateral information is frequently obtained from the family or friends of the client, with the client's consent. In the case of a psychological assessment, psychometric testing is likely to be conducted. This testing is tailored to the individual and their presenting problem behaviour. Typically this comprises of some measure of socially desirable responding, personality testing, and other supplementary tests as required. In most cases a structured risk assessment using a set of professional judgement guidelines (e.g. the HCR-20^{V3} [Douglas, Hart, Webster & Belfrage, 2013] or RSVP [Hart et al., 2003]) is also completed and informs the results of the wider assessment (McEwan et al 2014).

> This comprehensive assessment process allows the assessor to develop an explanatory formulation of the problem behaviour, including a functional analysis, which considers the psychological, psychiatric, and social determinants of the behaviour. A written report is provided to the referrer outlining the conclusions of the assessment and providing recommendations for management. In some cases, where risk level and lack of other support services warrants, this may include a recommendation to attend the PBP for ongoing treatment (McEwan et al., 2014, p. 365).

Purpose of the evaluation

A primary aim of the evaluation is to assess the impact of the PBP in reducing offence-specific recidivism. Part 2 of the Report provides an analysis of offending patterns before and after contact with the PBP for all individuals who were assessed at the PBP between January 2006 and January 2011[1]. It also discusses the mental health outcomes of individuals who were assessed and/or treated at the PBP to determine if treatment has an impact on patterns of mental health service usage. Finally, the report examines characteristics of clients who receive treatment at the PBP and includes direct feedback from PBP clients to further understand their experience.

The results of this evaluation will inform service development to ensure the program is employing best practice in the assessment, treatment and management of problem behaviours, as well as meeting the needs of clients in reducing harm to victims, the community and clients.

Key Questions

1. Is contact with the PBP effective in reducing the frequency, nature and time to reoffending?
2. What impact does receiving services from the PBP (assessment and/or treatment) have on mental health outcomes for clients?
3. Who are PBP treatment clients, what is the effect of treatment, and what is their experience?

Definition of terms

Reoffence is measured by charges incurred after the index assessment date, including charges that were laid during the treatment period.

Time at risk is the period of time between the date of assessment at the PBP and the date the individual first reoffended or the end of follow up period, whichever comes first. Time incarcerated for other offences was subtracted from this period. We also removed people who died from the follow-up analyses, ensuring that those in the community were still 'at risk' for re-offending.

Methodology

Data linkage procedure

To determine rates of reoffending and mental health service usage, Forensicare data were linked with data from the Department of Health (CMI), Victoria Police (LEAP), Corrections Victoria (PIMS) and the National Coronial Information Service (NCIS). Cases were matched using identifying information (first name, surname, aliases, date of birth, age range and gender). Once linked, the identifying information was removed for subsequent analyses.

Sample Descriptives

During the study period from January 2006 until January 2011, 901 individuals were assessed and/or treated at the PBP. Data could not be collected for all clients, reducing the final sample to 824. Individuals were on average 36.9 years old (range: 15-83; SD 12.7) at the time of the assessment or treatment episode with PBP. In total, 25 individuals were 18 and under at the time of PBP contact (15 years: 1; 16 years: 4; 17 years: 11; 18 years: 9). The majority were male (731, 88.7%; female 91, 11%) and did not self-identify as Aboriginal or Torres Strait Islander (774, 93.9%). A full account of the sample is contained in Report 1: *Describing Problem Behaviour Program Clients*.

[1] Individuals referred to the PBP who failed to attend for assessment are not discussed in this report.

Question 1: Is the PBP effective in reducing the frequency, nature and time to reoffence?

To answer this question, data were collected of all individuals who were assessed at the PBP between 2006 and 2011. Clients were grouped into three categories;

1. *Not recommended* (i.e. assessment only): Those who were assessed and not recommended for PBP treatment (n=612)
2. *Failed to attend:* Those assessed and recommended for treatment but who failed to attend (n=130). This includes those who failed to attend any treatment sessions as well as those who dropped out of treatment prior to completion. It is noted that clients who attend for treatment at the PBP are deemed to have completed treatment once they have progressed in their treatment gaols to a satisfactory level, as agreed upon by both the clinician and client.
3. *Treatment:* Those assessed and recommended for treatment who attended treatment (n=84*)*. This includes those who were determined to have completed treatment (n=65) as well as those who (n = 19) remained in treatment at the time of the study, with the latter group comprising 2.3% of the total treatment group.

Offending data were collected from Victoria Police for all clients from 2004 and 2012. This ensured that all clients had at least a two year period prior to assessment at the PBP, and gave a follow-up time of 6 months to 7.8 years (mean 3.89, SD 1.49).

A number of between-group and within-individual comparisons were made to determine the efficacy of PBP assessment and treatment in reducing reoffending. Individuals' reoffending rates and the severity of offending were compared before and after the PBP assessment. Reoffending rate was calculated using the average number of offences per month in the 2 years prior to PBP assessment and the 6 months to 2 years after PBP assessment. Severity of offending was coded using the Cormier-Lang System (Quinsey, Rice, Harris & Cormier, 2006) and severity of offending before and after PBP contact was compared and analysed.

In addition to evaluating the number of people who reoffended and the types of offences, time to reoffence was examined using Kaplan-Meier survival analyses (controlling for time in custody). Survival time comparisons were made between the *not recommended* and *failed to attend* groups, and between the *failed to attend* and *treatment* groups (neither analysis controlled for time in treatment). Log rank statistics were used to determine statistically significant between-group differences in time to reoffence.

Question 2: What impact does contact with the PBP (assessment and/or treatment) have on mental health outcomes for clients?

Mental health information was taken from the Victorian Case Psychiatric Register (VPCR, otherwise known as Client Management Index CMI). All information regarding contacts with the public mental health service (across the lifespan) was collected, including: the service contacted (e.g., CATT, Inpatient Acute), the specific program (e.g. PARC or EPPIC), types of contact (e.g. direct), duration of contact, and whether the person has been or was placed on a CTO. Diagnostic information was also coded (all diagnoses are recorded on CMI using ICD-10).

Primary psychiatric diagnoses were coded into categories, replicating previous research undertaken in the CFBS (Cutajar et al., 2010; Ducat, Ogloff & McEwan, 2013; Short et al., 2010; Wallace et al., 2004). The categories included: schizophrenia spectrum (e.g., schizophrenia, schizoaffective disorder, shared psychotic disorder), other psychotic (e.g., delusional disorders, and unspecified non-organic psychosis), bipolar affective disorder, depressive disorder, anxiety, eating disorders, paraphilias, impulse control, and substance use (as primary and any lifetime). A 'substance-use disorder' was defined as any type of

substance abuse, substance dependence, or substance-induced disorder (such as substance induced psychosis), excluding nicotine-related disorders.

Given the large number of potential diagnoses an individual may receive over a lifetime, diagnoses were only coded when they were upheld in 75% of the diagnoses given, or there was a clear diagnostic progression over time resulting in a clear diagnosis. This method has been used by several studies and demonstrates good reliability (Bennett et al., 2009; Krupinski et al., 1982; Short et al., 2010).

Frequency and nature of mental health service usage was compared for the period prior to and after PBP assessment.

Question 3: Who are PBP treatment clients, what is the impact of treatment, and what is their experience?

A repeated-measures design using the sign test was used to examine the changes in offending and mental health service usage pre- and post-treatment at the PBP. The sign test is used to determine whether there is systematic change over time in offending and mental health service usage, depending on treatment[2]. The sign test compares differences in paired values before and after treatment, and examines the overall direction of change in the entire group. Where treatment has not affected offending or service usage, the number of people with improvements should be approximately equal to the number of people without improvements. A significant sign test indicates that treatment has had some effect across the entire group.

Treatment clients attending the PBP during a two week period from 17 November 2014 to 28 November 2014 were asked to complete a written survey in which they rated their experience of the PBP and their perceptions of its effectiveness in targeting their problem behaviours. Participation in the survey was voluntary. Twenty-six clients attended for PBP treatment during the data collection period and 15 completed the survey (58% response rate). Those who participated were offered the opportunity to participate in a structured telephone interview regarding their experience of the program. Three clients consented to the telephone interview (20%).

Results

The reasons for referral to the PBP are included in Part 2 in greater detail. In summary, violence accounted for 46% of overall referrals; harmful sexual behaviour for a further third and stalking for a quarter (with a number of clients referred for multiple problem behaviours). Referrals to the PBP came from a range of sources, and for a range of reasons, as displayed in Table 7.

[2] The Wilcoxon signed-rank test was not used because the assumption of symmetrical distribution of differences between two related groups was violated.

Table 7. Breakdown of referrals to the PBP by referral source and presenting problem behaviour(s)

Referral Source	Number of referrals	Violence	Harmful sexual behaviour	Stalking	Firesetting	Multiple Problem Behaviours[c]
Community Corrections N (%)	346 (42.1)	155 (44.8)	82 (23.7)	134 (38.7)	18 (5.2)	67 (19.4)
Mental Health Services N (%)	280 (33.9)	151 (53.9)	94 (33.6)	53 (18.9)	23 (8.2)	45 (16.1)
Self-Referral N (%)	51 (6.2)	9 (17.6)	37 (72.5)	5 (9.8)	2 (3.9)	4 (7.8)
Other N (%)	144 (17.4)	61 (46.6)	50 (38.2)	20 (15.3)	9 (6.9)	14 (10.7)
Total[a] N (%)	821 (99.6)[b]	384 (46.6)	266 (32.3)	213 (25.8)	52 (6.3)	131 (15.9)

[a] Total is greater than 100% as clients can be referred for multiple problem behaviours
[b] Includes three cases with unknown referral source so total percentage ≠ 100%
[c] Cases in this column are also represented in the relevant specific problem behaviour columns

The vast majority of PBP clients have had previous contact with the Victorian public mental health system (90%). PBP clients were diagnosed with a range of psychiatric disorders including psychotic disorders (28%), depressive disorders (15%) and paraphilias (13%). This suggests that, although not based on a typical forensic mental health service model, and not a requirement for service, the PBP nonetheless routinely provides assistance to mentally disordered offenders and others experiencing serious mental health difficulties.

Question 1: Is the PBP effective in reducing the frequency, nature and time to reoffence?

Frequency of offending (pre- and post-contact with the PBP) across the Not Recommended, Treatment and Failed to Attend groups

Five hundred and twenty-five (63.7%) individuals did not reoffend after the PBP contact and almost half the sample had no formal offence history in the two years prior to the index PBP contact (400, 48.5%). A large proportion of reoffenders had a prior offence history (241, 80.6% of reoffenders). Conversely, only 58 (19.4% of reoffenders) individuals without a prior offending history went on to reoffend (χ^2 = 159.59, $p < 0.001$, $\Phi = 0.44$).

For those with an offending record (either pre- or post-PBP contact; n = 495, 60.1%), their offending careers were diverse. Nearly 20% were versatile offenders (five or more offence types ever), 12.3% were moderately versatile (3-4 offence types), and 69.5% were not versatile (1-2 offence types). A small proportion of individuals had only one offence type (108, 13.1%), while 329 (39.9%) individuals had no offences ever recorded during the data collection period. On average individuals had 4.9 (SD 10.5, range 0-110) prior offences recorded in their criminal history for the two years prior to the index PBP contact. Figure 4 shows criminal versatility by referral problem behaviour.

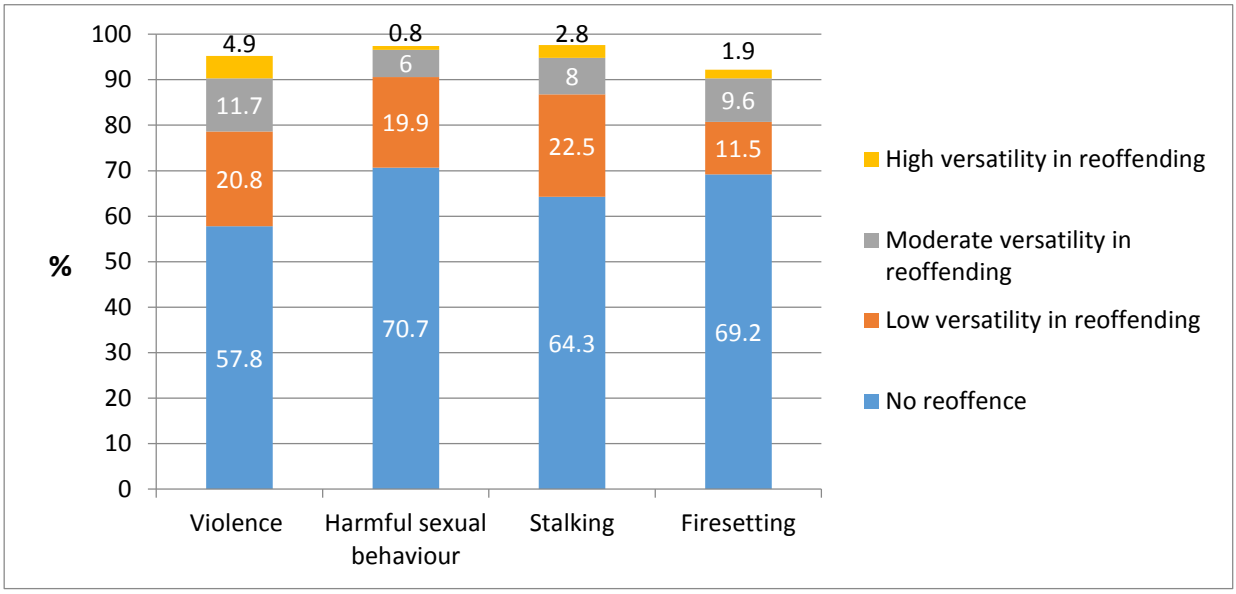


Figure 4. Criminal versatility in subsequent offending by referral problem behaviour

Two hundred and ninety-nine (36.3%) clients were charged with a subsequent offence; including violent offences (16%); breaching a legal order (3.6%); sexual assault (3.3%) and weapons offences (2.2%). The average time to reoffence was 14.41 months (range 0-69, SD 14.53). Reoffending patterns by referral problem behaviour were examined. For those with a presenting problem (PP) relating to violence (n = 384), 114 reoffended with violence (29.7% of individuals with PP relating to violence). Of these, approximately one fifth committed one to two other offence types in addition to violence, 11.7% committed 3-4 other offence types in addition to violence and the remaining 5% were considered highly versatile offenders, committing 5-6 other offence types in addition to violence. Of the total 266 individuals who were referred for harmful sexual behaviour or ideation 22 (8.3%) went on to reoffend with a sexual or child pornography offence. This group was comparatively less versatile than the violent offenders. While 20% committed 1-2 other offence types, only 6.7% committed 3-4 other types, and only 1% were highly versatile. Of the 213 who were referred for stalking 27 (12.7%) reoffended by stalking, and of the 52 referred for firesetting 3 (5.8%) reoffended by arson. Versatility statistics were not calculated for these groups.

Across the entire sample, the average number of offences post-PBP contact was 2.6 (SD 6.4, range 0-66). To take account of time available to offend (*time at risk*), both pre-and post-assessment, the average number of offences committed per month were calculated. Clients committed on average 0.09 (SD 0.19, range 0-1.83) offences per month prior to contact with the PBP, which reduced significantly to 0.06 (SD 0.13, range 0-1.02) offences per month after contact with the PBP (*Sign test* = -7.11, $p < 0.001$).

Time to reoffence across the Not Recommended, Treatment and Failed to attend groups

Amongst those who received subsequent charges (n = 299; 36.3%), time to reoffending differed significantly depending on whether or not clients were referred to and attended for treatment ($-2\log \chi^2 = 6.55$, $p < 0.05$). As shown in Figure 2, the *treatment* group took significantly longer to reoffend (average 23.52 months, range –0-68, SD 18.82) than the other two groups (*not recommended*: average 13.87 months, range 0 – 69, SD 14.48; *failed to attend*: average 17.05 months, range 0 -62, SD 15.19). In Figure 5, vertical lines represent censored cases. Cases are censored or excluded from the analysis where the line crosses the survival curve, as that is the maximum follow-up time available for that case.

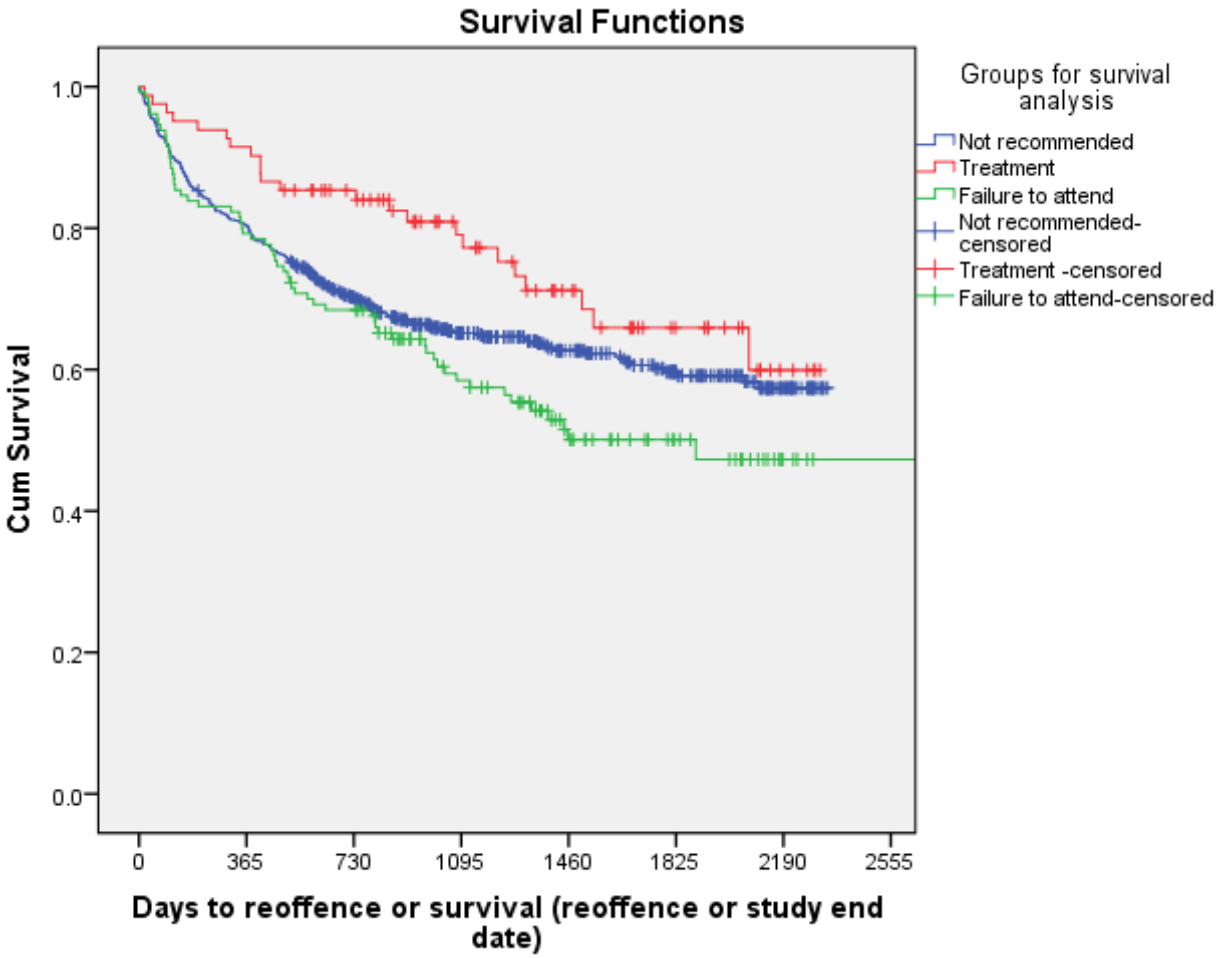


Figure 5: Survival curves representing days to reoffence for each of the study groups

Severity of offending (pre- and post-contact with the PBP) across the Not Recommended, Treatment and Failed to Attend groups

Just over half of the sample (435, 52.8%) had no change in the severity of offending pre- and post-assessment. This can likely be accounted for the large proportion of the sample who had no offending history. Just over one third of the sample (382, 34.2%) showed a decrease in severity (for example committing theft from assault), while the remaining 107 (13%) showed an increase (for example progressing from stalking to sexual assault). When individuals had no prior offending there was mostly no change in severity (n = 342, 85.5%), with the remaining 14.5% (58) showing an increase in the severity of offending. For those who reoffended after the index PBP contact, the most common types of reoffence were violence (138, 46.2%), breach of a legal order (134, 44.8%) and theft (92, 30.8%).

Differences in reoffending for clients from different referral sources

As shown in Table 8, of those clients who reoffended, there were some differences in patterns of reoffending depending on referral source.

Table 8. Comparison of reoffending rates by referral source

Referral Source	Number of Reoffenders N (% of referral source)	Number of subsequent offences			Average months to reoffence
		M	SD	Range	
Community Corrections	156 (45.1)	8.01	9.80	1 - 66	15.32
Area Mental Health Services (including youth)	86 (30.7)	5.53	7.39	1 - 31	15.36
Other	57 (31.3)	6.98	9.06	1 - 43	14.84

As can be seen in Table 8, clients referred from Community Corrections who reoffended committed significantly more offences after contact with the PBP than clients from Area Mental Health Services (U = 5181.5, $p < 0.01$, $\theta = 0.61$). However, there were no significant differences in the time to reoffence when comparisons are made by referral source (CCS, AMHS, Other), nor when only comparing CCS with AMHS clients. As can be seen in Figure 6 the severity of offending post-assessment between the CCS and AMHS groups is largely consistent with the overall group findings. While not significant, proportionally more of the AMHS clients experienced no change in severity than the CCS clients, a factor that is likely explained by the higher proportion of AMHS without an offending record. Overall, these between group differences were not significant ($\chi^2 = 4.33$ (df 2), $p < 0.12$,).

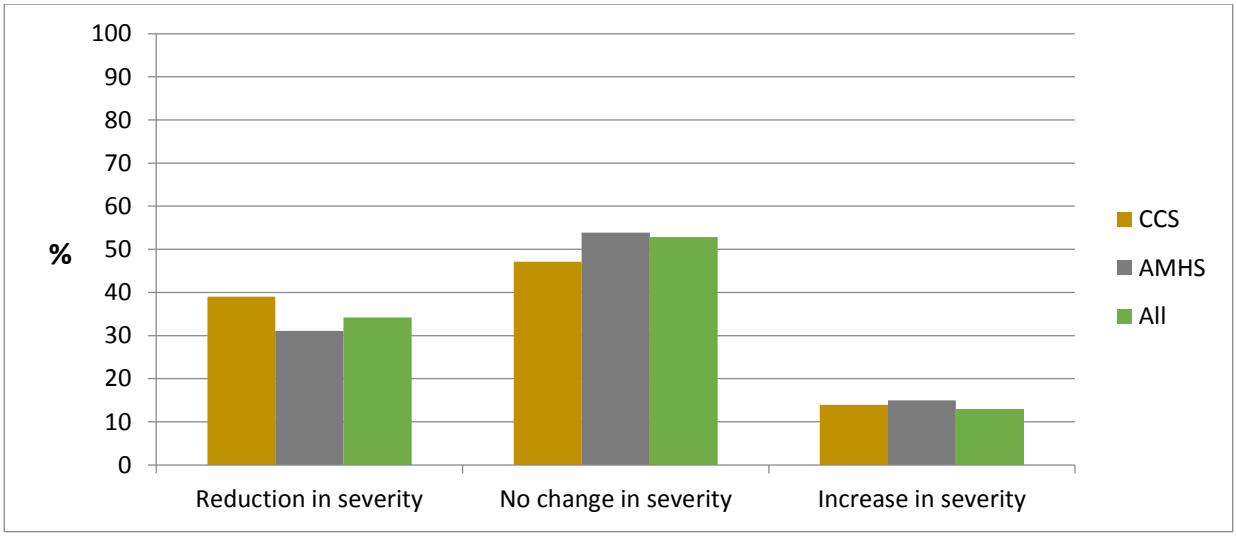


Figure 6. Comparison of severity of offending, pre- and post-PBP contact, by referral source.

Comparison of reoffending data for Not Recommended and Failed to attend groups

To determine whether the PBP is identifying appropriate clients for treatment, reoffending patterns between the *not recommended* and *failed to attend* clients were compared. In most cases, individuals who are assessed as moderate to high risk of offending behaviour where no other appropriate services are available are recommended for treatment following the primary consultation. As such *failed to attend* clients are moderate to high risk clients who are non-compliant with treatment and would be expected to offend more often than clients assessed and not recommended for treatment (in most cases lower risk clients or those engaged with other appropriate services).

Number and frequency of offending (pre- and post-contact with the PBP) for Not Recommended and Failed to attend groups

Overall, 46.2% of the *failed to attend* group reoffended, compared to 35.3% of the *not recommended* group ($\chi^2 = 5.41$, $p < 0.05$, $\varphi = 0.09$). The *not recommended* group also had significantly fewer offences post-PBP assessment (m = 2.40, range 0 – 49, SD = 5.87) compared with the *failed to attend* group (m = 3.93, range 0 – 66, SD = 9.05) ($U = 34874$, $p < 0.01$, $\theta = 0.44$). The prior and reoffending patterns of the two groups were compared to determine if assessment at the PBP impacts upon rates of reoffending. In the *not recommended* group, offences per months fell from an average of 0.10 (SD 0.19) to an average of 0.06 (SD 0.14) after the PBP assessment (*Sign test* = -6.5, *p < 0.001)*. In contrast, there was no significant change in the number of offences pre- and post-PBP episode for those who were referred for treatment but did not attend or dropped out of treatment prior to completion (Before: m = 0.09, SD 0.19; after: m = 0.09, SD 0.20; *sign test* = -1.30, *p* = 0.20).

Time to reoffence for Not Recommended and Failed to attend groups

When examining time from assessment to reoffence for the *not recommended* and *failed to attend* groups there was no significant difference, as seen in the survival curve in Figure 7 (-2log $\chi^2 = 2.58$, $p = 0.11$). Individuals in the *not recommended* group had an average time to reoffence of 13.87 months (range 0 – 69, SD 14.48), compared with the *failed to attend* group's average time of 17.05 months (range 0 -62, SD 15.19).

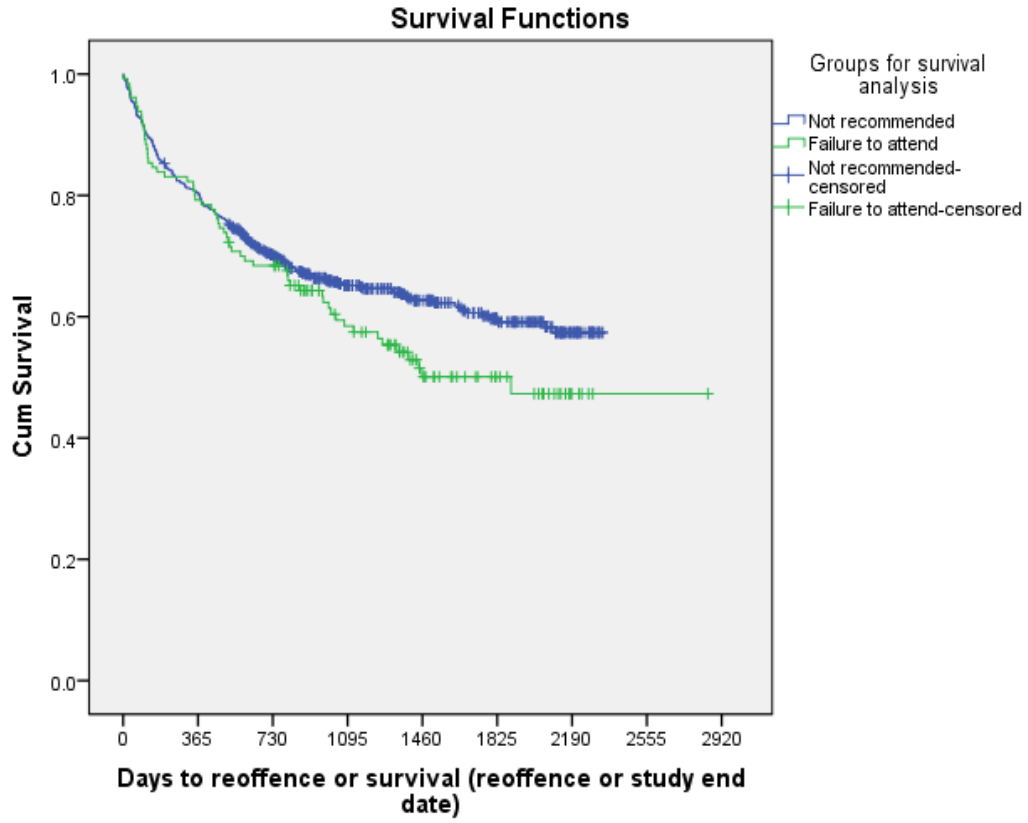


Figure 7: Comparison of the survival curves representing days to reoffence for the *Not Recommended* and *Failed to Attend* groups.

Severity of offending (pre- and post-contact with the PBP) for Not Recommended and Failed to Attend groups

Comparison of the severity of offending pre- and post-PBP contact in the *not recommended* and *failed to attend* groups, as shown in Figure 8, indicated that the majority of individuals in both groups had no change in severity of offending, one third had a decrease, and a small proportion showed an increase. These differences were not significant (χ^2 (df 2) = 4.20, p = 0.12.

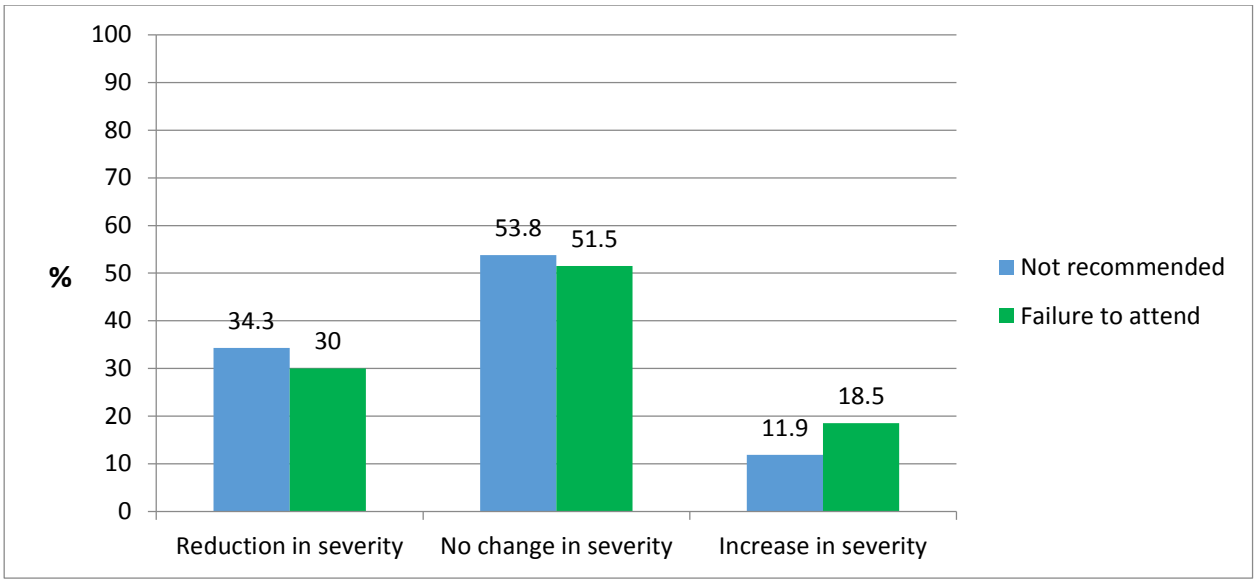


Figure 8: Comparison of severity of offending, pre- and post-PBP contact, between Not Recommended and Failure to Attend groups

Comparison of reoffending data for Failed to attend and Treatment groups

To determine whether treatment is effective when it has been recommended by the PBP following a primary consultation, comparison was made of the reoffending rates of clients who completed treatment or who remained in treatment at the time of the study (*treatment group)* and those failed to attend or who dropped out of treatment prior to satisfactory completion (*failed to attend group).* This compares groups of similar profile in terms of risk, complexity and lack of availability of other appropriate services. It was expected that the *treatment* group would have lower rates of reoffending compared to the *failed to attend* group.

Approximately 25% of clients seen for assessment at the PBP were recommended to receive individual treatment. However, 60% of these clients recommended for treatment dropped out prior to commencement or satisfactory completion. This relates to the persistent and challenging nature of the behaviours of many of these clients.

Number and frequency of offending (pre- and post-contact with the PBP) for Failed to attend and Treatment groups

Overall, 59 (72%) of the *treatment* group had not reoffended by the follow-up end date. In relation to those in the *treatment* group that did reoffend during the follow-up period (28%), this result was in comparison to 46.2% of the *failed to attend* group who reoffended (χ^2 = 6.92, p < 0.01). The *treatment* group also had significantly fewer offences post-PBP assessment (m = 1.8 range 0 – 34 SD = 5.18) compared with the *failed to attend* group (m = 3.93, range 0 – 66, SD = 9.05) (U =4297.5, p < 0.01). The prior and reoffending patterns of the two groups were compared to determine if treatment at the PBP impacts upon rates of reoffending. In the *treatment* group, offences per month fell from an average of

.08 (SD = .00) prior to PBP assessment, to .04 (SD = .11) after PBP treatment (*sign test* = -2.01, *p* = 0.05). In contrast, there was no significant change in the number of offences pre- and post-PBP episode for those who were referred for treatment but did not attend or dropped out of treatment prior to completion (Before: m = 0.09, SD 0.19; after: m = 0.09, SD 0.20; *sign test* = -1.30, *p* = 0.20).

Time to reoffence for Failed to attend and Treatment groups

When examining time from assessment to reoffence for the *treatment* and *failed to attend* groups there was a significant difference, as seen in the survival curve in Figure 9 (-2log χ^2 = 6.55, *p* = 0.01). Individuals in the *treatment* group had an average time to reoffence of 23.52 months (range 0 – 68, SD 18.82), compared with the *failed to attend* group's average time of 17.05 months (range 0 -62, SD 15.19).

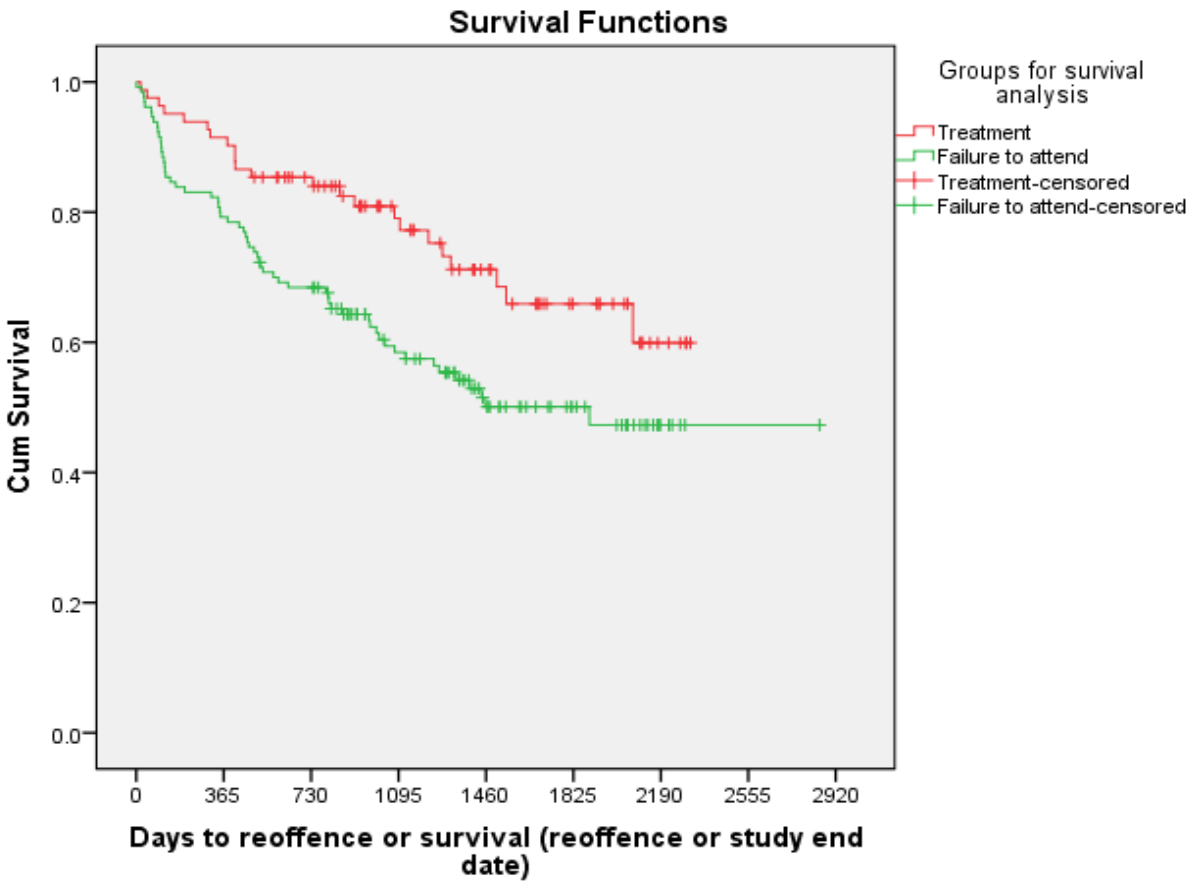


Figure 9: Comparison of the survival curves representing days to reoffence for the *Treatment* and *Failed to Attend* groups.

Severity of offending (pre- and post-contact with the PBP) for Failed to attend and Treatment groups

Comparison of the severity of offending pre- and post-PBP contact was examined by comparing the percentage of individuals who had an increase, decrease or no change in severity of reoffence depending on whether they completed treatment or not.

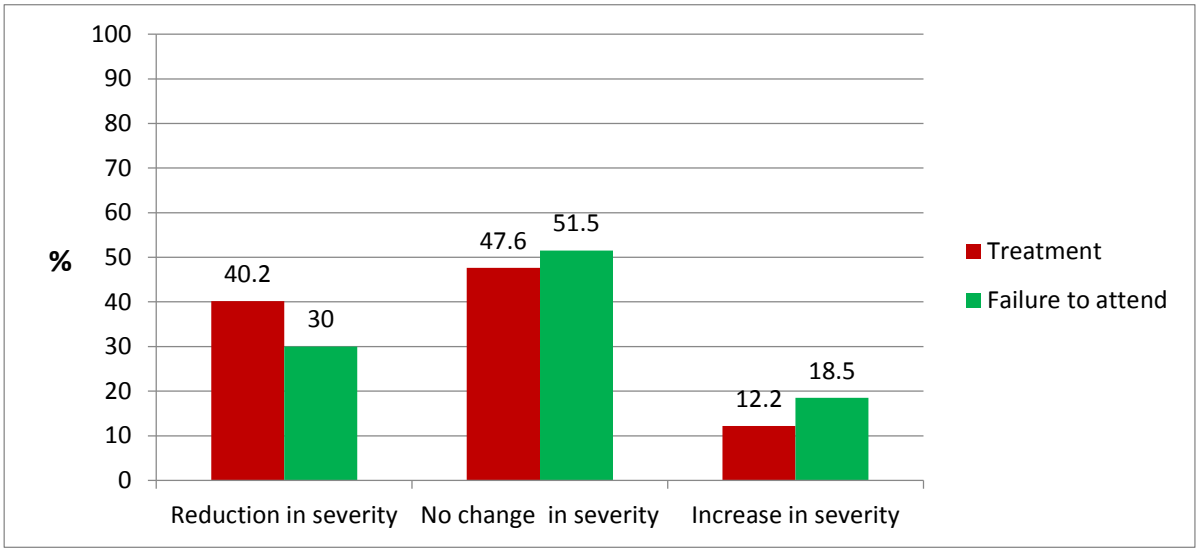


Figure 10: Comparison of severity of offending, pre- and post-PBP contact, between Treatment and Failure to Attend groups

As can be seen in Figure 10 both the *failed to attend* and *treatment* groups showed a reduction or no change in the severity of offending, while a small group showed an increase in severity. While proportionally more of the *treatment* group reduced the severity of their offending, overall changes in severity were not statistically significant (χ^2 (df 2) = 2.94, p = 0.23).

Question 2: What impact does contact with the PBP (assessment and/or treatment) have on mental health outcomes for clients?

This part of the report will examine the mental health service usage of individuals who were seen at the PBP. To determine the impact of mental health service usage of individuals before and after contact with the PBP (for all clients), contacts with the mental health system were examined.

As shown in Table 9 there was a significant reduction in outpatient contact pre-and post-PBP contact in each of the three groups. There was a significant reduction in inpatient admissions pre-and post-PBP contact for *not recommended* clients. Whilst there was a decrease in inpatient admissions for treatment clients, this did not reach significance. There was a significant difference in CATT usage for *not recommended* group and *treatment* group such that CATT usage decreased. There was a significant reduction in CTO usage pre- and post-PBP contact for the *not recommended* group.

There was no statistical association with reoffending and having had a prior psychiatric inpatient admission, CATT contact, or other outpatient contact prior to the PBP assessment. Reoffending was significantly related to previous CAMHS contact, with a greater number of reoffenders having had prior contact with a child or adolescent mental health service than not (χ^2 = 7.47, p < 0.01).

Table 9. Analysis of differences in the nature and number of contacts with mental health services before and after contact with the PBP, depending on treatment recommendation and attendance

Groups	Outpatient before (M, SD)	Outpatient after (M, SD)	Sign test	Inpatient before (M, SD)	Inpatient after (M, SD)	Sign test	CATT before (M, SD)	CATT after (M, SD)	Sign test	CTO before (M, SD)	CTO after (M, SD)	Sign test
Not recommended	1.53, 2.08	1.27, 2.13	-5.3***	2.91, 7.74	1.24, 4.27	-9.3***	0.72, 2.11	0.49, 2.96	-6.1**	1.06, 3.80	1.03, 2.75	-3.0**
Treatment	1.40, 0.95	0.49, 1.06	-5.7***	0.60, 1.54	0.28, 0.95	*W* -1.7	0.37, 0.92	0.20, 0.76	*W* -2.1*	0.18, 1.10	0.21, 1.26	*W* -0.1
Failed to attend	1.72, 1.36	1.18, 2.24	-5.8***	1.37, 3.84	0.82, 2.53	-1.9	0.37, 1.08	0.38, 1.28	*W* -0.03	0.48, 2.60	0.31, 1.31	*W* -0.2
Total	1.55, 1.89	1.17, 2.07	-8.87***	2.43, 6.88	1.07, 3.83	-9.33***	0.63, 1.90	0.44, 2.61	-6.24***	0.88, 3.45	0.84, 2.48	-2.77*

Note: *W* indicates use of Wilcoxon test for within group comparisons

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

Question 3: Who are PBP treatment clients and what is their experience?

Demographic Information

The majority of the 214 individuals who were referred for treatment at the PBP were male (n = 196, 91.6%; female n = 18, 8.4%). Consistent with the *not recommended* group, nearly half of the sample were referred by Community Corrections Services (n = 94, 43.9%), one-fifth came from Area Mental Health Services (n = 41, 19.2%) and the remaining 79 (36.9%) came from a range of other referral sources, including private and other community health, self-referrals and legal services. There were differences between the *treatment* group and the *failed to attend* group in terms of referral sources (see Figure 11).

"Always felt safe and supported"

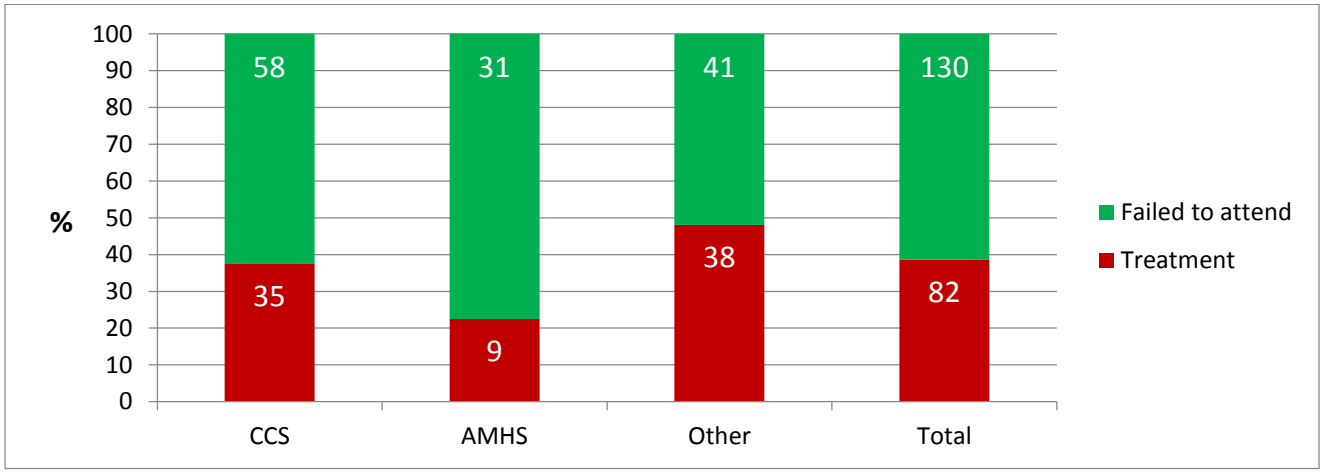


Figure 11: Referral source by *Treatment* and *Failure to Attend* groups (n (%))

Individuals were referred for treatment of a range of problem behaviours, as can be seen in Figure 12. As can be seen in this figure, there was little difference across the types of problem behaviours for treatment attenders (*treatment* group) compared to the *failed to attend* group.

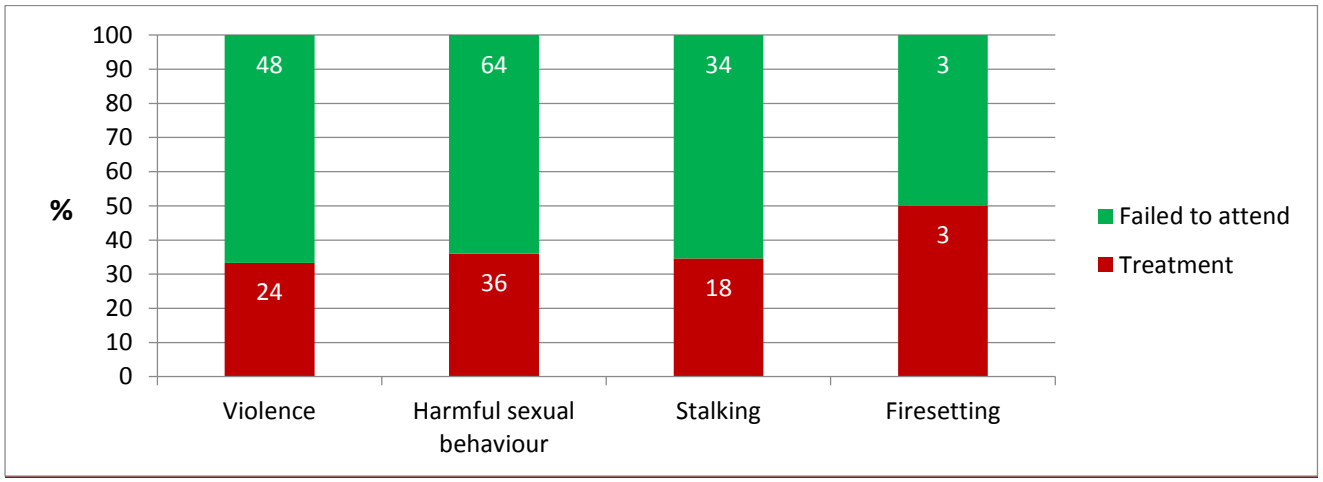


Figure 12: Referral problem behaviour by *Treatment* and *Failure to Attend* groups (n (%))

The average length of the treatment episode (i.e. the date the individual actually commenced treatment to separation from the service) ranged from 0 to 47 months (M = 8.44, SD = 9.03, median = 6 months) (*Note.* The end of the data collection period (30.12.2011) was taken as the treatment end date for individuals still in treatment at the time of data collection). Figure 13 shows the dispersion of months in treatment between those who completed treatment or were ongoing at the time of data collection and those who failed to complete treatment. Those in the *failed to attend* group spent an average of 6.59 (SD 7.10, median 4) months in treatment, while those who completed (*treatment*) spent an average of 11.24 (SD 10.49, median 8) months in treatment.

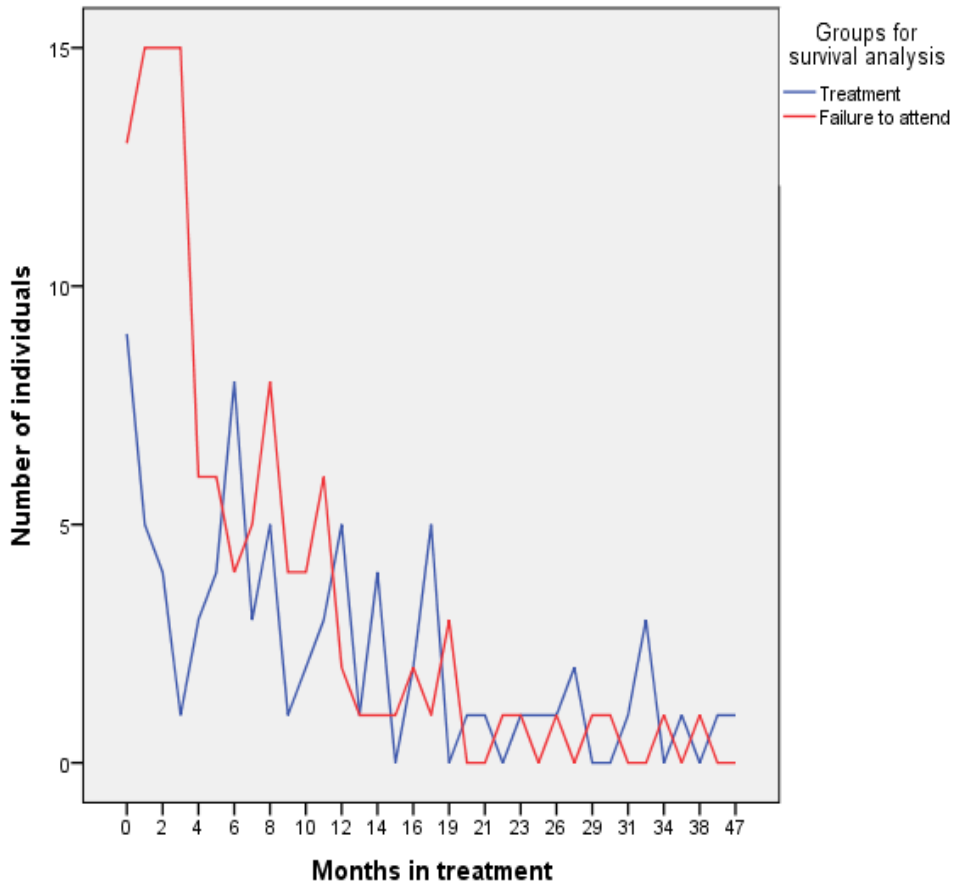


Figure 13. Dispersion of months spent in treatment for those who failed to attend any treatment as well as those who dropped out (*Failed to Attend group*) versus those who successfully completed or are continuing in treatment *(Treatment group)*.

"They helped me understand"

As can be seen in Figure 13, the highest rates of treatment failure occurred within six months of commencement of treatment, although some of the treatment failure group still dropped out of treatment after one to two years. There was considerable variability in the length of treatment for treatment completers with most completing treatment within two years.

Of those who had completed treatment or were ongoing treatment clients, 9 (11%) committed offences during their treatment episode (mean number of offences= 0.51, range of offences 0-16, SD = 2.32), and 23 (28%) committed offences after the treatment episode (mean number of offences 1.29, range 0 -18, SD = 3.14). However, 40 (48%) of these clients had committed offences in the two

years prior to the treatment episode (mean number of offences = 4.3, range 0-110, SD = 13.04). Overall, the number of offences after the treatment episode was significant less than the number prior to treatment (*Z sign test* = -2.56, *p* = 0.01). There was also a significant reduction in the number of offences committed during the treatment episode compared with the number committed prior to (*Z Sign test* = -4.90, *p* < 0.001) or after finishing treatment (*Z sign test* = -3.74, *p* < 0.001).

Client experience

Fifteen of the 31 clients who attended for treatment between 17 and 28 November 2014 responded to a feedback survey. Of these, 53.3% were referred from CCS, 26.7% were self-referred, 13.3% were referred by their Area Mental Health Service and 6.7% were from another referral source.

Clients were asked to rate their overall experience at the PBP. The vast majority indicated that they found the service to be 'very good' (73%), and almost all indicated that they felt 'very supported' by the service (80%). No clients felt the PBP provided a poor service or was unsupportive. Clients were also asked some specific questions about whether they perceived PBP treatment has assisted them. Eighty percent said that treatment helped them to understand the problem they were referred for (one individual felt it had not helped in this regard, others were neutral); 86% reported that treatment helped them to manage the problem (others were neutral); 93% indicated that treatment helped them to understand their offending behaviour and 80% believed it helped them to reduce their offending behaviour (these questions were not applicable for one client).

Discussion

This report aimed to answer three questions:

1. Is contact with the PBP effective in reducing the frequency, nature and time to reoffending?
2. What impact does receiving services from the PBP (assessment and/or treatment) have on mental health outcomes for clients?
3. Who are PBP treatment clients, what is the effect of treatment, and what is their experience?

Results relating to each question are discussed below, in addition to implications and recommendations for practice.

Reduction in the nature, frequency and time to reoffending

The results of this evaluation of the efficacy of the PBP in reducing the frequency, nature and time to reoffending shows that the Program is in fact successful by all three measures. These findings are particularly important given the high risk nature of most of the referrals received by the PBP. Specifically, the average number of offences per month reduced after PBP contact in the total sample and in all three sub-groups. The fact that all clients of the PBP experienced a reduction in reoffending, regardless of whether they were recommended for or attended treatment suggests that PBP assessments themselves have some impact on reoffending. It is likely that this is due to appropriate identification of risk reduction strategies, and implementation of these strategies by referring agencies.

Between group comparisons of time to reoffending showed that amongst those referred for treatment, clients who actually attended and completed treatment reoffended significantly more slowly than other PBP clients: on average 6 months later than those who did not attend for treatment, and 10 months later than those not recommended for treatment. Amongst those referred for treatment, approximately half experienced no change in the severity of offending post PBP contact,

while amongst the other half of this group, the vast majority experienced a reduction in severity and only a small minority committed further offences of a more severe nature.

"I am grateful to have been referred to Forensicare; it has changed my life"

The results suggest that PBP clinicians were generally making appropriate recommendations targeting higher risk clients for offence-specific treatment at Forensicare. Clients who were recommended for treatment but who did not attend (the *failed to attend* group), reoffended significantly more often than those who were not recommended for treatment. This finding can be taken as a proxy for the fact that those not recommended for treatment generally present a lower risk of reoffending than those who are recommended. Notably, while these two groups differed in the frequency of reoffending following their PBP assessment, there were no significant differences in the time to their first reoffence after PBP contact. In both groups, PBP clients who reoffended did so between 12 and 18 months post assessment or final treatment session. Moreover, there were no differences between these two groups in the number of clients who reoffended in a more severe way following PBP assessment.

Mental health outcomes for PBP clients

With regards to mental health outcomes and service usage of PBP clients, there were a range of different findings that reflect the heterogeneity of the sample. Perhaps the most important is that PBP clients frequently have contact with public mental health services, regardless of whether they are referred to Forensicare by Community Corrections, Area Mental Health Services or other services. Ninety percent of PBP clients have had contact with public mental health services prior to their PBP assessment. Overall, contact with the PBP coincided with a reduction in contact with community area mental health services. This was true both in the whole sample, and in each of the three recommendation/treatment subgroups. It is possible that this reduction reflects general improvement in clients' wellbeing (including in their mental health) associated with management strategies implemented post PBP assessment (whether by PBP treatment or other services). It could, however also be associated with an overall decrease in crisis-driven contacts. Pre-PBP crisis Assessment Team (CAT) and inpatient contacts in the *not recommended* group in particular may reflect a period of difficulty in which the problem behaviour was accompanied by these mental health contacts. Amongst this seemingly lower risk group, it is possible that with the resolution of the problem behaviour, the mental health contacts also reduced in frequency (or vice versa).

A particularly positive mental health outcome for PBP *treatment* clients is the reduction in CATT and outpatient contacts in this group. While it is impossible to be certain, the reduction may indicate the development of more effective strategies for managing mental health crises secondary to PBP treatment. Notably, a similar reduction was not observed in the *failed to attend* group. Overall the *failed to attend* group continued to utilise mental health services at the same rate as prior to their contact with the PBP. This difference suggests that assessment alone or partial treatment is not sufficient to result in positive mental health outcomes for these more complex and higher risk clients, and the specialist treatment service provided by the PBP generates positive outcomes for this category of clients when they complete treatment.

Efficacy of PBP treatment

Amongst those who were referred for and who attended *treatment* at the PBP, reoffending rates were significantly lower than in all other groups. Perhaps most importantly, clients who had completed or remained in *treatment* reoffended at significantly lower rates compared to clients who fail to attend/drop out of treatment. Furthermore, within the treatment group itself, there was a significant change in the average number of offences pre- and post-treatment, with significantly fewer offences per month in the time since treatment was completed. Interestingly, the period of lowest risk of offending appeared to be while the client was in treatment. Although reoffending rates increased after treatment was completed, rates nonetheless remained lower than pre-treatment offending. There was no significant change in the number of offences pre- and post-PBP contact for those who *failed to attend* as recommended.

One of the most concerning findings of this evaluation was the high rate of treatment drop out in the sample. Sixty percent of clients who were recommended to attend treatment either did not attend or ceased treatment prior to the recommended time. Amongst those who commenced but dropped out of treatment, actual time in treatment varied greatly. Fifty-nine individuals ceased treatment within the first six months – of these 14 never attended at all and a further 30 individuals ceased within three months. The remaining 32 clients dropped out of treatment after attending for between six months and almost four years, similar to the length of time that most treatment completers remained in treatment. The very positive results for those who attended and completed treatment suggests that an increased focus of the work of PBP clinicians should be on engaging clients to the extent possible to retain them in treatment. Moreover, where clients are recommended by external agencies (e.g., community corrections) to attend treatment, the expectation should be reinforced by staff in those agencies.

There is wide variation in the duration of treatment episodes at the PBP, with most clients successfully completing treatment within 6-12 months, while others remain with the service for 2-4 years or even longer in a very small number of cases. Length of a treatment episode is based on a number of factors including assessed risk level, engagement in treatment, and the possibility of making offence-related treatment gains. Regular clinical reviews determine whether or not treatment will continue to be offered in the face of poor engagement. Amongst the group who ceased treatment within the first six months, it is likely that there are a sizeable number of clients who failed to engage in treatment (e.g., they continued to have low motivation to attend or to change their behaviour). In these cases a clinical decision is made to cease treatment despite there being few gains and potentially with risk level remaining high. Amongst those who drop out at a later point, there are likely to be a number of Corrections-referred clients who chose not to voluntarily continue treatment after the end of their correctional order. It is possible that this late drop-out group also includes clients who have not engaged well but have been maintained in treatment due to anxiety about discharging someone who is assessed as presenting a high risk of future offending.

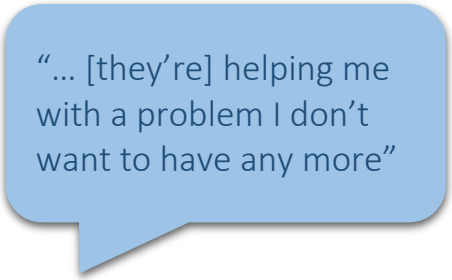
> "…I didn't know I had a problem till I got told"

It should be noted that this research was based on formal treatment commencement and separation dates recorded in the public mental health database, CMI. It was not possible to collect information about the actual number of treatment sessions attended by clients and it is possible that some clients

ceased attending mental health services some weeks or even months prior to being formally separated, artificially inflating their recorded length of treatment.

Given the high rate of recorded drop out, it will important to devote closer attention to the reasons that clients cease treatment prior to an agreed end, and the kinds of barriers that exist that prevent successful completion. This is particularly important given the demonstrated positive outcomes associated with treatment completion in this study. It may be that a combination of systemic measures (e.g., closer monitoring or liaison with Corrections Victoria officers regarding completion of ordered treatment), and psychological interventions (e.g., greater overt attention to clients' motivation and readiness to change prior to commencing offence-specific interventions) may go some way towards reducing drop out. This clearly needs to be a focus for the PBP and PBP stakeholders in the future. In addition, given the high success of treatment in significantly reducing re-offending among this high-risk sample, if funding was available, a greater number of clients should be referred for treatment

In the survey of current PBP treatment clients, almost all reported high levels of satisfaction with the service. Most importantly, the majority of clients reported that they have had a good experience at the PBP and felt supported. More specifically, they reported that the PBP has helped them to understand their problem behaviour, reduce this behaviour, understand unhelpful thinking habits, and feel better. It is recommended that client feedback frequently be sought as part of an ongoing evaluation of the program. Of course, it is possible that only well engaged clients who value the service chose to respond to the survey. It is noteworthy that the one client who provided negative evaluations identified that they did not understand why they had been referred to the program and did not believe that their behaviour was a problem.



In summary, the results of this evaluation study reinforce the pivotal role played by the Problem Behaviour Program in the assessment and treatment of client groups that are often unable to access treatment elsewhere, and whose behaviours impact on community safety. The PBP has demonstrated efficacy in reducing offending, particularly amongst clients who successfully complete treatment in the program. The positive results highlight the importance of the program not only continuing but expanding and developing so as to further meet the needs of the mental health and justice systems in reducing harm to victims, the community and clients.

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