# Chapter 4

# The inappropriate use of prison for forensic patients

If he's not guilty what is he doing here?[1]

…They are not prisoners, they are not convicts and they should not be treated as such.[2]

4.1 This chapter focuses on the experiences of people subject to forensic (custodial) orders who are indefinitely detained in prisons, and the lack of therapeutic options available to forensic patients in this environment.

4.2 The committee received evidence from Mr David Egege, Executive Director of the Disability Advocacy and Complaints Service of South Australia which highlighted an example of a forensic patient's experience in prison:

> Mr X was found guilty of an offence by reason of mental incompetence and he was sentenced to a limiting term of 13 years. After spending a couple of months of his sentence at the forensic facility James Nash House, he was transferred to Yatala Labour Prison, where he was incarcerated for seven years. A number of those years were spent in G-Division and a number of those years were also spent in solitary confinement. The public advocate has been very involved in this case. Patient X was, at times, kept on handcuff regime in a cell, where he slept on a concrete slab. I believe, as a forensic patient, he clearly should have had access to a clinical program available to any person who is in that situation, in custody, and who is a forensic patient.[3]

4.3 In its submission to the committee, Barriers 2 Justice described the circumstances of a person with an intellectual disability held in prison:

> The individual had been in prison for approximately one month. During this time he had been sexually propositioned by other prisoners. Although it is understood no abuse occurred, those with an intellectual disability in prison are likely to be at a higher risk of assault due to their increased vulnerability. It is also believed the individual may have been showing more extreme behaviours due to his reaction to the prison environment and his treatment by other prisoners.[4]

4.4 Ms Alison Youssef noted that some forensic patients are confused as to why they are being held in prison, with mental health issues emerging as a consequence:

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1 Barriers 2 Justice, *Submission 67*, p. 8.

2 Mr Russell Goldflam, President, Criminal Lawyers Association of the Northern Territory, *Committee Hansard*, Alice Springs, 26 October 2016, p. 3.

3 Mr David Egege, *Committee Hansard*, Alice Springs, 26 October 2016, p. 15.

4 Barriers 2 Justice, *Submission 67*, p. 12.

> Christopher and Kerry have suffered mentally during their time in prison. They both feel sad that they are unable to see family members and be part of their community… A neuro-psychological assessment conducted for the review recommended that it was not appropriate for Christopher to be in prison, and that his mental health was going to deteriorate markedly if he remained there.[5]

4.5 A number of submitters, in particular the Royal Australian New Zealand College of Psychiatrists (RANZCP), disagreed with the use of prisons to accommodate people with a cognitive or psychiatric impairment who had not been found guilty of any offence:

> Persons found unfit to stand trial or acquitted on an insanity finding must only be treated in appropriately designated health facilities, outside of prison environments, that are appropriate to individual clinical and risk management needs. They must not be treated as convicted criminals for that offence. A key principle is that prisons are not hospitals and should never be viewed as such.[6]

## Experience of prison for people with cognitive and psychiatric impairment

4.6 The Aboriginal Disability Justice Campaign (ADJC) has raised concerns about the 'use of maximum security prisons as default accommodation and support options' and 'the lack of clinical treatment which focus[es] on reducing the person's risk of harm to others'.[7] As noted in the previous chapter, people with cognitive and/or psychiatric impairment are held in prisons because there is a lack of other supported options in the community. In its submission to the committee, the Criminal Lawyers Association of the Northern Territory (CLANT) noted:

> People with complex cognitive and psychiatric needs and offending behaviours, or who are assessed as a risk to the community, are incarcerated and held indefinitely in maximum-security prisons in the [Northern Territory] NT largely because there is no or no sufficient alternative provision and no services to effect crime prevention through health and welfare.[8]

4.7 The ADJC agreed, adding that:

> prisons are not safe spaces for people with cognitive and psychiatric disabilities. Human rights breaches occur and people who remain unconvicted often languish in this centre with no exit pathway. It is a convenient place for governments to hide people away who have inconvenient circumstances who require intensive and expensive treatment, but does nothing to meet the legislative criteria that pertains to this group of people: that people are detained for the purposes of treatment in order to

5 Ms Alison Youssef, *Submission 73*, p. 6.

6 Royal Australian New Zealand College of Psychiatrists (RANZCP), Submission 17, pp 11–12.

7 ADJC, *Submission 76*, p. [3].

8 Criminal Lawyers Association of the Northern Territory, *Submission 18*, p. 3.

> reduce their risk of harm to others and to keep the community safe and that this occurs in the least restrictive manner possible.[9]

4.8 Ms Amanda Muller of the Geraldton Resource Centre likened Mr Marlon Noble's indefinite detention as a forensic patient in a prison thousands of kilometres from his home of Geraldton to her own experience of leaving home to go to university. Both left the support networks of home, but for vastly different reasons:

> I felt very isolated, very lonely, and that had quite an impact on me in terms of wanting to keep going and being able to make a go of that. Then I think about Marlon, who at a very similar age, as a teenager as well, got sent away from his home and his family. All those feelings that I experienced he would have experienced. But I was away for a positive reason; he was away because he had a disability. And I knew that I had to serve only five years; that was the length of time I had to do before I could return to my home and family. He had no idea how long he was going to be away. I was able to communicate on a regular basis with my family when I wanted to. There were four times a year when I was able to return home to them. He was not able to return home even when his mother went missing, and then when eventually she was found murdered his opportunity to return home for her funeral was with the embarrassment of being a prisoner and accompanied by a prison officer.[10]

4.9 In its submission, Barriers 2 Justice noted that 'forensic patients have complex psychiatric, medical and social needs that cannot be adequately addressed in a prison environment' adding that correctional officers often are not trained to provide support for forensic patients. This submission went further and noted:

> Holding forensic patients in the unsuitable prison environment causes their condition to deteriorate. Those placed in the general prison population are also at risk of both physical and sexual assault. According to Dr John Brayley: 'People in prison on the James Nash [South Australia forensic hospital] waiting list can exhibit a combination of distress and bewilderment. Their situation is reminiscent of historical descriptions of 19th century mental hospitals before modern treatments developed.'[11]

4.10 The committee has received evidence suggesting that not only do people on forensic orders lack access to therapeutic services, but that being in prison exposes them to substances and behaviours that result in further restriction and confinement. Ms Taryn Harvey of Developmental Disability WA highlighted the case of Jason who had been:

> …denied his right to a leave of absence, as given to him by the Mentally Impaired Accused Review Board under the act, by virtue of the fact that he was in Acacia Prison. Acacia Prison does not do day releases, so for many,

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9 ADJC, *Submission 76,* p. [4].

10 Ms Alison Muller, Principal Solicitor, Geraldton Resource Centre Inc., *Committee Hansard,* Perth, 19 September 2016, p. 22.

11 Barriers 2 Justice, *Submission 67*, pp 9–10.

> many months he was denied that right—one of the very few rights that he has—because of the security rating that he was given. That rating had nothing to do with any [violent] pattern of behaviour or aggravated behaviour within prison. It was a long-standing issue around substance abuse, regarding substances that he was having ready access to in prison and substances that he was not getting any support with in prison to address. Also, be aware that in Western Australia we have no adapted drug and alcohol treatment programs for people who are living with impairments.[12]

4.11 Chapter 5 will discuss the inappropriateness of Corrective Services being responsible for the therapeutic and support needs of forensic patients. Two case studies of people with cognitive and/or psychiatric impairments held in prison under forensic orders are presented below in Box. 4.1

12 Ms Taryn Harvey, CEO, Developmental Disability WA, *Committee Hansard*, Perth, 19 September 2016, p. 23. See also: Barriers 2 Justice, *Submission 67*, p. 8.

***Box 4.1—Inappropriateness of prison for people with cognitive and/or psychiatric impairments***

**CASE STUDY 1: Mr X**

Mr X was arrested and taken to the Silverwater remand centre (NSW) in March 2001 after assaulting a friend during a psychotic episode. Despite his psychosis and long history of violent crime, he was placed in a cell with [an offender] who had requested protective custody. Mr X kicked [the other man] to death within 15 minutes and was later charged with murder.

Over the next three years, Mr X who had previously attempted suicide in prison, was kept in segregation cells at various jails. During this time he suffered severe psychotic symptoms (auditory hallucinations, suicidal urges and a belief his mind was under control of the Australian Security Intelligence Organisation (ASIO)), for which he received no hospital treatment. In letters from jail, Mr X said he felt he was being slowly tortured to death. Mr X's clinical notes show that psychiatrists and nursing staff at Goulburn jail repeatedly requested his transfer to Long Bay jail hospital. One nurse wrote personally to a senior bureaucrat in the Health Department to express his concern. Instead, Mr X was isolated to a cell in the jail's high-risk-management unit in early 2003. A departmental letter to his family claimed that the transfer would help manage his condition.

At a court hearing three months later, one psychiatrist testified that the impact of Mr X's schizophrenia had a detrimental impact on his wellbeing. Two other psychiatrists disagreed with each other over Mr X's mental state; one said Mr X's psychotic symptoms had dissolved completely because of medication, the other said he was only in minor remission and required long term care.

In March 2004, Mr X was found not guilty of murder by reason of mental illness. It was recommended he be placed under supervision of the Mental Health Review Tribunal. Nine weeks later, Mr X was found hanging in his segregation cell in the main jail at Long Bay. At the time of his death, Mr X was still on the waiting list for the hospital. The correction officers who discovered Mr X hanging from the bars of his cell did not immediately attend to him, or attempt resuscitation, as they feared that Mr X had faked his own hanging and helping him would put their safety at risk.

Mr X had sent his last letter to his mother three weeks before he died. He ended the letter with a scrawled: 'HELP ME'.

**CASE STUDY 2: Patient X**

Patient X was found not guilty of an offence by reason of mental incompetence and sentenced to a limiting term of 13 years. After spending seven months of his sentence at the main forensic facility, James Nash House, Patient X was transferred to Yatala Labour Prison where he was incarcerated for seven years.

In Yatala, almost all of Patient X’s time was spent in solitary confinement. Solitary confinement, officially known as ‘segregated custody’, is when a prisoner is detained in isolation from all other prisoner in a segregated cell for all or nearly all of the day, with minimal environmental stimulation.

For the first two and a half years of his sentence, Patient X did not have access to psychiatric support. At one stage, he was placed in a very small dark cell, known by prisoners as the ‘fridge’. Patient X was kept on handcuff regime in the cell, where he slept on a concrete slab. Patient X in this period also requested time out of G Division, to have time with others in B division. He also wanted to have time in the gym to work out, a privilege that is usually available to forensic patients (and can be available to prisoners.) Patient X was a forensic patient and should have had access to a clinical program available to any person who is in the custody, supervision and care of the Minister for Mental Health, whether he was in G Division at Yatala or any other location.

It is worthy of note that in the 2011 United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan Méndez stated that there should be a world-wide ban on the practice of prolonged solitary confinement except in very exceptional circumstances and for as short a time as possible, with an absolute prohibition in the case of juveniles and people with mental health issues.

Source: Barriers 2 Justice, *Submission 67*, pp 6 & 8.

### *Cognitive and/or psychiatric impairment in the general prison population*

4.12 Although this inquiry is primarily focused on people subject to forensic orders, the committee is concerned more broadly with people with cognitive and/or psychiatric impairments who are in prison on regular custodial sentences. The Aboriginal Legal Service of WA provided an example of why prison is also inappropriate for many people with cognitive and/or psychiatric impairment:

> …last year I acted for a young Aboriginal man from the south west of Western Australia. At 17 he was diagnosed, fortuitously, with a brain tumour. It was untreatable. He was operated on, but the tumour would grow back. Some of the sequelae of the condition were epileptic fits and visual and auditory hallucinations. During a drug fuelled psychotic episode he burnt down the family home because he was aggrieved by his sisters giving his mother alcohol. He then went on and committed some very serious further offences. He was sentenced to a term of immediate imprisonment.
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> He would talk to himself in jail. He would get on the roof of the jail when he was hallucinating. He would have epileptic fits. The prisoners he was with in his unit could not cope and nor could the guards. The response was to place him in solitary confinement. He is destined to spend many years in jail in solitary confinement by dint of his impairment—no wonder he was also suicidal.[13]

### *Committee view*

4.13 The committee is extremely concerned about the inappropriate detention of forensic (custodial) patients in prison. The needs of this vulnerable group of people have not been met prior to their forensic or custodial order; equally, the committee is not convinced that the needs of this group have or will be met in a prison environment.

4.14 The committee is also concerned that legislative requirements to maintain and protect the safety of the community appear to far outweigh consideration given to the requirement to provide the least restrictive environment for a forensic patient. It is the committee's view that a more appropriate balance can be struck between these requirements that will deliver better outcomes for forensic patients.

4.15 The next section will discuss some of the issues with providing therapeutic services to people on forensic (custodial) orders held in prison.

## Therapeutic and behavioural treatment options in prison

4.16 A number of submitters and witnesses discussed the general principle that where a person is detained because they have a cognitive or psychiatric impairment, then there is a corresponding obligation to provide that person with therapeutic treatment that condition requires. RANZCP submitted that:

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13 Mr Peter Collins, Director, Aboriginal Legal Service of WA, *Committee Hansard*, Darwin, 25 October 2016, p. 16.

> Curtailment of individual liberties should be matched by providing adequate interventions and resources to assist in rehabilitation/long term care.[14]

4.17 Associate Professor Dan Howard, a lecturer in forensic mental health at the University of New South Wales, submitted:

> For a person found 'not guilty on the grounds of mental illness' to be detained in a prison is not acceptable by modern standards of clinical practice and human rights.[15]

4.18 Beyond a general principle of whether it is appropriate to accommodate people not found guilty of any offence in a prison, submitters stated that prisons were not an appropriate therapeutic environment for people with cognitive and/or psychiatric impairment. The Aboriginal Legal Service of Western Australia said that 'the services available for mentally impaired accused in prison (and for convicted prisoners with mental health issues) are seriously deficient.[16]

4.19 In their submission, the Western Australian Association for Mental Health outlined a report which found that accommodating people in prisons has been found to have a detrimental impact on therapeutic outcomes:

> The OICS [Office of the Inspector of Custodial Services] review of mentally impaired accused persons in 2014 found that people detained in prison were less likely to progress towards conditional or unconditional release than those in hospital.[17]

4.20 In its submission to the committee, the Northern Territory Government summarised the legislative approach to provision of therapeutic supports for forensic prisoners:

> Part IIA of the Criminal Code contemplates rehabilitation of supervised persons and envisages a process of transition from Custodial to Non-Custodial Supervision Orders, and ultimately, unconditional release. The principle of least restriction in sections such as 43ZM permeates reporting and decision making under Part IIA, and significant efforts are made to ensure a Supervision Order is tailored and reviewed periodically so as to impose the least restriction practicable in the circumstances having regard to the resources available, and the risk profile and needs of the supervised person.[18]

4.21 The committee acknowledges that provision of therapeutic supports and a transitional pathway out of prison is the intent of the legislation and indeed of the government. However, this is not the experience of forensic prisoners detained in

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14 Royal Australian New Zealand College of Psychiatrists (RANZCP) *Submission 17*, p. 4.

15 Associate Professor Dan Howard, *Submission 44*, p. 2.

16 Aboriginal Legal Service of Western Australia, *Submission 23a*, p. 3.

17 WAAMH, Submission 27, p. 12.

18 NT Government, *Submission 75*, p. 3.

prison. Mr Ian McKinlay, Spokesperson of the ADJC noted the resources being focused on a 'massive criminal justice infrastructure expansion' in the NT which is 'testimony to a continuing prison focused culture and unwillingness to build a community where all are accepted'.[19]

4.22 A significant impediment to the provision of therapeutic supports to forensic patients in prisons is that they are often not recognised as having different needs to the general prison population. In its submission to the committee, Barriers 2 Justice highlighted a common reaction of prison officers to forensic patients:

> In speaking with a veteran officer, with many years of service at South Australia's Yatala Labour Prison, whom I have come to know fairly well, I expressed my dismay that a forensic patient would be held in solitary confinement in prison for so many years. His reaction was, "What is 'forensic'?" I explained that it was someone who had been found not guilty by reason of mental impairment and he asked, "If he's not guilty what is he doing here?" Unfortunately, his reaction was far from unusual. Many of the officers do not have any knowledge of what forensic means. And if some do know, I found out that the daily notes given to officers about the various prisoners never even stated that he (Patient X) was forensic. This explained why he was treated exactly as though he had been found guilty with no tolerance or understanding shown for his mental condition, (Antisocial and Narcissistic Personality Disorder with Psychopathy) including his Obsessive Compulsive Disorder, which caused him to ask for cleaning products and bin liners (often denied) because he had to have his cell spotless.[20]

4.23 Another impediment to the therapeutic environment is where there is a blending of therapeutic objectives with the punitive nature of the corrections system. The two different objectives, one being to heal and the other being to punish and correct, have been described to the committee as often being in conflict. Mr David Woodroofe of the North Australian Aboriginal Justice Agency (NAAJA) described the original intent of the new Complex Behaviour Unit (CBU), which was constructed as part of the new Darwin Correctional Precinct.

> One of the key things that is particularly concerning is the need to have this sort of facility. The original purpose of this facility was to be a health primary focus, but something that was adjacent to the prison rather than being in the prison, and primarily being run by health professionals rather than by corrections as part of the prison system. That is the primary concern.[21]

4.24 NAAJA has highlighted this 'as a significant lost opportunity', noting that the CBU is 'now within the razor wire and part of the prison'. There are no facilities for

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19 Mr Ian McKinlay, Adult Guardian and Spokesperson, ADJC, *Committee Hansard*, Alice Springs, 26 October 2016, p. 19.

20 Barriers 2 Justice, *Submission 67*, pp 8–9.

21 Mr David Woodroofe, Principal Legal Officer, NAAJA, *Committee Hansard*, Alice Springs, 26 October 2016, p. 11.

forensic patients outside of a corrections environment in the NT.[22] Although the NT Department of Health (Office of Disability) is involved in providing services to patients in the CBU, the CBU remains a facility operated by corrections officers. Delivery of therapeutic and support services for forensic patients is explored further in Chapter 5.

4.25 Despite these criticisms, submitters have noted that in the NT the 'bones of a functioning forensic system exist'.[23] The ADJC added:

> This last point is one I wish to emphasise above all else: the barebones facilities that exist in the Northern Territory—with a proper expansion, with the proper clinical oversight and with the use of this behavioural support methodology—is totally capable of seeing all of those under current prison based supervision, after receiving initial behavioural support, transition to less restricted disability support, ideally within home communities and with family.[24]

4.26 The next chapter explores in more detail how forensic pathways might be improved and lead to enhanced outcomes for people with cognitive and/or psychiatric impairment.

### *Site visits to correctional facilities*

4.27 As part of this inquiry, the committee visited three facilities where forensic patients are held. Two such units, both in the Northern Territory, are located within corrections facilities. The Western Australian facility is a purpose built Disability Justice Centre, and is described in Chapter 5.

4.28 Following the committee's Darwin public hearing on 25 October 2015, the committee travelled to the Darwin Correctional Precinct (DCP) south of Darwin to conduct a site visit of the Complex Behaviour Unit (CBU) and the Step-Down Cottages. These facilities were opened in September 2015 and are described in box 4.2 below.

22 NAAJA, *Submission 60*, p. [7].

23 ADJC, *Submission 76*, p. [5].

24 Mr Ian McKinlay, Adult Guardian and Spokesperson, ADJC, *Committee Hansard*, Alice Springs, 26 October 2016, p. 19.

***Box 4.2—Committee site visit to the Darwin Correctional Precinct and Complex Behaviour Unit***

**Complex Behaviour Unit**

At the time of the visit, there were thirteen people on custodial supervision orders (forensic orders) housed in the CBU, with four people having been transitioned to the step-down cottages.

The CBU currently accommodates male and female forensic patients placed on a custodial supervision order or prisoners with severe disabilities. A range of therapeutic treatment options, life skills, rehabilitation and recreational options tailored to individual needs, are provided in the CBU with the aim of providing a transition pathway to supported living in the community. The facility provides a range of low, medium and high dependency male and female accommodation, although the low security part of this centre is not able to be staffed at this time due to a lack of dedicated funding. Staff at the CBU provide reports to the Supreme Court for a person's annual review. Staff will also develop and implement transition and treatment plans for people subject to custodial supervision orders in the CBU.

The CBU is housed in a corrections environment (different to the WA Bennett Brook Disability Justice Centre which is operated by the WA Disability Services Commission) and is operated by the NT Department of Corrections with support from the NT Department of Health. The CBU is led by a Clinical Manager as opposed to a corrections officer to ensure that the CBU is primarily focused on therapeutic outcomes rather than feeling like a jail. A Senior Corrections Officer and a number of Corrections Officers support the Clinical Manager and a range of professional medical and disability staff to operate the CBU. These Corrections Officers have volunteered to work in the CBU, and seek to fulfil a wide range of disability support services in addition to their standard corrective officer duties. DCP described a "partnership between Corrective Officers and professional staff". DCP also acknowledged that the CBU is still only new and developing new operating procedures and continually working to improve and optimise performance of the CBU.

4.29 Similarly, forensic patients are also kept in the Alice Springs Correctional Centre (ASCC) and in a separate step-down facility run by the Department of Health, the Secure Care Facility (SCF). The committee's visit to the ASCC and SCF on 26 October 2016 is documented in Box 4.3.

***Box 4.3—Committee site visit to the Alice Springs Correctional Centre – G Block (John Bens Unit)***

The Alice Springs Correctional Centre (ASCC) is located 20 minutes' drive south-west of Alice Springs. At the time of the visit, there were two people on custodial supervision orders (forensic orders) housed in the ASCC in G Block (John Bens Unit). One of the people living in G-Block visits the SCF three to five times a week on day trips as part of his transition plan.

The John Bens Unit (Unit) is a repurposed part of the maximum security wing (G-block) of the ASCC, designed to cater for people on custodial supervision orders. The Unit is sectioned off from the rest of the maximum security prisoners as a means to protect vulnerable people on custodial supervision orders from bullying and being taken advantage of.

People placed in the Unit are provided with a transition and treatment plan developed and coordinated by ASCC in conjunction with the Office of Disability, the Adult Guardian and medical professionals. This report may be commented on by the Supreme Court at the annual review; however, the development and on-going review of these plans can commence prior to the annual review and continue to occur over the rest of the year without input or oversight by the Supreme Court. Typically, these plans will have five stages whereby a person is progressively given greater freedoms, introduced to the SCF (a few hours then expanding to day trips) and a gradual removal of correctional officer in the presence of positive behaviours. ASCC and SCF utilise opposing behavioural approaches and philosophies reflective of the underlying purpose of each department—ASCC is more disciplinary—"you do this; you lose that"; whereas the SCF focuses on rewards—"you can have whatever you want if you display good behaviour". ASCC noted the vast improvement in specific individual's behaviour when exposed to the SCF approach, with a noticeable decrease in violent behaviour, and improved impulse control and understanding of consequences that flow from actions. An example of positive behavioural change is that if good behaviour is displayed when travelling to and from day visits at the SCF, then this will result in future visits to the SCF. Positive behaviour results in progression through the stages and can ultimately result in complete transfer to the SCF from the ASCC; likewise regressive behaviour results in demotion through the stages within the plan.

During the committee's visit to G-Block, the committee was shown to the cell of one custodial supervision (forensic) patient (Prisoner B). Prisoner B's cell is cordoned off from a central courtyard used by other prisoners. Prisoner B is not allowed to access the courtyard when other inmates are present; and is generally not allowed to mingle with other inmates. When Prisoner B does use the courtyard to play basketball, the other inmates are told not to speak to Prisoner B in case they aggravate or unsettle him. Prisoner B spends much of his day isolated and alone in his cell.

The committee commends the hard work and dedication of the corrections officers and other support staff who work with Prisoner B. The committee acknowledges Prisoner B's extremely challenging and sometimes violent behaviour and commend the corrections officers and disability support staff of the SCF who facilitate Prisoner B's day-trips to the SCF. Notwithstanding this, the committee is firmly of the view that a maximum prison is not an acceptable place for a severely intellectually impaired man to be indefinitely detained.

### *Committee view*

4.30 The committee notes there are limited options for therapeutic services and supports to be delivered to forensic patients within a prison environment. The committee acknowledges that there are practical considerations to support people with profoundly complex needs in prison, which include that correctional officers and their departments are generally not trained to support people with disability and there is limited funding within the corrections department to provide specialist disability supports and therapy.

4.31 In addition to the lack of therapeutic support, the committee is concerned that placement of people on forensic orders in prison unnecessarily exposes them to physical and sexual predation, and to extreme isolation—both within the prison and from the community. It is the committee's view that these two factors—lack of therapeutic support and exposure to a negative environment—lead to a regression in the behaviour of a person on forensic orders. So much so, that at the time of a regular review such regression ultimately leads to that forensic patient remaining in prison. It is the committee's strong view that in order to recalibrate this paradigm, forensic patients should not be held in prison.