Royal Commission into
Victoria's Mental Health System

# WITNESS STATEMENT OF DR EMMA CASSAR

I, Dr Emma Cassar, Commissioner of Corrections Victoria, Department of Justice & Community Safety (**the department**), of 121 Exhibition Street, Melbourne, say as follows:

## Introduction

### *Background and Qualifications*

1 I commenced my career as a forensic psychologist with Corrections Victoria in 1999. From there, I was the General Manager at a number of male and female prisons across the state and acted in various senior executive roles before becoming CEO of non-profit Open Family Australia in 2010 and then State Director for Mission Australia from 2011 to 2013.

2 From 2013 to 2014, I worked in the private sector as Business Development Director of Serco Australia, leading a number of Public Private Partnership bids across Australia and New Zealand followed by a number of years at KPMG as a Partner, leading the National Justice and Security sector.

3 I returned to Corrections Victoria in June 2018 as Commissioner. However, I am currently on a short-term secondment as Deputy State Controller - Operation Soteria to assist in the operational management of the COVID-19 accommodation program, and Larissa Strong is acting Commissioner during this time.

4 I hold a Doctorate in Forensic Psychology from the University of Melbourne.

5 I have more than more than 20 years' experience in the justice sector with roles spanning across government, private and non-profit organisation; I have also been the Australian representative on a number of global justice and security forums.

## Professional Capacity

6 I am giving evidence to the Royal Commission into Victoria's Mental Health System (the Royal Commission) on behalf of the department and I am authorised to do so.

*Please note that the information presented in this witness statement responds to matters requested by the Royal Commission*

7 In my substantive role, pursuant to section 8A of the *Corrections Act 1986* (Vic) (the Corrections Act), as Commissioner for Corrections Victoria (the Commissioner),[1] I am responsible for:

(a) assessing performance in the provision of all correctional services to achieve the safe custody and welfare of prisoners and offenders, including their mental health; and

(b) performing functions under the *Serious Offenders Act 2018* (Vic) (Serious Offenders Act) including the management and good order of residential facilities and the approval for offenders to access specialist mental health services outside of a residential facility; and

(c) exercising any other functions relating to correctional services that the Secretary may determine from time to time.

8 The Secretary may, under section 8 of the Corrections Act and section 345 of the Serious Offenders Act delegate to the Commissioner or any employee of the department, any of the Secretary's powers or functions.

9 The Secretary has delegated to the Commissioner powers and functions in the Corrections Act, the Serious Offenders Act, the *Sentencing Act 1991* (Vic) (Sentencing Act), the *Disability Act 2006* (Vic) and *Mental Health Act 2014* (Vic) (Mental Health Act) among other Acts.

10 The Secretary's powers under the Mental Health Act that are delegated to the Commissioner relate to Secure Treatment Orders (STOs) including the power to transfer a prisoner subject to an STO from a prison to a designated mental health service.

11 Throughout this statement, I will also provide evidence and reflections on what I have observed of the interface between the justice and mental health systems, through both my substantive role as Commissioner and in my prior experiences, including in the field of forensic psychology.

## Preamble

12 The objective of the mental health service system in custody is to meet the needs of people with mental illness in a recovery-focused manner - as is the goal of the broader mental health service system.

[1] The Secretary of the department (the Secretary) employs the Commissioner for Corrections Victoria: *Corrections Act 1986* (Vic) (Corrections Act), s 8A(1).

13 The mental health care of those in contact with the justice system, or at risk of contact, should be a part of a lifetime continuum of care responsive to their health needs. Access to and quality of mental health care should not change based on a person's legal status.

14 In response to the Royal Commission's inquiries, this statement sets out the roles and obligations of community and custodial corrections services in responding to the needs of people in contact with the criminal justice system and with a mental illness.

15 This statement will focus primarily on the interface between the corrections system, custodial mental health services funded and managed by the department, forensic mental health services in the community (including secure forensic mental health services currently provided at Thomas Embling Hospital), and the public specialist mental health system, led by regional Area Mental Health Services (AMHS). It also details investments made within the corrections system, as well as policy and practice changes aimed at improving access to and the quality of mental health services for prisoners, offenders and others with forensic needs who may be at risk of entering the corrections system. These systems and how they interact are described in Part 1 of this statement.

16 At present, the corrections system is too often acting as a mental health provider of last resort because people are unable to access mental health services in the community. Many justice system clients have complex needs and face a range of barriers to accessing mental health treatment in the community. This contributes to the overrepresentation of people with mental illness in custody as there are specific circumstances where a lack of capacity in the mental health or other social service systems directly causes incarceration. I discuss the impacts of the public specialist mental health system on the custodial system in more detail in Part 2 of this statement.

17 This statement highlights opportunities for operational improvement and reform, emphasising that a person-centred and multidisciplinary approach, co-designed with key sector partners, is essential to success. I discuss this in more detail in Part 3 of this statement.

18 While the corrections system will always support people with mental health needs, public specialist mental health services and programs need to be strengthened to reduce the likelihood that people with mental health needs enter or return to the corrections system. This can occur in part due to failing to receive care in the community, or directly due to the lack of available services as an alternative to custody. I discuss this in more detail in Part 4 of this statement.

19 These interventions must be inclusive of other social service needs, such as housing, employment, disability and alcohol and other drugs (AOD) services and supports. A more integrated social service system, with stronger and more connected access to services across the mental health service system, is expected to reduce contact for many with the justice system. I discuss this in more detail in Part 5 of this statement.

20 There must be a commitment to continued improvement of outcomes for people with mental health needs who are in contact with, or at risk of contact with, the justice system, not only in corrections settings but across the mental health system.

21 To that end, this statement will:

(a) Provide an overview of the corrections system and the relevant infrastructure, services and responsibilities of community corrections, prison and health staff to people with mental health needs.

(b) Outline the prevalence of mental illness in prisoners and offenders and note the connection with the gaps in the public specialist mental health system identified in the Royal Commission's Interim Report (the Interim Report), and advocate for adequate services in the community to be made available to prevent unnecessary incarceration.

(c) Identify opportunities to improve the mental health services provided in custody, including for Aboriginal Victorians, female prisoners, and prisoners experiencing crisis, and outline the rationale for retaining responsibility for custodial mental health services within the department.

(d) Examine the impacts of the lack of secure forensic capacity at Thomas Embling Hospital on the prison system, with specific recommendations for how to best provide compulsory treatment services to prisoners.

(e) Reflect on the improvements required to other systems and supports in the community to further reduce overrepresentation in the prison system and enable prisoners and offenders to receive effective treatment, including housing, AOD and disability services.

## Part 1 – Overview of the Victorian corrections system

22 Corrections Victoria is a business unit of the department and is responsible for delivering a corrections system that keeps our community safe. Its core focus is the safe and humane containment and rehabilitation of prisoners, building strategies to break the cycle of their offending as well as tackling the underlying causes of crime. I oversee the operation of 11 publicly operated prisons (including two women's prisons), three private prisons and two transition centres, as well as programs that supervise and help

rehabilitate offenders in the Victorian community. I also oversee the post-sentence scheme under the Serious Offenders Act, which includes community and detention orders for serious sexual and violent offenders.

23 In addition to prison-based services, I set the policy and practice requirements for community corrections and monitor their performance. Community Correctional Services manages community-based orders, parole and post-sentence orders in the community. This includes offenders who are subject to a Mental Health Treatment and Rehabilitation (MHTR) condition or conditions of their parole which require them to access mental health treatment. There are 57 community corrections services locations across the state.

24 Justice Health, a separate business unit of the department, oversees the delivery of health services in the prison system, namely primary health (including primary mental health) and specialist mental health services.

25 Correct Care Australasia, a private health services provider specialising in prison health care, is contracted by Justice Health to provide primary health services, including primary mental health services, in public prisons. In private prisons, these services are directly delivered or subcontracted by the prison operator. The following providers deliver mental health services in custody:

(a) Correct Care Australasia under subcontract to the GEO Group Australia provides primary mental health services in Ravenhall Correctional Centre.

(b) St Vincent's Correctional Health Service under subcontract to G4S provides primary mental health services at Port Philip Prison.

(c) The GEO Group Australia provides primary mental health services at Fulham Correctional Centre and provides consultant psychiatrist services via locum.

26 I note that primary mental health services may not be considered 'psychological' or 'psychiatric' services but are noted here for completeness. Corrections Victoria's Forensic Intervention Service provides intensive offence-specific interventions, which may include a psychological treatment component to address offending risk.

27 Specialist mental health services in all Victorian prisons are delivered by Forensicare under a single contract with the State (public prisons) or separate tripartite arrangements with the prison operator and the State (private prisons).

28 Corrections Victoria works in partnership with Justice Health and contracted service providers to ensure prisoners have access to the health and mental health services they need. I refer to the Associate Secretary's statement which provides a more comprehensive overview of Justice Health's role and the services it commissions.

29 Offenders in the community access mental health services provided through the broader mental health system.

### *Mental health services in Victorian prisons*

30 Corrections Victoria has a duty of care to all prisoners, which includes a responsibility to provide prisoners with appropriate healthcare. Section 47 of the Corrections Act sets out prisoners' rights, including "access to reasonable medical care and treatment necessary for the preservation of health", and if mentally ill, to access "special care and treatment as the medical officer considers necessary or desirable in the circumstances".

31 To support these rights, prisons are required to take reasonable steps to ensure that all prisoners have access to appropriate health services, including mental health services, throughout their period of incarceration. This includes when individual prisoners or prison units are subject to additional controls required to maintain security and good order.

32 Prisoners have the right to make complaints about any treatment they receive to a range of independent bodies, including the Mental Health Complaints Commissioner, the Health Complaints Commissioner and the Victorian Ombudsman. To respect the confidentiality of complaints, any letters to these bodies are exempt mail, meaning the contents of the mail are not screened, and any phone calls made to them are not monitored or recorded.

33 In addition to the broad obligation to provide mental health care for the wellbeing of prisoners, mental health care forms part of the approach to addressing recidivism. All offence-specific and offence-related programs delivered across the corrections system use the Risk Needs Responsivity model. This model determines interventions based on assessed risk of reoffending (Risk), the problem areas or needs specific to the offender that should be targeted to reduce risk (Need), and delivery of interventions in a way the offender will engage in and respond to (Responsivity).

34 Corrections Victoria's Forensic Intervention Service provides intensive offence-specific interventions, which may include a psychological treatment component to address offending risk.

35 Mental health services in the Victorian prison system include both primary and specialist services. Every Victorian prison has a clinic that provides primary mental health services on site, delivered by registered psychiatric nurses and doctors through a nurse-led model of care. Specialist mental health services are also available to prisoners across the system, including forensic outpatient and bed-based treatment services. This means that prisoners with mental illness have access to a range of stepped services to

meet their treatment needs and prevent deterioration of their mental health. I discuss mental health services delivered in custody further in Part 3 of this statement.

36 Every time a prisoner enters the system, a reception assessment is conducted to determine if they have any health, mental health or psychiatric conditions that require assessment and treatment or other supports, including any known or suspected conditions that have not been confirmed. All prisoners must receive a mental health assessment by a mental health professional within 24 hours of their reception into the prison system.

37 Prisoners with a known psychiatric illness or who are presenting with clinical risk factors are assigned a psychiatric risk rating (**P-rating**) which connects them to further assessment and treatment and assists Corrections Victoria in their placement and management.

38 Further assessments occur when prisoners are transferred between prisons, or when they display behaviours indicating a deterioration of concerning behaviour or a risk of suicide or self-harm (known as an 'at risk assessment'), or at a prisoner's request. They also receive a welfare check from a clinician following return from a court appointment. All prisoners are assessed for suicide and self-harm risk through a general mental health assessment on entry into prison and on transfer between prisons, and with a welfare check on return from court.

39 Prisoners receive an at-risk assessment by a mental health clinician within two hours of any time that Corrections Victoria staff are concerned that their behaviour may indicate a risk of suicide or self-harm. Where a suicide and self-harm risk is identified, a risk management plan is put in place.

40 If a prisoner requires a higher level of care based on clinical advice, they are accommodated in a purpose-built mental health unit. These units have capacity to deliver bed-based specialist services for up to 141 prisoners at any one time, and include:

(a) the Acute Assessment Unit at Melbourne Assessment Prison, a short stay unit for people requiring mental health assessment, with capacity for 16 men.

(b) the Marrmak Unit at Dame Phyllis Frost Centre, a unit for women who require ongoing, intensive treatment, who are assessed as high risk for self-harm/suicide related to serious mental illness, or who have age related mental illness requiring specialist treatment, with capacity for 20 women.

(c) the Rosewood unit at Dame Phyllis Frost Centre is part of the Health and Wellbeing Precinct, which also encompasses the Drug Treatment Unit (Caraniche) and Marrmak Mental Health Unit (Forensicare). Rosewood is a 48-

bed unit that provides a safe environment for women with complex needs who require additional support and/or supervision. Rosewood can be utilised as a step-down unit for Marrmak clients transitioning out, where multiple outpatients can reside, if assessed as appropriate. Rosewood custodial staff work closely with the resident Forensic Disability Supervisor/Occupational Therapist to provide a needs-based approach and employ positive behaviour support as part of their case management practices.

(d) the Ballerrt Yeram-boo-ee (Strong Tomorrow) service at Ravenhall Correctional Centre with capacity for 75 males. The service provides a flexible range of treatment interventions in a stepped care model, delivered by a multidisciplinary team including specialist mental health outpatient services for approximately 100 prisoners accommodated at the prison and the Community Integration Program to support prisoners with a serious mental illness and complex needs in their transition from prison back to the community.

(e) the St Paul's Psychosocial Unit at Port Phillip Prison with capacity for 30 men. The service provides specialised care, treatment and therapeutic programs to prisoners with a diagnosed mental illness who require psychosocial rehabilitation to minimise risk of relapse and enhance their social functioning in preparation for returning to the general prison environment or release to the community.[2]

41 Prisoners with serious mental illness requiring compulsory treatment are accommodated in a bed-based service at Ravenhall Correctional Centre or the Acute Assessment Unit at Melbourne Assessment Prison (men) or Dame Phyllis Frost Centre (women) while they await transfer to Thomas Embling Hospital. I discuss compulsory treatment for prisoners further in Part 4 of this statement.

### *Preventative mental health services provided by prison-based services*

42 For female prisoners, two local Centres Against Sexual Assault (CASAs) deliver the Women's Trauma Counselling Service to women in the Dame Phyllis Frost Centre and Tarrengower. This specialist trauma counselling program for women was developed in 2006 to respond to trauma caused by sexual assault and was expanded in 2016 following the Royal Commission into Family Violence. The program is delivered by local CASAs and provides both family violence and mental health supports for female offenders and supports approximately 170 prisoners at a time. The program provides trauma counselling services, trauma focused group sessions, and training and informational sessions for custodial staff.

[2] Forensicare Prison Forensic Mental Health Access Flow Coordination Guideline.

43 For remandees, who account for two in five adults in prison, the Adapt, Take Stock, Look Ahead Suite (ATLAS) of psycho-educational and wellbeing programs has been piloted. ATLAS encourages remandees to access suitable programs to support their mental health and wellbeing needs, reduce the pressure associated with the custodial environment, and build life skills for current and future use. ATLAS is delivered by Remand Program Facilitators. A review found ATLAS acted as a 'catch-all' service whereby Remand Program Facilitators provide care to remandees from reception and throughout their time on remand. A 2019 evaluation of the programs completed by the department found ATLAS to be successful in improving mental health and wellbeing outcomes for remandees.

### *Measurement of mental health outcomes in custody*

44 Mental health outcomes across the mental health system are measured through the 10-year mental health plan, which is governed by the Department of Health and Human Services (DHHS). There is currently a single indicator in the 10-year mental health plan outcomes framework relating to the justice system, measuring the proportion of prison entrants who, at prison reception assessment, are allocated a psychiatric risk rating. However, this does not measure therapeutic outcomes of mental health services delivered in custody. The department does not currently systematically track therapeutic outcomes across the prison system.

### *Policies and processes for the transitional care and treatment for people who are known to have a mental illness when they leave custody*

45 Prisoners with mental health concerns upon release will participate in transition planning to meet their mental health needs. For prisoners who have received in-prison mental health care, this includes a mental health professional working with the prisoner to develop a Mental Health Discharge Summary and plan for post-release treatment in the community, including making appointments as required.

46 In terms of non-clinical supports, Corrections Victoria has embedded programs to strengthen pre-release planning and post-release support.

47 Eligible prisoners can participate in post-release programs ReStart and ReConnect, where caseworkers can link offenders into community-based mental health support, as well as provide transportation and brokerage funding to access treatment and medication.

48 The Reintegration Program provides pre-release programs that are responsive to each prisoner's transitional needs on entry to prison, throughout their prison sentence and to assist with returning to the community. Post-release support is administered by prison-

based Assessment and Transition Coordinators within adult prisons and delivered in the community through community service agencies funded by the department. It is provided to prisoners who require more intensive support and linkages to related services.

49 I discuss opportunities to improve transition points further in Part 3 and information-sharing in Part 5 of this statement.

### *Relationship between mental illness and young people who are involved in both Youth Justice and the adult system*

50 Between 2008 and 2017 there were 1,725 individuals who entered Youth Justice custody and who would have turned 25 by the end of 2019. Of these, 55 per cent (n=957) later entered the adult Corrections Victoria system before they turned 25.

51 In 2019, there were 221 people who entered Corrections Victoria custody for the first time having previously spent time in Youth Justice custody between 2008 and 2019.[3] The majority were male (88 per cent), the vast majority (94 per cent) were aged 25 or younger and more than half (56 per cent) were under the age of 20. Close to one in six identified as Aboriginal (16 per cent).[4]

52 More than one third (37 per cent) had left Youth Justice custody less than one year prior to entering Corrections Victoria custody. Forty per cent had last been in Youth Justice custody more than three years prior to entering Corrections Victoria custody.

53 Nearly all of these people entered Corrections Victoria custody on remand (94 per cent). Assaults were the most serious offence charged or sentenced for almost half of all entries (47 per cent), and 12 per cent related to robbery.

54 Upon reception at an adult prison, staff must consider whether the young person presents as vulnerable and should be accommodated in a specialist youth unit. Within the prison system, there are three units specifically aimed at addressing the needs of young prisoners. For females, the preferred initial location for a young prisoner is Dame Phyllis Frost Centre (DPFC), while males are accommodated at Penhyn Unit at Port Phillip Prison, the Bambra and Bolinda Units at Ravenhall Correctional Centre, or the Nalu unit at Fulham Correctional Centre, depending on their security classification.

55 Within these units, there are programs designed to allow young offenders the opportunity to focus on individual development and cognitive behavioural integration in a controlled environment.

### *The relationship between Corrections Victoria and Thomas Embling Hospital*

56 For clarity, I wish to highlight that Thomas Embling Hospital is not a custodial facility or a custodial setting. It is a high security hospital, which has capacity and capability to accept a range of patients, including:

(a) Patients referred by the custodial system. These are prisoners who, upon admission to the hospital, are legally reclassified as **security patients** under the Mental Health Act. Legally, these patients are in the custody of the mental health service while receiving treatment and are no longer in my custody.

(b) Patients referred by the court system, such as those subject to orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) (CMIA). These patients are legally classified as **forensic patients**, though given I use the term 'forensic' in many other ways, in this statement I will refer to them as **CMIA patients**. Legally, these patients are in the custody of the mental health service while receiving treatment and are not in my custody. However, as discussed further below, CMIA patients can often spend a period of time in prison while waiting for a bed to become available at Thomas Embling Hospital, during which time they are considered prisoners and in my custody.

(c) Patients referred by other AMHS. These are patients who many never have committed an offence but would benefit from treatment in a more secure environment, such as if they require more complex restrictive interventions. These are referred to as **civil patients**.

57 Furthermore, Corrections Victoria does not provide or oversee any security services at Thomas Embling Hospital, including for security patients. This may be contrasted with when a prisoner is taken to a public hospital to receive other types of treatment, for example, if they require admission to a local Emergency Department. In these circumstances, a prisoner is escorted by a custodial officer while in the hospital. This does not occur at Thomas Embling Hospital, because the hospital has responsibility for and provides those security services itself.

### *The Victorian Government has invested significantly in mental health capacity in custody*

58 Successive governments have invested in expanding the mental health services available in custody to meet demand for specialist mental health services.

59 The most significant investment has been the establishment of Ravenhall Correctional Centre, which opened in 2017. This facility has a focus on prisoners with mental illness, young prisoners, and Aboriginal prisoners and services are tailored to the needs of these cohorts. Other recent investments include refurbishment and expansion of the Marrmak and Rosewood units at the Dame Phyllis Frost Centre, completed in 2018, and refurbishment of the Acute Assessment Unit at the Melbourne Assessment Prison, completed in 2019. Since 2017, this program of works has increased the prison system's dedicated mental health capacity by 75 beds and over half of the pre-existing 66 beds have been refurbished.

60 Government investment in specialist mental health infrastructure has also been accompanied by increased spending on primary and specialist mental health services to meet demand. A range of factors are taken into consideration to ensure services meet demand. For example, total annual expenditure on specialist mental health services across public prisons doubled in the six years between 2012-13 and 2018-19 (from $6.9 million to $13.9 million per annum). While the prison population has also grown significantly over that period, it has only grown at roughly half that rate. Of note, the daily average prisoner numbers across public prisons grew by 47 per cent between 2012-13 and 2018-19 (from 3,447 to 5,055).

61 There are no current plans for further expansion of specialist mental health infrastructure in Victorian prisons.

62 There are also a range of small-scale but important intervention programs with a focus on mental health offered to specific cohorts in custody that demonstrate the positive benefits that early intervention and proactive work can have. I would particularly highlight the ATLAS programs (referred to at [41] above) for remandees[5] and the Aboriginal Social and Emotional Wellbeing Plan and Continuity of Care Pilot, which are detailed in the Associate Secretary's statement.

### *Therapeutic considerations taken into account in the design of recent infrastructure*

63 The Guiding Principles for the Design and Expansion of the Victorian Prison System articulate that planning for the system is to include accommodation for prisoners with specific needs (such as prisoners with a mental illness or disability) in regimes that meet those needs. Prison design ensures that prisoners with mental health needs can be accommodated in a safe and secure environment that provides them with assistance to adjust to the prison and programs which address their individual needs and offending behaviours.

64 One of the key focus areas for the Ravenhall Correctional Centre and the refurbishment of the Marrmak Unit at Dame Phyllis Frost Centre was to deliver an integrated and holistic model of care for prisoners with a mental illness, and provide facilities with therapeutic environments to enhance treatment outcomes for prisoners with mental health needs and support the overall delivery of forensic mental health services.

65 In specifying requirements for these builds, the State wanted the design philosophy to reflect the principles of hope, healing and recovery in a non-institutional and patient-centred environment that is safe, facilitates interaction between clinical and custodial staff and patients, and maintains patient dignity without compromising the operational realities of safety and security.

66 Creating a physical, interpersonal and psychological environment that supports the therapeutic milieu is essential in the recovery process. Patient care areas that incorporate abundant natural light, access to external environments, colour, art, pleasant (but robust) furnishings have been shown to advance healing and recovery. These principles have been considered in the design of recent infrastructure.

## Part 2 – Untreated mental illness in the community contributes to overrepresentation in the corrections system

67 There is significant overrepresentation of people with a mental illness in the corrections system.

68 Of the 8,156 prisoners in Victorian prisons (public and private) on 1 March 2020, there were 2,351 prisoners with a mental health diagnosis, and 3,510 mental health diagnoses in total,[6] representing 29 per cent of prisoners (2351 of 8156). Depression (1650 prisoners), drug abuse disorders (715 prisoners) and anxiety disorders (192 prisoners) represented almost three quarters of all diagnoses (72.8 per cent).

69 This is significantly higher than the Royal Commission's estimates for community prevalence, which is that around 1 in 5 Victorians or 20 per cent will experience mental illness each year.[7]

70 Within community corrections, the prevalence of diagnosed mental illness is best indicated by the presence of a MHTR condition on a supervised Community Correction

[6] Indicates multiple diagnosis.

[7] Corrections data looked at prevalence in the population on one day, not over the course of a full year.

Order (**CCO**). As at 30 June 2019, 10,063 offenders were subject to a CCO with a supervision condition, and of those, 55.9 per cent (5,625) had a MHTR condition. [8]

### *Gaps in the mental health system contribute to overrepresentation, and can directly cause preventable incarceration*

71 The Interim Report found that there are treatment gaps for people with moderate or enduring mental illness, and treatment gaps for people with severe mental illness.

72 The Interim Report also reflects that constrained capacity results in increased reliance on emergency crisis interventions in the mental health system, resulting in poorer mental health outcomes and further pressure on the system.

73 Failure to provide treatment in the community can result in escalating contact with the justice system as well as deteriorating health outcomes.

74 In my experience, having regard to the state of prisoners' mental health needs as they enter custody, there are too many people coming into the corrections system who have not received adequate treatment and support in public specialist mental health services. In particular, prisoners with acute needs requiring compulsory treatment while in custody have generally been clients of one AMHS or more previously, but have been disconnected from the service for a period before they entered custody. In my opinion, this indicates that the public specialist mental health service system appears to be identifying but not meeting the needs of people at risk of offending. This must change if we are to address the overrepresentation of people with mental illness in the justice system.

75 In addition to the broad barriers to accessing care outlined in the Interim Report, people in contact with the corrections system are more likely than the general population to experience additional barriers to accessing care in the community. Offenders routinely experience overlapping and complex challenges that can include homelessness, AOD use and disability, as well as their mental illness.[9]

76 In my view, this contributes to the overrepresentation of people with mental illness entering the corrections system, as well as people entering the corrections system with more acute needs because they are not getting appropriate treatment in the public specialist mental health system.

[8] This does not include offenders on a CCO with a community work condition only or those on parole without a supervised order.

[9] Associate Secretary's witness statement to the Royal Commission, Part One.

77 There are also specific issues and gaps in forensic mental health and/or disability services that directly cause preventable incarceration.

78 As highlighted in the Interim Report, people on custodial treatment orders under the CMIA are routinely held in prison due to the lack of available services at Thomas Embling Hospital, the Disability Forensic Assessment and Treatment Service or other equivalent secure services. Furthermore, some people sentenced under CMIA do not meet the criteria for treatment at any service – effectively falling between the available treatment options and landing in custody as a result. This gap was highlighted in the Victorian Ombudsman's Investigation into the imprisonment of a woman found unfit to stand trial ('Rebecca case').[10]

79 A related gap is for offenders with disability requiring supported accommodation whose needs may be considered too complex to attract service providers through the National Disability Insurance Scheme (NDIS). This was evident in a highly-publicised case in 2017, where a man was held in custody on remand due to a lack of NDIS-funded services that could accommodate him on bail ('Francis case').[11]

80 Several submissions to the Royal Commission expressed concern regarding the practice of "therapeutic remand",[12] where a person is denied bail in order to ensure they receive treatment in prison, and incidences of people who are sentenced to a custodial sentence due to a lack of confidence that they will receive appropriate services in the community.[13]

81 While the corrections system does not collect data on how often bail is refused as a result of a desire to access prison health care, I am anecdotally aware that "therapeutic" remand continues to occur. I also note that while placing offenders on remand may provide access to mental health services, remandees are not able to access intensive offence-specific interventions, such as criminogenic AOD programs, provided to sentenced prisoners.

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[10] Investigation into the imprisonment of a woman found unfit to stand trial, Victorian Ombudsman, 16 October 2018. <https://www.ombudsman.vic.gov.au/our-impact/investigation-reports/investigation-into-the-imprisonment-of-a-woman-found-unfit-to-stand-trial/>.

[11] 'Emergency intervention to remove disabled man left in prison after NDIS providers refused to care for him', by Louise Milligan for 7.30, 9 November 2017 <https://www.abc.net.au/news/2017-11-09/emergency-intervention-to-remove-disabled-man-stuck-in-prison/9133634>.

[12] Federation of Community Legal Centres submission to the Royal Commission into Victoria's Mental Health, page 21, footnote 102; Victorian Parliament Drugs and Crime Prevention Committee 2010, 'Inquiry into the Impact of Drug-related Offending on Female Prisoner Numbers – Final Report', page 36

[13] Mental Health Legal Centre submission to the Royal Commission into Victoria's Mental Health page 6; Office of the Public Advocate submission to the Royal Commission, page 29

82 Each of these issues is an example of the custodial mental health system being used as a mental health provider of last resort due to issues with the public specialist mental health system or other systems providing adequate services, often simply due to capacity. The mental health and disability systems must have more capacity and capability to identify and activate necessary supports in a timely fashion when they are needed for diversion, bail or parole.

83 I encourage the Royal Commission to consider the specific needs of offenders and the need to avoid preventable incarceration when making recommendations regarding access to and navigation of the mental health system, and the interface between the mental health and disability systems.

84 I discuss the specific impacts of a lack of capacity in the forensic mental health system and opportunities for reform in Part 4 of this statement.

### *Reducing overrepresentation of mental illness in the corrections system will require a mental health system that has the capacity and capability to meet the needs of offenders*

85 In addition to the issues raised above I note that several submissions to,[14] and witnesses appearing before the Royal Commission[15] have highlighted that, for some people, the corrections system is the only place they have been able to reliably access long-term mental health care and treatment.

86 In particular, Caraniche's submission to the Royal Commission identifies that their clients experience a cycle of arrest and placement in care (either through a CCO or in custody), stabilisation due to consistent access to treatment, release to the community, disconnection from care and subsequent relapse and rearrest. This indicates that there is likely a population in custody that would have avoided incarceration if given access to and support to engage with effective, long-term care in the community.

87 Noting that the Interim Report has recommended immediate investment to meet immediate demand for acute treatment, the Royal Commission should consider the needs of these cohorts when making further recommendations regarding the capacity of the mental health system. In addition to having acute capacity, AMHS should also have capacity in sub-acute units and long-term residential services to accommodate offenders in circumstances where the alternative would be custody, including where a person requires treatment as a condition of bail or parole.

[14] Law Institute of Victoria submission to the Royal Commission into Victoria's Mental Health : page 46, paragraph 9.2/9.3, and paragraph 10.1 (page 48); Forensicare submission to the Royal Commission into Victoria's Mental Health: page 3

[15] Witness statement from Mary K Pershall to the RC - paragraph 69 (details her daughter's experience

88 Public specialist mental health services should have the capability to provide services that respond to the complex needs of clients who may be in contact with the corrections system. This should include improving the system's forensic capabilities to support patients' offence-related needs, as well as their broader clinical needs. The existing Forensic Mental Health in Community Health program could be considered as a model for enhancing the capabilities of community-based mental health services to support offenders with mental illness.

89 Any expansion of long-term residential mental health services in the community must be able to accommodate offenders on CCOs, people on bail, people on parole, people subject to post-sentence orders and former prisoners who require mental health treatment.

90 As noted by several submissions to the Royal Commission, an address within the catchment of an AMHS is required in order to receive treatment. This presents a specific barrier to offenders receiving ongoing care, as they are more likely to be homeless, transient or in insecure housing. I would support a recommendation to remove this requirement, given the disproportionate effect this requirement has on ex-prisoners and offenders on CCOs.

### *Challenges experienced in relation to offenders in the community*

91 Offenders in the community access mental health services provided through the community mental health system. The following challenges are commonly experienced in relation to offenders in the community:

(a) Often an offender with a serious mental health condition, like schizophrenia, may not be considered 'treatment ready' by mental health professionals due to their ongoing AOD use. Where an offender has a dual diagnosis and their concurrent needs are not able to be addressed by a dual diagnosis service, services that could provide assistance for one of their areas of need can be reluctant to accept a referral for that person due to concerns about whether the treatment will be effective. This results in some of the most complex offenders receiving little to no mental health specific treatment in the community.

(b) In regional areas, waitlists for forensic mental health services are long or offenders must travel to the city to engage appropriately qualified professionals. This is particularly true for young people under twenty five in Children and Youth/Adolescent Mental Health Service catchments, where there is even more restricted access to forensic mental health services.

(c) Often conditions on a court order specify referral to a General Practitioner (GP) to obtain a Mental Health Care Plan. In many cases, offenders do not have a

regular GP and may refuse authority for Community Correctional Services (CCS) to exchange information. GPs may also be unfamiliar with the criminal justice system or lack an understanding of the purpose of the order's condition. They may have limited information on the offender's mental health background and base their assessment on the offender's self-report. This may result in instances where GPs do not recommend treatment. In this case, CCS has difficulty in addressing the offender's identified mental health needs given a lack of alternative options. In other cases, the offender may be referred to treatment, but requests that the GP and professionals not share information with CCS, such as medication or referrals made to other health care professionals. This creates challenges for both the GP and CCS with respect to information sharing and monitoring offender outcomes and the conditions of the order. CCS may address this through interactions with the GP, with varying success and dependent on the offender's willingness to engage in the process.

92 Given these challenges, I consider the following two programs delivered by DHHS for offenders in the community to be effective at providing mental health treatment:

**Forensic Mental Health in Community Health**

93 Since late 2018, referral and treatment options for offenders in the community have been enhanced through the establishment of the DHHS Forensic Mental Health in Community Health (FMHiCH) initiative funded under the Forensic Mental Health Implementation Plan (FMHIP).

94 This program aims to connect offenders with treatment when they have a MHTR condition on their CCO, supporting compliance with the condition.

95 Prior to the introduction of the FMHiCH service, the majority of offenders in the community had significant difficulties accessing and completing treatment to fulfil their MHTR condition. This was because their mental health needs were not sufficiently severe or acute to engage an AMHS; or Commonwealth funded psychological counselling as part of a GP referral was not intensive enough, or suitable.

**Forensic Serious Offender Consultation Service**

96 The Forensic Serious Offender Consultation Service (F-SOCS) can be utilised by CCS to provide specialist advice and consultation. Delivered by Forensicare and funded by DHHS, F-SOCS aims to support CCS and mental health services in the management of individuals who have a serious mental illness (SMI) and a history of serious violent and/or sexual offending. The F-SOCS program targets offenders who are either not currently engaged with an AMHS or where engagement with these services is problematic.

97 F-SOCS provides forensic mental health assessments and facilitates access to the mental health sector for eligible offenders currently on an order supervised by CCS.

## Part 3 – Opportunities to improve custodial mental health services

98 As outlined above in this statement, primary and specialist mental health care services in custody currently provide a stepped care model for prisoners with mental health needs.

99 However, there are opportunities to improve the service offering in custody to address key gaps or to be more responsive to the needs of particular cohorts.

### *Recommendations applying to mental health services in the community will need to be reflected in custody*

100 The mental health services provided in custody are required to be equivalent to those available in the community through the broader mental health system.

101 This means that any Royal Commission recommendations regarding mental health practice and models of care for primary and specialist mental health care will be implemented in custodial mental health services as well. This includes any recommendations for models of care for specific cohorts, including women, Aboriginal Victorians, young adults, LGBTIQ Victorians, people with disability and people from culturally and linguistically diverse backgrounds.

102 While many reforms applying to the broader mental health system may be appropriate for direct application in the custodial environment, there are specific issues and gaps relating to mental health services in custody that I would encourage the Royal Commission to consider as requiring bespoke recommendations.

### *Services that are responsive to the specific needs of Aboriginal people in custody are required*

103 Aboriginal overrepresentation in the criminal justice system is inextricably linked to the intergenerational consequences of dispossession, disruption of culture and kinship systems and high rates of socioeconomic disadvantage.

104 Poor mental health is one of the primary social factors that heighten the risk of criminal justice system involvement for Aboriginal Victorians.[16] Seventy-two per cent of

[16] Underlying causes of Aboriginal over-representation, Aboriginal Justice Forum. <https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-over-representation-in-the-justice-system/underlying-causes-of-aboriginal>

Aboriginal women and 92 per cent of Aboriginal women in prison had received a lifetime diagnosis of mental illness.[17]

105 The Associate Secretary's witness statement sets out in detail a range of programs and reforms implemented across the justice system arising from the Victorian Aboriginal Justice Agreement, and notes that there is still more work to do, including for Aboriginal people in custody.

106 In particular, the management of Aboriginal people with a mental illness in custody, and the mental health services they receive, should be responsive to the specific harms to Aboriginal people caused by incarceration. These services should be co-designed with Aboriginal communities, including Aboriginal people with lived experience of mental illness and incarceration, and should ideally be delivered directly by or in conjunction with Aboriginal organisations in line with the principle of self-determination.

107 There is also potential for justice-responsive mental health services to be appropriate in the community as well, to ensure services can follow prisoners beyond the walls and address the lasting impact of incarceration on Aboriginal (ex-)prisoners, (ex-)offenders, their families and their communities.

108 I encourage the Royal Commission to consider the specific needs of Aboriginal people in custody, and of Aboriginal offenders more broadly, when making recommendations regarding the mental health system's service response for Aboriginal Victorians.

### *Models of care specifically for female prisoners and offenders with personality disorders*

109 In recognition of the high incidence of trauma and history of victimisation among female prisoners, a trauma-informed framework is being progressively introduced into the women's prison system to better respond to their specific needs.

110 We have evidence of significantly higher rates of personality disorders among women prisoners than women in the community. Personality disorders frequently occur alongside other mental health needs and complexities, such as trauma.[18] Female prisoners with personality disorders often have more than one diagnosis (depression, PTSD), experience severe impairment of psychosocial functioning and display complex and challenging behaviours including impulsivity, substance abuse, unusually intense

[17] Koori Prisoner Mental health and Cognitive Function Study – Final Report.

[18] T Butler et al, Mental disorders in Australian prisoners: a comparison with a community sample (Australia and New Zealand Journal of Psychiatry, 2006); C.S. Tye and P. E. Mullen, Mental disorders in female prisoners (Australia and New Zealand Journal of Psychiatry, 2006).

anger, self-harm or suicidality. Issues in personality disorder identification and treatment were also identified by the Ombudsman in the Rebecca case.

111 These symptoms and behaviours are difficult to treat and benefit from structured psychological therapies that are specifically designed for personality disorders. In 2015 Dialectical Behaviour Therapy (**DBT**) was the only treatment with enough high-quality research to be evaluated as effective for personality disorders by the Cochrane Database of Systematic Reviews [19]. DBT can be offered as two 24-week skills courses over one year, six-month and briefer skills training for acute care units and non-traditional settings. Due to the high churn and short stays in the women's prison system, a mix of short and long courses would be appropriate to deliver at Dame Phyllis Frost Centre to effectively meet the needs of this cohort.

### *Prisoners would benefit from access to counselling and psychology services, particularly at key transition points*

112 Currently psychology services are provided by Forensicare as part of its multidisciplinary suite of services for prisoners requiring specialist outpatient or bed-based mental health care.

113 Prisoners experiencing psychological distress or a low-to-moderate level mental illness (for example, some anxiety and depressive disorders) who do not require a specialist service response but would benefit from psychological counselling services do not currently have access to psychology or allied mental health services. In the community, these services are generally provided through the Medicare Better Access Scheme, which provides Medicare rebates for up to 10 psychology, social work or occupational therapy appointments per year. The Commonwealth does not currently provide for these or any other services to be made available to adults or young people in custody.

114 The Corrections Victoria Forensic Intervention Service is not funded for psychological wellbeing and distress tolerance sessions.

115 Expanding access to psychological services would also be expected to improve psychological wellbeing and potentially improve suicide prevention in custody.

116 Making additional counselling and psychology services available to prisoners, particularly at transition and other stressful points, would serve as a protective factor against suicide and self-harm.

[19] Linehan, Marsha; DBT Skills Training Manual Second Edition, The Guilford Press, New York, 2015, p. 16

### *There are opportunities to improve the responses to offenders and prisoners with mental illness and comorbid AOD use*

117 There is a high level of comorbidity of AOD use and mental illness in offender populations, with a 2015 study of Forensicare patients indicating 77 per cent had at least one lifetime diagnosis of a substance use disorder.[20]

118 The Justice Health Quality Framework and Justice Health AOD Quality Framework articulate the service requirements of health, mental health and AOD treatment providers in regard to AOD and Mental Health Programs and co-morbid responses.

119 When prisoners are engaged in AOD treatment and mental health treatment, feedback is overwhelmingly positive. However, factors such as short sentence length and remand status can prevent a prisoner from completing intensive treatment interventions.

120 There are capacity and capability issues across the dual diagnosis sector, where there are limited dual diagnosis (in this statement, referring to dual mental health and AOD diagnoses) clinicians and only one forensic dual diagnosis service for offenders which accepts referrals across the state: the High Risk Offenders Alcohol and Drug Service (HiROADS). As a result, referrals, assessment and treatment for AOD and mental health concerns occur almost always exclusively of each other.

121 There is an opportunity to increase dedicated roles for dual diagnosis management. This would allow for improved patient management and treatment for prisoners with comorbidities, better knowledge of referral options, improved referral pathways, upskilling of mental health and AOD staff, improved discharge planning and coordination.

122 Consistent with other submissions made to the Royal Commission to date,[21] increased availability of specialist forensic dual diagnosis clinicians would greatly benefit the health outcomes for both prisoners and offenders. It would reduce crisis presentations which can cause strain on emergency services, including police and emergency departments in the community.

123 There is also an opportunity to improve and embed collaborative practice within each provider, between providers and between custody and community providers. These include forensic mental health, primary health and AOD treatment providers. Improved collaboration, information sharing and integration of the reporting, monitoring and data

[20] James R. P. Ogloff, Diana Talevski, Anthea Lemphers, Melisa Wood, and Melanie Simmons, Co-Occurring Mental Illness, Substance Use Disorders, and Antisocial Personality Disorder Among Clients of Forensic Mental Health Services(Psychiatric Rehabilitation Journal, 2015) Vol. 38, No. 1, 16–23.

[21] VAADA submission to the Royal Commission in to Victorian Mental Health System (2019)- recommendations 1, 3, 10, 12, 13

collections, as highlighted in the Associate Secretary's discussion of priority reforms, will result in improved health outcomes for prisoners and offenders, for AOD and mental health services as it will for general continuity of care and transition services.

### *Opportunities to improve continuity of care through in-reach models of care*

124 Both entry to and exit from custody are difficult health care transition points, as no health services can 'follow' a person into prison. This poses significant challenges in the provision of continuous services throughout a person's life.

125 At the beginning of the custodial sentence, the custodial health service may not be able to identify a prisoner's existing health service providers and undertake clinical handover in a timely fashion.

126 At the end of the custodial sentence, there are different but similarly significant challenges. When a prisoner's release from prison is planned, either through the parole process or through straight release at the end of a sentence, it is possible to arrange mental health and other appointments ahead of release, noting the previously raised issues accessing AMHS where a prisoner is released into homelessness or uncertain housing. However, this creates a situation where a prisoner is expected to attend an appointment, potentially unsupported, and independently build a new therapeutic relationship while also adjusting to their return to the community.

127 For prisoners released directly from court, it is not possible to arrange appointments with AMHS or other mental health providers in the community before release. As these releases are unplanned and immediate, continuity issues cannot be resolved with discharge planning and require more systemic solutions.

128 One option that I would recommend the Royal Commission consider is for the discharge of prisoners to be supported by an assertive in-reach model where dedicated clinicians work with the prisoner and AMHS prior to their release to ensure a suitable discharge plan is in place. This would include that the prisoner has a relationship with their post-release treating physician and that the AMHS is engaged and prepared to treat the prisoner.

129 There may also be value in introducing a similar program for those newly received into custody who are held on remand, to promote continuity upon entry to custody and potentially address the issues we see with service disconnection upon unplanned release.

130 For Aboriginal prisoners, in-reach mental health services could be made available from Aboriginal community providers, reflecting an approach being trialled in relation to primary health care through the current Continuity of Care Pilot program.

131 An in-reach model of care would be expected to reduce the rates of disconnection from treatment following release, reducing the likelihood that a prisoner will return to custody as a result of a mental health crisis.

### *To meet my duty of care to prisoners, responsibility for adult custodial health services should continue to remain within the department*

132 I note that other evidence has been provided to the Royal Commission regarding the suitability of responsibility for custodial health service commissioning and oversight remaining within the Corrections portfolio, particularly as this is an anomaly when compared to other Australian jurisdictions.

133 In designing our current approach to health service delivery, the department has explicitly considered the benefits and challenges of alternative governance arrangements, including the relative merits of custodial health services being a responsibility of the Health portfolio as compared to the Corrections portfolio. It is my belief that a range of key outcomes would be compromised if these functions were to be moved into the Health or Mental Health portfolio, including:

(a) **Consideration of health, mental health and AOD service demand in design and budget for the custodial system.** Currently health and mental health services are funded as part of the overall per-bed output funding for prisons, which allows the funding and provision of mental health services to be directly responsive to changes in the prison system capacity and prison populations. Additionally, the alignment of mental health and prison budget levers over the past decade has enabled the design and build of Ravenhall Correctional Centre with a greater focus on mental health treatment for men.

(b) **Integration of health with other custodial services and clear link between health and the custodial system's community safety and rehabilitation objectives**. This includes local and expedient resolution of day-to-day operational issues and facilitation of collaborative case management and care planning. As noted above, the treatment of mental illness forms part of the overarching Risk, Needs and Responsivity framework for the rehabilitation of prisoners. Having the mental health services (or all health services) within the prison fragmented or not embedded into operations, with objectives and accountabilities set by a different department and Minister would risk disconnecting mental health from overall rehabilitation objectives.

(c) **Clear accountability for duty of care, particularly for complex case management and deaths in custody.** The current arrangements allow for a single, clear point of accountability for both custodial, health and mental health services in the event of critical incidents, including deaths in custody. This

prevents disputes over responsibility for responding to incidents and ensures closely coordinated responses by both clinical and custodial staff. If prison health services were managed by a separate entity outside the justice portfolio, it is likely that the department would still require its own internal health expertise to acquit its non-delegable duty of care which would create a risk of conflicts over accountability.

134 I acknowledge that there are a range of other objectives that may appear to be more easily achieved by the movement of custodial health services into a health portfolio. These include improved continuity of care and greater consistency and quality of services provided inside and outside custody. I note that my colleagues in other jurisdictions, most notably Queensland as identified through their Offender Health Services Review[22], experience challenges in achieving continuity of care and delivering community-commensurate care in custody even when custodial health services are delivered through the Health portfolio.

135 It is my view that there are other ways these objectives can be achieved that do not compromise the strengths of the current system and best learn from other jurisdictions, including:

**(a)** **Shared governance and decision-making across corrections and health services.** This already informs the way Justice Health performs its functions in respect of health services in custody and is now being rolled out further through the common client reforms to improve connections between other correctional and health services.

**(b)** **Improved information sharing between corrections and health services.** This will support continuity of care and management of risk, both in prison and community mental health settings.

(c) **Improved continuity of care through provision of in-reach services**. I discussed this matter in paragraphs 93-97 above.

(d) **Improved consistency of service offering inside and outside custody through introduction of psychological counselling services**. I discussed this matter in paragraphs 81-85 above.

[22] Queensland Department of Health, Clinical Excellence Division, Offender Health Services Review – Final Report- October 2018

### *Prisoners with disability have specific support needs, and face barriers accessing the NDIS*

136 There are challenges involved in the identification of disability in custodial environments. Prison is very late in a person's journey through the criminal justice system and limits the potential application of preventative or diversionary measures. Nonetheless, Corrections Victoria is working to ensure people with disability in custody and under supervision in the community are provided with the necessary supports and accommodations to facilitate their full and equal participation in available services and programs.

137 Though data is limited on the prevalence of disability among people across the Victorian justice system, available data indicates up to 42 per cent of men and 33 per cent of women in prison have an acquired brain injury compared with two per cent of the general community.[23] While the department currently does not have capacity to screen for intellectual disability or cognitive impairment when prisoners are received into custody, mechanisms are in place to identify:

(a) Prisoners already receiving supports, either through the NDIS or other providers.

(b) Prisoners who have been identified as having a disability through court proceedings.

(c) Prisoners with intellectual disability who are, or have been, clients of the Forensic Disability Program operated by DHHS.

138 The limits on identifying disability prevents the corrections system from providing the specific, tailored treatment and supports that prisoners with disabilities require. In addition, the transition to the NDIS has brought further complexity to the delivery of services to people with disability in the justice system. Under the NDIS, general disability services are now delivered by the Commonwealth scheme, while the Victorian Government retains responsibility for justice-related responses.

139 In practice there have been significant challenges ensuring prisoners with disabilities access NDIS funded supports and services. These challenges include the lack of coordination between and decoupling of disability and justice services. Discussions continue with the National Disability Insurance Agency and other jurisdictions to address these challenges.

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[23] Jackson, M et al., Acquired Brain Injury in the Victorian Prison System Corrections Victoria (2011), Series No.4) State Government of Victoria.

140 There are significant barriers to prisoners and people subject to community orders accessing NDIS and receiving services. Lack of NDIS funding and limited availability of services, particularly supported accommodation, can be a barrier that prevents a prisoner from being released. In response to these issues, the National Disability Insurance Agency recently introduced four Justice Liaison Officers (**JLOs**). JLOs work with state counterparts to facilitate a coordinated approach to supporting NDIS participants in youth and adult justice systems, focusing on people with disability in custody and pre-release planning.

141 While I welcome all assistance provided to prisoners to access NDIS, in practice the JLO mechanism is only the first step towards resolving the access challenges. Many prisoners with disabilities require support to effectively advocate for themselves and subsequently struggle to navigate, engage with and complete the complex NDIS planning and review processes. This means that in practice, a worker or advocate (whether prison-based or in the community) is required to support prisoners to access NDIS through the JLOs.

142 The lack of specialised providers available under NDIS to serve complex justice clients is an issue for those who need adequate supports or accommodation to qualify for bail or release from prison. There is a thin market of NDIS service providers willing to work with participants involved in the justice system, in particular those who engage in behaviours that present a significant risk to the community.

143 Offenders with disabilities should be supported to exit custody in a timely fashion with services in place that can meet their needs. For this to occur, additional supports are required to prepare a person with disability for release from custody (including preparation for bail or diversion if the person is held on remand) and disability services should have the skills and capacity to meet the complex needs of justice clients to facilitate this transition.

### *Reducing recidivism rates of offenders and prisoners*

144 Corrections Victoria collects data on the intersection between prisoners with psychiatric risk rating and those returning to prison.

145 For prisoners discharged from custody in Victoria in 2016-17 who returned to prison with a new sentenced prison episode within two years (i.e. 2018-19 return rate), the following is noted:

(a) 55.7 per cent of prisoners that had been assessed as having a serious or significant psychiatric condition prior to release in the denominator group were returned to prison.

(b) 50.5 per cent of prisoners that had a stable psychiatric condition prior to release in the denominator group were returned to prison.

(c) The rate of return to prison in 2017-18 for prisoners assessed as not having a psychiatric condition (no rating) was 36.2 per cent.

146 Victoria's rate of return to prison has generally seen an upward trend over the last 10 years, in line with the national rate. Over the last decade, Victoria's rate of return to prison has increased from 34.0 per cent in 2008-09, to 43.3 per cent in 2018-19.

147 The 2020 Report on Government Services demonstrates that Victoria's rate of return to prison in 2018-19 was lower than that of New South Wales, Queensland, Tasmania and the Northern Territory. It also showed that the Victorian result of 43.3 per cent was lower than the national average of 46.4 per cent. Over the last 10 years, Victoria has consistently reported a lower rate of return than the national average.

148 The statement as a whole outlines my views on reforms that will improve both mental health and justice outcomes, including recidivism outcomes, for offenders and prisoners with mental illness.

149 However, it is worth noting that given the extensive social and economic effect of COVID-19, demand for services is expected to increase significantly. Increased demand on service systems can exacerbate the difficulty in navigating multiple government services across different areas such as housing, mental health and AOD support, increasing the risk that unmet need will see people end up in the justice system.

150 The COVID-19 crisis has further highlighted existing systemic issues in the justice and social service systems, by placing increased demand on services particularly as these services work to address the requirements of clients with complex needs. This includes a lack of integration between service systems, information sharing barriers and inflexible funding arrangements.

151 Increased funding for services within existing system architecture will not, of itself, resolve these issues. A transformational change in system design is required to pursue dual objectives of both social and economic recovery. This will require a cross-portfolio strategy to facilitate the longer-term pathway to recovery, reduce disadvantage and support the most vulnerable Victorians. Reforms to be considered in this context include:

(a) increased family focused service design

(b) further integration of vocational, education, training and employment pathways

(c) improving access to housing for offenders and prisoners

(d) optimising prison system configuration i.e. single cell accommodation and dedicated treatment facilities.

## Part 4 – Forensic mental health services and compulsory treatment

### *Lack of capacity in the forensic mental health system means that the CMIA does not operate effectively*

152 The CMIA sets out that CMIA patients[24] should receive treatment in a forensic mental health service rather than being held in prison, reflecting that these individuals have not been found guilty of an offence.

153 However, the ongoing lack of capacity at Thomas Embling Hospital means that CMIA patients requiring specialist mental health treatment generally spend an extended period of time in prison before accessing treatment. In 2018-19, CMIA patients waited an average of 319 days in prison before accessing a bed at Thomas Embling Hospital.

154 This issue is compounded by the lack of step-down options from the current services offered at Thomas Embling Hospital or other secure facilities, meaning CMIA patients remain in Thomas Embling Hospital for longer than they should due to a lack of more appropriate service options.

155 More forensic and bed-based mental health services should be made available in the community at a range of security levels to facilitate effective step-up and step-down care for CMIA patients. Opportunities may be found to use these beds flexibly for other patients with forensic needs where CMIA cohorts are smaller, such as for women and young people.

### *Shortages in secure forensic mental health beds prevent the delivery of timely compulsory treatment to prisoners*

156 Thomas Embling Hospital[25] is currently the only facility at which prisoners can receive compulsory mental health treatment in a secure environment. Male prisoners requiring compulsory treatment currently wait an average of 17.5 days before accessing a bed at Thomas Embling Hospital.

157 There are delays to accessing compulsory treatment at Thomas Embling Hospital for both male and female prisoners. Female security patients experience a shorter delay to accessing compulsory treatment than male patients, noting that any delay causes mental health to further deteriorate. Female security patients are held in the Marrmak

[24] An explanation of this term is at paragraph 56 of this statement.

[25] An explanation of the relationship between Thomas Embling Hospital and Corrections Victoria is at paragraphs 56 and 57 of this statement.

unit at Dame Phyllis Frost Centre while awaiting transfer to Thomas Embling Hospital. Male prisoners awaiting transfer to Thomas Embling Hospital are held at Ravenhall Correctional Centre.

158 By comparison, people certified as requiring compulsory treatment in the community are usually admitted to a hospital to commence care immediately; this includes prisoners released from custody who are certified prior to release as requiring assessment for the purposes of providing compulsory treatment. This highlights the inequity of access to appropriate mental health treatment between security patients and civil patients,[26] which I encourage the Royal Commission to address in its final report.

159 Building additional secure beds will significantly improve timely access to services. Since the 8-bed Apsley Unit was opened at the Thomas Embling Hospital in March 2019 to improve access to treatment for security patients, the average waiting time for male prisoners fell by more than half from 36 days to 17.5 days.

160 Female prisoners face similar barriers to male prisoners to accessing compulsory treatment at Thomas Embling Hospital. While the average waiting time for female prisoners is shorter than that for male prisoners at 9 days, this is still not acceptable. Female prisoners and female offenders have fewer step-up and step-down secure treatment options in the community when compared to men, as illustrated by the Rebecca case.

161 As outlined, it is clear the current mix of secure and forensic infrastructure cannot meet demand from people who are already engaged in the justice system. This creates significant downstream impacts on the justice system's ability to fulfil any preventative or diversionary functions. The effect of this is that people may 'need' to enter custody before they can access services that meet their needs, potentially contributing to the overrepresentation of people with mental illness in custody.

162 While it is expected that there will always be demand for compulsory treatment from the custodial system, improving access to secure services in the community may prevent many people who have unmet mental health needs from entering custody in the first place, and therefore improve outcomes for individuals and reduce system pressures.

[26] An explanation of these terms is at paragraph 56 of this statement.

***These access issues cannot be appropriately addressed by providing compulsory treatment services in custody***

163 I appreciate the Royal Commission may consider the appropriateness of delivering compulsory mental health treatment inside prisons as a potential solution to the lack of secure infrastructure to provide compulsory treatment in the community.

164 While it might seem like an expedient solution to this problem in the short term, there are a number of reasons why it is not appropriate to deliver compulsory treatment in custody:

(a) **It is not consistent with the Charter of Human Rights and Responsibilities**. The Victorian Public Service Code of Conduct compels the Commissioner to first and foremost make decisions and provide advice consistent with the principles of the Charter and promote human rights as set out by the Charter. I have serious concerns about delivering involuntary mental health treatment to individuals who are, by definition, acutely unwell, in a prison having regard to the Charter. The Charter codifies the right to humane treatment when deprived of liberty (section 22), and the right to freedom from cruel, inhuman or degrading treatment (section 10) which explicitly states that people must not be subjected to medical treatment without their consent. The Victorian Parliament has already considered and determined what limitations to these rights are permissible to facilitate the delivery of compulsory treatment to prisoners, and put strict oversight and protections in place to ensure the treatment is in the person's best interests. The delivery of such treatment in a prison setting would place further restrictions on these rights, which I consider would be difficult to justify given alternative solutions are available.

(b) **Compulsory treatment is not operationally feasible in custody.** In a custodial environment, restraints and other methods classified as 'restrictive interventions' under the Mental Health Act need to be used for a range of reasons relating to the good order and management of a prison. Similarly, effective compulsory treatment of prisoners would require there be no lockdowns during the period of their treatment, which I cannot guarantee given the State's expectation that I ensure security and good order. This could lead to unacceptable clinical risk to the prisoners involved and, as outlined further below, may require a broader review of the Mental Health Act.

(c) **The custodial environment is not conducive to delivering effective compulsory treatment.** Prisons, even those with purpose-built mental health units, are still prisons, where prisoners receiving mental health services are held in cells and subject to regular lockdowns (including overnight). This extends to

care model practice. For example, patients must be subject to regular clinical observations to monitor their response to compulsory treatment, and if restrictive interventions are used (as is likely in prison for security and good order purposes), a clinician must clinically review a person no less frequently than every 15 minutes and sometimes continuously.[27] In a prison, custodial staff must accompany these observations, which has the potential to compromise the efficacy of treatment. Further, custodial and prison health service staffing models cannot currently accommodate these requirements and would require major uplift to do so, likely at a higher daily operating cost and lower efficacy than a community-based service.

(d) **It would compromise trust in and perception of clinicians in custody, reducing the effectiveness of broader mental health services and putting lives at risk**. Prisoners know that when they need to go to hospital and require invasive procedures, like compulsory treatment or surgery, they have access to hospitals. In circumstances when they cannot or do not consent to treatment as is the case with compulsory treatment, prisoners can be assured that these decisions are being made by doctors who are clinically independent from the custodial system and, being in a hospital, are not influenced by security considerations. If such procedures were to be performed in prisons, which are coercive environments, the clinical or therapeutic relationship would be compromised. This would put at risk both the efficacy of compulsory treatment for individual prisoners, and the trust that prisoners need to be able to place in clinicians before they will disclose to them their mental health concerns or participate in voluntary treatment. This is likely to diminish the effectiveness of mental health services and at-risk procedures within the prison system more broadly.

(e) **It would not be of equivalent quality to compulsory treatment provided to people in the community and carries risk of harm.** Given the above outlined operational constraints, compulsory treatment would be regularly disrupted in a prison environment and subject to additional non-clinical restrictive interventions. It is therefore expected to be of an inherently lower quality than compulsory treatment provided to people living in the community, creating a 'second class' of mental health care for prisoners. These issues present great health risks to the prisoner.

(f) **It is not consistent with the fundamental principles of the Mental Health Act.** Delivery of compulsory treatment in custody is inconsistent with the 'least restrictive' principle set out in the Mental Health Act, which is structured on the

[27] Part 6, Restrictive Interventions, of the *Mental Health Act 2014*, particularly sections 112 and 116.

premise that compulsory treatment will not be provided in custody.[28] This, in addition to the relevant Charter and treatment considerations outlined above, may warrant a full review of the Act should this matter be pursued.

165 I note that, in theory, prisoners could get some form of compulsory treatment more quickly if it were delivered in prisons. However, in light of the above concerns, I do not consider expediency to be a sufficient rationale to allow compulsory treatment in custody, especially since it would not be equivalent to services provided at Thomas Embling Hospital. For the many reasons outlined above, prisons cannot replicate or replace the therapeutic environment provided by a hospital for the effective provision of compulsory treatment.

166 It is for these reasons that I do not support the delivery of compulsory treatment in custody under any circumstances. I urge the Royal Commission to carefully consider any alternative proposals in light of the issues I have raised.

### *The most appropriate solution is to expand forensic treatment capacity*

167 I encourage the Royal Commission to consider the need for expanded forensic treatment capacity within the mental health system. I refer to the discussion of this in the Associate Secretary's statement and also note that addressing this need should be based on the following principles:

(a) There should be adequate capacity to ensure that any CMIA patients can be immediately placed in an appropriate bed-based service, without first being held in prison.

(b) The mental health system should provide forensic treatment options that span a range of security levels and enable step-up and step-down care (including longer-term residential beds) for all patient cohorts,[29] including appropriate stepped options for women.

(c) There should be enough bed-based services to enable prisoners to be transferred and commence compulsory treatment in the community immediately after they are certified as requiring such treatment.

(d) There should be adequate capacity for the mental health system to provide treatment of civil patients who are displaying behaviours that place them at high risk of serious offending and would benefit from treatment in a secure environment as a preventative measure.

[28] See, for example, section 67 which provides that certain compulsory treatment orders cannot be provided in custody.

[29] An explanation of the relevant cohorts is at paragraph 56 of this statement.

168 Noting that the disability system (including the NDIS) is also not meeting the needs of people subject to CMIA orders on the basis of cognitive disability, I also encourage the Royal Commission to consider this specific cohort.

## Part 5 – Other systemic reforms that would support improved mental health outcomes for Corrections clients

### *Housing is a key barrier to accessing mental health and other services*

169 As noted by multiple submissions to the Royal Commission and referenced above, homelessness and unstable housing can be a significant barrier to accessing mental health services, as well as other supports required to maintain good mental health.

170 In the community corrections system, homelessness and insecure housing is a direct barrier to accessing mental health treatment in AMHS, and consequently can present a barrier to meeting mental health treatment and rehabilitation conditions.

171 When assessing parole applications, the Adult Parole Board considers whether a prisoner will have suitable and stable accommodation arrangements on release.[30] This means that an inability to secure housing can lead to a longer period of incarceration. Lack of housing is also taken into account when considering bail and can result in a person being placed on remand.

172 In addition, there are specific challenges with sourcing appropriate accommodation for post-sentence offenders suffering from a serious mental illness. The limited facilities available often have significant waiting lists (often years).

173 Further, there is often reluctance for services to accommodate individuals with serious offending histories due to presence of other vulnerable persons in the facilities.

174 This can lead to offenders spending extended periods at residential facilities run by Corrections Victoria which are not appropriate for those with serious mental illness. This can increase their risk of reoffending, contrary to the purposes of the Serious Offenders Act.

175 I encourage the Royal Commission to consider the specific housing needs of people in the Corrections system when making recommendations about housing and mental health.

[30] Board Decisions, Adult Parole Board Victoria <https://www.adultparoleboard.vic.gov.au/board-decisions>.

### *Improved information sharing across systems will improve continuity of care upon entry into custody*

176 Ensuring continuity of care upon a person's entry into prison, where an individual's health and mental health information from community-based services could be made available to clinicians and Corrections staff assessing their needs in custody, can improve an important point of a person's mental health trajectory. This is an important part of Corrections Victoria's role in the mental health system.

177 Prisoners frequently enter custody without the contact details of their GP (if they have one at all) or their Medicare information (if they are covered by Medicare) and may not have a stable previous address (which is frequently required to search databases like MyHealthRecord). This makes it difficult for clinicians to contact previous care providers or access records to confirm pre-existing diagnostic information, prescriptions, or care plans in a timely fashion.

178 When a person is transferred from police custody or from the courts into custody, some information is received from police and the courts. However, this information is not always provided in sufficient time to inform reception screening. In addition, differences in screening and assessment processes and criteria within the justice system and between mental health services can limit the usefulness of the information received.

179 Consistent assessment and screening processes, as well as improved or consolidated information sharing across justice system bodies, would better inform intake assessments and subsequent treatment plan while in prison.

180 Forensicare as a designated mental health provider has access to the statewide Client Management Interface system which records a person's diagnoses and contact with the public specialist mental health system in the community. This enables information about diagnoses and treatment provided by AMHS to be access by the specialist mental health service. However, primary and secondary mental health services in the community, unless provided as part of an AMHS, are not recorded into the Client Management Interface record and so their records cannot be accessed by Forensicare.

181 If a prisoner is receiving treatment outside the public specialist mental health system at the time that they are taken into prison, it can be difficult to obtain previous treatment history, particularly if the prisoner cannot disclose their treatment history, treating practitioner and/or Medicare number. I encourage the Royal Commission to consider how to balance better integration between services (including Corrections Victoria and Justice Health) with personal privacy risks, given the highly sensitive nature of a person's mental health information, particularly in the context of people awaiting trial.

### *Further support and training for custodial staff would assist in managing mental health in custodial environments and mitigating the impact of custody on mental health*

182 As mental illness is significantly overrepresented in both prisons and in the community corrections cohort, the custodial workforces should be equipped to respond to, support and effectively manage offenders with mental illness.

183 In prisons, this includes ensuring that routine operational correctional policies and procedures are in place to respond to the mental health needs of prisoners while maintaining the security and good order of prisons. As an example of how corrections policies can be made more responsive to mental health, the Women's System Reform Project has introduced a trauma-informed framework that is being progressively introduced into the women's prison system.

184 Ensuring operational policies are appropriately supportive of the mental health of prisoners and offenders will also require corrections workers to be appropriately trained in responding to mental health. While some mental health training programs are currently in place for both prison and community corrections staff, I would encourage the Royal Commission to consider corrections workers as a key cohort with extensive requirements to work with mental illness when making recommendations about the workforce needs of non-clinical workforces.

185 With this in mind, an outline of the existing mental health training requirements for the corrections workforce is below.

**Custodial services**

186 Corrections Victoria offers a comprehensive prison officer pre-service and in-service training approach. Mental health content is integrated throughout course learning and explored in greater detail in sessions regarding Wellbeing, Case Management, Vulnerable prisoners and suicide and self-harm training, noting that prison officers do not deliver mental health services.

187 Training also includes a focus on priority cohorts including Aboriginal and Torres Strait Islander prisoners, cultural awareness, and trauma-informed training approaches.

188 Corrections Victoria is exploring the introduction of Mental Health and Aboriginal Healing units into the Certificate III in Correctional Practice as part of the pre-service training program. This has significant potential to increase Mental Health training throughout the pre-service program. There is also potential to apply and modify learning from working with female prisoners (identified via the Women's Reform Project) to

determine what can be incorporated into the training program for working with male prisoners.

**Community Correctional Services**

189 Corrections Victoria provides comprehensive training to CCS staff to ensure they are prepared with the knowledge, skills and competencies required to work effectively with offenders in the community. In recognition of the prevalence of mental health concerns and conditions in the offender population, training pathways include specific content on mental health. All staff commencing in CCS receive training on suicide and self harm. Case management staff receive training on the management of offenders with serious mental health conditions; and non-case management roles receive mental health training customised to their roles and responsibilities. A mental health focus is embedded across the CCS curriculum and is revisited in modules focused on working with offender cohorts with special needs such as Aboriginal offenders, women offenders, young adult offenders, offenders using alcohol and other drugs, and offenders with disabilities.

190 Competency is assessed in practice through completion of an accredited qualification in Correctional Practice.

191 Corrections Victoria is mindful of the mental health burden for staff working with complex offenders and includes specific training content on building resilience and self-care, with this theme revisited throughout the various learning modules. Similarly, training for CCS staff with supervisory responsibilities includes a focus on the mental health and wellbeing of team members.

192 Mental health training content is developed, validated and where required, delivered by trainers with specialist qualifications and expertise to ensure it is contemporary and evidence based.

193 Further development work is occurring to embed the concepts of trauma informed practice and intersectionality more broadly through the curriculum.

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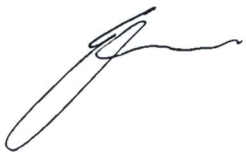

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