MAGISTRATES' COURT OF VICTORIA

Magistrates' Court of Victoria

SUBMISSION TO THE ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

JULY 2019

Foreword

The Magistrates' Court of Victoria sees firsthand many of the challenges facing Victorians with mental illness as far too many are channelled into the criminal justice system when their behaviours result in police charges and court appearances.

Every week judicial officers face having to remand people simply because there are no other options available to adequately respond to their mental health needs while ensuring the safety of the community.

A more thoughtful and coordinated approach by the justice and health sectors must be implemented to manage people whose unmanaged mental illness results in behaviours which are confronting or problematic in the community.

In those instances where a mentally unwell person's criminal behaviour is such that it warrants judicial intervention, there must be a broader range of options available to tailor individual, proportionate responses that are properly supported. These responses would necessarily be available at all the stages of the criminal justice process from arrest, to bail, remand, while awaiting hearing, and at sentencing; and would extend throughout the community, court, prison, and community corrections systems.

The Magistrates' Court is highly experienced in dealing with people with mental illness and would be well equipped to provide a broader range of responses, if provided with the resources to enable it to effectively triage people and channel them into the right programs.

The Court requires a range of diversionary options targeted at people with mental health and cognitive dysfunction that can be individually and appropriately structured through our specialist mental health response, the Assessment and Referral Court (ARC) List. This is currently offered at six locations around Victoria (with two more locations due to commence in 2019) but should be available throughout the state.

Of fundamental importance, the Court would like to see a wider range of therapeutic interventions and responses for people impacted by mental illness which do not involve incarceration, whether on remand or under sentence.

Judge Peter Lauritsen

Chief Magistrate
Magistrates' Court of Victoria

Table of contents

1. Executive summary

> *People with mental illness or cognitive impairment should ideally receive treatment in the community. Instead, due to the lack of services, housing and support, they are frequently imprisoned. We see this daily in our courts. There are often no other appropriate options to enable magistrates to make orders that ensure the safety of the community and the person. Appropriate alternatives are urgently required to ensure that these people are not treated unjustly.*[1]

Nearly half of all Australians aged 16 to 85 years will experience a mental health condition in their lifetime[2]; one in five had a mental illness or disorder in 2017–18[3] and eight Australians took their own life each day in 2017.[4] Only a small proportion of people with a mental illness will ever become involved in the justice system. Yet there is a higher prevalence of mental health conditions among people who do come into contact with the justice system (accused persons and victims) and the rate of undiagnosed and/or untreated mental illness for this cohort is also considerably higher than in the general population.[5]

Involvement in the justice system is often contemporaneous with, and contributes to, an individual's decline in mental wellbeing. Lack of timely access to, or disengagement from, mental health services may lead to behaviours that are difficult to manage or culminate in harm to the individual or others. Many people with mental illness who are involved in the justice system experience barriers to service and treatment, poor rehabilitation outcomes, are more likely to reoffend and end up cycling in and out of the justice and health systems.[6]

The Bail Review undertaken by the Hon Paul Coghlan QC saw significant reforms to the *Bail Act 1977* (Vic). The reforms adopted stricter tests to be granted bail and there is now a presumption against bail for more offences. These reforms have caused, in part, a notable increase in the numbers of people being held on remand and have disproportionately impacted those who experience mental illness. People who experience mental illness are being remanded for not attending court and/or committing offences against the Bail Act as a direct result of their socioeconomic circumstances, and a lack of community supports. Those with a mental illness are remaining in prison for periods of time that exceed any term of imprisonment that would be received on a finding of guilt as court support services and community services are inundated, creating unprecedented demand.

It is critical to recognise that mental health conditions often coexist with other complex socioeconomic and health issues such as history of trauma, alcohol and other drug use, unemployment, family breakdown, social isolation and homelessness, which are themselves risk factors for offending.

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[1] Magistrate Jelena Popovic, Deputy Chief Magistrate, Magistrates' Court of Victoria, July 2019.
[2] Australian Bureau of Statistics 2007, *National survey of health and wellbeing: summary of results*, ABS cat. no. 4326.0, viewed 11 June 2019, <https://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0>.
[3] Australian Bureau of Statistics 2018, *National health survey: first results 2017–18*, ABS cat. no. 4364.0.55.001, viewed 11 June 2019, <https://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001>.
[4] Australian Bureau of Statistics 2017, *Causes of Death, Australia,* cat. no. 3303.0, viewed 15 June, <https://www.abs.gov.au/ausstats/abs@.nsf/0/47E19CA15036B04BCA2577570014668B?Opendocument>.
[5] Australian Institute of Health and Welfare 2019, *The health of Australia's prisoners 2018*, AIHW cat. no. PHE 246, viewed 20 June 2019, <https://www.aihw.gov.au/getmedia/2e92f007-453d-48a1-9c6b-4c9531cf0371/aihw-phe-246.pdf.aspx?inline=true>; J Ogloff, M Davis, G Rivers & S Ross 2007, 'The identification of mental disorders in the criminal justice system', *Trends and Issues in Crime and Criminal Justice*, Australian Institute of Criminology, viewed 20 June 2019, <https://aic.gov.au/publications/tandi/tandi334>.
[6] Ibid.

Failure to address the underlying causes of offending behaviour—including mental health—leads to rising levels of crime and financial costs to the public. The Magistrates' Court of Victoria (MCV) recognises the need to improve client access to appropriate support services to reduce crime, increase public safety and avoid the individual, social and economic costs associated with mental illness.

Within this context, our submission has been informed by magistrates, court administrative staff, Specialist Court clinical staff, practitioners, case managers, court registrars, registry staff and program managers. Our submission highlights:

- current best practice
- key challenges and barriers
- recommendations for achieving best mental health outcomes in MCV.

1.1 Court reforms in response to mental health

Since 1997, MCV has introduced a range of specialist courts and court support programs to intervene with clients who have complex mental and physical health conditions or are impacted by socio-economic disadvantage.[7] The purpose for these courts and programs is to use the opportunity of each individual's engagement with the justice system to address the underlying causes of their offending, reduce future offending, increase community safety and increase the wellbeing of clients.

In 2010, MCV established the Assessment and Referral Court (ARC) List to identify and address the underlying causes of, or factors contributing to, offending for people who have a mental illness or cognitive impairment. ARC is governed by the legislative framework of the *Magistrates' Court Act 1989* (Vic)[8], and is MCV's primary targeted program for clients with a mental illness (and/or cognitive impairment). MCV's other Specialist Courts and Programs also inevitably provide assistance to clients with mental health issues, although their mental health status may not be the primary reason for their eligibility for those courts/programs.

The ARC List combines active court supervision or judicial monitoring with clinical case management. A team of advanced, clinically-trained and court-based case managers, including social workers and psychologists, develop and support clients to engage with tailored treatment and support plans. The primary focus of the program is to scaffold and support clients to engage with appropriate treatment and services to ensure they manage their functional and/or social disabilities (including mental illness, intellectual disability, acquired brain injury, autism spectrum disorder and neurological impairment).

The 2017–18 State Budget provided MCV with funding to expand ARC from Melbourne Magistrates' Court to two additional headquarter courts—one regional and one metropolitan. MCV is applying these resources to expand to seven court locations and assist clients across a wider geographic area. Moorabbin ARC commenced in January 2018, and Frankston ARC in July 2018. Latrobe Valley and Korumburra ARC commenced in December 2018 and Wonthaggi ARC in July 2019, while expansion of ARC into Sale and Bairnsdale is continuing in 2019.

[7] See Appendix 1 for a complete list of Specialist Courts and Programs and their locations across Victoria.
[8] See Sections 4S–4Y of the Magistrates' Court Act.

1.2 Summary of recommendations

Recommendation 1 Enhance the capability of mainstream Magistrates' Courts

Recommendation 2 Expand MCV Specialist Court and Program responses

Recommendation 3 Enhance communication between MCV and the mental health sector

Recommendation 4 Increase the capacity of the mental health sector

Recommendation 5 Expand sentencing options available to the Magistrates' Court of Victoria

Recommendation 6 Research and develop a multi-jurisdictional Koori Healing Court

Recommendation 7 Increase the capacity of forensic mental health services

Recommendation 8 Implement professional development, training and support in the justice sector

Recommendation 9 Consider legislative changes

Recommendation 10 Research, monitor and evaluate

Recommendation 11 Expand the Neighbourhood Justice model across Victoria

2. Introduction

The Magistrates' Court of Victoria (MCV) was established under section 4 of the Magistrates' Court Act. It exercises jurisdiction in criminal, civil, family law and intervention order matters. MCV plays a major role in Victoria's justice system, hearing over 90 per cent of all matters (criminal and civil) that come before Victorian courts.

MCV has 124 magistrates who preside over its courts in 51 venues across Victoria. A total of 718 staff deliver administrative, registry and specialist court-based clinical/practitioner services. MCV is organised into 12 administrative regions, each region consisting of a headquarter court and many also including satellite courts.[9] There are 10 Magistrates' courts in the metropolitan area and 41 in regional Victoria.

In 2016–17 over 300,000 cases were finalised by MCV. Of these, 65 per cent were criminal matters, 26 per cent were intervention orders (interim and other family violence and personal safety intervention orders) and nine per cent were civil matters.

MCV has responded to the steady increase of criminal matters in our justice system with innovation. Since 1998, MCV has introduced a range of specialist courts and court support programs to improve the effectiveness and efficiency of the court system to meet the needs of vulnerable and disadvantaged people, and to reduce crime by addressing the underlying reasons for people's offending behaviour.

These initiatives respond to population-level and individual factors that contribute to criminal behaviours and are a critical part of MCV's contemporary approach to delivering justice. They include programs to encourage or divert to appropriate treatment and services, people whose mental illness, cognitive impairment or substance use has contributed to their offending. They also encompass place-based community justice initiatives where the Court works in partnership with community organisations to prevent crime by reducing the impact of social disadvantage and building community resilience. These initiatives, organised under MCV's Specialist Courts and Programs (SCP) include[10]:

- Assessment and Referral Court (ARC) List
- Court Integrated Services Program (CISP)
- CISP Remand Outreach Program (CROP)
- CISP at the Bail and Remand Court (CISP BaRC)
- Criminal Justice Diversion Program
- Drug Court
- Koori Court
- Neighbourhood Justice Centre (NJC)
- Specialist family violence responses including Specialist Family Violence Courts (SFVC)
- Victims of Crime Assistance Tribunal (VOCAT).

The purpose of MCV's Specialist Courts and Programs is to increase clients' (victims and offenders) health and wellbeing, improve pro-social behaviour and compliance with court orders, reduce reoffending and improve community safety. They are solution-focused initiatives, established on the principles and practices of therapeutic jurisprudence, procedural fairness and restorative justice—recognised as humane, just and effective. The efficacy of therapeutic,

[9] See Appendix 1 for list of all Magistrates' Court locations in Victoria.
[10] See Appendix 1 for locations of Specialist Courts and Programs.

solution-focused and restorative approaches to justice have been proven locally and globally as 'smart on crime'.[11]

MCV's Specialist Courts and Programs are aligned with evidence-based best practice globally. Their court procedures and services utilise clients' contact with the justice system to engage them with treatment and support services under supervision of a magistrate. Unfortunately, MCV's specialist programs are not available at all court locations, resulting in unequal access to justice ('postcode justice'). Similarly, only select metropolitan and regional courts have access to court-based specialist mental health advice through the Department of Health and Human Services, Mental Health Advice and Response Service (MHARS).

Depending on the specialist court/program, clients can access support during their bail, remand or pre-sentence period. The period of engagement depends on the client's needs and the court/program model. The Neighbourhood Justice Centre (NJC) offers access to treatment and support pre- and post-sentence, while the Drug Court offers support services in the post-sentence period.

2.1 Terminology

The term 'mental illness', used throughout this submission is based on the definition provided in the Terms of Reference for the Royal Commission into Victoria's Mental Health System. Under this definition, mental illness is described as 'the experience of symptoms which impact thinking, perceptions, emotions, behaviour and relationships to others, or a combination of these'.

MCV acknowledges the working definitions of mental illness and mental disorders in key state and commonwealth legislation, national and international medical literature and by international bodies such as the World Health Organisation (WHO). Different key definitions are adopted and applied by MCV in the context of its work, including the *Mental Health Act 2014* (Vic)[12] and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

The term 'client' is used throughout this submission to refer to people who engage with MCV courts and/or services and experience mental illness irrespective of whether they have a formal diagnosis. 'Client' may include people who will/have appeared before the court as an accused person or witness in criminal matters, an applicant, affected family member, respondent or perpetrator in family violence intervention order proceedings, a party in civil proceedings and people who are victims of crime.

MCV acknowledges the need to recognise people with mental illness as individuals for whom mental illness or wellbeing is one aspect of their identity or experience and to provide a respectful and effective response that is tailored to each client's intersectional identity, multiple needs and lived experience.

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[11] CG Lee, F Cheesman, D Rottman, R Swaner, S Lambson, M Rempel & R Curtis 2013, *A community court grows in Brooklyn: a comprehensive evaluation of the Red Hook Community Justice Center,* National Center for State Courts, viewed 18 June 2019, <https://www.courtinnovation.org/sites/default/files/documents/RH%20Evaluation%20Final%20Report.pdf>; S Ross 2015, 'Evaluating neighbourhood justice: measuring and attributing outcomes for a community justice program', *Trends and Issues in Crime and Criminal Justice*, no. 499, Australian Institute of Criminology, viewed 18 June, <https://aic.gov.au/publications/tandi/tandi499>.

[12] Section 4(1) of the Mental Health Act defines mental illness as a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

3. The cost of mental illness to the justice system and community

In Australia in 2016–17, state and territory specialised mental health services cost around $5.7 billion in total, including public hospital services for admitted patients ($2.6 billion) and community mental health care services ($2.1 billion).[13] The per-person expenditure on specialised mental health services in 2016–17 was $206 per person in Victoria (the national average was $233 per person).

One of the most serious consequences of unresolved mental illness is suicide. In 2017, there was a total of 621 suicide deaths in Victoria[14], which equates to around 12 Victorians taking their own life every week. The implications of suicide reverberate from individuals to family and friends through to entire communities. Individuals who survive suicide attempts often sustain serious injuries that have a long-term impact on their physical and mental health.

In addition to the economic cost to state health systems and the emotional and quality-of-life costs to clients and their families, mental illness also has significant economic costs to the justice system and social costs to the broader community. These costs contextualise the value of efforts to divert people with mental illness to treatment and support services and away from the justice system.

When the justice system is unable to provide a non-custodial sentence, significant resources are required: the cost of imprisonment is more than 10 times the cost of community-based supervision. It was calculated in 2018 that each prisoner costs the state $127,000 a year on average[15] and with changes to bail laws, prison numbers have dramatically increased. As of June 2018, there were 7666 prisoners in the Victorian prison system.

The incidence of mental illness among prisoners is considerably higher than in the general community. Approximately 40 per cent of people entering prison report being diagnosed with a mental illness at some point in their lives.[16]

In 2016–17 the rate of people who returned to prison in Victoria within two years of being released was 43.6 per cent, close to the national average of 44.8 per cent. That same year, the rate of released prisoners returning to corrective services in Victoria within two years (including sentences served in prison and in the community) was 57.7 per cent.[17]

Victoria must invest in preventative strategies and early intervention in the community mental health sector to reduce the impact of mental illness on the person. Undiagnosed and untreated mental illness can increase the risk of a person entering and cycling though the justice system. The mechanisms of the broader justice system cannot provide a suitable or appropriate response to a person in the absence of treatment.

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[13] Australian Institute of Health and Welfare 2019, *Mental Health Services in Australia*, p. 28, viewed 20 June 2019, <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services/specialised-mental-health-services-expenditure>.
[14] Australian Bureau of Statistics 2017, *Causes of Death, Australia*, ABS cat. no. 3303.0, viewed 20 June, <https://www.abs.gov.au/ausstats/abs@.nsf/0/47E19CA15036B04BCA2577570014668B?Opendocument>.
[15] Victorian Auditor General 2014, *Mental health strategies for the justice system*, viewed 15 June 2019, <https://www.audit.vic.gov.au/sites/default/files/20141015-MH-Strategies-Justice.pdf>.
[16] Australian Institute of Health and Welfare, *The health of Australia's prisoners.*
[17] Sentencing Advisory Council 2018, Released prisoners returning to prison, viewed 20 June 2019, <https://www.sentencingcouncil.vic.gov.au/statistics/sentencing-statistics/released-prisoners-returning-to-prison>.

4. Current MCV response to mental health

4.1 Therapeutic approaches to justice

MCV initiatives over the past 20 years such as the Specialist Courts and Programs are based on the principles of therapeutic jurisprudence (TJ), an interdisciplinary method of legal scholarship that aims to reform the law and legal processes to positively impact the wellbeing of clients, reduce crime and increase public safety.

TJ considers the law's impact on the emotional life and psychological wellbeing of individuals within the justice system. It aims to increase awareness of the positive and negative behavioural consequences the law can produce for clients and the community. This approach encourages parliament and the judiciary to see whether the law and legal processes can be altered or applied in a way that simultaneously enhances client wellbeing and positive justice outcomes. A therapeutic model considers the roles of all court actors (judicial officers, clinical and registry staff, legal practitioners and police) in creating an environment and interactions that assist the client to accept responsibility and make positive changes in their lives.

An alternative to the 'revolving door' and adversarial approaches to criminal justice matters, solution-focused courts seek to address the underlying causes of an individual's offending behaviour, such as substance abuse or mental illness, and engage clients to promote pro-social outcomes. Solution-focused courts are characterised by: individualised justice, community engagement, collaboration, enhanced information, accountability and outcomes.

The practical application of TJ includes procedural fairness, key elements of which include the assumption that clients of a court have a right to be listened to, treated with respect, to understand the court process and why a decision was made, and that the decision-maker will be impartial. Research has shown that when clients feel respected and that they have been heard during a court appearance, they are more likely to comply with court orders.

Another therapeutic practice is restorative justice, which aims to restore victims' wellbeing and make people who have committed crime aware of the impact of their actions on others. Victim-offender mediation, conferencing and circle sentencing are all examples of restorative justice practices within MCV.

4.2 Assessment and Referral Court (ARC) List

The Assessment and Referral Court (ARC) List is MCV's primary targeted program for clients with a mental illness (and/or cognitive impairment) and is currently available in six courts in metropolitan and regional Victoria (Melbourne, Frankston, Moorabbin, Latrobe Valley, Korumburra and Wonthaggi) (see Appendix 1).

ARC was established in 2010 through an amendment to the Magistrates' Court Act. The initiative is a specialist therapeutic and solution-focused court that involves active court supervision, assessment, and case management for up to 12 months. To be eligible for ARC, a person must be in the community, consent to participate in ARC and meet the diagnostic criteria by:

- having a mental illness, intellectual disability, acquired brain injury, autism spectrum disorder, and/or neurological impairment, including (but not limited to) dementia
- having substantially reduced capacity in self-care, self-management, social interaction, or communication due to the condition (functional criteria)
- being likely to benefit from receiving coordinated services and participating in a problem-solving court process (needs criteria).

ARC assists a client if their disorder, or combination of disorders, causes substantial reduced capacity in the areas of self-management, social interaction and/or communication.

The aim of ARC is to address the needs and circumstances of the individual to bring about recovery and stabilisation. By assisting a person to access support within the community in the areas of mental health, disability services, drug treatment, housing, physical health and other services if required, the program can address underlying factors that contribute to offending behaviour.

Once a referral is accepted, the ARC case manager, together with the client, develops an Individual Support Plan (ISP) based on a comprehensive psychosocial assessment of the client's needs. This plan identifies areas where the client may have unmet needs that have contributed to their offending behaviour and sets out goals and outcomes to promote their recovery or stabilisation. Formal acceptance into ARC occurs when the magistrate approves the ISP. Together, the client, magistrate, case manager and sworn police member continue to work together for up to 12 months to achieve the goals outlined in the ISP.

Hearings in ARC are conducted in a less formal manner than a mainstream Magistrates' Court, with the client and their family sitting at the same table as the magistrate, police prosecutor, case manager, legal representative and other supports, to review their participation and progress towards the ISP goals. ARC is a problem-solving court, providing a coordinated response and strengthening the client's confidence and engagement with support services within the community. Successful participation in ARC is taken into account by the magistrate at completion of the client's episode in determining an appropriate sentence.

From 1 July 2018 to 30 April 2019, ARC received 236 referrals at all locations, with 93 new clients accepted onto the program. The expansion of ARC to Sale and Bairnsdale Magistrates' Courts is due to commence in 2019.

The ARC List provides a client-centred and problem-solving environment that empowers clients to engage with their rehabilitation and achieve positive behavioural change. The client is an active participant in their own recovery, and in turn, becomes responsible and accountable to complete and engage with their ISP with the help of justice supports. Consistency of magistrate, case managers and sworn police members are essential to the ARC process, providing direction and encouraging the clients to engage with the process. The presence of a sworn police member creates a relationship between the offender and Victoria Police, which can change perceptions, and assist in the client's rehabilitation, further reducing engagement or contact with the Victoria Police in the community. This positive interaction results in clients being successfully diverted away from the criminal justice system, as evidenced in the case study adapted from a letter sent by the client's family member in 2019.

CASE STUDY

Aaron[18] was diagnosed with chronic schizophrenia. Over two decades, hospitalisations were characterized by early discharge from hospital and mental health services denied due to funding issues and untimely delays. There were two major lapses with involuntary hospital admissions, after which there were no timely follow-up mental health services. A third major lapse was characterized by increasingly strange behaviours and eventually criminal behaviours.

Aaron was an involuntary patient for eight weeks, released, not followed up by mental health services and arrested for crimes committed that year. He was too ill to represent himself and unable to instruct his lawyers. Aaron was gaoled and as he was unable to nominate a 'visitor' or 'contact person', his whereabouts in the prison system were unknown.

After three months, Aaron's case came before the Magistrates' Court. He was ably represented by his community lawyers and referred first to the CISP, then to the ARC List. At the same time, Mental Health Services appointed a case manager who was able and available to assist Aaron.

For the first time in 24 years, the ARC List provided Aaron's family with hope. It was the first time his family had felt there may be help available to enable him to live safely in the community. Level 4 at the Melbourne Magistrates' Court became a familiar setting in which Aaron turned his life from one without a future to one where he had been given the support to engage with family and community.

The ARC List encouraged Aaron to participate in the justice system, the mental health system and the community, eventually resulting in him taking the opportunity afforded by ARC to get on with the rest of his life. On the last day of participation in the ARC List, Aaron drew a line and started afresh with his aspirations and goals.

Had ARC List not been available, it is very likely that Aaron would have remained in the criminal justice system.

[18] The name of the client in this case study—and all other case studies in this submission—has been changed to protect the identity of the client, and where necessary, identifying details have been omitted or altered.

5. Other MCV Specialist Courts and Programs

The ARC List is just one of the programs within MCV's SCP division. While eligibility for the ARC List is specifically aimed at people with a mental illness (and other neurological conditions), a high proportion of clients of the other MCV specialist courts and programs have also been diagnosed with mental illness or condition. The therapeutic nature of these courts/programs provides a more appropriate and effective way for them to access assessment, referrals and treatment services at different stages of a proceeding.

5.1 Court Integrated Services Program (CISP)

CISP was established in 2006 as a statewide court-based support program to assist clients to address their health and/or social needs, with the aim of reducing the likelihood of reoffending. CISP is a voluntary program, working with eligible clients during the bail (or pre-trial) stage of their criminal proceedings.

CISP is available to people charged with a criminal offence on bail, summons or remand pending a bail hearing, with a history of offending or the current offences indicate a likelihood of future offending. Further eligibility for CISP includes mental or physical illness, intellectual disability or acquired brain injury, alcohol or other drug dependency, family violence issues and inadequate social, family or economic support that contributes to the frequency and severity of offending.

CISP clients are provided with (on average) four months' individualised case management to support access to treatment and community support services (for example, drug and alcohol treatment, crisis accommodation, disability services and mental health services) to address their needs and reduce their risk of reoffending and risk to the community.

Case managers review the progress of clients to ensure they are 'kept in the court's view' and magistrates are provided with a progress report at each hearing during the period of case management. If the court deems it appropriate, clients may be required to appear regularly before the same magistrate for a review of their progress.

CISP is available at 20 Magistrates' Court venues across Victoria (see Appendix 1). Recent statistics for CISP:

- Referrals: 3,602 (1 July 2017–30 June 2018) and 3,524 (1 July 2018–30 April 2019)
- Assessments completed: 2,290 (1 July 2017–30 June 2018) and 2,019 (1 July 2018–30 April 2019)
- New clients accepted: 1,705 (1 July 2017–30 June 2018) and 1,716 (1 July 2018–30 April 2019)

5.2 CISP Remand Outreach Program (CROP)

CROP is a collaborative program between Corrections Victoria and MCV. It commenced as a pilot in 2014 and was funded on an ongoing basis in the 2017–18 State Budget. CROP extends CISP into prisons to work with individuals on remand. The objective of CROP is to support clients who are on remand and wish to apply for bail.

Keeping people in custody on remand when they may be suitable candidates for bail is unduly costly and has significant negative consequences, such as exacerbating mental health conditions and disrupting employment, family situations and accommodation. CROP proactively identifies people in custody who may be eligible for bail if appropriate supports are in place. Program staff liaise with prisoners and their legal representatives to identify eligible individuals in

custody and address barriers to receiving bail, such as mental health issues, homelessness, alcohol and/or other drug use.

Eligibility is prioritised for Aboriginal and Torres Strait Islander people, women, people in custody for the first time with complex mental health or cognitive functioning issues, homeless people, or those with extensive alcohol and/or other drug history.

CROP Assessment and Referral Practitioners (ARP) conduct assessments, develop case plans and undertake brief client interventions for people who are ineligible for CISP case management (in custody and for one-month post release) and set up immediate community-based supports (existing support or new referrals). The case plan is included in a report to the court for the client's bail application. If the bail application is successful, the client will be supported by a case manager from CISP.

CROP is available at the following locations (see also Appendix 1):

- Metropolitan Assessment Prison
- Metropolitan Remand Centre
- Port Phillip Prison
- Dame Phyllis Frost Centre
- Marngoneet Correctional Centre
- Ravenhall Correctional Centre
- An outreach service to HM Barwon Prison, Hopkins and Fulham Correctional Centres is available via audio visual link.

In 2017–18, CROP completed 954 assessments. From 1 July 2018 to 30 April 2019, CROP completed 1,220 assessments.

5.3 CISP at the Bail and Remand Court (CISP BaRC)

In response to Recommendation 29 of the Coghlan Review, the Bail and Remand Court (BaRC) commenced at the Melbourne Magistrates' Court on 30 April 2018. The model expands the night and weekend court operations that were introduced in January 2017 following the Bourke Street incident, and includes key stakeholders such as Victoria Police prosecutors, Victoria Legal Aid, Protective Services Officers, Community Correctional Services and CISP.

Following judicial approval, CISP case managers undertake assessments and may provide an 'on-call' service for magistrates and judicial registrars seeking advice on treatment options, system navigation and referral options for clients.

CISP provides advice to legal practitioners regarding appropriate treatment options, information regarding current CISP clients' past and current program and service engagement, program reports to relevant stakeholders, as well as support for clients exiting custody (such as the provision of material aid, Myki cards, identification of, and referral to accommodation services).

The BaRC model creates a more efficient process for those clients who are brought before the court in custody. In addition to providing greater access for clients who are arrested to first appear before the court, they now also have access to legal representation as well as assessments for bail support services.

BaRC has sittings at Melbourne Magistrates' Court from 10 am to 4 pm and from 4 pm to 9 pm seven days a week, and hears after-hours applications from across the metropolitan area, with police bringing clients to Melbourne for the hearings. From 1 July 2018 to 30 April 2019, CISP BaRC completed a total of 332 assessments.

5.4 Criminal Justice Diversion Program (CJDP)

The CJDP is a statewide program available at all MCV locations. It commenced as a pilot at Broadmeadows Magistrates' Court in 1997 and is governed by Section 59 of the *Criminal Procedure Act 2009* (Vic).

Diversion allows clients to redress their low-level offending behaviour by undertaking and completing appropriate court-imposed conditions, tailored to ensure victim involvement, reparation, community work, relevant counselling, donations to charities and rehabilitation programs.

To be eligible for the CJDP the client must acknowledge responsibility for the offending, which must be an offence that can be determined by the Magistrates' Court and that is not subject to a minimum or fixed sentence or penalty.

In 2018, Koori Diversion was implemented at five locations including Melbourne, Mildura, Shepparton, Geelong and Latrobe Valley Magistrates' Courts. In the 2017–18 financial year the CJDP received 7585 referrals across all locations.

5.5 Drug Court

Drug Court was established in 2002 at the Dandenong Magistrates' Court. Following a positive evaluation by KPMG in 2014, the Melbourne division of the Drug Court was launched in 2017 by the Premier of Victoria, with the establishment of two additional Drug Courts at Melbourne Magistrates' Court. The Melbourne expansion was central to the Premier's Ice Action Plan.

An evidence-based therapeutic treatment sentencing option is provided by Drug Court for people with a history of entrenched offending and drug and/or alcohol use. Clients are screened for eligibility then assessed for suitability for a Drug Treatment Order (DTO). The magistrate can choose to impose a term of imprisonment of up to two years to be served by way of a DTO.

Drug Court is available to clients with an entrenched history of criminal behaviour and alcohol and/or drug use, where the offending has occurred under the influence of, or to support substance use. Many in this cohort have underlying mental health and other comorbidities, and experience or are at high risk of homelessness. Drug Court recognises the causal interrelationship between substance use and mental health and provides targeted treatment and supports.

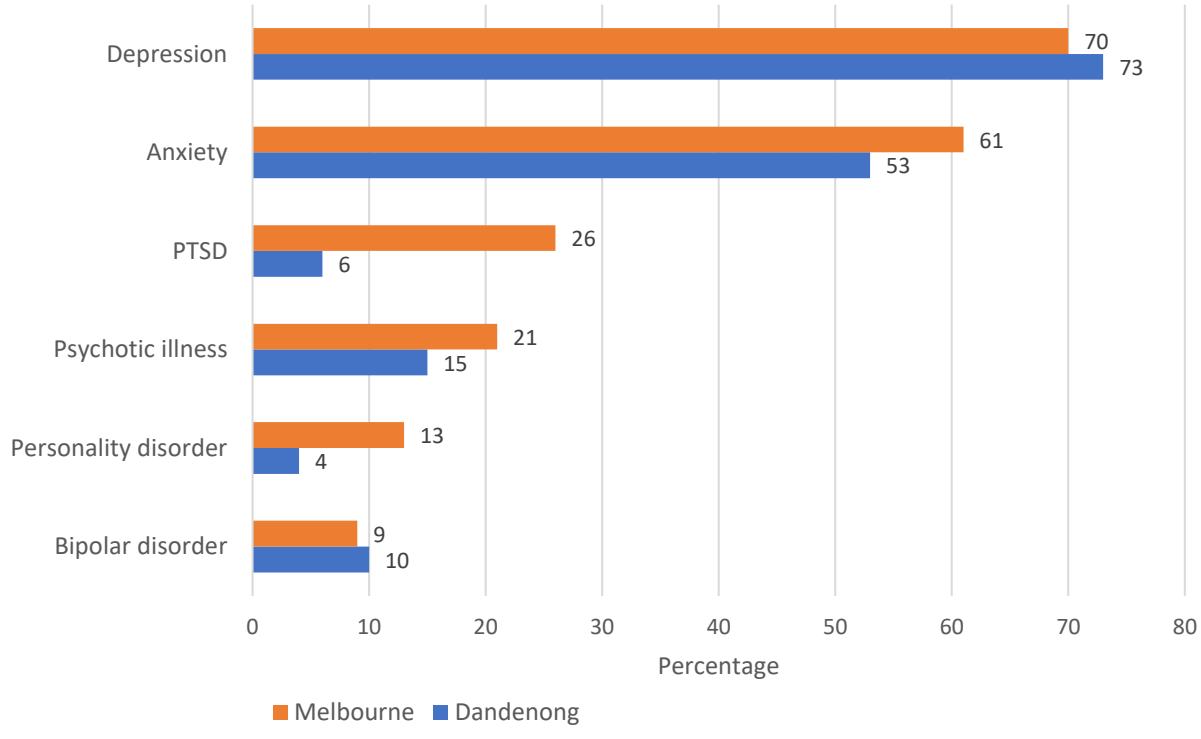
While no specific funding is allocated for a priority mental health response within the Drug Court program, case managers can utilise general brokerage funding to facilitate assessment and referrals where required, and link in to the general mental health service system.

Dandenong Drug Court is capped at 70 clients; Melbourne Drug Court is capped at 170 clients. As at April 2019, Dandenong Drug Court recorded 77 clients in total. As of July 2019, Dandenong Drug Court is over capacity and potential new clients must wait approximately three months to undertake an initial screening. Melbourne Drug Court recorded 104 clients in total, with on average nine new participants per month.

From March 2017– May 2019, 59 per cent of clients across both Drug Court sites identified at assessment as having a diagnosed mental health condition, with an increase in mental health diagnoses while on the program (mental health symptoms increased as drug use decreased). The six most frequently diagnosed conditions within this dual diagnosis group are shown in Figure 1 below:[19]

[19] The percentages represent the proportion of Drug Court clients assessed as having a mental illness that have

Figure 1: Most frequent mental health diagnoses reported at assessment by Drug Court clients with a mental health dual diagnosis March 2017 to May 2019



5.6 Koori Court

Koori Courts are specialist sentencing courts for Koori clients who plead guilty to a criminal offence and have agreed to have their matter heard in the Koori Court. Koori Court is the largest funded initiative of the Victorian Aboriginal Justice Agreement.

The Koori Court was first established as a pilot in Shepparton Magistrates' Court in 2002 and Broadmeadows Magistrates' Court in 2003. The *Magistrates' Court (Koori Court) Act 2002* (Vic) amended the Magistrates' Court Act and provided the framework for the establishment of the Koori Court, which has the power to 'regulate its own procedure'. An evaluation found that these two pilot locations achieved reductions in reoffending and greater awareness of the justice system within the Koori community. The Children's Koori Court was established at Melbourne in 2005 to assist young Koori people who have been found guilty of committing a criminal offence.

Elders and Respected Persons provide cultural advice to judicial officers and clients appearing in the Koori Court and help the Court understand the underlying issues impacting the client's offending behaviour. The Koori Court operates in an informal manner in a culturally appropriate hearing room. The magistrate, Aboriginal Elders and Respected Persons, Koori court officers, prosecution, community corrections officer, lawyer and family sit around the table and all parties are encouraged to take part in a conversation prior to the magistrate determining a sentencing outcome that is culturally appropriate and reduces the likelihood of reoffending.

each particular diagnosis, not percentages of all Drug Court clients with that diagnosis. The total is more than 100 per cent because clients often have multiple diagnoses.

To be eligible for Koori Court, clients must:

- be an Aboriginal and/or Torres Strait Islander person
- be charged with an offence that can be heard in the relevant court
- not be charged with a breach of family violence intervention order, interim intervention order or sexual offences (except Mildura Koori Court where breaches of family violence intervention orders are being piloted)
- plead guilty to the offence
- be willing to participate in the Koori Court sentencing conversation.

The main aims of the Koori Court are to:

- increase the accountability of the Koori community and clients
- reduce the number of breached court orders and the recidivism rate
- increase community awareness about community codes of conduct
- explore sentencing alternatives prior to imprisonment
- create a court system that is culturally responsive
- ensure greater participation by the Aboriginal community in the sentencing process to increase Koori ownership of the administration of the law.

In 2017–18, 1176 Koori clients accessed Magistrates' and Children's Koori Courts statewide. The table below shows locations and years for Koori Courts established across Victoria:

Koori Court location	Year commenced in Magistrates' Court	Year commenced in Children's Court
Shepparton	2002	2013
Broadmeadows	2003	
Warrnambool[20]	2004	2012
Hamilton	2004	2012
Portland	2004	2012
Mildura	2005	2007
Latrobe	2006	2012
Bairnsdale	2007	2012
Swan Hill	2008	2013
Melbourne	2014	2005
Geelong	2016	2016
Dandenong	2019	2014
Heidelberg		2014

[20] Koori Court at Hamilton and Portland are part of the Warrnambool Koori Court circuit and hearings are held on a rotating basis.

5.7 Koori Family Violence Initiatives

In November 2018, the Umalek Balit program was introduced at Melbourne Magistrates' Court, and subsequently introduced as a pilot in Mildura Law Courts in May 2019.

Umalek Balit, which means 'give strength' in Woiwurrung (the language of the Wurundjeri people) is a dedicated Koori family violence and victim support program designed to address the specific barriers faced by Aboriginal and Torres Strait Islander people when attending court and interacting with the justice system.

The service includes women's and men's practitioners who work with Aboriginal women and men to guide them through the Court's family violence-related response. The practitioners provide culturally relevant non-legal expertise in relation to family violence intervention orders, criminal matters arising from family violence and Victims of Crime Assistance Tribunal applications.

These services increase the Court's capacity to safely and effectively respond to Aboriginal family members. Umalek Balit is uniquely placed to respond to the dynamic risk factors that impact on Aboriginal people experiencing family violence and integrate with local services to improve the Court's responses to family violence.

Umalek Balit builds on a previous program, the Koori Family Violence Victim Support Program, that operated from Melbourne Magistrates' Court from 2011–2016. Umalek Balit represents the reinstatement of this previous program and has been developed with Aboriginal communities to help support self-determination and redress the historical inequities experienced by Aboriginal people within the justice system.

In May 2019 a 12-month pilot was introduced at Mildura Law Courts, which will enable family violence intervention order breaches to be heard in the Koori Court. It is intended that this pilot will provide Aboriginal victim-survivors of family violence and Aboriginal people who use violence with a more culturally appropriate response. This pilot will be externally evaluated after the 12-month period.

5.8 Neighbourhood Justice Centre (NJC)

The NJC is Australia's first community justice centre. It commenced in January 2007 as a pilot and was funded on an ongoing basis in the 2013–14 State Budget. The NJC was established 'with the objectives of simplifying access to the justice system and applying therapeutic and restorative approaches in the administration of justice'.[21] Referred to as a 'one-stop-justice-shop', the NJC comprises a multi-jurisdictional court, community lawyers, police prosecutors, a Community Correctional Services team, a broad range of treatment and support services, and specialist teams focused on crime prevention, justice innovation and education.

The goals of the NJC are to:

- prevent and reduce criminal and other harmful behaviour in the Yarra community
- increase confidence in, and access to, the justice system for the Yarra community
- strengthen the community justice model and facilitate the transfer of its practices to other courts and communities.

People eligible to have their criminal matter dealt with by the NJC, as per section 40 of the Magistrates' Court Act, include those (adults or children) where the client:

[21] Section 1(b) of the *Courts Legislation* (*Neighbourhood Justice Centre) Act 2006*.

- resides in City of Yarra
- is homeless and offence allegedly occurred in City of Yarra
- is homeless or residing in short-term accommodation in the City of Yarra
- is an Aboriginal person (including non-City of Yarra residents who demonstrate a close connection for social or community support within the City of Yarra) and offence allegedly occurred in City of Yarra.

Family violence/personal safety matters which meet one of the following criteria are also heard in the NJC Court:

- main cause of action occurred in City of Yarra
- either party resides in City of Yarra, is homeless or is an Aboriginal person (including non-City of Yarra residents who demonstrate a close connection for social or community support within the City of Yarra).

The NJC Court also hears Victorian Civil and Administrative Tribunal (VCAT) matters (residential tenancy, guardianship and civil claims) and victims of crime are assisted through its Victims of Crime Assistance Tribunal (VOCAT). The NJC has one magistrate presiding over the Magistrates' Court, Children's Court and VOCAT. VCAT members attend for VCAT cases. Sexual offences are not heard in the NJC Court.

NJC clients with mental health issues are managed by the NJC's Client Services Team (CST), which is comprised of expert service providers drawn from the City of Yarra and agencies outside of the City of Yarra that service the area. The CST provides non time-limited case management, screening, assessment and referral for individuals attending the NJC, not restricted to those with court/tribunal matters.

Services provided by the CST include intensive mental health outreach, clinical mental health services, alcohol and other drugs, housing, Koori issues, male family violence perpetrators, family violence support services (women or LGBTI), general case work, new arrivals, financial counselling, chaplaincy and victim's assistance.

The magistrate will, when appropriate, defer a client's sentence hearing until they have had the opportunity to engage with the available treatment and support services. This improves the likelihood of correction orders being completed successfully, reduces the likelihood of recidivism and improves safety in the local area.

In 2012 the Australian Institute of Criminology (AIC) evaluated the NJC's performance on recidivism, order compliance and impact on the local crime rate. This included a comparative analysis of recidivism rates for 187 NJC Court clients who received a therapeutic intervention or referral (May 2009 to March 2011), against a control group from another Magistrates' Court. The recidivism rate for the NJC clients was found to be 25 per cent lower than for the comparison Magistrates' Court clients where no therapeutic programs were available.[22]

A total of 32 per cent of the clients in the recidivism study above had a mental health counselling engagement or intervention.[23] When comparing the recidivism rate for NJC clients accessing mental health services with a matched cohort from a mainstream Magistrates' Court, the NJC client cohort was 22 per cent less likely to reoffend.[24]

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[22] Ross, 'Evaluating Neighbourhood Justice'.
[23] Statistics provided by the NJC.
[24] Statistics used in the 2012 AIC recidivism study (published in 2015) provided by NJC.

When the NJC was established, the City of Yarra had the highest crime rate of any Local Government Area (second to the City of Melbourne). By 2015, there had been a 31 per cent reduction in total crime. As crime rates are influenced by a wide range of economic, social, institutional and political factors, it is not possible to attribute this change solely to the NJC. It is, however, worth noting that the reduction in Yarra's crime rate was greater than that of comparable inner-urban areas during the same period. Also, LGAs with similar levels of social disadvantage to Yarra (Dandenong and Frankston) experienced a rise in their crime rate during the same period.

The AIC research also found that the proportion of community correction orders for high-risk clients that were cancelled due to a breach was 61 per cent lower at the NJC than the state average.[25]

The NJC's problem-solving approach for clients—including those with mental health issues—is strengthened through the NJC Officer role that convenes Problem-Solving Meetings (PSM) with the client. This is a voluntary, facilitated out-of-court process and can include court staff, service providers, family and/or support people to discuss issues the client faces while engaged in the justice system. The PSM can act as a 'circuit breaker' to motivate and enable clients to change persistent patterns of behaviour.

NJC CASE STUDY

Dinh came to Australia from Vietnam as an unaccompanied minor, having spent two years in a refugee camp. He had a lengthy history of offending, mainly for drug offences, and had received numerous community correction orders and suspended sentences, none of which he had successfully completed. He appeared at the NJC on charges of possess heroin, but his initial attendance at meetings with support services was sporadic and his compliance with treatment was poor. Dinh's lawyer referred him to Problem Solving. An assessment by a mental health clinician was arranged. A Problem-Solving Meeting (PSM) was delayed for two months while Dinh received treatment and his health stabilized.

During the two-hour PSM, Dinh spoke about an overwhelming sense of personal failure, having failed to achieve what so many other Vietnamese migrants had since arriving in Australia. He wanted to break out of the pattern in which feelings of failure led him to use drugs to forget his problems.

He gave a commitment that when disturbing thoughts and feelings occurred, he would take them to professionals who could help him and follow their advice. Parties to the PSM also agreed on a support and communication strategy for Dinh. When he returned to Court, Dinh received an 18-month community-based order with 100 hours of community work. He requested a follow-up PSM after sentencing, as he said he liked that way of working. He completed his community work four months early and during judicial monitoring Magistrate Fanning described his progress as 'exceptional'.

Dinh completed his order and has not reoffended since.

[25] Ross, 'Evaluating Neighbourhood Justice'.

5.9 Specialist Family Violence Courts (SFVC)

MCV is a frontline service in the response to family violence in Victoria. A total of 39,570 family violence intervention orders were finalised in Victoria in the financial year 2017–2018.[26] It is therefore critical for MCV to provide an effective response to ensure the safety of victims and accountability of perpetrators.

MCV operates within legislative frameworks to create a responsive court process and support broader systemic reform. In 2005, Victoria was the first jurisdiction in Australia to establish a separate court division to respond to family violence. The Family Violence Court Division (FVCD) was established at Ballarat and Heidelberg Magistrates' Courts as 'one-stop-justice-shops' for both survivor/victims and perpetrators.

On 28 September 2015, the State Coroner released their Finding—Inquest into the Death of Luke Geoffrey Batty (the Finding). Recommendation 6 of the Finding called for the existing FVCD to be expanded across Victoria. It recommended:

- specialist family violence case management for all matters involving families at high risk of family violence
- a senior specialist family violence registrar to coordinate the listing of all matters for the one family and manage the family violence team of registrars
- registrars interview and initiating/processing in-person applications have core competencies in family violence, including risk assessment
- family violence applicant and respondent support workers and family violence-trained Court Integrated Service Program (CISP) case managers at all courts
- the capacity to mandate respondents' timely access to, and participation in, men's behaviour change programs (MBCP)
- dedicated police prosecutors and civil advocates, family violence outreach workers and access to legal representation (for applicants and respondents)
- resourcing of the system to meet the requirement for legal representation (free legal aid), commensurate with demand at court locations

As a result of this inquest, in 2016 the Royal Commission into Family Violence (RCFV) made 227 recommendations to strengthen family violence prevention and responses. Twenty-five of these recommendations are led by MCV, including the development and creation of a statewide specialist court response to family violence.

In response to the RCFV, the 2017–18 Victorian State Budget allocated $130.3 million to establish five SFVCs at Ballarat, Frankston, Shepparton, Moorabbin and Heidelberg by 2020–21. SFVCs build and expand on the FVCD model currently in existence.

SFVCs represent an opportunity to embed the connection with mental health services within an integrated multidisciplinary one-magistrate, one-family model. Investment to provide SFVCs statewide is required to avoid 'postcode justice', especially for those who are further disadvantaged in regional communities.

The six core principals of SFVCs state that they are: victim-centred, risk-informed, therapeutic, inclusive, partnership and evolving (see Appendix 2).

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[26] Crime Statistics Agency, Magistrates' Court data tables, 2017–18, Table 1: Finalised Family Violence Intervention Order applications by type of application, July 2013 to June 2018, accessed 3 July 2019, <https://www.crimestatistics.vic.gov.au/family-violence-data-portal/family-violence-data-dashboard/magistrates-court>.

A core component of SFVCs is the focus on perpetrator interventions and accountability. MCV is currently working through the family violence perpetrator intervention project to address this deficiency with the implementation of a new Court Mandated Counselling Order Program (CMCOP) and the Integrated Counselling and Case Management (ICCM) trial in 2020.

The 12-month ICCM trial at Ballarat will provide a tailored plan with case management and counselling components for some perpetrators subject to family violence intervention orders (FVIO). It aims to address their complex needs, such as alcohol and drug misuse, homelessness and issues relating to mental and physical health, and to simultaneously keep those perpetrators in view.

As part of this trial, the Department of Health and Human Services (DHHS) has proposed for community health services to provide mental health services for adults on FVIOs with a moderate mental health condition. The initiative is intended to build on the DHHS Forensic Mental Health in Community Health Program.

5.10 Victims of Crime Assistance Tribunal (VOCAT)

VOCAT is a scheme established by the *Victims of Crime Assistance Act 1996* (Vic) to provide financial assistance to victims of violent crime. This includes primary victims (a person directly injured or killed by the act of violence), secondary victims (a person who witnesses a violent crime and suffers a resultant psychological injury) and related victims (close relatives of a person killed by an act of violence).

The types of awards include special financial assistance, and a range of services designed to assist in the recovery from the act of violence (including psychological services, medical services, loss of earnings, security expenses) and in exceptional circumstances a broader range of services that will assist in recovery.

Assistance is available to people who have suffered a physical or psychological injury as a result of an act of violence within Victoria. Evidence of the act of violence is collected in each case from police. Evidence of injury must be proven by a medical report or a psychologist's report. There are limiting provisions such as:

- the need to have regard to the character of the victim when considering if or how much to award
- the victim must report to, and cooperate with police
- awards or assistance from other schemes must be taken into account when considering awards at VOCAT.

In 2006, the Koori VOCAT List was established to assist in breaking down cultural barriers and to provide culturally sensitive responses for Aboriginal people.

VOCAT assistance is available online and at all 51 MCV locations. Approximately 90 per cent of matters are finalised based on documentation only and 10 per cent are finalised at a hearing.

The 2018 Victorian Law Reform Commission report into the Victims of Crime Assistance Act recommended that a new administrative financial assistance scheme be established outside of the court system. The Victorian government has accepted these recommendations in principle.

5.11 Mental Health Advice and Response Service (MHARS)

The Department of Health and Human Services is the lead agency for this initiative which was funded under the Forensic Mental Health Implementation Plan (FMHIP). The purpose of MHARS

is to provide court-based clinical mental health advice to improve the appropriateness of mental health interventions and referrals for people appearing before the Court and to reduce delays in court proceedings. MHARS funding expanded two existing services (the Mental Health Court Liaison Service and the Community Correctional Services Mental Health Court Advice Service) to provide clinical advice to magistrates on the mental health of clients at 13 Magistrates' Court locations.

6. Key learnings on mental health issues within MCV

6.1 The mental health sector: observed challenges

6.1.1 Dual diagnosis

Dual diagnosis refers to the situation of a person experiencing one or more diagnosed mental health conditions together with substance use disorders; this can also be referred to as comorbidity. Dual diagnosis can be defined as a mental health problem or disorder leading to or associated with substance use, substance use disorder leading to or associated with a mental health disorder and/or substance use worsening or altering the course of a persons' mental illness.[27] Dual diagnosis is common rather than exceptional.[28] Anecdotally, MCV has noticed an increase in the use of the drug crystal methamphetamine ('ice') and its contribution to, or exacerbation of, mental illness.

A significant proportion of clients who are engaged in the justice system present with multiple intersecting issues that underpin their history of offending. These need to be addressed to improve the individuals' health and wellbeing and justice outcomes for the community. These issues include homelessness, history of trauma, inter-generational poverty, lack of education, unemployment, physical disability or ill-health co-existing with mental health conditions.

For example, Drug Court staff work with dual diagnosis clients to manage the significant barriers to engagement with, and completion of, a DTO. This client cohort are at risk of lack of appropriate treatment or care for either, or both, the mental health condition and substance disorder. Dual diagnosis can cause a mental health service to refuse assistance if it is determined that the behaviours or symptoms are believed to stem from substance use and conversely, drug and alcohol services will decline admission or assistance if it is believed that mental health issues are the cause of problematic behaviours. Clients with a dual diagnosis are therefore at significant risk of falling through the gap, unable to access appropriate treatment for either diagnosis. These service barriers are compounded for forensic clients.

The complexities associated with dual diagnosis clients can result in incorrect assessments, misdiagnosis, repeated assessments that are not shared or followed up, lack of appropriate or tailored treatment, case management, continuum of care and/or outreach of Area Mental Health Services (AMHS) and short or episodic service engagement. These system failures can cause significant trauma for the client and trigger relapse or increased substance use. The issues associated with access to services for dual diagnosis clients is highlighted by the following case studies.

[27] Department of Health and Human Services Victoria, Dual diagnosis, viewed 26 June 2019, <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/specialist-responses/dual-diagnosis>.
[28] Ibid.

CASE STUDY

Basil was assessed and placed on a Drug Treatment Order (DTO). At the time of the assessment, Basil disclosed that he was diagnosed with drug-induced psychosis at 17 years of age. Since his diagnosis, Basil had been admitted to psychiatric wards for psychosis and he had also self-harmed in the past.

During the period of the DTO, Basil was admitted to the psychiatric ward at his local hospital. The hospital was unable to determine whether Basil's presentations were caused by an underlying psychiatric condition or drug use. After two weeks, the hospital commenced developing a discharge plan for Basil with the assistance of his Drug Court Clinical Advisor (CA).

The CA contacted the Dual Diagnosis Rehabilitation Centre. The Centre would not take admissions directly from a psychiatric ward or prison and required a three-week stabilisation period in the community. A withdrawal unit indicated that should Basil relapse once discharged they would review his intake.

Basil was discharged without a discharge plan and given a prescription for antipsychotic medication that he had to manage independently.

Approximately one week later, Basil voluntarily presented at his local emergency department. He assaulted his sister, was carrying a weapon for protection and was experiencing delusions. He was told by the hospital they could not assist him.

The next day he presented again at the local emergency department. After an overnight admission, a discharge plan was developed that included a follow-up at a psychiatric unit, with Basil required to contact the unit to arrange an appointment. Basil discharged himself prior to finalisation of the discharge plan and did not contact the unit or receive any medication.

Basil attended Drug Court House for his appointment and disclosed to his CA that he felt unwell and wanted help. Together, Basil and the CA called the psychiatric unit. The triage clinician advised they could not assist as his symptoms were drug-induced and he was homeless.

Basil was told to present to his local emergency department.

CASE STUDY

Sandra was placed on a DTO with a significant history of trauma, a diagnosis of schizophrenia and ice use. She attended Drug Court House presenting as floridly psychotic. Sandra believed she was being followed and that her life, and the lives of her loved ones, were at significant risk. Sandra had no stable accommodation and was placed in a hotel. This arrangement became untenable after the hotel staff became part of Sandra's delusions.

Concerned about the client's presentation, staff at Drug Court House contacted CATT. CATT advised that they must call an ambulance. The ambulance was called; however, the ambulance advised Drug Court to call Victoria Police. Victoria Police attended and ultimately called for an ambulance to attend Drug Court House to help Sandra.

After approximately an hour, the ambulance arrived. Sandra refused a mental health assessment and was therefore arrested by Victoria Police and transported to the emergency department of the local hospital. Following admission and a short period in hospital, Sandra was discharged to the care of her general practitioner.

Sandra advised that she attended the emergency department of a hospital for treatment and assistance almost every week but was never admitted.

Strenuous advocating by Drug Court staff resulted in the Area Mental Health Service attending and assessing Sandra at Drug Court House. Medication was prescribed; however, the service did not provide further support or referrals for Sandra in the community. The Drug Court team arranged weekly risk management meetings with her care team, daily appointments for her at Drug Court House, supported accommodation, visits to her at the accommodation, outreach referrals, and continual referrals to the Area Mental Health Service, while advocating with her GP to do the same. The authority of the Drug Court magistrate was also used to encourage Sandra to engage with alcohol and other drug treatment and commence music therapy, which provided a positive support. The Drug Court team set up consultations with psychiatrists who had previously assessed Sandra, but ongoing mental health treatment was not able to be arranged.

6.1.2 Housing and homelessness

Access to appropriate housing is critical to client health and wellbeing. Housing stability is an essential foundation for addressing a person's complex mental health needs. Research into the correlation between homelessness[29] and mental health found that the rate at which people in Australia with a reported mental health condition had experienced homelessness was more than double that of people without a mental health condition, and that this was the case irrespective of the level of disadvantage.[30]

The nexus between criminality and housing is complex. Research suggests that 'the relationship between criminality and homelessness can be broadly understood in terms of profound and often compounding forms of social and economic disadvantage.'[31] This includes the intersectionality of homelessness and mental health issues.

The social disadvantage associated with episodes of mental ill-health increases the risk of contact with police and the justice system. In 2004, the New South Wales Department of Corrective Services reported that people experiencing comorbid homelessness and mental health are 40 times more likely to be arrested that those in stable accommodation.[32] For example, rough sleeping[33] increases the visibility of any challenging behaviours associated with mental illness and those that are homeless are at increased risk of public order offences or

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[29] Section 3(1) of the Magistrates Court Act defines 'homeless person' as a person living in crisis accommodation, transitional accommodation or any other accommodation provided under the *Supported Accommodation Assistance Act 1994* of the Commonwealth, or a person who has inadequate access to safe and secure housing within the meaning of section 4 of the *Supported Accommodation Assistance Act 1994*.

[30] Australian Bureau of Statistics, *Mental Health and Experiences of Homelessness*, 2014, ABS cat. no. 4329.0.00.005, viewed 24 June 2019, <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4329.0.00.005~2014~Main%20Features~Mental%20Health%20experiences%20of%20homelessness~3>.

[31] A Bevitt, A Chigavazira, N Herault, G Johnson, J Moschion, R Scutella, Y Tseng, M Wooden & G Kalb 2015, 'Journey home research report no. 6: complete findings from waves 1 to 6', The University of Melbourne Faculty of Business and Economics, 2015, p. 65, viewed 1 July 2019, <https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0007/2202865/Scutella_et_al_Journeys_Home_Research_Report_W6.pdf> p. 74.

[32] Council to Homeless Persons, Messaging guide to the Royal Commission into Mental Health: housing, homelessness and mental health, viewed 1 July 2019, <https://chp.org.au/wp-content/uploads/2019/06/Council-to-Homeless-Persons-guide-to-housing-homelessness-and-the-Royal-Commission-into-Mental-Health-2019.pdf>.

[33] According to the Brotherhood of St Laurence, the term 'rough sleeping' refers to people who have no shelter or access to conventional dwellings. It may include sleeping in parks, on the streets, in cars, railway carriages, or derelict buildings, or in improvised dwellings such as tents.

charges such as beg alms.[34] If a client is remanded in custody, they are not likely to be granted bail without access to stable accommodation.

Under-investment in appropriate supported housing means that accommodation is limited or difficult to access for justice clients with mental health issues, particularly when co-occurring with substance use or disability. Programs such as the Atrium Housing and Support Program are welcomed by the justice system as they are changing the landscape and paving the way for holistic client-centred justice responses. Atrium is funded by Corrections Victoria and works alongside CISP to provide a wrap-around supported accommodation program which delivers a range of accommodation options to people who are homeless and on remand but seeking bail.

There are long waiting times for public and social housing and private rental accommodation is generally not affordable or sustainable for specialist courts or justice clients. High numbers of remandees and prisoners with short sentences make planning for release difficult, with little or no time for transition planning. Initial Assessment and Planning (IAP) staff within prisons and youth justice facilities provide limited service responses and require clients to attend homelessness 'entry points' upon release. People exiting custody often have conditions that stipulate where they can live and who they can live with, in addition to complex support needs.

Several MCV specialist programs include the provision of transitional housing, however the number of clients who need housing significantly outweighs supply. There are currently approximately 40 transitional houses (10 specifically for women) available for client's subject to CISP, CROP and/or ARC. In addition, the Dandenong Drug Court has 30 Transitional Housing Management properties and Melbourne Drug Court has access to up to 50 properties under a different (head lease) model.

Court clients who do not participate in these specialist programs are not eligible for this housing and are reliant on accessing housing by competing in the general market. The lack of housing pathways for current clients results in extended stays and precludes access to housing for new program participants.

Appropriate housing for clients with chronic mental health issues generally requires access to services to assist them to achieve and maintain housing stability, whether developing basic life skills to transition to independent living within the community or managing complex behaviours and reducing the risk of police re-engagement.

When clients with mental illness and/or cognitive impairment are assessed as not ready or able to live independently and require supported housing in the community, it tends to be either unavailable or in short supply. Furlong House, operated by DHHS, provides short-term accommodation for people with intellectual disabilities and/or psychiatric illness including clients seeking bail. While the Furlong House service model provides one-to-three months' accommodation, the Court was recently advised that a client remained for three years as there was no alternative supported accommodation available.

6.1.3 Assessment orders

The Mental Health Act provides a mechanism for a registered medical practitioner or mental health practitioner to make an assessment order if they have examined the person and are satisfied that the criteria for an assessment order is applicable.[35] The assessment order enables an authorised psychiatrist to examine the client without consent to determine whether the client

[34] See Section 49A of the *Summary Offences Act 1966* (Vic).
[35] See Part 3, Division 1 of the Mental Health Act.

requires compulsory mental health treatment or be taken to, or detained in a designated mental health service for assessment if required.

It is not uncommon for people in custody to present with a diagnosable and/or untreated mental health issue. In urgent circumstances where the client appears to need immediate treatment to prevent serious deterioration to their health and/or serious harm to themselves or others, they can be assessed by a Forensicare or MHARS clinician at the request of a legal practitioner, court support service or magistrate—with the client's consent. A magistrate can grant bail to a local hospital for an assessment. Unfortunately, at present a range of complex and piecemeal bail conditions are required with no certainty of treatment or positive outcome for the client.

Anecdotally, MCV has observed that clients in these situations are often assessed and discharged by the hospital without adequate treatment—often into homelessness—as the hospital has limited or no capacity to treat them. Notwithstanding the importance and focus of the Act on client rights, recovery and safeguarding, clients can be discharged without any engagement with mental health treatment, increasing the risk of escalation of issues and harm to the client or community.

Clients with a pending court matter are at risk of becoming lost between the mental health and criminal justice systems. If a client fails to attend a court mention or hearing, a warrant is likely to be issued. The resultant arrest by police is likely to further criminalise and alienate the client and increase social and financial costs for the community.

6.1.4 The National Disability Insurance Scheme (NDIS)

The introduction of the NDIS has undoubtedly benefited many people living with disabilities. Unfortunately, these benefits have not been shared equally. People with complex disabilities and disadvantage (including those in the justice system) are finding it difficult—sometimes impossible—to access support under the NDIS. The NDIS is not a social service offering a safety net, but an insurer that provides cover for certain events, specifically those considered 'reasonable and necessary' to support people with a disability. To realise potential benefits, clients need to be able to negotiate the language and complex processes of an insurance company and a market-based support system.

The difficulties in accessing the NDIS for people with multiple disabilities, complex needs and/or behaviours and concurrent social disadvantage are well documented.[36] The uptake of the NDIS has been particularly low among people with psychosocial disability.[37] Accessing the NDIS requires a person to gather evidence of their disability and prove their eligibility. This threshold can be extremely difficult for people who are homeless, lack capacity or family/social support to assist locating records or getting assessed. Funding and support options to gather evidence of disability are very limited and not covered by the NDIS. Access to affordable or fully-funded specialist assessment, such as neuropsychological testing, is limited. The challenges for people with complex needs do not end at service entry but can continue throughout the NDIS planning, support and review processes.

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[36] See: Office of the Public Advocate 2018, *The illusion of 'choice and control': the difficulties for people with complex and challenging support needs to obtain adequate support under the NDIS*, viewed 27 June 2019, <file:///C:/Users/Lrusso/Downloads/OPA_The%20Illusion%20of%20%E2%80%98Choice%20and%20Control%E2%80%99_WEB_FIN_V2.pdf>.

[37] See: University of Sydney & Community Mental health Australia 2018, *Mind the gap: the National Disability Insurance Scheme and psychosocial disability*; final report, stakeholder-identified gaps and solutions, viewed 27 June 2019, <http://sydney.edu.au/health-sciences/documents/mind-the-gap.pdf>.

Court Support Service staff frequently see clients in the justice system who could be accessing the NDIS but are not. Many of these clients need assertive outreach and advocacy support. The reduction and/or eventual winding-up of government services such as Disability Client Services (DCS), Community Mental Health Support Services (CMHSS), Partners in Recovery (PIR), Day to day Living (D2DL) and Personal Helpers and Mentors (PHaMS) has left a significant gap in support options. These services offered flexible outreach support and continuity for clients. The Forensic Disability Statewide Access Service (FDSAS) potentially can fulfil some of these needs but appears under resourced to cope with the demand.

6.2 The justice system: what works well

6.2.1 ARC and CISP

As stated above, the Assessment and Referral Court (ARC) List is MCV's primary targeted intervention to ensure access to justice and improved outcomes for clients with a mental illness or cognitive impairment due to intellectual disability, acquired brain injury, autism spectrum disorder and/or neurological impairment.

The ARC List is a good example of MCV's application of therapeutic justice to reduce crime and achieve better outcomes for clients and the community. It seeks to engage clients using a strengths-based approach to build motivation and capacity for behaviour change. The ARC team facilitates the client's experience of being heard, and works collaboratively with them, their family and service providers to address identified needs over time. The ARC magistrate leaves the traditional 'bench' to meet informally with the client, their family and the ARC team. The magistrate ensures that the client is given a voice in court, participates in developing their own tailored support plan and works collaboratively with service providers to problem-solve any progress issues that arise. The magistrate also provides accountability for the client's decision to participate in the program. For many clients, this experience of connection and accountability builds trust and confidence over time.

A significant proportion of ARC clients present with a primary diagnosis of mental illness. In the financial year 2016–2017, around 63 per cent of ARC List clients were in this category.[38] A quantitative study examining the effectiveness of ARC in terms of changes to recidivism rates in 2014 found that 'successful program completion was the most significant predictor of non-reoffending or a longer time to reoffending'.[39] Clients who completed the ARC List program were less likely to reoffend, and for those who did reoffend after completing the program, the severity of the offences was lower than for those who did not complete the program.[40]

The following features of ARC have been identified as key to its success:

- provides clients with the opportunity to tell their story in an informal and supportive environment
- consistency in magistrate
- experienced mental health clinicians provide assistance to the court
- all parties around the table
- encouragement to client

[38] Magistrates' Court of Victoria 2019, *Annual report 2016–2017*, p. 44-45
[39] B Chesser 2016, *Criminal courts and mental illness: the emergence of specialist problem-solving courts in Australia*, Sydney: Thomson Reuters, p. 150.
[40] Ibid, p. 122.

- changes in perceptions of authority, particularly with a sworn prosecutor involved
- the prosecutor goes back to their colleagues with stories of client success
- participation in the program is predicated on voluntary consent and this empowers the client
- goal-setting is a collaborative process and clients are supported to work towards achieving their goals and maintain commitment to the process
- provides a space for victims of offending behaviour to have a role in the justice process[41]
- the police prosecutor's involvement creates a conduit for increasing knowledge regarding clients with multiple and complex needs within the broader police force.

The ARC List has been recognised with a number of awards for its contribution to improving access to justice and creating better outcomes for clients:

- 2013 Melbourne Awards: winner in Contribution to Community by a Corporation category
- 2014 Australian Crime and Violence Prevention: Certificate of Merit
- 2014 Australia and New Zealand Mental Health Service (MHS) Award, Silver: award in recognition of notable achievement towards excellence, innovation and best practice in the Assessment and/or Treatment Program or Service category.

The Court Integrated Services Program (CISP) is an effective therapeutic initiative in the mainstream lists of MCV that provides support for clients to build motivation and capacity for behaviour change. While ARC is an intensive program for clients with complex needs and operates within a specific court format, CISP operates in mainstream Magistrates' Courts and the length of participation is time-limited (typically around four months).

For a number of clients, engagement with CISP is a condition of their bail. CISP provides the client with the supports they need to reduce the risk to the community and turn their offending around. For magistrates to grant bail without CISP, the magistrate would not be in the position to afford the client the opportunity to return to the community and engage with services. With the support of a CISP case manager, clients are assisted to, and held accountable for, attending appointments with treatment and service providers to address the underlying reasons for their offending. CISP case managers provide reports to magistrates with recommendations about a client's progress on the program, and the magistrate determines whether clients remain in the program.

An independent benefit cost analysis of CISP in 2009 compared the program benefits of a reduced rate and length of imprisonment for sentences received upon completion of CISP, and a reduction in the recidivism rate, against the costs of running the program. It was found that for every dollar invested in CISP there were savings for the community of between $1.70 and $5.90.[42]

CISP has also been recognised for its contribution to community safety and crime prevention:

- 2011 Melbourne Awards: finalist in Contribution to Community by a Corporation category
- 2016 Australian Crime and Violence Prevention Awards: Gold award in the community-led category.

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[41] Based on restorative justice principles, the victim is provided with the opportunity to discuss their experience and be involved in identifying ways to address any harm associated with the offending behaviour. This allows the victim and the general community to have a better understanding of mental health issues, and the importance of ARC and therapeutic jurisprudence.

[42] Price Waterhouse Coopers 2009, *Economic evaluation of the Court Integrated Services Program (CISP): final report on economic impacts of CISP*, p. iii, viewed 27 June 2019, <https://www.mcv.vic.gov.au/sites/default/files/2018-10/CISP%20economic%20evaluation.pdf>.

For the financial year 2016–2017, there were 2126 referrals to CISP, with 1313 clients (62 per cent) giving mental illness as either the primary reason for participation, or in combination with other issues.

CISP CASE STUDY

Deepak was a 43-year-old male who had two previous episodes with CISP in 2016 and 2017. Deepak was referred for a third episode of support in late 2018 as his offences were escalating in nature and he was charged with intending to cause serious injury, property damage, and breaches of a family violence intervention order.

Throughout the three-year period Deepak had contact with CISP he had been linked to services to assist with recurring homelessness and drug and alcohol treatment. He had engaged in psychological and neuropsychological assessments to ascertain any underlying mental health diagnosis.

Deepak engaged sporadically with the drug and alcohol service as well as the psychologist. Attempts to get a formal diagnosis failed as he was unable to follow up on referrals due to his unstable mental health and itinerant lifestyle. In the initial two years, Deepak still had limited family support but by the third referral his family had ceased contact with him, he was becoming increasingly isolated and his mental health was further declining. He repeatedly presented in chaos and his capacity to engage with services was significantly impacted. It was at this point where he was being excluded from residential accommodation due to his anti-social behaviours.

At the time of the third referral, CISP was privy to a significant amount of information about Deepak as current staff at CISP had previously worked with him. The former and current case manager were able to discuss with him his historical engagement and use this knowledge to develop a meaningful support plan. This allowed Deepak and the case manager to focus on securing stable accommodation and completing the psychiatric assessment. The psychiatric assessment was able to be conducted by a known CISP provider and occurred onsite at the Magistrates' Court. This provided Deepak with confidence as he was aware of his surroundings and the assessment was made a priority.

Following the assessment, Deepak was diagnosed with schizophrenia. This diagnosis provided Deepak with clarity; knowing he was not a bad person but in fact suffering from a significant mental health issue. This knowledge in turn supported his recovery. Deepak had a long-term relationship with his GP who was provided with a copy of the assessment report to ensure Deepak was thereafter appropriately treated and monitored.

At the closure of the CISP episode, Deepak secured stable accommodation for over four months, had been abstinent of all substance use and was looking and feeling healthy and alert. He had not yet reconciled with his family but expressed that once he continued his recovery he would consider this decision to rebuild this relationship.

Deepak received a community correction order at sentencing.

ARC CASE STUDY

Eudora, a 22-year-old woman, was referred to the ARC List by her CISP case manager. Eudora had been charged with aggravated burglary, theft and attempt to obtain property by deception. At the assessment, the following areas of need were identified:

- acquired brain injury (ABI) risk factors
- alcohol abuse
- grief and loss
- problem gambling.

Eudora's parents separated early in her life. At a young age she was also exposed to alcohol-fuelled domestic violence. She was 'kicked out' of home at age fourteen by her mother, after which she spent nine months living on the street. She had a significant history of poly-substance dependence, including the use of ice, amphetamines (speed), ecstasy and alcohol. She consumed alcohol daily, with illicit drug use every second day. Eudora would also spend $200 on electronic gaming machines three times a week.

Eudora required intensive case management as a possible client in the ARC List.

Eudora was successfully linked with a drug and alcohol counsellor by her case manager. After disclosing several head injuries, loss of consciousness and a history of poly-substance use since the age of 14, an ABI screening assessment was completed followed by a referral for a neuropsychologist assessment. As a result of the assessment, Eudora was diagnosed with an acquired brain injury of a mild to moderate nature. She was referred to a gambling help service, however ceased her engagement with the service after one attendance. Eudora was also referred for housing support.

After her engagement with CISP, Eudora was accepted onto ARC and an Individual Support Plan (ISP) was developed, which included the following goals:

- develop an increased self-understanding of the reasons underpinning and triggering her offending behaviour
- continue with drug and alcohol counselling
- attend an anger management course
- gain an understanding of the impact of her ABI
- engage in a mental health care plan
- commence vocational training
- gain casual employment.

Eudora's ISP was re-evaluated during her time on ARC to recognise her change in circumstances. At the completion of the ARC List, Eudora was abstinent from drug and alcohol use. She engaged in the development of a mental health care plan with her general practitioner, who then medically managed her mental health issues. She was prescribed a low-dose antidepressant and attended regular counselling where both her gambling and anger management issues were addressed.

Eudora fulfilled a long-standing ambition to work in hospitality and commenced a Certificate II in Hospitality. She also gained part-time employment in this field. Her matters were finalised in the ARC List and she received an adjournment with an undertaking for a period of 12 months on all charges as well as being required to pay a monetary amount to the court fund.

During her time with CISP and engagement with the ARC List, Eudora made significant improvements and gains in her life and did not reoffend.

6.3 The justice system: challenges

6.3.1 Police as first responders

MCV experiences a high volume of criminal cases each year and in 2016–2017 MCV heard 736,000 criminal hearings.[43] The overrepresentation of people with mental health issues within the justice system—including prison and remand—has been well documented by several studies.[44] In 2018, the Australian Institute of Health and Welfare reported that about 40 per cent of prison entrants reported a previous diagnosis of a mental health disorder (including alcohol and drug use disorders).[45]

MCV bears witness to this issue and recognises it as a critical problem caused by, in part, community-based services and responses being limited and under-resourced. A client's access to, and ongoing engagement with, appropriate mental health services can be impacted by changes in skilled or trusted staff, funding arrangements, geographical boundaries and service eligibility and complex referral processes.

These changes in the service system can increases the likelihood of Victoria Police being called out to respond to people with mental health symptoms manifesting in difficult behaviours. Police contact increases the probability of criminal charges. When mental health behaviours are criminalised, clients are likely to remain in custody where they do not have access to services that address their health and wellbeing needs. Prisons have in some circumstances become 'front line mental health care providers'[46] by default. Providing a law and order response to an episode of mental illness that requires medical intervention is not appropriate. For clients experiencing comorbid issues such as homelessness and mental illness, a person can be detained in police custody or prison as a method of safe management and containment.[47]

The following case study illustrates that a lack of community mental health response can result in the criminalisation of clients with mental health conditions.

CASE STUDY

Habib had a diagnosis of schizoaffective disorder, having experienced his first episode of psychosis in his early 20's. He also had a history of heavy alcohol consumption. Habib attended an emergency department at his local hospital, requesting treatment for his mental health issues. Frustrated by the wait time, he threatened to burn down the hospital.

Habib subsequently left the hospital, returning with a petrol bottle, and a cigarette lighter. In fear, a mental health nurse alerted security. Security convinced Habib to leave the building and return the petrol bottle to his vehicle. With security, Habib returned and spoke to the mental health nurse. He stated he wished to have a cigarette and produced a lighter. Habib was seized by the security officer and made a further treat to damage the hospital. The police attended, arrested and remanded Habib on charges of threats to damage or destroy property.[48]

After three days held in custody, Habib was granted bail of the conditions he reside with his family member and attend an appointment with his GP within seven days of his release.

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[43] Magistrates' Court of Victoria 2019, *Annual report 2016–2017*, p. 29.
[44] Chesser, p. 140.
[45] Australian Institute of Health and Welfare, *The health of Australia's prisoners*, p. 27.
[46] Peternelj-Taylor in Chesser, p. 140.
[47] Council to Homeless Persons, Messaging guide to the Royal Commission into Mental Health.
[48] Section 198 of the *Crimes Act 1958* (Vic).

While on bail, Habib was admitted into the Adult Acute Unit Hospital. He disclosed worsening depression and drinking alcohol to escape his thoughts. Habib was placed on an Involuntary Treatment Order for four weeks, significant changes in his medication were made and he was released from hospital four weeks later on a Community Treatment Order.

Approximately one month later, after consuming four bottles of wine at his family's residence, he left the residence and threatened to set fire to 'the place'. The family member believed that 'the place' was the hospital, and phoned emergency services on 000. Upon Habib's return to the residence, he was arrested and conveyed to his local police station. He was assessed by a mental health clinician. The report indicated he was cooperative, concise and articulate.

Habib was once again remanded in custody and his previous bail undertaking was revoked. His bail application was refused. Habib had no criminal history; this mental health episode was his first engagement with the criminal justice system and ARC was not available his region.

Upon presentation at Melbourne Assessment Prison, multiple changes were made to Habib's medication. At the time of his release, he was assessed as stable, engaging with his treatment plan and demonstrating insight into his mental health issues.

His discharge plan from custody was a referral to an Area Mental Health Service.

Habib remained in custody for over 100 days. He was ultimately sentenced to a community correction order (CCO). While CCOs are extremely onerous for people with a compromised capacity for compliance, it was the only disposition available that could provide a treatment regime.

6.3.2 Custody

If a client is imprisoned—either on remand or serving a sentence—the care and treatment received for their mental health issues is vital to their health and wellbeing upon release, and in turn reduces the risk of harm to the community.

The custodial setting can disrupt pharmacotherapy treatment and break the client's chain of community-based treatment. Research by the Australian Institute of Health and Welfare indicates that almost one in four prison entrants reported taking mental health-related medication, however only about one in six people in custody were dispensed mental health-related medication.[49] A corollary is the client's ability to meaningfully engage in their own court attendances and their hearing is also compromised.

Limited diagnostic and treatment opportunities and/or clients transitioning between inpatient and community mental health services means that clients and their diagnoses are often lost within the system. Consequently, MCV must rely upon internal supports and programs to provide a diagnosis and treatment report to properly develop a court order (pre-sentence or sentence) that protects both the client and community. MCV magistrates have noticed an increased incidence of significant delays in the provision of reports, causing great distress to clients and additional financial cost to the state.

Clinical assessments undertaken in custodial settings are often made under extreme time pressure and environmental constraints. This may sometimes lead to conclusions that rely more on a client's psychiatric history (or lack thereof), than on a thorough consideration of their

[49] Australian Institute of Health and Welfare 2018.

immediate presentation. This can cause delays in access to treatment, which has consequent ill-effects on the person's mental health care and wellbeing.

Prior to participating in pre- and post-sentence programs, there are limited diagnostic and treatment opportunities in the community. Despite the availability of Area Mental Health Services (AMHS), they often cannot provide the necessary service or supports to ensure meaningful engagement and treatment for clients. Lack of appropriate treatment, case management, continuum of care and/or outreach can result in clients absconding from any form of mental health services, leading to declining mental health and increased substance use.

MCV recognises that clients subject to a Community Treatment Order (CTO) or Involuntary Treatment Order (ITO) pursuant to the Mental Health Act can refuse treatment while held in prison. MCV has witnessed the potential negative impact this can have on the wellbeing and health of a client, and to the potential resolution of the criminal proceeding increasing the financial and emotional cost to the client and community.

MCV is also concerned by instances of clients with serious mental health conditions remaining within the general population of the prison, and not being provided with specialist care and treatment. Thomas Embling is a secure mental health service managed by Forensicare that provides involuntarily treatment to prisoners. In MCV's experience, there are significant delays for prisoners being transferred to this facility because of limited beds or, in some circumstances, clients remaining in the general population as there is no capacity.

Limited treatment options for clients charged with offences in the community can also lead to remand being the only viable option. Unfortunately, it is the experience of MCV that the remanding of mentally ill people due to their being no other option happens daily in our courts. This is illustrated by the case study below.

CASE STUDY

Ida was a young woman who lived in specialist mental health-supported accommodation in the community. She had been diagnosed with multiple mental health conditions, including post-traumatic stress disorder, borderline personality disorder, depression and she had experienced several episodes of psychosis.

During a psychotic episode, Ida was placed on an involuntary admission to a psychiatric hospital. The day she was released, Ida returned to her accommodation in an agitated state damaged the building and threatened staff. The police were contacted, and Ida was charged and remanded in the psychiatric unit of a women's prison.

At the bail hearing in the Magistrates' Court, the magistrate received a report identifying Ida's previous mental health diagnoses and indicating that she had a history of self-harm and intimate partner violence. Members of Ida's treatment support team gave evidence, stating that if discharged from hospital, she would need to be reassessed before returning to her accommodation and that it was unlikely she would be assessed as suitable to return.

The consultant psychiatrist's report to the court recommended that Ida's mental health would be best managed in the community. Sarah was still very unwell, and her behaviour was erratic. She was unable to take care of her personal health without assistance.

Although the magistrate believed it would have been ideal for Ida to have remained in the community, in consideration about whether there was a risk of her committing further offences while on bail, there were other factors that were taken into consideration. Ida was still acutely unwell but there was no certainty that she would be assessed as requiring involuntary inpatient

treatment, in which case she would be immediately discharged into the community without supports. If Ida was assessed as requiring involuntary inpatient treatment, there was no indication of the likely duration, follow up or continuing care. When discharged from hospital, it would be unlikely that Ida would be able to return to her supported accommodation. In that event, Ida would be a vulnerable, unwell young woman living on the streets at risk to herself and others.

The ultimate sentence in the event that the charges were found proven would not include a term of imprisonment. Incarceration on remand for these offences for a mentally unwell person with no priors is simply not warranted. However, the magistrate was left with no alternative but to refuse bail due to safety concerns for Ida and the community.

This case illustrates the injustices occasioned to mentally ill and cognitively impaired persons through lack of appropriate treatment, therapeutic options and support in the community.

There is some evidence to suggest that AMHS are reluctant to accept forensic clients. Dangerous behaviours, often symptoms of untreated or mistreated mental illness, or exhibited behaviours of mental illness and disability or alcohol/drug related issues, can be a barrier to AMHS treatment due to concerns about the negative impact of client's behaviour or risk to other patients and staff. This can also lead to the remand of clients with low level charges who, but for their mental illness, would be in the community.

6.3.3 Post-release issues

Clients leave custodial settings if released on bail pursuant to the Bail Act, or after serving all or part of their sentence.

If a client is released on bail with the condition to engage with CISP[50], the case manager helps coordinate community-based treatment and support services. Effective exit planning is contingent on timely access to appropriate mental health services for the client. Community mental health services are often subject to geographical boundaries and many clients who are homeless or itinerant cannot provide the residential or postal address required to access these services.

A fragmented mental health service and a lack of coordination between available services is a further barrier to clients accessing appropriate treatment and supports. Where treatment and pharmacotherapy regimes are not routinely shared between clinical services, this can negatively affect the client's stabilisation in the community. The consequence is that courts only have partial information on diagnosis, treatment or intervention options when making important decisions about client risk and needs and the management of community safety.

Similar issues arise in the timely release of Justice Health[51] reports required to develop discharge plans for clients who have been held in a custodial setting. Private psychologists are often engaged to assess clients and provide an evidence-based report to the Court. Notwithstanding the importance of these reports, the recommended treatment plan will be implemented by an alternative physician or mental health service, resulting in a lack of continuum of care.

Regional Victorians with complex presentations experience additional barriers to accessing treatment. Firstly, there is a lack of diversity of services and staff. For example, Metropolitan

[50] See sections 5.1 and 6.2.2 of this submission.
[51] Justice Health is responsible for the delivery of health services to prisoners in the State of Victoria. If a prisoner requires more intensive treatment for mental health issues or conditions, the prisoner will be treated by Forensicare.

AMHS tend to be truly multidisciplinary (social workers, occupational therapists, registered practical nurses and clinical/general psychologists). Sometimes there is less diversity in regional/rural AMHS teams (more RPN and newly-graduated psychologists, fewer occupational therapists and social workers). RPNs are often favoured as they can administer medication—addressing the regional shortages of medical officers and psychiatrists. Ultimately though, this narrows the clinical lens through which clients are assessed and treated and impacts the scope and quality of interventions.

Rural and regional areas frequently lack the full range of mental health services from primary to acute, as well as specialist youth and early intervention services. Stigma and discrimination can also play a role in discouraging people from accessing support and services in regional areas. These factors are compounded when someone is also involved in the criminal justice system.

6.3.4 Interrelationship between mental health, acquired brain injuries, intellectual disability and cognitive impairment

Offending is often connected to complex interrelated factors that must be considered and managed by MCV, impacting the resources and time required to provide an appropriate response. Client complexity can include an interplay of multiple factors including acquired brain injury (ABI), intellectual disability (ID) or cognitive impairment co-occurring with mental health issues. Clients with a cognitive disability can face greater challenges when engaging with the criminal justice system than other cohorts.[52] When clients' capacity to participate in the legal process or comply with court orders, programs and sentencing requirements is limited, offending behaviours[53] can readily escalate to a cycle of recidivism.[54]

A comprehensive research study into acquired brain injury within the Victorian prison population found that 33 per cent of women and 42 per cent of men in Victorian prisons have an ABI compared with two per cent of the general population.[55] This cohort's overrepresentation in prison can also be a result of further compounding complex vulnerabilities such as mental health issues. If a client has a cognitive impairment and experiences mental health issues, this adds a further complexity to the supports required. A client may struggle with basic skills or communication, and therefore a tailored individualised response must be considered by disability services to determine appropriate mental health treatment and care. A lack of multidisciplinary or trans-disciplinary services can also result in the client being treated as a cluster of conditions rather than a whole person.

A lack of coordinated and cohesive services, supports, and responses to this cohort in the community can have dire consequences, compromising the safety of the client and the community. Non-integrated service delivery can have significant and tragic outcomes when people fall through the cracks.

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[52] Victorian Ombudsman 2015, *Investigation into the rehabilitation and reintegration of prisoners in Victoria September 2015*, viewed 27 June 2019, <https://www.ombudsman.vic.gov.au/getattachment/5188692a-35b6-411f-907e-3e7704f45e17>para. 535.
[53] Centre for Innovative Justice & Jesuit Social Services Recognition 2017, respect and support: enabling justice for people with acquired brain injuries, viewed 27 June 2019, <https://cij.org.au/cms/wp-content/uploads/2018/08/rmit_cij_rrs_short_170823_01.pdf>.
[54] Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners*, para. 535.
[55] Arbias, Corrections Victoria & La Trobe University 2011, *Acquired Brain Injury in the Victorian Prison System*, Corrections Research Paper No. 4, p. 6, viewed 25 June 2019, <https://assets.justice.vic.gov.au/corrections/resources/36d7e731-e819-4ed3-972d-269b829b952d/acquired_brain_injury_in_the_victorian_prison_system.pdf>.

Given the interrelationship and similar complexities across different disabilities, MCV is of the view that a court service delivery model should be designed so that a person's needs and risks can be appropriately managed regardless of the specific diagnosis.

6.4 Koori Court and mental health services

MCV has concerns about the connection between untreated mental health issues, the increasing rate of suicide amongst young people and Aboriginal men, and the increasing number of Aboriginal women entering the prison system.

The number of women in prison in Victoria has risen sharply with a 49 per cent increase from June 2012 to June 2017. This increase has been largely attributed to the increase in women being held on remand, with 88 per cent of women who entered prison in 2017 doing so on remand. Aboriginal women constituted 17 per cent of the women who entered prison on remand that year[56], yet represented only 2.8 per cent of the female population in the 2016 Census.

In 2017, suicide was the second leading cause of death for Aboriginal and Torres Strait Islander men in Australia, with 125 men taking their own life.[57] Suicide accounted for 5.5 per cent of all Aboriginal deaths in 2017, nearly triple the rate for non-Aboriginal Australians (two per cent).[58]

In addition to these factors, it is also important to note that cultural identity and connection to kinship/family and country is critical to all Aboriginal people and in particular young people. The impact of assimilation and removal of Aboriginal children continues to impact Aboriginal young people and how they see themselves and their identity as Aboriginal people.

The 1991 Royal Commission into Aboriginal Deaths in Custody (RCIADIC) has previously highlighted the role of cultural dislocation, trauma, stress related to disadvantage, racism, alienation and exclusion as contributors to mental illness, substance misuse and suicide.[59] Unresolved grief and loss is seen as a significant issue for the mental health of Koori Court clients; this may be caused by loss of a relation or family member, disconnection from community, or the trauma experienced by members of the Stolen Generation.

Referral pathways to Aboriginal health organisations are regarded as critical in addressing the mental health needs of Koori Court clients. Specific Aboriginal health services offering mental health support are available in metropolitan Melbourne but not regional areas. In the regions, Aboriginal clients are referred to mainstream services for mental health support, yet many are reluctant to attend and fall through the gap. The provision of Aboriginal mental health services in regional areas is an important way to address this shortcoming.

Koori Court Officers record client-identified wellbeing issues including mental health, alcohol and/or other drug use as part of the court intake process. The client data for the period July 2018–May 2019 (Figure 2) indicates a very high prevalence of mental health issues and drug or alcohol dependency for adult Koori Court clients, with 43 per cent of clients identifying an issue with their mental health and 82 per cent identifying a problem with substance use.

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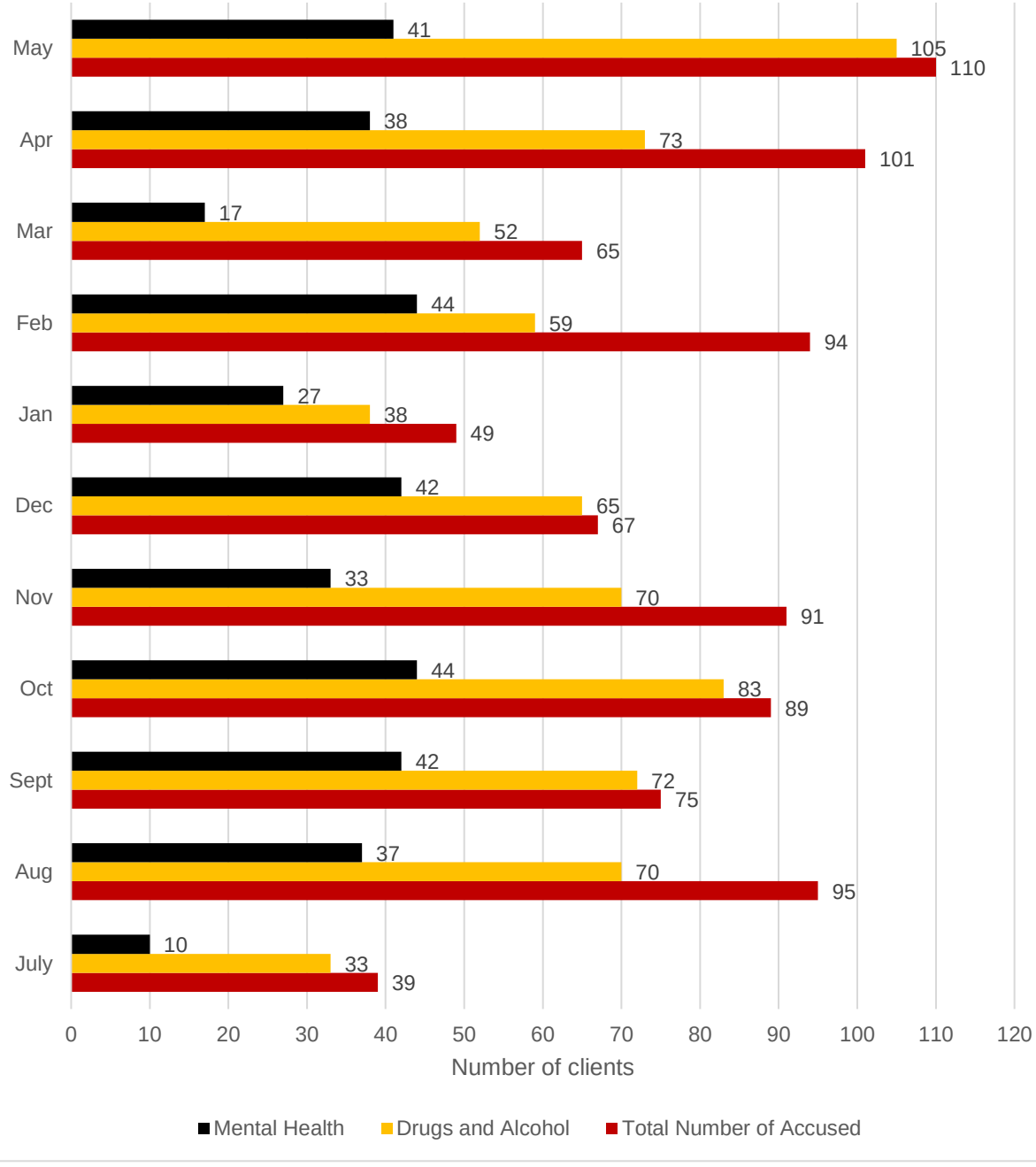
[56] Victorian Department of Justice and Community Safety 2019, *Women in the Victorian prison system*, p. 4, viewed 27 June 2019, <https://www.corrections.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2019/03/71/021fe80ab/women_in_prison2019.pdf>.
[57] Australian Bureau of Statistics, *Causes of death, Australia, 2017*.
[58] Ibid.
[59] N Purdie, P Dudgeon & R Walker 2010, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, viewed 29 June 2019, <https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/working-together-aboriginal-and-wellbeing-2014.pdf>.

Figure 2: Koori Court client-identified major causal issues (adults), July 2018–May 2019



Koori Court Officers are not trained to identify mental health issues, neurological conditions or acquired brain injury, nor is there a coordinated approach to assess whether an Aboriginal client has a mental health issue. Although magistrates in the Koori Court often order a mental health report, the length of time required to obtain the report means there is a significant chance that clients may reoffend prior to the report being available to the court. It is the experience of some Koori Court Officers, that for clients referred to a mental health service by a magistrate, sometimes no initial or follow up report is provided, impacting the client's wellbeing and court's ability to follow-up on progress.

6.5 Recognition of the intersection between family violence and mental health

Family violence has been recognised as a risk factor in Australia's national and state mental health and suicide prevention strategies since 2000 and as a risk factor for a trajectory into criminal offending since 1999. There is a bi-directional relationship between courts and treatment services, with people and their court cases moving across civil and criminal jurisdictions and involving a range of government and community-based services. This engagement is currently uncoordinated, with limited visibility and monitoring by MCV and other government departments.

The implementation of the Royal Commission into Family Violence (RCFV) recommendations has given MCV an understanding of the impact of systemic family violence reform. The following issues are important to consider in the context of the current examination of Victoria's mental health system:

- recognising the intersection between family violence and mental health
- recognising the intersection between family violence and acquired brain injury (ABI)[60]
- ensuring recommendations made by the Royal Commission into Victoria's Mental Health System build upon the systemic reform currently underway through implementation of the RCFV
- note learning from the RCFV where sequencing and timing of recommendations is important given the dependencies both within the Royal Commission into Victoria's Mental Health System and with the RCFV
- note the challenges in building the capability and size of the workforce given the current pressure on the sector and that this will be critical to achieve in the first instance.

6.5.1 Safety of the Victorian community and impact of acute mental health presentations within family violence matters

MCV, as well as the justice system, has a unique role and responsibility to maximise the safety of all Victorians. The seriousness of mental health presentations occurring in courts has a high-risk profile. Often clients are butting up against the public mental health system, and the gaps in services pose unacceptable risks. In relation to family violence, there is a high risk of injury and death of family members, including women and children. High-profile examples detailing these risks include coronial inquests into the deaths of Luke Batty, Kelly Thompson and others. The specialist approaches of MCV represent an opportunity for critical interventions at key points in time to reduce the risk of further criminality and impact on the Victorian community.

CASE STUDY

Joseph appeared before a magistrate for a family violence-related assault on his partner Bhumika. Joseph appeared to be having an acute psychotic episode, and therefore the magistrate agreed to the provision of bail on the undertaking of the Crisis Assessment and Treatment Team (CATT). However, shortly after assessment, Joseph was released out into the community due to a lack of public mental health services. Further, because of the lack of appropriate public housing options, Joseph had no suitable housing. While Joseph's family were concerned about the possibility of further violence, they were also concerned for Joseph's

[60] People with a pre-existing to ABI are more vulnerable to family violence and more prone to perpetrate family violence. Also, victims of family violence are vulnerable to ABI through physical abuse. See: https://www.braininjuryaustralia.org.au/download-bias-report-on-australias-first-research-into-family-violence-and-brain-injury/.

welfare and the possibility that he wouldn't attend further court appearances, so they let him stay in the family home.

Case studies like this pose unacceptable risks of further injury and death of family members.

The RCFV highlighted the growing awareness that accountability for perpetrators of family violence does not simply end at the point of issuing an intervention order, a criminal justice response or a referral to a men's behaviour change program (MBCP). There is a recognised need to create a 'web of accountability' that keeps perpetrators of family violence in view of the system, continues to challenge their behaviour, and addresses risk factors that impact their offending. This requires involvement of a suite of services in a coordinated health, human service and justice system response.

In relation to the connection with mental health, clients with acute presentations often leave magistrates with an inability to address family violence dynamics because a lack of integrated services. As such, MCV would like to move beyond a siloed, 'one-size-fits-all' approach to respondent interventions. For MCV this means several things:

- Working through effective service interventions and models. We need to build evidence of what interventions are working and how to combine these interventions into service models.
- Building integrated interventions with clear referral pathways for both perpetrators of family violence and victim/survivors. We need to use available evidence to construct pathways that are repeatable and predictable, but also sufficiently flexible to meet individual needs.
- Developing our understanding of respondent profiles, to build appropriate pathways for respondents with complex co-existing conditions that create conditions for sustained behaviour change.
- Creating a shared understanding of intake and assessment requirements for interventions to streamline assessment processes. We need to build a collaborative approach in practice to assessing and managing preparator risk.

We recognise that this reform will work best when all the departments and supporting agencies are working together—independently but collectively. The courts seek to collaborate and ensure that their response is consistent with the service principles and approaches in other parts of the system.

6.5.2 Impact on women

MCV is witness to a significant increase of women in Victoria's prisons. Between 2012 and 2017, the number of women on remand increased by 155 per cent.[61] In 2017, 88 per cent of women prisoners were being held on remand and Aboriginal and Torres Strait Islander women on remand increased from 13 to 17 per cent, a greater increase than for their male counterparts in 2017.[62] As there are relatively high numbers of women on remand, and on average they serve shorter sentences than men, access to programs and supports in prison—which may provide the necessary rehabilitative supports to increase wellbeing of the client and reduce recidivism—can be limited or unachievable.[63] While proper discharge planning is essential for reintegration into the community, the availability of these resources is also limited.

There are multiple complex factors contributing to issues faced by both male and female clients in the justice system, including housing and homelessness, dual diagnosis and mental illness.

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[61] Victorian Department of Justice and Community Safety, *Women in the Victorian prison system*.
[62] Ibid.
[63] Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, para 586.

However, MCV acknowledges the disproportionate impact of imprisonment on women, and often also on their dependants.

The experience and needs of women in prison who experience mental illness can dramatically differ from men. Female prisoners are more likely to report a history of mental illness compared to their male counterparts.[64] Women in prisons also 'experience a greater prevalence of high-acuity mental health conditions such as schizophrenia and major depressive disorder'.[65] In 2004 the Australian Institute of Criminology found that 87 per cent of women in prison were victims/survivors of sexual, physical and/or emotional abuse.[66]

Targeted and multi-disciplinary integrated health services both in the prison setting and the community are essential to identifying and assisting women in addressing underlying causes of offending.[67] Developing and investing in targeted intervention driven by a gender-based framework can provide responsive and timely support for women clients. According to the Australian Institute of Health and Welfare:

> Partner violence is a major health risk factor for women aged 25–44—with mental health conditions being the largest contributor to the disease burden from partner violence, followed by anxiety disorders and suicide and self-inflicted injuries.[68]

This impact is further compounded when looking at diverse communities, and the Aboriginal community. Access to short-term support and ongoing case management services for applicants in family violence matters are therefore also necessary to address the effects and impact of family violence on victims/survivors who are women. Access to services, applicants' assistance programs and a range of other community services must be available to provide responsive and timely support.

CISP CASE STUDY

Kerryn was a 42-year-old female referred to the CISP. Her charges included drug possession, breach of an intervention order, dealing with the proceeds of crime and various driving charges.

During her assessment, Kerryn presented with an open wound to her head that she advised was inflicted by her partner. Kerryn further described incidents of violence by her current partner including multiple assaults to her head, assaults with weapons being a power saw and taser gun and a gun being fired at her house. Kerryn advised she was fearful of her partner but was undecided about whether she was prepared to end the relationship. Although there had been repeated police call-outs due to family violence, Kerryn had to date declined to pursue charges

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[64] Australian Institute of Health and Welfare, *The health of Australia's prisoners*, p. 27.

[65] Victorian Department of Justice and Regulation 2017, *Strengthening connections: women's policy for the Victorian corrections system*, viewed 3 July 2019, <https://www.corrections.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2019/05/81/d0809d4db/djr%2B_cv%2B_womenpolicy.pdf>.

[66] Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners*, para. 584.

[67] The Marrmak program at Dame Phyliss Frost Centre is a residential program for women prisoners in the acute phase of a serious mental illness who require ongoing, intensive care and treatment, or in the sub-acute phase and require ongoing mental health inpatient care and treatment to promote full recovery, assessed as high risk for self-harm/suicide related to serious mental illness with age-related mental illness requiring specialist mental health inpatient care and treatment.

[68] Australian Institute of Health and Welfare 2019, *Family, domestic and sexual violence in Australia: continuing the national story*, AIHW cat. no. FDV 3, viewed 1 July 2019, <https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-australia-2019/contents/table-of-contents>.

against her partner.

The CISP case manager consulted with the CISP family violence case manager regarding Kerryn's circumstances and her safety. The CISP case manager completed a Common Risk Assessment Framework (CRAF) assessment with Kerryn. who had limited support, was socially isolated, and lack of access to transport (as the partner had damaged her car and she did not reside near public transport). Kerryn was assessed to be at extremely high risk due to the incidences of violence against her and her family members and the partner's record including a past conviction for attempted murder of a family member.

A personalised safety plan was formulated with Kerryn. This included referrals to Women's Health West (WHW) and to the High-Risk Police Register to occur alongside other treatment referrals for identified social needs. WHW supplied Kerryn with an emergency telephone and a taxi voucher allowing her to flee an unsafe or violent situation. Arrangements were made for Kerryn to meet with WHW in a location which would not alert her partner to her meeting with women's family violence services.

The Court was advised of Kerryn's risk factors, the ongoing concerns for her safety and information about how her continued experience of violence and trauma act as a barrier to her progress in treatment.

Kerryn remains in a relationship with her violent partner but is now linked to a specialised family violence psychologist, family violence supports and alcohol and other drug counselling.

7 Recommendations: achieving best practice for mental health outcomes

It is important that implementation of the recommendations below be properly funded to ensure effective client health, wellbeing and justice outcomes. Adequate resourcing is also necessary to ensure that service levels are sustainable in terms of workloads for staff across the health and human service system, justice system, court and judiciary. The system itself needs to be robust and sustainable to mitigate the risk of adverse workforce mental health outcomes.

Recommendation 1: Enhance the capability of mainstream Magistrates' Courts

a) Establish a Triage and Assessment Function (criminal jurisdiction), whereby a clinical advisor or support worker role would form part of court registry staff for clients with criminal matters in a magistrates' court.

The establishment of a Triage and Assessment Function (TAF) is a way to embed early intervention and prevention in the justice system. A multidisciplinary-designated worker or team would ensure that those who could benefit from early intervention, treatment, support or specialist responses are identified and assisted at the first possible opportunity. This approach creates clear pathways which maximise the 'window of opportunity' presented by a client's engagement in the justice system.

A TAF assessment would facilitate a tiered response tailored to assessed client need and risk:

Client need/risk level	Response
No Needs, No Risk	No service requirement
Low Needs, Low Risk	Explore justice redirection/community referral
Low Needs, Medium Risk	Early facilitated referrals to appropriate community-based services and agencies, including Koori, CALD, LGBTI and family violence services, where appropriate
Medium Needs, Medium Risk	Early facilitated referrals to appropriate community-based services and agencies combined with case management if required
Medium Needs, High Risk	Facilitated entry to a court-based programs and services such as CISP, Koori Court and ARC and secondary consultation with family violence specialists
High Needs, High Risk	ARC and Drug Court

The TAF would provide the client with timely engagement with appropriate services to address the range of complex psychosocial issues, including family violence, that could otherwise be overlooked or identified at a later stage in court proceedings.

A triage and assessment approach will improve justice outcomes. Early identification of client

needs will significantly streamline and improve the 'at-court' experience and reduce 'in-court' time for the client and/or adjournments and cost for the Court. Early intervention also increases client access to medium- to long-term services, reduces the risk of reoffending and increases community safety.

A stronger focus on collaboration between the Koori Court, CALD and other Koori services will ensure Aboriginal and CALD clients presenting with mental health issues do not fall through the gaps.

CASE STUDY

Ling was charged with theft and criminal damage and placed on bail. His matter was adjourned three times over three months. Within this three-month period, Ling offended again; allegedly threatening to kill his neighbour for throwing rubbish in a communal area. Ling was remanded in custody.

It became apparent in a custody setting that Ling suffered from significant mental health issues; he had been diagnosed with a schizoaffective disorder. He had stopped taking his medication and was no longer engaging with his Area Mental Health Service. He had presented at his local hospital emergency department for assistance; however, he was discharged.

Ling's unmanaged risk had led to further offending; causing greater risk to himself and the community. Further, as Ling is remanded in custody, there were funding implications in terms of MCV and Corrections Victoria.

UNDER PROPOSED MODEL: WHAT COULD HAPPEN NEXT

Ling attends court on the first mention. The Triage and Assessment Function (TAF) review the available material and charges and speak with Ling. This engagement triggers the need for an assessment and, with the consent of Ling, the TAF identifies that he had been diagnosed with a mental illness however was unable to access appropriate supports in the community. Ling is referred to CISP as targeted intervention is required at the earliest opportunity. CISP is able to engage with community services and provide an appropriate one-off referral and appointment for Ling. Ling returns to court in one month; he has not reoffended and is re-engaged with services and receiving treatment for his mental health issue.

If Ling had significant priors, he may be referred at the first opportunity to CISP for a more intensive intervention with case management over a longer period of time, or to the ARC List. Both CISP and ARC can provide judicial monitoring to support the transition to ongoing engagement with community-based mental health services.

It is important to incorporate a culturally-appropriate service and training for the TAF role to ensure that clients feel comfortable to disclose their cultural identify. One issue of concern expressed by staff of the Koori Court is that while registrars are the first point of contact for clients, it appears that they are reluctant to ask clients about their Aboriginal identity, and this can mean clients are not provided with access to culturally-appropriate services.

b) Establish a Triage and Assessment Function (civil jurisdiction), whereby a clinical advisor or support worker role would form part of the court registry team for respondents, protected persons or affected families of family violence or personal safety intervention orders.

When a person applies for a personal safety intervention order in matters where the behaviour that must be regulated to protect the 'protected person' is as a consequence of mental illness or

impairment, and not control or manipulation, proper enquires can be made with the victim and respondent to determine whether the court can provide appropriate interventions, support or treatment through community referrals prior to, or in conjunction with, an order being made. Subject to a risk assessment, the protected person and respondent may engage in an informal process or mediation to promote the safety of both parties and resolve underlying issues without a formal court order.[69]

In relation to family violence intervention orders, triage and assessment would be beneficial in terms of what support could be provided to clients presenting with mental illness or impairment to ensure family safety. Often those presenting with mental illness cannot attend men's behaviour change programs or other counselling, which may lead to increased breaches of family violence intervention orders. Triage and assessment could form a critical pathway to other court or community services available to assist in relation to those who perpetrate family violence but also presenting with mental illness concerns.

c) Expand ARC capabilities into mainstream MCV court settings with a list that sits parallel to the existing ARC List (referred to here as 'ARC Light').

To enhance equity of access, different levels of intervention are required to meet a range of client needs. MCV could work towards implementing effective interventions that balance the individual needs of the client, the victim and sentencing principles. Providing a range of interventions for clients with low-end to complex needs will ultimately ensure a more efficient court system and effective outcomes for clients and the community.

Currently, clients in ARC are subject to individual support plans (ISP).[70] Clients of ARC often require complex intervention from health services, ARC clinicians and a range of community organisations.

There are cohorts of people who enter the criminal justice system who may require a less intensive and more flexible engagement and who may not need a complex or lengthy ISP but would benefit from the infrastructure of ARC, including a magistrate with specialist knowledge, a more supportive court environment and the presence of a clinician.[71] The court-based clinician contributes professional expertise based on assessment.[72] They assess the client's presentation and needs provide advice to the court regarding appropriate treatment or plans that can be put into place and have the skills to work with clients to identify wellbeing goals and turn their offending behaviour around. The presence of a clinician and magistrate with an understanding of the principles of therapeutic jurisprudence ensures the client is given a voice in these hearings and the Court's authority is leveraged to support engagement in treatment and monitor outcomes.

The magistrate must weigh and balance all relevant considerations in the act of sentencing; including sentencing purposes, factors and principles enshrined in the *Sentencing Act 1991* (Vic). The development, expansion or redevelopment of any specialist courts or programmatic responses to mental health must be consistent with the sentencing principle of proportionality. Courts require specialist responses and resources to appropriately leverage this window of opportunity for clients presenting with mental health issues, however engagement in the justice

[69] Current options include a referral to Dispute Settlement Centre of Victoria.
[70] See section 4.2 of this submission: Assessment and Referral Court (ARC) List.
[71] Consistent magistrate, multidisciplinary teams and support services, informal court and review hearings.
[72] This could be a clinical or psychosocial assessment.

system is time limited and ideally justice and court interventions decrease within the context of clients having whole of life access to effective, coordinated, community based mental health services.

CASE STUDY UNDER PROPOSED MODEL: WHAT COULD HAPPEN

Matthew is a 22-year-old man, charged with theft from a shop and is recommended for diversion by Victoria Police. Upon speaking to a Triage and Assessment Function (TAF), it becomes clear that the offending is caused by an underlying mental health issue. Matthew is currently not engaging with any community mental health service or supports and expresses feeling isolated in the community.

Matthew is referred to 'ARC Light'. Matthew does not require the development of an ISP or intensive case management but would clearly benefit from support to access and engage with appropriate services. To reduce the risk of reoffending, consistent monitoring from the magistrate establishes a relationship of trust with Matthew and enhances his capability to comply with the diversion program.

The magistrate also refers Matthew to a CISP worker who assists with a referral to an appropriate community-based service. However, Matthew does not require full CISP case management and his matter is adjourned. Matthew attends court, and in an informal setting with the magistrate, explains in his own words the treatment plan and engagement with the mental health service provider.

The diversion plan is successfully completed, and the charges are discharged. Matthew continues to engage with the mental health service on an ongoing basis.

d) Expand the criteria of diversion to include 'mental impairment', for clients with a mental or cognitive impairment, in situations where the impairment contributed to the offending, and modify the current model from registrar management of diversion to a multidisciplinary team approach with court-based practitioners and brokerage funding to access services that support clients.

Rehabilitation is best achieved by diverting clients into appropriate community support services to address the underlying causes of their offending behaviour. Under this recommendation, the criteria for diversion would be expanded to provide a range of therapeutic support options for clients with a mental or cognitive impairment. A prior criminal history would not prohibit an offender from diversion if evidence is provided to the court of the connection between the mental impairment and offending.

This diversion category would operate in a similar manner to the current ARC List. The formal court process would be adjourned, and the magistrate would adopt a solution-focused approach to afford the client a voice and agency, working to improve mental health and justice outcomes together.

A plan would be developed, supported by the court and community-based health and support services. Court-based practitioners would provide appropriate referrals or case management depending on the needs of the client. Appropriate external community organisations and services would be engaged to provide evidence-based advice to inform the court on progress against or barriers to completion of the current plan. Consistent with ARC, clients who require a case manager would be provided with that assistance to co-ordinate services; as clients engaged with the justice system often require support to successfully navigate service re-engagement and treatment.

Proceedings would be deferred to enable the client to engage with services and case management support provided to address barriers or needs. Progress would be monitored by the same magistrate. Successful completion would result in the charges being discharged.

This program places responsibility for change with the client—in order for the program to be a success, they must acknowledge their offending and take responsibility—however, the level of support required is also available.

Including a 'mental impairment' criteria to diversion could also steer clients away from electing the defence of mental impairment pursuant to the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*. Not only is this an expensive process for the justice system, it can also be an extremely time-consuming process for the client that may lead to a range of complex legal and social consequences for them. In addition, if the defence of mental impairment is elected by the client and the matter remains in the Magistrates' Court, the only option available to the magistrate is to fully discharge the charges, unlike in higher jurisdictions where a court can order a supervision order in accordance with the relevant provisions of the Crimes (Mental Impairment and Unfitness to be Tried) Act.

This new diversion response could reduce the likelihood and severity of offending, provide a better quality of life for the client and reduce the risk to the community.

This recommendation is also supported by case law. The Verdins principles[73] provide the basis for a magistrate to consider mental impairment when sentencing. General and specific deterrence may 'be moderated or eliminated in the exercise of sentencing depending upon the nature and severity of the symptoms of the offender and the effect of the condition on the mental capacity of the offender at the date of offending and/or sentence'.[74]

A key component of this recommendation is that diversion is currently managed by registry staff (see table in Appendix 1). Under a 'mental impairment' diversion, clients would be provided with the opportunity to access court-based mental health practitioners with specialist knowledge and clinical skills.

CASE STUDY

Naruto was 18 years old and charged with making a threat to kill and criminal damage. He had no prior criminal history or history of violence.

Naruto had become angry at his brother; banging on the door to the point of it breaking and threatening to kill him. Naruto admitted to the police he was responsible for the offending and wanted to enter a plea of guilty to the charges. On the day of his hearing, his mother and father attended court in support of their son. They explained to the court that he had been diagnosed with borderline personality disorder and bipolar disorder. At the time of the offending, he was not engaging in any treatment. Naruto's paediatrician had ceased engagement as he had recently turned 18, and his parents had previously been struggling to engage a physician with the correct expertise and skills to assist their son.

However, since the offending, the family had engaged a new physician. Naruto was now undertaking pharmacotherapy and regularly attending appointments to learn how to manage his emotions and behaviours. The parents advised the court of notable improvements to their family

[73] Please see case: Verdins; Buckley; *Vo* (2007) 16 VR 269.
[74] Judicial College of Victoria, Overview of the Verdins principles, viewed 1 July 2019, <http://www.judicialcollege.vic.edu.au/eManuals/VSM/6136.htm>.

situation.

The presiding magistrate requested that Victoria Police consider diversion for Naruto. The police refused as it was considered unsuitable because the offending happened within a family violence context.

UNDER PROPOSED MODEL: WHAT COULD HAPPEN NEXT

In the proposed model, a court-supported program would assist the family in assessing and managing family violence risk while also accessing and coordinating appropriate services for Naruto. The significant support and monitoring by the court could reduce the risk of harm to the brother and increase community safety. The police may therefore consider diversion as an appropriate program for Naruto recognising community supports are in place and family violence risk has been assessed and managed in this instance.

Recommendation 2: Expand MCV Specialist Court and Program responses

a) Expand the Criminal Justice Diversion Program by adding the capability for psychosocial or clinical assessment and early referral of clients to appropriate community-based services and agencies, supported by case management and judicial monitoring option.

b) Fund brokerage to assist clients to access services.

c) Specialist Courts and Programs to be further resourced to provide better access to mental health services, including additional resourcing for a mental health nurse at any Drug Court sites.

d) Expansion of the number of clinicians in current ARC Lists to meet actual demand.

e) Expansion of ARC to courts across the state, in particular to regional Victoria, to increase access to justice and remove ‘postcode justice’.

f) Expansion of Specialist Family Violence Courts (SFVC) across the state, to expand the level of integrated services across the state and remove ‘postcode justice’.

g) Expansion of CISP Mental Health Advanced Case Manager roles and expansion of CISP Family Violence Advanced Case Manager role across the state to work with the SFVC.

h) Develop a multi-jurisdictional, flexible problem-solving court model that provides tailored/dual diagnosis programs that respond to complex client presentations, to be informed by specialist court programs such as CISP, ARC and Drug Court.

While the geographical availability of some specialist courts and programs such as CISP generally align with MCV’s headquarter court locations, there is a need for additional funding to ensure a correlation between resourcing and need in those locations and an expansion of all services to all regions. The availability of other specialist programs such as ARC and SFVCs needs improvement to meet the needs of clients with mental health issues. Many regional areas do not have specialised court or community-based services and appropriate investment is required to ameliorate the current situation of ‘postcode justice’.

In addition, MCV’s therapeutic jurisprudence model works most effectively when specialist programs and specialist staff are available at each court location, enabling staff to collaborate

broadly and provide a system of support in relation to a number co-occurring complex needs such as mental health, alcohol and drug issues, homelessness and family violence.

i) Creation of a specialist bail program linked with CISP for people with mental illness.

People with mental illness or cognitive impairment are often remanded in custody because they are deemed 'an unacceptable risk of committing further offences on bail, endangering the community or failing to appear on bail' due to their erratic behaviour or presentation, lack of accommodation and/or lack of ability to comply with court orders. This cohort is also more likely than others coming before the courts to either be on bail or a correction order.

A specialist bail response is urgently needed for these clients, so they can receive timely and appropriate treatment in the community. Given the availability of CISP clinicians in many areas of Victoria, CISP is the appropriate vehicle for establishing this response. To enable this, MCV requires resourcing to uplift clinical staff capabilities. This work requires collaboration with internal and external stakeholders to build a sustainable program which delivers best practice and positive outcomes for clients.

Such a response would ideally include:

- psychosocial support such as appropriate supported accommodation (with differing levels of care) and ongoing treatment
- urgent and comprehensive expert, professional, evidence-based mental health assessments.

The program would also ideally include the availability to the Court—at short notice—of independent psychiatrists who can:

- facilitate prompt inpatient admission (certify from court rather than releasing people on bail to attend their local mental health network for assessment when there is no certainty of admission)
- advise regarding appropriate bail conditions
- provide advice to clinical staff and magistrates
- assist in accessing appropriate services and arrange case planning and case management in the community.

j) Further resourcing for CISP to provide outreach to appropriate clients.

Outreach services will be particularly valuable for women who present with multiple co-morbidities. More generally, it is particularly important for clients who present with complex needs and who are clients of bail support programs, to encourage participation and compliance with program and bail requirements. Language and the terms of court orders can be difficult to understand by clients with complex needs who engage with specialist court services, both pre- and post-sentence. The more complex a client's need and personal circumstances, the more complex the conditions set by the Court. Therefore, an outreach model would provide additional support and assistance to reduce the risk of court order breaches and recidivism.

Recommendation 3: Enhance communication between MCV and the mental health sector

a) Investment in, and development of, an effective integrated mental health information sharing system between community mental health services and MCV.

Enhancing information sharing between community mental health services, MCV and hospitals can facilitate appropriate evidence-based intervention by the justice system and reduce the number of times that a client must retell their story, relive past traumas or disengage from services.

Such an information-sharing system would—with appropriate safeguards—provide timely, appropriate and accurate information and data regarding diagnosis, treatment and engagement that could be shared by relevant agencies (subject to consent) to ensure that any decision making is well-informed and evidence-based. It would mean that a client's medical history could follow them between hospital, custody and community health centres and that justice and health interventions could be coordinated and work together to support positive client outcomes.

Within the context of family violence reform, MCV now shares intervention order information with mental health services to assist them in risk assessment and risk management of family violence matters. MCV have established a central information sharing team (within the Family Violence Branch), that responds to requests from the mental health sector in a timely and responsive manner. Requests for information by mental health and other service providers are expected to continue to increase as more organisations become prescribed and trained to implement the Family Violence Information Sharing Scheme (FVISS).

The benefits of mental health services being prescribed in the FVISS are evident. Family Safety Victoria's evaluation of the information-sharing reform will provide valuable insights to inform the system architecture for information sharing to support mental health outcomes.

EXAMPLE: ENHANCED INFORMATION-SHARING PRACTICE MODEL

The Royal Commission into Family Violence (RCFV) found that organisations working with victim/survivors and perpetrators of family violence collect a wide variety of information that has the potential to keep survivor/victims safe and hold perpetrators to account. However, often that information wasn't shared effectively between organisations, which led to poor outcomes for survivor/victims of family violence.

As a result, the Family Violence Information Sharing Scheme (FVISS) was created by Part 5A of the *Family Violence Protection Act 2008* (Vic). Under the FVISS, Information Sharing Entities (ISEs) who are key organisations and services, can share information related to assessing or managing family violence risk. The FVISS supports ISEs to work systemically to keep perpetrators in view and accountable and promote the safety of victim/survivors of family violence. The FVISS has been developed within the context of other relevant information-sharing legislation, including privacy and child-protection legislation.

Section 5zc of the Family Violence Protection (Information Sharing and Risk Management) Regulations 2018 prescribes designated mental health services within the meaning of the Mental Health Act, to the extent that the service performs functions relating to the provision of mental health services. The prescription of mental health services in the FVISS assists the mental health sector to coordinate services and care with the work of family violence services.

b) Widen the criteria for standard expert reports to the Court from mental health clinicians to assess the risk of family violence and address issues of family violence.

Standard reports to the Court by independent expert mental health clinicians, such as Forensicare, frequently do not assess the level of family violence, nor seek to manage or address risk in the context of family violence. Providing expert advice on the link between, and impact of, mental illness and family violence can assist the Court in determining risk and developing effective safety plans when exercising its powers to grant bail or sentence. The importance of including family violence information is heightened where the perpetrator presents with co-morbidities that influence their behaviour.

CASE STUDY

Sam was charged with reckless cause injury, make a threat to kill and wilfully damage property. In addition, a three-year intervention order was granted at the last court hearing. The current charges were adjourned requesting a psychiatric court report to be undertaken because of concerns regarding presentations at court, psychiatric history, diagnosis of schizophrenia, drug abuse and threats of violence.

The final report lacked detail or confirmation due to a lack of material available to the clinician. Most importantly, the family violence intervention order was not provided. Where a client does not wish to answer questions, no further analysis is presented.

Therefore, the report briefly summarised the client's current circumstances, offences, psychiatric history, substance use history, medical history, family and personal history, mental state examination and opinions and recommendations. The findings stated no evidence of psychotic condition or mood disorder, however suggested concern of emotional regulation. No family violence risk factors were discussed, assessed, or recommendations made.

UNDER PROPOSED MODEL: WHAT COULD HAPPEN NEXT

Clinicians would have access to full court documentation, including family violence intervention order, relevant police L17 risk assessment or Courtlink narrative to understand family violence incidents. Relevant court staff who had contact with the client such as family violence practitioners should provide relevant risk assessments and safety plans that may have been developed. Psychiatric reports should undertake risk assessments in line with the Multi-Agency Risk Assessment and Management (MARAM) Framework.

Recommendation 4: Increase the capacity of the mental health sector

a) Investment in infrastructure and service models that provide a holistic response to people who present with comorbid mental illness and disability and/or dual diagnosis and/or homelessness.

b) Ensure proper access and treatment for people who have diagnoses that are considered to be lower impact such as borderline personality disorder or post-traumatic stress disorder.

c) Ensure people subject to an Inpatient Assessment Order following bail who are assessed at hospital receive appropriate treatment and support referrals before discharge and are subsequently followed up.

d) Improve discharge planning for people who have psychiatric hospital admission to ensure service continuity.

e) Develop systems to allow a person's mental health care to follow them when they move to a new area or are transient.

f) Develop a general admission gateway for people with disabilities including mental health, intellectual disability (ID), acquired brain injury (ABI), and then triage as appropriate.

g) Increase resourcing for Area Mental Health Services (AMHS) to expand support services such as outreach and case management.

h) Increase availability of, and greater support for, existing Aboriginal organisations (such as VACCHO) to support clients with mental health issues.

i) Increase quality and availability of mental health providers in regional areas, including services which are culturally-appropriate and competent in relation to sexual orientation and gender identity.

j) Increase long-term, secure and properly-resourced treatment beds in hospitals for people who are at significant risk in the community.

k) Reinstate services such as Mental Health Community Support Service (MHCSS) to provide support to people with high-prevalence mental health issues who are ineligible for ongoing support plans through National Disability Insurance Scheme (NDIS).

l) Re-establish the psychosocial recovery supports in the community that form a link between the courts, National Disability Insurance Scheme (NDIS) and forensic mental health system, that the NDIS has dismantled.

m) Timely and appropriate response through the development of a range of assistance programs for survivors/victims/witnesses of violence, to aid recovery and manage the risk of re-traumatisation through participation in criminal and family violence proceedings, including the giving of evidence.

n) Development of comprehensive case management services for perpetrators of family violence to address co-existing factors including drug and alcohol abuse, cognitive impairment, mental health, housing and homelessness.

o) Improve capacity for appropriate mental health assessment and treatment for clients on community correction orders and in prison.

Mental health services provide tailored responses to people with complex dual diagnoses who may be unable to engage in traditional methods of cognitive therapy or treatment. MCV recognises the challenges experienced by mental health services because of limited resources. The recommendations above for a systemic approach and increased service options and levels are made with the explicit understanding that they require considered planning and appropriate levels of funding to deliver the intended outcomes to clients and the community.

p) Development of a coordinated response to facilitate and arrange safe and supported accommodation, psychosocial supports and treatment services for clients transitioning from prison to the community.

The development of improved post-release services would require substantial additional resourcing for both local AMHS and forensic mental health services. Expending funds and resources to establish better-coordinated services may reduce recidivism rates and the costs associated with the cycle of incarceration. Importantly, it will also likely increase the chances of improved mental health outcomes for clients. Targeted education and employment opportunities in tandem with coordinated responses would also benefit the client and, by extension, the community.

Recommendation 5: Expand sentencing options available to the Magistrates' Court of Victoria

a) Development of a specialised mental health community correction order (CCO) disposition with specialist treatment and support services. This can be staffed by Community Correction Officers with mental health expertise and specialised knowledge and skills.

b) Additional sentencing options such as 'warning' or 'admonishment' or 'deferral of sentence in contemplation of dismissal' that allow for charges to be dismissed without a finding of guilt if the client completes, or complies with, conditions to engage with the Specialist Court Programs.

c) Consideration of alternative sentencing options such as discharge without conviction; a discretionary sentencing option enshrined in New Zealand law.

d) Consideration of a court order or probation order in the adult summary jurisdiction that would focus on restorative justice programs.

The Sentencing Act sets out the hierarchy of sentencing options available to the Court. The sentencing magistrate must balance the surrounding circumstances of an offence, the gravity of offending and circumstances of the client. Courts can draw upon current sentencing options to impose sentences consistent with the principles of the Sentencing Act[75] and therapeutic jurisprudence. Legislation further provides Specialists Courts with additional sentencing options such as therapeutic orders in lieu of prison (such as Drug Treatment Orders).

However, sentencing options that can be served in the community that are available to the Court are not always appropriate or meaningful to clients who experience mental illness.

An adjourned undertaking is held to be at the lower end of the sentencing hierarchy. Adjourned undertakings are typically reserved for minor offences and are imposed to allow for a variety of purposes, including the rehabilitation of the client to be served in the community unsupervised and for the existence of exceptional circumstances to justify the Court showing mercy to the client.[76] A magistrate can impose conditions to this undertaking to ensure the client addresses underlying causes of their offending behaviour. However, without proper supports and

[75] Part 2 of the Sentencing Act.
[76] Section 70 of the Sentencing Act.

assistance, compliance with court orders can be challenging for clients with limited capacity to comprehend or adhere to conditions.

Since the decision of *Re Matemberere* [2018] VSC 762[77], if a client re-offends during the operational period of an adjourned undertaking and is subsequently remanded, they must satisfy the test of 'exceptional circumstances' to be granted bail even if the original sentence was imposed for minor offending.[78] In practice, imposing an adjourned undertaking as a sentence can have significant consequences on the client's engagement with services in the community and rehabilitation prospects.

Fines can be extremely onerous for clients experiencing mental illness and many clients do not have the financial independence or means to pay any fine imposed by the Court. Even if deemed suitable for a community correction order, many clients who experience mental illness are ill-equipped to adhere to, or manage, numerous complex conditions.

e) Review international jurisdiction and practices (in particular, New Zealand) to expand available sentencing options.

Specific sentencing options for people who experience mental illness could reform current sentencing practices in the Magistrates' Court to further leverage and expand upon current therapeutic and specialist responses that aim to positively impact the health and wellbeing of the client, reduce recidivism and increase community safety.

The *Sentencing Act 2002* (New Zealand) introduced a sentencing option to New Zealand courts that can result in clients with mental illness being acquitted—provided their matter has been assessed successfully using a 'jurisdictional test of disproportionality' that weighs up the gravity of the offence against the consequences of conviction.

Under this legislation, a New Zealand sentencing court can utilise a two-staged inquiry to exercise their sentencing discretion to 'discharge without conviction'. If the thresholds of the two-staged inquiry are met, this discharge is deemed to be an acquittal.[79] Section 107 of the Sentencing Act (NZ) sets out the jurisdictional test of disproportionality. This test requires a judicial officer to assess the gravity of the offence, assess the direct and indirect consequences of a conviction (real and appreciable risk of consequences following a conviction) and consider whether the likely consequences of a conviction are disproportionate to the gravity of the offending. In considering the gravity of offending, the sentencing court must consider aggravating and mitigating circumstances related to the offending and to the client (including personal circumstances of the client such as their mental health and steps taken to engage in rehabilitative programs).[80]

If a client satisfies the threshold in Section 107 of the Sentencing Act (NZ), the judicial officer can impose a discharge without conviction in accordance with Section 106. Such a disposition may enhance rehabilitation prospects for a client, reducing recidivism, promoting community safety and eliminating the stigma associated with a criminal record or conviction.

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[77] Conditional release under Section 75 of the Sentencing Act is a 'sentence' for the purpose of Sections 4AA(2)(c)(v) of the Act and so requires an applicant who offends while on conditional release to show 'exceptional circumstances', [29]–[30].
[78] Under the Bail Act, if a client commits a schedule 2 offence whilst serving sentence for any schedule 1 or 2 offence, the onus is upon the client to satisfy the court of the 'exceptional circumstances' test to be granted bail and released into the community.
[79] Section 106(2) of the Sentencing Act (NZ).
[80] As per the case: ZvR [2012] NZCA 599.

In practice, a sentencing court can develop programs for clients with mental illness that balance the gravity of the offending with the needs and circumstances tailored to the client. Adherence to these programs can be monitored by the same magistrate over a reasonable period, and at the end the client is rewarded for their efforts by way of an acquittal.

MCV recognises that the outcome of an acquittal under this New Zealand legislation is similar to the discretion that can already be exercised by magistrates in the ARC List, whereby a client who completes or participates in an individual support plan (ISP) to the satisfaction of the Court may be discharged without any finding of guilty.[81]

A sentencing option such as this could exist in addition to the sentencing discretion available to the ARC List, and the diversion program. Moreover, it could also be exercised by magistrates in mainstream courts, making it available to a much broader cohort of clients who may experience high-prevalence but low-impact mental illness.

Further research is required to develop lateral and innovative sentencing options that aim to reduce reoffending and focus on the rehabilitative needs of the client. Ultimately, this can lead to reduced prison numbers and increased community safety.

The development of conditions that allow for trained and accredited professional to assist clients with the completion of programs that are founded on restorative justice principles and practices could achieve better outcomes for clients with mental illness. The trained or accredited professionals would also monitor compliance and provide opinions and suggestions to the Court if necessary, to assist the Court and the client. The conditions could be attached to current sentencing options available, such as an adjourned undertaking or diversion order, or a new court order such as adult probation could be considered. This sentencing option would be particularly applicable when the imposition of a community correction order is out of proportion to the gravity of offending and a fine is not considered appropriate.

Recommendation 6: Research and develop a multi-jurisdictional Koori Healing Court

a) Research and develop a multi-jurisdictional Koori Healing Court for clients with complex needs and multiple co-morbidities.[82]

The proposal for a multi-jurisdictional Koori Court would begin to address the issues outlined in section 6.4 of this submission and reduce over-representation of Koori people in custody, consistent with the recommendations of the Royal Commission into Aboriginal Deaths in Custody.

The proposed court would not replace current Koori Courts. It would investigate the expansion of the scope of the Koori Court to incorporate access to culturally-appropriate, specialist mental health and alcohol and drug treatment responses available within other specialist courts such as Drug Court and the ARC List. An eligible Koori client with multiple co-morbidities would not have to choose between the specialised court options but may elect to participate in a division of the Koori Court that provides longer term, court-mandated therapeutic interventions together with the culturally safe approaches and processes available in the Koori Court.

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[81] Section 4Y(2) of the Magistrates Court Act.
[82] The concept of the establishment of a Koori Healing Court was approved by the Aboriginal Justice Forum (AJF) caucus in 2017.

Subject to consultation with the Koori community, the policy framework could draw on the multi-jurisdictional NSW Drug Court and the Te Whare Whakapiki Wairua[83] (Alcohol and Other Drug Treatment Court) in New Zealand. The proposal is for a specialist, problem-solving response for Koori people with complex mental health and substance abuse presentations who are at serious risk to themselves and/or the community. The court would both address the underlying causes that lead to criminal behaviour and explore and implement approaches to divert Koori clients away from the criminal justice system.

The data collected by the Koori Court Unit captures underlying issues such as grief, loss, depression and other trauma and key mental health issues. This data will be integral to the establishment of the multi-jurisdictional Koori Healing Court for clients with complex needs and multiple co-morbidities to ensure supports for Aboriginal people to address their healing.

In accordance with the principles of self-determination, the development of any proposed model needs to be led by the Koori community with the Aboriginal Justice Forum as the appropriate governance body. The Koori Court Portfolio Committee would also play an instrumental role as Court Services Victoria's internal governance body.

The model would be informed by local cultural protocols and best practice in mental health and criminal justice responses in Victoria, interstate and internationally. MCV acknowledges extensive consultation, research and resourcing would be required to develop and implement this recommendation. Part of the research and consultation required would be to explore any barriers to a multi-jurisdictional court response.

Recommendation 7: Increase the capacity of forensic mental health services

a) Resourcing for additional beds for remand and sentenced clients in prison with acute mental illness. This would ensure that remandees receive appropriate mental health treatment. Appropriate treatment would promote the health and wellbeing of clients and include the development of appropriate treatment pathways prior to release from custody.

b) Increased investment and funding to Forensicare to increase the number of Forensicare practitioners available at MCV to facilitate assessments, provide timely advice to the Court and specialist programs such as CISP or SFVC, arrange community referrals and admission to local hospitals when required.

c) Increased investment and funding for Forensicare to provide timely, comprehensive at-court mental health assessments to strengthen the Court's response to clients with mental illness. This may include expanding current services provided by Forensicare to assess clients and prepare reports that address elements and factors for the purposes of bail.

d) Embedding forensic mental health services into the current AMHS throughout metropolitan and regional Victoria.

e) Development of a model for mobile or outreach mental health service assessments and intake (for example, by AMHS) at police watch-houses and court cells prior to bail applications and sentencing by the court.

[83] This is Maori for: 'The house that lifts the spirits'.

If independent advice regarding mental health diagnosis and treatment is considered appropriate and necessary by a magistrate, they can request a report from Forensicare. Forensicare practitioners are generally highly skilled and can provide independent evidence-based reports that are vital in formulating a coordinated health and justice response for mental health clients who experience multiple co-occurring forms of disadvantage and complex underlying co-morbidities which affect their wellbeing, behaviour in the community and risk of offending.

People who have avoided or been denied access to mental health services in the community are being remanded in situations where the offending may not be sufficiently serious that bail should ordinarily be refused (or a custodial sentence imposed).

Where a magistrate is provided with expert information/reports and treatment advice based on individual client assessments, the requisite tests pursuant to the Bail Act can be satisfied. Appropriate bail conditions can be crafted to mitigate any risk to the community and to support client wellbeing by requiring engagement with mental health services.

CASE STUDY

Faris was the respondent in an interim personal safety intervention order. The order was made by the Magistrates' Court to protect the applicant's neighbour Gerry from alleged verbal abuse by Faris.

Faris had a diagnosis of schizophrenia. Limited enquiries were made regarding the circumstances and needs of Faris at the time the order was made. The conditions of the order were strict, limiting Faris's freedom of movement and prohibiting communication with his neighbour Gerry.

After the commencement of the order, an incident occurred whereby Faris directed threatening words to Gerry (the protected person) who, feeling unsafe, contacted 000.

In comment to the police upon attendance, Faris asked to be left alone and stated to police that he, in fact, didn't feel safe with his neighbour. Faris was subsequently charged with breaching the order.[84]

Faris presented to the Magistrates' Court with a criminal history, however his record did not include a history of violent behaviour. At no time had he been sentenced to a term of imprisonment and was last before a magistrates' court over a decade ago. He did not attend the court hearing and a warrant was issued for his arrest. He was eventually remanded in custody.

A medical report was requested. In this instance, it did not provide all relevant information or the professional recommendations which could assist the magistrate to decide an appropriate sentence which included tailored interventions to assist Faris. Ideally, such reports would provide the magistrate with a comprehensive history of Faris's engagement with mental health services, his current diagnosis and pharmacotherapy regime.

In the absence of appropriate assessments, accessible community mental health services and safe supported accommodation, prisons can in effect become default mental health facilities. Rapidly increasing prison and remand populations create significant systemic pressures. Clients with pre-existing mental illness are vulnerable to further deterioration of mental health and wellbeing in this environment.

MCV supports research and investment to expand the capacity and integration of forensic mental

[84] Section 100(2) of the *Personal Safety Intervention Orders Act 2010* (Vic)

health services. The Victorian mental health response needs to address these issues and ensure continuity of clients' mental health care across the justice, community and health service systems.

Recommendation 8: Implement professional development, training and support in the justice sector

a) Investment to support a comprehensive and strategic whole-of-Victorian-courts safety and wellbeing strategy for judicial officers and Court staff. Professional development would focus on both identifying and proactively managing workplace mental health risks and improved mental health proficiency/competency in terms of the design and delivery of court services to clients impacted by mental illness.

b) Investment in training tailored to professional roles (registrars and trainee court registrars, court-based clinicians and practitioners, Koori Court Officers, Elders and Respected Persons, program, policy and project managers and magistrates) including:

- mental health first aid
- suicide prevention, intervention, and postvention
- alcohol and other drugs
- trauma-informed practice
- vicarious trauma
- resilience
- building cultural proficiency including the ability to identify and link Aboriginal and Torres Strait Islander clients to appropriate services
- building staff knowledge of the various services, roles and responsibilities within the mental health, human services, family violence and victim support ecosystems
- building organisational capacity for multidisciplinary collaboration.

MCV's workforce comprises a range of roles including judicial officers, registry staff, administrative staff, Koori Court Officers, specialist clinical staff, social workers, psychologists, case managers, family violence practitioners and program, policy and project managers.

For MCV to systemically support workforce and client disclosures in relation to mental wellbeing, it is necessary to uplift workforce capacity to identify, assess risk and provide best practice responses. For example, Specialist Family Violence, ARC, Drug Court practitioners and registrars and Koori Court staff all require regular mental health first-aid training and suicide and self-harm training, to ensure that staff are resourced to respond appropriately when clients (or colleagues) present with mental health symptoms or indicators of risk.

Vicarious trauma is an identified issue to be managed for MCV staff and judicial officers who provide direct services to the Victorian community—particularly those working in jurisdictions with direct exposure to potentially harmful content (for example, criminal matters, sex offences, victims of crime, family violence, Koori Court, Drug Court, ARC and NJC). In addition, large scale system reform, growth in demand, changing community expectations, cultural load, increasing client and case complexity and changing legislative requirements all have potential to impact staff and judicial workloads and wellbeing.

In addition, repeated interactions between Court staff and members of the community with unmanaged or challenging behaviours may impact staff wellbeing, unless provided with the requisite skills or being able to draw on professional social work or mental health training.

MCV's capacity to provide consistent high-quality, evidence-based responses for every client or participant affected by mental health issues requires a dual focus. The development of system-wide capacity to deliver services while simultaneously strengthening the health, safety and wellbeing of the MCV workforce is necessary. One strategy to support the wellbeing of staff is the establishment of peer support and supervision frameworks underpinned by contemporary research. Others are required to support the cultural change necessary to enhance the Court's capacity to collaborate and maintain effective partnerships.

Current systemic reforms rely on multidisciplinary coordinated approaches to address complex social problems. The Court's workforce requires new capabilities in intra- and inter-organisational collaboration to respond to complex needs and diversity and effectively share information and coordinate responses to clients across organisations and service systems.

Reforms that strengthen systems require MCV operational and therapeutic staff to develop new expertise. System reforms require the synthesis of numerous and sometimes competing organisational, professional, therapeutic and clinical frameworks. Unless design is robust and change well-managed, staff may not be provided with sufficient role or practice clarity, increasing susceptibility to burn out and vicarious trauma.

The Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework recognises that clients with mental illness—particularly women—are more likely to disclose family violence to a health care professional than police. Inadequate responses to clients who disclose violence or mental illness can be psychologically harmful, compound trauma, increase emotional distress and increase the safety risks, particularly where the client decides not to seek further assistance based on their adverse experience of help-seeking. In these circumstances, any mental illness may remain untreated and potentially increase in severity, and the client may remain in a harmful or violent relationship without an adequate safety plan or long-term recovery options.

Further work is required to develop and implement trauma-informed practices across the justice system, including within MCV. The systemic development of a trauma-informed approach requires training and support to ensure that staff are equipped to interact with clients with mental illness in ways that do not retraumatise the client and instead contributes to enhanced wellbeing and justice outcomes.[85]

A variety of responses within the justice system could be reviewed to develop frameworks and practices that improve the health and wellbeing of the client and improve the safety of the community. This cultural shift can also provide leadership that influences fellow participants in the justice system and the Victorian community; reducing stigma for those who experience mental illness and enhancing the wellbeing and safety of the individual and community.

All organisations, including MCV, must also ensure that any development is underpinned by an evidence-based framework that promotes and utilises access and equity standards when responding to change and considers the particular needs of all groups including, but not exclusive to the Koori, CALD, LGBTI, disability and regional communities.

[85] For example, the Blue Knot Foundation deliver trauma-informed, vicarious trauma and complex trauma training; see: https://www.blueknot.org.au/.

Recommendation 9: Consider legislative changes

a) Conduct an expanded review of the counselling orders scheme under Part 5 of the Family Violence Protection Act to not automatically render respondents with mental health issues ineligible for counselling programs and instead provide that clinical assessment will determine suitability and eligibility.

b) Expand mental health orders and conditions into the civil jurisdiction of family violence intervention orders and/or personal safety intervention orders.

Legislative change may be required to enable magistrates to order respondents with mental illness or other co-existing conditions to attend a service for assessment or engage in mental health treatment. Access to these services may be an important adjunct to orders, for example the counselling order provisions contained within the Family Violence Protection Act.

The Family Violence Protection Act is the legislative basis for Family Violence Intervention Order (FVIO) proceedings in the Court's civil jurisdiction. The orders and conditions for family violence respondents are limited to:

- counselling orders, to attend men's behaviour change programs, under Part 5 of the Family Violence Protection Act
- conditions as per Part 4, Division 5 of the Family Violence Protection Act, which include but are not limited to, the safety of the affected family members and children, prohibition of violence, exclusion of residence/placement of employment, variation of Family Court Orders, cancellation or suspension of firearms/weapons licenses.

Chapter 19 of the *Royal Commission into Family Violence Final Report* clearly identified that the health system, including mental health services, play a vital role in the identification and support of family violence victims. The interaction and intersection within the court environment between legal interventions and health interventions must be addressed to create a coherent, coordinated systemic response.

In relation to respondents, RCFV Recommendations 87, 89, and 90 identified that respondent interventions need to be expanded to ensure that respondents are offered the right intervention at the right time to curtail the prevalence and severity of family violence within the Victorian community. Services identified included services to address mental health of parties involved in FVIO proceedings.

It is important to note that there is a need to provide ongoing, substantive funding to ensure the longevity of integrated programs introduced to address issues of mental health and family violence.

A full review of Part 5 of the Family Violence Protection Act should be undertaken to ensure that the legislation goes beyond its current limited remit and is flexible and dynamic in its approach to family violence respondent interventions. Legislative change will support the implementation of options for court-mandated counselling beyond MBCPs and ensure appropriate respondent-intervention programs are available for sibling abuse, elder abuse, Aboriginal and Torres Strait Islanders, people with mental illness, physical and/or intellectual disability, culturally and linguistically diverse populations and people of all sexual orientations and gender identities.

Any review should address and ensure that access to mental health services is an automatic consideration in relation to both the respondent and affected family members when making

orders under Part 5. In particular, regard should be paid to Sections 129(3)(c) and 130(2)(b)(i), which currently work to specifically exclude respondents who have psychiatric or psychological conditions and for whom suitable counselling order programs are not currently available.

Within the criminal jurisdiction, the Court can make mental health assessments to inform sentencing and requiring clients to attend mandatory mental health services as part of community correction orders.[86] These orders are designed to address the underlying causes of offending and provide the client with strategies to address and improve their future behaviour and place within the community.

There is no legislative authority to allow the Court under the Family Violence Protection Act to make an order to assess or treat an underlying mental health condition, which may affect a respondent's ability to comply with or understand an intervention order or address the family violence behaviours. Legislative change is required for magistrates to leverage these types of orders in the FVIO civil jurisdiction, in conjunction with accessing MCV specialist services such as CISP, Drug Court and the ARC List.

Recommendation 10: Research, monitor and evaluate

a) Evaluate outcomes for people with a mental health issue by Specialist Court and Programs (ARC, CISP, Neighbourhood Justice Centre, Koori Court, Drug Court, Specialist Family Violence Court) in relation to:
   - reduced recidivism
   - diversion of clients from the justice system
   - facilitating access to, and engagement with, appropriate treatment and support services
   - enhanced quality of life
   - re-engagement with the community.

b) Broaden approach to evaluation of Specialist Courts and Programs beyond recidivism rates by adopting qualitative research methods to look at wellbeing, lifestyle and health outcomes and process (in alignment with the principles of therapeutic jurisprudence and procedural fairness) and trauma-informed practice.

c) Examine the capacity of the mental health system to respond and provide appropriate support to clients, including post-release from custody and Aboriginal people.

d) Examine barriers to effective exit planning for people with mental illness either completing sentence or being released on bail.

e) Develop long-term, committed and well-organised education and advertising initiatives aimed at improved interventions and greater inclusion of people with dual diagnosis. Different approaches and messages that draw from the lessons learned from other successful initiatives and programs could assist in developing effective educational tools to effect culture change through increased community understanding and awareness of the effect of dual diagnosis.

[86] The Sentencing Act, Part 5, Part 3A and Section 48D.

High-quality research, monitoring and evaluation is critical to the continuous improvement of the mental health sector and justice programs and courts in reaching their goals and achieving results including meeting the needs of client wellbeing, reducing recidivism and enhancing community safety.

f) An evaluation of the physical design of existing court spaces (including court rooms) to assess the potential of creating more user-centred, less confrontational and intimidating spaces—similar to the design principles used by architects of the Neighbourhood Justice Centre (NJC).

Physical court environments can be overwhelmingly crowded and noisy places, with a variety of touch points that people must navigate before court appearances or accessing services at court, including security check points, appearance counters and public waiting areas. Those with severe mental illness can be negatively impacted, triggering a range of associated behaviours, whether internalised or externalised.

With infrastructure changes or other process changes, the Court could explore how to support people to reduce auditory and other physical sensations to ensure those with mental illness have a space within courts that does not exacerbate trauma or triggering behaviours. Changes to practice should include options for deferred court attendance when this is in the client's best interests.

Recommendation 11: Expand the Neighbourhood Justice model across Victoria.

Community courts aim to increase offender accountability through therapeutic jurisprudence practices that encourage greater engagement of the offender with the Court, together with strict enforcement of noncustodial sanctions.

The Neighbourhood Justice Centre in Collingwood is currently Australia's only community justice centre. Inspired by the highly-successful Red Hook Community Justice Center in New York, the Collingwood NJC's achievements through its work with disadvantaged clients (including those with mental illness) in terms of reduced recidivism, a reduced crime rate and increased order compliance are detailed in section 5.7 of this submission. MCV recommends the expansion of the NJC model across Victoria to build on the benefits of the community justice model evidenced at the Collingwood NJC.

Locations that would most benefit from an NJC model would be those that have high levels of multi- generational socio-economic disadvantage, poorer health outcomes and higher-than-average crime rates, but which also have a relatively strong or emerging community sector able to support a community court model. Possible suitable locations include Sunshine, Geelong or the Latrobe Valley region.

The NJC's problem-solving approach for clients—including those with mental health issues—is strengthened through the NJC Officer role, which convenes Problem-Solving Meetings (PSM). This is a voluntary facilitated out-of-court process with the client, court staff, service providers, family and/or support people to discuss issues the client is facing while engaged with the justice system. The PSM can act as a 'circuit breaker' to motivate and enable clients to change persistent patterns of behaviour.

While the NJC has not yet calculated the direct and indirect savings it has generated from its improvements in community order compliance and recidivism, the principles of 'Justice

Reinvestment'[87] suggest that the savings in overall criminal justice spending resulting from the NJC's demonstrated improvements in community order compliance and recidivism should be calculated and reinvested.

Direct savings in overall criminal justice spending flowing from NJC's outcomes include savings in:

- policing costs
- corrections systems costs
- ongoing cost burden on the Victoria's universal services system (primarily health, human services, housing services) of disadvantage associated with a person's interaction with the criminal justice system.

Indirect savings include a reduced burden on the Victorian economy of disadvantage (primarily unemployment and poor productivity) associated with a person's interaction with the criminal justice system.

[87] See: http://www.justreinvest.org.au/what-is-justice-reinvestment/

Appendices

Appendix 1: MCV Specialist Courts and Programs by location, July 2019

Region	Court	Family Violence[1]					Court Support and Diversion Services						Koori	Drugs	Forensic	Volunteer
Barwon South West	Geelong										R		A/C			
	Colac										R					
	Hamilton										R		A/C*			
	Portland										R		A/C*			
	Warrnambool										R		A/C*			
Broadmeadows	Broadmeadows												A			
Dandenong	Dandenong												A/C			
Frankston	Frankston	F														
	Dromana										R					
	Moorabbin	F									R					
Gippsland	Latrobe Valley (Morwell)							F					A/C			
	Bairnsdale						F		F		R		A/C			
	Korumburra										R					
	Omeo										R					
	Orbost										R					
	Sale						F		F		R					
	Wonthaggi						F				R					
Grampians	Ballarat	F														
	Ararat										R					
	Bacchus Marsh										R					
	Edenhope										R					
	Hopetoun										R					
	Horsham										R					
	Nhill										R					
	Stawell										R					
	St Arnaud										R					
Heidelberg	Heidelberg	F			O			F					C			
Hume	Shepparton	F				F							A/C			
	Benalla										R					
	Cobram										R					
	Corryong										R					
	Mansfield										R					
	Myrtleford										R					
	Seymour										R					
	Wangaratta										R		F			
	Wodonga										R		F			
Loddon Mallee	Bendigo												F			
	Castlemaine										R					
	Echuca										R		F			
	Kerang										R					
	Kyneton										R					
	Maryborough										R					
	Mildura										R		A/C			
	Ouyen										R					
	Robinvale										R					
	Swan Hill										R		A/C			
Melbourne[2]	Melbourne[3]				O								A/C			
	Neighbourhood Justice Centre[4]		✓	✓		✓	✓	✓							✓	
Ringwood	Ringwood										R					
Sunshine	Sunshine															
	Werribee		PT	PT							R					

Key to table on next page

Specialist FV Court
FV Applicant Practitioner
FV Respondent Practitioner
LGBTI applicant & resp. FV workers
Umalek Balit (Koori FV Program)
Court Integrated Services Program
Koori CISP Case Manager
Assessment and Referral Court List
Court Advice and Support Officer
CISP at Bail and Remand Court
Criminal Justice Diversion Program
Enforcement Review Program
Koori Court Division
Drug Court
Mental Health Advice & Response Service
Court Network

KEY	
Headquarter court	
Satellite court	
A	Koori Court, adult jurisdiction (Magistrates' Court)
C	Koori Court, children's jurisdiction (Children's Court)
F	Future court/program
O	The LGBTI applicant and respondent FV workers from NJC also do outreach at Melbourne and Heidelberg Magistrates' Courts
PT	Part time
R	Diversion service provided by general registry staff
✓	NJC provides a comparable service onsite (CSV employee)
✓	NJC provides a comparable service onsite (specialist community service organisation)
*	Warrnambool Koori Court circuit (available on rotation)
1	Ballarat and Heidelberg are current Family Violence Court Divisions; Frankston and Moorabbin are 'relevant' courts; Shepparton to be gazetted as a Family Violence Court Division
2	CISP Remand Outreach Program (CROP) has 13 FTE positions in Victorian prisons
3	Koori VOCAT list available at Melbourne Magistrates' Court
4	In addition to the services indicated in table, NJC also provides the following services onsite via staff from specialist community service organisations: • housing • new arrivals support • financial counselling • general case worker • victim support • chaplaincy All services are available to clients of the NJC Court and City of Yarra residents

Appendix 2: Specialist Family Violence Courts core principles

Each victim survivor affected by family violence is recognised as a client of the court in their own right.

Victim survivors will be supported to navigate through their court experience. They should not carry the burden of family violence alone. When exercising its powers to hold perpetrators to account, the court will retain as its primary purpose the physical and psychological wellbeing of victim survivors.

Dynamic risk assessment and management occurs at every point in the court journey and drives decision making.

Risk assessment and management is continuous, collaborative and embedded in court processes. It will be underpinned by a shared understanding of risk, and whole-of-government frameworks and tools.

Each interaction with a victim survivor or perpetrator has therapeutic potential that should be maximised.

Therapeutic jurisprudence in the SFVCs has twin aims: to keep victims safe, and to hold perpetrators accountable. Every member of the SFVC team and broader court staff has a role to play in delivering a therapeutic jurisprudence approach.

A specialist family violence response must reflect the diverse needs and backgrounds of the community it serves.

The court model has been designed with the diversity of court users in mind, and further recognises that some court users may experience overlapping forms of discrimination. The SFVC team will act with empathy and work to advance the rights and dignity of all Victorians.

The SFVCs will act as centres for excellence in integrated service delivery and partnerships.

The court event is only one moment in an individual or family's journey, and courts cannot achieve positive change for people affected by family violence if they operate in isolation. The SFVCs will take a lead role in breaking down silos and driving a shared vision of change with service system partners.

The SFVC model will adapt and change as our knowledge of what works in family violence evolves.

What is leading practice now may not be leading practice in five or ten years. To continue to keep our communities safe and free from violence, the SFVC model will need to be continually reviewed and strengthened based on best available evidence and data.