ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Held via Zoom

On Tuesday, 9 June 2020 at 9am

Before: Ms Penny Armytage AM (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Mr Stephen O'Meara QC
Ms Georgina Coghlan
Ms Fiona Batten

THE CHAIR: Good morning, everyone. Welcome to the Commission's panel discussion on the interaction between our mental health system and our justice and forensic testimonies.

I am Penny Armytage, the Chair of the Royal Commission into Victoria's mental health system. I'm joined by my fellow Commissioners, Professor Allan Fels, Dr Alex Cockram and Professor Bernadette McSherry.

On behalf of the Commission I acknowledge Aboriginal peoples as the traditional owners across all the lands on which we are located for today's panel discussion and I pay my respects to their Elders past, present and emerging.

The Commission had sought the participation of Dr Emma Cassar of the Department of Justice and Community Safety in today's panel. Due to ongoing work across the Department as part of the response to Covid-19, Dr Cassar was unable to attend. The Department of Justice and Community Safety has instead provided a statement addressing a number of the key issues which will be explored today. This statement will be accessible through the Commission's website, together with the transcript and video from today's panel discussion.

We would like to discuss with you and seek your views about the critical topic of people living with a mental illness and their involvement in the forensic mental health system and the criminal justice system more broadly. When we speak of the criminal justice system, this includes the courts and corrections system and the involvement of people living with mental illness with police.

The Commission has received a wide variety of submissions which identify this as a critical topic. In its submission to the Commission, Victoria Legal Aid summarised the tenor of many of these submissions when it states that:

> *There is an over-representation in the criminal justice system of people, including young people with mental health issues. The justice system must not be the default mental health service provider.*

The submission goes on to say that people experiencing

mental health issues are at a greater risk of contact with the justice system and are over-represented in the prison and Youth Justice populations.

This is not a new problem. The Burdekin Report of 1993 is a seminal Human Rights and Equal Opportunity Commission national report into the human rights of people living with mental illness. Twenty-seven years ago the report concluded that many people were taken into custody or had their detention prolonged as a consequence of their mental illness or disorder going untreated, and that, untreated mental illness clearly causes some people to behave irresponsibly, irrationally or in a bizarre fashion. Sometimes this behaviour brings people to the attention of the police. In a small number of instances untreated mentally ill people commit violent actions against others.

In 2006 a Senate Select Committee inquiry regarding a national approach to mental health reached the same conclusion. The circumstances noted in these reports in 1993 and 2006 not only exist in Victoria today, they appear to have worsened.

In its interim report, the Commission referenced the latest survey of prisoner health of those in Australian prisons which indicated that 61 per cent of people entering Victorian prisons had a diagnosed mental illness, and 35 per cent of Victorian prisoners were referred to a prison mental health service.

Further, concerns around community safety have resulted in significant legislative reforms to the bail and parole systems. This has led to a large increase in the number of people imprisoned and on remand which appears to have exacerbated the situation for those living with mental illness.

We will be asking you questions today about how these issues might be addressed in an enduring way. I want to emphasise that our examination of these issues is not about laying blame or finding fault. Rather, our enquiries are very much forward-focused. We want to understand the various impacts which the Justice, Corrections and Forensic Mental Health systems have on people living with a mental illness. Importantly, we want to explore how these systems might be improved for the benefit of those engaged with them and the community more broadly.

A redesigned mental health system must enable consumers to access the treatment and support they need when they need it. In doing so, our services must respond, not only to the needs of individual consumers, but to our shared aspiration for a safe and connected community.

We must be able to do better for people like Leona, who in her evidence to the Commission stated:

> *When I think about my offence I feel like I had hit rock bottom, like the light inside me went out. It felt like I had charcoal in my chest and I lived like that for years and years.*

Today's panel discussion is just one way that the Commission is conducting its enquiries on this matter. In addition to considering the inputs received so far, the Commission is engaging further with consumers and carers as well as the mental health workforce to hear about their experiences and ideas for improvement.

Finally, on behalf of the Commission and my fellow Commissioners, I want to extend my gratitude to Mr Dan Nicholson, Ms Julie Edwards and Dr Shaymaa Elkadi. I know each of you have put a considerable amount of effort into preparing for today's discussions, we look forward to hearing your views, insights and ideas for change.

I will now ask Counsel Assisting, Georgina Coghlan, to provide some opening remarks before we formally begin the panel. Georgina.

MS COGHLAN: Thank you, Chair. I too extend thanks to Mr Nicholson, Ms Edwards and Dr Elkadi, they've all contributed so much time and energy to this process for which we're very grateful.

I should note that each panel member has provided a written statement which will be published on the website. Those statements cover a range of issues, not all of which will be touched on today. All panel members responded to a number of questions for the purposes of the panel discussion and some of those will be explored further today.

The purpose of this panel discussion, as the Chair said, is to share ideas on topics, identify points of agreement and disagreement if they exist.

At this point it's helpful to outline in broad terms some of the areas that will be addressed in today's discussion. Firstly, the over-representation of people with mental illness in the criminal justice system, the community discourse around mental illness and offending, problem solving courts and processes such as the Assessment and Referral Court, Neighbourhood Justice Centre, Koori Court and Drug Court, treatment and support in a custodial setting, and also treatment and support in transitioning in and out of custody.

The panel will discuss these topics in relation to adults and young people. Whilst the panel members may have different views as to the appropriate age bracket for young people in the context of the criminal justice system, and it is an evolving space, for the purpose of this discussion the panel members agree to approach it on the basis of an 18 to 25 age range.

Can I now just briefly introduce our panel members. Mr Dan Nicholson is the Executive Director of Criminal Law at Victoria Legal Aid and the Executive Director for the Western Suburbs at VLA. He is responsible for the delivery of legally aided criminal law services across the state. He has also held the role of Commissioner at the Victorian Law Reform Commission since 2018.

While VLA works directly with clients who are in the mental health system, much of their work with clients experiencing mental health issues is in their day-to-day work in mainstream systems for summary crime, indictable crime, child protection, family law, family violence, discrimination, social security, migration, tenancy, NDIS and prisoner legal help.

Ms Julie Edwards is the Chief Executive Officer of Jesuit Social Services. Ms Edwards has over 40 years of experience engaging with marginalised people and families experiencing breakdown and trauma. Jesuit Social Services is a social change organisation. It provides programs and advocacy around six main areas, two of which I'll highlight particularly for the purposes of the panel discussion today: justice and crime prevention for people involved in

the criminal justice system, and also mental health and wellbeing support for people with multiple and complex needs and those affected by trauma, suicide and complex bereavement.

Dr Shaymaa Elkadi is the newly appointed Executive Director of Strategy, Planning and Performance at Forensicare. Prior to that she was the Executive Director of Community Operations. In that former role Dr Elkadi's responsibilities included oversight of Forensicare's community forensic mental health service, partnering with Forensicare's clinical leaders to enhance organisation-wide clinical governance, ensuring delivery of service models, and organisation-wide leadership of various stakeholder portfolios.

Dr Elkadi's previous appointments include Clinical Governance and Performance Lead at Beyond Blue, and General Manager Rehabilitation and Re-Integration, Corrections Victoria.

On that note, perhaps if we can now commence with the panel discussion, and I propose to approach this by identifying the topic and then proceeding with a question and directing that to one of the panel members.

The first topic today that we'd like to canvass is the over-representation of people living with mental illness in the criminal justice system. And so, many of you have said in your statements and the Commission has heard time and time again that it's well accepted that there is this over-representation.

Perhaps if I could direct this first to you, Mr Nicholson, and pose this question: what can be done to prevent people with mental illness becoming involved with the criminal justice system?

MR NICHOLSON: Thanks, Ms Coghlan. So, I think we would identify three broad areas for change and I'll touch on each of those without running through everything in too much detail. The first is, we've identified in our submissions and recommendations and come through in the interim report that there's this big gap in the mental health system between the sort of 10 sessions by Medicare, and crisis and acute services where people often end up losing their liberty and autonomy and coming into contact

with the criminal justice system.

So, you know, the first issue is really about that missing middle of mental health services that doesn't have anything to do with the criminal justice system, that enables people to manage their mental health in the way that works for them, and enable their treatment to flex up and flex down in the community.

The second big area which I'll spend a bit more time on is really for people experiencing mental health issues, the net of the criminal justice system is just cast too wide. So, we see a number of factors in play in this net being cast too wide.

First is, the system has defaulted to police as the first responders for mental health issues and, while individual police do their best, the reality is that that just increases the likelihood of criminal justice involvement, and so we'd like to see as much as possible specialist health providers responding, or where police do need to respond, that it's done on a joint response like the existing PACE or mental health police response initiative.

And also, where police do and police inevitably will respond to people experiencing mental health issues on their own, that they're better trained to do that.

Then, when we see police involvement with people experiencing mental health issues we think we just have the wrong toolbox, I suppose, would be the best way to describe it, and some of the key reforms that we'd see to improve that net widening is summary offences reform, so particularly offences that disproportionately affect people with mental health issues like an addiction, you know, begging, offensive language, small scale drug possession; we think they should be removed from the current statute book as summary offences.

We'd like to see better access to caution and diversion and that's something we may touch on later in the discussion, and better charging practices, and I think there are some particular issues with children, you know, particularly the move from the child protection system into the contact with police, and we'd also like to see the age of criminal responsibility raised.

Another significant net widening issue that we've seen in recent years is the impact of the bail changes in Victoria, and we have seen firsthand the consequence of those changes which are probably best summarised by one of my experienced frontline managers who said, "People are more likely now to be in custody because of the issues in their lives, not the offences they've committed."

So we see a lot of people spending short periods on remand when they're not facing prison, and particularly that's acute for people experiencing mental health issues who may have difficulty complying with bail conditions, or are committing sort of repeated small-scale offences, and what that means is that they end up with short periods on remand which can be very disruptive to the environment, to the supports they have in the community but not long enough in custody to actually get support or treatment while they're there or meaningful transition.

And again, we would recommend changes which don't fundamentally change the architecture of the Bail Act but just make a number of important tweaks that would reduce those unintended consequences.

Lastly, I think when people do enter the criminal justice system, people find themselves unable to get out of it and it hinders their recovery, rather than what we see which is the opportunity for the criminal justice system to be a moment of intervention to help people to access supports and services, deal with the underlying causes of offending and support their recovery, and again, there are a number of things we can touch on in the course of this discussion which we'd recommend as change, including better access to problem solving courts, better support in the community, for community corrections orders and bail, and for those who are in custody, better treatment of support in custody and then the ability to transition out.

So I suppose I've covered a lot of ground quickly, but they're the three big areas that we see lead to over-representation and some of the areas where you could make significant change to improve that or reduce that impact.

MS COGHLAN: Thank you, Mr Nicholson, and we'll come back to some of those areas you touched on further in the

discussion, but can I direct that question to you, Ms Edwards. We just need to get you unmuted.

MS EDWARDS: Thank you, and thank you for the opportunity to present and be with you today, all of you, it's a very important issue close to our heart and I appreciate the opportunity. The architecture, I suppose, of the system from the most early intervention through to transitioning from custody that Dan Nicholson has presented is one that I accept and I probably will just be repeating a number of things which I won't do because I'm accepting that, but I will just add a few things.

I think some high-level overarching matters that need to be considered are housing; that's a huge issue for people with mental illness and people who get trapped really in the criminal justice system, but it's also a range of housing options with support, and that needs to be - the mental health service side of things needs to be delivered in a more flexible way.

One of the things that we note is increasingly - you know, we would say that the medicalisation of the mental health system means that even, for example, psychologists who we would hope would be more community connected often are not comfortable engaging with people in non-clinical settings, and that for us is really important. That people would be able to connect with people in their housing or special accommodation or other facility where they are living.

The other point I'll bring up about that which Dan has already referred to is the early intervention or early detection of people at early points of engagement. We know that people will end up at an Emergency Department many, many times with some mental health crisis before they get proper treatment. Often they are discharged and end up actually then, next time they're picked up it'll be by the police or in that system, so we think there are opportunities along the way and I would suggest Emergency Department is one such place where better intervention could be put in.

I think the embedding - our own experience of embedding, for example, a nurse with our Reconnect Team, so the team that works with people in the criminal justice system, has been very positive. So, a nurse or mental

health practitioner embedded with teams of case managers, whether that be Department case managers who are doing - with people on community corrections orders for example, or with organisations like ourselves, community service organisations who are doing that, I think that would be another pickup point where we could strengthen and divert people's engagement, including actually with police. We have seem some models overseas - well, I haven't seen them up-front, I've been reading about models overseas about police having social workers, and we do have some examples of that embedded with teams.

We are right now trying to do that in the area of adolescent family violence, because one in 10 call-outs for police around family violence are around adolescent family violence, and that is actually a big pickup point for young people and then gets criminalised and into the Justice system, so we'd like to see some alternatives there.

It will probably come up later, but there's the big elephant in the room in a way, which is men. We know that 93 per cent of the - approximately 92, 93, 94 per cent of the prison population is male, so if we want to intervene earlier I think we have to do something about that. Now, how far we go back in terms of trying to change patriarch and gender norms socially, I'm not sure what we need to do, but the reality is, this is something I think we have a blindness about. That's largely who we're talking about in this crossover around criminal matters and mental illness, and I think it's something that we need to pay greater attention to.

I think I'll leave it there, thanks, Ms Coghlan.

MS COGHLAN: (Inaudible).

DR ELKADI: Sorry, I was just unmuting myself. Thank you also for the opportunity to speak and to be here today. I think we're in agreement on the key issues that we've just spoken about in terms of the over-representation of people with mental illness in the criminal justice system.

What I do want to highlight is three aspects and I think the fundamental principle is around flipping the investment. There's a lot of investment in the criminal justice system in terms of various types of rehabilitation and re-integration services, but actually one of the

fundamental issues is around that early identification and assessment and early kind of holistic supports and being able to pick up those risks of mental illness and serious mental illness early, whether that's through schools, sporting clubs, hospitals, obviously the policing response as well, but actually to pick those things up early and have the appropriate kind of response early on as part of that early intervention and really that being a key part of prevention, I guess, that further kind of escalation into the criminal justice system.

We know that there is, as Dan mentioned, that missing middle. We might have some pockets of services at the beginning, but really, they are also in some ways too late; we need to be thinking about, for young people, how we identify serious mental illness for some of those particularly vulnerable communities, Aboriginal communities, refugee communities, how do we pick up those signs of serious mental illness early and well before they're in the criminal justice system, and providing an appropriate comprehensive wrap-around response.

And, I know we'll talk a little bit about some of those kinds of areas of support, but really, Julie's mentioned housing, but it goes beyond housing; it goes to alcohol and drug services, it goes to living skills, family and community connectedness; all of those things need to be part of that early or really comprehensive assessment opportunity and then a response to address the needs that are identified through that process.

The other two aspects that I wanted to emphasise is the diversion. There's been lots of talk and reviews of diversion over the years and I think, again, if we look at it from a staged process and trying to minimise people coming into contact with the criminal justice system, diversion being a more kind of proactive strategy I think is critical, and diversion again supported by the relevant community connections and supports that are necessary to keep people out of the system and to keep people from offending and re-offending.

The other aspect I wanted to emphasise is the post-release once people are in the criminal justice system and I know we will talk about this later, but I think if we're wanting to really impact the lives of people with serious mental illness who come into contact with the

criminal justice system, we also need to accept that some will and always will come into contact with the justice system, and it's how we support them when they leave and making sure that that support is in the best possible position to minimise those recidivism rates for people with serious mental illness and to actually have an intensive response that works with people in the long-term. We know that they're in the system because of long-term issues and so we need to work with them for the long-term when they come out of the system.

MS COGHLAN: (Inaudible).

DR ELKADI: Sorry, you're muted.

MS COGHLAN: Thanks. Thank you, Doctor. Ms Edwards, can I just go back to you for a moment. You've touched on the cohort of men, Dr Elkadi's touched on refugee and indigenous communities; can I just ask you, were there special or different needs of certain communities in terms of how to prevent involvement with the criminal justice system and those people with mental illness?

MS EDWARDS: Yes. We also work in the settlement and community building space and we are regularly advocating to the Federal Government for better settlement programs, so I think that is an issue both in terms of English classes that the support goes longer than the first five years, so I think there's a range of things that we need to do to help the settlement experience be a more positive one, and I think that would help prevent the penetration of the justice system.

We work with Aboriginal organisations like VACCA and VALS and VACCHO, et cetera, and of course the issue of over-representation of indigenous people is a massive one. What we've experienced being the deliverers of the transitional support over many years is sort of a changing feast of sometimes the ACCHOs are funded to provide that support, then that gets withdrawn, et cetera. We think that there should be an indigenous-specific response to Aboriginal people exiting custody and that those organisations should be supported to do that.

What often happens is, sometimes it happens for a while, then perhaps targets aren't met or something and then it's withdrawn, and organisations like Jesuit Social

Services have good track records of working in partnership with ACCHOs for a period of time, perhaps providing some of the monitoring and support roles around evaluations, et cetera. I think there are ways, I think we can be more creative about how we do that.

In terms of particular groups, I suppose I also wanted to mention young people, whether we say up to 25, as a particular group, that 18 to 25-year-old age group which I think we need a specialist response for; whether it be in terms of at the court, but also in custody and in the transitioning, so I think that's a particular cohort as well.

MS COGHLAN: Thank you, Ms Edwards. Mr Nicholson, can I just ask you about that as well, just whether there are particular groups that there are specific ways that they could be prevented from entering the criminal justice system, just bearing in mind those individuals impacted by mental illness in particular.

MR NICHOLSON: Sure, and again I agree with a lot of what Ms Edwards has said and I won't repeat that. But I think as a general proposition the criminal justice system in particular hasn't been very good at listening to the users of the system or the consumers of the system, and so, a big part of that redesign is actually engaging in much more design by consumers and that will help us understand the different experiences that particular groups have, in addition to Aboriginal people and young people. I would also just add, people with dual diagnosis of disability and mental health conditions and we see that's a significant area where people are falling through the cracks, perhaps not able to sufficiently access either set of services, or there aren't services out there that have the right skills or funding or workforce to manage both.

We've been particularly concerned about NDIS rollout not fulfilling its promise with that more individualised set of services built around a person; in fact, people are falling through the cracks more and losing services they had access to through the NDIS rollout, and what we're seeing as a practical consequence of that is, people are ending up in custody because they are arrested, there's not great support in custody for them, and they may lose, once there's some justice system involvement, they'll often lose the NDIS supports or other supports they've got on the

outside and will end up spending significant time in custody because of those gaps. So, that's another particular group that I think we need to address.

MS COGHLAN: Thank you, Mr Nicholson. Dr Elkadi, can I move to you just on this topic that we're covering at the moment, would you like to comment on that?

DR ELKADI: Yeah, I think there is - the broad principles of kind of rehabilitation in the criminal justice system are around the what works literature and one of the key principles around that is that responsivity. So, I think whether we're talking about broad kind of rehabilitation programs or we're talking about people with serious mental illness, the responsivity principle is critical in understanding the needs of particular cultural groups and the needs of particular vulnerable groups in the community and how we respond to them. You know, understanding the cultural responses to serious mental illness in certain cultures in the community is critical to actually getting a better outcome for those rather than waiting until they're in the justice system and service responses are limited.

It's a really interesting question around co-design in the criminal justice system, because it's certainly one where, if you ask a lot of women in the past having done lots of workshops with women in prison, men in prison, Aboriginal men and women in the community around their experience of the criminal justice system, there is an enormous amount of experience and I guess intelligence, if you like, that we can learn from, where in some ways they can tell us exactly all the things they thought they needed and perhaps sometimes what they didn't get that they thought would make a difference to their lives, and I think that's a very important consideration and something that I don't think is considered as often as it should be.

MS COGHLAN: Thank you, Doctor. Can I just stay with you for the moment and just ask you to elaborate on a point you made earlier about the importance of diversion, and just to understand what greater role diversion can play - and I'm asking this question broadly, not necessarily in relation to specific groups - again, focusing on those interacting with the criminal justice system and with mental illness or mental health issues.

DR ELKADI: Sure. So, I guess in kind of considering the

role of diversion in terms of keeping people out of the justice system, the critical element of that is about being able to, one, identify a response or a behaviour for someone, you know, and this is generally often at the moment most often the case in terms of a policing response; people come into contact with the police because of their behaviour, some of which has been described as bizarre, irresponsible, erratic, and actually being able to provide a response that takes them away from the criminal justice system by referring them to various agencies that can provide them with support, understanding what supports that they may already have, that they need to kind of strengthen, and actually providing a more integrated response rather than really just, either the cautioning, or even at the moment where some of the responses are to send them to an Emergency Department.

Now, while that may be an option, but actually we know how pressured our Emergency Departments are and they're not a mental health response, and they struggle, and in our experience looking at people discharged even from prison, they do struggle with the process of assessment and really kind of having the resources to assess someone's mental health needs, and actually to be able to link them with the appropriate services, whether that's housing or any other kind of emerging crisis services.

So the principle being that diversion on its own has to encompass a whole range of supports and facilitation of connections and community linkages that allow that diversion to really have a meaningful impact, otherwise we're just talking about repeated kind of episodes of diversion, if you like.

MS COGHLAN: Thank you, Doctor. Ms Edwards, can I direct that question to you: what increased role can diversion play?

MS EDWARDS: I think there's a point also, you know, how we describe diversion, whether we're talking about police or at the point of court, et cetera, but I think again, and we can't have social workers or maybe embedded with police teams everywhere, but there are particular times we're aware when police are called out to situations where, by having someone with, say, social work expertise or clinical expertise in the team - and again, I'm going back to our experience of adolescent family violence - is a really good

intervention to actually unpack the situation, perhaps make arrangements for the young person to be somewhere else for 24, 48 hours, while things are sorted through about what's the next step about keeping everyone safe.

At the moment there is, in that area for example, there's nothing else to do other than take the person into custody, to charge a person and take them into custody, so that's one area where we're seeing a lot of growth and we think it would be important, and it's early on in that person's circle in terms of violence as in we're talking about people under 18, so that's just a practical example.

I think, again, diversion from further penetration of the justice system, we would like to see, I suppose as a basis, that short-term sentences don't exist. For example, in Norway where we spent some time on a study tour, offences that were under a certain period of time, 12 months, 18 months, 2 years, actually those people never got to serve those sentences in custody.

By nature of the sentence, it was clear that it wasn't a violent offence, for example, so I think we could do some work to identify how we can keep people who have committed non-violent offences out of further penetration in the system, which then leads to, how do we get a range of community arrangements in place that can support, because I agree with what Shaymaa was saying, there's no point just diverting back, diverting into nothing. I think it's an identification point to get other services in place, rather than just delaying. Sometimes diversion can be delaying what's ultimately going to happen, there needs to be some intervention at that point.

If I go back to the very early part of the system though, I think it's important that the challenge there is not to just do a net widening thing. So, for example, with young people, the diversion program that's in place now through the courts is actually very good in terms of setting up a program that the young people comply with, in which case it doesn't even have to come back to court.

So, I think we just have to be aware at the very front-end our diversion program shouldn't actually become inadvertently a net widening program because we're guaranteeing that the young person will get some service at least and therefore magistrates and others are keen to

bring them in so at least they get something, so I think we have to watch that. When we talk about diversion it's good, but we don't want to bring more people into the system, and sometimes inadvertently that's what diversion programs can do, so they need to be geared to and they should actually be provided by community-based organisations rather than police and rather than by government departments, we believe, in that early stage, and then I think you can look along the continuum about what diversion means at different points.

And the other point I just reinforced then is at court, and we would like to see a presumption that short-term offences/sentences don't get served in custody. There's an enormous amount of, not just young people, of people who serve sentences, sometimes 14 days, many, many, many people, I haven't got the statistic with me now, but under 12 months.

And again, I'll just share a brief anecdote. When I was in Norway and I was talking to the Governor of one of the prisons there, he couldn't believe it, and he said, "So you've got a whole lot of people who are just churning in and out under 12 months?" And I said, "Yes", and he goes, "That would be a nightmare to manage as a prison governor."

And he talked about, everyone who comes into his prison, he's got there for two years. The others you just deal with some other way in the community, a range of community arrangements. It can be still perhaps turning up every day, electronic monitoring, perhaps even having to go in weekends and stay somewhere and do some therapeutic programs, but what he was saying is, everyone I've got is here for two years, the others have been dealt with elsewhere, and it means we can do some serious programs.

MS COGHLAN: Thank you, Ms Edwards. Mr Nicholson, can I direct that question to you.

MR NICHOLSON: Sure, so I mean, I think there's lots of elements to what we can broadly call diversion: so there's the pre-charge cautioning process and there's the post-charge diversion process, and then there's what are the measures we can use at court to divert people out of the system. But I suppose generally, you know, where people have come into contact with the criminal justice system because of mental health issues they're

experiencing, then for us it's clearly preferable and the evidence backs this up, for them to be diverted out without a charge or without a formal finding of guilt by a court.

You know, unfortunately it appears that the numbers of diversions and cautions are actually reducing in Victoria, even though it's a great success story, and the number of at court charge processes is increasing, even though generally the crime rate isn't particularly rising, so that's an unfortunate trend that needs to be addressed I think.

And I agree that the diversion to services is crucial, but it's also very important, as Ms Edwards said, that we don't impose so many conditions that police may be supervising, that in fact rather than diverting people out of the system who should never have been there to treatment and recovery, that we don't actually inadvertently drag them in further.

So, the referral to services, properly funded services is really important, but that's not the same as a whole lot of onerous conditions on cautions and diversions.

And I would say generally that we find that we spend a lot of time making the case with police for cautions and diversions to take place, and often that's rejected in what we think are suitable cases. So, we support removal of the police veto on diversion which we have in Victoria, and also court's ability to caution in the same way that police can which they have in New South Wales. Because, for me, diversion is like any other activity at court, if you like, it's not a sentencing disposition but it's similar, which is that the view of police is relevant but it shouldn't be determinative, so that a magistrate should be able to order diversion even if police disagree and that's not the case and that has a significant impact in our experience.

I can just touch on the short sentences issue if that's helpful at this point since Ms Edwards has raised it, and that is that we agree. I mean, I think generally, if you look at overseas jurisdictions, comparable jurisdictions, short sentences are on the way out, and there are various presumptions against short sentences and presumptions in favour of community supervision for short periods in other jurisdictions, which there's some more detail about in my statement and in some of the work Legal Aid's provided.

In Victoria we're going the other way particularly because of the unintended consequences of the bail laws, which is a very large number of people cycling through for short periods of remand and then, as the SAC data - Sentencing Advisory Council - shows, often being sentenced to time served in custody.

As I said before, really those short sentences are long enough to disrupt your supports on the outside but not long enough to get any help on the inside, and so, it makes it almost impossible to do proper transition planning when you have a large number of people coming through the system in short compass.

There's a range of views about presumptions against short sentences and it will only work, I think this is the crucial thing, if there is very significant investment in community supervision and community corrections, because otherwise there is the risk of just sentence escalation, if you like. You know, if you can't sentence someone to less than three months, well then you'll give them three months but they may have got a shorter period. The crucial thing in making it work would be proper investment in community supervision through community corrections orders or similar.

MS COGHLAN: Thank you. Mr Nicholson, can I just stay with you, I'm going to move onto the topic of community discourse, and the question I have is, how can a better informed community discourse around mental illness and offending be achieved?

MR NICHOLSON: Yes, so that's a big question. I mean, to start to acknowledge the issue, the first thing to say is that we do in Victoria have a particular concern about crime. If you look at the public issues data, people in Victoria are much more concerned about crime or law and order than other jurisdictions, even though statistically we are as safe or safer than most. There is a particular disconnect in Victoria between concern about safety and the reality which needs to be addressed, so there is work to do.

I would say that generally the debate about criminal justice in Victoria is fairly impoverished. So, as long as debate about criminal justice is dominated by three-word

slogans, it's very difficult to have a meaningful debate, and we need to have discussions about criminal justice. In particular about the intersection of criminal justice and mental health that extends to whole sentences and whole paragraphs, not just three-word slogans.

And also this division into good and evil, the wrongdoer and the wronged, which is strange because I think everyone actually can relate to the idea that a person is more than the worst thing they've done. It's not a difficult concept, everybody can relate to someone in their lives they know who's made mistakes and is not just the worst thing they've done.

In terms, I guess, of the way forward: first, if we've learned anything from the past few months it is that, if we lead with the evidence and do what's right, not what might just be popular in order to keep society safe, then the community actually responds well. And so, I hope we can learn some of the lessons of the recent months in the way that we talk about criminal justice in the future.

The second is, I think that we have forgotten how to tell the stories of our success, so if anyone has had the chances I have to go to a Drug Court graduation. For those who aren't familiar with it, if you get through the two years of your drug treatment order, at the end of the two-year period you actually have a graduation ceremony in the Magistrates' Court with the magistrate, the police prosecutor, the defence lawyer and others who give speeches, you get a certificate, you get a photo with the magistrate. It's the most extraordinarily joyful experience you'll ever have in a Magistrates' Court. Because what it does is, it tells the complex story of the person who's come through very often trauma or homelessness or significant mental health issues and addiction and turned their lives around with the right support and the right time and space.

So I think we have to trust ourselves to tell those complex stories and that people can turn their lives around, and successful stories, because there are plenty of those out there, otherwise all people hear is the failures in the system when they read about significant and serious crimes.

MS COGHLAN: Thank you, Mr Nicholson. Dr Elkadi, can I

direct that question to you.

DR ELKADI: I mean, Dan's just articulated that exceptionally well. You know, it's a really unpopular conversation to have when you're talking about someone who's done something really terrible. We know from incidents over the last few years that the conversation is overly simplistic and the debate just isn't really there about how we can respond in more meaningful ways, and the response of our criminal justice system solely isn't enough and we already know it's not working.

So I think one of the things that, you know, just to kind of reinforce Dan's comments is, as much as it is unpopular, I think if we can have that conversation, a more sophisticated conversation about the interface between serious mental illness and offending behaviour and have the community kind of be part of that and will bring them on the journey and that will always be supported by the evidence, because we already know that the evidence is there.

I kind of think about this also in the context of other jurisdictions and the Yellow Ribbon Project that's in Singapore and, whilst we may not necessarily agree with some of the prison operations in the Singapore environment, the Yellow Ribbon Project over there has been a remarkable success in the community owning recidivism outcomes and being part of that re-integration process for people coming out of prison, and recognising that everyone has a role to play, it's not just police, it's not just the prisons, it's not just the community corrections officers, actually every part of our community has a role to play.

And we have had some good success in some of these conversations in the community. Beyond Blue has opened the doors around what is mental illness and how to be aware of it and how to respond to mental illness in a way that is incredibly positive and has been incredibly engaging for the community over 20-odd years. It's really that conversation that now needs to move forward to the more difficult part and to sort of that more pointy end and more complex part, because people can live absolutely with mental illness and serious mental illness, and sometimes they do terrible things but that shouldn't define them forever.

And so, I think we've got some success in those community conversations, we just need to be brave enough to extend them further and to be more sophisticated in our debate.

MS COGHLAN: Thank you, Doctor. Ms Edwards, can I direct that question to you, please.

MS EDWARDS: Yes, thank you. Jesuit Social Services started a project, a campaign, a couple of years ago called Worth a Second Chance and that was specifically for trying to build understanding in the community around young people caught up in the youth justice system. We've learnt a bit out of that experience. Of course, we did that because, as others, my colleagues have said, Victoria's probably the safest place in the country to be, but that's not people's perceptions.

So, we also a few years ago felt that we didn't have the leadership either to implement evidence based programs compared with that being really fed by what the politicians or decision-makers thought was community sentiment, so we were interested in actually engaging with the community.

So this campaign, out of that campaign what we did was engage with the focus groups and engaged with people, and what we learnt was, first of all, as has been said, the perception is completely out of sync with the reality; in fact, when we presented at one place about the data, some say, "I think you got that wrong, love, you know, that's actually not the case", and we're saying, "No, this is actually Government stats, this is the facts."

So there's a big gap between perception and reality, and what we found was that when we were able to have an informed conversation - I mean a conversation, not a sort of a berating or just presentation of data, but actually have a conversation, getting people to contextualise the challenges that young people face, including thinking about the challenges in their own lives, because in fact it's not a separate breed of person. You know, we all actually have challenges at certain times in our lives, and to actually soften people's hearts to remember those things when they were a teenager or whatever.

What we found was that when people had that experience, members of the public, as long as they heard

that the young person was being held accountable in some way, they were able to really shift their perceptions. So, I suppose in broad, this is a restorative justice approach, so we would be keen to see that lens of a restorative justice approach applied more strongly across the criminal justice system, because ultimately what we're wanting to do is to restore a person to their family, to their community, actually back to themselves.

And I know we're going to get onto problem solving courts later, but just Dan mentioned one and that's our experience very much, and particularly when we visited New Zealand last year to have a look at those courts, it's very much about re-engaging a person back in that sense of belonging in the community we think's really important.

I just want to mention one other thing though which came out particularly out of our visit to New Zealand but also to other jurisdictions, was the leadership, and I think there's a sense that we need to get community sentiment on board, and I believe we do. But there are some places which have in a sense not waited for that, they have just shown the leadership, and I think New Zealand is one recent example of that, where Bill English who was the Prime Minister but when he was the Treasurer, or the Minister for Finance I think it was, he actually said that the justice system there, criminal justice, was a moral and fiscal failure and that it had been for 30 years.

Now, that leadership then led to Jacinda Ardern and Mr Little, the Justice Minister, being able to go through that door and get a bipartisan agreement about shifting the situation, and they began with a listening exercise around New Zealand listening to - and we've heard about the voice of people affected by that, they have the same problem of over-representation of indigenous people.

But it was actually the leadership, not necessarily waiting for the community, and I just want to say that, I think it can happen in parallel but, if we wait for community sentiment, we might be waiting a long time. And in fact, when people are listened to and get the information, they are capable of more than we think.

So, I just want to raise that point as well, I think it is a matter of leadership, not just waiting to convince the community that we're safer than they think they are.

MS COGHLAN: Thank you, Ms Edwards. Mr Nicholson, can I go back to you. We're going to move to the topic of problem solving courts and processes. You touched on your experience or VLA's experience in relation to the Drug Court.

Can I just ask more broadly what VLA's views are as to how well those types of courts and processes are working?

MR NICHOLSON: So we provide specialist lawyers into all of the - sorry, not all, most of the problem solving courts, so ARC and Drug, we have dedicated courts, we have dedicated lawyers, NJC [Neighbourhood Justice Centre] we have a dedicated lawyer, and obviously and have a lot of coverage in the Koori Court too. So, I'd say they are working well, that's our practice experience, that's also what the research tends to show.

I think I guess to put it simply you'd say, the courts, the problem solving courts, create the time and space for the lawyers and the judges, but also not just the time and space but the proper community supports, well resourced, to actually enable people to deal with the issues that have brought them into contact with the justice system, not just for the legal problem on the day, which is what we commonly see in the mainstream courts; and that's the crucial thing, is that time and space to deal with the broader issues that brought that person into contact with the justice system.

Also, just reflecting, Ms Armytage, on your opening about the client who talked about having hit rock bottom and having charcoal in their chest: if you look at the case studies in our submission about people involved in problem solving courts, it is really about hope and a second chance; that's really the emotion that comes through in their first-person statements which are in our submission.

So, yes, I think that proper access to services and time and space are the two crucial things, and the understanding that, you know, a magistrate should build a relationship with a person and understand the recovery may not be linear, but take a tailored approach to actually what the person's experience is to help them get through.

And I'd just say that, you know, it's a great shame

that our world class problem solving courts aren't available everywhere; they're only available, despite having been around for a number of years and well evaluated, they're only available in a relatively small number of places geographically. Programs like CISP, the supported bail program, are over-subscribed in many places and also not available elsewhere. So, in terms of solutions for us it's pretty simple, which is to roll out the things that we know work well in terms of problem solving courts everywhere.

And, of course, there is a longer term challenge around mainstreaming person-centred or problem solving approaches everywhere in the Magistrates' Court that has to be worked on at the same time, but I wouldn't wait for that to roll out the specific programs, CISP, ARC, Drug Court, Koori Court and everywhere, that's something that can be done immediately and in fact that will help with that longer term process of making the courts and justice system more human-centred because it means that in every location you've got magistrates, judicial officers, lawyers, police prosecutors, court staff who are working in that problem solving in a therapeutic way, so it helps in that mainstreaming process if you roll out the existing programs everywhere.

MS COGHLAN: Thank you, Mr Nicholson. Dr Elkadi, just picking up on what Mr Nicholson has said, what would you say is working well in those types of courts?

DR ELKADI: I think in my response what I'll kind of focus on is what those courts provide an opportunity to do without specific reference to particular courts, but essentially, the difference in those courts is that they look at the whole person; they consider the trajectory of what got them there and, as Dan said, actually giving them the time and space to look at those issues and then respond accordingly. And there is something about taking the whole person into the conversation and understanding all of their needs, drug and alcohol needs, housing needs, employment, education, all of those things, because we know that the evidence tells us that if we intervene in any one of those areas based on needs that we will get a better outcome.

I think the evidence is there, those problem solving courts have been evaluated, they're being rolled out more broadly, it's an evidence-based solution that is ready and

waiting really for an expansion.

What I will say also though is, Forensicare has the mental health advice and response service and that's a response service that's in six of the Magistrates' Courts, where people are referred to that service to determine or to identify whether they've got a history of a mental illness. Obviously Forensicare is able to do that because it has access to the various mental health databases and is able to provide back to the court or Community Corrections some advice about that person's mental illness and it's interfaced with their offending behaviour, and that's in the mainstream court, it's not in a problem solving court specifically.

But I think there's an opportunity to look at and understand how the courts are actually using that information and how it informs their decision making. There's not been a great deal of research around - there's been quite a bit of research around the specialist family violence courts and there's an example in the other courts that Dan mentioned, but a service like that in a mainstream court I think there's more to be understood because it gives us an opportunity actually to look at how we consider mental health in court interactions across the State. Again, it's not a particular problem solving court but it's actually an opportunity to inject that conversation around someone's mental illness into the court process.

It's not really yet well understood how well magistrates use that information, what considerations, how Community Corrections use that information in terms of recommending to the court any dispositions, and I think there's more work to be done to understand how we can not only invest in the problem solving courts that we know already, but actually what other kind of mental health type responses should be embedded in all courts regardless.

MS COGHLAN: Thank you, Doctor. Can I move to you, Ms Edwards, on this topic and discussing what's working well in those types of courts.

MS EDWARDS: Our experience is that they do work well for those people that were actually able to - who actually can get access them. Just talking to a colleague at Jesuit Social Services this morning about this very topic, it came up, and she was saying as others have said, they're not

widely accessible, that's a key problem, but basically they're very helpful.

My own experience of sitting in both overseas and here is, as others have said, it's a humanising situation. I think one of the major benefits about it is the flexibility and actually seeing the person in front of you and being able to tailor things, taking into account their particular circumstances, their particular needs, their particular problems, and getting a bit more of a nuanced response.

I just would also like to, having looked at a number of different ones, whether they be cultural ones, age appropriate, issue-related like the alcohol and drug courts, but also place. And my own experience and colleagues with the Neighbourhood Justice Centre, for example, I think I'd really like to also see some more place-based ones like that and the evaluation of that was very positive.

But again, if we're going back to the understanding that a person is essentially relational, and we're putting this restorative approach and about restoring themselves to the community, to culture et cetera, to family, then I think the idea of place is really important.

Because say, for example, in Collingwood, I know that there in the City of Yarra some of the services were brought around that person, some of the things that the community restorative actions they did were in their community, and so, there was a healing I think that went on at the same time.

I just think all these things depend on what lens we're putting on it: are we putting a place lens, are we putting an age lens, are we putting a problem lens, like you've got a mental health problem or you've got an alcohol and drug?

Whatever we do, I think we just have to realise we are still segmenting and looking at one component of the person and I think the main thing for us to bring to it is this understanding of the essential relational nature of the person and therefore a relationship-based response. So, even if we're looking at the mental health issue or the alcohol and drug issue or whatever it is, the family violence, that we need to be bringing around that person

the way of restoring them to a series of relationships that ultimately are going to be there and holding the person when the justice system intervention has walked away, et cetera. So, I just think that we need to have that lens on it, rather than, it's a better way to get your drug treatment done. I think we just have to keep coming back to the restoring and relationship based essence of these good interventions.

MS COGHLAN: Thank you, Ms Edwards, can I stay with you for the next question, which is, what supports do people need, those people who have a mental illness, to successfully comply with obligations from court orders?

MS EDWARDS: Again, it depends, but I'd say what we know is that we need a broader and a longer term support for people. Our experience is that - and again, it can be because it can be combined with an ABI, et cetera, and we know that 42 per cent of the male prison population for example has an acquired brain injury - our experience is that people often just aren't following or don't get what they're supposed to be doing, so I think it's really important that they're accompanied, especially through the time of perhaps an acute episode, or when they are in the process of trying to comply with a Community Corrections order, for example, that they are accompanied through that time to help them understand what they need to do.

The other thing is, and it goes back to what Dan said, sometimes the range of things that they have to comply with are very onerous and quite challenging and often competing with one another. So, our experience around that would be that there hasn't been a holistic look at the person and what they need to do, so they could be, for example, being pulled one way in terms of complying with their order and turning up to see someone, at the same time that they are endeavouring to connect with part-time work or are endeavouring to connect with some training option or some treatment option.

So we really see that often for example that they may be in a group or some kind of intervention, whether it be therapeutic or part of their order, but they're being pulled another way, and it's actually really demanding for them to manage that. So, we think that we need someone to take that holistic and integrated approach to them and accompany them particularly at times, for example, when

they are trying to complete an order. At that time particularly it's very taxing, even physically getting from one side of town to another to complete a component of that order, like an attendance at some treatment. So, that would be probably the main thing I would talk about at that point.

MS COGHLAN: Thank you, Ms Edwards. Mr Nicholson, what would you comment on there?

MR NICHOLSON: I think that overall across the community court orders and community supervision the two things that we see that people experiencing mental health issues particularly benefit from are specialist case management and direct link-up to specialist support services.

And so, that specialist case management is crucial not just to sort of compliance approach to your community order, but also the reality of a lot of the community supervision orders is that, it doesn't guarantee you access particularly to services; you can fold, if you like, your existing services that you may be able to access in there, but it doesn't generally increase access to those services or give you specialist - you know, better access to them. And so that means that, where there is a shortage of services, you're no better off, if you like, and your ability to use that time when you're on a community order to help in your recovery is limited.

I suppose that's the general position. In terms of the bail support program, we would support a specialist mental health program within that which would be particularly helpful.

MS COGHLAN: Can I just ask you to elaborate on that, are there particular components of that kind of program that you would recommend?

MR NICHOLSON: Yes, look, I think we see the current situation is that there can be delays in referrals to supports and appointments with psychologists, and a specialist program that could increase availability of those supports would just ensure that people, one, can get out of custody and get the support that they need on bail, but secondly, if they are on bail, give them a much better chance of complying with bail conditions and actually supporting their recovery which would keep them out of the

justice system in the medium term.

So I suppose, again, it's those two elements of access to services and specialist case management, not just compliance as part of that supervision, which is the two crucial elements.

MS COGHLAN: Thank you, Mr Nicholson. Dr Elkadi?

DR ELKADI: I think I'd sort of like to emphasise a couple of issues. One is, as Julie mentioned, the need for a holistic kind of approach. So, again, the evidence is there that if we intervene in housing, education, employment and training, living skills, family and community connectedness and mental health services as a kind of whole kind of suite of service responses, then we'll get a better outcome.

Those supports in the literature are really practical supports that allow people to kind of, I guess, be empowered in their recovery journey, but also actually build skills over time that actually prove to be useful obviously in leading more productive lives or living with their mental illness in a more manageable way.

In doing that, I think what we need to be mindful of is how we bring case management and understanding of clinical need together. So, at the moment they operate quite separately, whether that's in community mental health settings or in the justice space, there's kind of supervision on the one hand and then there's clinical assessment on the other, and clinical interventions. I think, in order for us to kind of be able to provide that holistic approach there is actually a need to consider how those things can be brought together and how we have really multidisciplinary teams that, where your case manager has a very good, albeit not a fully qualified clinician, sound clinical understanding of the needs; equally, your clinician who's involved has a very sound understanding of supervision obligations and those other elements that will be incredibly important to keeping people out of prison.

I think there are lots of challenges in that. There's a workforce development issue that we need to think about in terms of how we deliver and develop a workforce that can complement the service delivery that we need and the service model that we need, and how we can actually bring

in those community-based services in a way that is kind of seamless and is kind of dynamic. So, people will need housing services first and foremost before they can consider any other issues around education or employment or being involved in any kind of clinical support because, if they don't have anywhere to live, then all of those things become really quite unimportant to them at the time, and to actually have a service response that can shift and change and fluctuate with the needs of the person.

You know, I guess what we've done so far is to have a scattergun approach; because all of these services are siloed and they're operating across the kind of government public sector service sector, and not for profit and so on, and sometimes private, that we just have a scattergun approach where we refer to everywhere and let's hope for the first thing that hits and start with that. Actually what we need is a more comprehensive kind of assessment based approach that can identify what the needs are, a plan for what those needs are and for the service system to work together.

An example of that is the RAMP in the family violence space where we've got now the risk assessment management panels working with different organisations around the table. They are working with the most high risk families and individuals, but actually there's a recognition that there's more than a policing response and more than a mental health response that's required to get those individuals - or to mitigate the risks for those individuals.

MS COGHLAN: Can I just pick up on, you mentioned workforce development. Can you just elaborate really the key components of that in what you were describing?

DR ELKADI: Yes. So, I think, you know, and I guess in this I'll reflect on my time in Corrections. We have case management kind of roles that are in the system and they are often quite separate from the clinical interventions that are being provided.

So I think the workforce that we need to support the outcomes that we need has to be a workforce that can think in those multiple dimensions: the supervision, the compliance, the clinical need, and actually the psychosocial needs. So, actually we need to have and

develop and build a professional workforce in this space that has consideration of all of those things and then is supported by the specific professionals that we need. It's not to say that a case manager should be acting as a clinician, but actually they should be understanding clinical need and working closely with a clinician.

I think the workforce that we have at the moment, for reasons of resources and other structural kind of reasons, really only work on a need to know basis, and of course, you don't know what you need to know until it sometimes is too late, so actually to have a more integrated response.

I think the example that I think about is when we have clinical reviews for clients with mental illness or serious mental illness in our services. The purpose of a clinical review is to consider all aspects of their needs, and I just wonder and I often think about whether a process like that within the justice system would actually yield us the outcomes that we're looking for.

MS COGHLAN: Thank you, Doctor. We're going to take a break shortly, but is there anyone else who would like to comment, Ms Edwards or Mr Nicholson, on that topic?

MS EDWARDS: Are you talking specifically about workforce?

MS COGHLAN: No, just more broadly on the supports that are needed.

MS EDWARDS: I think we've - with my colleagues, I think that's been covered. I think it's the breadth, it's taking the holistic thing, it's making sure it's not just about compliance but about attending to need. Unless we address the underlying need, not just manage the risks or make sure people complete their orders, then we're just going to have a repeat. So, yes, I think we've covered that.

MR NICHOLSON: Yes, and I strongly endorse what Dr Elkadi said as well; it's a very sophisticated answer.

MS COGHLAN: Thank you. Perhaps now, if we have a 10 minute break, so we'll be returning at 10.30. Okay, I'll see everyone then.

SHORT ADJOURNMENT

THE CHAIR: Okay, Georgina, I think we're all back, so let's get started, thank you.

MS COGHLAN: So, the next topic we're moving on to is treatment and support in custody. The questions I'm asking relate to both adult custody and youth justice.

If I could direct this first of all to you, Dr Elkadi, and I'm going to ask you about optimal treatment and support. If I could ask you to address that question firstly in a broad way, particularly in relation to youth. So, if you could address it in that way.

It's quite a long question, so bear with me and I'm happy to come back and repeat it later too if that's needed. The question is this: what does optimal treatment and support for people with mental illness in custody look like? And we're interested in knowing how it can be improved and if there's a way to prioritise those improvements?

DR ELKADI: Okay. I think one of the three themes that has come through in the conversation to date today has been about integration and that early identification process, and I would say that it's really no different in the custodial setting.

I would say that an optimal model or service model for supporting people with a serious mental illness or mental illness in custody is around that kind of early identification as they come into the system and doing that in an integrated way.

At the moment we have multiple different types of assessments, clinical assessments even that happen in the system as people come into the system. The information sharing across those assessments is a question that over time should be considered and addressed, and then using that assessment process - and the assessment process should be geared towards again, the psychosocial, the clinical and any kind of legal needs there might be - but essentially to understand what those needs are and to actually have an active plan about how those needs are addressed throughout the course of the sentence.

If we think about the comments earlier about very short sentences, it is near on impossible to address those

issues in very short sentences because people need time to kind of adjust to being in prison; then there's the issue of being transferred to various locations and moving across locations where the continuity of care might be broken; and then you have the issue of, by the time you've identified what the needs are they are ready to leave.

So I think when we talk about the optimal care, we need to have the time and space to deliver it, we need to have an integrated approach, and again that's multidisciplinary that takes into account security needs of a custody setting - there's no doubt that those two things need to be balanced in terms of mental health care needs and security needs, but actually to have the time and space to do it in a way that allows for the planning of people when they go back for their return to the community from the minute they come in and I know we'll kind of address that a little later.

The critical question in that becomes how do you do that when, you know, over 75 per cent of people in our system have sentences of less than, you know, 12 to 18 months, and where really we don't have an integrated service response for serious mental illness. We've got our offending behaviour offence specific service responses, we've got our mental health responses, we've got our education and employment kind of responses, all of those currently operate in parallel; there needs to be a point of entry into the system where all of those things are brought together and then there's an active process by which needs are monitored, acted on and there is a dynamic and changing plan for that person as they move through their custody or their term of custody, including planning for their release.

MS COGHLAN: Is it possible, in identifying those various aspects, to prioritise something at this point in time?

DR ELKADI: I think one of the things to kind of remember is that, as people are coming into prison there's a whole bunch of really complex factors that are in their lives at that time.

So, in some ways, in order for you to understand their needs and that assessment process at the outset, you also kind of need to deal with what they're leaving behind in the community, and sometimes that's understanding their

connection with their family, understanding what their housing issues are, child support, their Centrelink situation, really kind of dealing with those emergency crisis needs at the outset. So, for example, they're not accumulating debts while they're in custody and then on the other end of their sentence they've got a massive debt to deal with when they're back out in the community, but actually to deal with those crisis needs. Then really dealing with those mental health AOD [Alcohol and other Drugs] offence-specific needs, because they become the key tools for that person to address further issues around how they sustain their own housing, how they build on their living skills, how they re-establish connections with their community, how they build employment opportunities for themselves and how they work with other agencies to kind of be empowered in that journey of recovery.

So, I think people come into prison in a state of crisis, their lives are in crisis, and I think that has to be the number one priority, and then we really need to move on to those immediate therapeutic clinical needs because they are the ones that arguably can take the longest to address, but they also become those critical foundations for success in some of those other domains.

In terms of youth, I'll only speak to youth in the context of my experience with it as entry into the adult system because that's where my experience is largely based.

There is a need to actually have a specific service response for youth that takes into account their developmental needs, the circumstances of their life again in a more integrated way, and to have actually a system that thinks about the transition if someone is in the youth system and how we share information to support them if they move into the adult system.

Again, at the moment the systems kind of operates in silos. There is an opportunity to really treat the system as one. Obviously, we don't want young people to end up in the adult system, but actually they do and we know they do, so it's really about how do we build continuity across these two systems so that at every point there's an opportunity to mitigate their further - their becoming further entrenched in the system along the way.

Shared models of care: we've got a dual track system

that operates. Could we have something like that in the mental health space? What that might look like I'm not sure, but I think actually thinking about that people 18 to 25 are that middle, where they could be in either system and actually the two systems really need to work as one at that point.

MS COGHLAN: Thank you, Dr Elkadi. Can I move on to you, Ms Edwards.

MS EDWARDS: Yes. A couple of things, I suppose, just over the cup of tea break thinking about it all, it really - and this question fits with that - it just highlights what we call the web of disadvantage that people are caught in, and again we've talked a lot, as Shaymaa has just said, about the need for integration.

I suppose what stands out for me is, thinking again about that situation in Norway where they had a reduced population that they were working with, I suppose I want to use this opportunity to say, we do have to look at all points of the system, we need to clear out the system of those 75 or whatever it is as Shaymaa said, 75 per cent of people who are in there on sentences less than 12 or 18 months. If we did that, which obviously involves changes to legislation et cetera. I think there are some structural things I just wanted to bring up at this point and then I'll get more specifically to that.

But if we lifted the age of criminal responsibility to 14, if we had a dual track system for example up to 25, and if we ensure that, for example, that people whose criminal matters related mainly to their mental illness, weren't in custody but were doing some other kind of - involved in some other kind of community arrangements, we reduce the pool in custody to the extent that we can actually do something meaningful, so I just wanted to put it in that context.

The only other thing I'd add to what's been said then, is that, I think we need to broaden the lens or the understanding of mental health beyond the clinical. So, for example, our experience would be that the things - just like us, you and me - the things that impact on people's mental health are things like loneliness, lack of meaning and purpose, isolation, physical amenities, and again, the best jurisdictions will actually even look at the physical

infrastructure: can people see out to the sky, can they see trees et cetera. And I think we underestimate the impact of those matters on people's mental health and wellbeing.

We still pick up people from custody who are exiting straight from isolation, solitary confinement, whatever you want to call it, managed behaviour programs, but straight from isolation into our care. We pick up people who aren't able to - we picked up one Aboriginal woman who wasn't able to walk properly because her muscles had atrophy while she was in isolation.

So these matters, it's not necessarily what clinical assessment someone's had, what therapeutic treatment they've had in terms of what medication or - these are actually the sort of things that affect all of us as human beings, and I think we need to take that broader lens when we're considering people's mental health: connection to family, connection to culture, connection to nature, and yes, connection basically and relationship.

Specifically on young people, I think probably the same would apply, but particularly we need to - and some shifts have already started in the youth justice system now - but we would like to see no 10 to 14-year-old in custody, and we need to really do, again, what the others have said, it's the absence of things like adequate housing, engagement in education, all of those things that make someone more liable to end up, for example, on remand rather than on bail in the community.

So, it's a broad answer, but it's basically saying you can't isolate just one factor, you have to look at the breadth of issues, but the main thing I'd like to say is a broader lens on what we consider as productive or conducive to mental health and wellbeing.

MS COGHLAN: Thank you, Ms Edwards. Mr Nicholson?

MR NICHOLSON: Thanks. Again, I won't repeat what I think are very good points made by both my fellow panel members, but just a couple of things in addition.

First, I agree that sort of somewhat counter-intuitively given the question, actually a massive investment in better community supports is going to be the best way to provide better support in custody: firstly,

because you'll keep more people out and therefore - particularly people on short sentences - and therefore enable Corrections and people working in the Corrections and youth justice areas to really focus on those who are there, but also because it enables better reaching in of those services and managing transition right through someone's involvement in the justice system; again, we'll talk about that in a moment.

I would say generally one of the big challenges we see is there's been such a rapid expansion of numbers in the Corrections system and that hasn't been matched by an increase in the number of - the amount of treatment and beds, particularly obviously Thomas Embling Hospital was designed at a time when we had a much, much smaller Corrections system and hasn't grown at the same pace.

The consequence we see of that is people that are very often in custody become unwell or because they're not getting the right treatment become more unwell and aren't able to plead to their matters, they become unfit to plead, and then they get stuck in remand so this cycle continues. So, that increased access to treatment for people who are very unwell is absolutely crucial, because then you can start resolving their legal matters and getting them out of custody or into the right form of treatment faster.

They may become, for example, with the right treatment, fit to plead again and then can get out on bail or resolve their matters and get back into the community with support.

Likewise, in the youth justice system we've seen real challenges with people getting the right kind of support while they're on remand and that can leave them on remand for a long period of time.

So, in terms of priorities, I think expansion of Thomas Embling Hospital or similar is pretty crucial, a crucial part of this. I think the overcrowding in prisons and the use of lockdowns or solitary confinement - not solitary - lockdowns or isolation is a major issue which should be addressed and, likewise, we've seen a number of Ombudsman's reports about that and we've seen also very similar challenges in the youth justice system.

So, addressing that partly through a reduction of the

number of people in custody, but also the way that we manage them is a priority for us.

Specifically, in the youth system, we have highlighted in our previous submissions in our work the kind of lack of access to services in the youth justice system, but I would say that in recent weeks the 10 year Youth Justice Plan has been released and that makes a number of recommendations about better access to mental health support in the youth justice system from courts, right through to custody and forensic beds, and we think those recommendations if implemented go a long way to addressing some of those concerns.

Lastly, I agree with the point about the young person transitioning into the adult system and more specific mental health services to support them in custody and in transitioning out is crucial. Thanks.

MS COGHLAN: Mr Nicholson, can I just stay with you for a moment and just pick up on a matter that was raised in previous discussion about a greater suite or access to voluntary treatment in custody; is that something that you'd like to expand on?

MR NICHOLSON: Yes, just to say, I mean, I think there's a discussion about what's the role of compulsory treatment in custody and voluntary treatment, and our view is that there should be increased access to voluntary treatment in custody, but that compulsory treatment - there shouldn't be compulsory treatment in prisons, that it should be done through Thomas Embling Hospital or similar specialist facilities, and that's really for the simple reason that, in our view, if the intention of compulsory treatment is to be recovery-focused but also to have as minimal restrictions or rights/restrictions as possible, that is just very difficult in a prison setting. That's our reason for that view, in short.

MS COGHLAN: Thank you. Can I pick up on that question with you, Dr Elkadi, and this is in relation to compulsory treatment in custody, do you want to comment on that?

DR ELKADI: Just briefly to say that I agree with Dan's comments around, you know, the best place to provide mental health treatment is in a mental health facility or service, but I guess I kind of go to the question that there is a

lot of debate around compulsory treatment in prisons.

The question, I guess, raises the issue of, why is it there and why are we debating this, and whether the question itself would be absent if we had a mental health system that was able to better respond to the mental health needs of the people in the justice system or ahead of them entering the justice system.

MS COGHLAN: Thank you. Ms Edwards, is there something that you'd like to comment on?

MS EDWARDS: I hadn't commented on this previously. I think that the points that are made are good in terms of, definitely we would like to see an increase in voluntary mental health services for people, but I just want to support Dan's comment about, if someone is needing compulsory treatment, our view would be that that shouldn't occur in a custodial setting, as in, in the prison where they are; it might need to be in a secure facility, but not in custody.

MS COGHLAN: Thank you. Ms Edwards, could I just stay with you for the moment, we're actually moving on to the next and final topic which is transitioning to and from custody.

Again, I'm directing these questions at not only the adult system but also the youth system, but if I could ask you to address the first question in a broad way and then come to youth-specific secondly.

The question is, what are the optimal treatment and support needs for people with mental illness when they're going into custody and coming out of custody?

MS EDWARDS: I think it goes back to probably some points that have been made generally, which is that, again, as much as we can get holistic care and a real accurate assessment of what the person's needs are, also that we need to be looking at - and a number of us have said this - we need to be looking at the exit plan.

Given that some people are in there for a matter of days literally I think - it's not like they are there for two years - I think we need to start looking at the transition from the moment that people arrive. And it

depends, sometimes we're talking about remand, sometimes we're talking about sentence, but either way, people are often in custody for a very short period of time.

Our experience, it goes to what Dan said earlier, is that it's short enough time - it's a long enough time to disrupt things like housing, and we would like to see shifts in that, in terms of their tenancy not being unsettled, but it's a short enough time to get almost no treatment in custody.

Again, it's very difficult because you've got a flooded system, but it is true that we've also got 60-plus per cent of people with mental illness in there. So you know, it is hard when it's so overloaded to know what to do and when people are there for such a short time. But if, as we're told, that everyone does get a thorough mental health assessment when they go in there, then we really need to use from day one that opportunity, I suppose, to set out a plan for what is going to happen, either when they are in custody - - -

But let's remember, we know from our own experience, that even court ordered participation in groups or in treatment in custody, it actually doesn't get to happen because people are moved, or they're in for too short a time, or in the youth space it was more because there was a lockdown and people couldn't get to groups. So, on paper it can look very good, but in reality it often isn't happening.

So again, it depends whether you've got someone in there for 14 days, three months or whatever, but it's an opportunity I suppose; once they're there, what's the plan, and that's where, especially for short-term ones, the transition through to the community and the adequate planning so that there's a continuity of care. I can say in adult justice that has improved over the last year with sharing of some information that hadn't happened previously.

We'd been asking for years, because we would pick someone up, they didn't know their own mental health plan, and they'd been told that we were told, but they didn't know it and we weren't allowed to have it, so we weren't therefore able to support people in complying with treatment, in getting to appointments, et cetera. There

has been a shift and an improvement with that.

So, in other words, from the moment that someone arrives we should be looking at what can we do in the 14 days or in the three months whatever, but always with an eye on exiting and what can be put in place in the community.

Again, for example us doing the reconnect work and that sort of picking up people during the transition, the idea is we're supposed to, up to six weeks before, be able to re-introduce to the person and begin that relationship. It often doesn't help. Again, nobody's fault other than the overloading of the system, and so sometimes we are meeting someone on the day that they are released; it again just goes completely counter to the relationship-based approach where we're trying to help them make a successful transition and to connect with services out in the community.

I think they're the main points. With youth justice what's happened now which is good, is that there is one caseworker who would be following the person inside custody and out. Now, that's a very small system relative to the adult system, so I'm not sure how that would translate, but it is a very good development, that the young person doesn't start again with, you know, having someone new looking after them.

One thing I wanted to just mention, I was conscious of the fact, for example, when we were in Norway one Corrections officer in a particular unit will have three prisoners that he has a particular relationship with. So, rather than it be a very large setting, we think that - again going to what I said about the broader lens of mental health - when you can have people in smaller units where they can have more meaningful engagement and have some relationships that are recognising who they are, how they're going, are aware that someone didn't turn up to see them, for example, or that they're slow to get out of bed or all of those things, when it can be smaller and more manageable and that you have a staff member with a particular eye on just a few people, we think all those sort of things, which are outside perhaps strictly what the treatment is, but they are the things that will help hold someone and help sustain them in a good state of mental health and wellbeing, so again, often relationship-based.

One point I will make which I haven't made today is about trauma and I think that it's important, and this goes to the quality I suppose of the staff: we'd really want to see trauma-informed practice. We know that even with the men that I was talking about, we work with serious violent offenders and sex offenders, and most of those are also victims of violence, for example. So, if we're wanting to see a change, we think we need to be able to bring a trauma-informed lens to our work.

And of course that goes to workforce, and my last comment about this will be, again, in the best jurisdictions that we saw overseas, Corrections officers have a minimum of two years and are moving to bachelor degree qualifications. Systems do it differently: some systems we saw have the security staff in a sense on the boundary, but all those who are actually engaging with the prisoners in the day-to-day are social workers, or educators, or have some other kind of relevant qualification. And we saw other models where in fact the actual Correction officers had that kind of qualification.

I think that we can't underestimate the impact and importance of the small day-to-day interactions outside the clinical formal treatment plan that someone is on. So, again, I'm going to the quality of the people, the quality of the relationship, and of course we need sophisticated, evidence-informed mental health interventions, but I don't think it just sits within a white coat, I think it sits within the range of relationships and the range of activities that a young person or an adult is doing in their day-to-day life as it would with you or me.

MS COGHLAN: Thank you, Ms Edwards. Dr Elkadi, could I address that question to you, we're on the topic of transitioning to and from custody, so those people living with mental illness, what's the best possible care and support they can receive?

DR ELKADI: So, I think, as kind of Julie pointed out and we've pointed out on various occasions today, the necessity and the criticality of starting to plan for someone's release from the day they come in, and that transition planning again needs to be holistic and to understand the person from all angles really.

There are three elements though and layers of this that we need to think about: one is, how do you do that for someone who's on remand. We know that a big chunk of our system is now people on remand and what can you really do and what is a reasonable kind of transition plan when you don't actually even know when you're going to be leaving; and whether people will actually be interested in having that conversation with you as someone providing that care.

They're short sentences, and again, what kind of re-integration planning can you do for someone on a very short sentence, sometimes only days. So, by the time you know when they're sentenced they're kind of within days of leaving and what would be a meaningful re-integration conversation to have there.

Then the long sentences, and those would be the ones that I'd say, you know, subject potentially to a parole period, and in that context what we've seen over the past is an investment in that very pointy end, so the high risk serious violent and sex offenders, and not really actually thought about in some ways paying that investment forward for those who come into the system with serious mental illness early, whether they're on remand or on short sentences, and how we can provide a kind of wrap-around approach that extends well into community supports to enable them - well, to prevent that escalation to the more serious offending.

I think that's kind of been the challenge around the investment in re-integration, is to actually, where are we going to get the best value-add for the community, where are we going to get the greatest community safety, where are we actually going to get a more cost-effective option and actually thinking about investing in that transition and re-integration planning for people on remand and on short sentences as opposed to those that are, you know, in for very long periods of time.

The other thing I'll add to that is that, there is obviously a change in the parole application process, and there's really not a good understanding just yet of how that has impacted people with a serious mental illness, and how do they apply for that process, are they disadvantaged in that process, what impacts on parole have there been for people with a serious mental illness if that is kind of known, and there is no data currently available about that.

And so, again it makes it difficult to plan and affects that re-integration conversation, because obviously from a parole perspective you need to have had a whole range of conversations around re-integration planning including where are you going to live, what treatment have you had, what are your supports outside, what's your risk if you go back into the community, and to understand how that's impacted people with serious mental illness is really important.

I think the transition needs to extend into the community. We've talked a lot about short sentences and some of these people really that get short sentences may be best served by community-based dispositions, and not to forget that transition and re-integration needs to also happen for people on community-based dispositions.

So we shouldn't assume that, because someone is in the community, that they are connected to the community; we shouldn't assume that they have the appropriate supports in place, or that they can easily access them, or that they even know where to go and what supports they need.

So there is that kind of continuity because of the trend and flow through the system that people with serious mental illness will struggle to kind of access the appropriate services in the system and we need to have a proactive approach that takes into account what their sentencing situation is, but actually not to assume that the supports are - it just is more easily accessible if they actually came into the community and have a community-based disposition, and that transition and re-integration has the outcome of building community connection, that community connection needs to happen across all sentencing options.

MS COGHLAN: Can I just ask you, Doctor, in relation to any youth-specific aspects of transitioning?

DR ELKADI: Again, my experience is mainly in the adult system and that's been kind of - you know, it's a much, much bigger system, but I also often think about, it is a small number of young people in the youth system relative obviously to the adult system, and how we can actually, again, reverse that focus of the investment to those early stages and actually extend it well into the community,

their community supports and community release to make sure that they are supported in the long-term. Again, we're talking about some very significant and complex mental health family psychosocial issues that can't be dealt with with short-term re-integration options.

MS COGHLAN: Thank you, Doctor. Mr Nicholson?

MR NICHOLSON: Thanks. I should say, this is an area of service delivery we're less involved in. We certainly see the consequences of our failure in this area, because the people who come back into custody or into the criminal justice system are the people that we see, so I'll just say that first.

Look, I agree with the comments about transition starting on the day that someone enters custody or indeed before and working with them throughout their involvement in the non-custodial and community areas, in custody and then back out into the community. There's a major challenge about lack of planning and support and supervision as people exit into the community and the significant reduction in the number of people who get parole as part of that, that we see fewer people being released on supervision than they were before. So the combination of reduction in the number of people getting parole in Victoria and the short sentences means that more than ever people are released kind of cold into the community with limited supports, and so that makes that early transition planning more important than ever.

There are lots of things that one could talk about in this area and I won't repeat what Dr Elkadi said and Ms Edwards has said, but I think access to housing in transition is one thing I would just highlight. We see a very high number of people accessing homelessness services, I believe it may be as high as 50 per cent in the time after release from prison, and it's difficult to see how someone experiencing mental health issues could possibly get either decent care and supports and really engage in recovery without adequate housing available, and that in reality is the situation that a number of people, a very large proportion of people are being exposed to on release, so I would absolutely put housing very close to the top of the list of supports that people need, and investment which would, given the cost of incarcerating people, more than repay itself very quickly.

The other thing I would just note is, we see a particular issue with people on custodial supervision orders in Thomas Embling transitioning into the non-custodial system and into the civil mental health system, so the gaps in step-down supervision and service delivery for that particular cohort of clients. It's not something, Dr Elkadi, you've already addressed, but the way that people transition from Thomas Embling into the civil mental health system, I think, is a crucial piece of work to also - in order to get more flow through the system, but also support people to recover and return to the community.

MS COGHLAN: Yes, Ms Edwards?

MS EDWARDS: I got a bit carried away with what happens inside and didn't really answer the transition side of things which was the heart of the question, so if you don't mind I just want to go back and make one or two comments, which is just particularly - there's a few things about housing and accommodation.

Just this week we have started a trial where Maribyrnong Detention Centre has been transferred to - instead of being for people seeking asylum is being used for people exiting custody. It's a COVID-related response because we know that between 40 and 50 per cent of people exiting custody exit into homelessness, and because of Covid-19 the idea was, there was a desire to do something different, so that is being used starting - the first person is arriving there from custody on Friday and it will house 44 people.

What inadvertently this is giving us is an opportunity to trial something that we've long been wanting to trial, which is step-down accommodation for people exiting custody. And they can be there for up to six months, they may be there a lot shorter, but what we need is that sort of - it will be very interesting to see how that goes and the evaluation of that.

But we need places where people who would be otherwise exiting into homelessness can go and be supported, and in a sense it is a step-down because, from there, further work will be done to actually find longer term housing options to make sure that treatment around mental health in the community has actually transferred to the community, that

they are connected with the services they need; that might be for a month, two months, three months or up to six months, so it's really a safety valve in there, I suppose, to make sure that that transition is smoother. So, I think they're the sort of things, but that's just one example. We need a range of housing options especially when we know about that percentage.

The other thing I'll just mention is the importance again of family and community. We know that, if there's any likelihood of keeping people connected with their family and community, that's one of the greatest safeguards in terms of their mental health and in terms of not re-offending. So, I think, in terms of when people are making that transition, we've got to do as much as we can while people are in custody to make sure they're connected.

And for Aboriginal people that is particularly the case and there's a few things I'd say there. One is that, there is often an assumption that Aboriginal people will return to family and community, and they want to and usually that's something that everybody wants, but there has been harm done at times, and again I'd say this restorative approach work needs to be done while the person's in custody to address the harm done, to address the barriers to successful re-integration and connection back with family and community, because otherwise they're brought there, they're dropped there, and in fact there will be a blow-up because the underlying issue wasn't resolved.

So, we're trialling at the moment - Jesuit Social Services is involved more in the youth custody space with some restorative interventions, it's not through the courts, it's actually just using a restorative approach with family and community while the person is in custody to help that transition back into the community more seamless. Thank you.

MS COGHLAN: Mr Nicholson?

MR NICHOLSON: Yes, and we strongly support that, the restorative justice practices too.

Just, look, I feel like I may have been strong on the problem identification and not so much on the solutions in my previous answer, so all I'd say is I think there are

successful programs like the Judy Lazarus Centre and Forensicare's Tambo Program in existence which are doing a pretty good job of transition, so that the issue may be to scale up those existing successful programs rather than having to build something completely new.

And again, this is probably something that's come through more generally in the Royal Commission's investigations and something we see a lot in the criminal justice system, we can become a land of pilots here in Victoria and we do have a number of successful programs that simply need the investment to scale them up and make them a more permanent and widespread part of the system.

MS COGHLAN: Thank you, Mr Nicholson. Ms Edwards, can I just come back to you for a moment and touch on - this is the final topic that we will be addressing, but it's something that you and Dr Elkadi have addressed and it's the information sharing aspect of treatment support.

You commented that more recently things have improved in that space, can you just briefly describe how that is and perhaps how things could be better improved.

MS EDWARDS: Yes. I'm not necessarily going to the specifics of it, but I know that we worked with Justice Health, as did others for a long time to make sure that there would be better sharing of health and mental health information when someone's exiting custody. That was for years we were just getting nowhere and now we do get a summary report. I can't speak to the detail of that, but it has allowed us to improve the care of people as they transition from custody.

Because even, for example, what medications are on, and often in the past the actual person, the person exiting custody, would be wanting us to have that information but we weren't able to get it. So, it wasn't like - they were giving permission for us to have it, but we weren't getting it, so now that's improved.

I don't have the detail other than to say, our staff tell us it's made a big difference in being able to actually help the person access the treatment, the medication and other services that they need.

MS COGHLAN: Thank you, Ms Edwards. Dr Elkadi, did you

want to comment further on that topic?

DR ELKADI: Yes, thank you. So, the information that now as I understand it gets shared is the discharge plan that gets shared with the reconnect service providers which Julie's referring to.

I think there is an issue around how we share information in the system within the system, and then into the community, and I think actually some of that is because of archaic systems, where we've got multiple systems in multiple places recording different pieces of information and not kind of a single source of truth. And it's also a factor of possibly different understandings of what can be shared under what legal provisions and, you know, I'm not a legal expert, but I can certainly recount many conversations where there have been questions about whether we can share information, what can be shared in the process of supporting someone's either treatment or transition back into the community.

I think one of the things we shouldn't forget is also the information sharing between places like correctional facilities or even Thomas Embling or Forensicare's community mental health services and area mental health services. Ultimately either people will start at the area mental health service and by some trajectory end up with Forensicare or the reverse will also be true, they'll come out into the community or be subject to a community-based program and non-custodial supervision order where the treatment may have initially started with Forensicare, then has moved into an area in mental health services, so to be able to share information across systems.

I think the critical point is a lack of clarity about what can be shared and the infrastructure doesn't support it, so it can often be a very tedious, onerous, lengthy process to negotiate what can be shared, how, in what form.

And in some cases you kind of don't know what you don't know, so there is a risk there in that we're only getting a slice of the pie about a person, when actually to help their recovery and to manage their safety in the community we should really have a more comprehensive view and a clearer understanding of that person, whether it's from prison-based information or area mental health services or other community supports that that person may

have been receiving.

MS COGHLAN: Thank you, Doctor. Just finally, Mr Nicholson, is there anything you'd like to say on this topic?

MR NICHOLSON: No, nothing further to add.

MS COGHLAN: Thank you. That concludes the questions that I have to ask the panel members today. I'm very grateful for your participation and contribution. I'll hand over to the Chair now who will invite the Commissioners to ask questions. Thank you, Chair.

THE CHAIR: Thank you very much, Ms Coghlan. Thank you all very much for the conversation and for your very informative witness statements. I think we can be left in no doubt, there is a strong mutual interest between the criminal justice system and the mental health system in improving outcomes for consumers with mental illness.

I think what's clear is that, we've got a growing dimension of an issue, not a reducing one, and Dr Elkadi, thank you for some of the material in your witness statement where you highlighted in one point, you know, we've had over the last decade 3,000 extra police recruited and deployed, weekend courts have opened, and you talked about new magistrates have been appointed and we've had very substantial growth in prison infrastructure and prison numbers as a result of all of that. You also talk about the fact that the diversion rate has reduced from 25.6 per cent to 12.5 per cent, the prison population has grown by 70 per cent in that period, of which 40 per cent are estimated on remand, and there have been a decrease in parole rates by 61 per cent.

So, some of the things that you've all advocated for have been a strong emphasis on diversion, stronger response; for example, Mr Nicholson, you talked about the value of problem solving courts that demonstrated efficacy, they haven't grown proportionately to those other investments that have been described. So, there's a strong fundamental design about how you get the balance in the system that we've known about for a very long time. A bit like the introductory comments I made, these are not new, the understanding about this has been there for a very long time.

But you still have, just going further to your witness statement, Dr Elkadi, you do talk about the fact that you still however, in 2020, we still have a system where Corrections is largely focused on the risk of re-offending and the area mental health services are focused on treatment, and you note that these two objectives are not always aligned, and that you suggest therefore what is needed is a shared understanding of mental health and offending behaviour risks and how they impact each other.

I think that's absolutely fundamental in terms of us thinking about the ongoing management of these issues. Can you give me a sense of how you think we could develop that shared understanding? What would be an approach that might be taken to improving that understanding across both the criminal justice system and the mental health system?

DR ELKADI: Commissioner, that's a tricky question.

THE CHAIR: All of our questions now are tricky. I'd like to make the point that some of the other issues we've known about, we just haven't been able to address them in a sustained way, so maybe this is one of the ones that's at the heart of why not.

DR ELKADI: I think one of the things I've experienced in conversations around some of those disparate understandings of which risk am I managing: am I managing the risk of mental illness or am I managing the risk of re-offending, comes down to a structural issue around how the services are designed and what they see as their roles and responsibilities.

You know, and it is no-one's fault, that in an area mental health service they'll say my main focus is their mental health. If their mental health is stable and they're offending, that's not my issue. If their mental health is not stable, then we can have a conversation about what impact that will have on their risk of re-offending, but often there's no action that can be taken until they re-offend, and so we end up kind of stuck in this, well, whose responsibility is it?

So I think this kind of points to the comments I was making earlier about actually having joint teams and people working together for people that are in the system, and

actually some shared kind of targets and goals and objectives and a shared definition of what success looks like because I think if you ask those two streams of service as an example, their definition of what success looks like for them would be quite different.

It's actually about bringing them together and actually looking at, if the person is in the centre, what is it that they need and they will need a bit of everything, they will need support from the mental health service, they will need to be supported through offence-specific interventions, they will need to be supported through housing and all of those things, it's about actually how we bring the services together.

It's tricky because it's hard to step back from when you're on autopilot in delivery of services to kind of understand, well, how do I consider what the Corrections space is thinking about?

The critical example we see in that is when people are discharged straight into Emergency Departments on inpatient assessment orders, and health services kind of not really knowing what to do with someone who's got a serious mental illness but seems to be kind of stable, but they've been sent there for further assessment into the community, but actually they've served their sentence, they've not re-offended, they're not sort of unwell enough to be re-admitted and so they get discharged. And you hear some of those frustrations from police about, 'we send people to Emergency Departments and then they just get released into the community.' Everyone is operating in a silo of their role and responsibility without putting (indistinct) and the person needs to be at the centre.

THE CHAIR: Can I just take that a little bit further, because one of the challenges clearly is, we've got a very significant number of individuals who are engaging in both of these service systems at various points, and I think your summary about how that plays out is very true, which means they become part of the responsibility of the mental health system or the criminal justice system and when are they are in such circumstances that it needs that coordinated approach, and the reality is the coordinated approach will often be most intense for the most at-risk and high-risk people.

If you think about the trends that we've observed, they have largely been driven by very serious adverse events, serious offending, harm, significant harms to others and the broader community safety.

You do talk about the Problem Behaviour Program that's run by Forensicare as being an example of where you target that high-risk group and have, presumably, shared planning and intervention. What scope do you think there is about the importance of that sort of function performed by Forensicare, because I presume it's relatively small at the moment?

DR ELKADI: Yeah, it's quite a small program, it's staffed by about 12 clinicians and it is essentially a state-wide service, and it is limited to people in the community, so it doesn't obviously extend into the prison system, but it is essentially a specialist one-on-one service particularly catered for people who demonstrate a high or moderate risk in those problematic behaviours: arson, paedophilia, sexual offences, violent offences.

So it is a small program in scope, but I think there's actually a bit more of a role that we can play in making the community or community agencies more aware of that service.

At the moment the bulk of our referrals come from Community Corrections for people on parole or on community-based dispositions, but we also in that program can take self-referrals, we can take referrals from private providers and police. So, there's kind of been a little bit of nervousness about how broadly we make this program known because, you know, do we open the floodgates and how do we deal with demand?

But there's also a conversation about how much in that diversion/early intervention space do people know about that service and how can we actually really pitch it as really a state-wide service with outreach into regional areas included where we can kind of address some of these behaviours in their earlier stages and not wait until we end up with a higher risk offender.

THE CHAIR: That may well be something of interest for us to follow up in terms of the potential, because clearly earlier intervention while people are in the community

before various serious offences are committed is something I think we're all motivated to see what else can be done to try and change that dynamic.

DR ELKADI: Yes, certainly I think that would be an opportunity.

THE CHAIR: Do any of the other panel members want to comment on that before I hand over to Professor McSherry?

MS EDWARDS: I'd just like to say something to you. I think, completely accept the proposition that it depends what we're employed to do or which Department we're sitting in, or how we see the problem, how we're defining the problem, is then the response that is going to be given.

I suppose that goes to the point, I think there are, as you were indicating, Chair, there are some people who are seen as so high risk that in fact we will sometimes get that multidisciplinary panel around them, whether it be through MACNI or whatever, we can do that; but that's going to be - given the volume of people that we're talking about, that's actually only going to touch a small percentage probably, which brings me back to the workforce development issue. I really think that we need to broaden or ensure that the staff we've got can work across those domains; that they actually understand the legal requirements and the justice requirements, they understand the mental health needs, and they understand probably a range of other things that are social needs.

Often times we see people who are getting the clinical care but have had no - nobody's picked up that they're homelessness, nobody's picked up that they're completely isolated, they're just treating them with the lens - the specific lens through which door they've come. So, I think we really have to do that as well.

One other point, in case it doesn't come up later and it's connected with this, I suppose I just wanted to raise the issue of borderline personality disorder, in that, our own experience, we have a number of people who, especially young people, who have a range of problems, mental health problems, they may have come to us actually through that or they may have come through the justice system, but the justice system engagement has actually been quite minimal, that hasn't been the major thing. But they have serious

problems and when we have tried to get the help for them in the mental health system we haven't been able to, and I'm talking about serious, you know, trying to suicide every day, threatening to hurt people, et cetera, so we've been offering care and we have not been able to get the care because we're told, you know, it doesn't fit the criteria around mental health, or it's behavioural or it's something that doesn't fit the Act and they're not allowed to, we also understand that, they're saying we can't detain this person.

So I just really wanted to raise it because some of those people have gone on to commit the very, very serious offences actually, and they just weren't meeting certain thresholds. And I'm not saying there's a lot, but often when they do commit an offence it's a very serious one, and in fact they've been, whichever language you want to put on it, seriously unwell for a long time but the service offering to respond to that just hasn't been there.

THE CHAIR: Thank you. Mr Nicholson?

MR NICHOLSON: Yeah, just to add to that point, I think my colleague, Tim Marsh, who acts for a number of the people charged with the most serious offences where there's often a crime with mental impairment element to the case, he says that in all his time talking to families no-one's ever said this came out of the blue; on the contrary, it's largely come because they've been trying to get them into various service interventions and haven't been able to do that over time.

And I think, we've seen in some of our most complex clients that have got significant mental health issues, but also other significant intellectual disabilities or other disabilities, that there may be that - we've seen cases where there's that intense intervention in custody, but once a person's then released into the community that sort of weekly panel meeting may fall away that was really providing that support, so actually you end up with less support in the community than you had in custody, which seems to me to be the wrong way around with the investment.

Just the last thing, I'd say more generally going away from all the acute cases, I think the thing that the mental health system and the justice system ought to have to try and have in common is this idea that they can be a moment

of intervention in someone's life to assist recovery. I think if you look at recovery as a broad concept of not just treating the mental health, you know, the mental health issues with medication or whatever, but helping them live their most productive lives, that's absolutely the role of the criminal justice system at that early stage of being a moment of intervention to address the underlying causes of offending and that's the common thread that we need to get between those two systems in those very many cases that aren't at the most acute end.

THE CHAIR: Yes, and I think probably the point I was making there was more, you get the community licence to deal with some of those other large volume matters, and to do exactly what you're suggesting, Mr Nicholson, if you also deal well with the various serious end - - -

MR NICHOLSON: Completely agree.

THE CHAIR: - - - and try and prevent some of those harms that have driven some of the dynamics that we've seen currently, so a very good reminder though about the need to have a balance at both ends of the spectrum. So, Professor McSherry, what would you like to ask?

COMMISSIONER McSHERRY: Yes, I have a question for, I think first up, Ms Edwards. I think it's paragraphs 41 and 42 of your statement, you talk a little bit about the framing in relation to youth justice in particular.

Some of the data we've received as Commissioners has been quite concerning in relation to the use of restraints and seclusion on young people in mental health facilities, and that raises concerns about the whole sort of occupational health and safety and risk framing in relation to young people.

I know that there are some general attitudes out there in relation to young people in particular that discipline, a firm hand is important and, therefore, there's this legal framework that's set up around discipline, deterrence, community protection and safety and so on, and you mentioned that there hasn't been a clear vision in relation to rehabilitation, and to some extent I think that may flow down from the adult system, in that, even looking at the sentencing principles in the Sentencing Act you have to punish is the very first guideline, the purpose of the Act,

and then you have deterrence, community protection, denunciation, and there's only one guideline that talks about enabling, I think, conditions for rehabilitation; there's nothing about to rehabilitate the offender.

So I'm really interested in your perceptions here, and particularly in relation to this intersection for young people with very severe mental health conditions, and in particular your experience in Norway; how this principle of normalcy works that you refer to in your statement and whether that carries over in relation to young people with mental health conditions.

MS EDWARDS: Thank you. Yes, I've got both Norway and Spain were in my mind as you spoke. Perhaps I'll go first to the Spain experience, because straight away I started smiling because as we travelled around Europe and were looking at these facilities which were very good in lots of ways in Norway and in Germany and in other places, and they would show us, here is the room when someone has been self-harming or is a risk to themselves or to others, here's the room and you'd see it and they'd show you that, you know, no hanging spots and all that we can imagine, you know, the toilets behind that can't be seen, and there's the low window that people can look in, et cetera, et cetera.

Anyhow, so we were seeing these very proudly being shown to us in all the places we visited. When we got to Spain and we started looking at some of the youth justice facilities, it was just because really we'd seen them everywhere else, so I said where's the room you remove someone to, where's the isolation room, you know, if someone's at risk to themselves, and they actually didn't understand the question and would say, "What do you mean?" And we'd say, "If someone was on suicide watch what would you do?" They literally didn't - and then they went, "Their bedroom."

Then they said, "Do you mean to say you would actually - are people actually taking them and they're isolated? They're struggling, they're suicidal and they put them in a room like - what?" They said, "No, they would be in their bedroom and in fact we would put the person they are most connected with, staff or other young person, in there with them because that's what they need", sort of like the human response. So, they didn't have these special rooms and

that just came to mind as you said that. That really struck me.

For example, in Norway with the principle of normalcy, what that meant was that that was reflected, you know, in everything from the vision about rehabilitation, re-socialisation, re-education, and our youth justice system now has a clearer vision than it did. And, as Dan said, the new strategy was just released two weeks ago, but it went from everything from the vision and, therefore, everyone was there for that purpose and that's why therefore staff are trained to a certain level, you know, they're educated; they brought it through to the physical infrastructure of the building, and they were pleasant places to be; they were very conscious of the fact of artwork, of the views that you get out the window, et cetera, the amenity.

So, in normalcy the idea is, they are citizens, so their punishment is the depravation of their liberty, that's it, everything else is not supposed to be punitive. In some of the places we went, for example, while there would be some health practitioners in the facility, really the health service was provided by the local community; because the idea is, they're citizens, they're entitled to the health care that everybody else has, and so, the GPs et cetera would come from outside in to provide that like they would in any other place they were living.

So that was important in terms of that, but I think again, going back to the Spanish example, it just struck me that sometimes we forget the person and what a person might need at a time like that, and the fact that they couldn't even understand our question, to me, was very interesting.

I've probably got a little bit sidetracked because my mind went back to those things, have I answered your question or is there anything else that you wanted?

COMMISSIONER McSHERRY: Yes, that answers it very well, because it's that balancing between, you know, the punishment and the denunciation and the rehabilitation that sometimes gets lost, and particularly when we talk about young people.

But that brings me on, if I may, to ask one more question to Mr Nicholson who, you mentioned consumer-led or

designed processes and programs, we've certainly been looking at that across the mental health system.

I'm just wondering, are there vehicles at the moment to ensure the voice of the people themselves, particularly young people, can be heard, and so that their stories actually get out there to the community?

MR NICHOLSON: Yeah, there are some. I mean, I think as a general proposition, no doubt in your deliberations and investigations you've heard a lot about consumer leadership and the importance of that in the mental health system. In the criminal justice system it is far less developed in general.

I doubt there would be a single major criminal justice organisation that would have a dedicated consumer leadership role, and that includes Legal Aid. We have consumer leadership roles in relation to our mental health services but not specifically focused on our criminal justice services, so there's a lot of way to go in that respect in criminal justice, and I'd say generally that's reflected in a system which is too often designed around lawyers and judicial officers and others and not around the actual users of the system, that plays out in practice in the way the courts operate, in my view. So, there's a lot of work to do to re-arrange that system with the user at the centre and to listen to consumer voices.

I think there are some encouraging examples. I think there's some good work done in the youth justice custodial environment now with young people's groups - I've forgotten the name, but where people are heard, and so, there is that opportunity for participation.

There's been some work done through the Women Transforming Justice Project to train up consumer leaders in that context and also through the recent Transforming Justice work done at the Centre for Innovative Justice focused on prisoners with acquired brain injury, so there are some green shoots, if you like, but I think there's a lot more that could be done.

COMMISSIONER McSHERRY: Thank you.

THE CHAIR: If we can now go to Dr Cockram.

COMMISSIONER COCKRAM: Thank you. My question is to Mr Nicholson, and it's really trying to understand at the problem solving court and processes how to create a really comprehensive and integrated approach at that point in the cycle. Understandably, you were recommending more widespread and more universal access to those programmes across different Victorian jurisdictions.

But I guess I'm trying to understand that, if we've got problem solving courts that have been separated by either issues like AOD, or by cultural aspects, or by age or by - there obviously isn't one particularly for people experiencing mental illness as part of their process; and given we understand the intersectionality where people experiencing mental illness may well be part of some of those other already defined problem solving processes, I'm trying to understand, is the segregation to a specific siloed system versus a more integrated approach like assist in other things, which way here is a better way to go to make sure that people's preceding and ongoing issues around experiencing mental illness are appropriately addressed through the criminal justice system in that context? Have you got some thoughts on that?

MR NICHOLSON: It's a great question and something that we've thought about a lot in the context of how do you make the system overall more problem solving, or more therapeutic, whatever your preferred choice of words is.

So first there is the ARC list which focus specifically focused on people with mental health issues that relate to their offending, so there is that, and again, it's available only in Melbourne, down the south-east of Melbourne and in Gippsland, so a limited take-up.

Look, there have at various points been projects to try and transform courts as a whole and bring together those more problem solving approaches. Probably those projects have never entirely got off the ground and the funding investment hasn't come through for those over the years, so that's why we would tend to favour, rather than waiting for the perfect solution, to expand what we have that we know works.

I accept the point that, in an ideal world you would build a court system where the mainstream, you know, every

court user, had an intervention or a response which was based around the issues in their life and helped them to address it; that would be the ideal, so that's something we need to work towards. But I think we haven't - we've found it difficult to deliver that, and it is a very big task given the demand pressures on the Magistrates' Court in particular to make that change, so that's why we would support beginning by expanding what's there.

And, as I said, I think that does actually help in the mainstreaming process if you like, if you want to call it that, because then suddenly in every court you have support workers, magistrates, Legal Aid lawyers, police prosecutors who are working in that more problem solving way, and it may be that at the back end of the system, the support workers, it does look more integrated rather than sort of strictly separated programmes.

So yeah, I don't think there's any perfect answer to your question. We have erred on the side of that approach because we think that's what's more immediately achievable in the short-term while you work towards that long-term integration piece.

COMMISSIONER COCKRAM: Just, and this is my lack of knowledge completely: but is it the case that, if there are lists running in the specialist courts, that general magistrates rotate through them? So, do all magistrates get exposed to those more specialised courts?

MR NICHOLSON: No, they don't, so you have a specialist magistrate that sits in Drug Court, and that's very important because a huge part of the success of the model is the relationship you build with a magistrate.

Indeed, I went to a Drug Court graduation where someone who - it was last year - and, to give you an indication, this person had started in Pentridge Prison at 18, so that would tell you how long they'd been involved in the criminal justice system given they were at one point housed in Pentridge. One of the things they said, "Well, in all those times I've been to court, I've never built a relationship with a judicial officer before", and they had in the course of the two years in Drug Court.

So, that's a very important part of it, but of course, as you have more of these programmes, more magistrates do

tend to rotate through the programmes for extended periods; you know, not one week at time, but it certainly increases the contact of the judicial officers and, as I said, and Legal Aid lawyers and police prosecutors with those more problem solving ways of working, which are very different to the high-paced mainstream of the courts.

THE CHAIR: Thank you. Professor Fels.

COMMISSIONER FELS: I have one main question; if there's time, I have a couple of smaller ones. By the way, I'd like to thank the witnesses for their excellent statements and for their comments this morning.

On the question of community attitudes, I found your discussion good but somewhat dis-spiriting, of course, and notwithstanding a comment by Ms Edwards that we need some leadership in this situation from politicians and so on, but I wondered if I can come at it from another angle, also a bit dis-spiriting, and see what you have to say.

Community safety: what can you offer us that would make us feel a bit safer, and also - in all the things you're saying - and also, what would be convincing to people who are mainly interested in community safety? That's a bit different from objectively what would improve safety, but what would work in persuading the community safety-minded people that the reforms are good? Also, if you are taking the community safety aspect, would your priorities maybe be any different?

Now, I think I have to address it to one person: maybe Mr Nicholson.

MR NICHOLSON: I was hoping you'd address it somewhere else first so I had a moment to gather my thoughts.

I mean, I think one of the challenges is the exclusive focus on safety and not on what makes us a fair and more just society in criminal justice, because actually we've seen just this weekend in the middle of a pandemic enormous protests, you know, looking at - with a real focus on Aboriginal incarceration and deaths in custody, and that's about ending inequality in our society. So, the more we can frame it not exclusively in terms of safety, the more opportunity there is in the conversation.

Look, at the risk of repeating myself I'd just say this: we've learnt in the past three months that, if we follow the evidence and do things that might not immediately seem attractive, we can together keep the community safe.

And what we would be asking in criminal justice is, again, follow the evidence and do those things in the community that would actually keep the community safe, not necessarily the things that we may all want to do at any given point or want to happen to others and, to me, that's the crucial learning from the past few months that we can apply into the discussion about criminal justice and people experiencing mental health conditions.

Just lastly, just briefly, we also forget how quickly the conversation about mental health turned around because of leadership and examples. I mean, I'm a North Melbourne supporter, I remember going to the football when a North Melbourne supporter first disclosed experiencing severe depression, and the things that were shouted out for the first month in the crowd were the most despicable things, but you would never see that only 10 years later. So, I think things can turn around really quickly with the right examples and the right leadership.

THE CHAIR: Can I just ask a follow-up question on that, Professor Fels, and I'll come back to you, and maybe it take a little bit from what Mr Nicholson also said.

The place of engaging through restorative justice and having victims sometimes be the advocates for some of these changes, what scope in relation to improved understanding - I'm just building on your theme of a more fair and just society. If you have the restorative justice practices that Ms Edwards was recommending, would you also potentially have more advocacy on behalf of victims for a balanced response?

MR NICHOLSON: I mean, I can absolutely quickly respond to that, which is, I think that two of the big changes to make the criminal justice system more user-centred are problem solving approaches and restorative justice approaches, and those two things can go hand-in-hand and they will make the biggest difference in getting buy-in from everyone in the community to the kind of interventions that actually work. So, yes, I agree.

THE CHAIR: Professor Fels, do you want to go on?

COMMISSIONER FELS: Yeah. Second, a lot has been said by all the witnesses about families and carers, and Julie Edwards towards the end said some very specific things, but even to milk this subject a bit further, is there more that could be done beyond what you just said to get a better engagement of families and carers in this situation? Maybe Julie Edwards, although it was mentioned by all including Dr Elkadi.

MS EDWARDS: Thank you. Yes, I think the reality is, by the time it comes to the attention of the various systems or the interconnected systems of criminal justice and mental health, for example, we're talking about something that isn't a surprise, that families have probably been struggling with for quite a long time and are probably quite bruised by at this stage, so usually families haven't walked away but they have been feeling like they're banging their head up against a wall really to get the kind of care that they need.

So, I suppose I just situate it, in that, it's not like I think families are wanting to disengage mostly, I think they're just at their wits end. And I think sometimes there are - and whether it's restorative - but we need to have sometimes mediated conversations with family and with the person - we can call it restorative justice interventions - but where we're actually doing some problem solving about what's needed; and sometimes, with family, the best thing, for example, is that they aren't at the place where the person is living, but that they are able to maintain a relationship in the long-term.

Again, our experience would be that families, as I say, aren't wanting to walk away, but really, they need also to be supported and resourced to do it, and it is often the best link that a person who is caught up in the criminal justice system who has mental health problem needs but there needs to be support at that level too and they're usually not, they're usually not supported and, you know, they often are the subject of perhaps violence at times, or people not complying with medication et cetera, and families just need that extra level of support.

COMMISSIONER FELS: Final question, meant to be a short

one to Mr Nicholson who, amongst others of you commented on NDIS and I didn't fully understand. I'm just wondering if you could give us a moment's dummies guide to NDIS, when it's meant to apply and when it's not meant to apply, and other aspects of it and prisons or justice.

MR NICHOLSON: I'm happy to provide some more material in writing given the time, but I guess the short thing I'd say is, it's partly about access to the scheme, but a large part of it is, we have a number of clients who have significant NDIS packages but there are very thin markets, if you like, for people with Justice involvement, which is a technical way of saying they can't pay anyone to do the work for them any more. As soon as they get into prison their providers won't continue to work with them, basically, and so, there's a very - there's lack of proper services, even for people who have packages, to actually access the care that they need.

And that was a known problem when NDIS was set up, that there would be thin markets in regional areas, but also thin markets for certain complex clients and those with Justice involvement. Unfortunately, nothing properly has been done to provide a provider of last resort or providers of last resort who would assist people.

So, that's really the challenge, it's a known issue that simply sadly wasn't addressed, and there are providers, a small number of providers in the Justice system that can help, but the current funding model simply doesn't work for them, so it's simply a matter of investing in providers of last resort.

There are a bunch of other issues which I can give you information about, but that's really the main issue that I've been dealing with.

So literally we will have people who have supports, they assault someone in the community, they're remanded in custody, and they can't get bail because their service provider won't help any more. And that's no criticism of the service providers who aren't set up for it, but it's just a classic situation of market failure.

COMMISSIONER FELS: Thank you.

THE CHAIR: Thank you, and thank you all very much for

your time today. I think you have highlighted for us where some of the big challenges sit in terms of our service system design given our remit is around the design of a reformed mental health system, but we can't have that system given the prevalence of the interface of the justice system, in particular the criminal justice system, without reconciling how these two systems can work together into the future.

I think today's conversation has also said, we've put consumers at the centre of our redesigned systems, those living with mental illness and their families and carers, and I think you, Mr Nicholson, highlighted how underdeveloped that concept has been in terms of the design of the current criminal justice system interfaces, and so, that's something we'll have to really think about in terms of taking forward our ideas.

Ms Coghlan, thank you very much for leading the evidence before us this afternoon. Thank you to our three panel members - I should say this morning, nearly this afternoon - our three panel members again for the care you've put into the preparation of your witness statements, your comprehensive responses to our discussions today, and for those where you've indicated a willingness to follow up on some of the issues with us, we would be very keen to take you up on those opportunities.

So, thank you all very much, and we've had a very informative and helpful suggestion session this morning, so thank you.

MS EDWARDS: Thank you.

MR NICHOLSON: Thanks very much.

AT 11.58AM THE COMMISSION WAS ADJOURNED

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