

**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

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

5  
6 I am Penny Armytage, the Chair of the Royal Commission  
7 into Victoria's mental health system. I'm joined by my  
8 fellow Commissioners, Professor Allan Fels, Dr Alex Cockram  
9 and Professor Bernadette McSherry.

10  
11 On behalf of the Commission I acknowledge Aboriginal  
12 peoples as the traditional owners across all the lands on  
13 which we are located for today's panel discussion and I pay  
14 my respects to their Elders past, present and emerging.

15  
16 The Commission had sought the participation of Dr Emma  
17 Cassar of the Department of Justice and Community Safety in  
18 today's panel. Due to ongoing work across the Department  
19 as part of the response to Covid-19, Dr Cassar was unable  
20 to attend. The Department of Justice and Community Safety  
21 has instead provided a statement addressing a number of the  
22 key issues which will be explored today. This statement  
23 will be accessible through the Commission's website,  
24 together with the transcript and video from today's panel  
25 discussion.

26  
27 We would like to discuss with you and seek your views  
28 about the critical topic of people living with a mental  
29 illness and their involvement in the forensic mental health  
30 system and the criminal justice system more broadly. When  
31 we speak of the criminal justice system, this includes the  
32 courts and corrections system and the involvement of people  
33 living with mental illness with police.

34  
35 The Commission has received a wide variety of  
36 submissions which identify this as a critical topic. In  
37 its submission to the Commission, Victoria Legal Aid  
38 summarised the tenor of many of these submissions when it  
39 states that:

40  
41 *There is an over-representation in the*  
42 *criminal justice system of people,*  
43 *including young people with mental health*  
44 *issues. The justice system must not be the*  
45 *default mental health service provider.*

46  
47 The submission goes on to say that people experiencing

1 mental health issues are at a greater risk of contact with  
2 the justice system and are over-represented in the prison  
3 and Youth Justice populations.  
4

5 This is not a new problem. The Burdekin Report of  
6 1993 is a seminal Human Rights and Equal Opportunity  
7 Commission national report into the human rights of people  
8 living with mental illness. Twenty-seven years ago the  
9 report concluded that many people were taken into custody  
10 or had their detention prolonged as a consequence of their  
11 mental illness or disorder going untreated, and that,  
12 untreated mental illness clearly causes some people to  
13 behave irresponsibly, irrationally or in a bizarre fashion.  
14 Sometimes this behaviour brings people to the attention of  
15 the police. In a small number of instances untreated  
16 mentally ill people commit violent actions against others.  
17

18 In 2006 a Senate Select Committee inquiry regarding a  
19 national approach to mental health reached the same  
20 conclusion. The circumstances noted in these reports in  
21 1993 and 2006 not only exist in Victoria today, they appear  
22 to have worsened.  
23

24 In its interim report, the Commission referenced the  
25 latest survey of prisoner health of those in Australian  
26 prisons which indicated that 61 per cent of people entering  
27 Victorian prisons had a diagnosed mental illness, and  
28 35 per cent of Victorian prisoners were referred to a  
29 prison mental health service.  
30

31 Further, concerns around community safety have  
32 resulted in significant legislative reforms to the bail and  
33 parole systems. This has led to a large increase in the  
34 number of people imprisoned and on remand which appears to  
35 have exacerbated the situation for those living with mental  
36 illness.  
37

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

1  
2 A redesigned mental health system must enable  
3 consumers to access the treatment and support they need  
4 when they need it. In doing so, our services must respond,  
5 not only to the needs of individual consumers, but to our  
6 shared aspiration for a safe and connected community.  
7

8 We must be able to do better for people like Leona,  
9 who in her evidence to the Commission stated:  
10

11 *When I think about my offence I feel like I*  
12 *had hit rock bottom, like the light inside*  
13 *me went out. It felt like I had charcoal*  
14 *in my chest and I lived like that for years*  
15 *and years.*  
16

17 Today's panel discussion is just one way that the  
18 Commission is conducting its enquiries on this matter. In  
19 addition to considering the inputs received so far, the  
20 Commission is engaging further with consumers and carers as  
21 well as the mental health workforce to hear about their  
22 experiences and ideas for improvement.  
23

24 Finally, on behalf of the Commission and my fellow  
25 Commissioners, I want to extend my gratitude to Mr Dan  
26 Nicholson, Ms Julie Edwards and Dr Shaymaa Elkadi. I know  
27 each of you have put a considerable amount of effort into  
28 preparing for today's discussions, we look forward to  
29 hearing your views, insights and ideas for change.  
30

31 I will now ask Counsel Assisting, Georgina Coghlan, to  
32 provide some opening remarks before we formally begin the  
33 panel. Georgina.  
34

35 MS COGHLAN: Thank you, Chair. I too extend thanks to  
36 Mr Nicholson, Ms Edwards and Dr Elkadi, they've all  
37 contributed so much time and energy to this process for  
38 which we're very grateful.  
39

40 I should note that each panel member has provided a  
41 written statement which will be published on the website.  
42 Those statements cover a range of issues, not all of which  
43 will be touched on today. All panel members responded to a  
44 number of questions for the purposes of the panel  
45 discussion and some of those will be explored further  
46 today.  
47

1           The purpose of this panel discussion, as the Chair  
2 said, is to share ideas on topics, identify points of  
3 agreement and disagreement if they exist.  
4

5           At this point it's helpful to outline in broad terms  
6 some of the areas that will be addressed in today's  
7 discussion. Firstly, the over-representation of people  
8 with mental illness in the criminal justice system, the  
9 community discourse around mental illness and offending,  
10 problem solving courts and processes such as the Assessment  
11 and Referral Court, Neighbourhood Justice Centre, Koori  
12 Court and Drug Court, treatment and support in a custodial  
13 setting, and also treatment and support in transitioning in  
14 and out of custody.  
15

16           The panel will discuss these topics in relation to  
17 adults and young people. Whilst the panel members may have  
18 different views as to the appropriate age bracket for young  
19 people in the context of the criminal justice system, and  
20 it is an evolving space, for the purpose of this discussion  
21 the panel members agree to approach it on the basis of an  
22 18 to 25 age range.  
23

24           Can I now just briefly introduce our panel members.  
25 Mr Dan Nicholson is the Executive Director of Criminal Law  
26 at Victoria Legal Aid and the Executive Director for the  
27 Western Suburbs at VLA. He is responsible for the delivery  
28 of legally aided criminal law services across the state.  
29 He has also held the role of Commissioner at the Victorian  
30 Law Reform Commission since 2018.  
31

32           While VLA works directly with clients who are in the  
33 mental health system, much of their work with clients  
34 experiencing mental health issues is in their day-to-day  
35 work in mainstream systems for summary crime, indictable  
36 crime, child protection, family law, family violence,  
37 discrimination, social security, migration, tenancy, NDIS  
38 and prisoner legal help.  
39

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

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

5  
6 Dr Shaymaa Elkadi is the newly appointed Executive  
7 Director of Strategy, Planning and Performance at  
8 Forensicare. Prior to that she was the Executive Director  
9 of Community Operations. In that former role Dr Elkadi's  
10 responsibilities included oversight of Forensicare's  
11 community forensic mental health service, partnering with  
12 Forensicare's clinical leaders to enhance organisation-wide  
13 clinical governance, ensuring delivery of service models,  
14 and organisation-wide leadership of various stakeholder  
15 portfolios.

16  
17 Dr Elkadi's previous appointments include Clinical  
18 Governance and Performance Lead at Beyond Blue, and General  
19 Manager Rehabilitation and Re-Integration, Corrections  
20 Victoria.

21  
22 On that note, perhaps if we can now commence with the  
23 panel discussion, and I propose to approach this by  
24 identifying the topic and then proceeding with a question  
25 and directing that to one of the panel members.

26  
27 The first topic today that we'd like to canvass is the  
28 over-representation of people living with mental illness in  
29 the criminal justice system. And so, many of you have said  
30 in your statements and the Commission has heard time and  
31 time again that it's well accepted that there is this  
32 over-representation.

33  
34 Perhaps if I could direct this first to you,  
35 Mr Nicholson, and pose this question: what can be done to  
36 prevent people with mental illness becoming involved with  
37 the criminal justice system?

38  
39 MR NICHOLSON: Thanks, Ms Coghlan. So, I think we would  
40 identify three broad areas for change and I'll touch on  
41 each of those without running through everything in too  
42 much detail. The first is, we've identified in our  
43 submissions and recommendations and come through in the  
44 interim report that there's this big gap in the mental  
45 health system between the sort of 10 sessions by Medicare,  
46 and crisis and acute services where people often end up  
47 losing their liberty and autonomy and coming into contact

1 with the criminal justice system.

2

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

9

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

15

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

25

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

29

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

40

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

1  
2 Another significant net widening issue that we've seen  
3 in recent years is the impact of the bail changes in  
4 Victoria, and we have seen firsthand the consequence of  
5 those changes which are probably best summarised by one of  
6 my experienced frontline managers who said, "People are  
7 more likely now to be in custody because of the issues in  
8 their lives, not the offences they've committed."  
9

10 So we see a lot of people spending short periods on  
11 remand when they're not facing prison, and particularly  
12 that's acute for people experiencing mental health issues  
13 who may have difficulty complying with bail conditions, or  
14 are committing sort of repeated small-scale offences, and  
15 what that means is that they end up with short periods on  
16 remand which can be very disruptive to the environment, to  
17 the supports they have in the community but not long enough  
18 in custody to actually get support or treatment while  
19 they're there or meaningful transition.  
20

21 And again, we would recommend changes which don't  
22 fundamentally change the architecture of the Bail Act but  
23 just make a number of important tweaks that would reduce  
24 those unintended consequences.  
25

26 Lastly, I think when people do enter the criminal  
27 justice system, people find themselves unable to get out of  
28 it and it hinders their recovery, rather than what we see  
29 which is the opportunity for the criminal justice system to  
30 be a moment of intervention to help people to access  
31 supports and services, deal with the underlying causes of  
32 offending and support their recovery, and again, there are  
33 a number of things we can touch on in the course of this  
34 discussion which we'd recommend as change, including better  
35 access to problem solving courts, better support in the  
36 community, for community corrections orders and bail, and  
37 for those who are in custody, better treatment of support  
38 in custody and then the ability to transition out.  
39

40 So I suppose I've covered a lot of ground quickly, but  
41 they're the three big areas that we see lead to  
42 over-representation and some of the areas where you could  
43 make significant change to improve that or reduce that  
44 impact.  
45

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



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

3  
4 MS EDWARDS: Thank you, and thank you for the opportunity  
5 to present and be with you today, all of you, it's a very  
6 important issue close to our heart and I appreciate the  
7 opportunity. The architecture, I suppose, of the system  
8 from the most early intervention through to transitioning  
9 from custody that Dan Nicholson has presented is one that I  
10 accept and I probably will just be repeating a number of  
11 things which I won't do because I'm accepting that, but I  
12 will just add a few things.

13  
14 I think some high-level overarching matters that need  
15 to be considered are housing; that's a huge issue for  
16 people with mental illness and people who get trapped  
17 really in the criminal justice system, but it's also a  
18 range of housing options with support, and that needs to  
19 be - the mental health service side of things needs to be  
20 delivered in a more flexible way.

21  
22 One of the things that we note is increasingly - you  
23 know, we would say that the medicalisation of the mental  
24 health system means that even, for example, psychologists  
25 who we would hope would be more community connected often  
26 are not comfortable engaging with people in non-clinical  
27 settings, and that for us is really important. That people  
28 would be able to connect with people in their housing or  
29 special accommodation or other facility where they are  
30 living.

31  
32 The other point I'll bring up about that which Dan has  
33 already referred to is the early intervention or early  
34 detection of people at early points of engagement. We know  
35 that people will end up at an Emergency Department many,  
36 many times with some mental health crisis before they get  
37 proper treatment. Often they are discharged and end up  
38 actually then, next time they're picked up it'll be by the  
39 police or in that system, so we think there are  
40 opportunities along the way and I would suggest Emergency  
41 Department is one such place where better intervention  
42 could be put in.

43  
44 I think the embedding - our own experience of  
45 embedding, for example, a nurse with our Reconnect Team, so  
46 the team that works with people in the criminal justice  
47 system, has been very positive. So, a nurse or mental

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

12  
13 We are right now trying to do that in the area of  
14 adolescent family violence, because one in 10 call-outs for  
15 police around family violence are around adolescent family  
16 violence, and that is actually a big pickup point for young  
17 people and then gets criminalised and into the Justice  
18 system, so we'd like to see some alternatives there.

19  
20 It will probably come up later, but there's the big  
21 elephant in the room in a way, which is men. We know that  
22 93 per cent of the - approximately 92, 93, 94 per cent of  
23 the prison population is male, so if we want to intervene  
24 earlier I think we have to do something about that. Now,  
25 how far we go back in terms of trying to change patriarchy  
26 and gender norms socially, I'm not sure what we need to do,  
27 but the reality is, this is something I think we have a  
28 blindness about. That's largely who we're talking about in  
29 this crossover around criminal matters and mental illness,  
30 and I think it's something that we need to pay greater  
31 attention to.

32  
33 I think I'll leave it there, thanks, Ms Coghlan.

34  
35 MS COGHLAN: (Inaudible).

36  
37 DR ELKADI: Sorry, I was just unmuting myself. Thank you  
38 also for the opportunity to speak and to be here today. I  
39 think we're in agreement on the key issues that we've just  
40 spoken about in terms of the over-representation of people  
41 with mental illness in the criminal justice system.

42  
43 What I do want to highlight is three aspects and I  
44 think the fundamental principle is around flipping the  
45 investment. There's a lot of investment in the criminal  
46 justice system in terms of various types of rehabilitation  
47 and re-integration services, but actually one of the

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

11  
12 We know that there is, as Dan mentioned, that missing  
13 middle. We might have some pockets of services at the  
14 beginning, but really, they are also in some ways too late;  
15 we need to be thinking about, for young people, how we  
16 identify serious mental illness for some of those  
17 particularly vulnerable communities, Aboriginal  
18 communities, refugee communities, how do we pick up those  
19 signs of serious mental illness early and well before  
20 they're in the criminal justice system, and providing an  
21 appropriate comprehensive wrap-around response.

22  
23 And, I know we'll talk a little bit about some of  
24 those kinds of areas of support, but really, Julie's  
25 mentioned housing, but it goes beyond housing; it goes to  
26 alcohol and drug services, it goes to living skills, family  
27 and community connectedness; all of those things need to be  
28 part of that early or really comprehensive assessment  
29 opportunity and then a response to address the needs that  
30 are identified through that process.

31  
32 The other two aspects that I wanted to emphasise is  
33 the diversion. There's been lots of talk and reviews of  
34 diversion over the years and I think, again, if we look at  
35 it from a staged process and trying to minimise people  
36 coming into contact with the criminal justice system,  
37 diversion being a more kind of proactive strategy I think  
38 is critical, and diversion again supported by the relevant  
39 community connections and supports that are necessary to  
40 keep people out of the system and to keep people from  
41 offending and re-offending.

42  
43 The other aspect I wanted to emphasise is the  
44 post-release once people are in the criminal justice system  
45 and I know we will talk about this later, but I think if  
46 we're wanting to really impact the lives of people with  
47 serious mental illness who come into contact with the

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

11  
12 MS COGHLAN: (Inaudible).

13  
14 DR ELKADI: Sorry, you're muted.

15  
16 MS COGHLAN: Thanks. Thank you, Doctor. Ms Edwards, can  
17 I just go back to you for a moment. You've touched on the  
18 cohort of men, Dr Elkadi's touched on refugee and  
19 indigenous communities; can I just ask you, were there  
20 special or different needs of certain communities in terms  
21 of how to prevent involvement with the criminal justice  
22 system and those people with mental illness?

23  
24 MS EDWARDS: Yes. We also work in the settlement and  
25 community building space and we are regularly advocating to  
26 the Federal Government for better settlement programs, so I  
27 think that is an issue both in terms of English classes  
28 that the support goes longer than the first five years, so  
29 I think there's a range of things that we need to do to  
30 help the settlement experience be a more positive one, and  
31 I think that would help prevent the penetration of the  
32 justice system.

33  
34 We work with Aboriginal organisations like VACCA and  
35 VALS and VACCHO, et cetera, and of course the issue of  
36 over-representation of indigenous people is a massive one.  
37 What we've experienced being the deliverers of the  
38 transitional support over many years is sort of a changing  
39 feast of sometimes the ACCHOs are funded to provide that  
40 support, then that gets withdrawn, et cetera. We think  
41 that there should be an indigenous-specific response to  
42 Aboriginal people exiting custody and that those  
43 organisations should be supported to do that.

44  
45 What often happens is, sometimes it happens for a  
46 while, then perhaps targets aren't met or something and  
47 then it's withdrawn, and organisations like Jesuit Social

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

6  
7 In terms of particular groups, I suppose I also wanted  
8 to mention young people, whether we say up to 25, as a  
9 particular group, that 18 to 25-year-old age group which I  
10 think we need a specialist response for; whether it be in  
11 terms of at the court, but also in custody and in the  
12 transitioning, so I think that's a particular cohort as  
13 well.

14  
15 MS COGHLAN: Thank you, Ms Edwards. Mr Nicholson, can I  
16 just ask you about that as well, just whether there are  
17 particular groups that there are specific ways that they  
18 could be prevented from entering the criminal justice  
19 system, just bearing in mind those individuals impacted by  
20 mental illness in particular.

21  
22 MR NICHOLSON: Sure, and again I agree with a lot of what  
23 Ms Edwards has said and I won't repeat that. But I think  
24 as a general proposition the criminal justice system in  
25 particular hasn't been very good at listening to the users  
26 of the system or the consumers of the system, and so, a big  
27 part of that redesign is actually engaging in much more  
28 design by consumers and that will help us understand the  
29 different experiences that particular groups have, in  
30 addition to Aboriginal people and young people. I would  
31 also just add, people with dual diagnosis of disability and  
32 mental health conditions and we see that's a significant  
33 area where people are falling through the cracks, perhaps  
34 not able to sufficiently access either set of services, or  
35 there aren't services out there that have the right skills  
36 or funding or workforce to manage both.

37  
38 We've been particularly concerned about NDIS rollout  
39 not fulfilling its promise with that more individualised  
40 set of services built around a person; in fact, people are  
41 falling through the cracks more and losing services they  
42 had access to through the NDIS rollout, and what we're  
43 seeing as a practical consequence of that is, people are  
44 ending up in custody because they are arrested, there's not  
45 great support in custody for them, and they may lose, once  
46 there's some justice system involvement, they'll often lose  
47 the NDIS supports or other supports they've got on the

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

4  
5 MS COGHLAN: Thank you, Mr Nicholson. Dr Elkadi, can I  
6 move to you just on this topic that we're covering at the  
7 moment, would you like to comment on that?

8  
9 DR ELKADI: Yeah, I think there is - the broad principles  
10 of kind of rehabilitation in the criminal justice system  
11 are around the what works literature and one of the key  
12 principles around that is that responsivity. So, I think  
13 whether we're talking about broad kind of rehabilitation  
14 programs or we're talking about people with serious mental  
15 illness, the responsivity principle is critical in  
16 understanding the needs of particular cultural groups and  
17 the needs of particular vulnerable groups in the community  
18 and how we respond to them. You know, understanding the  
19 cultural responses to serious mental illness in certain  
20 cultures in the community is critical to actually getting a  
21 better outcome for those rather than waiting until they're  
22 in the justice system and service responses are limited.

23  
24 It's a really interesting question around co-design in  
25 the criminal justice system, because it's certainly one  
26 where, if you ask a lot of women in the past having done  
27 lots of workshops with women in prison, men in prison,  
28 Aboriginal men and women in the community around their  
29 experience of the criminal justice system, there is an  
30 enormous amount of experience and I guess intelligence, if  
31 you like, that we can learn from, where in some ways they  
32 can tell us exactly all the things they thought they needed  
33 and perhaps sometimes what they didn't get that they  
34 thought would make a difference to their lives, and I think  
35 that's a very important consideration and something that I  
36 don't think is considered as often as it should be.

37  
38 MS COGHLAN: Thank you, Doctor. Can I just stay with you  
39 for the moment and just ask you to elaborate on a point you  
40 made earlier about the importance of diversion, and just to  
41 understand what greater role diversion can play - and I'm  
42 asking this question broadly, not necessarily in relation  
43 to specific groups - again, focusing on those interacting  
44 with the criminal justice system and with mental illness or  
45 mental health issues.

46  
47 DR ELKADI: Sure. So, I guess in kind of considering the

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

17  
18 Now, while that may be an option, but actually we know  
19 how pressured our Emergency Departments are and they're not  
20 a mental health response, and they struggle, and in our  
21 experience looking at people discharged even from prison,  
22 they do struggle with the process of assessment and really  
23 kind of having the resources to assess someone's mental  
24 health needs, and actually to be able to link them with the  
25 appropriate services, whether that's housing or any other  
26 kind of emerging crisis services.

27  
28 So the principle being that diversion on its own has  
29 to encompass a whole range of supports and facilitation of  
30 connections and community linkages that allow that  
31 diversion to really have a meaningful impact, otherwise  
32 we're just talking about repeated kind of episodes of  
33 diversion, if you like.

34  
35 MS COGLAN: Thank you, Doctor. Ms Edwards, can I direct  
36 that question to you: what increased role can diversion  
37 play?

38  
39 MS EDWARDS: I think there's a point also, you know, how  
40 we describe diversion, whether we're talking about police  
41 or at the point of court, et cetera, but I think again, and  
42 we can't have social workers or maybe embedded with police  
43 teams everywhere, but there are particular times we're  
44 aware when police are called out to situations where, by  
45 having someone with, say, social work expertise or clinical  
46 expertise in the team - and again, I'm going back to our  
47 experience of adolescent family violence - is a really good

1 intervention to actually unpack the situation, perhaps make  
2 arrangements for the young person to be somewhere else for  
3 24, 48 hours, while things are sorted through about what's  
4 the next step about keeping everyone safe.

5  
6 At the moment there is, in that area for example,  
7 there's nothing else to do other than take the person into  
8 custody, to charge a person and take them into custody, so  
9 that's one area where we're seeing a lot of growth and we  
10 think it would be important, and it's early on in that  
11 person's circle in terms of violence as in we're talking  
12 about people under 18, so that's just a practical example.

13  
14 I think, again, diversion from further penetration of  
15 the justice system, we would like to see, I suppose as a  
16 basis, that short-term sentences don't exist. For example,  
17 in Norway where we spent some time on a study tour,  
18 offences that were under a certain period of time,  
19 12 months, 18 months, 2 years, actually those people never  
20 got to serve those sentences in custody.

21  
22 By nature of the sentence, it was clear that it wasn't  
23 a violent offence, for example, so I think we could do some  
24 work to identify how we can keep people who have committed  
25 non-violent offences out of further penetration in the  
26 system, which then leads to, how do we get a range of  
27 community arrangements in place that can support, because I  
28 agree with what Shaymaa was saying, there's no point just  
29 diverting back, diverting into nothing. I think it's an  
30 identification point to get other services in place, rather  
31 than just delaying. Sometimes diversion can be delaying  
32 what's ultimately going to happen, there needs to be some  
33 intervention at that point.

34  
35 If I go back to the very early part of the system  
36 though, I think it's important that the challenge there is  
37 not to just do a net widening thing. So, for example, with  
38 young people, the diversion program that's in place now  
39 through the courts is actually very good in terms of  
40 setting up a program that the young people comply with, in  
41 which case it doesn't even have to come back to court.

42  
43 So, I think we just have to be aware at the very  
44 front-end our diversion program shouldn't actually become  
45 inadvertently a net widening program because we're  
46 guaranteeing that the young person will get some service at  
47 least and therefore magistrates and others are keen to



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

11  
12 And the other point I just reinforced then is at  
13 court, and we would like to see a presumption that  
14 short-term offences/sentences don't get served in custody.  
15 There's an enormous amount of, not just young people, of  
16 people who serve sentences, sometimes 14 days, many, many,  
17 many people, I haven't got the statistic with me now, but  
18 under 12 months.

19  
20 And again, I'll just share a brief anecdote. When I  
21 was in Norway and I was talking to the Governor of one of  
22 the prisons there, he couldn't believe it, and he said, "So  
23 you've got a whole lot of people who are just churning in  
24 and out under 12 months?" And I said, "Yes", and he goes,  
25 "That would be a nightmare to manage as a prison governor."

26  
27 And he talked about, everyone who comes into his  
28 prison, he's got there for two years. The others you just  
29 deal with some other way in the community, a range of  
30 community arrangements. It can be still perhaps turning up  
31 every day, electronic monitoring, perhaps even having to go  
32 in weekends and stay somewhere and do some therapeutic  
33 programs, but what he was saying is, everyone I've got is  
34 here for two years, the others have been dealt with  
35 elsewhere, and it means we can do some serious programs.

36  
37 MS COGHLAN: Thank you, Ms Edwards. Mr Nicholson, can I  
38 direct that question to you.

39  
40 MR NICHOLSON: Sure, so I mean, I think there's lots of  
41 elements to what we can broadly call diversion: so there's  
42 the pre-charge cautioning process and there's the  
43 post-charge diversion process, and then there's what are  
44 the measures we can use at court to divert people out of  
45 the system. But I suppose generally, you know, where  
46 people have come into contact with the criminal justice  
47 system because of mental health issues they're

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

4  
5 You know, unfortunately it appears that the numbers of  
6 diversions and cautions are actually reducing in Victoria,  
7 even though it's a great success story, and the number of  
8 at court charge processes is increasing, even though  
9 generally the crime rate isn't particularly rising, so  
10 that's an unfortunate trend that needs to be addressed I  
11 think.

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

19  
20 So, the referral to services, properly funded services  
21 is really important, but that's not the same as a whole lot  
22 of onerous conditions on cautions and diversions.

23  
24 And I would say generally that we find that we spend a  
25 lot of time making the case with police for cautions and  
26 diversions to take place, and often that's rejected in what  
27 we think are suitable cases. So, we support removal of the  
28 police veto on diversion which we have in Victoria, and  
29 also court's ability to caution in the same way that police  
30 can which they have in New South Wales. Because, for me,  
31 diversion is like any other activity at court, if you like,  
32 it's not a sentencing disposition but it's similar, which  
33 is that the view of police is relevant but it shouldn't be  
34 determinative, so that a magistrate should be able to  
35 order diversion even if police disagree and that's not the  
36 case and that has a significant impact in our experience.

37  
38 I can just touch on the short sentences issue if  
39 that's helpful at this point since Ms Edwards has raised  
40 it, and that is that we agree. I mean, I think generally,  
41 if you look at overseas jurisdictions, comparable  
42 jurisdictions, short sentences are on the way out, and  
43 there are various presumptions against short sentences and  
44 presumptions in favour of community supervision for short  
45 periods in other jurisdictions, which there's some more  
46 detail about in my statement and in some of the work Legal  
47 Aid's provided.

1  
2 In Victoria we're going the other way particularly  
3 because of the unintended consequences of the bail laws,  
4 which is a very large number of people cycling through for  
5 short periods of remand and then, as the SAC data -  
6 Sentencing Advisory Council - shows, often being sentenced  
7 to time served in custody.

8  
9 As I said before, really those short sentences are  
10 long enough to disrupt your supports on the outside but not  
11 long enough to get any help on the inside, and so, it makes  
12 it almost impossible to do proper transition planning when  
13 you have a large number of people coming through the system  
14 in short compass.

15  
16 There's a range of views about presumptions against  
17 short sentences and it will only work, I think this is the  
18 crucial thing, if there is very significant investment in  
19 community supervision and community corrections, because  
20 otherwise there is the risk of just sentence escalation, if  
21 you like. You know, if you can't sentence someone to less  
22 than three months, well then you'll give them three months  
23 but they may have got a shorter period. The crucial thing  
24 in making it work would be proper investment in community  
25 supervision through community corrections orders or  
26 similar.

27  
28 MS COGHLAN: Thank you. Mr Nicholson, can I just stay  
29 with you, I'm going to move onto the topic of community  
30 discourse, and the question I have is, how can a better  
31 informed community discourse around mental illness and  
32 offending be achieved?

33  
34 MR NICHOLSON: Yes, so that's a big question. I mean, to  
35 start to acknowledge the issue, the first thing to say is  
36 that we do in Victoria have a particular concern about  
37 crime. If you look at the public issues data, people in  
38 Victoria are much more concerned about crime or law and  
39 order than other jurisdictions, even though statistically  
40 we are as safe or safer than most. There is a particular  
41 disconnect in Victoria between concern about safety and the  
42 reality which needs to be addressed, so there is work to  
43 do.

44  
45 I would say that generally the debate about criminal  
46 justice in Victoria is fairly impoverished. So, as long as  
47 debate about criminal justice is dominated by three-word

1 slogans, it's very difficult to have a meaningful debate,  
2 and we need to have discussions about criminal justice. In  
3 particular about the intersection of criminal justice and  
4 mental health that extends to whole sentences and whole  
5 paragraphs, not just three-word slogans.  
6

7 And also this division into good and evil, the  
8 wrongdoer and the wronged, which is strange because I think  
9 everyone actually can relate to the idea that a person is  
10 more than the worst thing they've done. It's not a  
11 difficult concept, everybody can relate to someone in their  
12 lives they know who's made mistakes and is not just the  
13 worst thing they've done.  
14

15 In terms, I guess, of the way forward: first, if we've  
16 learned anything from the past few months it is that, if we  
17 lead with the evidence and do what's right, not what might  
18 just be popular in order to keep society safe, then the  
19 community actually responds well. And so, I hope we can  
20 learn some of the lessons of the recent months in the way  
21 that we talk about criminal justice in the future.  
22

23 The second is, I think that we have forgotten how to  
24 tell the stories of our success, so if anyone has had the  
25 chances I have to go to a Drug Court graduation. For those  
26 who aren't familiar with it, if you get through the two  
27 years of your drug treatment order, at the end of the  
28 two-year period you actually have a graduation ceremony in  
29 the Magistrates' Court with the magistrate, the police  
30 prosecutor, the defence lawyer and others who give  
31 speeches, you get a certificate, you get a photo with the  
32 magistrate. It's the most extraordinarily joyful  
33 experience you'll ever have in a Magistrates' Court.  
34 Because what it does is, it tells the complex story of the  
35 person who's come through very often trauma or homelessness  
36 or significant mental health issues and addiction and  
37 turned their lives around with the right support and the  
38 right time and space.  
39

40 So I think we have to trust ourselves to tell those  
41 complex stories and that people can turn their lives  
42 around, and successful stories, because there are plenty of  
43 those out there, otherwise all people hear is the failures  
44 in the system when they read about significant and serious  
45 crimes.  
46

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

1 direct that question to you.

2

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

12

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

22

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

34

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

47

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

5  
6 MS COGHLAN:   Thank you, Doctor. Ms Edwards, can I direct  
7 that question to you, please.

8  
9 MS EDWARDS:   Yes, thank you. Jesuit Social Services  
10 started a project, a campaign, a couple of years ago called  
11 Worth a Second Chance and that was specifically for trying  
12 to build understanding in the community around young people  
13 caught up in the youth justice system. We've learnt a bit  
14 out of that experience. Of course, we did that because, as  
15 others, my colleagues have said, Victoria's probably the  
16 safest place in the country to be, but that's not people's  
17 perceptions.

18  
19           So, we also a few years ago felt that we didn't have  
20 the leadership either to implement evidence based programs  
21 compared with that being really fed by what the politicians  
22 or decision-makers thought was community sentiment, so we  
23 were interested in actually engaging with the community.

24  
25           So this campaign, out of that campaign what we did was  
26 engage with the focus groups and engaged with people, and  
27 what we learnt was, first of all, as has been said, the  
28 perception is completely out of sync with the reality; in  
29 fact, when we presented at one place about the data, some  
30 say, "I think you got that wrong, love, you know, that's  
31 actually not the case", and we're saying, "No, this is  
32 actually Government stats, this is the facts."

33  
34           So there's a big gap between perception and reality,  
35 and what we found was that when we were able to have an  
36 informed conversation - I mean a conversation, not a sort  
37 of a berating or just presentation of data, but actually  
38 have a conversation, getting people to contextualise the  
39 challenges that young people face, including thinking about  
40 the challenges in their own lives, because in fact it's not  
41 a separate breed of person. You know, we all actually have  
42 challenges at certain times in our lives, and to actually  
43 soften people's hearts to remember those things when they  
44 were a teenager or whatever.

45  
46           What we found was that when people had that  
47 experience, members of the public, as long as they heard

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

9  
10 And I know we're going to get onto problem solving  
11 courts later, but just Dan mentioned one and that's our  
12 experience very much, and particularly when we visited  
13 New Zealand last year to have a look at those courts, it's  
14 very much about re-engaging a person back in that sense of  
15 belonging in the community we think's really important.

16  
17 I just want to mention one other thing though which  
18 came out particularly out of our visit to New Zealand but  
19 also to other jurisdictions, was the leadership, and I  
20 think there's a sense that we need to get community  
21 sentiment on board, and I believe we do. But there are  
22 some places which have in a sense not waited for that, they  
23 have just shown the leadership, and I think New Zealand is  
24 one recent example of that, where Bill English who was the  
25 Prime Minister but when he was the Treasurer, or the  
26 Minister for Finance I think it was, he actually said that  
27 the justice system there, criminal justice, was a moral and  
28 fiscal failure and that it had been for 30 years.

29  
30 Now, that leadership then led to Jacinda Ardern and  
31 Mr Little, the Justice Minister, being able to go through  
32 that door and get a bipartisan agreement about shifting the  
33 situation, and they began with a listening exercise around  
34 New Zealand listening to - and we've heard about the voice  
35 of people affected by that, they have the same problem of  
36 over-representation of indigenous people.

37  
38 But it was actually the leadership, not necessarily  
39 waiting for the community, and I just want to say that, I  
40 think it can happen in parallel but, if we wait for  
41 community sentiment, we might be waiting a long time. And  
42 in fact, when people are listened to and get the  
43 information, they are capable of more than we think.

44  
45 So, I just want to raise that point as well, I think  
46 it is a matter of leadership, not just waiting to convince  
47 the community that we're safer than they think they are.

1  
2 MS COGHLAN: Thank you, Ms Edwards. Mr Nicholson, can I  
3 go back to you. We're going to move to the topic of  
4 problem solving courts and processes. You touched on your  
5 experience or VLA's experience in relation to the Drug  
6 Court.

7  
8 Can I just ask more broadly what VLA's views are as to  
9 how well those types of courts and processes are working?

10  
11 MR NICHOLSON: So we provide specialist lawyers into all  
12 of the - sorry, not all, most of the problem solving  
13 courts, so ARC and Drug, we have dedicated courts, we have  
14 dedicated lawyers, NJC [Neighbourhood Justice Centre] we  
15 have a dedicated lawyer, and obviously and have a lot of  
16 coverage in the Koori Court too. So, I'd say they are  
17 working well, that's our practice experience, that's also  
18 what the research tends to show.

19  
20 I think I guess to put it simply you'd say, the  
21 courts, the problem solving courts, create the time and  
22 space for the lawyers and the judges, but also not just the  
23 time and space but the proper community supports, well  
24 resourced, to actually enable people to deal with the  
25 issues that have brought them into contact with the justice  
26 system, not just for the legal problem on the day, which is  
27 what we commonly see in the mainstream courts; and that's  
28 the crucial thing, is that time and space to deal with the  
29 broader issues that brought that person into contact with  
30 the justice system.

31  
32 Also, just reflecting, Ms Armytage, on your opening  
33 about the client who talked about having hit rock bottom  
34 and having charcoal in their chest: if you look at the case  
35 studies in our submission about people involved in problem  
36 solving courts, it is really about hope and a second  
37 chance; that's really the emotion that comes through in  
38 their first-person statements which are in our submission.

39  
40 So, yes, I think that proper access to services and  
41 time and space are the two crucial things, and the  
42 understanding that, you know, a magistrate should build a  
43 relationship with a person and understand the recovery may  
44 not be linear, but take a tailored approach to actually  
45 what the person's experience is to help them get through.

46  
47 And I'd just say that, you know, it's a great shame



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

11  
12 And, of course, there is a longer term challenge  
13 around mainstreaming person-centred or problem solving  
14 approaches everywhere in the Magistrates' Court that has to  
15 be worked on at the same time, but I wouldn't wait for that  
16 to roll out the specific programs, CISP, ARC, Drug Court,  
17 Koori Court and everywhere, that's something that can be  
18 done immediately and in fact that will help with that  
19 longer term process of making the courts and justice system  
20 more human-centred because it means that in every location  
21 you've got magistrates, judicial officers, lawyers, police  
22 prosecutors, court staff who are working in that problem  
23 solving in a therapeutic way, so it helps in that  
24 mainstreaming process if you roll out the existing programs  
25 everywhere.

26  
27 MS COGLAN: Thank you, Mr Nicholson. Dr Elkadi, just  
28 picking up on what Mr Nicholson has said, what would you  
29 say is working well in those types of courts?

30  
31 DR ELKADI: I think in my response what I'll kind of focus  
32 on is what those courts provide an opportunity to do  
33 without specific reference to particular courts, but  
34 essentially, the difference in those courts is that they  
35 look at the whole person; they consider the trajectory of  
36 what got them there and, as Dan said, actually giving them  
37 the time and space to look at those issues and then respond  
38 accordingly. And there is something about taking the whole  
39 person into the conversation and understanding all of their  
40 needs, drug and alcohol needs, housing needs, employment,  
41 education, all of those things, because we know that the  
42 evidence tells us that if we intervene in any one of those  
43 areas based on needs that we will get a better outcome.

44  
45 I think the evidence is there, those problem solving  
46 courts have been evaluated, they're being rolled out more  
47 broadly, it's an evidence-based solution that is ready and

1 waiting really for an expansion.

2

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

15

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

29

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

38

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

42

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

1 widely accessible, that's a key problem, but basically  
2 they're very helpful.  
3

4 My own experience of sitting in both overseas and here  
5 is, as others have said, it's a humanising situation. I  
6 think one of the major benefits about it is the flexibility  
7 and actually seeing the person in front of you and being  
8 able to tailor things, taking into account their particular  
9 circumstances, their particular needs, their particular  
10 problems, and getting a bit more of a nuanced response.  
11

12 I just would also like to, having looked at a number  
13 of different ones, whether they be cultural ones, age  
14 appropriate, issue-related like the alcohol and drug  
15 courts, but also place. And my own experience and  
16 colleagues with the Neighbourhood Justice Centre, for  
17 example, I think I'd really like to also see some more  
18 place-based ones like that and the evaluation of that was  
19 very positive.  
20

21 But again, if we're going back to the understanding  
22 that a person is essentially relational, and we're putting  
23 this restorative approach and about restoring themselves to  
24 the community, to culture et cetera, to family, then I  
25 think the idea of place is really important.  
26

27 Because say, for example, in Collingwood, I know that  
28 there in the City of Yarra some of the services were  
29 brought around that person, some of the things that the  
30 community restorative actions they did were in their  
31 community, and so, there was a healing I think that went on  
32 at the same time.  
33

34 I just think all these things depend on what lens  
35 we're putting on it: are we putting a place lens, are we  
36 putting an age lens, are we putting a problem lens, like  
37 you've got a mental health problem or you've got an alcohol  
38 and drug?  
39

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

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

9  
10 MS COGHLAN: Thank you, Ms Edwards, can I stay with you  
11 for the next question, which is, what supports do people  
12 need, those people who have a mental illness, to  
13 successfully comply with obligations from court orders?

14  
15 MS EDWARDS: Again, it depends, but I'd say what we know  
16 is that we need a broader and a longer term support for  
17 people. Our experience is that - and again, it can be  
18 because it can be combined with an ABI, et cetera, and we  
19 know that 42 per cent of the male prison population for  
20 example has an acquired brain injury - our experience is  
21 that people often just aren't following or don't get what  
22 they're supposed to be doing, so I think it's really  
23 important that they're accompanied, especially through the  
24 time of perhaps an acute episode, or when they are in the  
25 process of trying to comply with a Community Corrections  
26 order, for example, that they are accompanied through that  
27 time to help them understand what they need to do.

28  
29 The other thing is, and it goes back to what Dan said,  
30 sometimes the range of things that they have to comply with  
31 are very onerous and quite challenging and often competing  
32 with one another. So, our experience around that would be  
33 that there hasn't been a holistic look at the person and  
34 what they need to do, so they could be, for example, being  
35 pulled one way in terms of complying with their order and  
36 turning up to see someone, at the same time that they are  
37 endeavouring to connect with part-time work or are  
38 endeavouring to connect with some training option or some  
39 treatment option.

40  
41 So we really see that often for example that they may  
42 be in a group or some kind of intervention, whether it be  
43 therapeutic or part of their order, but they're being  
44 pulled another way, and it's actually really demanding for  
45 them to manage that. So, we think that we need someone to  
46 take that holistic and integrated approach to them and  
47 accompany them particularly at times, for example, when

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

7  
8 MS COGHLAN: Thank you, Ms Edwards. Mr Nicholson, what  
9 would you comment on there?

10  
11 MR NICHOLSON: I think that overall across the community  
12 court orders and community supervision the two things that  
13 we see that people experiencing mental health issues  
14 particularly benefit from are specialist case management  
15 and direct link-up to specialist support services.

16  
17 And so, that specialist case management is crucial not  
18 just to sort of compliance approach to your community  
19 order, but also the reality of a lot of the community  
20 supervision orders is that, it doesn't guarantee you access  
21 particularly to services; you can fold, if you like, your  
22 existing services that you may be able to access in there,  
23 but it doesn't generally increase access to those services  
24 or give you specialist - you know, better access to them.  
25 And so that means that, where there is a shortage of  
26 services, you're no better off, if you like, and your  
27 ability to use that time when you're on a community  
28 order to help in your recovery is limited.

29  
30 I suppose that's the general position. In terms of  
31 the bail support program, we would support a specialist  
32 mental health program within that which would be  
33 particularly helpful.

34  
35 MS COGHLAN: Can I just ask you to elaborate on that, are  
36 there particular components of that kind of program that  
37 you would recommend?

38  
39 MR NICHOLSON: Yes, look, I think we see the current  
40 situation is that there can be delays in referrals to  
41 supports and appointments with psychologists, and a  
42 specialist program that could increase availability of  
43 those supports would just ensure that people, one, can get  
44 out of custody and get the support that they need on bail,  
45 but secondly, if they are on bail, give them a much better  
46 chance of complying with bail conditions and actually  
47 supporting their recovery which would keep them out of the

1 justice system in the medium term.

2

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

7

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

9

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

18

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

25

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

42

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

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

10  
11 You know, I guess what we've done so far is to have a  
12 scattergun approach; because all of these services are  
13 siloed and they're operating across the kind of government  
14 public sector service sector, and not for profit and so on,  
15 and sometimes private, that we just have a scattergun  
16 approach where we refer to everywhere and let's hope for  
17 the first thing that hits and start with that. Actually  
18 what we need is a more comprehensive kind of assessment  
19 based approach that can identify what the needs are, a plan  
20 for what those needs are and for the service system to work  
21 together.

22  
23 An example of that is the RAMP in the family violence  
24 space where we've got now the risk assessment management  
25 panels working with different organisations around the  
26 table. They are working with the most high risk families  
27 and individuals, but actually there's a recognition that  
28 there's more than a policing response and more than a  
29 mental health response that's required to get those  
30 individuals - or to mitigate the risks for those  
31 individuals.

32  
33 MS COGHLAN: Can I just pick up on, you mentioned  
34 workforce development. Can you just elaborate really the  
35 key components of that in what you were describing?

36  
37 DR ELKADI: Yes. So, I think, you know, and I guess in  
38 this I'll reflect on my time in Corrections. We have case  
39 management kind of roles that are in the system and they  
40 are often quite separate from the clinical interventions  
41 that are being provided.

42  
43 So I think the workforce that we need to support the  
44 outcomes that we need has to be a workforce that can think  
45 in those multiple dimensions: the supervision, the  
46 compliance, the clinical need, and actually the  
47 psychosocial needs. So, actually we need to have and

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

7  
8 I think the workforce that we have at the moment, for  
9 reasons of resources and other structural kind of reasons,  
10 really only work on a need to know basis, and of course,  
11 you don't know what you need to know until it sometimes is  
12 too late, so actually to have a more integrated response.

13  
14 I think the example that I think about is when we have  
15 clinical reviews for clients with mental illness or serious  
16 mental illness in our services. The purpose of a clinical  
17 review is to consider all aspects of their needs, and I  
18 just wonder and I often think about whether a process like  
19 that within the justice system would actually yield us the  
20 outcomes that we're looking for.

21  
22 MS COGHLAN: Thank you, Doctor. We're going to take a  
23 break shortly, but is there anyone else who would like to  
24 comment, Ms Edwards or Mr Nicholson, on that topic?

25  
26 MS EDWARDS: Are you talking specifically about workforce?

27  
28 MS COGHLAN: No, just more broadly on the supports that  
29 are needed.

30  
31 MS EDWARDS: I think we've - with my colleagues, I think  
32 that's been covered. I think it's the breadth, it's taking  
33 the holistic thing, it's making sure it's not just about  
34 compliance but about attending to need. Unless we address  
35 the underlying need, not just manage the risks or make sure  
36 people complete their orders, then we're just going to have  
37 a repeat. So, yes, I think we've covered that.

38  
39 MR NICHOLSON: Yes, and I strongly endorse what Dr Elkadi  
40 said as well; it's a very sophisticated answer.

41  
42 MS COGHLAN: Thank you. Perhaps now, if we have a  
43 10 minute break, so we'll be returning at 10.30. Okay,  
44 I'll see everyone then.

45  
46 **SHORT ADJOURNMENT**  
47



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

3

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

7

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

13

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

21

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

27

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

33

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

45

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

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

7  
8 So I think when we talk about the optimal care, we  
9 need to have the time and space to deliver it, we need to  
10 have an integrated approach, and again that's  
11 multidisciplinary that takes into account security needs of  
12 a custody setting - there's no doubt that those two things  
13 need to be balanced in terms of mental health care needs  
14 and security needs, but actually to have the time and space  
15 to do it in a way that allows for the planning of people  
16 when they go back for their return to the community from  
17 the minute they come in and I know we'll kind of address  
18 that a little later.

19  
20 The critical question in that becomes how do you do  
21 that when, you know, over 75 per cent of people in our  
22 system have sentences of less than, you know, 12 to  
23 18 months, and where really we don't have an integrated  
24 service response for serious mental illness. We've got our  
25 offending behaviour offence specific service responses,  
26 we've got our mental health responses, we've got our  
27 education and employment kind of responses, all of those  
28 currently operate in parallel; there needs to be a point of  
29 entry into the system where all of those things are brought  
30 together and then there's an active process by which needs  
31 are monitored, acted on and there is a dynamic and changing  
32 plan for that person as they move through their custody or  
33 their term of custody, including planning for their  
34 release.

35  
36 MS COGHLAN: Is it possible, in identifying those various  
37 aspects, to prioritise something at this point in time?

38  
39 DR ELKADI: I think one of the things to kind of remember  
40 is that, as people are coming into prison there's a whole  
41 bunch of really complex factors that are in their lives at  
42 that time.

43  
44 So, in some ways, in order for you to understand their  
45 needs and that assessment process at the outset, you also  
46 kind of need to deal with what they're leaving behind in  
47 the community, and sometimes that's understanding their

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

17  
18 So, I think people come into prison in a state of  
19 crisis, their lives are in crisis, and I think that has to  
20 be the number one priority, and then we really need to move  
21 on to those immediate therapeutic clinical needs because  
22 they are the ones that arguably can take the longest to  
23 address, but they also become those critical foundations  
24 for success in some of those other domains.

25  
26 In terms of youth, I'll only speak to youth in the  
27 context of my experience with it as entry into the adult  
28 system because that's where my experience is largely based.

29  
30 There is a need to actually have a specific service  
31 response for youth that takes into account their  
32 developmental needs, the circumstances of their life again  
33 in a more integrated way, and to have actually a system  
34 that thinks about the transition if someone is in the youth  
35 system and how we share information to support them if they  
36 move into the adult system.

37  
38 Again, at the moment the systems kind of operates in  
39 silos. There is an opportunity to really treat the system  
40 as one. Obviously, we don't want young people to end up in  
41 the adult system, but actually they do and we know they do,  
42 so it's really about how do we build continuity across  
43 these two systems so that at every point there's an  
44 opportunity to mitigate their further - their becoming  
45 further entrenched in the system along the way.

46  
47 Shared models of care: we've got a dual track system

1 that operates. Could we have something like that in the  
2 mental health space? What that might look like I'm not  
3 sure, but I think actually thinking about that people 18 to  
4 25 are that middle, where they could be in either system  
5 and actually the two systems really need to work as one at  
6 that point.

7

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

10

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

17

18 I suppose what stands out for me is, thinking again  
19 about that situation in Norway where they had a reduced  
20 population that they were working with, I suppose I want to  
21 use this opportunity to say, we do have to look at all  
22 points of the system, we need to clear out the system of  
23 those 75 or whatever it is as Shaymaa said, 75 per cent of  
24 people who are in there on sentences less than 12 or  
25 18 months. If we did that, which obviously involves  
26 changes to legislation et cetera. I think there are some  
27 structural things I just wanted to bring up at this  
28 point and then I'll get more specifically to that.

29

30 But if we lifted the age of criminal responsibility to  
31 14, if we had a dual track system for example up to 25, and  
32 if we ensure that, for example, that people whose criminal  
33 matters related mainly to their mental illness, weren't in  
34 custody but were doing some other kind of - involved in  
35 some other kind of community arrangements, we reduce the  
36 pool in custody to the extent that we can actually do  
37 something meaningful, so I just wanted to put it in that  
38 context.

39

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

1 infrastructure: can people see out to the sky, can they see  
2 trees et cetera. And I think we underestimate the impact  
3 of those matters on people's mental health and wellbeing.  
4

5 We still pick up people from custody who are exiting  
6 straight from isolation, solitary confinement, whatever you  
7 want to call it, managed behaviour programs, but straight  
8 from isolation into our care. We pick up people who aren't  
9 able to - we picked up one Aboriginal woman who wasn't able  
10 to walk properly because her muscles had atrophy while she  
11 was in isolation.  
12

13 So these matters, it's not necessarily what clinical  
14 assessment someone's had, what therapeutic treatment  
15 they've had in terms of what medication or - these are  
16 actually the sort of things that affect all of us as human  
17 beings, and I think we need to take that broader lens when  
18 we're considering people's mental health: connection to  
19 family, connection to culture, connection to nature, and  
20 yes, connection basically and relationship.  
21

22 Specifically on young people, I think probably the  
23 same would apply, but particularly we need to - and some  
24 shifts have already started in the youth justice system  
25 now - but we would like to see no 10 to 14-year-old in  
26 custody, and we need to really do, again, what the others  
27 have said, it's the absence of things like adequate  
28 housing, engagement in education, all of those things that  
29 make someone more liable to end up, for example, on remand  
30 rather than on bail in the community.  
31

32 So, it's a broad answer, but it's basically saying you  
33 can't isolate just one factor, you have to look at the  
34 breadth of issues, but the main thing I'd like to say is a  
35 broader lens on what we consider as productive or conducive  
36 to mental health and wellbeing.  
37

38 MS COGHLAN: Thank you, Ms Edwards. Mr Nicholson?  
39

40 MR NICHOLSON: Thanks. Again, I won't repeat what I think  
41 are very good points made by both my fellow panel members,  
42 but just a couple of things in addition.  
43

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

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

9  
10 I would say generally one of the big challenges we see  
11 is there's been such a rapid expansion of numbers in the  
12 Corrections system and that hasn't been matched by an  
13 increase in the number of - the amount of treatment and  
14 beds, particularly obviously Thomas Embling Hospital was  
15 designed at a time when we had a much, much smaller  
16 Corrections system and hasn't grown at the same pace.

17  
18 The consequence we see of that is people that are very  
19 often in custody become unwell or because they're not  
20 getting the right treatment become more unwell and aren't  
21 able to plead to their matters, they become unfit to plead,  
22 and then they get stuck in remand so this cycle continues.  
23 So, that increased access to treatment for people who are  
24 very unwell is absolutely crucial, because then you can  
25 start resolving their legal matters and getting them out of  
26 custody or into the right form of treatment faster.

27  
28 They may become, for example, with the right  
29 treatment, fit to plead again and then can get out on bail  
30 or resolve their matters and get back into the community  
31 with support.

32  
33 Likewise, in the youth justice system we've seen real  
34 challenges with people getting the right kind of support  
35 while they're on remand and that can leave them on remand  
36 for a long period of time.

37  
38 So, in terms of priorities, I think expansion of  
39 Thomas Embling Hospital or similar is pretty crucial, a  
40 crucial part of this. I think the overcrowding in prisons  
41 and the use of lockdowns or solitary confinement - not  
42 solitary - lockdowns or isolation is a major issue which  
43 should be addressed and, likewise, we've seen a number of  
44 Ombudsman's reports about that and we've seen also very  
45 similar challenges in the youth justice system.

46  
47 So, addressing that partly through a reduction of the

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

3  
4 Specifically, in the youth system, we have highlighted  
5 in our previous submissions in our work the kind of lack of  
6 access to services in the youth justice system, but I would  
7 say that in recent weeks the 10 year Youth Justice Plan has  
8 been released and that makes a number of recommendations  
9 about better access to mental health support in the youth  
10 justice system from courts, right through to custody and  
11 forensic beds, and we think those recommendations if  
12 implemented go a long way to addressing some of those  
13 concerns.

14  
15 Lastly, I agree with the point about the young person  
16 transitioning into the adult system and more specific  
17 mental health services to support them in custody and in  
18 transitioning out is crucial. Thanks.

19  
20 MS COGHLAN: Mr Nicholson, can I just stay with you for a  
21 moment and just pick up on a matter that was raised in  
22 previous discussion about a greater suite or access to  
23 voluntary treatment in custody; is that something that  
24 you'd like to expand on?

25  
26 MR NICHOLSON: Yes, just to say, I mean, I think there's a  
27 discussion about what's the role of compulsory treatment in  
28 custody and voluntary treatment, and our view is that there  
29 should be increased access to voluntary treatment in  
30 custody, but that compulsory treatment - there shouldn't be  
31 compulsory treatment in prisons, that it should be done  
32 through Thomas Embling Hospital or similar specialist  
33 facilities, and that's really for the simple reason that,  
34 in our view, if the intention of compulsory treatment is to  
35 be recovery-focused but also to have as minimal  
36 restrictions or rights/restrictions as possible, that is  
37 just very difficult in a prison setting. That's our reason  
38 for that view, in short.

39  
40 MS COGHLAN: Thank you. Can I pick up on that question  
41 with you, Dr Elkadi, and this is in relation to compulsory  
42 treatment in custody, do you want to comment on that?

43  
44 DR ELKADI: Just briefly to say that I agree with Dan's  
45 comments around, you know, the best place to provide mental  
46 health treatment is in a mental health facility or service,  
47 but I guess I kind of go to the question that there is a

1 lot of debate around compulsory treatment in prisons.

2

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

9

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

12

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

22

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

27

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

32

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

36

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

43

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



1 depends, sometimes we're talking about remand, sometimes  
2 we're talking about sentence, but either way, people are  
3 often in custody for a very short period of time.  
4

5 Our experience, it goes to what Dan said earlier, is  
6 that it's short enough time - it's a long enough time to  
7 disrupt things like housing, and we would like to see  
8 shifts in that, in terms of their tenancy not being  
9 unsettled, but it's a short enough time to get almost no  
10 treatment in custody.  
11

12 Again, it's very difficult because you've got a  
13 flooded system, but it is true that we've also got  
14 60-plus per cent of people with mental illness in there.  
15 So you know, it is hard when it's so overloaded to know  
16 what to do and when people are there for such a short time.  
17 But if, as we're told, that everyone does get a thorough  
18 mental health assessment when they go in there, then we  
19 really need to use from day one that opportunity, I  
20 suppose, to set out a plan for what is going to happen,  
21 either when they are in custody - - -  
22

23 But let's remember, we know from our own experience,  
24 that even court ordered participation in groups or in  
25 treatment in custody, it actually doesn't get to happen  
26 because people are moved, or they're in for too short a  
27 time, or in the youth space it was more because there was a  
28 lockdown and people couldn't get to groups. So, on paper  
29 it can look very good, but in reality it often isn't  
30 happening.  
31

32 So again, it depends whether you've got someone in  
33 there for 14 days, three months or whatever, but it's an  
34 opportunity I suppose; once they're there, what's the plan,  
35 and that's where, especially for short-term ones, the  
36 transition through to the community and the adequate  
37 planning so that there's a continuity of care. I can say  
38 in adult justice that has improved over the last year with  
39 sharing of some information that hadn't happened  
40 previously.  
41

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

1 has been a shift and an improvement with that.

2

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

8

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

20

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

29

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

1  
2 One point I will make which I haven't made today is  
3 about trauma and I think that it's important, and this goes  
4 to the quality I suppose of the staff: we'd really want to  
5 see trauma-informed practice. We know that even with the  
6 men that I was talking about, we work with serious violent  
7 offenders and sex offenders, and most of those are also  
8 victims of violence, for example. So, if we're wanting to  
9 see a change, we think we need to be able to bring a  
10 trauma-informed lens to our work.  
11

12 And of course that goes to workforce, and my last  
13 comment about this will be, again, in the best  
14 jurisdictions that we saw overseas, Corrections officers  
15 have a minimum of two years and are moving to bachelor  
16 degree qualifications. Systems do it differently: some  
17 systems we saw have the security staff in a sense on the  
18 boundary, but all those who are actually engaging with the  
19 prisoners in the day-to-day are social workers, or  
20 educators, or have some other kind of relevant  
21 qualification. And we saw other models where in fact the  
22 actual Correction officers had that kind of qualification.  
23

24 I think that we can't underestimate the impact and  
25 importance of the small day-to-day interactions outside the  
26 clinical formal treatment plan that someone is on. So,  
27 again, I'm going to the quality of the people, the quality  
28 of the relationship, and of course we need sophisticated,  
29 evidence-informed mental health interventions, but I don't  
30 think it just sits within a white coat, I think it sits  
31 within the range of relationships and the range of  
32 activities that a young person or an adult is doing in  
33 their day-to-day life as it would with you or me.  
34

35 MS COGLAN: Thank you, Ms Edwards. Dr Elkadi, could I  
36 address that question to you, we're on the topic of  
37 transitioning to and from custody, so those people living  
38 with mental illness, what's the best possible care and  
39 support they can receive?  
40

41 DR ELKADI: So, I think, as kind of Julie pointed out and  
42 we've pointed out on various occasions today, the necessity  
43 and the criticality of starting to plan for someone's  
44 release from the day they come in, and that transition  
45 planning again needs to be holistic and to understand the  
46 person from all angles really.  
47

1           There are three elements though and layers of this  
2 that we need to think about: one is, how do you do that for  
3 someone who's on remand. We know that a big chunk of our  
4 system is now people on remand and what can you really do  
5 and what is a reasonable kind of transition plan when you  
6 don't actually even know when you're going to be leaving;  
7 and whether people will actually be interested in having  
8 that conversation with you as someone providing that care.  
9

10           They're short sentences, and again, what kind of  
11 re-integration planning can you do for someone on a very  
12 short sentence, sometimes only days. So, by the time you  
13 know when they're sentenced they're kind of within days of  
14 leaving and what would be a meaningful re-integration  
15 conversation to have there.  
16

17           Then the long sentences, and those would be the ones  
18 that I'd say, you know, subject potentially to a parole  
19 period, and in that context what we've seen over the past  
20 is an investment in that very pointy end, so the high risk  
21 serious violent and sex offenders, and not really actually  
22 thought about in some ways paying that investment forward  
23 for those who come into the system with serious mental  
24 illness early, whether they're on remand or on short  
25 sentences, and how we can provide a kind of wrap-around  
26 approach that extends well into community supports to  
27 enable them - well, to prevent that escalation to the more  
28 serious offending.  
29

30           I think that's kind of been the challenge around the  
31 investment in re-integration, is to actually, where are we  
32 going to get the best value-add for the community, where  
33 are we going to get the greatest community safety, where  
34 are we actually going to get a more cost-effective option  
35 and actually thinking about investing in that transition  
36 and re-integration planning for people on remand and on  
37 short sentences as opposed to those that are, you know, in  
38 for very long periods of time.  
39

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

1  
2 And so, again it makes it difficult to plan and  
3 affects that re-integration conversation, because obviously  
4 from a parole perspective you need to have had a whole  
5 range of conversations around re-integration planning  
6 including where are you going to live, what treatment have  
7 you had, what are your supports outside, what's your risk  
8 if you go back into the community, and to understand how  
9 that's impacted people with serious mental illness is  
10 really important.

11  
12 I think the transition needs to extend into the  
13 community. We've talked a lot about short sentences and  
14 some of these people really that get short sentences may be  
15 best served by community-based dispositions, and not to  
16 forget that transition and re-integration needs to also  
17 happen for people on community-based dispositions.

18  
19 So we shouldn't assume that, because someone is in the  
20 community, that they are connected to the community; we  
21 shouldn't assume that they have the appropriate supports in  
22 place, or that they can easily access them, or that they  
23 even know where to go and what supports they need.

24  
25 So there is that kind of continuity because of the  
26 trend and flow through the system that people with serious  
27 mental illness will struggle to kind of access the  
28 appropriate services in the system and we need to have a  
29 proactive approach that takes into account what their  
30 sentencing situation is, but actually not to assume that  
31 the supports are - it just is more easily accessible if  
32 they actually came into the community and have a  
33 community-based disposition, and that transition and  
34 re-integration has the outcome of building community  
35 connection, that community connection needs to happen  
36 across all sentencing options.

37  
38 MS COGHLAN: Can I just ask you, Doctor, in relation to  
39 any youth-specific aspects of transitioning?

40  
41 DR ELKADI: Again, my experience is mainly in the adult  
42 system and that's been kind of - you know, it's a much,  
43 much bigger system, but I also often think about, it is a  
44 small number of young people in the youth system relative  
45 obviously to the adult system, and how we can actually,  
46 again, reverse that focus of the investment to those early  
47 stages and actually extend it well into the community,

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

6  
7 MS COGHLAN: Thank you, Doctor. Mr Nicholson?

8  
9 MR NICHOLSON: Thanks. I should say, this is an area of  
10 service delivery we're less involved in. We certainly see  
11 the consequences of our failure in this area, because the  
12 people who come back into custody or into the criminal  
13 justice system are the people that we see, so I'll just say  
14 that first.

15  
16 Look, I agree with the comments about transition  
17 starting on the day that someone enters custody or indeed  
18 before and working with them throughout their involvement  
19 in the non-custodial and community areas, in custody and  
20 then back out into the community. There's a major  
21 challenge about lack of planning and support and  
22 supervision as people exit into the community and the  
23 significant reduction in the number of people who get  
24 parole as part of that, that we see fewer people being  
25 released on supervision than they were before. So the  
26 combination of reduction in the number of people getting  
27 parole in Victoria and the short sentences means that more  
28 than ever people are released kind of cold into the  
29 community with limited supports, and so that makes that  
30 early transition planning more important than ever.

31  
32 There are lots of things that one could talk about in  
33 this area and I won't repeat what Dr Elkadi said and  
34 Ms Edwards has said, but I think access to housing in  
35 transition is one thing I would just highlight. We see a  
36 very high number of people accessing homelessness services,  
37 I believe it may be as high as 50 per cent in the time  
38 after release from prison, and it's difficult to see how  
39 someone experiencing mental health issues could possibly  
40 get either decent care and supports and really engage in  
41 recovery without adequate housing available, and that in  
42 reality is the situation that a number of people, a very  
43 large proportion of people are being exposed to on release,  
44 so I would absolutely put housing very close to the top of  
45 the list of supports that people need, and investment which  
46 would, given the cost of incarcerating people, more than  
47 repay itself very quickly.

1  
2           The other thing I would just note is, we see a  
3 particular issue with people on custodial supervision  
4 orders in Thomas Embling transitioning into the  
5 non-custodial system and into the civil mental health  
6 system, so the gaps in step-down supervision and service  
7 delivery for that particular cohort of clients. It's not  
8 something, Dr Elkadi, you've already addressed, but the way  
9 that people transition from Thomas Embling into the civil  
10 mental health system, I think, is a crucial piece of work  
11 to also - in order to get more flow through the system, but  
12 also support people to recover and return to the community.  
13

14 MS COGHLAN:     Yes, Ms Edwards?

15  
16 MS EDWARDS:     I got a bit carried away with what happens  
17 inside and didn't really answer the transition side of  
18 things which was the heart of the question, so if you don't  
19 mind I just want to go back and make one or two comments,  
20 which is just particularly - there's a few things about  
21 housing and accommodation.  
22

23           Just this week we have started a trial where  
24 Maribyrnong Detention Centre has been transferred to -  
25 instead of being for people seeking asylum is being used  
26 for people exiting custody. It's a COVID-related response  
27 because we know that between 40 and 50 per cent of people  
28 exiting custody exit into homelessness, and because of  
29 Covid-19 the idea was, there was a desire to do something  
30 different, so that is being used starting - the first  
31 person is arriving there from custody on Friday and it will  
32 house 44 people.  
33

34           What inadvertently this is giving us is an opportunity  
35 to trial something that we've long been wanting to trial,  
36 which is step-down accommodation for people exiting  
37 custody. And they can be there for up to six months, they  
38 may be there a lot shorter, but what we need is that sort  
39 of - it will be very interesting to see how that goes and  
40 the evaluation of that.  
41

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

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

8  
9 The other thing I'll just mention is the importance  
10 again of family and community. We know that, if there's  
11 any likelihood of keeping people connected with their  
12 family and community, that's one of the greatest safeguards  
13 in terms of their mental health and in terms of not  
14 re-offending. So, I think, in terms of when people are  
15 making that transition, we've got to do as much as we can  
16 while people are in custody to make sure they're connected.

17  
18 And for Aboriginal people that is particularly the  
19 case and there's a few things I'd say there. One is that,  
20 there is often an assumption that Aboriginal people will  
21 return to family and community, and they want to and  
22 usually that's something that everybody wants, but there  
23 has been harm done at times, and again I'd say this  
24 restorative approach work needs to be done while the  
25 person's in custody to address the harm done, to address  
26 the barriers to successful re-integration and connection  
27 back with family and community, because otherwise they're  
28 brought there, they're dropped there, and in fact there  
29 will be a blow-up because the underlying issue wasn't  
30 resolved.

31  
32 So, we're trialling at the moment - Jesuit Social  
33 Services is involved more in the youth custody space with  
34 some restorative interventions, it's not through the  
35 courts, it's actually just using a restorative approach  
36 with family and community while the person is in custody to  
37 help that transition back into the community more seamless.  
38 Thank you.

39  
40 MS COGLAN: Mr Nicholson?

41  
42 MR NICHOLSON: Yes, and we strongly support that, the  
43 restorative justice practices too.

44  
45 Just, look, I feel like I may have been strong on the  
46 problem identification and not so much on the solutions in  
47 my previous answer, so all I'd say is I think there are



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

6  
7 And again, this is probably something that's come  
8 through more generally in the Royal Commission's  
9 investigations and something we see a lot in the criminal  
10 justice system, we can become a land of pilots here in  
11 Victoria and we do have a number of successful programs  
12 that simply need the investment to scale them up and make  
13 them a more permanent and widespread part of the system.

14  
15 MS COGHLAN: Thank you, Mr Nicholson. Ms Edwards, can I  
16 just come back to you for a moment and touch on - this is  
17 the final topic that we will be addressing, but it's  
18 something that you and Dr Elkadi have addressed and it's  
19 the information sharing aspect of treatment support.

20  
21 You commented that more recently things have improved  
22 in that space, can you just briefly describe how that is  
23 and perhaps how things could be better improved.

24  
25 MS EDWARDS: Yes. I'm not necessarily going to the  
26 specifics of it, but I know that we worked with Justice  
27 Health, as did others for a long time to make sure that  
28 there would be better sharing of health and mental health  
29 information when someone's exiting custody. That was  
30 for years we were just getting nowhere and now we do get a  
31 summary report. I can't speak to the detail of that, but  
32 it has allowed us to improve the care of people as they  
33 transition from custody.

34  
35 Because even, for example, what medications are on,  
36 and often in the past the actual person, the person exiting  
37 custody, would be wanting us to have that information but  
38 we weren't able to get it. So, it wasn't like - they were  
39 giving permission for us to have it, but we weren't getting  
40 it, so now that's improved.

41  
42 I don't have the detail other than to say, our staff  
43 tell us it's made a big difference in being able to  
44 actually help the person access the treatment, the  
45 medication and other services that they need.

46  
47 MS COGHLAN: Thank you, Ms Edwards. Dr Elkadi, did you

1 want to comment further on that topic?

2

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

7

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

21

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

34

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

39

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

1 have been receiving.

2

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

6

7 MR NICHOLSON: No, nothing further to add.

8

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

14

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

21

22 I think what's clear is that, we've got a growing  
23 dimension of an issue, not a reducing one, and Dr Elkadi,  
24 thank you for some of the material in your witness  
25 statement where you highlighted in one point, you know,  
26 we've had over the last decade 3,000 extra police recruited  
27 and deployed, weekend courts have opened, and you talked  
28 about new magistrates have been appointed and we've had  
29 very substantial growth in prison infrastructure and prison  
30 numbers as a result of all of that. You also talk about  
31 the fact that the diversion rate has reduced from  
32 25.6 per cent to 12.5 per cent, the prison population has  
33 grown by 70 per cent in that period, of which 40 per cent  
34 are estimated on remand, and there have been a decrease in  
35 parole rates by 61 per cent.

36

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

1  
2 But you still have, just going further to your witness  
3 statement, Dr Elkadi, you do talk about the fact that you  
4 still however, in 2020, we still have a system where  
5 Corrections is largely focused on the risk of re-offending  
6 and the area mental health services are focused on  
7 treatment, and you note that these two objectives are not  
8 always aligned, and that you suggest therefore what is  
9 needed is a shared understanding of mental health and  
10 offending behaviour risks and how they impact each other.

11  
12 I think that's absolutely fundamental in terms of us  
13 thinking about the ongoing management of these issues. Can  
14 you give me a sense of how you think we could develop that  
15 shared understanding? What would be an approach that might  
16 be taken to improving that understanding across both the  
17 criminal justice system and the mental health system?

18  
19 DR ELKADI: Commissioner, that's a tricky question.

20  
21 THE CHAIR: All of our questions now are tricky. I'd like  
22 to make the point that some of the other issues we've known  
23 about, we just haven't been able to address them in a  
24 sustained way, so maybe this is one of the ones that's at  
25 the heart of why not.

26  
27 DR ELKADI: I think one of the things I've experienced in  
28 conversations around some of those disparate understandings  
29 of which risk am I managing: am I managing the risk of  
30 mental illness or am I managing the risk of re-offending,  
31 comes down to a structural issue around how the services  
32 are designed and what they see as their roles and  
33 responsibilities.

34  
35 You know, and it is no-one's fault, that in an area  
36 mental health service they'll say my main focus is their  
37 mental health. If their mental health is stable and  
38 they're offending, that's not my issue. If their mental  
39 health is not stable, then we can have a conversation about  
40 what impact that will have on their risk of re-offending,  
41 but often there's no action that can be taken until they  
42 re-offend, and so we end up kind of stuck in this, well,  
43 whose responsibility is it?

44  
45 So I think this kind of points to the comments I was  
46 making earlier about actually having joint teams and people  
47 working together for people that are in the system, and

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

6  
7 It's actually about bringing them together and  
8 actually looking at, if the person is in the centre, what  
9 is it that they need and they will need a bit of  
10 everything, they will need support from the mental health  
11 service, they will need to be supported through  
12 offence-specific interventions, they will need to be  
13 supported through housing and all of those things, it's  
14 about actually how we bring the services together.

15  
16 It's tricky because it's hard to step back from when  
17 you're on autopilot in delivery of services to kind of  
18 understand, well, how do I consider what the Corrections  
19 space is thinking about?

20  
21 The critical example we see in that is when people are  
22 discharged straight into Emergency Departments on inpatient  
23 assessment orders, and health services kind of not really  
24 knowing what to do with someone who's got a serious mental  
25 illness but seems to be kind of stable, but they've been  
26 sent there for further assessment into the community, but  
27 actually they've served their sentence, they've not  
28 re-offended, they're not sort of unwell enough to be  
29 re-admitted and so they get discharged. And you hear some  
30 of those frustrations from police about, 'we send people to  
31 Emergency Departments and then they just get released into  
32 the community.' Everyone is operating in a silo of their  
33 role and responsibility without putting (indistinct) and  
34 the person needs to be at the centre.

35  
36 THE CHAIR: Can I just take that a little bit further,  
37 because one of the challenges clearly is, we've got a very  
38 significant number of individuals who are engaging in both  
39 of these service systems at various points, and I think  
40 your summary about how that plays out is very true, which  
41 means they become part of the responsibility of the mental  
42 health system or the criminal justice system and when are  
43 they are in such circumstances that it needs that  
44 coordinated approach, and the reality is the coordinated  
45 approach will often be most intense for the most at-risk  
46 and high-risk people.

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

5  
6           You do talk about the Problem Behaviour Program that's  
7 run by Forensicare as being an example of where you target  
8 that high-risk group and have, presumably, shared planning  
9 and intervention. What scope do you think there is about  
10 the importance of that sort of function performed by  
11 Forensicare, because I presume it's relatively small at the  
12 moment?

13  
14 DR ELKADI: Yeah, it's quite a small program, it's staffed  
15 by about 12 clinicians and it is essentially a state-wide  
16 service, and it is limited to people in the community, so  
17 it doesn't obviously extend into the prison system, but it  
18 is essentially a specialist one-on-one service particularly  
19 catered for people who demonstrate a high or moderate risk  
20 in those problematic behaviours: arson, paedophilia, sexual  
21 offences, violent offences.

22  
23           So it is a small program in scope, but I think there's  
24 actually a bit more of a role that we can play in making  
25 the community or community agencies more aware of that  
26 service.

27  
28           At the moment the bulk of our referrals come from  
29 Community Corrections for people on parole or on  
30 community-based dispositions, but we also in that program  
31 can take self-referrals, we can take referrals from private  
32 providers and police. So, there's kind of been a little  
33 bit of nervousness about how broadly we make this program  
34 known because, you know, do we open the floodgates and how  
35 do we deal with demand?

36  
37           But there's also a conversation about how much in that  
38 diversion/early intervention space do people know about  
39 that service and how can we actually really pitch it as  
40 really a state-wide service with outreach into regional  
41 areas included where we can kind of address some of these  
42 behaviours in their earlier stages and not wait until we  
43 end up with a higher risk offender.

44  
45 THE CHAIR: That may well be something of interest for us  
46 to follow up in terms of the potential, because clearly  
47 earlier intervention while people are in the community

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

4  
5 DR ELKADI: Yes, certainly I think that would be an  
6 opportunity.

7  
8 THE CHAIR: Do any of the other panel members want to  
9 comment on that before I hand over to Professor McSherry?

10  
11 MS EDWARDS: I'd just like to say something to you. I  
12 think, completely accept the proposition that it depends  
13 what we're employed to do or which Department we're sitting  
14 in, or how we see the problem, how we're defining the  
15 problem, is then the response that is going to be given.

16  
17 I suppose that goes to the point, I think there are,  
18 as you were indicating, Chair, there are some people who  
19 are seen as so high risk that in fact we will sometimes get  
20 that multidisciplinary panel around them, whether it be  
21 through MACNI or whatever, we can do that; but that's going  
22 to be - given the volume of people that we're talking  
23 about, that's actually only going to touch a small  
24 percentage probably, which brings me back to the workforce  
25 development issue. I really think that we need to broaden  
26 or ensure that the staff we've got can work across those  
27 domains; that they actually understand the legal  
28 requirements and the justice requirements, they understand  
29 the mental health needs, and they understand probably a  
30 range of other things that are social needs.

31  
32 Often times we see people who are getting the clinical  
33 care but have had no - nobody's picked up that they're  
34 homelessness, nobody's picked up that they're completely  
35 isolated, they're just treating them with the lens - the  
36 specific lens through which door they've come. So, I think  
37 we really have to do that as well.

38  
39 One other point, in case it doesn't come up later and  
40 it's connected with this, I suppose I just wanted to raise  
41 the issue of borderline personality disorder, in that, our  
42 own experience, we have a number of people who, especially  
43 young people, who have a range of problems, mental health  
44 problems, they may have come to us actually through that or  
45 they may have come through the justice system, but the  
46 justice system engagement has actually been quite minimal,  
47 that hasn't been the major thing. But they have serious

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

11  
12 So I just really wanted to raise it because some of  
13 those people have gone on to commit the very, very serious  
14 offences actually, and they just weren't meeting certain  
15 thresholds. And I'm not saying there's a lot, but often  
16 when they do commit an offence it's a very serious one, and  
17 in fact they've been, whichever language you want to put on  
18 it, seriously unwell for a long time but the service  
19 offering to respond to that just hasn't been there.

20  
21 THE CHAIR: Thank you. Mr Nicholson?

22  
23 MR NICHOLSON: Yeah, just to add to that point, I think my  
24 colleague, Tim Marsh, who acts for a number of the people  
25 charged with the most serious offences where there's often  
26 a crime with mental impairment element to the case, he says  
27 that in all his time talking to families no-one's ever said  
28 this came out of the blue; on the contrary, it's largely  
29 come because they've been trying to get them into various  
30 service interventions and haven't been able to do that over  
31 time.

32  
33 And I think, we've seen in some of our most complex  
34 clients that have got significant mental health issues, but  
35 also other significant intellectual disabilities or other  
36 disabilities, that there may be that - we've seen cases  
37 where there's that intense intervention in custody, but  
38 once a person's then released into the community that sort  
39 of weekly panel meeting may fall away that was really  
40 providing that support, so actually you end up with less  
41 support in the community than you had in custody, which  
42 seems to me to be the wrong way around with the investment.

43  
44 Just the last thing, I'd say more generally going away  
45 from all the acute cases, I think the thing that the mental  
46 health system and the justice system ought to have to try  
47 and have in common is this idea that they can be a moment



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

11  
12 THE CHAIR: Yes, and I think probably the point I was  
13 making there was more, you get the community licence to  
14 deal with some of those other large volume matters, and to  
15 do exactly what you're suggesting, Mr Nicholson, if you  
16 also deal well with the various serious end - - -

17  
18 MR NICHOLSON: Completely agree.

19  
20 THE CHAIR: - - - and try and prevent some of those harms  
21 that have driven some of the dynamics that we've seen  
22 currently, so a very good reminder though about the need to  
23 have a balance at both ends of the spectrum. So, Professor  
24 McSherry, what would you like to ask?

25  
26 COMMISSIONER McSHERRY: Yes, I have a question for, I  
27 think first up, Ms Edwards. I think it's paragraphs 41 and  
28 42 of your statement, you talk a little bit about the  
29 framing in relation to youth justice in particular.

30  
31 Some of the data we've received as Commissioners has  
32 been quite concerning in relation to the use of restraints  
33 and seclusion on young people in mental health facilities,  
34 and that raises concerns about the whole sort of  
35 occupational health and safety and risk framing in relation  
36 to young people.

37  
38 I know that there are some general attitudes out there  
39 in relation to young people in particular that discipline,  
40 a firm hand is important and, therefore, there's this legal  
41 framework that's set up around discipline, deterrence,  
42 community protection and safety and so on, and you  
43 mentioned that there hasn't been a clear vision in relation  
44 to rehabilitation, and to some extent I think that may flow  
45 down from the adult system, in that, even looking at the  
46 sentencing principles in the Sentencing Act you have to  
47 punish is the very first guideline, the purpose of the Act,

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

5  
6 So I'm really interested in your perceptions here, and  
7 particularly in relation to this intersection for young  
8 people with very severe mental health conditions, and in  
9 particular your experience in Norway; how this principle of  
10 normalcy works that you refer to in your statement and  
11 whether that carries over in relation to young people with  
12 mental health conditions.

13  
14 MS EDWARDS: Thank you. Yes, I've got both Norway and  
15 Spain were in my mind as you spoke. Perhaps I'll go first  
16 to the Spain experience, because straight away I started  
17 smiling because as we travelled around Europe and were  
18 looking at these facilities which were very good in lots of  
19 ways in Norway and in Germany and in other places, and they  
20 would show us, here is the room when someone has been  
21 self-harming or is a risk to themselves or to others,  
22 here's the room and you'd see it and they'd show you that,  
23 you know, no hanging spots and all that we can imagine, you  
24 know, the toilets behind that can't be seen, and there's  
25 the low window that people can look in, et cetera,  
26 et cetera.

27  
28 Anyhow, so we were seeing these very proudly being  
29 shown to us in all the places we visited. When we got to  
30 Spain and we started looking at some of the youth justice  
31 facilities, it was just because really we'd seen them  
32 everywhere else, so I said where's the room you remove  
33 someone to, where's the isolation room, you know, if  
34 someone's at risk to themselves, and they actually didn't  
35 understand the question and would say, "What do you mean?"  
36 And we'd say, "If someone was on suicide watch what would  
37 you do?" They literally didn't - and then they went,  
38 "Their bedroom."

39  
40 Then they said, "Do you mean to say you would actually  
41 - are people actually taking them and they're isolated?  
42 They're struggling, they're suicidal and they put them in a  
43 room like - what?" They said, "No, they would be in their  
44 bedroom and in fact we would put the person they are most  
45 connected with, staff or other young person, in there with  
46 them because that's what they need", sort of like the human  
47 response. So, they didn't have these special rooms and

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

3  
4 For example, in Norway with the principle of normalcy,  
5 what that meant was that that was reflected, you know, in  
6 everything from the vision about rehabilitation,  
7 re-socialisation, re-education, and our youth justice  
8 system now has a clearer vision than it did. And, as Dan  
9 said, the new strategy was just released two weeks ago, but  
10 it went from everything from the vision and, therefore,  
11 everyone was there for that purpose and that's why  
12 therefore staff are trained to a certain level, you know,  
13 they're educated; they brought it through to the physical  
14 infrastructure of the building, and they were pleasant  
15 places to be; they were very conscious of the fact of  
16 artwork, of the views that you get out the window,  
17 et cetera, the amenity.

18  
19 So, in normalcy the idea is, they are citizens, so  
20 their punishment is the deprivation of their liberty,  
21 that's it, everything else is not supposed to be punitive.  
22 In some of the places we went, for example, while there  
23 would be some health practitioners in the facility, really  
24 the health service was provided by the local community;  
25 because the idea is, they're citizens, they're entitled to  
26 the health care that everybody else has, and so, the GPs  
27 et cetera would come from outside in to provide that like  
28 they would in any other place they were living.

29  
30 So that was important in terms of that, but I think  
31 again, going back to the Spanish example, it just struck me  
32 that sometimes we forget the person and what a person might  
33 need at a time like that, and the fact that they couldn't  
34 even understand our question, to me, was very interesting.

35  
36 I've probably got a little bit sidetracked because my  
37 mind went back to those things, have I answered your  
38 question or is there anything else that you wanted?

39  
40 COMMISSIONER McSHERRY: Yes, that answers it very well,  
41 because it's that balancing between, you know, the  
42 punishment and the denunciation and the rehabilitation that  
43 sometimes gets lost, and particularly when we talk about  
44 young people.

45  
46 But that brings me on, if I may, to ask one more  
47 question to Mr Nicholson who, you mentioned consumer-led or

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

3

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

8

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

15

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

29

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

35

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

43

44 COMMISSIONER McSHERRY: Thank you.

45

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

47

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

8  
9 But I guess I'm trying to understand that, if we've  
10 got problem solving courts that have been separated by  
11 either issues like AOD, or by cultural aspects, or by age  
12 or by - there obviously isn't one particularly for people  
13 experiencing mental illness as part of their process; and  
14 given we understand the intersectionality where people  
15 experiencing mental illness may well be part of some of  
16 those other already defined problem solving processes, I'm  
17 trying to understand, is the segregation to a specific  
18 siloed system versus a more integrated approach like assist  
19 in other things, which way here is a better way to go to  
20 make sure that people's preceding and ongoing issues around  
21 experiencing mental illness are appropriately addressed  
22 through the criminal justice system in that context? Have  
23 you got some thoughts on that?

24  
25 MR NICHOLSON: It's a great question and something that  
26 we've thought about a lot in the context of how do you make  
27 the system overall more problem solving, or more  
28 therapeutic, whatever your preferred choice of words is.

29  
30 So first there is the ARC list which focus  
31 specifically focused on people with mental health issues  
32 that relate to their offending, so there is that, and  
33 again, it's available only in Melbourne, down the  
34 south-east of Melbourne and in Gippsland, so a limited  
35 take-up.

36  
37 Look, there have at various points been projects to  
38 try and transform courts as a whole and bring together  
39 those more problem solving approaches. Probably those  
40 projects have never entirely got off the ground and the  
41 funding investment hasn't come through for those over  
42 the years, so that's why we would tend to favour, rather  
43 than waiting for the perfect solution, to expand what we  
44 have that we know works.

45  
46 I accept the point that, in an ideal world you would  
47 build a court system where the mainstream, you know, every

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

9  
10 And, as I said, I think that does actually help in the  
11 mainstreaming process if you like, if you want to call it  
12 that, because then suddenly in every court you have support  
13 workers, magistrates, Legal Aid lawyers, police prosecutors  
14 who are working in that more problem solving way, and it  
15 may be that at the back end of the system, the support  
16 workers, it does look more integrated rather than sort of  
17 strictly separated programmes.

18  
19 So yeah, I don't think there's any perfect answer to  
20 your question. We have erred on the side of that approach  
21 because we think that's what's more immediately achievable  
22 in the short-term while you work towards that long-term  
23 integration piece.

24  
25 COMMISSIONER COCKRAM: Just, and this is my lack of  
26 knowledge completely: but is it the case that, if there are  
27 lists running in the specialist courts, that general  
28 magistrates rotate through them? So, do all magistrates  
29 get exposed to those more specialised courts?

30  
31 MR NICHOLSON: No, they don't, so you have a specialist  
32 magistrate that sits in Drug Court, and that's very  
33 important because a huge part of the success of the model  
34 is the relationship you build with a magistrate.

35  
36 Indeed, I went to a Drug Court graduation where  
37 someone who - it was last year - and, to give you an  
38 indication, this person had started in Pentridge Prison at  
39 18, so that would tell you how long they'd been involved in  
40 the criminal justice system given they were at one  
41 point housed in Pentridge. One of the things they said,  
42 "Well, in all those times I've been to court, I've never  
43 built a relationship with a judicial officer before", and  
44 they had in the course of the two years in Drug Court.

45  
46 So, that's a very important part of it, but of course,  
47 as you have more of these programmes, more magistrates do

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

7  
8 THE CHAIR: Thank you. Professor Fels.

9  
10 COMMISSIONER FELLS: I have one main question; if there's  
11 time, I have a couple of smaller ones. By the way, I'd  
12 like to thank the witnesses for their excellent statements  
13 and for their comments this morning.

14  
15 On the question of community attitudes, I found your  
16 discussion good but somewhat dis-spiriting, of course, and  
17 notwithstanding a comment by Ms Edwards that we need some  
18 leadership in this situation from politicians and so on,  
19 but I wondered if I can come at it from another angle, also  
20 a bit dis-spiriting, and see what you have to say.

21  
22 Community safety: what can you offer us that would  
23 make us feel a bit safer, and also - in all the things  
24 you're saying - and also, what would be convincing to  
25 people who are mainly interested in community safety?  
26 That's a bit different from objectively what would improve  
27 safety, but what would work in persuading the community  
28 safety-minded people that the reforms are good? Also, if  
29 you are taking the community safety aspect, would your  
30 priorities maybe be any different?

31  
32 Now, I think I have to address it to one person: maybe  
33 Mr Nicholson.

34  
35 MR NICHOLSON: I was hoping you'd address it somewhere  
36 else first so I had a moment to gather my thoughts.

37  
38 I mean, I think one of the challenges is the exclusive  
39 focus on safety and not on what makes us a fair and more  
40 just society in criminal justice, because actually we've  
41 seen just this weekend in the middle of a pandemic enormous  
42 protests, you know, looking at - with a real focus on  
43 Aboriginal incarceration and deaths in custody, and that's  
44 about ending inequality in our society. So, the more we  
45 can frame it not exclusively in terms of safety, the more  
46 opportunity there is in the conversation.

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

6  
7           And what we would be asking in criminal justice is,  
8 again, follow the evidence and do those things in the  
9 community that would actually keep the community safe, not  
10 necessarily the things that we may all want to do at any  
11 given point or want to happen to others and, to me, that's  
12 the crucial learning from the past few months that we can  
13 apply into the discussion about criminal justice and people  
14 experiencing mental health conditions.

15  
16           Just lastly, just briefly, we also forget how quickly  
17 the conversation about mental health turned around because  
18 of leadership and examples. I mean, I'm a North Melbourne  
19 supporter, I remember going to the football when a North  
20 Melbourne supporter first disclosed experiencing severe  
21 depression, and the things that were shouted out for the  
22 first month in the crowd were the most despicable things,  
23 but you would never see that only 10 years later. So, I  
24 think things can turn around really quickly with the right  
25 examples and the right leadership.

26  
27 THE CHAIR: Can I just ask a follow-up question on that,  
28 Professor Fels, and I'll come back to you, and maybe it  
29 take a little bit from what Mr Nicholson also said.

30  
31           The place of engaging through restorative justice and  
32 having victims sometimes be the advocates for some of these  
33 changes, what scope in relation to improved understanding  
34 - I'm just building on your theme of a more fair and just  
35 society. If you have the restorative justice practices  
36 that Ms Edwards was recommending, would you also  
37 potentially have more advocacy on behalf of victims for a  
38 balanced response?

39  
40 MR NICHOLSON: I mean, I can absolutely quickly respond to  
41 that, which is, I think that two of the big changes to make  
42 the criminal justice system more user-centred are problem  
43 solving approaches and restorative justice approaches, and  
44 those two things can go hand-in-hand and they will make the  
45 biggest difference in getting buy-in from everyone in the  
46 community to the kind of interventions that actually work.  
47 So, yes, I agree.



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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

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

6  
7 MR NICHOLSON: I'm happy to provide some more material in  
8 writing given the time, but I guess the short thing I'd say  
9 is, it's partly about access to the scheme, but a large  
10 part of it is, we have a number of clients who have  
11 significant NDIS packages but there are very thin markets,  
12 if you like, for people with Justice involvement, which is  
13 a technical way of saying they can't pay anyone to do the  
14 work for them any more. As soon as they get into prison  
15 their providers won't continue to work with them,  
16 basically, and so, there's a very - there's lack of proper  
17 services, even for people who have packages, to actually  
18 access the care that they need.

19  
20 And that was a known problem when NDIS was set up,  
21 that there would be thin markets in regional areas, but  
22 also thin markets for certain complex clients and those  
23 with Justice involvement. Unfortunately, nothing properly  
24 has been done to provide a provider of last resort or  
25 providers of last resort who would assist people.

26  
27 So, that's really the challenge, it's a known issue  
28 that simply sadly wasn't addressed, and there are  
29 providers, a small number of providers in the Justice  
30 system that can help, but the current funding model simply  
31 doesn't work for them, so it's simply a matter of investing  
32 in providers of last resort.

33  
34 There are a bunch of other issues which I can give you  
35 information about, but that's really the main issue that  
36 I've been dealing with.

37  
38 So literally we will have people who have supports,  
39 they assault someone in the community, they're remanded in  
40 custody, and they can't get bail because their service  
41 provider won't help any more. And that's no criticism of  
42 the service providers who aren't set up for it, but it's  
43 just a classic situation of market failure.

44  
45 COMMISSIONER FELLS: Thank you.

46  
47 THE CHAIR: Thank you, and thank you all very much for

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

9  
10 I think today's conversation has also said, we've put  
11 consumers at the centre of our redesigned systems, those  
12 living with mental illness and their families and carers,  
13 and I think you, Mr Nicholson, highlighted how  
14 underdeveloped that concept has been in terms of the design  
15 of the current criminal justice system interfaces, and so,  
16 that's something we'll have to really think about in terms  
17 of taking forward our ideas.

18  
19 Ms Coghlan, thank you very much for leading the  
20 evidence before us this afternoon. Thank you to our three  
21 panel members - I should say this morning, nearly this  
22 afternoon - our three panel members again for the care  
23 you've put into the preparation of your witness statements,  
24 your comprehensive responses to our discussions today, and  
25 for those where you've indicated a willingness to follow up  
26 on some of the issues with us, we would be very keen to  
27 take you up on those opportunities.

28  
29 So, thank you all very much, and we've had a very  
30 informative and helpful suggestion session this morning, so  
31 thank you.

32  
33 MS EDWARDS: Thank you.

34  
35 MR NICHOLSON: Thanks very much.

36  
37 **AT 11.58AM THE COMMISSION WAS ADJOURNED**  
38  
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47

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