Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF ASSOCIATE SECRETARY PETA MCCAMMON

I, Peta McCammon, Associate Secretary, Department of Justice and Community Safety, of 121 Exhibition Street, Melbourne in the state of Victoria, say as follows:

Part One – Introduction: mental health and the justice system

Introduction

1 I am the Associate Secretary of the Victorian Department of Justice and Community Safety.

2 Due to the Secretary's role in leading key aspects of the government response to the COVID-19 pandemic, the Secretary of the department appointed me to this role in March 2020. This role includes assisting the Secretary with the day-to-day management of the department and to lead on key non-COVID related projects and policies.

3 I make this statement to the Royal Commission into Victoria's Mental Health System (**Royal Commission**) in response to a letter dated **24 March 2020**, being a request for a statement in writing from the Secretary. I have been authorised to make this statement on behalf of the department, in my capacity as Associate Secretary.

4 This statement is true and correct to the best of my knowledge and belief. I make this statement based on matters within my own knowledge, and documents and records of the department, which I have reviewed. I also base this statement on data, information and advice produced or provided to me by officers within the department.

Qualifications and experience

5 In addition to my current role as Associate Secretary of the department, my substantive role is Deputy Secretary, Service Delivery Reform, Coordination and Workplace Safety.

6 Prior to my appointment as Deputy Secretary, I held various roles in the Victorian Public Service including:

(a) Executive Director of Family Violence and the National Disability Insurance Scheme, in the Social Policy and Service Delivery Division of the Department of Premier and Cabinet;

(b) Director of the Family Violence Branch in the Social Policy and Service Delivery Division of the Department of Premier and Cabinet; and

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

(c) Assistant Director, Portfolio Analysis in the Budget and Financial Management Division of the Department of Treasury and Finance.

7 I hold the following qualifications:

(a) a Masters of Public Administration from the Australian and New Zealand School of Government; and

(b) a Bachelor of Arts/Commerce (Honours) from Monash University.

Current role and responsibilities

8 In my capacity as Associate Secretary, I am responsible for functions delegated by the Secretary as necessary which are unrelated to COVID-19 management, and to the extent that the responsibilities can be delegated. The department oversees the administration of justice in Victoria and aims to support the community and strive for a safer, fairer and stronger Victoria.

9 The department provides advice to the following ministers who are responsible for the justice portfolio:

(a) the Attorney-General;

(b) the Minister for Police and Emergency Services;

(c) the Minister for Crime Prevention, Corrections, Youth Justice and Victim Support; and

(d) the Minister for Consumer Affairs, Gaming and Liquor Regulation.

10 This advice encompasses the department's relationship with the various agencies that encompass the justice portfolio, noting the independence of key agencies such as Victoria Police and the courts.

Witness statement overview

11 My statement sets out the department's responses to the Royal Commission's questions in the following order, with key themes highlighted in the body of the statement:

(a) Part One provides an introduction and overview of the current state of the mental health system as it interacts with the justice system.

(b) Part Two examines current opportunities to divert people with mental illness from ongoing contact with the justice system, with a particular focus on therapeutic responses through diversion programs, early intervention strategies, and referral pathways into community based mental health treatment.

(c) Part Three details the adult corrections system and describes the frameworks in place to provide mental health supports to prisoners and offenders on community orders. This is part of the Secretary's legal custody of prisoners under section 6A of the Corrections Act 1986 (Vic) (**the Corrections Act**) and her statutory obligations under the Corrections Act to provide a safe and secure custodial environment.

(d) Part Four and Part Five of the statement specifically cover the mental health of Aboriginal Victorians in the justice system – to highlight the importance of Aboriginal self-determination as a driving force of reform – and the importance of a differentiated approach to addressing the unique needs of children and young people in Youth Justice.

(e) Finally, Part Six of the statement outlines key issues requiring further attention and key elements of the department's approach to reform and innovation in relation to mental health.

12 At the end of the statement, an appendix to Parts One through Five has been provided. The appendices contain supporting detail and evidence. These should not be considered standalone documents but addenda to content that is provided in this main section. This ensures all questions are answered properly and contextualised within the body of the statement, without impeding the reader's engagement with the flow of statement with often very detailed information. My statement should also be read alongside that of the Commissioner for Corrections, Dr Emma Cassar, which I refer to as appropriate.

Critical issues at the interface of the mental health and criminal justice systems

13 The mental health care of people in contact with the justice system, or at risk of contact, should be a part of a lifetime continuum of care that steps up and down with people's health needs, not their legal status. Too often, however, the interface between the justice system and the mental health system is characterised by discontinuity, in particular:

(a) fragmentation or a lack of coordination between the many justice and community services with which a person with mental illness may engage;

(b) capacity constraints in community-based mental health services that result in the correctional, Youth Justice and forensic mental health systems becoming mental health treatment providers of last resort; and

(c) interrupted transitions out of the criminal justice system and back into the community.

14 Broadly speaking, there are two potential outcomes for common clients of the justice and health and human services positioned at this interface. The first is discontinuity and fragmentation, which leads to overrepresentation. If this is to be avoided, the alternative is

a justice and mental health interface that, wherever possible, diverts justice clients with mental illness along therapeutic pathways while meeting their mental health needs for the duration of their engagement with the justice system. This cannot happen by treating mental illness as an isolated need, as all too often mental illness is one of a set of complex and intersecting needs such as housing, and alcohol and other drug (AOD) issues.

15 This means that the justice and mental health interface must be approached as a multifaceted set of intersecting needs and services. It also means that the continuum of care must extend sufficiently far before (early intervention and prevention), during and after (transitional supports) engagement with the justice system.

Current justice policy settings

16 On 1 January 2019, the Department of Justice and Community Safety (previously the Department of Justice and Regulation) was established as part of structural changes to government to assist in delivering the Victorian Government's reform agenda.

17 In the same month, the Secretary established the Board of Management to lead the Government's renewed focus on improving community safety, victim services, regulatory services and crime prevention, while building strong collaboration across the justice system. This revised governance structure is designed to support a continued justice policy focus on increasing community safety by prioritising policing, law enforcement and crime prevention activities.[1]

18 The department provides policy and organisational management focus for a justice and community safety system that works together to build a safer, fairer and stronger Victoria by:

(a) integrating services and tailoring them for local communities;

(b) prioritising Victorians in need;

(c) focusing on victims and survivors; and

(d) strengthening stakeholder partnerships.

19 It is the department's view that justice policy settings should balance the following key concerns:

(a) maintenance of the rule of law and the proper administration of justice;

(b) upholding fundamental human rights protected under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter of Human Rights**);

[1] Department of Justice and Community Safety, 'Annual Report 2018-19', https://www.justice.vic.gov.au/annual-reports/annual-report-2018-19.

(c) respecting the views of victims and ensuring the protection of the community;

(d) the need to modify procedure so as not to cause undue distress, including ensuring procedures do not cause deterioration of the mental health of an accused person, offender or victim of crime;

(e) a preference to provide therapeutic responses, including to people with mental illness; and

(f) risk to the safety and welfare of any person, including the obligation to provide health care for adults and young people in custody.

20 It is the department's position that the policy and legislative parameters for the criminal justice system response to mental health is part of the broader obligation to provide a criminal justice system that promotes community safety, holds offenders to account, puts victims first, supports rehabilitation and prevents the cycle of reoffending. The Youth Justice system has similar obligations with a strong focus on supporting rehabilitation in children and young people. These parameters also take into account the relevant rights in the Charter of Human Rights. This includes the right to a fair trial, the right to recognition and equality before the law and the right to protection from torture and cruel, inhuman or degrading treatment, which encompasses the right to humane treatment when deprived of liberty.

21 The current policies in relation to Youth Justice, bail, parole, corrections, sentencing and victim services are critical elements of the criminal justice response to mental health. They are underpinned by a range of statutory schemes, which are explained in detail in the relevant sections below.[2]

22 This statement largely relates to the department's responsibilities regarding the criminal justice system. However, the department also oversees certain civil law protections, including measures for guardianship and enduring power of attorney for people experiencing mental illness, as well as the regulation of liquor and gaming, which I briefly outline below given its significant overlap with mental health. I would be happy to answer any questions the Royal Commission may have regarding any of these and related matters, such as fines, which I provide a brief overview of below.

The relationship between mental ill-heath and alcohol misuse

23 The experts are clear that there are three possibilities regarding the relationship between alcohol and mental illness:

[2] See Youth Justice in Appendix E, bail from paragraph 115, diversions from paragraph 96, parole from paragraph 120, corrections from paragraph 199, sentencing from paragraph 133, and victims from paragraph 84.

(a) alcohol misuse can lead to mental health problems, especially depression and anxiety;

(b) mental health issues can lead to unhealthy alcohol consumption; and

(c) in some cases, mental health and alcohol issues just happen to co-occur with no reason in an individual.

24 As noted above, alcohol can have a major impact on mental health. There is growing evidence that alcohol increases the risk of some mental health problems, like depression and anxiety. Around 37 per cent of people who report problems with alcohol also have a co-occurring anxiety and/or mood disorder.[3] The risk of having a mental illness is around four times higher for people who drink alcohol heavily than for people who do not.

25 The regulatory framework for liquor is largely about the supply of liquor. The primary object of the *Liquor Control Reform Act 1998* (**Liquor Control Reform Act**) is to minimise harm[4] – for example, one of the aims of alcohol supply regulation is to prevent minors from consuming alcohol. By making sure that liquor licensees comply with the Liquor Control Reform Act via enforcement activity, potential harms that arise from the misuse and abuse of alcohol are minimised.

The relationship between mental ill-heath and gambling

26 Gambling harm often occurs alongside mental health conditions. In 2017, the Victorian Responsible Gambling Foundation reported that 41 per cent of people seeking treatment for mental illness gamble.[5]

27 Gambling harm may be a factor leading to mental illness, and experiencing mental illness may lead to gambling harm. People seeking treatment for a mental health condition are eight times more likely than the general public to experience problem gambling. There is also significant overlap between the gambling, mental health and alcohol and drug treatment sectors.[6]

28 The Victorian Government has implemented a range of policies to reduce harm from gambling. This includes the YourPlay pre-commitment system, limits on EFTPOS withdrawals in gaming venues and caps on the number of gaming machines across the state and in vulnerable areas. In addition, Victoria has worked with other states and territories to impose consumer protections on online wagering, including a national self-

---

[3]. Burns L, Teesson M. 'Alcohol use disorders comorbid with anxiety, depression and drug use disorders. Findings from the Australian National Survey of Mental Health and Well Being', *Drug Alcohol Depend.* vol. 68, no. 3, 2002, p.299-307

[4] *Liquor Control Reform Act 1998* (Vic), s.4, ss.2

[5] Lubman, D, Manning, V, Dowling, N, Rodda, S, Lee, S, Garde, E, Merkouris, S & Volberg, R, 'Problem gambling in people seeking treatment for mental illness', 2017, Victorian Responsible Gambling Foundation, Melbourne, p. 2.

[6] Lubman, et al. p. 7.

exclusion system and voluntary pre-commitment. These measures reduce harm for those with and without mental illness.

29 The Victorian Government has also provided $153 million in funding to the Victorian Responsible Gambling Foundation (**VRGF**) to reduce gambling harm, including funding the Gambler's Help treatment sector. The VRGF has funded the Alfred Hospital to provide a range of specialised services to support people experiencing mental health and gambling problems, including face-to-face support in rural clinics for Gambler's Help clients presenting with complex mental health challenges and training for allied health professionals on gambling screening, assessment and treatment.

Victorian Government programs to respond to and support individuals at risk of radicalisation

30 The Victorian Government has committed to developing programs and services to support individuals at risk of radicalisation towards violent extremism, including those with complex needs, including mental health. It is well understood that mental health can be one of a number of underlying factors driving a person's behaviour. Research shows that there is no one path to radicalisation to violent extremism, and the factors that can drive this process can cut across areas including racism (including Islamophobia and Anti-Semitism), homophobia, family violence, toxic masculinities, substance abuse, social isolation and mental ill-health. The complexity and seriousness of the offending behaviour in the context of terrorism and violent extremism requires a holistic approach to assessing the risks, needs and responsivity issues that an individual presents.

31 The Victorian Government is exploring ways to improve coordination across government to ensure more holistic support for people experiencing mental health and other psychosocial issues that could contribute to their risk of radicalisation towards violent extremism. This aims to align Victoria's Countering Violent Extremism efforts to ensure that relevant agencies have the capacity and capability to identify, assess and respond to risks of violent extremism at the earliest possible point, and that any response is consistent across justice portfolio agencies and other government departments and service providers.

32 The Victorian Government established the Fixated Threat Assessment Centre (**FTAC**) in March 2018 which includes specialist police, forensic and mental health experts all under one roof to coordinate and oversee case conferences for people referred for support and intervention. Persons who are brought to the FTAC's attention have been referred to a variety of services including mental health community care, mental health inpatient care, AOD care and specialist youth service providers. Referred people are additionally managed via prosecution and referral to local or other policing agencies including Corrections Victoria.

33 Further research may be required to fully investigate the links between mental ill health and radicalisation towards violent extremism, particularly in relation to the psychological states associated with a personal crisis, a cognitive opening, and the consequent search for meaning, which can be fulfilled with extremist worldviews and a justification of the use of violence to those ends.

Justice system overrepresentation of adults and young people with mental illness

34 Any account of the interface between the justice and mental health systems must address the problem of overrepresentation of people in contact with the criminal justice system who have a mental illness. Australian and international research identifies disproportionally high rates of mental illness in the offender population. Rates of major mental illness such as schizophrenia and depression are found to be between three to five times higher than the general community, with prevalence in custodial populations also found to be higher in those remanded prior to trial.[7]

35 The high prevalence of mental health issues in custodial populations across Australia is reflected in the regular data collection surveys conducted by the Australian Institute of Health and Welfare (**AIHW**). *The Health of Australia's Prisoners* 2015 survey found that around 49 per cent of Australian prison entrants reported a previous diagnosis of a mental health condition, including AOD use disorders.[8] The AIHW data set, which is based on a snapshot of prison entrants over a two-week period across the country (excluding NSW), found that 60 per cent of Victorian prison entrants had a previous diagnosis of a mental health disorder, which is above the nationally reported figure.[9]

36 The 2018 AIHW report also noted the findings of an Australian population-based data linkage study of people in their 20s and 30s. The study of this cohort found that 32 per cent of those with a psychiatric illness had been arrested during a 10-year period, and the first arrest for this group often occurred before their first contact with mental health services.[10]

37 International experiences are similar, with Bebbington et al's 2017 study of two London-based prisons finding higher prevalence of mental health problems that tended to be more severe than those in the broader community, with 53.8 per cent meeting criteria for

---

[7] See for example, Ogloff J, Davis M, Rivers G & Ross S. 'The identification of mental disorders in the criminal justice system', *Trends & issues in crime and criminal justice*, no. 334, 2007.Canberra: Australian Institute of Criminology. https://aic.gov.au/publications/tandi/tandi334

[8] Australian Institute of Health and Welfare 2015. 'The health of Australia's prisoners 2015'. Cat. no. PHE 207. Canberra: AIHW.

[9] Ibid.

[10] Morgan VA, Morgan F, Valuri G, Ferrante A, Castle D & Jablensky A., 'A whole-of-population study of the prevalence and patterns of criminal offending in people with schizophrenia and other mental illness', *Psychol Med*, 43, p.1869–80; cited in the Australian Institute of Health and Welfare 2018, p.28.

depressive disorders, 34.2 per cent personality disorders, 26.8 per cent anxiety disorders and 12 per cent psychosis.[11]

38 In Victoria, in both the adult and youth custodial populations there is a high prevalence of people with mental health needs. It is important to note that the incidence and experience of mental illness in children and young people in custodial environments is different to that of adults, as is outlined in Part Five of this statement.

39 All prisoners entering the prison system are assessed to determine if they have any psychiatric conditions that require immediate treatment or diagnosis, including any known or suspected conditions that have not been confirmed, and are assigned a psychiatric risk rating (P-rating). P-ratings are an indicator of psychiatric conditions requiring a service response. These ratings are informed by clinical information and are tools to assess a person's risk to themselves and their environment. P-ratings are not a tool to diagnose a mental health condition but are helpful in identifying prisoners with relevant needs.

40 As at 30 June 2019, 40 per cent of Victoria's prisoners had been assessed as having a psychiatric condition, with six per cent identified as having a serious or significant condition, which typically requires more intensive treatment and specialist placement within the prison system.[12]

41 On this date, a larger proportion of those with a psychiatric condition than the general prison population were on remand (39 per cent compared with 35 per cent), however this difference is far greater when looking at the cohort with a serious or significant condition. Almost two-thirds (63 per cent) of this cohort were on remand (324 of 515 prisoners) suggesting a disproportionate use of remand for persons with more acute mental health issues.[13] While not conclusive, this data aligns with various submissions to the Royal Commission indicating the continued use of 'therapeutic remand', where a person is denied bail in order to ensure they receive treatment in prison.

42 The results of the department-run 2018 Annual Survey of Young People in Youth Justice in Victoria found that of the 908 children and young people under Youth Justice

[11] Bebbington, P., Jakobowitz, S., McKensie, N., Killaspy, H., Iveson, R., Duffield, G. and Kerr, M. 'Assessing needs for psychiatric treatment in prisoners: 1. Prevalence of disorder', *Social Psychiatry and Psychiatric Epidemiology*, vol. 52, no. 2,2017,p. 221-229.

[12] Figures sourced from the Corrections Victoria Data Warehouse. A serious or significant psychiatric condition includes prisoners with a current P1 rating (serious psychiatric condition requiring intensive and/or immediate care) or P2 rating (significant psychiatric condition requiring psychiatric treatment). Prisoners with a P3 rating (stable psychiatric condition requiring continuing treatment or monitoring) are included in the overall total. Prisoners with a 'PA' rating (suspected psychiatric condition requiring assessment) are excluded from this data.

[13] Figures sourced from the Corrections Victoria Data Warehouse.

supervision (on community and custodial orders) on 31 December 2018, 49 per cent presented with mental health issues.

43 Additionally, data from custodial mental health services shows that 367 (45 per cent) young people in custody during the period July 2019 to May 2020 had a diagnosis recorded, including a substance use-related disorder.[14] Further information on their diagnosis is at Part Five – paragraph 420.

44 As discussed below, mental health is one of multiple factors that may place someone at risk of contact with the justice system.[15] Many offenders with mental illness experience overlapping and complex challenges that can include social and economic disadvantage, AOD use and cognitive disability. To address mental illness within the justice system, it is important to understand that people experiencing mental illness are not a homogenous group and that their needs are not simple – that is, limited to mental health – but complex. Addressing a mental health condition in isolation from other needs and criminogenic risk factors (factors shown to predict criminal offending) is often too narrow an approach to producing lasting outcomes for individuals and community safety. Ongoing mental health service design also needs to take into consideration the needs of priority cohorts in the justice system, including Aboriginal people and women who have experienced trauma.

Nature of offences committed by persons with poor mental health

45 The nature of the relationship between mental illness and offending behaviour is complex, and available data on the nature of offending for cohorts of offenders with mental illness is limited.

46 While the prevalence of mental illness in the offending population is evident, the nature of the relationship is unclear. Research suggests that this should not be considered a causal relationship.[16]

47 Prisoner population statistics as at 30 June 2019 demonstrate that the most serious offence or charge category[17] for which prisoners with an identified psychiatric condition

---

[14] Mastercare – Justice Health Electronic Medical Record for Young People in Custody.

[15] Research suggests that the prevalence of mental illness in the offender population should not be considered a causal relationship as the nature of this relationship still remains unclear.

[16] The following excerpt from Trebilckock and Weston (2020) Mental Health and Offending: Care, Coercion and Control summarises this: "While it is clear that offenders have a prevalence of mental disorder, one fundamental challenge is that the mental health problems experienced by those offenders may have little to do with their offending behaviour. While correlations of mental disorder and offending certainly exist, associations between mental disorder and offending do not explain the nature of the relationship (Vinkers et al., 2011) and 'any causal basis for the association between mental illness and offending has yet to be established' (Peay, 2009:49). Moreover, the precise nature of the relationship is not only unclear, it is impossible to define (Peay. 2011)." p.10.

[17] Prisoners may be in custody for multiple offences. The most serious offence represents the offence for which the prisoner has received the longest sentence in the current episode for a single count of the offence. For unconvicted and unsentenced prisoners the most serious charge relates is the charge with the lowest offence classification code. The Crime Statistics Agency developed this offence classification, available at

were most commonly in custody for was assault (24 per cent), followed by burglary (15 per cent), and sex offences (14 per cent).

48 While the offence profile for prisoners assessed as having a psychiatric condition is broadly similar to other prisoners, a slightly higher proportion have a more serious charge or offence related to assault or burglary. This trend has remained broadly consistent over recent years.

Violent offences

49 As noted above, the most serious offence or charge category for which prisoners with an identified psychiatric condition are most commonly in custody for is assault (24 per cent). This category includes offences causing injury, including serious injury, as well as threats and other unspecified offences against the person.

50 However, violent offending may also be associated with other offences against the person (for example, homicide and sex offences) as well as some aggravated burglary or robbery offences. Overall, around 56 per cent of prisoners with a psychiatric condition had one or more violent offences charges (not necessarily their most serious offence). This compares to 50 per cent for the overall prison population.

Relevance of age and/or substance use on types of offences committed

51 Data available from existing prison reporting systems provides no definitive indication that age is a factor in offences committed by prisoners identified as having a serious or significant psychiatric condition. There is also no information readily available to assess the impact of substance abuse on types of offences committed.

52 The most serious offences and charges for adult prisoners by age are fairly similar between prisoners assessed as having a serious or significant psychiatric condition and other prisoners.

53 In the overall prison population, younger adult prisoners tend to have their most serious offence or charge related to assault and burglary, while a higher proportion of older prisoners have sexual offences as their most serious offence or charge.

---

https://www.crimestatistics.vic.gov.au/about-the-data/classifications-and-victorian-map-boundaries/offence-classification, which is largely based on the structure and principles of the Australian and New Zealand Standard Offence Classification (ANZSOC).

Intellectual disability or cognitive impairment bearing on types of offences committed

54 The department does not routinely formally screen for or diagnose intellectual disabilities or cognitive impairments for people in custody. There are challenges involved in the identification of disability in custodial environments. More can and must be done to improve screening at every stage of the criminal justice system to improve justice outcomes for people with disability. Prisoners' functioning and life skills are however, taken into account through the Risk Needs Responsivity model[18] which is applied across prison and correctional settings in Victoria. Planning for placement while in prison, rehabilitation and reintegration will therefore give consideration to the functional capacity of a person. Systematic diagnosis of intellectual disability or cognitive impairment is not currently performed by the department and would require considerable resourcing to implement as it would necessitate introducing additional, disability-specific screening processes and diagnosis by psychologists and neuropsychologists.

55 Data on rates of cognitive impairment in the prison population are limited to prisoners who are current or former clients of the Department of Health and Human Services (**DHHS**) with a known intellectual disability. As at 30 June 2019, these prisoners comprised less than four per cent of the prison population. Intellectual disability as defined by DHHS does not include acquired brain injury.

56 Prisoners with an intellectual disability are more likely than other prisoners to also have been assessed as having a psychiatric condition. Based on the 30 June 2019 data,[19] around 57 per cent of prisoners with an intellectual disability were classified as having a psychiatric condition, compared with 40 per cent for the overall prison population. However, this cohort is too small to enable robust conclusions to be drawn regarding the offence profile.

57 Compared with the general prison population, and all prisoners with a psychiatric condition, a larger proportion of prisoners with an identified intellectual disability had a most serious offence or charge in the categories of assault (28 per cent) and burglary (27 per cent). However, as the number of prisoners identified as having an intellectual disability in addition to a psychiatric condition is relatively small (less than two per cent of the prison population), caution should be taken when attempting to draw conclusions about differences in offence profile.

[18] This model determines interventions based on assessed risk of reoffending (Risk), the problem areas or needs specific to the offender that should be targeted to reduce risk (Need), and delivery of interventions in a way the offender will engage in and respond to (Responsivity).

[19] Figures sourced from the Corrections Victoria Data Warehouse; unpublished extract, as at June 2020.

Reasons for the overrepresentation of persons with mental illness in the criminal justice system

58 Research into criminogenic risk factors has shown that experiences of disadvantage across a series of life domains can increase an individual's risk of escalating contact with the justice system and predict reoffending. These life domains include housing, employment, AOD use, mental health and education. Many individuals in the justice system experience disadvantage across these domains and require an integrated and holistic service system to respond to these overlapping factors.

59 As referenced in the Royal Commission's Interim Report, mental health should not be isolated from these intersecting factors that often combine to increase a person's risk of contact with the justice system. Fragmentation between systems and navigation challenges posed by geographic catchments, unresponsive funding mechanisms, dispersed governance, data limitations, workforce constraints and barriers to accessing care when not in 'crisis' state are systemic issues to be addressed through the redesign of Victoria's mental health system.

60 It is difficult to establish a causal relationship between mental illness and contact with the justice system, however the prevalence of mental illness in the justice system suggests there is an association.[20] One explanation of this association may be that if a person is not receiving appropriate care that meets their needs – for example, if there are no secure treatment facilities, no longer-term residential care options accessible to them, or they frequently move between different service catchments – they can disengage from treatment, which can contribute to a deterioration in their mental health and other circumstances. This may then increase their risk of coming into contact with the justice system.[21]

61 While increases to the prison population have increased the number of people with mental illness in the prison system, Corrections Victoria's P-rating data indicates that the prevalence has remained stable.

62 As such, meeting demand in the community mental health system (along with support for other criminogenic needs) may help people to reduce or avoid contact with the justice system and reduce the number of mental health consumers in contact with the justice system.

---

[20] For a relatively small number of offenders, the department considers that their mental health problems may directly cause offending behaviour. In many other cases, mental health problems are one of a number of contributors to offending behaviour. In addition, offenders often have mental health problems that do not contribute to their offending behaviour.

[21] Sodhi-Berry N, Preen DB, Alan J, Knuiman M, Morgan VA. 'Pre-sentence mental health service use by adult offenders in Western Australia: baseline results from a longitudinal whole-population cohort study', *Crim Behav Ment Health*, vol 24, no. 3, p. 204-221. doi:10.1002/cbm.1901.

Demand pressures on the mental health system

63 As the Royal Commission's Interim Report found, in general only the most acutely unwell receive treatment, and many people with mental illness in the community either do not, or cannot, access services. While there is limited data to support the link between a lack of access to services and increased risk of contact with the justice system, the prevalence of mental illness in the justice system suggests that untreated mental illness may lead to an escalation of legal problems, particularly when combined with other unmet needs such as AOD use and housing. As noted in the Victorian Government's submission to the Royal Commission, there is significant unmet demand for people with a moderate and severe mental illness, who are not receiving a service from either the public or private mental health systems.[22]

Where mental health demand pressures intersect with justice system engagement

64 The risk of worsening mental health is compounded by limited access in the community to early intervention services. Such services provide treatment that addresses a mental health episode before it becomes a crisis and/or contributes to a risk of offending or escalation of a person's involvement in the criminal justice system.[23] For example, a lack of adequate community mental health responses, supported by other wrap-around services including legal assistance can result in perverse outcomes, such as a person being refused bail or sentenced to custody if the court system does not consider that a person will reliably receive appropriate treatment in the community. This is discussed further in Part Two.

65 As noted elsewhere in this statement, prisoners or young people and those on remand are frequently entering the custodial system with untreated mental illness as they are not able to access mental health services they need while in the community.

66 This in turn means that adult and Youth Justice custodial systems are operating as mental health providers of last resort, where this may have been avoided with access to appropriate care at an earlier time. This highlights a range of missed opportunities to intervene early and provide treatment and other necessary services.

67 Limited access to services can also adversely affect offenders when they transition back into the community. For example, when a person is not supported with appropriate and accessible mental health care and social services when transitioning back into the

---

[22] Victorian Government submission to the Royal Commission into Victoria's Mental Health System at https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/5215/6514/1027/Victorian_Government.pdf p. 23-24.

[23] Farrell M, Boys A, Singleton N, et al. Predictors of mental health service utilization in the 12 months before imprisonment: analysis of results from a national prisons survey. *Aust N Z J Psychiatry*. 2006;40(6-7):548-553. doi:10.1080/j.1440-1614.2006.01836.x

community, their risk of re-entry into the justice system and re-incarceration can increase. Without ongoing treatment and related support, a person's mental wellbeing can again deteriorate, impacting on their capacity to make decisions that prevent their potential to offend.

68 As a result, offenders with mental illness can be caught in a cycle of repeated involvement with the state's criminal justice agencies. For example, prisoners with a psychiatric condition are more likely to return to prison than prisoners without one. Further information can be found on recidivism from paragraph 156.

69 Expanding the capacity and locations of certain forensic programs for young people and adults could help people with a mental illness in, or at risk of, contact with the justice system access appropriate services in community settings. These programs would support clients with complex needs and build the capacity of the broader community mental health sector to support clients with justice needs. This could include:

(a) provision of community-based forensic mental health services, including expanding the Forensic Mental Health in Community Health (**FMHiCH**) Program for adults and the Community Forensic Youth Mental Health Service for young people; and

(b) provision of care planning services for adult and youth offenders with mental health needs, including expanding the Youth Justice Mental Health Initiative and equivalent adult services, such as the Forensic Clinical Specialist program.

70 Some clients would also benefit from intensive care in medium-to long-term residential treatment facilities. Enhanced Transition Support Units (**TSUs**) can provide a suitable environment for people who are at risk of offending and have complex needs. TSUs are home-like residential settings where people live and are supported to develop independent living skills, manage behaviours and access mental health care.

71 As noted in the Interim Report, the lack of capacity in secure forensic mental health facilities directly results in people subject to *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (**CMIA**) orders being placed in custody who would otherwise be treated in a mental health facility or disability service provider. As noted in the Forensicare 2018/19 Annual Report, people with a mental illness subject to custodial supervision orders under the CMIA, currently wait, on average, 319 days in prison before accessing a bed at Thomas Embling Hospital.[24] Youth Justice data indicates that three young people have been detained in Parkville Youth Justice Precinct in the last five years pursuant to

[24] Forensicare Annual Report accessed at https://www.forensicare.vic.gov.au/wp-content/uploads/2019/10/201910-FC-Annual-Report-2018-19-FINAL-WEB.pdf.

a Custodial Supervision Order (**CSO**) following a finding of being unfit to stand trial or not guilty by reason of mental impairment.

Systemic barriers contribute to a lack of access to mental health services

72 As previously noted, criminogenic risk factors are often experienced across a number of life domains, and an integrated and holistic service response is needed to address these overlapping factors.

73 The Interim Report notes that complex therapeutic needs call for integrated, multidisciplinary care that is responsive to clients' needs across multiple life domains with continuity of care across custody and community-based services. Unfortunately, our existing systems are stretched and often fragmented, and cannot provide the necessary supports for current and potential justice clients who often experience intersecting disadvantage and co-occurring conditions including trauma, physical health issues, AOD use, acquired brain injury and cognitive impairment.

74 In addition, systemic barriers prevent access to timely and appropriate care, including but not limited to a lack of culturally safe service offerings, financial barriers, lack of family and community connections, homelessness and discrimination.

75 By joining up service systems through initiatives such as the Common Clients reforms (discussed further below), we hope to equip the system to identify and respond to the complex and intersecting issues as well as continue to address systemic barriers preventing a person from accessing the care and support services they need. Joined up systems will also address gaps that affect the timely and appropriate provision of accessible referral pathways into multidisciplinary treatment and support services, which holistically address mental health needs alongside other risk factors including homelessness and AOD use.

Addressing the problem of overrepresentation

76 The department has undertaken significant work to develop reform directions that address structural issues affecting Victorians engaged in the justice system due to compounding disadvantage, including mental illness. One of the department's main policy and delivery priorities is focusing on early intervention and crime prevention for at risk groups and developing innovative approaches to reduce recidivism. This involves:

(a) partnering with government and non-government stakeholders to design and deliver a crime prevention reform agenda and strategy;

(b) supporting initiatives to reduce entries into the criminal justice system and recidivism;

(c) developing approaches to pre- and post-release support for prisoners;

(d) supporting community-based offenders and enhancing reintegration pathways;

(e) using pre-plea options to divert young people from the criminal justice system; and

(f) supporting children and young people with complex needs to address the unique circumstances and context of youth offending.

77 The department takes an evidence-based approach to work to reduce the risk of contact with the criminal justice system faced by priority cohorts. Priority cohorts include those who tend to be overrepresented in the justice system and experience intersecting forms of disadvantage. This includes people living with mental illness.

78 Examples of initiatives designed to work with priority cohorts include developing approaches to reduce the incarceration of women; providing culturally appropriate services to Aboriginal people to support Aboriginal self-determination and reduce overrepresentation in the criminal justice system; and improving processes within justice agencies to address discrimination against LGBTIQ people.[25]

79 A common feature of many priority cohorts is the intersectionality of different forms of discrimination, for example in relation to sexuality, age, race and gender. Policy and service delivery priorities should therefore promote inclusion and access across the justice system and seek to reduce systemic barriers to accessing justice systems.

80 As mentioned, individuals' experience of mental illness within the justice system is frequently accompanied by additional complex, intersecting needs. The interface between the mental health system and the justice system is therefore multifaceted, cutting across a range of government and non-government agencies and engaging justice clients through a range of contact points. It is almost misleading to refer to this as an interface between only two systems, due to the range of additional, intersecting factors that define the complexity of clients' needs.

81 Addressing the overrepresentation of people with mental illness in the justice system therefore calls for a nuanced strategy. The department proposes that the effective management of this interface be guided by a set of complementary objectives to address mental health in the justice system by:

(a) recognising that those who find themselves at this interface are often common clients of a range of service responses from across justice and health and human services, which calls for a multifaceted response;

[25] Department of Justice and Community Safety, 'Corporate Plan 2019-23', p. 6 Accessed at https://www.justice.vic.gov.au/corporate-plan-2019-23

(b) minimising the overrepresentation of people with mental illness in the justice system through prevention, early intervention and diversion along therapeutic pathways;

(c) providing adequate support and treatment, including forensic mental health services, to adults and young people in the justice system so that their mental health needs are adequately met;

(d) dealing with the trauma, wellbeing and self-esteem issues that most children and young people in the Youth Justice system carry, regardless of whether they have received a formal diagnosis of mental illness; and

(e) ensuring that transitions out of the justice system and back into the community are supported by adequate mental health services in the community, including for the purpose of ensuring continuity of care where required.

82 The current challenge is the gap, or the set of gaps, between optimal outcomes for each of these objectives and the status quo. These gaps are caused by a lack of overarching system design to ensure that the system is holistic and designed around a person's needs. Without a comprehensive system design, a person with mental illness cannot access and transition to necessary services as required. Similarly, without adequate forensic supports, too many people who are in contact with the justice system and are experiencing mental illness will not receive the support they need.

Common Clients reform[26]

83 One of the department's most important reform initiatives to address some of these gaps is the Common Clients reform. The Common Clients reform was established earlier this year as a partnership between the department and DHHS. The Common Clients reform is focused on improving outcomes for priority cohorts, including for people in, and exiting prison, with the aim of reducing their contact with the criminal justice system and improving health, social and wellbeing outcomes. This reform is a partnership between the two departments and the justice and social services sectors that aims to break down system barriers and strengthen the ways we work together, so people get the help they need to improve their lives earlier, instead of ending up in crisis services or the justice system.

84 The Common Clients reform guides the department's efforts to address challenges associated with the overrepresentation of people with mental illness in the criminal justice system. A key enabler of this reform is the removal of system barriers that result in

[26] I discuss Common Clients in greater detail in Part 6.

treatment and service gaps for individuals who are connected to multiple systems, including justice and social services.

85 An intersectional approach to systemic reform acknowledges that people experience multiple intersecting forms of disadvantage including, and not limited to, mental illness, homelessness, disability, involvement with child protection, and legal issues. Barriers between each of these systems can result in deterioration of mental health, escalation of legal problems and the emergence of crisis-driven rather than prevention-focused systems.

86 Common Clients reform represents a new approach to service delivery for clients of multiple government services. This work is designed to deliver better integrated services that aim to reduce repeated and escalated contact of common clients of the department's and DHHS services by ensuring people are referred to appropriate pathways. Common Clients reform is based on the idea that system usage and justice system engagement is more akin to a matrix than a linear trajectory.

87 Analysis by the department and DHHS indicates that many common clients, regardless of age or location, have similar experiences and share a common trajectory. For many of these clients, crisis services, such as child protection, the emergency department and Victoria Police are the first point of contact for a person with escalating needs. Emergency department presentations, for example, are often related to mental health. Linked data between the department and DHHS indicates that complexity quickly compounds from there, with many individuals accessing seven or more services, such as homelessness, AOD, family violence and corrections.

88 Common Clients reform is working towards an integrated service model, providing Victorians experiencing vulnerability with better connected pathways, interventions and transitions across health, social and justice services. This means that the service model will be tailored to cohorts within specific settings, but still based on common foundational features that allow multiple service systems to work together and identify issues before they escalate.

89 A key aim of the reform is to ensure that, regardless of who funds services, people get the help they need to improve their lives earlier, instead of ending up – or remaining – in crisis services or the justice system. This requires greater integration, coordination and planning between the two departments, and recognises that often people access multiple systems and services at once – but these are crisis and response driven, rather than preventative.

90 Common Clients reform complements other priority reform directions in relation to mental health and the justice system, including:

(a) improving early intervention, assessment and community-based support, especially for children and young people;

(b) promoting greater use of the joint police and mental health clinical responses to improve immediate responses to people with mental illness;

(c) improving treatment and support, through a continuity of care model, including transition in and out of custody and when supervised in the community, and in-reach services delivered in custody by mental health services based in the community; and

(d) as a part of broader justice reforms, ensuring that criminal law responses to mental illness appropriately balance treatment and community safety outcomes, supported by additional clinical supports in courts.

91 Further responses to the Royal Commission's questions regarding the Common Clients reform initiative are below from paragraph 516515.

Forensic Mental Health Implementation Plan addresses priority reforms in forensic mental health

92 In October 2014, the Victorian Auditor-General's Office released a report titled Mental Health Strategies in the Justice System, which assessed the effectiveness of planning and coordination for mental health across the justice system. The report found that while both justice and health agencies recognised the importance of addressing mental health issues in the criminal justice system, there was no overarching strategy, and a lack of effective coordination between agencies.

93 In response to this report, the department and DHHS established the Criminal Justice and Mental Health System Planning and Strategic Coordination Board, in order to ensure strategic leadership and co-ordination across the criminal justice and mental health systems. In addition to departmental representatives, this group included representatives from Victoria Police, the Magistrates' and County Courts, and Forensicare.

94 In 2016 this group was renamed the Forensic Mental Health Advisory Board, and expanded to include mental health specialists that facilitate expert guidance and co-ordination across the criminal justice and mental health systems. This Board leads the development of the Forensic mental health implementation plan (**FMHIP**) as a key component of the Government's 10 year mental health strategy.

The State funded the FMHIP in the 2017-18 Budget. The FMHIP sets out a suite of initiatives to address the priority reforms in forensic mental health

95 The FMHIP provided funding for services to support mentally ill offenders, master planning of secure forensic mental health facilities (including Thomas Embling Hospital), and forensic mental health services in custody and the community (including youth-specific forensic mental health services in custody and the community). It also funded police and court services to support mentally ill offenders.

96 Implementation of the initiatives funded through the FMHIP was overseen by the Forensic Mental Health Advisory Board following the FMHIP's announcement, and several of the initiatives have now been fully rolled out. Some of these initiatives include expanding and enhancing the Mental Health Advice and Response Service (**MHARS**) in Magistrates' Courts across Victoria and Custodial Forensic Youth Mental Health Service (**FYMHS**) in Youth Justice Precincts, and establishing a Community Forensic Youth Mental Health Service (**Community FYMHS**).

Key changes in justice policy and community attitudes over the last decade

97 The problem of overrepresentation and how to address it is also shaped by some of the main changes to justice policy and community attitudes over the last decade. What follows is an overview of key themes, with a more detailed description provided in Appendix A.

98 Justice policy changes over the last decade have in part been driven by government priorities and law reforms designed to enhance community safety, put victims first and hold offenders to account. At the same time there have been growing concerns about the increasing number of persons detained in prisons in Victoria, and interest in how changes to bail laws may impact groups such as women and Aboriginal Victorians. These concerns are addressed in the course of my statement.

99 The department plays a key role in maintaining a strong criminal justice system that prioritises community safety by holding offenders to account and embedding therapeutic jurisprudence principles in evidence-based initiatives, which are detailed later in my statement. Justice policy is multifaceted, with a need to balance competing concerns and reflects changes in community attitudes and government priorities of the day. Changes over the last 10 years reflect this, including:

(a) statutory minimum sentences for violent attacks against emergency workers;

(b) a standard sentence scheme that prescribes standard sentences for 12 of the state's most serious crimes, including murder, rape and sexual offences involving children;

(c) increasing penalties for some serious and violent crimes committed by children and young people, including for those who assault Youth Justice officers while in detention;

(d) creating a presumption in favour of uplifting serious youth offences, such as aggravated home invasion and aggravated carjacking, from the Children's Court of Victoria to the higher courts, for those aged 16 years or older; and

(e) expanding Victoria's post-sentence serious sex offender scheme to also include the supervision and detention of serious violent offenders after they have served their sentence, to ensure community safety.

100 The current Government also introduced bail law reforms, which commenced in 2018, to the *Bail Amendment (Stage One) Act 2017*, the *Bail Amendment (Stage Two) Act 2018* and the *Justice Legislation Amendment (Terrorism) Act 2018*. These reforms followed the 2017 Bail Review undertaken by the former Director of Public Prosecutions and Supreme Court Justice, the Hon Paul Coghlan QC[27] and the 2017 reports of the Expert Panel on Terrorism and Violent Extremism and Response Powers.

101 These reforms made it more difficult for serious and repeat offenders to get bail.

102 Stakeholders have highlighted concerns that bail reforms have put additional demand on Victoria's prison system through the increases in the remand population noted earlier. They have also noted that making it more difficult for individuals to access bail may disproportionately impact women, children, Aboriginal people and homeless people and that repeated lower level offending may result in someone being subject to one of the reverse onus tests for bail, including the exceptional circumstances test.

103 The number of prison receptions has more than doubled over the last 10 years (2008-09 to 2018-19), and the proportion of prisoners received on remand increased from 64 per cent to 86 per cent of all receptions. The rate of imprisonment has also increased from 104.9 to 157.1 prisoners per 100,000 Victorian. The number of prisoners on remand in June 2009 was 815 (19 per cent of the prison population) and in June 2019 this had increased to 2973 (37 per cent of the prison population).[28] There may be a range of contributing factors for this increase.

---

[27] Coghlan, P *First Advice to the Victorian Government*, Melbourne, 2017; Victorian Government, *Government Response to the Bail Review (Advice Provided by the Hon Paul Coghlan QC on 3 April 2017)*, Melbourne, 2017.

[28] Corrections Victoria, 'Prisoner Profile', 2019. Accessed at https://www.corrections.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2020/06/aa/114d40f57/infocv_prisoner_profile2019.PDF; Corrections Victoria, Corrections Victoria, 'Prison Receptions', 2019. Accessed at https://www.corrections.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2020/06/93/f30914aae/infocv_prison_reception2019.pdf.

104 Further detail on changes to bail laws, including the reverse onus test, is included at Appendix A.

105 While the bail reforms, and in particular the 2013[29] and 2018 reforms, have partly contributed to increases in the remand population, policing can also result in more people entering the bail and remand system. Police discretion about how to respond to a person who is alleged to have committed a crime is therefore a pivotal point in determining whether or not a person enters the justice system in the first place. And if they do, whether or not the person is arrested and charged.

106 In line with the Government's focus on diverting non-violent offenders that are not a risk to the community from the criminal justice system, the department is continuing to monitor the operation of bail laws and consider opportunities to address unintended impacts on vulnerable individuals.

107 The Crime Statistics Agency research on bail will examine the impacts of bail legislation changes on community safety, on demand across the justice system and on individual outcomes for alleged offenders.

108 Other key reforms which have impacted bail legislation and the remand population are set out further in Appendix A.

Embedding victim survivor experience in our work

109 Victims of crime can also be offenders (the victim-offender overlap). In particular, research has connected an increased likelihood of offending in child victims of sexual abuse, and linked female offending with backgrounds of sexual victimisation and mental illness, often a result of complex trauma.[30] The justice system must therefore be equipped to deal with the unique needs of all victim survivors.

110 Over the last 10 years, measures have been introduced to reduce the difficulties victims experience when participating in the justice system. These measures respond to increasing advocacy by victim support agencies, by victims themselves, and evidence-based reviews[31] documenting the impact of the justice system on victims.

---

[29] See Appendix A.

[30] See for example, Royal Commission into Institutional Responses to Child Sexual Abuse, Final Report, Vol III, p 144; https://www.correctiveservices.justice.nsw.gov.au/Documents/women-as-offenders-women-as-victims-the-role-of-corrections-in-supporting-women-with-histories-of-sexual-assault.pdf; and https://www.corrections.vic.gov.au/women-in-the-victorian-prison-system-0.

[31] For example: Royal Commission into Family Violence, *Final report* 2016; Victorian Law Reform Commission (VLRC), *The Role of Victims of Crime in the Criminal Trial Process*, Report, August 2016; Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report*, 2017; VLRC, *Review of the Victims of Crime Assistance Act 1996*, Report, July 2018; Centre for Innovative Justice, *Victim Service Review Stage 1: Strengthening Victoria's victim support system - Final Report September 2019,* (Melbourne: RMIT University, 2019); Centre for Innovative

111 Embedding victim survivor perspectives in justice system design and in policy and practice development is another important priority for the department. This includes areas such as law reform, post-sentence arrangements, workplace safety, sexual assault, family violence and emergency management and with improvements to the wider victim service system. Appendix A provides further detail on changes to victims policy over the last 10 years and the department's efforts to promote the interests of victim survivors in the administration and reform of the justice system, as well as ensuring the delivery of quality victim support services.

112 In addition to these changes in the criminal justice system, reforms to the civil law have promoted the rights of persons experiencing mental illness to self-determination, which can interact with their participation in the criminal justice system. The *Guardianship and Administration Act 2019* commenced on 1 March 2020 and contains key reforms to improve self-determination, being:

(a) a presumption that a person has the capacity to make decisions unless evidence is provided otherwise and recognition that a person also has decision-making capacity if they can make decisions with support; and

(b) if a guardian or administrator must be appointed, they must make decisions that reflect the person's will and preferences (for example, to live independently and well), unless it would cause the person serious harm.

Changing community attitudes to mental illness and offending

113 There have been some significant changes to community attitudes to mental illness over the last decade. While there has been a marked improvement in the community's understanding of, and attitude toward, mental illness in general, there is still often an issue around the stigmatisation of people with mental illness as a threat to community safety. High-profile incidents with a link to mental illness can contribute to community fear and calls for stronger laws. The media can play a role in this too by amplifying stigmatising stereotypes about mental illnesses, as explained by Dr Chris Groot in the Royal Commission's first round of hearings.[32]

114 There can also be a perception in the community that unfitness to stand trial or verdicts of not guilty due to mental impairment demonstrate a contemporary trend towards lenient

---

Justice, *Victim Service Review Stage 2: Strengthening Victoria's victim support system - Final Report December 2019*, (Melbourne: RMIT University, 2019).

[32] "It is theorised that mass media plays an important role in establishing and maintaining stigmatised stereotypes about schizophrenia in particular. There is data that shows that there is a bias in TV news reporting around mental illnesses like schizophrenia in particular to reporting violent crime. It is most often the case that the experience of mental illness was an insignificant factor in relation to the reported crime, but often in modern media illness is paired with violence without necessary elaborative context. This reporting style creates a simple yet powerful association in the viewing public between an illness like schizophrenia and violence." (Witness Statement of Dr Chris Groot, 2019, paragraphs 67-68. Accessed at https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/3615/6765/4554/WIT.0001.0069.0001.pdf).

sentencing, despite the longstanding common law basis for these outcomes. Improving community understanding through balanced media reporting and public discourse is an important way of improving community understanding of mental illness, offending and criminal responsibility. Moves in recent years by the courts to broadcast judges' sentencing remarks help to demystify the legal process and promote greater public understanding of the many factors that need to be considered during sentencing.

115 The increasing understanding of mental health issues in the community in recent times should be leveraged in public discourse to promote a more balanced discussion regarding mental health in the justice system. Promoting greater understanding of the victim-offender overlap would support this.

116 However, as discussed above, the assumption that mental illness causes criminal behaviour narrows what should be a broader engagement with a complex set of factors – mental health issues, homelessness, and AOD use for example – which give a stronger indication of a person's risk of engagement with the criminal justice system. Trauma, including intergenerational trauma, and racism are also key factors, particularly for Aboriginal Victorians.

117 As noted, many offenders have also been victims of crime[33] and these overlapping cohorts experience similar rates of mental illness, and intersecting disadvantage. While there is a need for strong laws to hold offenders to account, this must be accompanied by a long-term community safety agenda that acknowledges the need for appropriate supports, including mental health treatment, to prevent crime, promote rehabilitation and reduce reoffending.

118 Community attitudes should also be informed by evidence of the benefits for individuals and community safety of initiatives to divert people with mental illness from unnecessary or prolonged engagement with the justice system, which is the subject of the next part of my statement.

33 This is most notable among young people in the Youth Justice system where there is significant overlap between children and young people involved with Youth Justice and those in contact with Child Protection. For example, the results of the 2018 Annual Survey of Young People in Youth Justice in Victoria found that of those under Youth Justice supervision in custody and community on 31 December 2018, 52 per cent had been the subject of a child protection report. These young people's backgrounds are often characterised by significant trauma and disadvantage.

Part Two – Opportunities to divert people with mental illness from ongoing contact with the justice system

Introduction

119 As a broad principle rather than a narrow legal concept, the aim of diversion is to reduce unnecessary engagement with the justice system. Where mental health and intersecting issues have escalated to bring a person in contact with the justice system, diversion can function as a critical intervention to address issues that, left alone, may drive prolonged and repeated engagement.

120 This principle is enacted across the justice system in different ways, ranging from police cautions through to therapeutic interventions by courts and the corrections system that seek to guide offenders towards rehabilitation and away from avoidably prolonged engagement with the criminal justice system. For courts, this can include a range of sentencing dispositions and therapeutic interventions. Where mental health and intersecting issues have escalated to bring a person in contact with the justice system, diversion can function as a critical intervention to address issues that, left alone, may drive prolonged and repeated engagement.

121 The justice system's capacity to deliver effective diversions for clients with mental health issues is dependent to a significant degree on the availability and suitability of mental health services in the community. Diversion programs largely rely on capacity in community-based mental health programs to provide services to referrals. Where programs are at capacity, people with mental illness who are suitable candidates for these diversion programs may, for example, be refused a court order such as bail and be put on remand, as discussed below. While diversion programs are a broad ranging workstream across the department, the reform opportunities here are generally confined to those which focus on people with mental health needs who are engaged with the justice system.

Diversion and health-led responses for people with a mental illness involved in the justice system

122 The department believes that there is a need to prioritise health-led responses for people with a mental illness in the justice system who have been charged with less serious offences. This will help to address the significant overrepresentation of people with mental illness in the criminal justice system.

123 One recent example of reform to support health-led responses is the government's announcement of its intention in principle to abolish public drunkenness offences.

Decriminalising public drunkenness and replacing it with a health-based response will help to provide vulnerable Victorians with appropriate support.

124 How health-led responses can operate will depend, amongst other factors, on the individual, the severity of their illness, and the relationship between a person's mental illness and their offending.

125 Diversionary programs create an opportunity to embed health-led responses when dealing with people with a mental illness in the justice system. As noted above, diversion opportunities are available across a number of points of contact between community members and the justice system, including police and court-based diversions.

126 This section provides an overview of key trends in diversion, bail, parole and recidivism, linking to more detailed responses in Appendix B.

Diversions

The role of police in the mental health system

127 Due to early intervention mechanisms not operating as effectively as they should, police are often the first responders to attend to people in a mental health crisis. They do so often without any clinical assistance. In 2017-18, police made around 43,000 interventions in response to psychiatric crises and suicide threats or attempts.[34] In 2018-19, police also made around 14,000 transfers to an emergency department or designated health facility.[35]

128 When engaging with people with a known or suspected mental illness, police are required to make immediate judgment calls whether to: refer a person to a mental health service; apprehend a person to be assessed by a medical practitioner where they present a risk of serious and imminent harm to themselves or others; issue a warning, caution, diversion or infringement notice; or arrest a person where they have committed an offence.

129 As noted in the Victoria Police submission to the Royal Commission and Assistant Commissioner Glenn Weir's statement, "unnecessary contact between police and people experiencing mental health issues should be minimised as this can compound stigma and add to the person's trauma, leading to suboptimal outcomes."[36]

---

[34]Victorian Government submission to the Royal Commission into Victoria's Mental Health System at https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/5215/6514/1027/Victorian_Government.pdf p 24.

[35]Witness Statement Assistant Commissioner, Glenn Weir, 2019, p. 12. Accessed at https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/3115/6314/9157/Assistant_Commissioner_Glenn_Weir.pdf

[36] Ibid. p. 28

130 Increasing police access to advice from mental health clinicians in the field can improve police decision-making and offer pathways to timely mental health assessments, treatments and services. Increased police access to clinical support would also improve assessment and treatment outcomes for people in police custody. This will also assist police to engage with people with mental illness with complex and multiple needs.

Diversion and early intervention for children and young people

131 Victoria has one of the lowest rates of children and young people in custody of any Australian jurisdiction. The success of the diversion of children and young people from Victoria's Youth Justice system relies on police cautioning efforts as well as the diversionary programs available to this cohort. These include the Youth Support Service (detailed further in Part Five) and the Children's Court Youth Diversion Service (**CCYD**).

132 The CCYD provides a pre-plea option for young people to divert children and young people from further progression into the criminal justice system. It supports the child or young person to accept responsibility for their behaviour, understand the harm caused by their actions and complete a diversion plan involving activities intended to reduce the likelihood of further offending.

133 These programs have high uptake, and keep children and young people from being under Youth Justice community or custodial supervision. For example, the Children's Court Youth Diversion Service oversaw 1595 matters between January to December 2019.

134 Whilst there is no legislative basis for cautions in Victoria, Victoria Police policy enables police officers to make decisions about issuing cautions for children in circumstances where the offender admits the offence, the parent or guardian consents to the caution and is present at the time the caution is issued, and the offender has no criminal history. As in all matters regarding Victoria Police, the department's role is to provide policy support and oversight as part of its broader responsibilities oversighting the criminal justice system.

135 Police cautions are available for low-level offending including shop theft and personal use/possession (cannabis) offences, which attract a drug diversion caution.

136 As noted in Assistant Commissioner Glenn Weir's statement there are a number of joint initiatives between Victoria Police, Ambulance Victoria, mental health service providers and other relevant service providers to enhance interventions and, ultimately, outcomes for people experiencing mental health issues who have contact with police.[37] These are further detailed in Appendix B.

[37] Ibid. p. 18

137 The department and Victoria Police are committed to considering further reform opportunities to bolster capability to respond to people with mental health support needs, including by way of using cautions and diversions.

138 For example, the Aboriginal Youth Cautioning Program (**AYCP**) is a five-year program of work by Victoria Police, in consultation with Aboriginal communities, to increase and enhance the use of cautioning and diversion options via a community-led model. It aims to address the overrepresentation of Aboriginal young people in the criminal justice system. I refer to Part Four of this statement which provides further detail on this program.

139 The key benefit of police cautioning is that coupling diversion opportunities with referrals to services will help divert people with mental illness away from the justice system and towards therapeutic paths. This is a better outcome as it promotes early intervention rather than a crisis-driven response. This will likely require the expansion of community-based mental health services that are equipped to support the increased number of forensic clients.

140 When people cannot be diverted, better mental health services for people in police custody could improve outcomes. The service offering in custody must therefore be tailored to the needs of different cohorts, such as women, people from culturally and linguistically diverse (**CALD**) backgrounds and Aboriginal people.

141 As mentioned, Victoria Police is responsible for developing its approach to cautioning and diversion, which is not legislated. Victoria Police is therefore best placed to directly address the issue of whether changes to police policy and practices have resulted in the disproportionate representation of young people and adults that are experiencing mental illness and are in the criminal justice system.

Bail

142 The number of prisoners on remand has almost tripled between June 2013 and June 2019 (from 954 to 2973), increasing from 19 per cent to 37 per cent of the prison population. This may be due to a range of factors, including legislative changes to criminalise breaching a bail condition and committing an indictable offence while on bail. Other contributing factors could include the response to recommendations made by former Director of Public Prosecutions and Supreme Court Justice, the Hon Paul Coghlan QC, in the Bail Review, following the Bourke Street tragedy on 20 January 2017.

143 One of the ways mental health issues are taken into account in relation to bail is the need for bail decision makers to consider 'surrounding circumstances', which include "any

special vulnerability of the accused, including being a child or an Aboriginal person, being in ill health or having a cognitive impairment, an intellectual disability or a mental illness".[38]

144 For people seeking bail at some venues of the Magistrates' Court, the Court Integrated Support Program (**CISP**) is available anytime between the accused person being charged up until sentencing. CISP aims to reduce the likelihood of people re-offending by assisting them to access support services (more information on CISP is available at paragraph 184c and Appendix B).

Parole

145 People with mental illness applying for parole also need access to community services that will be able to support their needs. Following parole reform, prisoners are able to apply for parole 12 months prior to their earliest eligibility date. This promotes a robust assessment process and the identification of transitional needs including mental health assessment and treatment needs. Despite the parole planning process, parolees can still experience difficulties in accessing timely treatment upon release.

146 While there are competing demands for housing across the justice and social services sector, it is important to note that there is currently a lack of suitable and affordable housing options for justice clients, particularly those leaving prison. As the Adult Parole Board will not release a person onto parole into homelessness,[39] a lack of affordable housing reduces the ability of the Parole Board to support a person to access parole. This means prisoners are spending longer in custody than they otherwise would, and for people being released at the end of their sentence, this means release without any additional supervision or monitoring in the community.[40] These straight releases may also be to homelessness.

147 In 2018-19, nearly 20 per cent of rejected parole applications cited absence of accommodation as a reason for denial. [41]

148 Homelessness is a significant contributor to reoffending. Nationally, the AIHW found in 2019 that approximately one-third (33 per cent) of prison entrants said they were homeless in the four weeks prior to entering prison. 8.4 per cent of prisoner receptions

---

[38] *Bail Act 1977* (Vic), s.3AAA

[39] In making decisions to grant parole, the Board carefully considers all relevant information with the paramount consideration being the safety and protection of the community. This includes whether proposed accommodation is suitable and stable.

The most prevalent factor for the Board to deny parole was that the prisoner's risk to the community was too great. Other prevalent factors included the prisoner having insufficient time remaining on their sentence for parole to be of benefit and an absence of suitable accommodation, as precarious or unsuitable accommodation can be a major risk factor for re-offending. The Board's requirement to treat the safety and protection of the community as its paramount consideration means that the Board cannot grant parole in such cases. See Adult Parole Board, Annual Report 2018-2019. [41] Adult Parole Board data.

[41] Adult Parole Board data.

during 2018 (1044 of 12,486 receptions) were recorded by Victoria Police as having no fixed address.

149 In 2017-18, 5102 or nearly 50 per cent of releases (10,780) from adult prisons accessed homelessness services in the 12 months following release.

150 As is outlined in Part 7.3.6 of the Interim Report, a lack of housing and insecure housing is a direct barrier to accessing mental health treatment through Area Mental Health Services (**AMHS**), which requires that a person has an address within the relevant catchment area.

151 This is also an issue for children and young people with mental health needs transitioning to the community from custody with a lack of housing or insecure housing. Following the 2018 Annual Survey of Young People in Youth Justice in Victoria, of the 174 children and young people supervised in custody on 31 December 2018 who were subsequently released from custody, 24 per cent were residing in accommodation other than living with family, relatives or kin, or a residential care or out of home care placement.

152 Recently, the department has been exploring options to support prisoners to access additional housing via head leasing and private rental options upon release from custody.

153 Prison-based Initial Assessment workers, through homeless support agencies, have had access to additional Housing Establishment funding and Private Rental Assistance Package. This funding allows workers to place clients who would be leaving prison into homelessness in temporary hotel accommodation as part of the COVID-19 response whilst a longer term option was sought. Once released offenders are able to attend a Homelessness Entry Point for assistance with securing a longer-term housing option, which might include:

(a) social housing – this could be public housing, community, or transitional (up to 12 months) housing;

(b) a registered rooming house;

(c) private rental;

(d) return to living with family or friends; or

(e) a woman's refuge, if family violence is an issue.

154 Brokerage may be available to assist an offender to access funding for security bonds or where the payment of rent in advance is required. Where an offender has access to post-release support, such as ReStart or ReConnect, their workers can also help with securing accommodation.

Recidivism

155 Recidivism can be defined in many ways for the purposes of understanding the prevalence and nature of re-offending. The rate at which sentenced prisoners return to custody with a new sentence within two years is a nationally agreed measure used to assess criminal justice system performance. While this measure provides a source of comparability across states and territories, it has limited utility in understanding the true rate of re-offending amongst persons in contact with the justice system. Notwithstanding, the data provides a useful source to understand trends for different groups within the Victorian sentenced prisoner cohort.

156 While it has been consistently shown in recent years that there is a higher rate of return to prison for prisoners with a psychiatric condition than other prisoners, trends within these groups have differed. Between 2014-15 and 2018-19 the rate of return for prisoners with a psychiatric condition has fallen (from 54.3 per cent to 51.3 per cent), while the rate for other prisoners has increased (from 32 per cent to 36.2 per cent), resulting in an increasing rate of return overall.[42]

157 Drivers of trends in the rate of return to prison are complex and involve the combined impact of a range of criminal justice system policies and practices. More in-depth analysis would be required to understand if these statistics reflect any systemic trends.

Breaking or reducing the cycle of recidivism

158 The optimal way to ensure people with mental illness who have contact with the criminal justice system are not caught in a cycle of recidivism is by providing access to the right suite of supports and treatment.

159 An example of policy that has been developed to ensure people in custody have access to treatment and support is the Corrections Women's Policy 'Strengthening Connections'. This policy was formulated to address the "missing middle" in mental health care for women in custody. The 'Strengthening Connections' policy provides for the staged introduction of a new trauma-informed approach to the provision of mental health care in the women's prison system.

160 There are also significant efforts underway across government to address the demands on the criminal justice system through legislative and policy reform, including to address recidivism. An example of this is the government's September 2019 announcement of a $14.5 million investment in a women's diversion and rehabilitation package. This package

[42] Figures from the recidivism data extracted for the Royal Commission under a Notice to Produce issued to the department.

is aimed at expanding support services and programs for women in prisons with the aim of reducing reoffending and, thus, the overall number of women in prisons.

161 Funding is being invested into supporting women leaving custody through strengthened employment opportunities and improved access to housing; continuing successful family violence programs for women prisoners; and enhancing the management of women in prison with complex needs. Funding has also been invested in expanding legal and housing support, as well as a feasibility study for a culturally responsive residential diversion program for Aboriginal women similar to the Wulgunggo Ngalu Learning Place for Aboriginal men.[43]

162 Over $14 million in funding was invested for a number of diversion and early intervention activities for children and young people early in their contact with Youth Justice in the 2018-19 year. This went toward the Children's Court Youth Diversion Service, Youth Support Service, Aboriginal Youth Support Service, Youth Justice Group Conferencing Program and early intervention and diversionary components of the Aboriginal Youth Justice Program.

163 Recidivism can also be addressed by ensuring continuity of care as a person moves between custody and the community. For many who are placed into custody, their mental health treatment is interrupted. The department recognises that people with mental illness in custody would benefit from the commencement of treatment with community mental health providers prior to their release, the continuity of care where that treatment already exists, and the building of connections with the mental health provider they will use in the community.

164 There are examples of this model already within the criminal justice system. We are currently piloting continuity of health care programs for adult Aboriginal prisoners, where Aboriginal community service providers in-reach to prisons to build relationships and an understanding of need, and then provide support post release.

165 The department has developed a continuity of care model which would enable mental health services based in the community to be delivered in custody. This model recognises justice settings as part of the broader mental health system and is designed to improve the likelihood of people continuing to receive the mental health services they need when they return to the community, which in turn reduces the likelihood they will reoffend. It is yet to be funded or implemented.

[43] Further detail about this program is set out in Part Four at paragraph 366.

Fines

166 Like the broader criminal justice system, the fines system, which includes infringement and court fines, can have a disproportionate impact on people with mental health needs. Infringement fines are typically issued for low-level offending and are intended to ensure fine recipients assume responsibility for their offending while avoiding entry into the criminal justice system. Given the volume of the fines system, which issued around 4.3 million infringement fines in 2018-19, and the broad range of infringement offences, including traffic, parking and public behaviour-related fines, the fines system is a significant early point of contact for people with mental illness with the criminal justice system.

167 Fine recipients who address their fines, financially or otherwise, have a reduced rate of re-offending. The Sentencing Advisory Council noted in its 2014 report, *Imposition and Enforcement of Court Fines and Infringement Penalties in Victoria,* that those who successfully expiate their Magistrates' Court fine (including by non-financial means) have a lower rate of re-offending after two years (18 per cent) than those who do not (29 per cent).[44] It also noted, in support of the conversion of fines to a term of imprisonment imposed for another offence, that people who are able to leave prison free of debt are far less likely to return to prison (30 per cent compared to 50 per cent of offenders with debt).[45]

168 In light of these findings, Victoria's fines system has increasingly strengthened opportunities for diversion and early support for people with mental illness who incur fines, first through the *Infringements Act 2006* and, more recently, through expanded initiatives for disadvantaged Victorians in the *Fines Reform Act 2014* (**Fines Reform Act**). Currently, a person with mental illness has a range of options to ensure they do not face inappropriate punitive consequences for offending. A person with mental illness who receives an infringement fine causally linked to their limited ability to comply with the law may make an application to review whether a fine should be issued, or to cancel the enforcement of a fine, on the ground of "special circumstances". If the application is successful, the fine is typically withdrawn, with no further action being taken. Between 1 January 2018 and 31 December 2019, over 6000 individuals applied to the Director, Fines Victoria to cancel enforcement of their fines on the grounds of "special circumstances" with the vast majority of these applications approved.

169 A person with mental illness may also be eligible to expiate their infringement fine debt through the Work and Development Permit (**WDP**) Scheme or, where they face multiple

[44] Sentencing Advisory Council *Imposition and Enforcement of Court Fines and Infringement Penalties in Victoria*, 2014, p. 45.

[45] Sentencing Advisory Council, p. 204.

intersecting issues such as family violence the Family Violence Scheme, available under the Fines Reform Act. The WDP scheme allows eligible people to work off their fine debt by undertaking approved activities that address the underlying causes of their offending, such as treatment from a health practitioner or drug and alcohol counselling. From the commencement of the WDP scheme in July 2017 to February 2020, around 2500 WDP applications have been received, and some $4.5 million in fines debt worked off, through participation in treatment and other activities

Sentencing and courts

Sentencing considerations with regard to people with mental illness

170 Consideration of mental impairment and mental illness in sentencing decisions has been embedded in the justice system over time, including through reforms to the *Mental Health Act 2014*(Vic) (**Mental Health Act**) and *the Sentencing Act 1991* (**Sentencing Act**), for example:

(a) Section 5(2) of the Sentencing Act prescribes that, in sentencing an offender, a court must have regard to certain matters. In this context, the mental health of an offender may be relevant to the consideration of the offender's 'moral culpability' and can be a 'mitigating factor' in the sentencing exercise.

(b) With the introduction of the Mental Health Act in 2014, the nature of an offender's impaired mental functioning pursuant to the Sentencing Act now includes mental illness within the definition of impaired mental functioning, meaning that if an offender's mental illness is causally linked to the commission of an offence and substantially reduces the offender's culpability, certain sentencing restrictions, such as statutory minimum sentences or custodial order requirements, may not apply.

171 Further details on these and other sentencing considerations are provided at Appendix B.

172 It is also important to note policies which balance rehabilitation with just punishment and community safety in serious offences. Rehabilitation is an important sentencing consideration for persons who have committed offences which were caused or contributed to by a mental illness and is an important factor in preventing reoffending. However, that consideration must be balanced with an appropriate response to the nature and gravity of certain crimes which both ensures community safety and meets community expectations.

173 This balance is illustrated in Victoria's reforms to sentencing laws which are designed to protect emergency service workers from occupational violence. These reforms reflect the unique and critical role of these workers in protecting the Victorian community and the

inherent risk involved in the work of emergency first responders. Further information on this can be found at Appendix B.

Dispositions currently available to courts to facilitate treatment for mental illness

Dispositions available to courts to facilitate mental health treatment

174 In Victoria, Courts determine what sentence is appropriate. Judges and magistrates do this by applying the process described as 'instinctive synthesis'.[46] This process involves weighing all the relevant competing factors and then making a value judgment as to what is appropriate in the circumstances.

175 Through this exercise, judges must take into account mitigating circumstances — including in appropriate circumstances a person's "impaired mental functioning"[47] — and may apply the principle of rehabilitation, which can facilitate the treatment for mental illnesses. While rehabilitation is important, it is not the only relevant factor and, in certain cases, may need to take a "back seat" to other competing considerations (such as just punishment, deterrence, denunciation or community protection).[48]

176 A range of sentencing dispositions are available to the courts which can directly facilitate treatment for mental illness, thereby reducing or eliminating factors which contributed to offending conduct. These dispositions include:

(a) adjourned undertakings with a condition to engage in mental health treatment;

(b) Community Correction Orders (**CCO**) with a mental health rehabilitation and treatment (**MHRT**) conditions (see further below) or, in certain circumstances, a Mandatory Treatment and Monitoring Orders;

(c) Court Secure Treatment Orders; and

(d) for persons with a dual disability, Justice Plan conditions as part of a CCO or adjourned undertaking.[49]

---

[46] *Dalgleish (a pseudonym) v The Queen* (2017) HCA 40.

[47] *R v Verdins* (2007) 16 VR 269

[48] *DPP v Lawrence* [2004] VSCA 154 [22]; *Veen* (No 2) (1988) 164 CLR 465, 477.

[49] Where a child or young person is sentenced by the Children's Court, a range of youth-specific dispositions are available under the Children, Youth and Families Act 2005 (CYFA) that may facilitate mental health treatment. Probation orders, youth supervision orders, youth attendance orders and youth control orders are all community-based sentences that are supervised by Youth Justice. The Court can order that a child or young person undergo medical, psychiatric or psychological counselling or treatment as a special condition of one of these orders. For children or young people with an intellectual disability, the Court can order that the child or young person participate in disability services identified in a pre-sentence report plan of service (the Justice Plan equivalent), as a special condition of one of these orders. The CYFA also includes a range of unsupervised orders – the non-accountable undertaking, accountable undertaking, and good behaviour bond – which may be imposed with or without conditions at the discretion of the Court.

Note that rehabilitation is especially important in the context of the Children's Court's decision-making. The Court must have regard to the suitability of the sentence to the child or young person. This allows the Court to consider the individual needs and vulnerabilities of a child or young person when determining their sentence.

177 In addition, if the court considers a term of imprisonment to be the only appropriate disposition, mental health treatment can still be facilitated in two ways. Firstly, where the term of imprisonment is 12 months or less, the court can make a combination sentence (i.e. imprisonment followed by a CCO). The CCO can contain a MHRT condition. Secondly, where the term of imprisonment is more than 12 months, the court may take rehabilitative factors into account when setting a non-parole period thereby allowing the offender to benefit from a longer period of supervision post-release. In both cases, conditions can be made requiring the offender to undergo and submit to mental health treatment. Further information on CCOs and parole is provided at paragraph 264.

178 The department is also considering how to best ensure that the Sentencing Act promotes consistency and transparency in the sentencing process and ensures that the hierarchy of sentencing dispositions meets the needs of the community.

Supporting and investing in responses to people with a mental illness, including to reduce recidivism

179 The Victorian Government supports the courts to facilitate the treatment needs of offenders with mental illness in contact with the criminal jurisdiction in a number of ways. This includes preparing pre-sentence reports and providing reports as to a person's fitness to stand trial. Courts are also supported through the development of therapeutic justice projects.

180 In recent years, Victoria has made a sizeable investment in programs to support diversion and reduce the rates of recidivism, especially amongst offenders with mental illness. Through the Victorian Budget, additional funding has been provided to Court Services Victoria (**CSV**) for flagship projects and initiatives provided by the courts, discussed below.

181 Investment has also been made to ensure that judicial officers have a good understanding of mental illness. For example, the Judicial College of Victoria (**JCV**) works to provide educational programs to judicial officers to increase awareness about the social context and circumstances surrounding offending behaviour, including mental illness.

Court-led initiatives can support diversion to therapeutic pathways where appropriate

182 Several therapeutic justice interventions are currently underway in Victoria's court system to divert people with mental illness away from becoming entrenched in the justice system and provide an alternative and more person-centred pathway through the justice system.

183 Therapeutic court interventions recognise the underlying causes of offending and aim to address these causes and reduce reoffending. It is widely accepted that the benefits of therapeutic and specialised courts in rehabilitating offenders are achieved by addressing the underlying causes of offending behaviour. In the long term, it is expected that these approaches will keep Victorians safe by reducing recidivism. A series of therapeutic court interventions have been implemented in the Magistrates' Court of Victoria, including:

(a) Mental Health Advice and Response Service, which enables clinical services to intervene early in the criminal justice process by identifying where individuals charged with an offence and appearing before the court have a mental illness;

(b) providing timely advice to the courts on those illnesses and facilitating referrals to treatment providers;

(c) Assessment and Referral Court List, which provides intensive and pre-sentence support and judicial supervision to accused persons with mental illness or cognitive impairment;

(d) CISP, which links accused persons to support services, including drug and alcohol treatment, mental health services, and crisis and supported accommodation;

(e) Victorian Drug Court, which provides for the sentencing and supervision of the treatment of offenders with a drug and/or alcohol dependency and whose dependency contributed to their offending. Further information regarding the expansion of the Drug Court is set out in Appendix B of my statement;

(f) Neighbourhood Justice Centre in Collingwood, which brings together a multi-jurisdictional court with a range of support services and community initiatives, including legal assistance, mental health support, financial counselling, AOD counselling, and housing support;

(g) The Children's Court Clinic, which services the Children's Court of Victoria (the Children's Court). The Clinic is a team of clinical and forensic psychologists and neuro and consulting psychiatrists, who make clinical assessments of children and provide other clinical assessments and recommendations in relation to children, youth and families. These expert clinical assessments assist the Court in its decision-making in both the Criminal and Family Divisions of the Court;

(h) Specialist Family Violence Court Division, which offers a specialist response to family violence matters through purpose-built physical environment, enhanced resourcing, staff specialisation and support, user centred and innovative practices, inclusivity and improved safety for families attending court. It currently operates at three venues (Shepparton, Ballarat and Moorabbin);

(i) Koori Court,[50] which ensures sentencing orders are appropriate to the cultural needs of certain Koori offenders and assists them to address issues relating to their offending behaviour, which include mental illness; and

(j) The Koori Children's Court, which is a sentencing Court, involves the Koori community in the court process. There are currently 12 Koori Children's Courts across Victoria sitting in: Melbourne, Heidelberg, Dandenong, Mildura, Latrobe Valley (Morwell), Bairnsdale, Warrnambool, Portland, Hamilton, Geelong, Swan Hill and Shepparton.

184 Further information on each initiative is set out in Appendix B of my statement.

Planning of therapeutic justice initiatives

185 CSV, as the independent administrative body supporting the courts and in conjunction with the relevant jurisdiction (such as the Specialist Courts area of the Magistrates' Court), has primary responsibility for the administration and delivery of therapeutic court operations. The expansion and evolution of these specialist courts is ultimately the responsibility for the Attorney-General and Government with guidance from the courts.

186 In this regard, the department is currently working with CSV, the Courts and DHHS to understand the design parameters of a potentially integrated therapeutic intervention model and how therapeutic court interventions could be expanded to enable state-wide coverage and the type of service delivery models that will improve or enhance the integration of existing therapeutic court interventions. To this end, the department is working with CSV, the County Court of Victoria and the Magistrates' Court of Victoria to

[50] Koori Courts operate in the Children's, Magistrates' and County Courts. Defendants must plead guilty to have their matter heard in Koori Court. All Koori Courts involve Elders and Respected Persons in court proceedings and seek to create an environment where Aboriginal families, communities and service providers feel more able to participate in the court process. Through a more informal court process defendants and others are more comfortable telling their stories and revealing the factors that contributed to offending, this assists Magistrates' and Judges to ensure sentencing order are appropriate and address underlying factors contributing to offending behaviour. To be eligible for entry into the Koori Court, you must:

- Be Aboriginal and/or Torres Strait Islander.
- Be charged with an offence that can be heard in a Magistrates' Court.
- Be charged with an offence that does not involve family violence offences or sexual assault.
- Live within, or have been charged within, the boundary area of a Koori Court.
- Plead guilty to the offence.
- Be willing to come to Koori Court to talk about your story and join in the sentencing conversation.

(Source: 'Koori Court A Defendant's Guide' An Initiative of the Aboriginal Justice Forum. Accessed at https://www.mcv.vic.gov.au/sites/default/files/2018-10/Koori%20Court%20-%20A%20defendant%27s%20guide%20brochure.pdf).

explore how the Drug Court could enhance its model to respond to the needs of people experiencing mental illness.

187 As noted in Part One and the Interim Report, complex therapeutic needs call for integrated, multidisciplinary care that is responsive to clients' needs across multiple life domains. There is a risk that in rightly improving the user's experience at court by better targeting and tailoring the practice and supports of the court to their needs, fragmentation, siloing and stretching of services is replicated within the courts. Therefore, it is vital that as we evolve these innovative and integral specialist and therapeutic responses, we are mindful of these risks and actively integrate the 'common client' logic and philosophy into this work.

Supporting courts in considering appropriate responses to people with a mental illness

188 The department supports the courts to facilitate the treatment needs of offenders with mental illness in contact with the criminal jurisdiction in a number of ways. This includes preparing pre-sentence reports, providing reports as to a person's fitness to stand trial and supporting MHARS through Forensicare.

Supervision orders under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997

Existing scheme

189 The CMIA applies to the Supreme and County Courts and, since 2014, the Children's Court. Fitness to stand trial investigations can only be conducted by those courts. The defence of mental impairment is available in the Magistrates' Court, but if the Magistrates' Court makes a finding of not guilty because of mental impairment, the Magistrates' Court cannot make a supervision order and the person must be discharged. Mental impairment, including mental illness, cognitive impairment and intellectual disability, can affect criminal defendants in two ways:

(a) First, if the impairment makes the defendant incapable of understanding and participating in a trial, they are unfit to be tried. If the defendant is not acquitted, they can be made subject to a supervision order.

(b) Second, if the mental impairment affected the defendant's capacity to understand the nature of their conduct or that it was wrong, they can be found not guilty because of mental impairment. These defendants can also be placed on supervision orders.

190 Supervision orders are not a sentence. Rather, their purpose is treatment and protection of the community. They can be custodial, involving detention in a mental health facility, disability service or prison, or non-custodial. Supervision orders are subject to review hearings by the Court (in practice, usually the same judge) that imposed the order to monitor a person's progress on the order and decide if it should be confirmed, varied or revoked. While supervision orders are indefinite until revoked, orders have a 'nominal term' corresponding to the seriousness of the offence. The expiration of the nominal term triggers a major review of the supervision order and a presumption in favour of release applies at and following a major review.

Proposed amendments

191 The *Crimes (Mental Impairment and Unfitness to be Tried) Amendment Bill* (**CMIA Amendment Bill**) was introduced to Parliament in March 2020. The CMIA Amendment Bill has a default commencement date of 1 July 2021, which will provide time for the Director of Public Prosecutions and the Mental Health Tribunal to prepare for, and assume their new functions, and allow time for affected agencies to undertake the planning necessary to transition all current supervision orders to the new regime of five-yearly reviews.[51]

192 The CMIA Amendment Bill aims to improve the overall experience of people subject to CMIA supervision by improving court procedures, reducing delay and introducing a system of mandatory, regular progress reviews. The CMIA Amendment Bill aims to improve the treatment of people with cognitive impairments under the CMIA.

193 The CMIA Amendment Bill will implement the following significant reforms in line with Victorian Law Reform Commission's (**VLRC**) recommendations, as well as transferring the functions of the Forensic Leave Panel to the Mental Health Tribunal:

(a) create a set of statutory principles to guide courts with managing persons subject to the CMIA – the principles recognise the particular needs of mentally impaired accused people and assist decision makers to act in accordance with the underlying objectives of the CMIA;

(b) reframe the definition of fitness to stand trial – to shift focus to whether the person can be afforded a fair trial, as recommended by the VLRC, which enhances the right to a fair hearing;

(c) create a statutory definition of 'mental impairment' – this will make clear that for the purposes of the CMIA, a mental impairment includes mental illness and a cognitive impairment, such as an intellectual disability.

[51] Crimes (Mental Impairment and Unfitness to be Tried) Amendment Bill 2020 Explanatory Memorandum.

(d) introduce a system of mandatory regular progress reviews of supervision orders – the frequency of reviews reflects CMIA principles of least restriction and gradual integration, acting as a safeguard against arbitrary detention;

(e) improve procedures for hearings, including the provision of expert reports; and

(f) amend the Disability Act 2006 (Disability Act) to expand the functions and powers of the Senior Practitioner – Disability, who is responsible for ensuring the rights of individuals with an intellectual disability on CMIA supervision orders are protected and that appropriate standards are applied to their treatment.

194 The CMIA Amendment Bill also makes a number of amendments to improve the treatment of victims. These include:

(a) a provision for victims to be notified, if they wish, when a leave decision is made by the Mental Health Tribunal that significantly reduces a person's level of supervision;

(b) a requirement of the Mental Health Tribunal to have regard to the circumstances of victims, where known, when considering what leave conditions are appropriate to impose on short-term leave; and

(c) new provisions which allow victim and family statements to be read aloud in court in the same way victim impact statements are currently read out during sentencing hearings.

195 The CMIA Amendment Bill does not provide for children and young people on custodial supervision orders to be accommodated in a therapeutic facility. This is in part due to there currently being no therapeutic facility in Victoria to accommodate children and young people on custodial supervision orders and therefore children and young people are detained in Youth Justice custodial centres. Once a purpose-built facility is available, the department will consider amendments to the CMIA to allow for children and young people on custodial supervision orders to be accommodated in a therapeutic facility.

Lack of infrastructure and services can undermine therapeutic effectiveness of the CMIA

196 The effective operation of the CMIA legislative scheme relies on the availability of appropriate facilities and services to appropriately manage people on supervision orders. A lack of appropriate secure forensic facilities for people with cognitive impairment or mental illness can result in people subject to custodial supervision orders being detained in a prison rather than in a secure forensic treatment facility, which is more therapeutic (forensic infrastructure is discussed further in Parts Three, Five and Six).

197 Access to appropriate facilities and services can also depend on a person's diagnoses, particularly whether they fall within eligibility criteria for services under the Disability and Mental Health Acts. Service gaps may arise when people have been found unfit to stand trial or not guilty because of mental impairment but nonetheless are not eligible for services under the Mental Health Act or Disability Act. Responsibility for finding solutions to service gaps can also be unclear due to the number of different agencies responsible for managing people subject to CMIA orders.

198 While the intention of a custodial supervision order is to provide for treatment in a secure mental health or disability facility, in practice the consistent lack of available beds means that people subject to custodial treatment orders are frequently spending significant periods of time in prison while waiting for a bed to become available.[52]

New approaches for those subject to custodial treatment orders

Investments in adequate secure forensic treatment facilities and mental health services infrastructure

199 Legislative amendments to the CMIA will not reduce the number of people being detained in prison who should be receiving treatment. The CMIA legislative regime is clear that the court cannot make a supervision order detaining a person in a prison unless satisfied there is no practicable alternative in the circumstances (prison should be a last resort and the least restrictive means reasonably available). The desired outcome therefore requires investment in adequate secure forensic treatment facilities.

200 As noted above, linking access to services with eligibility for services under the Mental Health Act and the Disability Act can also result in service gaps for people subject to CMIA supervision orders.[53] Investment in services and programs for people who present with complex diagnoses would improve service responses for people subject to CMIA supervision orders.

201 As discussed above, the number of entities involved in CMIA service provision and gaps in services and programs can result in a lack of clarity about which entity is ultimately responsible for finding service solutions. A number of reviews have recommended clearer governance to oversee forensic services provided to people subject to CMIA supervision orders. In response to a Victorian Ombudsman's[54] recommendation, DHHS has designated the Deputy Secretary, Health and Wellbeing, to coordinate and oversee the

[52] The issue of wait times for justice involved mental health consumers is discussed again from paragraph 301.

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

[54] Ibid.

department's service responses to people subject to CMIA proceedings, and act as a contact point for agencies, people and the courts.

202 There is a thin market for the provision of services to people with disability in the justice system who require accommodation and an integrated model of care and support.[55] The Commonwealth Department of Social Services and the National Disability Insurance Agency (**NDIA**) have commissioned the National Disability Insurance Scheme (**NDIS**) Thin Markets Project to develop strategies to address supply gaps in 'thin markets' in the NDIS, including supports for people with complex needs.[56] The Victorian Government continues to raise issues around pricing with the Commonwealth and is undertaking a bilateral project with the Commonwealth to examine future NDIS pricing arrangements.

203 Infrastructure investments in AMHS, as well as building the capability of AMHS to service the needs of offenders, will also enable them to better provide services to offenders who do not fall within the CMIA but who have a serious mental illness and have committed relatively minor crimes. This should specifically include removing barriers to accessing care through AMHS due to lack of housing. This provides greater assurance to courts that appropriate care can be provided in the community. This will reduce unnecessary incarceration of people with a mental illness.

A more integrated approach to CMIA patient management

204 There are a range of points in the mental health system where improved cross-government governance has the potential to improve outcomes for clients. The improved governance and management of patient care for clients who are subject to orders under the CMIA has particular potential to improve the person-centred supports for clients, and the mental health and health outcomes for patients.

205 Subject to passage through Parliament, the CMIA Amendment Bill will go some way to improving governance arrangements by improving the requirements for expert reports, requiring treatment plans to be prepared for people with cognitive impairments subject to custodial supervision orders, and requiring the court to appoint a supervisor when making a non-custodial supervision order.

206 While legislative amendment will improve the CMIA statutory scheme, non-legislative changes, particularly with regard to governance, are also needed to improve the service response to people subject to CMIA supervision, and particularly to provide a more

[55] Victorian Ombudsman, 'Investigation into the imprisonment of a woman found unfit to stand trial', 16 October 2018, https://www.ombudsman.vic.gov.au/our-impact/investigation-reports/investigation-into-the-imprisonment-of-a-woman-found-unfit-to-stand-trial/#full-report, paragraph 347 to 350 and 382.

[56] Further information on the NDIS Thin Markets Project is available at https://engage.dss.gov.au/ndis-thin-markets-project/.

integrated approach to CMIA patient management. As noted above, work is underway to strengthen cross-government governance to improve service responses to people subject to CMIA supervision. This is particularly important for people subject to CMIA supervision orders who are at risk of poor outcomes because their needs fall outside standard service responses.

207 Diversion, in the broadest sense of the word, can provide therapeutic and related supports to largely prevent (for example, cautions) or reduce a person's engagement with the criminal justice system. Adults in custodial settings nevertheless require mental health supports, which is the subject of the next part of my statement (with specific issues relating to Aboriginal people and young people addressed in the parts 4 and 5 respectively).

Part Three – Supports within community and custodial corrections

Victorian prisons – the current service landscape

208 This section provides an overview of the Victorian prison system's response to mental health need, with further detail at Appendix C as indicated.

The right to reasonable access to care and treatment

209 Where an adult with a mental illness is in custody, the State has specific legal obligations to provide that person with appropriate health care, including mental health care. Section 47(1)(f) of the Corrections Act gives prisoners the right to access reasonable medical care and treatment, provided by the State, that is necessary for the preservation of health.[57]

210 Section 200 of the *Serious Offenders Act 2018* (the **Serious Offenders Act**) provides similar rights to access medical care to post-sentence offenders residing in a residential treatment facility under a supervision order.[58]

211 The Corrections Act imposes a duty of care on the Secretary of the department to achieve the safe custody and welfare of prisoners and offenders.[59] The State also has an interest

---

[57] *Corrections Act 1986*, part 6 section 47 'prisoners rights', available at https://content.legislation.vic.gov.au/sites/default/files/2020-04/86-117aa15120authorised_0.pdf. This also includes, with the approval of the principal medical officer but at the prisoner's own expense, additional care and treatment from a private registered medical practitioner, dentist, physiotherapist or chiropractor chosen by the prisoner. Section 47(1)(g) further gives prisoners that are mentally ill the right to have reasonable access, within the prison or with the Governor's approval, outside a prison, to such special care and treatment as the medical officer considers necessary or desirable in the circumstances.

[58] *Serious Offenders Act 2018*, part 13 section 200 'offenders' rights', available at https://content.legislation.vic.gov.au/sites/default/files/2020-04/18-27aa005 per cent20authorised.pdf. Further, section 200(1) of the Serious Offenders Act gives offenders access to reasonable specialist care and treatment of offenders with a mental illness, or outside the facility with the Commissioner's approval.

[59] *Corrections Act 1986*, part 2, section 7(1), available at https://content.legislation.vic.gov.au/sites/default/files/2020-04/86-117aa151%20authorised per centper cent20authorised_0.pdf. 'The Secretary is responsible for monitoring performance in the provision of all correctional services to achieve the safe custody and welfare of prisoners and

in providing forensic mental health services as a specialist area of mental health for people with a mental illness who have offended or are at risk of offending, both to support the mental health and wellbeing of this group, and also to improve community safety.

Timely identification and treatment of prisoners' mental health needs

212 There are a range of mechanisms in place that ensure that prisoners' mental health needs are identified and met in a timely fashion.

213 All people entering the prison system are assessed by a mental health clinician within 24 hours of reception to determine if they have any psychiatric or mental health needs as a part of the reception process.[60] For 2018-19, 97.7 per cent of prisoners received their reception assessments within 24 hours (the required timeframe).[61]

214 When a prisoner is identified as at risk of suicide or self-harm, they receive a suicide and self-harm risk assessment from a mental health clinician within 2 hours, with the shortened response time reflecting the urgency of these needs. In 2018-19, 99.2 per cent of prisoners identified as at risk of suicide or self-harm were assessed within 2 hours (the required timeframe).[62]

215 When mental health needs are identified through the reception assessment, at risk assessment, or at any other point in custody (for example, self-referral to the health centre, at transfer to another prison, or at return from court), clinicians can refer prisoners for further care and treatment, including referral to the specialist mental health service provided by Forensicare, as clinically required. There are also a range of responses to manage suicide and self-harm risk, including placement in specially designed cells that minimise the opportunity for self-harm (known as 'Muirhead' cells), regular observations and clinical reviews.

---

offenders'; part 2, section 8(1) 'The Secretary may, by instrument, delegate to the Commissioner or to any other employee of the Department or to any officer within the meaning of Part 5 or Part 9 any function, power, duty or responsibility of the Secretary'.

[60] This is a requirement set out in Corrections operational policies and is a contractual requirement on prison health service providers that is reported as a performance measure in the annual State Budget. Further information on this requirement can be found in the Commissioner of Corrections' witness statement.

[61] It is noted that this 2018-19 figure is the expected outcome against this performance measure reported in the 2019-20 Budget, to be confirmed in the final 2020-21 Budget Papers. Victorian Government, 'Victorian Budget 19/20: Budget Paper 3: Service Delivery', available at https://s3-ap-southeast-2.amazonaws.com/budgetfiles201920.budget.vic.gov.au/2019-20+State+Budget+-+Service+Delivery.pdf, p. 270.

[62] It is noted that this 2018-19 figure is the expected outcome against this performance measure reported in the 2019-20 Budget, to be confirmed in the final 2020-21 Budget Papers. Victorian Government, 'Victorian Budget 19/20', op. cit., p. 270. 2018-19 figures are expected to be produced through the 2020/21 Budget Papers in October 2020.

216 On the advice of a clinician, prisoners can also be assigned a psychiatric risk rating (P-rating)[63] or a suicide or self-harm risk rating (S-rating)[64] to inform their custodial management, such as placement decisions and case planning. These tools ensure information about mental health needs and risks is accessible to staff who are not clinically trained.

Impact of growing prisoner population on mental health need

217 There has been an increase in the number of people in custodial environments over recent years, with prisoner numbers across public and private prisons increasing from 6519 prisoners at 30 June 2016 to 8102 prisoners at 30 June 2019.

218 The proportion of people with mental illness has remained relatively stable, but a larger prison population has meant an increase in the overall number of people with mental illness in prison.

Recent improvements to the custodial system's response to mental health need and the growing prisoner population

219 The department has invested in specialist mental health units in prisons to meet the demand for specialist services due to the prevalence of mental illness among prisoners and growth of overall prisoner numbers.

220 The department considered alternative models in the procurement and recommissioning of custodial health services through this expansion. This has included reviews of contemporary services, examination of developments in evidence-based practice, and broader considerations relating to the overall efficiency and effectiveness of clinical practice and service delivery.

221 An example of an alternative mental health service delivery model is that delivered at Ravenhall Correctional Centre (**Ravenhall**), which was commissioned to meet demand for specialist mental services in the men's prison system. The Ravenhall model provides a contemporary, recovery-focused approach to addressing the mental health needs of prisoners, delivered through an integrated and stepped model of care, consistent with that outlined in the DHHS *Because Mental Health Matters Reform Strategy 2009-2019*.[65]

---

[63] P-ratings are an indicator of psychiatric conditions requiring a service response. These ratings are informed by clinical information and are tools to assess a person's risk to themselves and their environment. P-ratings are not a tool to diagnose a mental health condition but are helpful for identifying prisoners with relevant needs.

[64] S-ratings are an indicator of current, or history of, suicide or self-harm risk. These ratings are informed by clinical information and are tools to assess a person's risk to themselves and their environment. S-ratings are not a tool to diagnose a mental health condition but are helpful for identifying prisoners with relevant needs.

[65] Department of Health and Human Services, 'Because Mental Health Matters – Victorian Mental Health Reform Strategy 2009 – 2019', February 2009, available at

222 The opening of Ravenhall in 2017 provided a step change in the delivery of forensic mental health services across the men's prison system by providing a flexible range of treatment interventions (stepped care model) in bed-based and outpatient settings, delivered by a multidisciplinary team and in purpose-built facilities, to support the treatment and management of men with mental illness.

223 The commencement of the new service delivery model at Ravenhall was accompanied by the introduction of forensic mental health bed flow coordination and a substantial update of the forensic mental health sections of the Justice Health Quality Framework to give effect to the new model of care. These changes both expanded the capacity of the system and improved the efficiency with which it operates, including through improved coordination with Thomas Embling Hospital.

224 Other prison specialist mental health services have also been significantly expanded and improved in recent years, including through the introduction of the Mobile Forensic Mental Health Service and refurbishment of bed-based specialist mental health units at Dame Phyllis Frost Centre (**DPFC**), Melbourne Assessment Prison (**MAP**) and Port Phillip Prison.

225 While this expansion of services in custody is providing additional support to voluntary mental health patients, the substantial increase in the prison population has not been matched with an equivalent increase in secure forensic mental health treatment capacity for prisoners requiring compulsory treatment under the Mental Health Act (security patients), which can only be provided in a hospital setting. This results in security patients experiencing delays in receiving treatment that they are certified as requiring immediately. These matters are discussed further in the section on forensic infrastructure at Part Six.

Forensicare's capacity to meet demand for specialist services

226 The capacity of specialist mental health units in Victorian prisons is considered adequate to meet current and projected demand for bed-based services in the medium term, particularly if the implementation of the Royal Commission's recommendations leads to a reduction in the overrepresentation of people with a mental illness entering custody and an expansion of secure treatment services in the community for security and forensic patients. There are, however, gaps for key cohorts which are addressed further in my statement at Part Six.

227 Forensicare has experienced challenges in recruiting qualified staff to resource the recent planned expansions of its services, including its prison operations.

---

https://www2.health.vic.gov.au/about/publications/researchandreports/Because-Mental-Health-Matters---Victorian-Mental-Health-Reform-Strategy-2009---2019, p. 36.

228 The department anticipates that a long-term recruitment strategy will be needed for Forensicare to meet its current commitments and anticipated growth in demand for its services. This is similar to the highly successful strategy, implemented in advance of the commissioning of Ravenhall, that enabled Forensicare to fully staff the facility by the time operations commenced.

The role of prison officers in supporting the provision of mental health treatment in prisons

229 Prison officers, both those employed by the department and those employed by private prison operators, play an important role in supporting the mental health and wellbeing of prisoners. While Corrections officers do not provide clinical management or any primary or specialist clinical mental health services to prisoners, they receive training to work closely with health service providers to provide a range of supports, including:

(a) facilitating access for prisoners to primary or specialist clinical mental health services where the need for this is indicated;

(b) actively raising any concerns about prisoner mental health with supervisors and health service providers, including referral of prisoners for assessment or review; and

(c) implementing the management of a prisoner's mental illness in accordance with the recommendations of mental health professionals.

The women's prison system also provides a trauma-informed mental health response

230 A specialist women's trauma counselling program is being delivered at DPFC and Tarrengower Prison. This specialist program was developed in 2006 to respond to trauma caused by sexual assault, and expanded in 2016 following the Royal Commission into Family Violence. The program delivers both family violence and mental health supports to approximately 170 female prisoners at a time.

231 It is provided by local Centres Against Sexual Assault (**CASA**) organisations through trauma-focused group sessions, and training and informational sessions for custodial staff.

232 As part of the Women's System Reform Project, a trauma-informed framework is being progressively introduced into the women's prison system. This will include the adaptation of routine operational practices and embedding trauma-informed principles in the physical, built prison environment.

233 Staff recruitment at DPFC has also been re-designed to attract custodial staff with personal qualities that are more suitable for implementing a trauma-informed framework. This approach to recruitment has significant potential for being applied more widely in the justice system.

234 Further consideration is being given to ways to reduce the risks and impacts associated with prison operating procedures. This includes ways to remove physical, environmental and emotional stressors that can impact on the rehabilitative prospect for people with mental illness in custody.

Justice Health

235 Justice Health, a business unit of the department, oversees the delivery of health services in the prison system and Youth Justice centres,[66] namely primary health (including primary mental health) and specialist mental health services. This ensures prisoners have access to a range of stepped general and mental health services to meet their needs.

236 Historically, custodial health service oversight functions were held by the then Department of Human Services (prior to the mid-1990s) and then distributed between that department and the then Department of Justice from the mid-1990s until 2007. Following an independent review of custodial health oversight arrangements in 2006, Justice Health was established in 2007 to consolidate health policy, service planning and commissioning and oversight functions for the Victorian prison system. This change in arrangements aimed to achieve greater consistency and continuity of care across the system, and ensure that the objective of meeting the health and mental health needs of prisoners was integrated into broader correctional service planning, design and funding allocation.

237 Justice Health's responsibilities include setting the policy and standards for, and clinical oversight of, health services (including mental health services) provided in all Victorian prisons, both public and private, integrated prison health service planning, and commissioning and contract management of health services delivered in public prisons.

238 I refer the Royal Commission to the evidence provided by Dr Emma Cassar, Commissioner of Corrections Victoria, for further information about how Corrections Victoria and Justice Health work together.

[66] Justice Health's role in managing health services for young people held in custody is explained in further detail in Part Five of my statement.

Justice Health Quality Framework – the standard of care provided to prisoners

239 A guiding principle for custodial health service delivery is that people in custody should receive health services equivalent to those available in the general community through the public health system.

240 The Justice Health Quality Framework (**Quality Framework**) sets out the Health Service Standards for Victoria's prisons, positioned within the broader context of:

(a) international agreements, including the Nelson Mandela Rules,[67] regarding the treatment of people in custody;

(b) national standards and guidelines, including the National Health and Medical Research Council Guidelines[68] and the National Safety and Quality Health Service (**NSQHS**) Standards;[69]

(c) relevant Victorian legislation, particularly the Charter of Human Rights, *Health Records Act 2001* (the **Health Records Act**),[70] and the Corrections Act;[71] and

(d) operational requirements, as prescribed by the Commissioner of Corrections Victoria and relevant delegates.

241 The Quality Framework is the overarching framework that governs all health care service provision to prisoners to assure that appropriate standards of care are being met in Victorian prisons, both public and private. It also sets out minimum standards and specific requirements that regulate the clinical delivery of mental health care in custody.

242 Examples of requirements that are specific to the custodial setting include the requirement to comply with mandated response times for priority services (such as reception mental health assessments and suicide and self-harm risk assessments), health service involvement in prisoner placement decisions, and protocols around discharge from custody.

---

[67] The Nelson Mandela Rules are the United Nations standard minimum rules for the treatment of prisoners. The Rules are universally acknowledged minimum standards for the management of prison facilities and treatment of prisoners that were originally adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders in 1955 and has influenced the development of prison laws, policies and practices in Member States all over the world. The Nelson Mandela Rules are available at https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf.

[68] These are evidence-based guidelines developed by the National Health and Medical Research Council to promote health, prevent harm and encourage best practice. The guidelines are available at https://www.nhmrc.gov.au/health-advice/guidelinesc.

[69] The NSQHS Standards provide a nationally consistent statement of the level of care consumers can expect from health service organisations. The primary aim of the Standards is to protect the public from harm and to improve the quality of health service provision. The Standards are available at https://www.safetyandquality.gov.au/standards/nsqhs-standards.

[70] *Health Records Act 2001*, available at https://content.legislation.vic.gov.au/sites/default/files/2020-04/06-43aa014%20authorised.pdf.

[71] *Corrections Act 1986*, op. cit.

243 Justice Health's role in providing clinical oversight of mental health service quality and safety in prisons is described in greater detail in Appendix C.

The optimal structural, governance, accountability and oversight arrangements for delivery of custodial primary and specialist mental health services

244 Victoria has established strong governance, accountability and oversight arrangements for custodial and forensic mental health services, and they are being strengthened by an ongoing commitment to collaborate across government departments. This whole-of-government approach is required to ensure optimal custodial and forensic mental health services can be delivered for those in correctional services, in Youth Justice Centres or subject to supervision orders under the CMIA.

245 Consideration of future governance arrangements should retain a whole-of-government approach and enable closer integration of mental health services delivered in custody with the broader mental health system. This should include opportunities for mental health services delivered in custody and the community to improve clinical practice for offender populations. Any such arrangement, however, would need to be balanced against the need for the Secretary to acquit her duty of care to people in custody, including the provision of appropriate mental health care.

246 The current division of responsibilities for adult mental health services between the department and DHHS with respect to delivery of mental health services in custody (the department), the community (DHHS) and secure forensic mental health facilities (DHHS and Forensicare) reflect the arrangements put in place with the establishment of Justice Health.

247 It is the department's position that retaining its responsibility and accountability for planning and delivery of custodial mental health services is the optimal arrangement, noting the need to closely integrate mental health service delivery with other custodial functions and to acquit the Secretary's duty of care to people in custody. The current Justice Health Joint Management Committee provides an opportunity for DHHS to be engaged in setting the strategic direction for, and overseeing the performance of, Justice Health and prison health services.[72]

248 There would be a benefit to future governance arrangements including a mechanism to ensure appropriate accountability for people placed in custody due to lack of available services in the community.

249 Offenders in the community should receive specialist mental health services in an AMHS setting, and should not be diverted into justice-focused or forensic-specific services.

[72] Further information on the Justice Health Joint Management Committee can be found in Appendix C.

Embedding forensic clinicians into AMHS and building capacity of those services is critical to meet the needs of these clients. This is currently a core role of Forensicare, and these functions are critical to ensuring mainstream services are responsive to the needs of offenders. While DHHS should retain responsibility for the development of programs servicing offenders in the community, the department should be closely consulted as consistent with other work underway to coordinate service responses across departments (e.g. common clients reform). The cooperative governance approach to the development of the FMHIP is a good model for the development of future offender-based programs.

250 There are a large number of independent bodies that perform valuable oversight functions in relation to mental health service provision in the correctional system, such as the Commission for Children and Young People, the Victorian Ombudsman, the Coroners Court of Victoria, the Mental Health Complaints Commissioner and the Office of the Chief Psychiatrist. These oversight bodies are set out in more detail in Appendix C. It is the department's position that, other than expanding the role of the Chief Psychiatrist to include oversight of specialist mental health services delivered in custody, there is not a need for additional independent oversight.

251 Should the Royal Commission recommend governance or oversight changes to the broader mental health system, the department would encourage custodial specialist health services to be included, subject to retaining the Secretary's duty of care to people in custody.

Victorian prisons – opportunities for improvement

Demonstrated need for additional psychological support services for prisoners experiencing distress

252 Prisoners can access mental health treatment from the primary and specialist mental health services in custody. However, there is a service gap for prisoners experiencing psychological distress or a low to moderate level mental illness (for example, some anxiety and depressive disorders) who do not require a specialist service response but would benefit from psychological counselling services.

253 Remandees are a particularly vulnerable group, as they cannot access criminogenic programs in custody as they have not been found guilty of a crime, and the uncertain length of their period in custody creates barriers to connecting them with services upon release. It is the department's position that they would benefit from a tailored approach.

254 Currently, psychology services and counselling are provided in adult custody through Forensicare's specialist mental health services, and is therefore not appropriate for prisoners who do not have acute needs but who would benefit from psychology services

as a preventative or early intervention measure. Making psychological and counselling services available to prisoners with low acuity or no diagnosed mental illness would improve mental health outcomes across the prison population and would assist in preventing prisoners from developing mental illness while in custody.

255 Psychological services could be expanded in prisons, with a focus on service provision at transition points including entrance to custody, isolation, attendance at court, significant life events (such as death and divorce), and movements within custody.

256 Such services would align with existing supports and with the services available in the community. Additional services provided in custody could ideally include in-reach services and psychological counselling in custody.

257 For remandees, who account for two in five adults in prison, the Adapt, Take Stock, Look Ahead Suite (**ATLAS**) of psycho-educational and wellbeing programs has been piloted with great success. ATLAS encourages remandees to access suitable programs to support their mental health and wellbeing needs, reduce the pressure associated with the custodial environment, and build life skills for current and future use.[73] ATLAS is delivered by Remand Program Facilitators, which a review found acted as a 'catch-all' service whereby they provide care to remandees from reception and throughout their time on remand. A 2019 evaluation of the programs completed by the department found ATLAS to be successful in improving mental health and wellbeing outcomes for remandees.

258 More mid-range psychological support services, such as counselling, could be introduced to fill these service gaps for prisoners experiencing distress, particularly those on remand.

259 Another reform opportunity stems from prisoners' ineligibility for publicly funded mental health supports including counselling, psychology services or mental health-focused allied health through the Medicare Better Access Scheme.[74] The Commonwealth does not currently provide any Medicare rebates for health services delivered in custodial settings, including mental health services. Commonwealth rebates for these and other mental health services in custody could improve access and continuity of care over the course of a person's life.

260 Noting that the Victorian Government has submitted to the Productivity Commission's inquiry into Mental Health that the Commonwealth should make Medicare funding available for mental health services in custody,[75] prisoners would benefit from services

[73] Further information on ATLAS is available at https://www.corrections.vic.gov.au/release/transitional-programs.

[74] For further information on the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative is available athttps://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-ba.

[75] Victorian Government, 'Productivity Commission mental health inquiry: Whole of Victorian Government submission', available at https://www.pc.gov.au/__data/assets/pdf_file/0015/241341/sub483-mental-health.pdf, p. 14.

being provided that are equivalent to those funded by the Medicare Better Access initiative.

Community mental health services in-reach into custodial environments to improve continuity of care

261 Prison mental health services do not always receive information about an individual's pre-incarceration care. In addition, mental health services in the community face barriers to accessing clinically useful information from the criminal justice system. Prisoners are frequently released into uncertain accommodation, or may be unable to engage with the community mental health service they are referred to due to demand, or the lack of a culturally appropriate service, causing pre-release discharge plans to fail. The impact of post-release homelessness on disconnection from treatment is raised in several submissions to the Royal Commission, including Forensicare's.[76] For adults on remand and young people in custody, the shorter average stay in custody also impacts the ability to diagnose, commence and sustain effective treatment.

262 People in custody would therefore benefit from in-reach services which allow them to commence treatment with community mental health providers prior to release, to deliver continuity of care and build connections with the mental health provider they will use in the community.

263 For Aboriginal prisoners, the existing continuity of health care pilot could be further expanded, in partnership with the Aboriginal community.[77]

Tracking mental health outcomes creates an evidence base for effective service design

264 While investments in the Victorian correctional health system have been made to meet the increasing demand for primary and specialist mental health services, mental health outcomes for prisoners over the course of their time in custody and following release to the community are not currently tracked. Accordingly, there is limited data on the impact of custodial healthcare services for prisoners and young people in custody over the course of their lifetimes.

265 This creates challenges for the department to gain a comprehensive understanding of the longer-term outcomes of the services it offers in correctional settings.

---

[76] Forensicare's formal submission to the Commission is available at https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/4215/6513/7242/Forensicare.pdf, p. 17.

[77] Justice Health and Corrections Victoria, 'Aboriginal Social and Emotional Wellbeing Plan', Feburary 2017, available at https://www.justice.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2020/06/a0/4861e17c7/aboriginal%2Bsocial%2Band%2Bemotional%2Bwellbeing%2Bplan.pdf, pp. 14, 19.

266 It is important that the department adapts and responds proactively to keep pace with the growth in service demand, but it is equally important that improvements to current and future service design are underpinned by a robust evidence base and service delivery planning is outcomes focused.

267 The shift to outcomes focused service delivery will require significant thinking about what a mental health outcome is, how it can be consistently measured across DHHS and the department's services, and how government can best use this information to inform service delivery.

268 Improving whole of system data collection, sharing and use of unique identifiers between the justice and mental health systems may enable better tracking of outcomes for offenders with mental ill health.

269 For custodial mental health services, the shift to an outcomes focus must also account for what outcomes are feasible for services delivered in correctional settings to achieve. It should recognise the inherent harms of incarceration and the adverse impacts that prisons can have on offenders who are mentally ill.

Access to timely compulsory treatment services in the community

270 Another enhancement would be to resolve the capacity issues at Thomas Embling Hospital. As discussed in more detail in Part Six of my statement and in the next section on the custodial system and compulsory treatment, Thomas Embling Hospital's status as the sole provider of secure compulsory treatment creates a concentrated pressure on the beds available for security patients, as well as forensic and civil patients who also require treatment there.

271 The ongoing lack of bed capacity at Thomas Embling Hospital is now a longstanding critical pressure point in the forensic mental health system. Resolving this issue would result in more effective utilisation of existing specialist mental health bed-based services in Victorian prisons, as it would reduce or eliminate the need to hold security and forensic patients as prisoners in those units while they await transfer to hospital for treatment.

The custodial system and compulsory treatment

272 Prisoners with mental illness receive a range of mental health services in custody, including outpatient and bed-based services. However, the Mental Health Act requires that where an acutely unwell prisoner is refusing treatment, compulsory treatment can

only be provided by a designated mental health service.[78] Prisons are not designated mental health facilities under the Mental Health Act.

273 There are specific provisions regarding compulsory treatment of prisoners in sections 275 and 276 of the Mental Health Act that require that where a prisoner has a mental illness and needs immediate treatment to prevent serious deterioration in the person's mental or physical health, or serious harm to the person or another person – they must be taken to a designated mental health service.[79]

274 In addition, section 67 of the Mental Health Act provides that certain orders requiring compulsory assessment or treatment cannot have effect while a person is in custody.[80] This emphasises a key principle of the Mental Health Act, which is to deliver treatment in the least restrictive manner possible, which cannot be achieved in highly restrictive custodial settings.

275 Service responses for prisoners with severe mental illness who require compulsory treatment are restricted by the limited capacity of specialist secure therapeutic facilities outside of prisons. While there may appear to be some merit in the prospect of alleviating this supply issue by allowing compulsory treatment in prisons, this would not be appropriate. It is the department's position that resources would be better directed to increasing appropriate therapeutic services for prisoners in designated mental health facilities.

276 Furthermore, delivering compulsory treatment in custody would be incompatible with internationally and nationally agreed principles of best practice under the United Nations Standard Minimum Rules for the Treatment of Prisoners (**the Nelson Mandela Rules**),[81] the National Statement for Principles for Forensic Mental Health,[82] the advice of the Royal

---

[78] A designated mental health service is a health service that may provide compulsory assessment and treatment to people in accordance with the Mental Health Act. Further information on designated mental health services is available at https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/compulsory-treatment/designated-mental-health-services.

[79] *Mental Health Act 2014*, Part 11 Section 275, available at https://content.legislation.vic.gov.au/sites/default/files/2020-02/14-26aa022 per cent20authorised.pdf. 'A Secure Treatment Order is a Order made by the Secretary to the Department of Justice and Regulation that enables a person who is subject to the Order to be compulsorily taken from a prison or other place of confinement to a designated mental health service and detained and treated in the designated mental health service'.

[80] ibid, part 4 section 67(2) 'An Order to which this section applies has no effect while a person who is subject to the Order is detained in custody'.

[81] The Nelson Mandela Rules state that prisoners 'diagnosed with severe mental disabilities and/or health conditions, for whom staying in prison would mean an exacerbation of their condition, shall not be detained in prisons, and arrangements shall be made to transfer them to mental health facilities as soon as possible'.United Nations Office on Drugs and Crime, 'The United Nations Standard Minimum Rules for the Treatment of Prisoners: the Nelson Mandela Rules', available at https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf.

[82] Principle 3 of the National Statement of Principles for Forensic Mental Health, endorsed by the Australian Health Ministers' Council in 2002 and the Corrections Services Ministers' Council in 2007. Australian Health Ministers' Advisory Council Mental Health Standing Committee, 'National Statement of Principles for Forensic Mental Health',

Australian and New Zealand College of Psychiatrists[83] and the advice of the World Health Organisation.[84]

277 In the Victorian context, the department is concerned that it would be at odds with the Charter of Human Rights and the Mental Health Act, which aims 'to provide for persons to receive assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and dignity'.[85]

278 The department understands that in New South Wales, compulsory treatment is provided in Long Bay Hospital, a health facility established within Long Bay Prison. This is enabled by their statutory scheme which accommodates the provision of compulsory treatment and other tertiary health services at Long Bay.[86] For the reasons outlined above, including Victoria's pre-existing human rights and mental health treatment principles, the department would not support the adoption of a similar legal framework in Victoria.

279 For further evidence regarding the appropriateness of delivering compulsory treatment in Victorian prisons, I refer the Royal Commission to the evidence provided by Dr Cassar.

Discharge of prisoners to emergency departments for mental health treatment

280 In some cases, a prisoner has reached the end of their term of imprisonment but continues to experience acute mental illness. In those cases, the prison health service provider may seek to have an assessment order made under the Mental Health Act,[87] which results in the prisoner being transported via ambulance to a designated mental health service for admission upon their release.

281 Prisoners in this situation may have disengaged from treatment and are awaiting transfer to Thomas Embling Hospital for compulsory treatment. Prisoners with acute mental health

---

2006, available at https://www.aihw.gov.au/getmedia/e615a500-d412-4b0b-84f7-fe0b7fb00f5f/National-Forensic-Mental-Health-Principles.pdf.aspx, p. 7.

[83] Royal Australian and New Zealand College of Psychiatrists (RANZCP), 'Involuntary mental health treatment in custody: position statement 93, November 2017, available at https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/involuntary-mental-health-treatment-in-custody.

[84] World Health Organisation, *Trenčín statement on prisons and mental health*, 2007, available at https://www.euro.who.int/__data/assets/pdf_file/0006/99006/E91402.pdf?ua=1, p.6.

[85] *Mental Health Act 2014* , op. cit., Part 2 Section 10(b), available at https://content.legislation.vic.gov.au/sites/default/files/2020-02/14-26aa022.per cent20authorised.pdf.

[86] The *Mental Health Act 2007 (NSW)* provides that patients under the Act may only be treatment involuntarily within a declared mental health facility Selected parts of NSW correctional centres have been declared under the Act for this purpose (e.g. Long Bay Hospital within the Long Bay Correctional Complex). Further information is available at B Clugston, M Perrin et al., 'Prison Mental Health Services: A Comparison of Australian Jurisdictions', available at https://qcmhr.uq.edu.au/wp-content/uploads/2018/04/PMHS-NATIONAL-SURVEY-FINAL_20180416.pdf, p. 11.

[87] An assessment order authorises the compulsory assessment of a person to determine whether the person required compulsory mental health treatment, and is the first step to initiating compulsory mental health treatment. A registered medical practitioner or a mental health practitioner may make an assessment order if they have examined the person and are satisfied that the criteria for an assessment order apply to the person. Further information on assessment orders is available at https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/compulsory-treatment/assessment-orders.

needs (including those coming up for release) are accommodated in a therapeutic, specialist mental health unit in the prison system. The department makes all reasonable efforts to engage these prisoners in voluntary treatment while they are in specialist mental health units in custody, but compulsory treatment is not provided for the reasons I outlined above.[88]

282 The fact that prisoners are able to access compulsory treatment immediately when released, but not while in custody highlights the impact of secure bed shortages on access to treatment.

The community corrections system, parole and serious offenders

283 Offenders in the community access mental health care as per other members of the public, including from primary, secondary, public specialist and private mental health providers. The department is not responsible for the delivery of services to offenders in the community, however works closely with DHHS as the responsible department in developing offender-specific programs.[89] Most of the discussion in the next section on CCOs applies generally across the other two categories, with differences noted as required. Further detail to the overview below is provided at Appendix C.

284 Where an offender is placed on a community-based disposition— a CCO for adults[90]— they are supported and monitored for compliance by Community Correctional Services (**CCS**) staff.

285 Where a CCO contains a condition that an offender engage with mental health assessments and/or treatment,[91] department staff support offenders to access community mental health services and receive ongoing training and professional development to identify and respond to mental health concerns.

286 CCS staff undertake a range of functions including:

(a) Reviewing previous mental health assessments and psychological reports to determine whether to recommend that the court impose a Mental Health Treatment and Rehabilitation (**MHTR**) condition.

---

[88] The service at Ravenhall has reduced the incidence of prisoners being certified as requiring compulsory treatment at Thomas Embling Hospital. The success of this service in engaging prisoners with acute needs with voluntary treatment has resulted in approximately four prisoners per month being decertified as a result of commencing or recommencing voluntary care.

[89] DHHS is responsible for mental health services and programs delivered through Community Corrections.

[90] Equivalent community-based orders that are available to young offenders in Victoria include: Probation Orders, Youth Attendance Orders, Youth Supervision Orders and Youth Control Orders.

[91] For adult offenders on CCOs, a Mental Health Treatment and Rehabilitation (MHTR) condition can be placed on an order requiring an offender to attend mental health treatment. MHTRs are an indicator of the presence of mental illness, however not all offenders with a MHTR condition have a serious mental illness, and not all offenders with a mental illness have a MHTR condition on their order.

(b) Facilitating offenders' access to primary or specialist clinical mental health services where this is required during the operational period of the CCO.

287 CCS staff may also refer offenders to local General Practitioners for a Mental Health Care Plan or to private psychologists or psychiatrists.

Services available to respond to the mental health needs of offenders in the community

288 Offenders on CCOs can access mental health services in the community in line with other members of the community, noting that MHTR conditions may require that a prisoner attend a particular type of service as a condition of their order.

289 Additionally, there are some services and programs, funded and managed by DHHS, that provide services specifically for offenders in the community, including:

(a) the High-Risk Offenders Alcohol and Drug Service (**Hi-ROADS**) to address complexities that may increase the risk of offending behaviours;[92] and

(b) the FMHiCH program,[93] which provides community-based mental health assessment and treatment services for offenders, including those subject to a CCO or parole, who have moderately severe mental health issues and have a condition on their order to undertake mental health treatment.

290 In some cases, appropriate community-based options are not available, and this only becomes apparent after sentencing, resulting in difficulties with administering orders for CCS and offenders to comply. For example, where a MHTR condition specifies that an offender should obtain a mental health treatment plan under the Medicare Better Access initiative, but the offender's general practitioner determines that a mental health treatment plan is not clinically required, it is not possible for the offender to comply with the terms of the MHTR condition. Similarly, if an offender is not able to access an AMHS due to lack of housing or a lack of capacity in that service, they may be unable to comply with this condition of their order.

[92] Hi-ROADS is delivered by Caraniche in partnership with DHHS to provide a specialist forensic alcohol and other drug service to support offenders with significant co-existing substance use and mental health concerns – complexities that may increase the risk of offending behaviours.

[93] The FMHiCH is an initiative funded under the Forensic Mental Health Implementation Plan (FMHiP). This service has been available since November 2018 and will be evaluated by DHHS. The Department will contribute to that evaluation. Refer to Part 3 of the Commissioner of Corrections Victoria's witness statement on the FMHiCH program.

Services available to offenders with disability, including psychosocial disability, in the community

291 Prior to the transition to the NDIS, Victoria delivered forensic disability services bundled together with general disability services through DHHS. Following the transition of general disability services to the NDIS, Victoria retained responsibility for offence-specific responses tied to Victoria's criminal justice system under the Applied Principles and Tables of Services.[94]

292 The transition to the NDIS in Victoria has brought additional complexity to the delivery of services to people with disability involved in the criminal justice system, resulting in increasingly fragmented service delivery between layers of government and ongoing issues at the justice interface. Under the NDIS, general disability services are now delivered by the Commonwealth scheme, while the Victorian Government retains responsibility for justice-related responses. In practice, there have been significant challenges with ensuring people with disabilities in the justice system access NDIS funded supports and services.

293 The department is working collaboratively with the NDIA and states and territories to improve system-wide responses and supports for NDIS participants involved in the justice system. This includes clarifying jurisdictional responsibilities, addressing challenges for government in delivering coordinated and appropriate services and supports, and addressing barriers for people with disability involved in the justice system in accessing the NDIS. A recent outcome of this work is the NDIA's introduction of Justice Liaison Officers to be a point of contact for workers within the justice system to coordinate support for NDIS participants in youth and adult justice systems.

Serious offenders

294 The department also has responsibilities to respond to the mental health needs of offenders subject to post-sentence supervision under the Serious Offenders Act.

295 The primary purpose of orders made under the Serious Offenders Act is to provide for the enhanced protection of the community from offenders who present an unacceptable risk of harm to the community after they have served their prison sentence.[95] The

---

[94] Council of Australian Governments, 'Principles to Determine the Responsibilities of the NDIS and other Service Systems', November 2015, available at https://www.coag.gov.au/sites/default/files/communique/NDIS-Principles-to-Determine-Responsibilities-NDIS-and-Other-Service.pdf.

[95] *Serious Offenders Act 2018*, op. cit., Part 1 Section 1(a) the purposes of this Act are 'primarily, to provide for enhanced protection of the community by requiring offenders…who present an unacceptable risk of harm to the community to be subject to ongoing detention and supervision.'

secondary purpose is to facilitate the treatment and rehabilitation of offenders subject to a supervision order or detention order.[96]

296 Generally, this is facilitated through conditions imposed on an offender's order (such as participation in treatment programs and drug testing) and the day-to-day case management of the offender (such as facilitating access to mental health services and treatment).

297 Ensuring timely delivery and receipt of services such as mental health treatment is critical for progressing offenders' rehabilitation and in reducing risk to the community.

298 In Victoria, a Serious Offenders Multi Agency Panel is responsible for coordinating delivery of rehabilitative services to serious (adult) offenders. The Panel brings together executives from the department, DHHS and Victoria Police to act with a shared responsibility for service delivery and to resolve any service-related issues. The Panel is also responsible for identifying and resolving gaps in services provided to serious offenders by the three agencies.

299 Serious offenders with a mental illness will have their treatment needs outlined in a Coordinated Services Plan that is developed by the Multi Agency Panel. These Plans detail the services to be delivered to an offender to address their risk of reoffending and are reviewed by both the Multi Agency Panel and the Post Sentence Authority[97] at least every six months. The reviews focus on ensuring offenders receive all necessary treatment and rehabilitation services in a timely manner, including mental health treatment.

300 The Multi Agency Panel is responsible for ensuring that people subject to orders under the Serious Offenders Act receive timely access to services and that any delays to services are resolved promptly.

301 This can be achieved through an agency prioritising an offender on a waiting list for services or providing short term financial assistance (brokerage) to fund a gap for a professional service to ensure the service continues. This could include funding for serious offenders to access psychological treatment when their mental health care plan is exhausted.

302 There is a legislative responsibility under the Serious Offenders Act for all three agencies to ensure that offenders subject to the Act are provided with the mental health services they require. While all three agencies work together to resolve issues that arise for an

[96] *Serious Offenders Act 2018*, op. cit., Part 1 Section 1(b) …'secondly, to facilitate the treatment and rehabilitation of those offenders'.

[97] The Post Sentence Authority is responsible for independent monitoring of serious offenders on post sentence orders as well as oversight of Victoria's post sentence scheme.

offender regarding their access to mental health services, department members are responsible for highlighting a mental health need or blockage that has arisen during the course of supervising an offender and escalating this to the Multi Agency Panel.

Addressing accommodation challenges faced by people who are subject to the Serious Offenders Act

303 Accessing mental health beds, supported accommodation for disability and social housing remains challenging, even with the statutory requirement of the Serious Offenders Act for agencies to share responsibility, provide reasonable assistance and identify and take steps to resolve issues. The limited facilities available often have significant waiting lists – in many instances, this could be years. Services are often reluctant to accommodate individuals with serious offending histories due to the presence of other vulnerable persons in the facilities. This can lead to offenders spending extended periods at post sentence residential facilities operated by Corrections Victoria which are not appropriate for those with serious mental illness as this may exacerbate their mental health issues and increase their risk of reoffending.

304 To address accommodation challenges faced by people subject to the Serious Offenders Act, individual cases may be escalated to the Multi Agency Panel for resolution. A dedicated staff member from the local DHHS-operated AMHS also oversees offenders at post sentence residential facilities suffering from mental illness. This has led to greater oversight of offenders' mental health trajectory and improved stability which has provided opportunities for offenders to transition from facilities into community settings.

305 The Forensicare Serious Offender Consultation Service (**F-SOCS**) provides an assessment and ongoing consultation service for offenders who present with a serious mental illness and are considered a high risk of violent or sexual offending.[98] F-SCOS has also assisted with referring serious offenders to specialised accommodation.

306 The combination of increased AMHS involvement, access to F-SOCS and the commencement of the Multi Agency Panel has seen improvements in addressing serious offenders' accommodation challenges over the last 18 months. However, a number of offenders at post sentence residential facilities still require access to specialised mental health accommodation.

[98] Further information on F-SOCS is available at https://www.forensicare.vic.gov.au/wp-content/uploads/2016/09/201807-Forensicare-Enhanced-Forensic-Consultation-Service.pdf.

307 A key obstacle to gaining access to specialised accommodation remains the limited number of beds available at Secure Extended Care Units,[99] Community Care Units,[100] Transitional Support Units,[101] and units that can specifically accommodate higher risk violent offenders and male sex offenders (particularly as there are very limited male-only units).

Self-harm or suicide risk of corrections clients (prisoners and offenders)

308 The department monitors rates of self-harm and attempted suicide amongst prisoners and publishes annual statistics on these rates in its Annual Reports.[102]

309 As at 30 June 2019, 53 per cent of prisoners are identified as having a history of being at risk of suicide or self-harm. A smaller proportion were identified as having a potential risk (0.7 per cent) and 0.2 per cent as an immediate or significant risk of suicide or self-harm.[103]

310 The rate of self-harm by Victorian prisoners was 7.4 incidents per 100 prisoners in 2018-19, a small increase from 6.6 incidents per 100 prisoners in 2017-18.[104] The rate of attempted suicide was 0.3 incidents per 100 prisoners in 2018-19 and remained stable from the previous year.[105]

311 If CCS staff are concerned about suicide or self-harm risk for community offenders, they refer them to community mental health or suicide prevention services.

312 Accurate monitoring of rates of self-harm and attempted suicide amongst offenders in the community is more complex, as these incidents are not necessarily consistently disclosed to Victoria Police or to the department. Where incidents of self-harm come to the attention of health professionals in the public system, particularly in hospital settings, these are recorded in health datasets. Analysis of linked data could provide insights into the subset of offenders in the community whose self-harm has been recorded by hospitals, but this would likely produce an undercount due to the different reporting criteria and mechanisms

---

99 Secure extended care units provide medium to long-term inpatient treatment and rehabilitation for people who have unremitting and severe symptoms of mental illness or disorder. These units are located in hospital settings.

100 Community care units provide clinical care and rehabilitation services in a home-like environment. They support the recovery of people seriously affected by mental illness to develop or relearn skills in self-care, communication and social skills in a community-based residential facility.

101 Transitional Support Units are suited to people with complex needs who may require long-term service treatment. They are based on a therapeutic and recovery focused model of care for a staged transition back into the community.

102 The department's annual reports are available at https://www.justice.vic.gov.au/annual-reports.

103 Figures sourced from the Corrections Victoria Data Warehouse.

104 Department of Justice and Community Safety, 'Annual Report 2018-19' available at https://www.justice.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2020/06/bb/3683c1b28/DJCS_Annual_Report_2018-19.pdf, p. 117.

105 ibid., p. 117.

adopted by each department and agency. Additionally, undercounts arise because self-harm does not always result in serious injury or attendance at a hospital, and where it does result in hospital attendance, the injury may not be disclosed as arising from self-harm behaviours.

The role of Corrections officers in managing prisoners at risk of suicide or self-harm in prison

313 A comprehensive set of operational procedures for managing prisoners at risk of suicide or self-harm is set out in state-wide prison 'At Risk' Procedures,[106] which state that Victorian prisons will maximise the safety of 'at risk' prisoners principally through:

(a) the reception process, which includes the identification and addressing of 'at risk' issues in the critical first few days of each prisoner's term of imprisonment;

(b) the prompt identification and effective management of 'at risk' issues that arise after transfer from another location, return from Court (including Tele-court) or at any other time during a prisoner's term of imprisonment;

(c) the fostering of a prison environment that is positive, responsive and supportive; and

(d) effective communication and information sharing (and documentation) between all parties who have a role to play in the management of prisoners.

314 The 'At Risk' Procedures define and set out the differing roles of Corrections officers compared to mental health professionals. As previously discussed, Corrections officers do not provide clinical management or any primary or specialist clinical mental health services to prisoners but receive training to recognise and respond to the behavioural indicators of an 'at risk' prisoner.

315 Working closely with health service providers, Corrections officers are required to perform a range of activities in supporting the management of prisoners at risk of suicide or self-harm, including:

(a) Implementing key 'at risk' management responses in accordance with the 'At Risk' Procedures and in collaboration with mental health professionals.

(b) Recording and clearly indicating on the prisoner's file, all known incidents of suicide or self-harm (including those in the community or a psychiatric hospital setting) and any current 'at risk' status. This information is obtained through disclosure by the prisoner, from the prisoner's health records (if obtained by the

[106] Correctional Suicide Prevention Framework, available at https://www.corrections.vic.gov.au/correctional-suicide-prevention-framework.

prison) or from police if a risk assessment was undertaken while the prisoner was in police custody.

(c) Managing 'at risk' prisoners in accordance with a risk management plan and recommendations of the assessing mental health professional, including specific management requirements for high-risk prisoners, such as 15-minute observations, placement in specially-designed cells, and removal of items that could be used to self-harm.

The role of Corrections officers in managing offenders at risk of suicide or self-harm in the community

316 A comprehensive set of operational procedures for managing offenders in the community at risk of suicide or self-harm is set out in various CCS Practice Guidelines.[107] These guidelines outline the following mandatory requirements:

(a) complete a Suicide And Self Harm (**SASH**) screening tool checklist with the offender during their initial induction or their release from custody;

(b) if an offender is presenting with suicidal risks, the case manager has a duty of care to, and must, contact and refer the offender to the area mental health service as well as direct the offender to other community agencies; and

(c) if the offender has a history of SASH, regular SASH screening tools are to be completed during supervision sessions.

317 Case managers work closely with mental health service providers in the community to ensure the ongoing support and safety of the offender. This involves the case manager facilitating and engaging in case conferences with professional supports and regularly making contact with mental health professionals, general practitioners and other counsellors.

318 An offender's S-rating is applied based on suicide and/or self-harm history and updated depending on current presentation. This provides all CCS staff with an overview of the offender's potential risk management needs.

319 Case managers may request police to conduct welfare checks on offenders if there is a concern for suicide risk.

[107] Ibid.

Improving the custodial system's response to prisoners and offenders at risk of suicide and self-harm

320 In response to an increase in the number and rate of suicides and attempted suicides in custody in the last four years, a range of recent efforts (detailed in the next paragraph) have been introduced to improve the custodial system's response to suicide and self-harm risk.

321 Recent changes include:

(a) updating operational procedures in custodial environments and community corrections to manage prisoners at risk of suicide and self-harm;

(b) reviewing the mental health and suicide training provided to custodial officers, noting that prison officers in facilities that have higher rates of mental illness (such as Ravenhall) receive additional mental health training; and

(c) redeveloping mental health training for CCS staff.

322 The department would recommend the Royal Commission consider increased suicide risk associated with contact with the justice system when making broader recommendations regarding suicide prevention in the Victorian community. For example, the Hospital Outreach Post-Suicidal Engagement (**HOPE**) program[108] currently being expanded at the Royal Commission's recommendation is not accessible to prisoners who have recently attempted suicide, as hospital outreach workers are not funded to go into prisons. Significant work has occurred on suicide prevention in custodial settings, to ensure the Secretary is able to acquit her duty of care, but more could be done to connect suicide prevention activities inside and outside custody for this cohort that is particularly vulnerable to suicide and self-harm.

323 I refer the Royal Commission to the section earlier in this statement on "Victorian prisons – opportunities for improvement" for further opportunities to improve the prison system's response to suicide and self-harm risk.

Part Four – Justice and mental health for Aboriginal Victorians

Overrepresentation of Aboriginal people in adult custody

324 Aboriginal adults in Victoria are vastly overrepresented in the criminal justice system, including in custodial settings. In 2018, Aboriginal people made up 0.6 per cent of the Victorian population but accounted for 9 per cent of all prisoners in Victoria.

[108] Further information on the HOPE program is available at https://www2.health.vic.gov.au/mental-health/prevention-and-promotion/suicide-prevention-in-victoria.

325 Aboriginal people in custody also experience higher rates of diagnosed mental illness, dependence disorders, and substance use than non-Aboriginal people in custody. In 2013, 72 per cent of Aboriginal women in custody and 92 per cent of Aboriginal men in custody had received a lifetime mental health diagnosis.[109]

Self-determination through the Aboriginal Justice Forum and the Aboriginal Justice Agreements

Embedding self-determination

326 Aboriginal self-determination is the centrepiece of the department's work with the Aboriginal community, and the programs developed to support Aboriginal clients and respond to Aboriginal overrepresentation in the justice system. This is guided by several overarching strategies, including the Victorian Aboriginal Affairs Framework, the Aboriginal Justice Agreement (**AJA**), and the Aboriginal Family Violence 10 Year Agreement *Dhelk Dja*. The AJA is the longest running of these agreements, and the longest running of its kind.

327 As the AJA highlights, embedding Aboriginal self-determination in justice policy creates a strong foundation for effective service delivery to close the gap between Aboriginal and non-Aboriginal justice outcomes. This acknowledges that Aboriginal people understand the priorities and concerns in their local areas, and the involvement of Aboriginal leaders ensures community buy-in and culturally appropriate solutions.[110] Aboriginal self-determination has been a practice that successive governments have worked to embed in Victoria, and the Aboriginal Justice Forum (**AJF**) is a strong example of its success.

328 The AJF, including the Aboriginal Justice Caucus (**AJC**) (formerly Koori Caucus), is the key mechanism through which Aboriginal self-determination is embedded in justice policy and systems, and through which the Aboriginal community engages with government about Aboriginal justice outcomes. All programs developed for Aboriginal clients within the justice system are developed by, or in close consultation with the AJF and the AJC.

329 Aboriginal perspectives inform the work of the AJF in two key ways – through the Aboriginal membership (nine elected regional representatives and representatives from several statewide Aboriginal Community Controlled Organisations (**ACCO**)) who make up the AJC and the Community Forums that are held each time the AJF meets. The Community Forums provide community members with direct access to justice decision-makers to raise issues of concerns and seek action in response to them.

---

[109] Ogloff, J.R; Patterson, J; Cutajar, M; Adams, K; Thomas S; & Halacas, C; Koori Prisoner Mental Health and Cognitive Function Study – Final Report 2013.

[110] *Burra Lotjpa Dunguludja* Aboriginal Justice Agreement Phase 4, 2018, page 11.

Aboriginal Justice Forum and Aboriginal Justice Caucus

330 The Secretary is co-chair of the AJF along with the Chairperson of the Regional Aboriginal Justice Advisory Committee (**RAJAC**) in whichever region the AJF is being held.

331 Through these consultation mechanisms, the department ensures that the principles of self-determination and the preferences and needs of the Aboriginal community are addressed effectively, including by considering the need for a holistic approach to mental health and wellbeing in any relevant work.

332 While I can reflect on AJF discussions around proposed responses to reduce involvement with the justice system for Aboriginal people living with mental illness, in keeping with the partnership principles underpinning the AJA, it is critical that our Aboriginal partners to the AJA are afforded an opportunity to set out their perspectives in their own voice. I am pleased that the AJC is also invited to engage with the Royal Commission.

Issues raised by the Aboriginal Justice Forum and Aboriginal Justice Caucus concerning overrepresentation of Aboriginal people in the justice system

333 The AJF is currently focused on addressing the disproportionate number of young Aboriginal people in the justice system, the need for targeted programs, and the impact of recent community safety reforms.

334 Providing culturally-based prevention, early intervention and diversion programs for Aboriginal young people and adults across the state remains a priority, as does ensuring there are sufficient positions in community and custody to support and build Aboriginal people's social and emotional wellbeing.

335 Difficulties meeting people's housing, employment, mental health and other treatment needs as they transition from justice institutions back into community is also a frequent topic of discussion.

336 I have expanded on these concerns at Appendix D.

Reducing overrepresentation: diversion and early intervention

Aboriginal Justice Forum and Aboriginal Justice Caucus views on reducing overrepresentation

337 The AJF and the department's work to uplift services for Aboriginal people in the justice system is underpinned by the 'principles for ways of working' and the Aboriginal Justice Outcomes Framework set out most recently in AJA4.

338 AJA4 notes that progress towards addressing overrepresentation of Aboriginal people in the justice system, and improving Aboriginal justice outcomes, requires the effective enactment of four key strategies measured through key indicators:

(a) policy and system change;

(b) early intervention and prevention: the number of early intervention and prevention programs available;

(c) diversion: the rates of successful diversion away from the justice system through successful completion of community corrections orders, the use of cautioning, and the number of people involved in Aboriginal diversion programs; and

(d) rehabilitation: measured through lower rates of recidivism and higher rates of completion of offender behaviour programs and cultural programs.

339 The AJF has prescribed these indicators as key markers of the success of the Agreement, and of improved Aboriginal justice outcomes. They will sit alongside several other indicators that reflect Aboriginal measures of achievement.

Current programs to reduce Aboriginal overrepresentation in the justice system

340 In recent years, working with the AJF, the department has implemented a number of innovative, community-led programs to respond to Aboriginal overrepresentation in the justice system. While there is still work to be done in this area, these programs have made a valuable contribution to this work, and demonstrate the department's ongoing commitment to a community designed and led approach to these issues. I encourage the Royal Commission to consider the success of these programs in their recommendations for any further reform. The programs include:

(a) the Koori Women's Diversion Program;

(b) culturally specific health and wellbeing supports for Aboriginal prisoners, with a focus on improving mental health; and

(c) expansion of the Drug Court.

The Aboriginal Social and Emotional Wellbeing Plan

341 The Aboriginal Social and Emotional Wellbeing Plan (**ASEWP**) was an initiative of the third phase of the AJA. It was developed by Justice Health and Corrections Victoria with the AJC and other Aboriginal justice stakeholders, and endorsed by the AJF. It provides the blueprint for social and emotional wellbeing services for Aboriginal people in the justice system.

342 The ASEWP identified five priority areas for the department, in partnership with the Aboriginal community, to focus on improving the health and wellbeing of Aboriginal people in the justice system. These five areas are:

(a) prevention and health promotion;

(b) culturally capable workforce;

(c) culturally safe and responsive services;

(d) continuity of care; and

(e) working from and building an evidence base.

343 The ASEWP is now complete, and the evaluation of the plan is expected to be finalised in 2020. The ASEWP demonstrated a number of positive outcomes for Aboriginal people in the justice system, and it will be important to maintain the ASEWP programs which have worked well.

344 To give effect to the ASEWP, a number of key initiatives have been implemented, that focused on building cultural competency for healthcare workers, and the provision of a suite of Aboriginal care programs, as well as the state-wide Indigenous Arts Program, the Kaka Wangity Wangin-Mirrie, the Aboriginal Continuity of Care Pilot[111], and cultural safety standards for health services.

345 In addition, broader mainstream policies in the justice system, particularly within the Corrections system, have been adjusted to reflect the need for culturally appropriate and person-centred services to be provided to Aboriginal people in the justice system.

346 These are further detailed at Appendix D.

Developing an equivalent of Wulgunggo Ngalu for female offenders

347 Wulgunggo Ngalu Learning Place (**WNLP**) is a statewide, culturally appropriate residential diversion program for up to 18 Aboriginal men at any one time who have been sentenced by the court to a CCO. It provides them with an important opportunity to learn new skills, reconnect with, or further strengthen their culture, and participate in programs and activities to help them address their offending behaviour. Evaluations of WNLP have found a range of positive long-term outcomes for participants who are more likely to

[111] The department has recently provided funding ($200,000) to extend the Aboriginal Continuity of Care Pilot until 31 December 2020.

successfully complete their CCOs than those who do not participate in the WNLP program.[112]

348 The AJC and broader Aboriginal community have long expressed the need for a residential facility for Aboriginal women in contact with the system to reduce further contact with the justice system. As noted earlier in my statement, AJA4 funding was made available to explore the feasibility of a residential program like WNLP to provide cultural and gender-specific supports for Aboriginal women involved in the justice system.

349 An ACCO has been engaged to deliver a literature review, undertake community consultations and prepare a report detailing the preferred residential model for Aboriginal women. Work has commenced to co-design a model, but community consultations have been delayed by COVID-19 restrictions.

Further work on Aboriginal social and emotional wellbeing

350 While the ASEWP is complete, the priority areas that it identified continue to guide work on social and emotional wellbeing and a number of the initiatives continue.

351 The Rehabilitation and Reintegration Collaborative Working Group (**RRCWG**) oversees and facilitates the implementation and monitoring of AJA4 initiatives and key projects within Corrections Victoria and Justice Health.

352 The RRCWG has an established workplan that includes 14 separate AJA4 initiatives with project planning for each initiative. The initiatives of particular relevance to the Royal Commission are further detailed at Appendix D.

353 This work will continue to contribute to and improve Aboriginal social and emotional wellbeing beyond the prescribed plan. It will also continue to embed Aboriginal self-determination and community-led approaches in the government's responses to the mental health needs of Aboriginal people.

Effectiveness of the Aboriginal Justice Agreement

354 The achievements of the four phases of the AJA demonstrate its effectiveness and success in enabling Aboriginal self-determination and working in sustained partnership with the Aboriginal community to improve outcomes for Aboriginal people within the justice system. Evaluations of the AJA suggest there are fewer Aboriginal people involved in the criminal justice system than would have been the case if the AJA did not exist (see Appendix D, paragraph 166). In addition, the more than 50 evaluations and reviews of

[112] Wulgunggo Ngalu Learning Place – Final Evaluation Report, Clear Horizon 2013 https://www.corrections.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2019/05/b8/e6056b1fb/wnlp_evaluationfinal.pdf.

AJA initiatives speak to the achievements of individual programs, services and processes. I have provided further detail on the findings of these evaluations at Appendix D.

Effectiveness of programs designed by the AJF

355 As evidenced by the evaluations and reviews at Appendix D, and the experience of the department, the targeted programs designed by the AJF have been effective. However, the programs are overwhelmed by high demand, an increasing prison population and are often time limited.

356 The AJF have noted that additional capacity for a number of programs, including the Aboriginal Wellbeing Officers, the Koori Women's Diversion Program and the Journeys Program,[113] may help to relieve this demand pressure, and make the programs more effective in supporting the growing number of Aboriginal adults in custody, given their increasingly complex needs.

357 Separate research supports the AJF's concerns about high demand on programs: the high demand for services, as well as the time limited nature of most programs, was noted in the Koori Prisoners Mental Health and Cognitive Function Study.[114] The Study noted that the time limited nature of programs is often a barrier to the accessibility of mental health and health programs in custody. The consequence of their short-term nature makes the programs unreliable and reduces trust in the programs amongst clients.[115]

Issues, innovation and reform

358 Aboriginal community engagement through the AJF and the AJC has been an example of highly successful codesign and person-centred responses in the justice system which I consider should be used as a blueprint for these practices across the department. Further work is nevertheless required to support Aboriginal people in the justice system, which we will work closely with the Aboriginal community to progress.

359 A key finding of the Royal Commission into Aboriginal Deaths in Custody was the need to reduce the rate at which Aboriginal and Torres Strait Islander people are imprisoned by breaking the cycle of imprisonment and diverting people away from prison. Diversion

[113] The Journeys Program, also known as Bramung Jaarn involves Elders and mentors working closely with young Aboriginal males (10-17 years) as they transition to adulthood. The Program provides young men with the support, tools and opportunities they need to set and achieve life goals and aims to empower participants, nurture leadership potential, promote help-seeking behaviour, build protective factors and provide connections back to culture.

[114] Ogloff, J.R; Patterson, J; Cutajar, M; Adams, K; Thomas S; & Halacas, C; Koori Prisoner Mental Health and Cognitive Function Study – Final Report 2013.

[115] Community trust is a critical component of programs developed by the Aboriginal community; as highlighted by other evidence provided to the Royal Commission, such as the statement provided by Andrew Jackomos (paragraph 55).

is one of the four key strategies recognised in the AJA as critical to realising improved justice outcomes for Aboriginal young people and adults, particularly those with mental health issues or poor social and emotional wellbeing.

Building on successes to date

360 There are a number of programs discussed here and at Appendix D that have supported progress towards addressing overrepresentation of Aboriginal people in the justice system and improving Aboriginal justice outcomes.

361 These programs will continue to respond to points of the justice system where there are gaps in the culturally appropriate services available and help ensure that the programs that are in place are responsive, safe, and community-led.

362 In addition to (and in support of) the goals set out in AJA4, the AJF has made recommendations to expand current pieces of work, which could contribute to reducing overrepresentation in the justice system. These include:

(a) an Aboriginal men's diversion program similar to the Koori Women's Diversion Program;

(b) further support for the existing Koori Women's Diversion Program and youth diversion programs, which have significant waitlists of people with interrelated health and social care needs (such as AOD and mental health) by, amongst other things, establishing residential facilities to enhance these programs by providing around-the-clock support for those most in need; and

(c) more Aboriginal Wellbeing Officers.

363 The AJF also continues to advocate for more culturally appropriate responses to ensure culturally safe care at Thomas Embling Hospital. Any recommendations that the Commission may make about Thomas Embling Hospital and Aboriginal social and emotional wellbeing should consider how these issues work in concert with one another. Such work is an important aspect of a person-centred and integrated approach to mental health care and mental health reform. A culturally appropriate approach to compulsory treatment will also need to be considered with DHHS.

Overrepresentation of Aboriginal children and young people in custody

364 Aboriginal young people in Victoria are overrepresented in the Youth Justice system, including in custodial settings. In 2018-19, there was an average of 145 Aboriginal young people under Youth Justice supervision per day, 74 per cent of whom were aged 10-17 years old and 26 per cent were aged 18+. On any given day, around 79 per cent of

Aboriginal young people were supervised in community, whilst around 21 per cent were in custody.[116]

365 Under the AJA, the department has committed to close the gap in the rate of Aboriginal and non-Aboriginal people under Youth Justice supervision by 2031. To be on track to meet the target, there needs to be fewer than 89 Aboriginal young people (aged 10 to 17 years) under justice supervision on an average day by 2023, or a reduction of 43 young people.

366 The rate of Aboriginal young people aged 10 to 17 under Youth Justice supervision, is currently below the trajectory required to close the gap by 2031. The latest set of data shows that to meet the 2023 target, that there now needs to be at least 19 fewer Aboriginal young people aged 10 to 17 years under justice supervision on an average day.[117]

367 In 2018-19, Aboriginal young people aged 10-17 years in Victoria were over 11 times more likely to be under Youth Justice supervision than non-Aboriginal young people of the same age. While overrepresentation remains high, it decreased by 16 per cent when compared to 2017-18.[118]

368 There are a complex and interrelated set of factors driving Aboriginal children's and young people's contact with the justice system occurring against a background of the impact of colonisation, dispossession, systemic racism, inter-generational trauma and socioeconomic disadvantage.

369 These factors also include parental issues such as family violence, AOD use and mental health issues, incarceration, and neglect. Early trauma and victimisation and neglect increase the likelihood of child protection involvement and/or the early age onset of offending. Once in contact with the justice system, Aboriginal young people often experience frequent short periods of time in custody on remand. Some also cycle between the Child Protection (out-of-home care) and Youth Justice.

Unique needs of Aboriginal children and young people in Youth Justice

370 Aboriginal young people have multiple and complex needs. Many come into contact with the justice system at an earlier age than non-Aboriginal young people, and have multiple contacts with the criminal justice system thereafter, often progressing to the adult custodial system.

---

[116] AIHW, Youth Justice in Australia 2018-19, Table S10a, published May 2020 from https://www.aihw.gov.au/reports/youth-justice/youth-justice-in-australia-2018-19/data. Note: the department does not hold statistics on the total Aboriginal engagement with the justice system (including fines).

[117] Ibid.

[118] AIHW, Youth Justice in Australia 2018-19, Table 3.1 page 9, published May 2020 from https://www.aihw.gov.au/reports/youth-justice/youth-justice-in-australia-2018-19/data.

371 According to the 2018 Annual Survey of Young People in Youth Justice in Victoria (**Annual Survey**), 55 per cent of Aboriginal young people were subject to a previous child protection order and 33 per cent were subject to a current children protection order, compared to 35 per cent and 21 per cent respectively of non-Aboriginal children.

372 Aboriginal children and young people also experience high levels of homelessness with no fixed address or reside in insecure housing prior to custody. According to the Annual Survey, 51 per cent of Aboriginal young people in the justice system present with mental health issues compared to 49 per cent for non-Aboriginal young people.

373 Of particular concern for Aboriginal young people in Youth Justice is the proportion who have simultaneous mental health, disability and substance use needs. The Annual Survey, found that, in addition to the slightly higher prevalence of mental health issues, Aboriginal young people experienced a higher level of complexity and issues than their Youth Justice counterparts:

(a) a history of self-harm or suicidal ideation - 33 per cent compared to 28 per cent;

(b) cognitive difficulties - 46 per cent compared to 28 per cent;

(c) an identified disability - 27 per cent compared to 16 per cent;

(d) a history of both AOD misuse - 61 per cent compared to 50 per cent; and

(e) offending under the influence of alcohol and/or drugs - 83 per cent compared to 71 per cent.

374 Many of these issues are responses to trauma and are also co-occurring. The Annual Survey found 80 per cent of Aboriginal children and young people were victims of abuse trauma and neglect compared to 61 per cent of non-Aboriginal young people.

375 Key stakeholders report that young people with multiple and complex needs are not able to have all their needs addressed through individual services and that substance use often impacts on assessments of mental health and cognitive impairment.

376 The profile of young Aboriginal women in Youth Justice indicates they have multiple and complex needs. The Annual Survey indicates that Aboriginal girls and young women were often victims of abuse, trauma and neglect as a child (87 per cent), and had experienced family violence (60 per cent). Moreover, 70 per cent also had prior or current involvement with child protection.

377 Additionally this cohort experienced mental health issues (63 per cent) but only 23 per cent had a formal mental health diagnosis. Many have a history of self-harm or suicidal ideation, experience cognitive disabilities, and have a history of drug or alcohol misuse.

This level of instability and lack of support, combined with a history of repeat offending, increases the likelihood of further contact with the justice system and being incarcerated.

378 Due to the small size of the Aboriginal girls and young women's cohort in Youth Justice there are few services designed to respond to the unique cultural and gender-based needs in both community and custody.

379 In addition, the needs of LGBTIQ Aboriginal young people are currently not addressed and should be considered in the context of Social and Emotional Wellbeing responses.

Self-determination through the Aboriginal Justice Forum and the Aboriginal Justice Agreements

380 The AJA, AJF and AJC, and how they embed self-determination into justice responses, are described above. General issues raised by the AJF and AJC concerning overrepresentation of young Aboriginal people in the justice system are also detailed above.

381 The AJF and AJC have identified opportunities to intensify the support provided to young people engaged with the justice system.

382 These opportunities include the development of an Aboriginal Youth Justice Strategy, which is being developed in response to recommendations of the Youth Justice Review[119] and in partnership with the AJC under AJA4.

383 The focus of the Strategy is: furthering Aboriginal self-determination through an Aboriginal community-led response; amplifying the voice of Aboriginal children and young people; building a culturally safe and inclusive system; and addressing overrepresentation (including alternatives to custody), to achieve the AJA4 target of 43 fewer Aboriginal children and young people under Youth Justice supervision on an average day by 2023.

384 Another opportunity is the report from the Koori Youth Justice Taskforce which will make recommendations about the support needed by Aboriginal young people engaged in the justice system by reviewing all aspects of their care, education, health, connection to culture and safety.

385 The Taskforce is a joint initiative of the department and the Commission for Children and Young People and is led by the Commissioner for Aboriginal Children and Young People.

386 Parallel to the Taskforce, the Commission has also engaged with Aboriginal children and young people, families and communities to develop solutions through an independent

[119] Armytage, P. & Ogloff, J. 'Youth Justice Review and Strategy: Meeting Needs and Reducing Reoffending,' 2017. Accessed at

Inquiry called Our Youth, Our Way. A single report combining findings and recommendations from the Taskforce and Inquiry will focus, in part, on the supports needed by Aboriginal young people in the justice system.

387 The AJC, through their work on self-determination, have contributed to the development of the new Youth Justice Act, through the development of a submission Equality for Our Kids. This lays the groundwork for greater Aboriginal community decision making over the care and management of their young people in contact with the justice system.

388 These reforms being developed with the AJC and the AJF will continue to ensure that the department's work with the Aboriginal community reflects community concerns, and is culturally appropriate, sustainable, and responsive to the very specific needs of this cohort of young people.

389 The AJC have also continued to raise legislative reform with government arising from their view that the incarceration of Aboriginal children and young people is inherently harmful and are seeking the development of alternatives to custody, for both young people on remand or under sentence such as residential healing programs on country.

390 The AJC are continuing to raise with Government the need to legislative reform where the age of criminal responsibility is increased to a minimum of 14 years, and for a minimum age for detention.

Diversion for Aboriginal children and young people is a community priority

Culturally safe diversion programs for Aboriginal young people

391 Although Aboriginal children and young people are able to access services and supports available for all young people in Youth Justice (described in Part Five), these services are not always suitably designed to meet their additional unique and specific needs.

392 AJA4 includes an action to deliver community-based, intensive diversion programs for children and young people who have had, or are vulnerable to, involvement with the criminal justice system, and to address factors contributing to offending.

393 To implement initiatives under AJA4, the department plays a key role in providing grants to ACCOs to deliver locally designed and delivered responses to address local needs. This approach aligns with the Victorian Government's commitment to self-determination.

394 Under AJA4, funding was provided to support four community-based intensive youth diversion programs for Aboriginal young people. Those identified by the AJC to be supported under AJA4 are detailed at Appendix D.

395 Under AJA4, funding was provided to support four community-based intensive youth diversion programs for Aboriginal young people. These include The Journeys Program, a Cultural Mentoring Program and the Dungulayin Mileka Massive Murray Paddle Program. These programs were found to be effective when previously funded through time-limited competitive grants. They use mentoring, sport, art and culture to engage participants and enhance their confidence, self-esteem, social and emotional wellbeing and other protective factors that divert young people away from further negative contact with police and the justice system.

396 Additional funding of over $4 million will expand the Baroona Youth Healing Program and bring its bed capacity from six to 15. The funding will support program and facility redevelopment to reduce the number of Aboriginal young people held in remand. The program is holistic and includes a focus on mental health. While the redeveloped service will increase capacity, it is unlikely to meet growing demand, particularly for young Aboriginal women. In addition to these programs, a range of other diversion programs exist, including:

(a) the Aboriginal Youth Support Service (**AYSS**);

(b) the Aboriginal Youth Cautioning Program; and

(c) the Aboriginal Youth Justice Program.

397 Details of these programs are set out in Appendix D.

Issues, innovation and reform

Current reform work underway

398 In 2018, the department committed to the development of an Aboriginal social and emotional wellbeing plan for Aboriginal children and young people in the Youth Justice system, as part of its response to the recommendations from the Victorian Equal Opportunity and Human Rights Commission and Commissioner for Children and Young People joint report on cultural rights in Youth Justice Centres.

399 Central to this recommendation is the requirement that the social and emotional wellbeing strategy for Aboriginal children and young people in Youth Justice recognise the fundamental role of culture, community and spirituality in Aboriginal wellbeing, and aims to support such connections.

400 The Koori Youth Council Report *"Ngaga-dji (Hear Me): young voices creating change for justice"* identified that applying non-Aboriginal frameworks to understand Aboriginal children's needs and strengths has proven to be unsuccessful. Instead, building on the work of the Australian Indigenous Psychologists Association, they recommend the

adoption of the Aboriginal social and emotional wellbeing wheel, so that Aboriginal children are supported by Aboriginal definitions of identity and wellbeing, and where the self is seen as inseparable from culture, family and community.

401 In Victoria the *Balit Murrup* was the first Aboriginal Social and Emotional Wellbeing Strategy and long-term models of care are being developed. In recent years, much work has been done around the development of culturally based healing models in family violence and responding to the needs of the stolen generation. As it did in the corrections system, this provides the foundation for the work the department is doing with the AJC and other Aboriginal justice stakeholders to develop a social and emotional wellbeing model of care for Aboriginal young people in Victoria's Youth Justice system.

402 A targeted Social and Emotional Wellbeing Strategy for Aboriginal young people could, in a similar way as it has done for Aboriginal adults, underpin workstreams across the custodial environment to provide targeted programs to this cohort.

Opportunities identified through Taskforce and the Aboriginal Justice Caucus

403 Under the development of an Aboriginal Youth Justice Strategy, and in response to matters raised as part of the process of reviewing the cases of 296 Aboriginal children and young people during the Koori Taskforce, AJC recommended the following ways to reduce the overrepresentation of Aboriginal children in Youth Justice and improve their overall wellbeing, and strengthen culture:

(a) intensive case management;

(b) holistic, culturally grounded wrap-around services and models of care;

(c) connection to culture; and

(d) continuity of care.

Intensive case management

404 Early findings from the Koori Youth Justice Taskforce review process shows that these young people are often not able to find specific help through individual services for their complex needs. Instead, they require Aboriginal developed and led intensive case management that is holistic and provides wrap-around support for Aboriginal young people and their families. The AJC has been recommending this approach for a long time. This approach would be complemented by regular case management review panels based on the Taskforce case review sessions, where CCYP, the department and ACCOs would lead a review of complex cases four times per year.

Holistic, culturally grounded wrap-around services and models of care

405 In the development of the Aboriginal Youth Justice Strategy and under AJA4, AJC has long recommended the need for holistic, culturally grounded wrap-around services and therapeutic healing models of care for Aboriginal young people engaged in the justice system (inclusive of mental health support) that address the drivers of Aboriginal young people's offending. These models would be developed and provided by ACCOs. There would also be opportunities to partner with specialist providers to meet the needs of Aboriginal young people with mental health needs.

406 The AJC have also identified that Aboriginal children and young people progress well into the Youth Justice system before they get the help they need. Light touch diversions are not able to respond to the complex needs of many Aboriginal children and young people, and often overlook the role trauma and victimisation is playing in their offending. The AJC has advocated for greater provision of victim support and trauma services for Aboriginal children and young people at the earliest opportunity, particularly at the time that their first experience of victimisation occurs. Intervening early in this way will help prevent development of problem behaviours and mental health issues.

407 Recognising the importance of addressing trauma and healing also extends to reducing reoffending and recidivism by ensuring Youth Justice services are underpinned by trauma informed care, as well as the adoption of restorative justice approaches across the justice continuum. The East Metropolitan and Hume RAJACs are currently piloting models of restorative justice developed by local communities as part of AJA4 implementation. Further work will need to be undertaken to develop restorative and trauma-informed care across the Youth Justice system in community and custodial settings.

408 Although Aboriginal children and young people are able to access services and supports available for all young people in Youth Justice (described in Part Five), it is important to note that there are currently no Aboriginal specific mental health programs for Aboriginal young people in Youth Justice. Though recently, a position has been created within health services in custody to employ an Aboriginal health professional.

Connection to culture

409 Connection to culture is a significant protective factor against criminogenic and mental health risk for Aboriginal children and young people. The AJC has identified the centrality of keeping young people strong in their identity, connected to their families, community and country as foundation for the Strategy. Cultural connection can be strengthened and supported through establishment of youth hubs in local ACCOs, provision of mentoring, youth groups and cultural programs for all Aboriginal children and young people, especially those who are vulnerable. While this will provide the basis for strong prevention

and early intervention opportunities, the AJC also recommend that cultural frameworks developed and delivered by Aboriginal communities underpin more intensive interventions for Aboriginal children and young people with more complex needs.

410 There are opportunities for reforms that recognise the significance of, and facilitate the maintenance or strengthening of connection to culture. In particular, 'On Country' healing infrastructure/services have been advocated for by the AJC. Additionally, the AJC has identified the opportunity for a reform that provides for an On Country remand centre that links with these healing services, in recognition of the overrepresentation and unique needs of Aboriginal children and young people involved with Youth Justice.

Continuity in care

411 Aboriginal young people experience frequent, short cycles of incarceration marked by high levels of reoffending. This is in part due to them not meeting the risk threshold to access mainstream youth offending programs in custody and community due to the short lengths of their order and the low level nature of their offences.

412 The AJC has long advocated for the provision of Aboriginal specific programs by Aboriginal organisations in the community and through in-reach programs in custodial settings. This can be completed by transition support and through care programs such as the Aboriginal Through Care project currently piloted by Victorian Aboriginal Child Care Agency at Parkville, as a joint Commonwealth-State initiative. A critical opportunity, currently not incorporated in this model, is that of continuity of care especially in relation to mental health issues.

Other reform opportunities identified

413 Increasing access to targeted programs for Aboriginal young people is vital not just to respond effectively to the complex needs of young people, but also to decrease the overrepresentation of Aboriginal people in the justice system even further over the longer term.

Part Five – Youth Justice and mental health

Overview of the legislative framework governing the Youth Justice system

414 A comprehensive overview of the legislative framework is detailed in Appendix E.

The unique needs of children and young people in Youth Justice

415 Only a small number of children and young people have contact with the Youth Justice system over their life. On an average day in 2019-20 (YTD to 22 June), 916 children and

young people were under Youth Justice supervision. Their ages range from 11 to 24 years old and they had an average age of 16.75 years old. Most children and young people in contact with Youth Justice are supervised in the community, with 731 managed in the community and 185 in custody on an average day in 2019-20.

416 Children and young people in contact with Youth Justice present with higher rates of mental illness than the wider group of young people in Victoria and higher rates compared to adults in the criminal justice system.

417 The results of the 2018 Annual Survey of Young People in Youth Justice in Victoria (**Annual Survey**) found that of the 908 children and young people under Youth Justice supervision (on community and custodial orders) on 31 December 2018, 49 per cent presented with mental health issues.

418 The Annual Survey also showed that children and young people with mental health issues in Youth Justice demonstrate complex needs and comorbidities, including:

(a) 23 per cent also had housing needs;

(b) 80 per cent were also victims of abuse;

(c) 58 per cent had been the subject of a report to Child Protection;

(d) 55 per cent had also experienced family violence;

(e) 51 per cent also had a history of self-harm or suicidal ideation;

(f) 38 per cent also presented with cognitive difficulties or other disabilities that impacted their daily functioning; and

(g) 92 per cent also had a history of drug or alcohol abuse.

419 Additionally, data from custodial mental health services shows that 367 (45 per cent) of young people in custody during the period July 2019 to May 2020 had a diagnosis recorded, including a substance use-related disorder. The top four diagnoses recorded (excluding substance use-related diagnoses) were:

(a) reaction to stress and adjustment disorders (including Post Traumatic Street Disorder (**PTSD**), acute stress reaction, and adjustment disorder);

(b) attention deficit hyperactivity disorder (**ADHD**) and other hyperkinetic disorders;

(c) depressive disorders; and

(d) schizophrenia, schizotypal and delusional disorders.

420 This further illustrates the complex needs and comorbidities of children and young people with mental illness in custody.

Children and young people require a differentiated approach

421 As outlined above, children and young people with mental illness in Youth Justice frequently present with complex mental health needs and therefore have different needs to adults in the criminal justice system.

422 Adolescent brains do not fully develop until young people are well into their early 20s. This means that children and young people have a greater capacity for rehabilitation and change.[120] However, it also means they have less capacity to understand the consequences of their decisions and less ability to regulate their emotions.[121]

423 Legally, immaturity in adolescent brain development is recognised as a factor that affects youth offending.[122] This is because children and young people lack the insight, judgment and self-control of a rational adult. This, combined with an increased susceptibility to peer influence, means children and young people are more likely to engage in risk-taking behaviour associated with adolescence and come to the attention of police and the criminal justice system.

424 Children and young people in contact with Youth Justice often have significant histories of abuse, neglect and trauma and exposure to family violence. They frequently experience inequality and disadvantage across one or more social and economic indicators.

425 Contact with the Youth Justice system is an indicator that a child or young person is deviating from normal developmental trajectories, and thus has unaddressed needs. Young people in Youth Justice exhibit a high rate of trauma that results in a higher incidence of mental illness. The other co-occurring needs, outlined at paragraph 419, are also associated with their trauma. Children and young people involved with Youth Justice can also display challenging behaviours associated with their trauma and the impact of these unaddressed needs on their development. These all demonstrate the multi-faceted impact trauma can have on a child or young person.

426 Mental health and justice responses must take a holistic and integrated approach to address the complex needs associated with Youth Justice involvement, that I have outlined above.

---

[120] C.M. Chu & J. Ogloff (2012) 'Sentencing of adolescent offenders in Victoria: A review of empirical evidence and practice', *Psychiatry, Psychology and the Law*, 19(3).

[121] E. Scott & L. Steinberg (2010) *Rethinking Juvenile Justice*, Cambridge, Harvard University Press.

[122] *Bradley Webster (a pseudonym) v The Queen* [2016] VSCA 66 [8]; C.M. Chu & J. Ogloff (2012) 'Sentencing of adolescent offenders in Victoria: A review of empirical evidence and practice', *Psychiatry, Psychology and the Law*, 19(3); A. Ortiz (2004) 'Adolescence, rain development and legal culpability', Juvenile Justice Center, American Bar Association website, accessed 18 January 2017; S. Schad (2011) 'Adolescent decision making: Reduced culpability in the criminal justice system and recognition of culpability in other legal contexts', *Journal of Health Care Law and Policy*, 14(2).

427 In addition to the complex needs and comorbidities described above, there is an overlap between mental health and criminogenic risk factors. As such, early intervention and diversion focusing on addressing the mental health needs of children and young people can have a long-lasting impact on both their mental health and their engagement with the youth and adult justice systems.

428 Details around the legislative framework governing the Youth Justice system, as well as legislative reforms impacting children and young people involved with Youth Justice, are provided at Appendix E.

How the mental health and associated needs of children and young people in Youth Justice are met

429 A guiding principle for Youth Justice custodial health service delivery is that young people in custody should receive health services equivalent to those available in the general community through the public health system. A key example of the requirements that are unique to the Youth Justice custodial setting include facilitating access to care in custody in a timely fashion, including compliance with mandated response times for priority services such as suicide and self-harm risk assessments and mental health assessments upon reception. Other standards common to health care provision, such as medication management, are also implemented differently in custody due to the security environment.

430 Children and young people with mental health needs who are engaged with the Youth Justice system are supported by both the mainstream community-based mental health support system, as well as a range of specific program and service interventions delivered through the Youth Justice system.

431 There are gaps in current service delivery across mainstream and the Youth Justice service systems, that I will address later in my statement.

432 The recently released Youth Justice Strategic Plan 2020-2030 (**the Plan**), which implements a key recommendation from the Youth Justice Strategy and Review[123], provides a blueprint for responding to the unique needs of children and young people by delivering a more effective Youth Justice system. It reflects the varied backgrounds and needs of children and young people in Youth Justice who are likely to exhibit multiple, overlapping vulnerabilities.

433 The Plan recognises the need for close collaboration with service delivery partners and a coordinated, multiagency and multisystem service response to reduce reoffending.

[123] Youth Justice Review and Strategy: Meeting needs and reducing offending.

434 The Plan acknowledges that strengthening mental health responses and services for all Victorians is a key priority for the government.

435 Youth Justice mental health services and supports are designed and delivered to meet the particular needs of children and young people. These services and supports are addressed below and include:

(a) mental health services in the community for children and young people in Youth Justice;

(b) mental health services in custody for children and young people in Youth Justice;

(c) Youth Justice workforce requirements and training; and

(d) other key Youth Justice services that support mental health and wellbeing.

Mental health services in the community for children and young people in Youth Justice

436 The Community FYMHS was introduced in 2019 under the Forensic Mental Health Implementation Plan, by DHHS in close consultation with the department. It delivers youth-specific forensic mental health services from two sites in metropolitan Melbourne with capacity to treat approximately 100 young people per annum. Data and discussion around the current operation of this service is found below from paragraph 476.

437 This builds on the Youth Justice Mental Health Initiative (**YJMHI**) introduced in 2010 which supports Youth Justice case managers to manage young people with mental illness and refer young people into mental health services. The service aims to facilitate access to mental health services for young people who require a mental health assessment, treatment or a referral and are subject to the supervision of Youth Justice (either when leaving custody or otherwise supervised in the community).

438 These DHHS programs fill a critical gap in specialist youth mental health services and have demonstrated positive outcomes such as improving mental health outcomes and improving diversion of young people with a serious mental illness from the justice system.

439 There is also the Children's Court Mental Health Advice and Response Service (**Children's Court MHARS**), which provides expert advice to Magistrates concerning the mental health of a child or young person who is appearing before the criminal division of the Children's Court. The advice represents the current assessment of the mental health of a young person, with a view that the clinician make recommendations to the Children's Court about possible referrals to appropriate mental health services in the community for the young person. Further information on this is provided in Appendix E.

440 These programs are further detailed in Appendix E.

Mental health services in custody for children and young people in Youth Justice

441 Justice Health is responsible for delivering health services to children and young people in custody. This includes integrated health service planning, overseeing contractual compliance, and setting the policy and standards for health care, including primary mental health care and forensic mental health care, in all Victorian Youth Justice centres.

442 Justice Health acquired responsibility for managing the delivery of these services and youth offending programs to Youth Justice centres following the transfer of the Youth Justice portfolio from DHHS to the department in 2017.

443 The Victorian Government has invested in expanding primary health and mental health services for young people in custody under the Forensic Mental Health Implementation Plan.

444 The 2018-19 State Budget provided $18.7 million in funding to improve health and mental health services for children and young people in custody. This has been implemented through new contracts with Correct Care Australasia and Orygen Youth Health, which commenced in February 2019. These services are delivered in Parkville and Malmsbury Youth Justice Precincts.

445 The Custodial FYMHS program provides specialist, multidisciplinary mental health services to young people in Youth Justice custody. Orygen Youth Health delivers these services by a multidisciplinary team of clinicians and specialists who provide specialist assessment and treatment services at the two Youth Justice Centres five days a week and on call. Data and discussion around this service's current operation is found below from paragraph 476.

446 This capacity in Youth Justice will be further expanded upon the completion of dedicated beds at the planned Cherry Creek Youth Justice Precinct.

447 Ongoing access to assessment and primary health and mental health services is available through the Primary Health and Mental Health Services in custody. The Primary Health and Mental Health Service, which operates 24-hours a day, seven days a week, is the first point of contact if Youth Justice custodial staff have any concerns about a young person's mental health. Through this service, children and young people in custody have access to psychiatric nursing services and counselling services.

448 The Primary Health and Mental Health Service may refer young people experiencing, or at risk of developing, a mental health problem or illness to Custodial FYMHS as required. They may also refer young people experiencing psychological distress. This may include acute or enduring psychological distress, problems relating to adjustment within the custodial environment. It also may include ongoing or longer-term psychosocial

intervention and support for mental health conditions and support related to family and peer issues.

449 The Primary Health and Mental Health Service will provide advice to Youth Justice staff on the young person's treatment plan, possible side effects of prescribed medications and strategies staff can use to support the young person. This service will also consult with Youth Justice staff to monitor the young person's response to treatment.

450 All young people undergo a comprehensive health assessment on admission to custody. Initial health and mental health screening must occur within 24 hours of reception into custody (12 hours for Aboriginal and/or Torres Strait Islander yopung people) to identify and manage clinical risks and any immediate mental health care needs. A follow up comprehensive mental health assessment occurs within 72 hours of reception. As a result of these assessments, further referrals or follow up appointments occur as clinically indicated.

451 Young people may also be referred to an Aboriginal Health Worker to support their mental health care, which must occur in consultation with an Aboriginal Liaison Officer.

452 These programs and the details of Justice Health's role in their provision are further detailed at Appendix E.

Youth Justice workforce requirements and training

453 The strong wellbeing of children and young people in custody has a positive impact on behaviour. Youth Justice staff are supported to promote the wellbeing, mental health and other needs of children and young people through training and support and practice requirements. For community staff, they are also supported through the new case management framework. A discussion around the remaining gaps in the capabilities of the workforce and the specific needs of the Youth Justice cohort is outlined below at paragraph 489 to 491.

454 The new evidence-based case management framework introduced in February 2019 is used by Youth Justice staff to address the holistic needs of children and young people under supervision. The case management framework also introduced the Massachusetts Youth Screening Instrument (**MAYSI-2**) screen which facilitates mental health issues being factored into the case management and parole plans of children and young people. Further details of the case management framework and approach to mental health is provided at Appendix E.

455 All new Youth Justice staff in the community are supported to understand and respond the mental health needs of children and young people in Youth Justice through:

(a) induction training relating to appropriately screening young people with issues or concerns relating to mental health, cognitive impairment and family violence; and

(b) induction and skills development training on recognising the signs of a child or young person who may be thinking of suicide and how to respond with appropriate management and interventions.

456 Youth Justice staff in custody are supported to understand and respond to the mental health needs of children and young people in Youth Justice through:

(a) induction training to understand the link between unmet childhood needs and trauma on brain development;

(b) induction training around how to work with people who have experienced trauma; and

(c) induction and annual refresher training to develop skills on recognising the signs of a child or young person who may be thinking of self-harm or suicide, how to work with children and young people at risk of self-harm or suicide, and how to respond with appropriate management and interventions.

Mental health capability building activities provided by through Youth Justice Mental Health Initiative (YJMHI)

457 Youth Justice staff in custody play an important role in providing children and young people with mental health needs with day-to-day support. Staff do this by encouraging prosocial behaviour and making referrals to the Primary Mental Health Service when there are concerns about a young person's mental health in custody.

458 Youth Justice staff are also encouraged to work collaboratively with health services so there is an integrated approach. This approach enables staff to support young people with mental health conditions or psychological distress in custody and to support their case management needs when they transition back into the community.

459 Directors Instructions provide instructions for all custodial Youth Justice staff about mental health treatment and the management and care to be provided to young people experiencing or at risk of experiencing mental health issues. This includes immediate responses to suicidal and self-harming behaviours and the prevention of suicidal and self-harming behaviour.

460 Directors Instructions detail custodial staff responsibilities in relation to:

(a) identifying signs and symptoms of potential mental health problems;

(b) referring those exhibiting indications of mental health problems to the primary mental health services in custody; and

(c) supporting young people with mental health problems (for example, through building positive working relationships and encouraging daily routine).

461 Beyond the training provided on working with people at risk of suicide or self-harm, Directors Instructions also provide instruction for all custodial Youth Justice staff about immediate responses to suicidal and self-harming behaviours and the prevention of suicidal and self-harming behaviour.

462 Directors Instructions outline the responsibilities of custodial staff in relation to:

(a) building positive working relationships and assertive engagement with children and young people;

(b) supporting the identification of risk of self-harm;

(c) referring those exhibiting early warning signs of distress and risk of self-harm to be assessed;

(d) supporting individual plans to manage self-harm risk;

(e) the observation of young people at risk of suicide or self-harm; and

(f) self-harm and suicide interventions and management strategies.

463 Health services in custody include the provision of at-risk assessments for children and young people at risk of suicide or self-harm. These assessments are to be completed within two hours of identification of the need by an appropriately qualified mental health professional of identification.

Other key Youth Justice services that also support mental health and wellbeing

464 Core Youth Justice services promote opportunities for the rehabilitation of children and young people. When provided in combination with mental health services, they can support the holistic needs of children and young people to be met.

465 Youth Justice funds community sector organisations as part of the Youth Support Service program. The Youth Support Service is a voluntary, community-based early intervention service for young people at risk of entering the justice system. It supports children and young people through providing outreach support and facilitating access to education, employment and training, drug and alcohol treatment, health and mental health services. Children and young people may be referred to the Youth Support Service upon contact with Victoria Police.

466 Where a court finds a child or young person guilty of a criminal offence, the court can request that a pre-sentence report is prepared to inform sentencing considerations. The report provides detail around the factors contributing to the child or young person's

offending and their risk factors. The report will include information relating to the child or young person's mental health needs where this is relevant.

467 The Youth Justice Community Support Service (**YJCSS**) is undertaken in partnership with community service organisations across Victoria. YJCSS provides integrated and intensive support and services to young people involved with Youth Justice services in the community to complement case management undertaken by youth justice workers. This support includes accommodation (where required) to improve their social connectedness, economic participation, and transition to independence. YJCSS can remain involved beyond statutory supervision, which is limited to the length of the court order.

Gaps, emerging risks and opportunities for reform in Youth Justice

468 There are a number of gaps and emerging risks that impact mental health outcomes for children and young people at risk of contact or in contact with Youth Justice, including:

(a) limitations in the availability of and access to mainstream and community services and supports;

(b) limitations in the availability of current forensic youth mental health services;

(c) insufficient responses to support the holistic needs and wellbeing of all children and young people involved with Youth Justice;

(d) lack of engagement with children and young people leading to a service design that does not meet their specific needs; and

(e) gaps in mental health infrastructure that restrict the ability for children and young people involved with Youth Justice to have their needs met (secure and non-secure).

Limitations in the availability of, and access to, mainstream and community services and supports

469 Prevention and early intervention to address the sub-clinical and clinical symptoms of mental illness can positively impact a child or young person's mental health trajectory and risk of justice system involvement.

470 The current approach of mental health services lacks a strong community prevention approach to support children and young people who may be at risk of Youth Justice involvement. The current approach also relies on the families of children and young people reaching into the health system, where they come up against barriers and access

issues.[124] Young people and families involved in the Youth Justice system can often be highly vulnerable and unlikely to reach into services proactively. More support is required to educate families of children and young people and their communities around mental health. More support is also required to reach into these families early and provide necessary interventions.

471 Gaps also exist in the identification of emerging or escalating mental health symptoms in upstream systems (such as education and health) and in accessible, youth-appropriate treatment options within these systems.

472 Community-based providers of mental health services for young people tend to be focused on those with lower acuity mental health issues like Headspace or school counselling, or the higher acuity end at Child and Adolescent Mental Health Service (**CAMHS**), Child and Youth Mental Health Service (**CYMHS**) or hospital admission. There is a gap between two ends of the acuity spectrum for people experiencing moderate acuity mental health issues, which impacts young people at risk of contact with Youth Justice.

473 There is an indication that children and young people involved with the Youth Justice system have often not received the services required to address their mental health needs. There is not currently an effective way of measuring access issues related to children and young people. However, the results of the 2018 Annual Survey of Young People in Youth Justice in Victoria show that as of 31 December 2018, of the 361 children and young people on community orders who presented with mental health issues, only 144 were accessing mental health supports or services. This may be due to their challenging behavioural presentations resulting in access issues. That is, they may be turned away from mental health supports and services in the community because their behavioural presentations are often too challenging or complex.

474 There are opportunities for reforms, which include:

(a) to advocate for mental health services to adapt their engagement efforts with family and community systems:

(1) to promote health education within children, young people and families; and

(2) to reach out to families early to follow up, intervene and support, rather than waiting for families to try and reach into the health system at the point of escalation or increased acuity;

[124] Interim Report, *The Royal Commission into Victoria's Mental Health System*, Lack of support for families and carers, p. 280.

(b) to improve the identification and assessment of the mental health and associated needs common to the Youth Justice cohort, particularly in mainstream services, such as education and health;

(c) to improve the availability of services that provide appropriate specialist treatment for the "missing middle" as young people's mental health issues escalate; and

(d) to provide improved or priority access to mental health services for young people at risk, or engaged with Youth Justice (due to their vulnerability and general lack of strong wellbeing and positive mental health).

Limitations in the availability of current forensic youth mental health services

475 Community FYMHS is a small service that provides the essential opportunity to intervene early with young people with forensic needs requiring specialist service. With a current capacity of 100 young people and a high threshold for entry, including that the young person be referred from within the CAMHS/CYMHS system, not the courts or justice system, there is likely to be latent demand that is currently unmet.

476 Community FYMHS comprises four full time equivalent (FTE) staff, two in the North West Metropolitan Region (Orygen Youth Health) and two in the Southern Metropolitan Region (Alfred Health). While it is a state-wide service, Community FYMHS only has physical service locations in metropolitan Melbourne. This means that some young people cannot access mental health services in their area that can offer sufficient support, expertise and capability to meet their needs.

477 Community FYMHS currently services a total of 100 young people per annum. As an estimate of demand, up to 50 per cent of children and young people (based on previously referenced survey data at paragraph 418) on community orders may present mental health issues and require care. This equates to up to 825 young people who might benefit from support through Community FYMHS per annum.

478 Additionally, up to 25 per cent of young people who participate in diversion may have a diagnosed mental illness based on recent data compiled for the Children's Court Youth Diversion Annual Report. This equates to up to an additional 395 young people that may benefit from support through Community FYMHS per annum.

479 Custodial FYMHS comprises approximately 12 FTE across Parkville and Malmsbury Youth Justice Precincts. This includes one FTE for a psychiatrist, psychiatric registrar (plus additional cover), neuropsychologist and stream leader, and six FTE for mental health clinicians. The service has an average case load of approximately 80 young people at one time, although this can range from 65 to over 100 young people depending on demand. The mental health clinicians have an average of 13 children and young people on their caseloads, up to a maximum of 23 children and young people at a time.

480 Prior to the commencement of Custodial FYMHS, the volume and complexity of children and young people in custody with mental health concerns was not anticipated. After commencement, it immediately experienced high levels of demand from young people with complex mental health presentations who require intensive treatment.

481 From July 2019 to May 2020, 50 per cent of children and young people in custody during the same period received a service from Custodial FYMHS. Young people received between one and 79 occasions of service, with an average of approximately nine occasions of service per young person. Over one third (37 per cent) of these young people received up to three occasions of service, and one third (33 per cent) received more than 10 occasions of service.

482 Data described above in the *Unique needs of children and young people* section at paragraph 419 illustrates the complexity of children and young people presenting with mental health issues.

483 It is important to note in this context that the availability of forensic youth mental health services is impacted by shortages among the forensic youth mental health workforce. As noted in Part Six of this statement, there are shortages in forensic mental health workforce which are even more pronounced for the youth forensic mental health workforce.

484 There are opportunities to explore whether existing services could be expanded or models adapted to support young people to have their mental health needs met through the critical transition from custody to community. For example, the Community Offender Advice and Treatment Services (**COATS**) is an adult specialist forensic AOD service that serves as a "one door" discharge for adults with forensic AOD issues transitioning from custody to community. This model could be adapted for young people with a focus on mental health issues to address gaps in continuity of mental health treatment during this critical transition.

Further initiatives to support specific cohorts across the justice system

Cohorts in the correctional system

485 DHHS is also evaluating initiatives implemented as part of the FMHIP. This evaluation evidence will form the basis for any further expansions of these services.

Insufficient responses to support the holistic needs and wellbeing of all children and young people involved with Youth Justice

486 There are limitations in the current mainstream and community mental health services that can mean that the specific and unique needs of children and young people at risk of involvement, or involved with the justice system are unmet, including that:

(a) Mainstream mental health services are often not responsive to the particular needs of the cohort at risk of involvement or involved with Youth Justice, due to capability and capacity limitations around managing those exhibiting challenging or offending behaviours.

(b) Service responses can lack a holistic approach to meet these multiple and complex needs.

(c) There are limited services that provide support and intervene at the level of family, community or cultural group. Children and young people rely more on their family, community and cultural group than their adult counterparts.

(d) There are also limited services available to meet the unique needs of cohorts of children and young people who are overrepresented in Youth Justice. This includes children and young people from CALD backgrounds. This is in addition to the issues raised at paragraph 371 for Aboriginal children and young people.

487 The following reform opportunities in mainstream and community services may assist these services to better support the mental health needs and associated risk factors of children and young people involved, or at risk of involvement with the justice system:

(a) build the capability of generalist youth mental health practitioners to manage children and young people exhibiting challenging or offending behaviours;

(b) improve the capability among mental health services to respond to multiple needs and comorbidities;

(c) provide further services focused on addressing the multiple and complex needs and comorbidities of the Youth Justice cohort, in particular, through addressing the overlap between mental health and AOD issues;

(d) increase the availability of mental health services that intervene or provide treatment by reaching into family, community or cultural group systems; and

(e) provide culturally relevant services and treatment to meet the particular needs of cohorts that are overrepresented in youth justice.

488 Youth Justice staff need intensive training and support to build their capability to address the underlying, multiple and complex needs of children and young people. As a workforce primarily at base grades, there is a gap in addressing the complex mental health needs of the cohort. There are opportunities to embed capability within the workforce by establishing multi-disciplinary teams in Youth Justice that support staff to work with children and young people with multiple and complex needs to support their mental health and wellbeing and improve behaviour.

489 Additionally, forensic youth mental health clinicians and specialists can lack the capability (for example, skills to respond to those with dual diagnoses, understanding forensic clients, and trauma-informed care) to meet the multiple and complex needs often associated with children and young people with mental health needs involved with Youth Justice. Limitations among capacity and capabilities restrict the current forensic mental health services available in Youth Justice custody to meet these multiple and complex needs.

490 Capability uplift among the forensic youth mental health workforce would support forensic services to better meet the needs of the cohort. For example, programs in both community and custody could better target children and young people with complex needs with additional clinicians with disability expertise, mental health nurse practitioners, speech therapists, occupational therapists and addiction specialists.

Lack of engagement with children and young people leading to service design that does not meet their specific needs

491 The efficacy and appropriateness of services and programs relies on how responsive they are to the unique issues, challenges and experiences faced by the target cohort.

492 There are a limited number of formal mechanisms for children and young people involved with Youth Justice to voice their perspectives and be heard and contribute to the understanding of issues and the design of mental health and wellbeing services. Consequently, there is a lack of services and programs that incorporate the voice of children and young people in their design.

493 This is particularly true for young people from CALD backgrounds and Aboriginal young people across the Youth Justice system, as well as their families and communities.

494 There is an opportunity for the experience of children and young people to be considered in, and inform the design of, the mental health service system, particularly those engaged with Youth Justice and Child Protection.

Gaps in mental health infrastructure that restrict the ability for children and young people involved with Youth Justice to have their needs met (secure and non-secure)

495 As highlighted in the Interim Report, there is currently no dedicated secure mental health treatment facility (such as at Thomas Embling Hospital) for the provision of compulsory treatment to young people in custody, or who are subject to custodial treatment orders under the CMIA.

496 Further, currently children and young people in custody requiring compulsory treatment receive treatment in standard, non-secure wards, which pose challenges to the treatment of the young person in question, the treatment of others in the ward, and to the site's security. Young people who receive custodial treatment orders under the CMIA are also held in custody due to a lack of alternatives.

497 To partially address this gap, a three-bed secure unit for young people is currently under construction at the Ursula Frayne Centre at Footscray Hospital for young people and is due for completion in July 2020. These beds will provide compulsory treatment for children and young people in custody.

498 The unit is only designed for the delivery of compulsory treatment for young people with severe mental illness and does not contain the long-term accommodation that would be required to treat young people under CMIA custodial treatment orders.

499 The Victorian Government has also funded the development of a new Youth Justice centre at Cherry Creek, which will include dedicated mental health beds for young males aged between 15 and 18 with a mental health condition who engage voluntarily. The unit is intended to prevent further deterioration of their condition and admission to a community inpatient unit for compulsory treatment.

500 After these two initial investments, there will still be some cohorts of young people in Youth Justice custody who do not receive an appropriate treatment response due to lack of relevant secure mental health infrastructure.

501 Cohorts of young people who will remain underserved after the Footscray and Cherry Creek developments include:

(a) children and young people on custodial supervision orders under the CMIA due to mental illness and/or disability;

(b) children and young people involved with Youth Justice receiving mental health treatment who would benefit from step-up secure care options, which will be limited otherwise to the three-bed unit at Footscray Hospital once open;

(c) girls and young women aged 10 to 18 years-old in custody; and

(d) boys and young men aged 10 to 14 years-old in custody.

502 Accommodation remains a significant issue. There is a shortage in affordable mental health supported accommodation options that are specific to young people, and appropriate for those involved in the justice system.

503 The best treatment outcomes for young people with mental health issues are facilitated by tailored mental health supported accommodation. Ideally, this requires a step-up /

step-down approach to transition them into a more intensive or a less intensive but supported model, as required.

504 There is an opportunity to expand non-secure therapeutic residential treatment options specifically designated to young people and appropriate for those with Youth Justice engagement, potentially including:

(a) transitional Support Units to fill the accommodation gap for young people transitioning out of custody; and

(b) a Community Care Unit for young people (16-25) with complex mental health needs.

Part Six – Strategic elements of reform

Introduction

505 Throughout Parts One to Five of my statement, I have discussed many successful pilots, service gaps, and reform opportunities for the Royal Commission's consideration. These reflect the extensive work done to continually improve how the department supports people with mental health needs who engage with the justice system. The department acknowledges that there is more to be done and that reforms to the mental health system foreshadowed in the Interim Report present a unique opportunity for targeted innovation and reform in the justice system.

506 Further to the reform opportunities highlighted so far, there are key system-wide reforms that prioritise the needs of justice-connected clients:

(a) strengthen the capacity to shift people from custody towards therapeutic pathways and support easier access to services;

(b) further strengthen mechanisms to identify and meet a person's unique needs at all points of their engagement with the criminal justice system;

(c) ensure service design is informed by lived experience and is culturally safe;

(d) ensure justice services are underpinned by robust data collection and outcomes-focused governance and that information is shared between justice and mental health systems to improve client outcomes;

(e) increase supports to victims of crime to respond to their mental health needs;

(f) support capacity and capability or skills uplift in clinicians and specialists to provide expert interdisciplinary services to justice clients;

(g) help justice workforces to support people with mental illness, and commonly associated comorbidities and needs;

(h) prioritise facilities and infrastructure that will enable this work; and

(i) consideration of broader policy factors, including the dynamic effect of COVID-19 on the public health system, to inform system redesign and provide better mental health outcomes for mental health consumers engaged in the justice system.

507 These nine overarching priorities will drive further reform work. Many of the reform opportunities highlighted throughout my statement connect closely to these reform priorities – in particular, the Common Clients reform set out in Part One and the emphasis on early intervention, diversion away from the justice system, and importance of access to services discussed throughout.

System-wide investments in improved mental health services

508 Inadequate levels of accessible and affordable mental health services across Victoria have a disproportionate impact on priority cohorts, particularly those in contact or at higher risk of contact with the justice system. The criminal justice system becomes a mental health provider of last resort and the embodiment of a crisis-driven response to mental health needs better addressed earlier in a person's continuum of care.

509 There are a number of key areas where system-wide investment will improve mental health services, particularly services to which justice clients can be easily referred. This should improve mental health outcomes for these cohorts and reduce preventable incarceration. These have been highlighted throughout my statement and they include:

(a) Offenders and people at risk of offending in the community should receive the same primary, secondary and specialist mental health services that other members of the public can access. These services should develop the appropriate capability to address the mental health needs of people in contact with the justice system, including the capability to treat people with co-occurring conditions.

(b) It is also necessary to invest in the highly specialist services required to treat people subject to an order under the CMIA, to prevent them being held in custody due to a lack of available services and supports. This includes people being held in custody in a prison due to a lack of adequate secure forensic treatment facilities and people being subject to custodial supervision orders rather than non-custodial supervision orders because of a lack of available treatments or services in the community.

(c) Where offenders in the community have a mental illness, they frequently face barriers in accessing mental health care through GPs and allied mental health services, as well as treatment for more acute conditions through AMHS. These

barriers may arise due to their status as offenders, or for other reasons such as comorbidities, economic factors or disengagement.

(d) Any implementation of health-led responses for people with mental illness in the justice system should consider these barriers and build the capacity and willingness of the primary health, allied mental health and specialist mental health systems to provide services to justice-involved consumers. Models such as the FMHiCH program, which embeds Forensicare clinicians in AMHS to support treatment of offenders in the community with MHTR orders, could inform how to address this issue.

510 Investment in early intervention would be expected to reduce, but not eliminate, demand for specialist mental health services and infrastructure in prisons. This is likely to create a range of benefits, including:

(a) improved whole-of-life outcomes for the individual, through earlier intervention and reduced trauma related to their incarceration;

(b) reduced cost to the community for the person's treatment, as treating people in the community is cheaper than incarceration; and

(c) improved community safety as those for whom their mental illness and related factors contribute to their offending are receiving appropriate treatment.

511 Reducing the proportion of offenders entering the prison system with untreated mental illness requiring access to specialist treatment would help reduce any long-term need for further expansion of these services.

Forensic mental health programs in the community

512 Forensic mental health programs in the community support justice-involved consumers and build the capacity of the broader community mental health sector to support clients with justice needs. As noted above, in the context of adult offenders, this could include expanding the FMHiCH Program and the Forensic Clinical Specialist Program.

513 These programs deliver specialist forensic mental health support to community-based offenders and would support the mental health needs of offenders by de-escalating and diverting from further engagement with the justice system.

514 Noting that these programs are the responsibility of DHHS to deliver, greater capacity and capability of primary, secondary and specialist mental health services to treat the mental health needs of offenders would be expected to reduce the incidence of offenders disengaging from or not receiving treatment.

Common Clients reform

515 As discussed earlier, referring people to appropriate therapeutic pathways must be supported by a multifaceted service model calibrated to the intersecting needs of common clients of the department, DHHS and the broader justice and community services sectors. This work is being progressed as part of the Common Clients Reform Project.

516 The aim of this work is to establish a flexible approach to service delivery that meets the needs of clients and takes early intervention and preventative approaches to keep them out of the system, while also ensuring that clients receive support, irrespective of their entry point in the service system.

517 We know that health and wellbeing outcomes are poorer for clients who have needs that span multiple systems, and demand for overstretched services continues to rise. Significantly, across almost all common client priority cohorts, mental health services are the most frequently accessed.[125] The Common Clients reform is well placed to deliver a coordinated effort across the department and DHHS to deliver an integrated service response and improve client outcomes, including in the area of mental health.

518 While Common Clients reform is not exclusively focused on people with mental health needs, its integrated and flexible approach to service delivery provides a model for further reform of the interface between the justice and mental health systems.

Scope, governance and intended outcomes

519 We know from experience that strong governance that listens to clients' voices and works in with local decision-making plays a critical role in the success of a reform. The Common Clients reform is supported by an integrated governance structure through Local Site Executive Committees (**LSECs**), which consist of local senior executives, managers and subject matter experts within the department and from DHHS working together to deliver services on the ground. This reflects a key priority for shared governance, which is to engage with service providers, clients and community to ensure that services are practical and respond directly to clients' needs and local priorities.

520 Four demonstration sites were established to implement the LSEC governance structure. At these demonstration sites, LSECs have implemented shared ways to identify and support common clients, build workforce capacity and implement new models of care.

[125] The four initial priority cohorts include: young people in residential care at risk of coming into contact with the justice system; young men in Youth Justice experiencing complex mental health and AOD issues; adult men in the justice system experiencing complex mental health and AOD issues; and women who are overrepresented in the prison system as a result of poverty and homelessness.

521 COVID-19 demonstrated that the integrated governance established through Common Clients reform successfully supported areas to respond quickly to vulnerable families. This governance model is critical to future reforms including information sharing, integrated services and funding reform.

Ensuring integrated and responsive services

522 Implementation of the Common Clients service model will be supported by a range of enablers, including workforce capability, better information sharing and flexible funding, with the aim of providing clients with seamless interactions between health, social and justice services at all points of interaction with these service systems.

523 The most important aspect of optimising access to justice for people with mental health needs, and a key objective of the Common Clients reform, is ensuring that services facilitate early intervention and are as integrated and responsive to individual needs as possible.

524 As the Royal Commission highlighted in the Interim Report, as much as possible, new reforms should be informed by lived experience of the mental health system (the importance of 'client voice'), and focused on how best to respond to complex and intersecting needs. Co-design of this work should leverage existing mechanisms, such as the AJF and the Justice Stakeholder Forum.[126]

525 Improving treatment pathways for offenders can be addressed through improvements to continuity of care and potential information sharing reforms, as discussed below.

From 'provider of last resort' to constructive point of intervention

526 In Part One of my statement, I noted some of the limitations of the broader mental health system (see paragraph 74). Due to the gaps in the broader mental health system, as well as specific barriers faced by people at risk of contact with the justice system, for some people entering custody, the custodial environment is their first opportunity to regularly access specialist mental health care. A Forensicare study of prisoners requiring compulsory treatment in custody in 2015 noted that 80 per cent of those prisoners had previously received services from an AMHS, with a median gap of a year between when they last received a service and entering custody.

527 This means that a high number of people are entering custody with untreated mental illness. While it is always preferable to identify and treat people before they enter custody, where people with mental illness enter custody, the system can use this as an intervention

[126] Comprising peak bodies, service delivery and advocacy organisations, courts, commissioners, academics and individual representatives, the Justice Stakeholder Forum (JSF) is the primary mechanism to update stakeholders on the department's reform agenda and program of work. The JSF meet quarterly.

point to provide person-centred and holistic mental health services. Then, by also embedding continuity of care, we can ensure that this engagement with treatment is not lost when a person transitions out of custody into the community.

528 As discussed briefly in Part One of my statement, transitioning from custody back into the community is complex, particularly in relation to mental health care, and the limitations of the broader mental health system can mean that people do not always have access to continuous and joined up care. Prisoners leaving prison can also lose access to ongoing treatment, due to limited availability of long-term residential treatment in the community that is accessible to and appropriate for offenders (for example, secure services).

529 While the justice system has several programs in place to connect prisoners leaving prison with ongoing mental health care, such as developing discharge plans, ReConnect, Restart and the Aboriginal Continuity of Care pilot, there are opportunities to further improve offenders' engagement with mental health care in the community. The Common Clients reform framework brings a new perspective to this issue, as it prioritises person-centred care and connection between services. These reforms will have as their central focus making sure services like these are accessible across both the justice and other service systems, to decrease people's vulnerability as they move between different services. Alongside the Common Clients reform, and potentially leveraging from them, improved continuity of care could also be achieved through in-reach models of care with AMHS commencing treatment prior to release.

530 The mental health and justice systems can take entry into custody as an opportunity to provide a person with high quality health (and mental health) interventions that the person was not accessing in the community for a variety of reasons. This is not about accepting the status quo of the corrections system as a mental health provider of last resort, but rather leveraging the combined resources of the justice system and AMHS to effect a transformation in the care a prisoner will eventually receive when he or she returns to the community.

531 The foundational service model for Common Clients reform involves providing supported transitions for clients, including people leaving custody. It is envisaged that exit planning will begin well in advance and will involve coordination and cooperation between multiple services. In this way, the Common Clients reform work will facilitate an effective and therapeutically oriented response to individual and community needs. This current reform work provides an extremely useful framework to continually improve the cross-departmental approach to continuity of care and coordination.

532 As the Common Clients reform evolves, there may be opportunities to consider broader cohorts who engage closely with DHHS and the department's services, including CMIA

clients. As this happens, shared information and data about these groups will highlight further opportunities for coordinated governance and services between departments.

Information sharing between justice and mental health systems

Adequacy of current information sharing arrangements between justice and forensic mental health systems for the facilitation of effective treatment and support

533 Under current data collection systems across health, human services and the justice system, it is difficult to achieve shared, available and high-quality information about a person's identity, diagnosis and comorbidities. This is because systems may define and triage various forms of disability, mental health issues and other comorbidities differently due to differing foci, contexts and competencies.

534 For example, it is difficult to link individuals across justice and health databases, with linkage usually requiring identifying information for some justice clients that is difficult to verify (for example, residential address for those with insecure housing) or non-existent (for example, Medicare number for non-residents).

535 However, there has been some success in this area that could be built upon. As a public designated mental health service, Forensicare has access to the statewide Client Management Interface/Operational Data Store system, managed by DHHS, which registers all public mental health patients. This system allows Forensicare to see other engagements their patients (including prisoners) have had with other mental health services. It also allows Forensicare to record information about treatment provided to people in custody and other justice clients.

536 However, although useful in providing care to those with higher acuity needs, it:

(a) does not facilitate information sharing about clients with low-to moderate-acuity conditions who do not require specialist treatment;

(b) does not facilitate information sharing with GPs and other primary mental health providers; and

(c) is not accessible to contracted primary health service providers in custody.

537 The Royal Commission may wish to consider opportunities to build on these existing systems to address these gaps, including consistent approaches to the detection of mental ill health and other co-occurring issues.

Measures to address information sharing blockages

538 The department has two Electronic Medical Record (**EMR**) systems that are managed by Justice Health – one for Corrections, one for Youth Justice. A person's record comprises all health information held by the department, such as test results, assessments completed, prescriptions, encounter notes and case plans. The department directly manages all health information regarding prisoners and young people in custody separately from their other custodial records, consistent with the its obligations under the Health Records Act. Upon entry to the prison or Youth Justice custodial systems, every person's consent is sought for the collection and use of their health information in line with relevant privacy legislation.

539 Health service providers in custody prepare discharge plans with a summary of a prisoner's or young person's health care on their release, with a view to enabling a prisoner or young person to continue care.

540 The EMRs have been designed to support fast and effective information sharing in the prison system. However, the EMRs are not directly accessible to community-based health service providers, including to hospitals who receive prisoners for emergency treatment.[127] In the event that a person in custody needs to access community-based services such as a hospital emergency department, clinically relevant documents from the person's record in the EMR system accompany the person to ensure receiving clinicians have the information they require to provide ongoing care. This ensures the privacy of the prisoner's complete medical history is respected, while also giving community-based providers the clinically relevant information from the EMR that they need to deliver care.

541 This is consistent with community expectations regarding the higher level of protection that should be afforded to health information and acquits the department's obligation to uphold the privacy of the prisoner's health information in accordance with the Health Records Act[128].

542 The department would welcome the Royal Commission's consideration of how health records in a custodial environment could be appropriately shared as part of its broader consideration of information sharing arrangements. However, this consideration should note that a prisoner's health record often also contains sensitive non-health information, such as details of prison incidents, a prisoner's placement, staff names and other information

[127] This practice is consistent with the *Health Records Act 2001* (Vic), s. 19.

[128] *Health Records Act 2001* (Vic), s. 25.

Systemic reform across the mental health system will be more sustainable and effective if supported by effective information sharing

543 Given the relationship – albeit complex – between mental health and offending and the prevalence of mental health issues amongst those in contact with the justice system, sharing information across mental health services, Victoria Police, the courts and Corrections and Youth Justice should assist in providing better mental health care and treatment. Improved information sharing is also key to facilitating greater collaboration and knowledge sharing between different service providers and government agencies involved in a person's care, which is central to the delivery of an integrated service model.

544 More robust information sharing is critical to diverting people with mental illness away from an often cyclical process of continued justice involvement. Investment in whole-of-government data and systems reform can potentially improve outcomes for people in contact with the justice system, including by enabling more effective diversion and referral efforts and by facilitating continuity of care.

545 For example, where a mental health service provides treatment and care to a young person at risk of offending and maintains a relationship with Victoria Police, that relationship and information sharing may assist in diverting that person from entry into custody – for example, through cautions or diversions. Similarly, if a mental health provider is fully informed about the care needs of a prisoner leaving custody, their ability to provide effective care is enhanced.

546 This could potentially be achieved by further consolidating clinical records of justice clients and oversight of clinical functions within the department.

547 As previously described, for many individuals, contact with the criminal justice system can lead to the first identification and treatment of pre-existing health issues, including mental health. This means custodial health services offer a public health opportunity to commence treatment that will ideally continue after their release to the community. This requires good information sharing protocols and the consent of the individual receiving care.

548 Continuity of care requires integration between custodial and community-based health services and broader social support services, as well as mechanisms that support and motivate individuals to remain engaged with their treatment during periods of change.

549 While some of these integration issues may be legislative or technological, strengthening relationships between the justice system health services and broader community-based services is also critical to overcoming issues in information sharing.

550 The importance of continuity of care also applies to those on remand (recognising the increasing remand population and the relatively short periods individuals may spend in custody). Effective mental health treatment programs that address mental health problems and criminogenic risk factors together have been shown to reduce recidivism and deliver a benefit to the individual and the community as a result.[129] This means that if information is shared to support continuity of care, it will increase the possibility that the person does not return to the criminal justice system.

551 Discharge planning is a key opportunity for effective information sharing to enable continuity of care beyond prison and to support the continuation of any health gains made as a result of accessing custodial health services. There is also a need to motivate and support the individual to remain engaged in treatment, address the stigma and reluctance to treat forensic consumers in community-based services, and overcome access barriers associated with catchment areas that often exclude individuals without stable housing.

552 Any reform should allow for the effective collection and sharing of information and tracking of outcomes from the point of first contact to subsequent points as people transition between different settings (for example, through community, acute and forensic mental health services). Collection and sharing of this information is particularly important in relation to those people transitioning into and out of police and corrections custody as it has the potential to improve the treatment and overall justice system response to them.

553 At the same time the risks and sensitivities associated with the information that may be exchanged between services – particularly issues around privacy, consent and potential stigmatisation – also need to be considered. Any new protocols and practices must be co-designed with people with lived experience, and a wide range of service providers, with a strong focus on consent from participants, transparency about the way the data will be used, and safeguards against misuse.

554 The family violence reforms are a good example of how legislative reform can improve interagency data collection and sharing to support system-wide responsiveness, noting that family violence information sharing exists for a different purpose, and in quite a different context. Improved data sharing practices as part of Common Clients reform will also serve as a useful example for ensuring that essential privacy and data protections are articulated in a way that promotes rather than hinders good mental health outcomes for justice clients.

[129] Skeem JL, Steadman HJ, Manchak SM: Applicability of the risk-need-responsivity model to persons with mental illness involved in the criminal justice system. Psychiatric Services 66:916–922, 2015. Accessed at https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201400448.

Data reform to improve system design and service planning

555 While shared information about individual clients can lead to better continuity of care, shared data will lead to improved evidence bases and policy outcomes.

The Crime Statistics Agency and the interface between crime statistics and offender health profiles

556 A detailed analysis of the relationship between health and offending requires data linkage between justice and health datasets that is currently unavailable to the Crime Statistics Agency. However, the Crime Statistics Agency holds a wealth of linked data relating to the characteristics of offenders, their victimisation, their offending patterns over time, and their pathways through the justice system from police, through the criminal courts and into Youth Justice and corrective services.

557 Previous pilot work has proved the feasibility of linking public mental health client records with criminal justice data. However, this is of limited value, as it does not capture the full scope of information required to cover people's engagement with private mental health practitioners as well as the public system. Noting that access to information and evidence is critical to designing and delivering the best possible supports for clients, work is underway as part of the Common Clients reform to improve information sharing across services systems. Linked data across the department and DHHS has been leveraged to inform the Common Clients reform work, including providing a view of client journeys of specific client cohorts through service systems and service interactions.[130] This work will continue to guide reform efforts and direction.

558 The Crime Statistics Agency could undertake developmental linkage work to bridge gaps between existing public system health indicators and service contacts, the full range of personal health data held by Justice Health and data about people's offending and victimisation profiles from criminal justice data sources. This work could provide a vastly more detailed understanding of the nexus between mental illness, services accessed and offending in Victoria, and more broadly the relationships between overall health and wellbeing, offending and victimisation.

559 Linked data assets are vital for ensuring integrated system responses can be developed and evaluated based on the best available data and evidence. Such data assets would be invaluable for understanding the current relationships (baselines) and then also for

[130] For example, linked data analysis from the Common Clients reform work found that mental health issues are a major reason for emergency-department contacts. This suggests that complex mental health issues are not being effectively addressed through early intervention services. Further work is required to understand the reasons for trends in client (non)engagement, which could be due to service gaps, inadequate referral pathways and/or service inefficiencies.

ongoing monitoring of the impacts of criminal justice reforms on those with a mental illness.

560 An analysis program mining this data asset would support the establishment of a public evidence base to disseminate research insights on, for example:

(a) the volume of various cohorts of offenders who have indicators of mental illness;

(b) the impact of access to treatment at the time of an offence on the nature of offences committed;[131]

(c) how the offending behaviour of those with mental illnesses differs from the offending behaviour of other offenders;

(d) changing trends over time;

(e) the criminal justice pathways of those with mental illness; and

(f) the effectiveness of reforms and interventions designed to provide additional support to those with mental illness, or to divert them away from the justice system.

561 I also note the limitations on Corrections Victoria data relating to prisoners and their mental health which are outlined above from paragraph 265.

Access to de-identified prisoner health data for the purposes of improving future forensic health services and outcomes

562 There is an opportunity to better integrate data from operational systems established for the primary purpose of capturing health treatment data for prisoners within the strategic data holdings of the department.

563 Current approaches to the collation of data for evaluation and research purposes are ad hoc and require manual approaches to linking data. Integration of Justice Health data into other justice data assets would open up significant analysis opportunities. Establishing data linkage between diagnosis and treatment information and the custodial episode would provide improved capacity for regular reporting on the health profile of prisoners as well as facilitating improved outcome measurement. This work would need to be underpinned by the informed consent of prisoners and young people in custody, consistent with the Health Privacy Principles in the Health Records Act.

[131] The department is not currently able to produce data that analyses the relationship between access to treatment at the time of an offence and the nature of the offence but notes that this is something that could be undertaken through a dedicated research project.

Should a forensic health data registry be established (including forensic mental health) for this purpose?

564 I have noted above the benefits and possible concerns with increased information sharing in a forensic context. Further to this, it would be preferable for department-held mental health data to be incorporated into a whole-of-mental health system data approach, rather than a separate forensic-only data approach.

565 It is also important to be clear about the purpose of any such registry, in particular, whether the approach to improving future forensic health services and outcomes is to be driven by a registry with a research or an operational focus. The latter presents a greater challenge but also potentially greater benefits, consistent with the joined-up governance approach being developed through Common Clients reform.

566 The integrated service model envisaged in the Common Clients reform will need to be supported by a range of enablers, including improved information sharing and data and evidence-informed decision-making.

567 Investment in whole of government data and systems reform, particularly reforms that improve the measurement of mental health outcomes within community-based mental health services, can also improve outcomes for people in contact with the justice system. This will enable more effective diversion and referral efforts and continuity of care. For example, improved data collection on mental illness for specific cohorts in contact with the criminal justice system, in particular Aboriginal people, and people from culturally and linguistically diverse backgrounds, will enable review and improvement of existing criminal justice and mental health responses to these groups.

Victims of crime

Police support for victims of crime

568 Offenders are often also victims of crime, which creates a complex dynamic of offending and mental health needs. For example, a significant proportion of female offenders have experienced family violence, sexual assault and neglect in childhood. Anecdotal information from the Victims of Crime Helpline tells us there is often a complex co-representation of mental health alongside other significant issues in the lives of victims, such as childhood abuse, family violence, unemployment, homelessness and social disconnection.

569 Victims of crime with mental illness may be doubly stigmatised due to their history of victimisation and, often, associated trauma. Additional intersecting needs associated with AOD use, homelessness, disability, family violence or sexual abuse may increase the need for tailored supports.

570 Police are often the initial point of contact for victims of crime. Enhancing clinical supports available to police, including connections with victim-focused services that can appropriately treat crime-related trauma, can improve outcomes for victims. This should include early intervention, referral and treatment services accessible shortly after engaging with police. This could involve priority access to mental health services and other supports to immediately address the trauma of being a victim of crime and connecting victims to sustainable community treatment options.

Mental health experts in victim services

571 Victim Services, through services including the Victims of Crime Helpline, the Victims Assistance Program and the Victims Register, are often the first point of contact for victims of crime who self-harm or who are suicidal. While all Victim Services staff are trained in trauma-informed practice, there is no dedicated funding to ensure Victim Services staff consistently receive training in mental health.

572 A 2018 survey of training (the **survey**)[132] for Victim Services staff identified a need for a stronger capability for mental health first aid and 'suicide assist' training. Some of the comments from the survey participants demonstrated the critical role of training to ensure the workplace is adequately equipped to assist victims of crime with complex mental health needs or for whom the crime is likely to cause severe mental health impacts. This type of work is resource intensive and requires a level of specialisation or expertise that is often outside the scope of victim services.

573 Through the provision of clinical and expert support, victim services staff would have improved mental health capability which would ensure that victims of crime with a mental illness receive a more appropriate, trauma-informed and specialised response. Clinical and expert support will also contribute to a safer workplace for victim services staff who may have a high risk of exposure to vicarious trauma.

574 This capability lead model has been successfully used to improve the family violence response for Victims Services following the Royal Commission into Family Violence. Victim Services' Family Violence Practice Lead is responsible for coaching and mentoring victim services staff, developing policies to support best practice in dealing with family violence and providing training. The Family Violence Practice Lead also maintains relationships and improves practices with external stakeholders such as Victoria Police and the broader family violence service sector. Since the commencement of the Family Violence Practice Lead in 2018, victim services staff report feeling more confident to appropriately deal with family violence victims.

---

[132] Community Operations and Victims Support Agency, *Victim Services Staff Training Survey: Summary of Results*, 18 December 2018, pg. 7, 8, 10.

Support for victims in court

575 The Intermediary Pilot Program has made a significant contribution to the supports available for victims of crime. This program provides skilled communications specialists to ensure that more vulnerable victims, such as child victims and adults with a cognitive impairment who are complainants in homicide and sexual offence cases, are able to communicate their evidence to police and the courts to increase their access to justice.[133] Since the beginning of the program, the most frequent communication issue identified in the initial request for an intermediary has been mental health and trauma.

576 The May 2019 process evaluation of the Intermediary Pilot Program demonstrates that the program has significant support from users of intermediaries, the judiciary, legal practitioners and police and it has contributed to better practice, processes and outcomes in the justice system. The evaluation shows that:

(a) Victims and witnesses who had access to an intermediary felt heard, were less confused and intimidated, and experienced less trauma. They also provided better quality evidence and felt able to participate more effectively at multiple court stages.[134]

(b) Police members who worked with intermediaries had greater confidence in the quality of evidence due to improved communication with victims and witnesses and there was more appropriate identification and filtering of cases that should not progress to court.

(c) Police members who worked with intermediaries improved their communication skills and understanding of victims' needs, which they then applied to other areas of police work.

(d) There were less interruptions to questioning, which saved time for all court participants, and the program has enhanced cross jurisdictional collaboration so that victims experienced the justice system as more responsive to their needs.[135]

Workforce

Justice workforce implications of a redesign of the mental health system

577 A redesign of the mental health system will require increasing capability and capacity of specialist and general workforces within the justice system.

---

[133] Cognitive impairment (as defined in the *Criminal Procedure Act 2009*) includes mental illness, intellectual disability, and dementia or brain injury.

[134] Department of Justice and Community Safety, *Intermediary Pilot Program: Process Evaluation*, 2019, p. 5.

[135] Ibid.

578 The Royal Commission's Interim Report noted that a more progressive mental health system will require people to work better in partnership with consumers, families and carers, along with strengthened models of multidisciplinary care.

579 The workforce must have the values and skills to provide consumer-focused, recovery-oriented and safe services in a collaborative, accountable and transparent way.

580 Clinical and broader justice workforce capability building must also include capability to respond to the diverse needs of all service users. Capability to embed an intersectional approach across service design and delivery is an integral element of successful systemic reform.

581 The Royal Commission may wish to consider forensic mental health specialisations, and the broader custodial mental health workforce, when making recommendations regarding workforce capacity and development, which will be critical in ensuring the needs of justice-connected mental health consumers are met in any system redesign.

582 Consultation undertaken in 2019 with workforce, clients and service providers as part of the Common Clients reform found that there is currently insufficient workforce capacity to support increasingly complex clients – that is, clients with multiple, intersecting needs – and that the system itself requires reform. At the same time, there was also significant optimism that better collaboration between those involved in providing mental health care and treatment for those in contact with the justice system could, along with shared planning and common outcomes, increase capacity and provide better results for people. Consultation also highlighted that shared outcomes are a key enabler in driving greater collaboration to measure impact and enable continuous learning and improvement for workforce capacity and capability.

583 A long-term workforce strategy that supports the uplift of both generalist and specialist workforces across justice, health and human services will need to be an ongoing priority in the implementation of further reform.

Core justice workforce attributes, capabilities and skills that enhance the experience of people with mental illness in contact with the justice system

Community based mental health service providers need to be able to respond to the needs of their justice-connected clients

584 Community based mental health service providers will need the capability to respond to clients, both young people and adults, who are engaged in the justice system, or are likely to be. These issues are detailed further in relation to children and young people involved with Youth Justice in Part Five.

585 Further embedding forensic specialists and capability within mainstream disciplines, such as youth services and AMHS, will be foundational to a prevention-focused approach. Such an approach will also need to be responsive to intersectional and varied needs of clients from a wide range of backgrounds. Workforces such as victim support, custodial and community justice workforces need improved support and training to address clients' mental health needs.

586 It is also necessary for community-based mental health service providers and targeted services provided to Aboriginal people through ACCOs ensure their workers are equipped to support clients who are engaged in the justice system, or are at risk of contact. This reform opportunity is detailed further in relation to children and young people involved with Youth Justice, including Aboriginal young people, earlier in my statement.

Improving the mental health capability of department workforces to support reform

587 Corrections and Youth Justice custodial officers are required to manage and support cohorts with complex needs, including a high prevalence of mental illness.

588 The mental health capability of departmental workforces will be critical to the success of reforms to the mental health system, to effectively and sustainably manage the complex needs of adult offenders and young people involved with Youth Justice.

589 Beyond the specialist responses required to adequately support adult offenders and young people involved with the Youth Justice system with complex needs, including mental health needs, the general justice system workforces would also benefit from an improved understanding of the complexities of mental illness, and will require support to implement practice improvements. These workforces include custodial workforces, community corrections, community Youth Justice workers, people working in the courts, and victim support services.

590 As discussed in Part Three, while Custodial and Community Corrections officers receive a wide range of training to assist in responding to these complex needs, including to recognise and respond to potential mental health concerns in prisoners, adult offenders in the community and young people who offend there nonetheless remains a gap between staff capabilities and the needs of complex cohorts.

591 Educating the workforce in how to understand and recognise mental health and intervene safely at a basic level (with support of clinicians) would be valuable to assist in the early identification and intervention for young people in the justice system affected by a mental illness.

592 Educating the workforce about how to navigate what is a complicated and complex service system, from understanding who to contact to obtain support, when to manage a case up, to how to explain the case to a clinician in order to get a good treatment outcome, is equally valuable.

593 As noted above, Corrections and Youth Justice workforces, and the strategies that support them, will need to include people with lived experience of mental health, as well as people from a wide range of communities and priority groups, to ensure that the system is as supportive and responsive as it needs to be.

594 Across the rest of the justice system, workforce uplift can draw on lessons from recent reforms in family violence workforce uplift, workforce uplift for victim services, and trauma-informed training for custodial officers.

The capacity of Forensicare and other custodial health services to meet demand for specialist services

The unavailability of suitably qualified forensic mental health clinicians presents a barrier to the necessary expansion of forensic mental health services in custody and the community

595 Forensicare and other custodial health services have experienced challenges in the recruitment of qualified staff to resource the recent planned expansions of its services, including its prison operations. This is due to increased demand for clinical skills across a range of social sectors, as well as perceptions around working in a custodial environment.

596 As noted above, the department anticipates that a long-term recruitment strategy will be needed to meet its current commitments and further demand for its services, similar to the highly successful strategy implemented in advance of the commissioning of Ravenhall that enabled Forensicare to fully staff the facility at the time it opened.

597 In the short-term, the unavailability of suitably qualified forensic mental health clinicians, which is a barrier to expanding forensic mental health services, can potentially be addressed through equipping providers to attract forensic clinicians from elsewhere in Australia, or potentially overseas, requiring some limited investment to improve the recruitment capability of Forensicare and other providers.

598 In the long-term, it is preferable to invest appropriately in education and professional development in Victoria to create a sustainable pipeline of specialist forensic mental health clinicians, and in strategies to attract and retain these clinicians to work with a particularly challenging patient cohort.

599 Clinicians and specialists require capability uplift (for example, to improve skills in dual diagnosis, understanding forensic clients, and trauma-informed care) to engage clients with complex needs, including forensic clients. Mental health and other clinicians in custodial environments would benefit from support to work with patients with complex needs, such as those with comorbid disability or AOD use.

Growing and supporting forensic mental health workforces

600 Any capital investment in specialist forensic mental health services in prison, Youth Justice or in the community would need to be accompanied by appropriate investments in a forensic mental health workforce. The lack of suitably qualified staff has prevented the timely opening of new inpatient services at Forensicare facilities. For example, the opening of the Apsley Unit at Thomas Embling Hospital was delayed for seven months due to insufficient staffing levels. This placed continued stress on the prison mental health system.

601 Given that a shortage of forensic mental health clinicians has impacted the ability to increase the delivery of services, the specific needs of forensic mental health, custodial health, and forensic disability workforces must be considered in the development of workforce pipelines and retention strategies.

602 Workforce strategic planning should also consider mechanisms to build forensic capacity in mainstream systems. Workforce uplift includes capability uplift for clinicians and specialists who need to be better equipped to support clients with complex needs, including forensic needs.

Forensic infrastructure

More secure forensic mental health beds are required to meet demand

Planning and delivery

603 Planning and delivery of mental health infrastructure is a protracted process complicated by the complexities at the interface of the mental health and justice systems.

604 Long lead times between planning and delivery of forensic mental health infrastructure (which require planning and strategic investment over a sustained period) hamper efforts by government to respond rapidly to changing demand pressures.

605 While a difficulty across the whole mental health system, this issue is compounded at the justice interface by other factors including high costs (for example due to the cost of building to security requirements) and staff capacity and retention.

606 The department works closely with Forensicare and with DHHS, who are responsible for secure mental health infrastructure, to develop and implement the expansion of forensic mental health service capacity. Forensicare has appointed a prison access flow coordinator and a hospital access flow coordinator to manage prisoner flow through bed-based services across the prison system and Thomas Embling Hospital.

607 The department is responsible for the care of offenders placed under these orders until they are admitted as patients into mental health facilities, but has a very limited role in the development of the physical infrastructure, which is where much of the shortage lies.

Thomas Embling Hospital

608 The only mental health facility in Victoria that meets the requirements of the Mental Health Act to provide secure compulsory treatment is Thomas Embling Hospital.

609 Thomas Embling Hospital's status as the sole provider of secure compulsory treatment creates a concentrated pressure on the beds available for security patients, as well as forensic and civil patients who require treatment at Thomas Embling Hospital. The supply of beds has not kept pace with the demands from prisons, the court system and the general public.

610 The ongoing absence of bed capacity at Thomas Embling Hospital is now a longstanding critical pressure point in the forensic mental health system. When Thomas Embling Hospital was initially established in April 2000, there were 116 beds. As at April 2019, capacity had increased to 136 beds.[136] By contrast, in June 2000, the total prisoner population was 3153. As at 31 March 2020, the total prisoner population was 8087.

611 For the second half of 2019, the average wait time for transfer to Thomas Embling Hospital for a security patient was 18 days for women and 28.7 days for men. People with similar mental health treatment needs in the community are likely to be immediately admitted to a hospital.

612 These systematic delays and barriers to treatment pose significant risks to the health and safety of prisoners in custody. The delays mean that prisoners with acute needs who are refusing treatment occupy beds in specialist mental health units in custody, at the expense of those engaging with treatment voluntarily who would potentially benefit from access to a bed-based service.

613 Demand pressure on specialist mental health units within custody is expected to be eased if there is increased capacity in the secure forensic mental health system to immediately

[136] Note: not all beds at Thomas Embling Hospital are available to prisoners (security patients). As noted above, Thomas Embling Hospital also provides care to forensic and civil patients.

accommodate and treat prisoners requiring compulsory treatment and people subject to custodial treatment orders under the CMIA. This will support clinicians to engage in more preventative and voluntary treatment in custody.

Demand pressure at Thomas Embling Hospital for specific cohorts

614 Thomas Embling Hospital currently only has one dedicated acute unit for women, and all step-down services provided on site (for example, rehabilitation units) are either mixed gender or male-only.

615 This means that female prisoners and other women who require secure treatment do not have access to the full scope of step-up and step-down secure forensic mental health services that men do. While women typically receive treatment at Thomas Embling Hospital faster than men do, this gap in the service offering may mask latent demand (particularly in the community) and compromise treatment outcomes for women.

616 As noted in Part Five, there is also a need for forensic mental health infrastructure to support children and young people in contact with the Youth Justice system. While the rooms at Cherry Creek will provide a much-needed service, they will not be suitable for all young people. For example, there is still a need to increase the service offers to girls or young women in custody or to boys under the age of 15 as these groups of young people will not have access to dedicated mental health rooms at the Parkville precinct. The Government is taking steps to increase dedicated mental health infrastructure across Youth Justice precincts (as discussed above from paragraph 496).

Policy considerations

617 The following section outlines how the department incorporates the community's growing understanding of mental illness into policy development and legislative reform. Departmental policy considerations take into account the overrepresentation of people living with mental illness in the justice system, and utilise available policy levers to promote community safety through therapeutic pathways away from and out of the justice system.

Managing impacts of proposed changes on people living with mental illness during reform

618 The department takes steps to try to ensure that proposed legislative changes do not compound disadvantage arising from a mental illness, in particular:

(a) criminal justice system responses should not be used in lieu of appropriate community mental health responses to mental illness;

(b) statutory schemes should avoid compounding intersecting disadvantage by considering whether a response will disadvantage particular groups who are differently impacted by mental illness, including women, Aboriginal Victorians and LGBTIQ Victorians; and

(c) if a statutory scheme or other policy reform could result in differential treatment for offenders with a mental illness, it is necessary to consider and balance the impacts to all involved.

619 When legislating general criminal law reforms, it may also be necessary to consider and to balance the following considerations or principles:

(a) whether the proposed law is likely to disproportionately affect people with a mental illness or mental health impairment;

(b) whether the proposed law provides sufficient judicial discretion to take into account the mental health of an offender, the severity of the crime and the preservation of community safety in decision making or as mitigating factors in the sentencing exercise; and

(c) whether adequate infrastructure, programs and treatment options are in place to support implementation of the proposed law.

620 Government also has a role in making laws to protect victims of crime from trauma. The steps taken to support victims and de-escalate the effects of traumatisation, are outlined in my earlier discussion.

621 Policy leadership more broadly also involves producing overarching strategies that influence the policy development agenda across the justice system. For example, the Access to Justice Review 2016[137] recommended that the Government do more to support integrated, tailored, and targeted service delivery for client groups with additional needs. This recommendation, accepted by the Government, has informed subsequent policy development and project design.

Mechanisms through which policy makers can be required to give consideration to, and prioritise, policies with positive mental health impacts

622 Regulatory mechanisms can be used to encourage policymakers to consider the impact of new policy or legislation. There are a range of regulatory mechanisms which encourage

[137] See Recommendation 3.4 in Department of Justice and Regulation, 'Access to Justice Review', August 2016, p. 189. Accessed at https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-engage.files/3314/8601/7221/Access_to_Justice_Review_-_Report_and_recommendations_Volume_1.PDF

policymakers to consider the impact of new policy and legislation on individuals and their human rights, their health, and their environment.

623 For example, the Charter of Human Rights ensures that the introduction of new legislation into Parliament must include a Statement of Compatibility, to demonstrate its alignment to the rights set out in the Charter.

624 The Cabinet Submission process contains a similar mechanism, for a broader range of considerations. It ensures that any submission made to the Victorian Cabinet or a Cabinet Committee has considered the social, economic, environmental, human rights, local government and regional impacts of any new policy or piece of legislation. Social impacts naturally include consideration of factors which contribute to health and mental health needs in the community, though this is not made explicit.

625 If a mental health impact assessment, or similar, were to be regulated in Victoria, this would likely be one of the most constructive places for its inclusion.

626 There are examples in other industries and jurisdictions of regulatory mechanisms which ask the policy maker to consider the health impacts of a proposal. Such health impact assessments or statements could potentially include mental health impact considerations.

627 The value of formally including mental health impact considerations in the development of new policy and legislation, where applicable and relevant, is that it allows for a comprehensive consideration of the mental health impacts of a given policy, particularly from people with lived experience. However, there are other ways to include the voices of those with lived experience in policy development, as demonstrated by the contribution of victim representatives on the Victims of Crime Consultative Committee, to the development and review of justice policy and legislation. In addition, the Family Violence Victim Survivors Advisory Council has made significant and valuable contributions to family violence policy following the Royal Commission into Family Violence.

628 This approach allows for voices of lived experience to be at the centre of stakeholder engagement in relevant policy development, and is arguably more meaningful than a prescriptive regulation which compels brief consideration of mental health impacts. This is particularly relevant for the development of policy for Aboriginal Victorians in line with the principles of self-determination.

629 The regulatory impacts of an instrument which requires policy makers to detail their considerations of mental health could outweigh the benefits, particularly if it just encourages a merely formal, 'box-ticking' exercise. These efforts may be better focused on uplifting service delivery and workforce capabilities, particularly given the breadth and number of major reforms in Victoria at present, including reforms to the mental health system following the finalisation of this Royal Commission.

COVID-19 responses

630 Though the full impact of the pandemic is still unknown, the unprecedented social and economic consequences of COVID-19 have likely compounded disadvantage for vulnerable Victorians, including those with multiple and complex needs, with anticipated increased demand for services at a higher cost to government.

631 New cohorts, such as young people and older Victorians, are also expected to enter our service systems as a result of financial and housing instability, and unemployment.

632 Evidence has consistently shown that social disadvantage is persistent among those who are at risk of or in contact with the justice system, including individuals with mental health and/or AOD issues. Such cohorts are particularly vulnerable to compounded social disadvantage expected as a result of the social isolation and economic downturn.

633 To enable an effective and rapid response to the COVID-19 pandemic crisis, in March the Government and public service was temporarily reorganised. The most senior levels of the Victorian public service have been structured to focus on six core missions to help respond to the emergency.

634 The department's Secretary leads the Mission for Restoration and Reform of Public Services – People, along with the Secretaries to DHHS and the Department of Education and Training.[138] In delivering on this mission, these departments have followed guiding principles which include putting people at the centre of service delivery design and solutions for justice and social services, and promoting the rights of all Victorians, particularly the vulnerable. Due to alignment with the health system, the impacts of COVID-19 on the mental health system have been managed under the Health Emergency mission by the Secretary, DHHS. The impact of COVID-19 on the justice and social services sector has disrupted delivery of some services which may have impacted clients with mental health issues in the justice system.

635 A range of services in the justice system have shifted to remote service delivery in line with requirements of the public health response to COVID-19. One example is the change to CISP. CISP has shifted its services to remote delivery where possible, including the provision of mental health assessment and treatment in line with the majority of the social service sector. Although this has enabled some clients to continue to receive the support they need during the pandemic, remote delivery has challenges for some people such as for those who do not have access to a device capable of remote delivery or receive a lower intensity of service.

[138] On 12 June the Premier revised the Mission structure to reflect a focus on recovery. Previously there were eight core missions and I was responsible for Continuity of Essential Services – People and Restoration of public services – People, jointly with the Secretary DET.

636 There has also been a vast increase in the use Audio-Visual Link and WebEx in the court system to hear a higher volume of matters remotely, with high-risk matters (e.g. family violence) being prioritised. As with CISP, reliance on remote service delivery for legal services and courts means that more people can continue to have access to justice during the pandemic, however it also means that people experiencing mental health issues may be receiving different service responses than they would if their interactions with lawyers and courts were occurring in person.

637 To keep correctional facilitates as safe as possible from the introduction of COVID-19, Corrections Victoria has suspended personal visits in prison, which has been balanced – where possible – by an increase in access to telephone and video call facilities. Face-to-face professional visits have been limited to essential visits only, for example where alternative arrangements are unable to be met. All prisoners entering custody are now required to complete a 14-day quarantine period, which includes access to enhanced distress interventions in addition to existing health and mental health supports. Primary health services and forensic mental health services continue to be delivered, with increased use of telehealth where possible and appropriate. Other services are being delivered remotely where possible or in other ways that support physical distancing requirements, including offending behaviour programs, education, and AOD programs.

638 Similar adjustments have been made in Youth Justice centres and, where suitable, adults and young people who are subject to community-based orders have been supervised remotely (for example, supervision and program appointments undertaken via telephone or video calls). Offenders considered high priority based on heightened risk to the community have continued to report to CCS locations by appointment, adhering to safe social distancing practices. In addition to existing supports and services, vulnerable offenders in the community are being supported based on their individual risks as needs, such as continued access to face-to-face appointments for offenders who have difficulty accessing using technology – including offenders with an intellectual disability.

639 More broadly, I understand many services, including mental health services, are pivoting towards a mixed model of both face-to-face service delivery and telehealth, noting the expansion of technology-based service options.

640 Recognising the disproportionate impacts of COVID-19 on vulnerable cohorts, part of the response has also included investment in emergency housing for complex cases, noting the increased risk of homelessness during the extended health emergency. Such cases include clients leaving the justice system (for example, women exiting prison into homelessness) and those with significant mental health or AOD needs exiting prison into homelessness. This investment includes an additional complexity 'loading' for support services, such as case management, welfare support, housing brokerage and support to access AOD services.

641 As mentioned above, the Common Clients reform was established to deliver a coordinated effort across the department and DHHS to deliver an integrated service response and improve client outcomes.It is also an important opportunity to better partner with the funded sector and empower providers to collaborate and work flexibly to deliver better outcomes for clients. Meaningful engagement will be critical to the success of reform and will help to ensure that changes reflect the lived experiences, needs and priorities of both clients and those delivering services and managing the system. The department's and the Government's management of the COVID-19 crisis will continue to evolve over the coming months.

642 Any reforms will inevitably need to be considered and implemented within the COVID-19 policy environment. As a result of the concentration of health (including mental health) resources and funding on the management of the pandemic, it may be that reforms recommended by the Royal Commission take longer to implement than they otherwise would have. There will likely be opportunities to draw on the technological advances in services that have resulted from COVID-19, including telehealth resources and video conferencing, which has the potential to uplift service delivery in remote areas or complex environments, such as custody, and I encourage the Royal Commission to consider these opportunities closely. Finally, changes to workforce composition and the economy more broadly may be an opportunity for mental health and justice workforces to grow.

sign here ►

print name Peta McCammon

date 13/08/2020

Royal Commission into
Victoria's Mental Health System

APPENDICES TO WITNESS STATEMENT OF ASSOCIATE SECRETARY PETA MCCAMMON

Appendix A. Additional information for Part One: Overview of mental health and the justice system

People living with mental illness in the justice system

1 In Part One of my statement, I discuss the issue of overrepresentation of adults and young people with mental illness in the justice system and emphasise that any account of the interface between the justice and mental health systems must address the disproportionally high rates of mental illness in the offender population. Below, I provide further detail to the matters discussed in Part One of my statement.

How justice policy has changed over the last decade

2 The issue of overrepresentation of adults and young people with mental illness in the justice system must also be understood within the context of how justice policy has evolved over the last decade.

3 As discussed in Part One of my statement, justice policy changes over the last 10 years reflect and have responded to a range of forces, including government law reform priorities designed to enhance community safety, an increasing focus on victims, and developing community understandings of the complex relationship between mental illness and offending.

4 The Department of Justice and Community Safety (the **department**) plays a key role in maintaining a strong criminal justice system that prioritises community protection by holding offenders to account. This work is also informed by an emphasis on embedding therapeutic jurisprudence principles in evidence-based initiatives to respond to offenders, particularly offenders with mental illness.[1]

5 Appendix A will set out in further detail some of the major reforms to bail legislation which have had the most significant impacts on justice policy in Victoria, to provide some further historical detail relevant to the analysis provided in Part One of the statement.

[1] I discuss therapeutic justice interventions that are currently underway in Victoria's court system in further detail in Part Two of my statement.

6 An increased focus on community safety over the last decade has been reflected in a number of legislative reforms, including family violence reforms, the introduction of new offences, and stronger settings for key aspects of sentencing, bail and parole.

7 Legislative changes that have taken effect since 2010 commenced with reforms by the then government in the *Bail Amendment Act 2010*[2] to respond to 40 recommendations made by the Victorian Law Reform Commission in its 2007 report Review of the Bail Act: Final Report.[3] These recommendations focused on clarification of the existing law and enhancement of the operation of the bail system.

8 Following this and a change of government in 2010, the incoming government introduced further legislative changes, in particular:

(a) changes to bail laws, which sought to enhance community safety with clearer bail laws and tougher penalties for breaches;[4]

(b) the abolition of suspended sentences in 2014.[5]

9 The then government made further bail law changes in the *Bail Amendment Act 2013*,[6] which created two new offences: breaching a condition of bail (failing to comply with bail conditions) and committing an indictable offence while on bail. Accused persons arrested and charged for any of the offences against the *Bail Act 1977* (the **Bail Act**), were subject to a reverse-onus test for bail.[7] The amendments also broadened the situations where the reverse-onus tests apply.

10 Subsequent changes in the *Bail Amendment Act 2016*[8] amended the breach of bail condition offence so that it does not apply to children. Other changes relating to children in this Act included creating child-specific factors to be considered in bail decisions and

---

[2] *Bail Amendment Act 2010*, available at https://content.legislation.vic.gov.au/sites/default/files/54e79406-ba63-3cd0-85f7-885f911720bd_10-070a.pdf.

[3] Victorian Law Reform Commission, 'Review of the Bail Act: Final Report', August 2007, available at https://www.lawreform.vic.gov.au/sites/default/files/VLRC_Review_of_the_Bail_Act_Final_Report.pdf.

[4] " Under a Baillieu government bail laws will be clearer, breaches will attract penalties, offenders face the prospect of an additional charge with a longer jail sentence and the community and the courts will be better informed, and the community will be better protected," quoted in Sydney Morning Herald, 'Bail bracelets absurd: lawyers', 5 July 2010, accessed at https://www.smh.com.au/national/bail-bracelets-absurd-lawyers-20100705-zw19.html.

[5] Suspended sentences were introduced in Victoria in 1985 and allowed a court to suspend all or part of an imprisonment sentence for a specified period. Further information is available at https://www.sentencingcouncil.vic.gov.au/about-sentencing/abolished-sentencing-orders.

[6] *Bail Amendment Act 2013*, available at https://content.legislation.vic.gov.au/sites/default/files/d2922035-bec6-34a4-a822-25010f5f309c_13-044aa%20authorised.pdf.

[7] The *Bail Act* lists offences which do not have a general entitlement to bail. Accused people charged with those offences have to satisfy the court that they should be granted bail, rather than the prosecution satisfying the court that they should not. 'Reverse onus' offences are offences whether the onus (or legal burden) is on the accused rather than the prosecution – this is an exception to the general rule that the prosecution must prove the case against the accused beyond reasonable doubt.

[8] *Bail Amendment Act 2016*, available at https://content.legislation.vic.gov.au/sites/default/files/3803bce3-f1e4-357c-93d5-79c750e39701_16-001aa%20authorised.pdf.

creating a presumption in favour of initiating criminal proceedings against children by summons rather than arrest.

11 These child-related changes to the Bail Act responded to a considerable increase in the number of children remanded since 2012.[9] Another change in this Act increased the maximum penalty for the offence of failing to answer bail from 12 months imprisonment to two years imprisonment.

12 The current government also introduced further bail reforms which commenced in 2018. These reforms were in the *Bail Amendment (Stage One) Act 2017*, the *Bail Amendment (Stage Two) Act 2018* and the *Justice Legislation Amendment (Terrorism) Act 2018*.

13 These reforms followed the 2017 Bail Review[10] undertaken by the former Director of Public Prosecutions and Supreme Court Justice, the Hon Paul Coghlan QC and the 2017 reports of the Expert Panel on Terrorism and Violent Extremism Prevention and Response Powers,[11] led by former Victorian Chief Commissioner of Police, Ken Lay AO and former Victorian Court of Appeal Justice, the Hon David Harper AM. The major community safety reforms which impacted bail legislation are listed in the statement.

14 The 2018 reforms made it more difficult for serious and repeat offenders to get bail. However, the way the reforms operate in practice means that someone who is accused of repeated lower level offending may be subject to one of the reverse onus tests for bail, including the exceptional circumstances test.

15 For example, an accused who is on bail for a low value shop theft and is arrested for committing a second theft offence must establish that a compelling reason exists justifying the grant of bail. If the person is bailed again and they are alleged to have committed a third theft offence while on bail, they must establish that exceptional circumstances exist that justify the grant of bail. In line with the current government's focus on diverting non-violent offenders that are not a risk to the community from the criminal justice system, the department is continuing to monitor the operation of Victoria's bail laws and consider opportunities to address any unintended impacts on lower level offenders and vulnerable cohorts.

16 The 2018 reforms also specifically provide that in certain circumstances, a different approach must be taken in respect of 'vulnerable adults', defined as those with a cognitive, physical or mental health impairment. These provisions set out when, and by

---

[9] Sentencing Advisory Board, 'Sentencing Children in Victoria Data Update Report', July 2016, p. 8. Accessed at http://youthlaw.asn.au/wp-content/uploads/2016/07/Sentencing-Children-in-Victoria-Data-Update-Report.pdf.

[10] P Coghlan, 'First Advice to the Victorian Government', 2017; Victorian Government, 'Government Response to the Bail Review (Advice Provided by the Hon Paul Coghlan QC on 3 April 2017)', 2017. Both documents are available at https://engage.vic.gov.au/bailreview.

[11] The Expert Panel on Terrorism's reports are available at https://www.vic.gov.au/what-government-doing-protect-victorian-community.

whom, bail can be granted for 'vulnerable adults', and work to minimise the time these persons spend in police custody prior to a bail decision. For example, police may not remand such persons, but can grant them bail:

(a) Vulnerable adults are exempted from the police remand system. This means that vulnerable adults who have been refused bail by police outside of ordinary court hours may apply to a bail justice for bail, rather than waiting to be brought before a court.

(b) Vulnerable adults are exempted from the requirement that only a court can grant bail to persons accused of certain serious offences and who are already on two or more undertakings of bail for other indictable offences. In these circumstances, police, or subsequently a bail justice, can grant bail to a vulnerable adult.

(c) Vulnerable adults are, in certain circumstances, exempted from the requirement that only a court can grant bail to accused persons who are subject to the reverse-onus exceptional circumstances test. In these circumstances, police, or subsequently a bail justice, can grant bail to a vulnerable adult.

17 Additionally, one of the 'surrounding circumstances' a bail decision maker must take into account when applying the tests for bail is "any special vulnerability of the accused, including being a child or an Aboriginal person, being in ill health or having a cognitive impairment, an intellectual disability or a mental illness".

18 An example of reforms that balance the imperatives that I discussed is the introduction of Youth Control Orders and the Intensive Bail Scheme,[12] which is discussed further at Appendix E as part of further information on Youth Justice and mental health.

19 Over the past 7 years, there have been considerable reforms to strengthen Victoria's parole system and promote community safety and protection. During 2013-2014, the parole laws under the *Corrections Act 1986* (**Corrections Act**) were amended several times.[13] These reforms responded to recommendations made by former High Court Justice Ian Callinan AC in his report, *Review of the parole system in Victoria* (July 2013)

---

[12] A Youth Control Order operates as an alternative to detention by imposing intense requirements for supervision, support and court monitoring of children aged 10 to 17 years, for up to 12 months. A Youth Control Order can only be made where the offence is punishable by imprisonment – the purpose of the order is to help a child develop an ability to abide by the law, and engage them in education, training or work. Further information is available at https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/children-specific-circumstances/youth-control-orders-advice.
The Intensive Bail Scheme provides an alternative to remand for high risk young people that have had frequent, severe or chronic contact with the Youth Justice system who would not otherwise be granted supervised bail. Further information is available at https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/children-specific-circumstances/intensive-bail-advice.

[13] See *Corrections Amendment Act 2013*, *Justice Legislation Amendment (Cancellation of Parole and Other Matters) Act 2013*, *Corrections Amendment (Parole Reform) Act 2013*, *Corrections Amendment (Breach of Parole) Act 2013*, *Justice Legislation Amendment (Discovery Disclosure and Other Matters) Act 2014*, *Corrections Legislation Amendment Act 2014* and *Corrections Amendment (Further Parole Reform) Act 2014*).

as well as making broader changes to the parole system. Key reforms during this period included:

(a) ensuring that the safety and protection of the community is the paramount consideration in all parole decisions;

(b) introducing a two-tier decision-making process for prisoners seeking parole in respect of a serious violent offence or a sexual offence, overseen by the Chairperson of the Board;

(c) providing for the variation or cancellation of parole in circumstances where a prisoner is charged with or convicted of certain offences while on parole;

(d) making it an offence for a prisoner to breach a prescribed term or condition or their parole order without reasonable excuse.

20 The parole regime has been further strengthened through reforms targeting particularly serious offending. In 2016, the *Justice Legislation Amendment (Parole Reform and Other Matters) Act 2016* introduced presumptions against the grant of parole for prisoners serving terms of imprisonment for the murder of a police officer, and for prisoners serving terms of imprisonment for certain fatal offences where the body or remains of the victim have not been located ('no body' cases). The police murderer parole provisions were further clarified in 2018 under the *Corrections Amendment (Parole) Act 2018*. Further parole reforms were also introduced in 2018 in response to recommendations made by the Expert Panel on Terrorism and Violent Extremism Prevention and Response Powers. The *Justice Legislation Amendment (Terrorism) Act 2018* amended the Corrections Act to introduce presumptions against the granting of parole, and in favour of the cancellation of parole, for prisoners who had prior convictions for, or links to, terrorism, or who otherwise posed a terrorism risk.

Policies, supports and services for victim survivors

21 As I discuss in Part One of my statement, embedding the perspectives of victim survivors in development of policy and practice is an important priority for the department. This section outlines mechanisms that the department has put in place to promote the interests of victim survivors in the administration and reform of the justice system, and to better support the mental health of victims. It provides further detail on how victims policy has evolved over the last 10 years in recognition of the impact of crime on the mental health of victims.

Advocacy from victims and their representatives has influenced a range of policy measures that support victim survivors to participate in the justice system

22 Over the last 10 years, a number of measures have been introduced to reduce the difficulties victims experience when participating in the justice system through ensuring the delivery of quality victim support services. These measures respond to increasing advocacy by victim support agencies and evidence-based reviews[14] documenting the impact of crime on the mental health of victims and include:

(a) in 2010, a broadening of protections for victims when giving evidence,[15] particularly in sexual assault and family violence matters, to also include non-complainants;[16]

(b) requiring the use of video and audio recorded evidence (**VARE**) in certain circumstance to reduce the frequency with which certain victims (children and victims with a cognitive impairment) are required to give evidence. Over the last decade, the use of VARE has been expanded to apply to criminal proceedings that relate to family violence matters;[17]

(c) amending the *Sentencing Act 1991* (the **Sentencing Act**) in 2011 to grant victims the right to read victim impact statements out in court,[18] and in 2018 to allow a court to accept the whole of a victim impact statement despite it containing inadmissible material;[19]

(d) requiring the Director of Public Prosecutions to seek a victim's views in relation to certain decisions such as discontinuing a prosecution or accepting a plea to a lesser charge;[20]

(e) establishing the Victims of Crime Commissioner in 2014 and the expansion of the Commissioner's powers in 2019[21]; and

---

[14] For example: Royal Commission into Family Violence, *Final report* 2016; Victorian Law Reform Commission (VLRC), *The Role of Victims of Crime in the Criminal Trial Process*, Report, August 2016; Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report*, 2017; VLRC, *Review of the Victims of Crime Assistance Act 1996*, Report, July 2018; Centre for Innovative Justice, *Victim Service Review Stage 1: Strengthening Victoria's victim support system - Final Report September 2019*, (Melbourne: RMIT University, 2019); Centre for Innovative Justice, *Victim Service Review Stage 2: Strengthening Victoria's victim support system - Final Report December 2019*, (Melbourne: RMIT University, 2019).

[15] *Criminal Procedure Act 2009* (Vic), Part 8.2 – Witnesses, Division 4 (alternative arrangements for giving evidence).

[16] *Justice Legislation Amendment Act 2010* (Vic).

[17] *Family Violence Protection Amendment Act 2017* (Vic).

[18] VLRC, *The Role of Victims of Crime in the Criminal Trial Process*, Report, August 2016, pg. 19.

[19] *Victims and Other Legislation Amendment Act 2018* (Vic). This was in response to recommendations from the Victorian Law Reform Commission's 2016 report 'Victims of Crime in the Criminal Trial Process'.

[20] *Victims and Other Legislation Amendment Act 2018* (Vic).

[21] The role of Victims of Crime Commissioner was established in 2014 and legislated in the *Victims of Crime Commissioner Act 2015*. The Commissioner's role was strengthened in 2019 through the *Victims and Other*

(f) improving access to compensation and financial assistance under the *Victims of Crime Assistance Act 1996* and the Sentencing Act, including for claims by victims of physical or sexual abuse who were children at the time of the abuse[22] and improving access to the Prisoner Compensation Quarantine Fund.[23]

The department's efforts to improve policies, supports and services for victim survivors

23 The department is developing an administrative financial assistance scheme for victims of crime that prioritises victims' therapeutic needs and supports and aims to provide assistance that is fair, timely and predictable. New legislation under which the scheme can operate will be required. The department will consult closely with stakeholders in developing the scheme.

24 Other examples include:

(a) improving the experience of family violence victim survivors who are applying for review of their fines;

(b) increasing access to justice for vulnerable witnesses through the Intermediary Pilot Program (established in Victim Services, Support and Reform within the department), which provides better support to communicate their evidence to police and courts. Intermediaries are skilled communication specialists who support children and people with cognitive impairment who are victims of crime to provide evidence to police and to the court;[24]

(c) strengthening support for victims in the event of critical incidents and violent crime.

25 Victim Services, Support and Reform provides a suite of front-line services for victims of crime. These include the Victims of Crime Helpline, the Victims Assistance Program and the Victims Register, as well as a range of other services focused on vulnerable witnesses (including the Child Witness Service) and victims of young offenders.

26 The Victims Assistance Program is a state-wide program that provides victims with flexible case management services that continue throughout the criminal justice process

---

Legislation Amendment Act 2018 to enable review of the way agencies have handled complaints under the *Victims Charter Act 2006*.

[22] *Justice Legislation Amendment (Victims) Act 2018* (Vic).

[23] The Prisoner Compensation Quarantine Fund (PCQF) was established in 2008 under the *Corrections Act 1986*. Victims of a prisoner who receives compensation are notified of the compensation by the Victims Register if they are eligible to be on the Register, or by public notice. As eligibility for the PCQF is broader than eligibility for the Victims Register, in 2020, the department established a separate PCQF Register to enable more victims to be directly notified.

[24] See Part 6 of the witness statement for further information on the Intermediary Pilot Program.

according to individual needs. There are other services for victims of family violence and sexual assault to which victims are referred for specialised support.

27 Victim Services Support and Reform has also developed a range of service innovations for victims of crime, including the Family Violence Restorative Justice Service and the Intermediary Pilot Program.

28 The department recently commissioned a comprehensive review of victim services – the Victim Services Review (the **VSR**) – which was completed in early 2020.

29 The VSR considered the victim support system in its entirety across government and non-government services. It examined the strengths and limitations of the system and included direct feedback from victims of crime who have experienced the criminal justice process and the victim support system as clients.

30 The VSR found that the victim support system service in Victoria compares favourably to interstate and international models, but that the system is somewhat fragmented, hard to navigate and needs to strengthen its capacity to support victims with complex trauma. This includes responding to the compounding effects on mental health caused by the trauma experienced by victims of crime (during and after the relevant offending and during any subsequent criminal justice process).[25]

31 The VSR set out a roadmap for future improvements to build a contemporary support system, to ensure it is effective, equitable and responsive to the diverse needs of victims. This would support an enhanced service model and enable victims with existing mental health issues, including trauma-related mental health issues, to be effectively case managed with appropriate supports.

Appendix B. Additional information for Part Two: Opportunities to divert people with mental illness from ongoing contact with the criminal justice system

32 Part Two of my statement provides an overview of diversion practices and recidivism. This appendix discusses diversion practices and recidivism in Victoria in further detail.

[25] Centre for Innovative Justice, *Victim Service Review Stage 1: Strengthening Victoria's victim support system - Final Report September 2019*, (Melbourne: RMIT University, 2019), pg. 5; Centre for Innovative Justice, *Victim Service Review Stage 2: Strengthening Victoria's victim support system - Final Report December 2019*, RMIT University, 2019, pg. 9, 10 and 205.

Diversion

Police diversion and early intervention

33 Assistant Commissioner Glenn Weir's statement to the Royal Commission notes a number of joint initiatives between Victoria Police, Ambulance Victoria, mental health service providers and other relevant service providers to enhance interventions for people experiencing mental health issues who have contact with police.[26] These initiatives are diversionary in the sense that they potentially avoid a person having to come into contact with the criminal justice system.

34 Examples of initiatives referred to in Assistant Commissioner Weir's statement include:

(a) the Embedded Youth Outreach Program;

(b) the Victorian Fixated Threat Assessment Centre;

(c) Police, Ambulance and Clinical Early Response / Mental Health and Police program;

(d) Victoria Police e-Referral system.

Legislative provisions provide for court-based diversion for adults and children

35 Section 59 of the Criminal Procedure Act 2009 establishes a pre-plea diversion program for accused adults who are charged with a summary offence or an indictable offence that is triable summarily.[27]

36 The accused must acknowledge responsibility for the offence and the Magistrates' Court must consider the accused's participation in the diversion program appropriate. Both the prosecution and the accused must also consent to the accused participating in the program.

37 If the accused completes the program to the satisfaction of the Magistrates' Court, no plea is taken and the court must discharge the accused without any finding of guilt. If not, and the accused is subsequently found guilty of the offence, the Court must take into account the extent to which the accused complied with the program when sentencing them.

---

[26] Further information on the initiatives referred here can be obtained from paragraphs 21, 83 and 94 of Assistant Commissioner Glenn Weir's witness statement to the Royal Commission, available at https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/3115/6314/9157/Assistant_Commissioner_Glenn_Weir.pdf.

[27] *Criminal Procedure Act 2009* (Vic), Part 3.3 Section 59(1), available at https://content.legislation.vic.gov.au/sites/default/files/2020-04/09-7aa075%20authorised.pdf. This section does not apply to offences such as cancellation or suspension of a license or permit to drive a motor vehicle and other offences against section 49(1) of the *Road Safety Act 1986* (Vic).

38 A pre-plea diversion program for accused who are children is established by the *Children, Youth and Families Act 2005* (**CYF Act**). Similar to the adult pre-plea diversion program, the child must acknowledge responsibility for the offence and both the prosecution and the child must consent to the child participating in the program.

39 In some circumstances, the Act allows the Children's Court of Victoria to refuse to accept a plea of guilty from a child, or may allow the child to withdraw such a plea, if the Court considers it necessary to consider the appropriateness of diversion.[28]

40 The Act also sets out the purposes of diversion to guide the operation of the provisions, and expressly requires the prosecution to consider a number of matters when determining whether to consent to a child participating in the diversion program. Guidance is also provided in the Act regarding the matters the Court is to consider when determining whether participating in the diversion program is appropriate and also regarding the type of program to order.

Sentencing and courts

Sentencing considerations with regard to people with mental illness

Consideration of mental impairment and mental illness in sentencing decisions has been embedded in the justice system over time

41 This is evident in reforms to the *Mental Health Act 2014* (the **Mental Health Act**), the Sentencing Act, the introduction of the Koori Court and the Drug Court, and the reforms to emergency worker harm laws. These are each explained below.

42 As a starting point, section 5(2) of the Sentencing Act prescribes that, in sentencing an offender, a court must have regard to certain matters. In this context, the mental health of an offender may be relevant to the consideration of the offender's 'moral culpability' and can be a 'mitigating factor' in the sentencing exercise.

43 The possible impacts of an offender's mental health on sentencing are outlined in the case of Verdins.[29] In *Verdins*, the Court of Appeal identified six ways that mental impairment may be relevant to sentencing:

(a) It may reduce an offender's moral culpability and so affect what is considered to be a just punishment and lessen the need for denunciation.

(b) It may have a bearing on the kind of sentence that is imposed and the conditions under which it should be served.

---

[28] *Children, Youth and Families Act 2005* (Vic), Part 5.2 Section 365D(2).

[29] *R v Verdins* (2007) 16 VR 269.

(c) General deterrence may be moderated or eliminated as a consideration depending on the nature and severity of the offender's symptoms, and the effect of their impairment at the time of offending, sentence, or both.

(d) Specific deterrence may be similarly moderated or eliminated in the same circumstances.

(e) The existence of an impairment at the time of sentencing, or its reasonably foreseeable reoccurrence, may mean that a specific sentence may weigh more heavily on the offender than it would on a person in normal health.

(f) If there is a serious risk that imprisonment will have a significantly adverse impact on the offender's mental health, this will be a mitigating factor.

44 However, it is important to note that the principles from the Verdins case will not apply to all offenders with a mental illness. This is because the Verdins case is concerned with whether an offender is mentally or intellectually impaired (whether the impairment is caused by mental illness or otherwise), and how the impairment affected them at the time of the offending or is likely to affect their experience of imprisonment. Verdins principles only apply to offenders with impaired mental or intellectual functioning, and will not apply in cases involving offenders who do not have such an impairment.

45 Impaired mental functioning, for the purposes of sentencing, may be distinguished from mental impairment under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*. Under that Act, the defence of mental impairment is established if an accused was suffering from a mental impairment at the time of engaging in conduct constituting the alleged offence, and that the mental impairment affected the accused so that they either did not understand the nature and quality of their conduct, or did not know their conduct was wrong. By contrast, for the purposes of sentencing, a person's impaired mental functioning may be of such a level that it is relevant as a mitigating factor in sentencing, but it does not preclude a person from being criminally responsible for their actions and being found guilty of an offence.

46 With the introduction of the Mental Health Act in 2014, the nature of an offender's impaired mental functioning pursuant to the Sentencing Act now includes mental illness within the definition of impaired mental functioning. Therefore, since 2014, if an offender's mental illness is causally linked to the commission of an offence and substantially reduces the offender's culpability, certain sentencing restrictions, such as statutory minimum sentences or custodial order requirements, may not apply.

Court-led initiatives can support diversion to therapeutic pathways where appropriate

47 As described in Part Two of my statement, the Magistrates' Court of Victoria has implemented a series of therapeutic court interventions. An overview of each is outlined below.

The Mental Health Advice and Response Service

48 The Mental Health Advice and Response Service (**MHARS**) is a significant expansion of the earlier Mental Health Expansion Pilot which was funded in 2017-18 under the Forensic Mental Health Implementation Plan (**FMHIP**) and is led by the Department of Health and Human Services (**DHHS**) in recognition of the high rate of Mental Health Treatment and Rehabilitation conditions being attached to Community Correction Orders (**CCO**).

49 The 2017-18 Budget supported MHARS to commence phased implementation at Sunshine and Melbourne Magistrates' Courts on 2 July 2018, which later expanded to the now 13 Magistrates' Court locations included across Victoria. Currently, 26 full-time equivalent (**FTE**) clinicians operate at 13 Magistrates' Court locations, including five regional courts and eight metropolitan courts in and around Melbourne. On 1 July 2019, MHARS was expanded to include one FTE at the Bail and Remand Court. MHARS was expanded to the Children's Court of Victoria in May 2019 (see Appendix E) and as per the Magistrate's Annual Report, expanded to the Ballarat Bail and Remand Court in November 2019.

50 MHARS facilitates the provision of specialist clinical mental health advice to magistrates on the mental health of accused persons in court proceedings, enabling the court system to more effectively take mental health into account when making judicial determinations, including on the capacity of the accused to participate in court proceedings. Referrals may be made from a range of sources including Magistrates, legal practitioners and Community Correctional Services (**CCS**).

51 MHARS also enables clinical services to intervene early in the criminal justice process by identifying where individuals charged with an offence and appearing before the court have a mental illness, and by providing timely advice and linkage with treatment providers. Where needed, immediate psychiatric intervention is provided, and a referral is made to the appropriate mental health services.

52 Priority is given to providing immediate responses to those presenting to the court who are acutely mentally unwell. This helps magistrates to ensure people with mental illness are placed on diversion pathways that suit their needs.

Assessment and Referral Court List (ARC List)

53 An independent evaluation conducted by Deloitte Access Economics in 2014 concluded that the ARC List had progressed toward its stated objectives and expected outcomes, including reduced rate and severity of offending. The evaluation has not been publicly released.

54 The evaluation noted that, compared to the period before entering the ARC List, participation in the ARC List had:

(a) substantially reduced the rate of offending by participants during their ARC List participation, and slightly reduced rate in the two years after exit from the ARC List;

(b) reduced the average severity of offending during and after participation in the ARC List;

(c) reduced the rate and length of imprisonment among participants during and after their participation. For example: 61 prison bed days were saved per participant in the two years after their ARC List program completion;

(d) increased compliance with court community orders during and after ARC List participation;

(e) improved the capacity of generic services to work with participants, who had more of their needs met, and were engaging more with services;

(f) improved links between court support services and community agencies, with service usage and frequency increased, and individual service plans created for the majority of participants. Participation in the ARC List was also found to have led to improvements in participants' perceived quality of life upon their exit from the ARC List, and improvements in participants' health, mental health and social wellbeing.

55 The evaluation also forecast that in five years, the ARC List would generate savings of $2.24 for every $1 invested in it. This benefit was attributed to a decreased rate and severity of reoffending, and fewer days spent in prison and under CCOs – both benefits applying during a person's participation in the ARC List and for the two years following their exit.

56 Data from the Magistrates' Court also indicates the benefits of the ARC List. For example, of the 550 participants accepted into the ARC List since its commencement in 2010, 82 per cent (or 451 individuals) have completed the program successfully.

57 The 2015-16 Victorian Budget provided $12.7 million for the ARC List and the 2017-18 Victorian Budget allocated $20.4 million for the expansion of the ARC List (as part of the FMHIP).

Court Integrated Services Program

58 The Court Integrated Services Program (**CISP**) links accused persons to support services, including drug and alcohol treatment, mental health services, and crisis and supported accommodation.

59 The period of engagement by an accused person with CISP is usually up to four months.

60 The 2009 University of Melbourne CISP Evaluation indicated that, given this relatively short period of engagement, it would be unreasonable to expect any significant change in anything other than relatively minor mental health problems. However, there was a statistically significant increase in physical and mental health (pre- and post-CISP SF-12 scores, a measure of health status) for CISP participants while in the program.

61 The evaluation also noted:

(a) across the program, 35 per cent (1,246 clients) were identified as having a possible mental health problem, and of those around 40 per cent were receiving treatment with a referral for mental health services for one in every five CISP clients engaged;

(b) mental health problems were much more common in women than in men (48.4 per cent versus 34.7 per cent), and became more prevalent as clients got older;

(c) around one third of CISP clients were recorded as having more than one offending related drug, alcohol or mental health problem;

(d) clients who had both substance abuse and mental health problems were particularly difficult to deal with and staff require clinical experience with drug, alcohol and mental health issues.

The Neighbourhood Justice Centre in Collingwood

62 Neighbourhood Justice Centre (**NJC**) in Collingwood brings together a multi-jurisdictional court with a range of support services and community initiatives, including legal assistance, mental health support, financial counselling, alcohol and drug counselling, and housing support. In particular, a mental health clinician from St Vincent's Mental Health Service is based at the NJC to offer clinical assessment, short-term support and appropriate referral to individuals who are worried about their mental health.

63 Community justice at NJC provides police with a platform to prevent crime from happening in the first place. At NJC, police prosecutors work with defence lawyers and correctional services on outcomes that serve the needs of justice and the needs of offenders who need help to climb out of the spiral of offending, and the court works with support services, which are available to everyone.

64 An evaluation of the NJC conducted by KPMG in 2012 found that the NJC was making progress towards increasing community safety by reducing crime and reoffending. Specifically, the evaluation found that NJC users reoffended approximately five per cent less than a matched sample group who had been through the mainstream Magistrates' Court over the first twelve months (28.5 per cent to 33.5 per cent). At 24 months, there was a significantly better (16.7 per cent) difference in recidivism between NJC users and mainstream Magistrates' Court users (55 per cent to 71.7 per cent).

Children's Court of Victoria

65 The Children's Court of Victoria is a specialist court that focuses on the rights of children, young people and their families, often who present with often multiple and complex problems, including mental health issues. The Children's Court Clinic services the Children's Court.

66 The Clinic operates as an independent body that is continued and maintained by the Secretary to the department. The Clinic is a team of clinical and forensic psychologists and neuro- and consulting psychiatrists, who make clinical assessments of children and provide other clinical assessments and recommendations in relation to children, youth and families. These expert clinical assessments assist the Court in its decision-making in both the Criminal and Family Divisions of the Court.

Specialist Family Violence Court Division

67 The Specialist Family Violence Court Division currently operates at three venues (Shepparton, Ballarat and Moorabbin), offering a specialist response to family violence matters through purpose-built physical environment, enhanced resourcing, staff specialisation and support, user centred and innovative practices, inclusivity and improved safety for families attending court. Specialist Family Violence Courts will serve as a centre for excellence in the delivery of integrated family violence court services.

Koori Court and Koori Children's Court

68 Koori Court ensures sentencing orders are appropriate to the cultural needs of certain Koori offenders and assists them to address issues relating to their offending behaviour, which include mental illness.

69 The Koori Children's Court, which is a sentencing Court, involves the Koori community in the court process. There are currently 12 Koori Children's Courts across Victoria sitting in Melbourne, Heidelberg, Dandenong, Mildura, Latrobe Valley (Morwell), Bairnsdale, Warrnambool, Portland, Hamilton, Geelong, Swan Hill and Shepparton.

Victorian Drug Court

70 As is recognised in the Interim Report, there is frequently a close relationship between poor mental health and the misuse of alcohol and other drugs (**AOD**).[30] Assisting people address their AOD issues can improve their prospects of mental health recovery and wellbeing. The department considers recent initiatives to expand the Drug Court as contributing to these efforts.

71 The Drug Court provides for the sentencing of offenders whose dependency on AOD contributed to their offending, and for judicial supervision of their treatment. This is relevant due to the prevalence of comorbid substance abuse issues and mental illness amongst offenders

72 The Drug Court attempts to address the contributing role of underlying AOD issues to offending by providing participants with an opportunity to receive drug treatment and stay drug- and crime-free. Drug Treatment Orders (**DTO**) (to be renamed Drug and Alcohol Treatment Orders) operate as an alternative sentencing option to a term of imprisonment. They are therapeutically-oriented and are aimed at, amongst other things, reducing the offending's health risks associated with AOD dependency.[31] A component of a DTO can include that a person submit to psychiatric or psychological assessment.[32] This allows for the holistic treatment of a person, including their mental health needs.

73 The Drug Court imposes and administers DTOs, which have both a custodial and a treatment and supervision part. The custodial part cannot exceed two years imprisonment and is served in the community to allow the offender to receive their AOD treatment. The treatment and supervision part complements this by addressing the specific needs of the offender's AOD dependency. The order includes conditions that must be complied with, such as submitting to drug testing and engaging in drug and mental health treatment. Their compliance and progress is supervised by a judicial officer and supported by case managers, clinical advisors, and counsellors.

74 Evaluations of the Drug Court conducted by Turning Point and Acumen Alliance (in 2005) and KPMG (in 2014) found:

---

[30] Interim Report, page 35 [2.2.6].

[31] *Sentencing Act 1991* (Vic) s 18X.

[32] *Sentencing Act 1991* (Vic) s 18ZG.

(a) across each of the health risk domains assessed (medical, psychiatric, and AOD), significant progress was observed as participants moved through the program's three phases. For example, the cohort in their third and final phase of the program had improved their "low risk" rating in the medical domain from 50 to 94 per cent, in the psychiatric domain from 44 to 89 per cent low risk, and in the AOD domain from 17 to 100 per cent;

(b) there was evidence that the Drug Court effectively improved the health and wellbeing of participants through the reduction of criminogenic risk factors, reduced AOD use and improved connection to the community;

(c) 42 per cent less imprisonment days for Drug Court participants who would have been placed in custody if not for a Drug Treatment Order;

(d) 29 percentage point lower rate of reoffending over the first 24 months after completing a Drug Treatment Order.

Expansion of the Drug Court

75 The 2019-20 State Budget included $35 million to be invested into facilitating the expansion of the Drug Court to the regional areas surrounding Ballarat and Shepparton, as well as the establishment of a Drug Court trial in the County Court. On 18 March 2020, the Justice Legislation Amendment (Drug Court and Other Matters) Bill 2020 was introduced into Parliament so that this expansion can take effect. The expansion is expected to provide capacity for up to 120 offenders to address their drug and alcohol issues and offending.

76 As the Drug Court currently only operates in Melbourne and Dandenong, this would make the problem solving and rehabilitative approach of the Drug Court available to more Victorians, particularly to those who reside in regional Victoria. The Shepparton and Ballarat expansion is planned to commence hearing cases in 2021-22 and as the County Court trial will be the first project of its kind in the Victorian intermediate court, the timeline for its first cases remains a matter for Courts Services Victoria.

77 Similarly to the way the Drug Court operates now in the Magistrates' Court, the Drug Court in the County Court will operate within a framework established by legislation and will provide an alternative sentencing option for suitable offenders who make a deliberate decision to engage with the process and commit to addressing their underlying problems by doing so.

78 The legislation creating the Drug Court in the County Court will also rename Drug Treatment Orders to Drug and Alcohol Treatment Orders, reflecting the availability of the program for offenders affected by alcohol dependency, and the role it can play in their offending behaviour.

79 While the schemes in the two courts are broadly similar, the Drug Court in the County Court has slightly more restrictive criteria for participation and will also have a continuing supervisory role in dealing with any future summary offences committed by offenders who are subject to its orders. By addressing the underlying drivers of their offending behaviour, the program is expected to help reduce future reoffending by a cohort who, if left untreated, are likely to become further and further entrenched by repeated appearances before the mainstream courts.

80 The department continues to consider possible future expansions of the Drug Court where the need and demand exists, noting the high intensity and cost of the program comparative to other therapeutic court interventions. They are, however, an excellent example of how Victoria's justice and social service agencies can work together to improve people's experiences in accessing services over the course of their lives and of how individuals can be diverted from future offending through targeted, wrap-around service delivery. As noted above, these outcomes benefit not only the offenders in question, but the wider community.

81 The department is also working with Courts Services Victoria, the County Court of Victoria and the Magistrates' Court of Victoria to consider how the Drug Court can be evolved to meet the needs of people experiencing mental illness as part of the pilot expansion in the Magistrates' Court of Victoria and County Court of Victoria.

82 Expansion of the Drug Court could impact positively on the justice system response to mental health in particular groups. For example, in the Aboriginal Justice context, the Koori Prisoner Mental Health and Cognitive Function Study found rates of substance abuse and dependence disorders were greatly over-represented with 92.9 per cent of Aboriginal women in prison and 76 per cent of Aboriginal men in prison found to have a lifetime substance misuse disorder.[33] Most people with mental illnesses had a co-occurring substance misuse disorder.

Policies which balance rehabilitation with just punishment and community safety in serious offences

83 Victoria's emergency worker harm laws were introduced in 2014. These changes were designed to better protect emergency workers who are performing their duties and protecting Victorians from being exposed to violence and intimidation in the course of their duties by acting as a deterrent against such behaviour.

84 Reflecting the objective seriousness of offences which cause injury to emergency workers, the laws introduced in 2018 provide that a statutory minimum non-parole period

[33] Professor James R. P. Ogloff, Dr. Jenny Patterson, Dr. Margaret Cutajar, Dr. Karen Adams, Professor Stuart Thomas, & Mr. Chris Halacas, *Koori Prisoner Mental Health and Cognitive Function Study*, Final Report, 2013, p. 13.

of at least six months applies, subject to specific exceptions. These exceptions include where a court is satisfied that a 'special reason' applies.[34] The legislation defines a 'special reason' to include where:[35]

(a) the offender had impaired mental functioning that was causally linked to the commission of the offence and substantially reduces their culpability;

(b) the offender has impaired mental functioning and the burden of imprisonment would have a substantially and materially greater than the ordinary burden of imprisonment.

85 Further, on 18 June 2020 the Sentencing Amendment (Emergency Worker Harm) Bill 2020 (**the Bill**) passed Parliament. It now awaits Royal Assent.

86 Among other things, the Bill narrows the range of circumstances in which a 'special reason' not to impose a statutory minimum sentence may apply by stating that that special reason will not apply where an offender's impaired mental functioning is caused substantially by self-induced intoxication. Without the changes made by the Bill, a special reason will not exist only where an offender's impaired mental functioning was solely caused by self-induced intoxication. This has meant that where there is any other operative cause of an offender's impaired mental functioning, a special reason not to impose a statutory minimum will apply.

87 The change made by the Bill will mean that special reasons will not apply where the substantial cause of an offender's impaired mental functioning was self-induced intoxication. This means that there might be offenders with impaired mental functioning that has other causes who will now be subject to statutory minimum sentences, if the substantial cause of their impaired mental functioning was their self-induced intoxication, and not other underlying causes of that impaired functioning.

Appendix C. Additional information for Part Three: Supports within community and custodial corrections

Governance of custodial and forensic mental health services

88 Prior to 2007, responsibility for the delivery of health services and health service governance in Victorian prisons was shared between the Department of Human Services and the Department of Justice. An independent review by PricewaterhouseCoopers in 2006 recommended that these functions be consolidated within the then Department of

[34] Other exceptions are where the offender is aged under 18 years, or where the charge is a complicity offence (e.g. assisting, encouraging or inciting the physical commission of the offence).

[35] Other 'special reasons' include providing assistance to police.

Justice. The department established the Justice Health unit to consolidate these functions in 2007.

89 The establishment of the Justice Health unit saw the transfer of forensic monitoring and health planning resources from DHHS to merge with the Department of Justice's existing custodial health unit. While this was recognised as being contrary to international trends which look to integrate governance within the health department, it has promoted the delivery of consistent health services across the Victorian prison system and established strong links between the health and the custodial system planning and operations.

90 Key achievements resulting from this justice-led approach to custodial health delivery include the establishment of the Justice Health Quality Framework (**Quality Framework**) to govern health services provided across both public and private prisons, the establishment of a single Electronic Medical Record accessible at all prison sites, and more integrated service design and planning across corrections and health services, which was a factor driving the planning and design of Ravenhall Correctional Centre.

91 The Justice Health Joint Management Committee (**JMC**) oversees custodial health service delivery, with representatives from DHHS and the department. Further clinical guidance and advice on prisoner health issues is provided by the Justice Health Principal Medical Officer (**PMO**), who provides independent clinical guidance and advice on key health issues for patients in custodial settings, and the Justice Health Clinical Advisory Committee, chaired by the PMO with DHHS and community membership, which provides broad ranging clinical advice to Justice Health.

92 Since its establishment in the department in 2007, Justice Health has expanded efforts to improve the health and wellbeing of offenders beyond prison walls by working with DHHS on a range of key projects to expand the forensic mental health service offering. This includes leading the development of the Forensic Mental Health Implementation Plan (**FMHIP**).

93 The Forensic Mental Health Advisory Board was established to oversee the implementation of the FMHIP. The Forensic Mental Health Advisory Board is an inter-agency forum including representatives of the department, DHHS, the Department of Premier and Cabinet (**DPC**), Victoria Police, the Courts and mental health specialists. It facilitates expert guidance and co-ordination across the criminal justice and mental health systems.

Contracting arrangements in place for custodial mental health services

94 Primary mental health services in public prisons are delivered by Correct Care Australasia. The delivery of these services is directly overseen and managed by Justice Health.

95 In private prisons, health services are subcontracted by the prison operators. The delivery of these services is subject to Justice Health policies (including the Quality Framework) and performance governance (including the oversight of the JMC) but is directly overseen by Corrections Victoria as the contract manager.

96 In adult public prisons, this service offers nurse-led treatment and care along with on-site general practitioners. Correct Care Australasia refers prisoners with more specialist or complex mental health needs to Forensicare who is the sole provider of specialist mental health services across Victoria's public and private prisons.

97 Forensicare is contracted to provide a range of outpatient and bed-based services across the prison system as follows:

(a) bed-based and outpatient services at Dame Phyllis Frost Centre (**DPFC**), Ravenhall Correctional Centre (**Ravenhall**), Port Phillip Prison and Melbourne Assessment Prison (**MAP**);

(b) consultant psychiatry and nurse practitioner services at regional public prisons;

(c) Mobile Forensic Mental Health Service at metropolitan public prisons;

(d) Community Integration Program at DPFC, Ravenhall, Metropolitan Remand Centre and MAP.

The Justice Health Quality Framework (the Quality Framework)

98 The Quality Framework was established in 2009 to provide for consistent standards for, and assessment of, health and mental health services provided in Victorian prisons. After its implementation in the public prison system, it was extended to private prison contracts.

99 Historically, the Quality Framework is only subject to major review as part of the process of commissioning or recommissioning health services, and was therefore last revised in 2014.

100 Sections of the Quality Framework can be updated ad hoc in response to the results of Justice Health clinical audits, improvement plans developed by Justice Health or Corrections Victoria in response to adverse events, responses to recommendations of independent bodies such as the Coroners Court of Victoria, consumer feedback (such as through the annual prisoner surveys) or from policy and research into best practice

conducted by the department. In this way, the Quality Framework is a tool to give effect to system-wide service changes.

101 Any amendments to the Quality Framework would result in changes to the services required across all sites and therefore come at cost. It is generally considered best value to align broader reviews of the Quality Framework with the recommissioning process.

Assessment of contracted health services against the Quality Framework

102 The Quality Framework requires health service providers to collate a range of data for individual clients. This data includes the number of service admissions, clinical interventions that take place, wait times for services, the number of mental health recovery plans completed and reviewed, and evidence of integration[36] between forensic mental health services, broader prison health services, community mental health services and designated mental health services that deliver compulsory treatment such as Thomas Embling Hospital.[37] This data is used by Justice Health to monitor services and contractual compliance.

103 Regular audits of contracted health service providers are conducted by Justice Health Clinical Governance officers and can include reviews of electronic medical records, review of existing policies and procedures and on-site assessment of service provision. These audits usually focus on a particular area of service (for example, at risk procedures, medication management or reception assessments) and are conducted regularly to ensure continuous service improvement. This is in addition to the investigation of incidents where health care was a factor, including deaths in custody.

Addressing non-compliance issues by health service providers

104 Justice Health conducts meetings every six weeks with service providers who operate in adult prisons and monthly meetings with service providers in Youth Justice centres where compliance with service requirements are discussed and any required remedial action plans are put in place. Justice Health has primary responsibility for addressing non-compliance with providers and escalating concerns through contractual mechanisms as required.

105 Health service provider compliance, performance and audit outcomes are also reported quarterly to the JMC as part of its oversight function.

---

[36] Integration in this context refers to services working collaboratively as a care team.

[37] Data collected by health service providers is used for auditing purposes but also serves as a records base for Justice Health.

Monitoring clinical incidents

106 All health service providers are required to report clinical incidents to Justice Health in line with Justice Health policies.

107 All clinical incidents are reviewed and investigated by the Justice Health Clinical Governance team to ensure appropriate and prompt action has been taken to address the circumstances that caused the incident, including a root cause analysis. As outlined above, Justice Health ensures remedial action plans are put in place by health service providers as required, and non-compliance is actioned through contractual mechanisms.

Planning for mental health capacity and capability in corrections

108 For primary and specialist mental health services delivered in Victorian prisons, the department is responsible for ensuring there are adequate primary and specialist mental health services in prisons to meet demand, and that those services are responsive to the varied needs of prisoner populations.

109 Service planning and changes are informed by changes in demand (for example, growth in prisoner numbers resulting in a need for additional health staff to provide an adequate service response) or to implement service improvements that address identified gaps.

110 The Mobile Forensic Mental Health Service is an example of a new service implemented to address a gap for prisoners with a mental illness at nominated prisons. It was developed by the department in collaboration with Forensicare to expand specialist mental health services in prisons without a dedicated mental health unit to reduce the need to transport prisoners to prisons with more centralised mental health services such as Ravenhall.

111 For new prisons, health service planning (including mental health service planning) is considered as part of the broader prison commissioning process and takes into account the expected prisoner profile of the new prison.

112 For offenders in the community,[38] DHHS has responsibility for the capacity and capability of any mental health services that provide services to offenders. DHHS works in partnership with the department on the development of programs they propose and which are relevant to the justice system, such as the Forensic Mental Health in Community Health program **(FMHiCH)** and MHARS.

113 For post sentence offenders, this responsibility is shared. The department is responsible for assisting offenders with accessing services (refer to the section on Serious Offenders

[38] This includes court, post-sentence and parole settings.

at Part Three of the statement for further information) and DHHS is responsible for ensuring that the required services are available to offenders.

114 Post sentence offenders predominantly access mental health services through their general practitioner or private psychological interventions via a Mental Health Care Plan – the department has little control over these private mental health services.

115 The department is also responsible for uplifting the mental health capability of the non-clinical workforces it employs, including custodial and community corrections officers. Key programs that build this mental health capability in community justice workforces are the responsibility of DHHS.

Independent oversight

116 A range of bodies perform valuable oversight functions in relation to mental health service provision in the correctional system.

The Justice Assurance and Review Office (JARO)

117 JARO is a business unit of the department that is separate and independent from the department's Youth Justice and Corrections and Justice Services groups.

118 JARO drives continuous improvement in Victoria's justice systems by striving to make the systems better for the community, staff and people held within and visiting justice facilities.

119 JARO provides the Secretary with current, objective information on areas of risk, the adequacy of existing controls and opportunities for improvement in the performance of Youth Justice Precincts, Youth Justice community services, prisons, Community Correctional Services and prisoner transport services. These contribute to informed decision-making by senior department leaders.

120 JARO works consultatively with Youth Justice, Corrections Victoria and Justice Health and often seeks input from Justice Health on the clinical health and management of offenders. JARO may contract independent subject matter experts and liaises with Victoria Police, the Coroners Court of Victoria, the Commissioner for Children and Young People and the Victorian Ombudsman.

121 JARO administers the Independent Prison Visitor (**IPV**) Scheme, on behalf of the Minister for Corrections. The IPV Scheme engages volunteers to provide independent advice to

the Minister about the operations and activities within Victoria's prisons from a community perspective.[39]

122 Under Burra Lotjpa Dunguludja, the fourth phase of the Aboriginal Justice Agreement (**AJA4**), JARO is also responsible for reviewing and co-designing the IPV Scheme to enable greater representation of Aboriginal community volunteers in the scheme. This commitment may contribute to self-determination as well as it leads to more culturally appropriate supports being made available in the justice system for Aboriginal people.

The Commission for Children and Young People (CCYP)

123 The CCYP is an independent statutory body that promotes improvement in policies and practices affecting the safety and wellbeing of Victorian children and young people, with a particular focus on vulnerable children and young people. A number of CCYP reports and inquiries have considered the Youth Justice system, including systemic inquiries into services for vulnerable children and young people, individual inquiries about the safety and wellbeing of an individual or group and child death inquiries.[40]

124 The CCYP has two Commissioners: the Principal Commissioner, and the Commissioner for Aboriginal Children and Young People. Each has advocacy roles with respect to children in Youth Justice.

125 The CCYP is provided with all Category One incident reports in relation to young people in custody, and a selection of Category Two incident reports including those in relation to suicidal and self-harming behaviours.[41]

126 The CCYP also provides an Independent Visitor Program where trained volunteers visit Youth Justice facilities on a monthly basis.[42] Visitors can talk to staff and young people, meet with the general manager after observing the facility, and produce reports for the

---

[39] Further information on the IPV Scheme is available at https://www.corrections.vic.gov.au/volunteering/independent-prison-visitor-scheme.

[40] Commission for Children and Young People, *Upholding Children's Rights: Systemic Inquirers*, https://ccyp.vic.gov.au/upholding-childrens-rights/systemic-inquiries/.

[41] Youth Justice records incidents that occur in custodial facilities as Category One or Category Two incidents dependent upon the seriousness of the incident and the potential for harm:

- Category One incidents are the more serious incidents and are published on the department's website and CCYP annual report. They include conduct that poses a serious threat to life of self or others and serious impact upon the health and wellbeing of staff or young people. This includes all allegations of assault by staff against young people, serious assault or riotous behaviour involving large groups of young people, assaults resulting in significant injuries, any hospitalisation.
- Category Two incidents include dangerous and disruptive behaviour, property damage, medication diversion, possession of contraband, lower level assault and some suicidal and self-harming behaviour.

[42] Futher information on the CCYP's Independent Visitor Program is available at https://ccyp.vic.gov.au/upholding-childrens-rights/independent-visitor-program/.

Commissioner. The CCYP actively recruits Aboriginal and culturally and linguistically diverse volunteers to these roles.

127 In partnership with the CCYP, the department established the Koori Youth Justice Taskforce in 2018 to review the cases of all Aboriginal children and young people in contact with the Youth Justice system over a six month period (1 October 2018 – 31 March 2019).[43] This timeframe was chosen to create a manageable set of data which would provide a snapshot of the experiences of Aboriginal children and young people in the Youth Justice system. The chosen timeframe would enable the data to be analysed and ready in time for Regional Forums and Individual Case Planning Sessions to begin in June 2019 and also fit within the timeframes set for the project in the Terms of Reference. CCYP reports on progress of the Taskforce to the Aboriginal Justice Forum (AJF), the oversight body for the AJA.[44]

Victorian Ombudsman

128 The Victorian Ombudsman is an independent oversight body representing Victorians in their encounters with the public sector. A number of investigations have looked into the provision of mental health services in the correctional system.[45] The department has a strong record of accepting and implementing recommendations made by the Victorian Ombudsman.

Mental Health Complaints Commissioner (MHCC)

129 The MHCC is an independent, specialist body established under the Mental Health Act to safeguard rights, resolve complaints about Victorian public mental health services and recommend improvements. The MHCC can receive complaints regarding mental health services in custody and exercise its powers to investigate in the normal way.[46] These complaints are generally resolved by Justice Health in consultation with the relevant health service provider.

---

[43] The Aboriginal Youth Justice Taskforce is a key initiative of AJA4. It aims to: address issues that impact on the cultural connectedness and social and emotional wellbeing of the young person/s, and identify and address the systemic issues contributing to the overrepresentation of Aboriginal children and young people in Youth Justice. Further information on the Taskforce is available at https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-justice-outcomes-framework/goal-41-greater-accountability-for-justice-5.

[44] The Aboriginal Justice Forum and the AJA are discussed in further detail in Appendix D.

[45] The Ombudsman's investigation reports are available at https://www.ombudsman.vic.gov.au/our-impact/investigation-reports/.

[46] Futher information on the MHCC is available at https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/oversight-and-service-improvement/mental-health-complaints-commissioner.

Office of the Public Advocate (OPA)

130 The Victorian Public Advocate (**Public Advocate**) is appointed to protect and promote the rights, interests and dignity of people with disability (specifically intellectual impairment, mental disorder, brain injury or dementia) living in Victoria. The OPA gives effect to these functions.

131 The core function of the Public Advocate is to advocate for the rights of persons with disabilities, especially disabilities which affect the ability to communicate or make decisions. This can include persons with mental illness. For example, the OPA provides a Community Visitors program as a safeguard for residents at mental health facilities.[47]

132 A further function of the Public Advocate is to act as a 'guardian of last resort' for people with cognitive impairment, including impairment arising from mental illness. A family member or friend can also be appointed to this role.

133 With respect to prisoners, the Public Advocate has performed its broader advocacy function on behalf of persons with disabilities with respect to prisoners – for example, advocating for the introduction of National Disability Insurance Scheme (**NDIS**) assessments for prisoners, including prisoners with chronic mental health problems.

134 The Public Advocate can also apply to the Victorian Civil and Administrative Tribunal to have a Guardianship Order made with respect to a prisoner who has impaired decision-making capacity, which could be caused by mental illness or other conditions affecting cognition. The Public Advocate can also be appointed to act as a guardian with respect to a prisoner under its general guardianship powers. If appointed, the guardian can advocate and make decisions for the prisoner in place of the prisoner themselves, to the extent that the Guardianship Order allows.[48] The Guardianship and Administration Act 2019 also now requires that a person's will and preferences must, as far as possible, be taken into account in decision-making.[49] The extent to which these powers can be exercised can be limited by the nature of the correctional facility and the scope of decision-making accorded to the residents.

---

[47] The OPA's Community Visitors are volunteers empowered by law to visit Victorian disability accommodation services, supported residential services and mental health facilities. Community Visitors observe the environment and staff interaction with residents and patients, make enquiries and inspect documents, and where possible communicate with residents and patients to ensure they are being cared for and supported with dignity and respect, and to identify any issues of concern. Further information on the OPA's Community Visitors is available at https://www.publicadvocate.vic.gov.au/our-services/community-visitors.

[48] Futher information on guardianship is available at https://www.publicadvocate.vic.gov.au/resources/booklets/guardianship-and-administration-1/686-guardianship-guide/file.

[49] *Guardianship and Administration Act 2019*, available at https://content.legislation.vic.gov.au/sites/default/files/2020-04/19-13aa003%20authorised.pdf.

135 The OPA also runs a program within prisons where an experienced and trained volunteer, known as a Corrections Independent Support Officer (**CISO**), can be made available to support prisoners with diagnosed intellectual disabilities while they are in the prison disciplinary system. The CISO program has not been expressly extended to prisoners with mental illness or acquired brain injuries.[50] However, intellectual and physical disabilities are often comorbid with chronic mental health difficulties, so the program is likely to support a number of prisoners with both diagnoses. This program is an extension of OPA's Independent Third Person (**ITP**) program,[51] where children and persons with disability are provided with a trained support volunteer during police questioning.

Victorian Auditor-General's Office (VAGO)

136 VAGO conducts financial and performance audits to ensure that public sector entities are transparent and accountable to the Victorian Parliament and the community. Performance audits assess whether government agencies, programs and services are meeting their objectives effectively, using resources economically and efficiently, and complying with legislation.

137 The performance audit program is set out in an annual plan that outlines a rolling three-year planning cycle. Audit topics are selected following an environmental scan and extensive consultation to identify risks, challenges and emerging issues across the public sector.

138 VAGO tabled its audit report Ravenhall Prison: Rehabilitating and Reintegrating Prisoners in March 2020.[52] Although Ravenhall provides forensic mental health services, the focus of this audit was the potential for the strategic and operational environment at Ravenhall to improve prisoner rehabilitation and reintegration outcomes and reduce recidivism. The department accepted the report's three recommendations which addressed the prison's performance and evaluation frameworks, and the composition of the prisoner cohort. Since accepting these recommendations, the department has initiated discussion with service providers at Ravenhall and with relevant internal stakeholders to deliver on the VAGO recommendations by the agreed timeframes.

---

[50] CISO provide assistance and support to prisoners with a diagnosed intellectual disability during disciplinary hearings, at all adult prisons in Victoria. The CISO program is currently limited to prisoners with a diagnosed intellectual disability and excludes those with cognitive impairment caused by other conditions, such as mental illness or an Acquired Brain Injury. Further information on CISO is available at https://www.publicadvocate.vic.gov.au/volunteering/corrections-independent-support-officers.

[51] ITPs attend police interviews for adults and young people with disability to ensure that they are not disadvantaged during the interview process. ITPs are trained to support and assist the person with disability through the interview process. Further information on the ITP program is available at https://www.publicadvocate.vic.gov.au/volunteering/independent-third-persons.

[52] Victorian Auditor-General's Office, 'Ravenhall Prison: Rehabilitating and Reintegrating Prisoners', March 2020, available at https://www.audit.vic.gov.au/sites/default/files/2020-03/20200319-Ravenhall-report.pdf.

139 In recent years, VAGO has examined mental health service provision in the correctional system as part of Managing Rehabilitation Services in Youth Detention (2018),[53] and Managing Community Corrections Orders (2017),[54] and more comprehensively in Mental Health Strategies for the Justice System (2014).[55]

Coroners Court of Victoria

140 The Coroners Court of Victoria independently investigates reportable deaths, including deaths in custody, contributes to public health and safety through coroners' findings, and provides recommendations targeted at the reduction of preventable deaths.[56]

141 Coroners are empowered to investigate all deaths in state custody. Prison officers are required to report deaths in prison to the coroner.

142 The department has a strong record of accepting and implementing recommendations made by coronial inquiries.

Office of the Chief Psychiatrist (OCP)

143 Currently the Chief Psychiatrist does not exercise his functions[57] in overseeing designated mental health services with respect to Forensicare's delivery of services in Victoria's prisons. Enabling the OCP to provide some additional clinical oversight of prison mental health services could be implemented, however, this would need to continue to recognise the Secretary's legal custody of prisoners under section 6A of the Corrections Act, and duty of care and statutory obligations under the Corrections Act to provide a safe and secure custodial environment.

Overlap, duplication and gaps

144 The department and independent integrity bodies work consultatively to avoid or minimise duplication. The department does not consider there to be any duplication in independent oversight specific to the custodial mental health system.

---

[53] Victorian Auditor-General's Office, 'Managing Rehabilitation Services in Youth Detention', August 2018, available at https://www.audit.vic.gov.au/sites/default/files/2018-08/20180808-Youth-Detention.pdf.

[54] Victorian Auditor-General's Office, 'Managing Community Corrections Orders', February 2017, available at https://www.audit.vic.gov.au/sites/default/files/20170208-Community-Corrections.pdf.

[55]. Victorian Auditor-General's Office, op. cit.

[56] The *Coroners Act 2008* allows a coroner to make recommendations as part of their finding following an investigation into a death. Recommendations can be made to any Minister, public statutory authority or entity that may help prevent similar deaths. Anyone who receives a recommendation from a coroner must respond, in writing, within three months stating what action, if any, has or will be taken. The Court will publish inquest findings with recommendations and the responses to its recommendations, available at https://www.coronerscourt.vic.gov.au/inquests-findings/findings.

[57] Victoria's Chief Psychiatrist is Dr Neil Coventry. The core functions of the Chief Psychiatrist include: conducting clinical practice audits and clinical reviews, monitoring the provision of mental health services in order to improve quality and safety, and giving direction to mental health service providers about providing mental health services.

145 Other than the gap relating to the powers of the Chief Psychiatrist, the department does not consider there to be any gaps relating to the independent oversight of custodial mental health services.

Appendix D. Additional Information on Part Four: Aboriginal Justice Agreement and Aboriginal Social and Emotional Wellbeing

History of the Aboriginal Justice Forum (AJF) and the Aboriginal Justice Agreement (AJA) 1 – 4

146 The AJF was established by the Victorian Government in 2000, in response to the Royal Commission into Aboriginal Deaths in Custody. The Aboriginal community representatives worked with government to develop the first AJA in 2000, and government and Aboriginal Community partners have built on the first Agreement and renewed it in subsequent phases.

147 The AJA underpins extensive work and governance by the Aboriginal community, as well as a range of other pieces of strategic work to support improved Aboriginal justice outcomes.

148 Since 2000, the AJA has operated in four phases.[58] Each of the four AJAs since 2000 has overseen major initiatives to improve outcomes for the Aboriginal community and reduce overrepresentation of Aboriginal people in the justice system. The initiatives respond to the issues as identified by the Aboriginal community in a culturally-appropriate, person-centred and safe way. This approach is proven to be a more effective and sustainable means of supporting all clients, including Aboriginal community members.

149 Subsequent phases of the AJA have built upon the principles and achievements of their predecessors. The second AJA began in 2006, the third in 2013, and the fourth was agreed in 2018. The AJA is the longest running agreement of its kind, and each of these four agreements have broken new ground in improving Aboriginal services within the justice system.

150 Implementation of the AJA is overseen by a range of key governance groups: the AJF, Regional Aboriginal Justice Advisory Committees, Local Aboriginal Justice Actions Committees and Collaborative Working Groups.

151 The AJF brings together the most senior representatives of Victoria's Aboriginal communities and the justice, human services, health and education government portfolios in order to oversee the development, implementation, monitoring and direction of the

[58] To ensure the AJA remains relevant, responsive and effective each phase is developed, implemented, evaluated and revised over a five year period. The first Agreement was established in 2000, the second phase began in 2006, the third in 2013 and the fourth in 2018. Each new agreement is developed and led by the Aboriginal community.

Agreement. These partnership structures are replicated at regional and local levels through nine Regional Aboriginal Justice Advisory Committees that build community participation in AJA work, advocate for program and service changes, provide advice and expertise in the development and implementation of place-based initiatives and plans. Local Aboriginal Justice Action Committees bring together local Aboriginal community members, justice agency staff and judicial representatives to develop and inform local responses to Aboriginal justice and community safety issues and to enable local justice issues to be identified and resolved locally.

152 The 2018 evaluation of the third phase of the AJA[59] found that these AJA governance structures have been instrumental in giving voice to Aboriginal people across the state.[60]

153 It found that the successive agreements have built the capacity of government as much as it has strengthened the capacity of community. The model has provided a conduit for government agencies to better connect with the people we serve – to gain insights and understanding that improve the design and delivery of services for Aboriginal people.

154 Through the AJF and AJA's 1- 4, the AJC have worked with government to design a range of positions, programs, policies and processes to address overrepresentation of Aboriginal people in the criminal justice system and improve Aboriginal justice outcomes. My statement details these programs further at paragraphs 392-397.

155 In recent years, the Victorian government has committed significant funds towards improving outcomes for Aboriginal people engaged in the justice system to continue this critical work. For example, in 2018 under the fourth phase of the Agreement, the Victorian government committed $40.3 million[61] upon the launch of AJA4, with $15 million dedicated to expand community-based justice programs and other services for Aboriginal people in the justice system, and to develop new community-led and designed responses. These include three family-centred projects and two restorative justice projects being implemented in the Eastern Metropolitan and Hume regions.

156 AJA4 aims to continue to improve Aboriginal Justice outcomes, to continue to address Aboriginal overrepresentation in the justice system, and to progress Aboriginal self-determination as the core policy approach to addressing these issues. The underlying causes of Aboriginal overrepresentation in the justice system are detailed in the AJAs, the Victorian Aboriginal Affairs Framework and the Aboriginal Social and Emotional Wellbeing Plan (**ASEWP**).

---

[59] Each of the AJAs have been subject to extensive evaluations; of programs within the Agreement, and of the Agreements themselves.

[60] Clear Horizon, Evaluation of the partnership arrangement of the Aboriginal Justice Agreement (Phase 3), p.48.

[61] Burra Lotjpa Dunguludja Victorian Aboriginal Justice Agreement (Phase 4), p. 6.

157 Some examples of the work across the department to improve Aboriginal justice outcomes, which have been designed by the Aboriginal community, include the ASEWP (detailed in my response in Part Four of my statement), the Koori Women's Diversion Program, the Aboriginal Youth Cautioning Program, the Local Justice Worker Program and Aboriginal Youth Justice Strategy (outlined in my statement).

Issues raised by the Aboriginal Justice Forum and Aboriginal Justice Caucus concerning overrepresentation of Aboriginal people in the justice system

158 The AJF is currently focused on addressing the disproportionate number of young Aboriginal people in the justice system, high demand for targeted programs, and the impact of recent community safety reforms. Providing culturally-based prevention, early intervention and diversion programs for Aboriginal young people and adults across the State remains a priority, as does ensuring there are sufficient positions in community and custody to support and build Aboriginal people's social and emotional wellbeing. Difficulties meeting people's housing, employment, health and other treatment needs as they transition from justice institutions back into community is also a frequent topic of discussion.

Disproportionate impact of bail legislation reforms on Aboriginal people

159 During the Community Forum at the February 2020 AJF, concerns were raised in relation to the recent death of an Aboriginal woman in custody. Other stories were shared highlighting that Aboriginal women and men with mental health issues are being negatively impacted by recent changes to bail legislation.

160 At this meeting, the department acknowledged that the recent bail law reforms have had a significant impact on Aboriginal people, and that work is underway to address this. The department is continually working with the Aboriginal community, to consider how best to address Aboriginal overrepresentation in the justice system and any disproportionate impact of law reforms.

Re-evaluating and expanding existing programs

161 Further, during the February 2020 AJF meeting, Corrections Victoria and the AJF acknowledged that some programs need to be re-evaluated in order to consider how best to respond to growing demand, and to expand the availability of some programs to groups such as Aboriginal women and young people. For example, it was agreed that the mental health programs available at DPFC needed to be re-evaluated, and that the demand in the Marrmak Unit at DPFC needs to be considered. Work to reduce demand across the prison system is ongoing, as discussed in Part Two of my Statement, and this includes

considerations of Aboriginal people in custody. Demand on the Marrmak Unit at DPFC can be considered as part of this work.

AJF and Aboriginal Justice Caucus views on reducing overrepresentation

Work underpinned by a shared outcomes framework

162 As noted in Part Four of my statement, the AJF and the department work to uplift services for Aboriginal people in the justice system is underpinned by the 'principles for ways of working' and the Aboriginal Justice Outcomes Framework set out most recently in AJA4.

163 The AJA4 highlights the 'principles for ways of working,' which capture some of the current priority considerations for this work to: prioritise self-determination; support cultural strengthening; be strengths based; be trauma informed; be restorative; use therapeutic approaches; respond to context and specific needs; be holistic in responses; protect cultural rights and address unconscious bias.

164 Alongside these principles, AJA4 adopts an outcomes approach to allow for flexible responses to emerging challenges based on the best available evidence and learning. The AJA4 Outcomes Framework captures what is intended to be achieved under the Agreement, detailing ten goals, linked to 24 desired outcomes. Each outcome has associated progress indicators to measure its success, as defined by government and community. The AJA4 principles outline how partners to the Agreement will work together to implement actions to achieve the desired outcomes.

165 In the pursuit of systemic reform, and policy and legislative change to reduce Aboriginal overrepresentation in the criminal justice system, AJA4 also includes a goal to ensure that Aboriginal people are not disproportionately worse off under justice policies and legislation. Among the actions agreed to progress this goal are:

(a) Consider Aboriginal Impact Assessment mechanisms to identify the potential impact of new justice policies and legislation on Aboriginal Victorians (and remedy any disproportionate adverse impacts).

(b) Trial Aboriginal Community Justice Reports modelled on Canada's Gladue reports to provide information to judicial officers about an Aboriginal person's life experience and history that impacts their offending, and to identify more suitable sentencing arrangements to address these underlying factors (including mental health issues).

Evaluations demonstrating the effectiveness of the AJAs

External evaluations

166 Several evaluations of the AJAs have been conducted to assess their effectiveness in achieving their desired goals. Nous Group conducted an evaluation of AJA2[62] in 2012 and found that it had delivered significant improvement in justice outcomes for Aboriginal people in Victoria and as a result there were fewer Aboriginal offences, offenders and people in prison than expected (based on earlier trends). A Social Return on Investment analysis conducted as part of the evaluation of AJA2 found a return to the Victorian Government of between $1.65 and $1.85 for every dollar invested in AJA programs and initiatives.[63]

167 The evaluation of AJA3 completed in 2018[64] found that the partnership between government and Aboriginal community demonstrates a level of maturation not replicated elsewhere across government. It has been pivotal in effecting real change in terms of embedding cultural awareness and the adoption of an Aboriginal lens for the development of new strategies, policies and initiatives.[65] As the Aboriginal co-chairs for the fourth AJA noted, this AJA, more than ever before, has been shaped by Aboriginal people in the pursuit of self-determination.

Evaluation and monitoring

168 As the evaluations have shown and the department agrees, the AJAs have also been an effective way of working with the Aboriginal community to evaluate and measure the outcomes of programs developed by the Aboriginal community. The Monitoring, Evaluation and Learning Framework developed to support implementation of the AJA continues to evolve with each subsequent phase of the agreement. The Framework[66] has been agreed by Aboriginal community stakeholders, to ensure they are respectful of Aboriginal values as well as accepted guidelines for conducting ethical research.

Community experience

169 Feedback from the Aboriginal community on the support that Aboriginal Wellbeing Officers (**AWOs**) provide to Aboriginal prisoners has been positive. These positions were

---

[62] Nous Group, Evaluation of the Aboriginal Justice Agreement – Phase 2, 2012.

[63] Ibid.

[64] The Evaluation of AJA3 ran from 2017-2018 and comprised three distinct parts: Evaluation of the partnership arrangements of the Aboriginal Justice Agreement (Phase 3); Place-based evaluation of the Aboriginal Justice Agreement (Phase 3) and an Evaluation synthesis highlighting the collective evidence from numerous evaluations of AJA programs to identify what works, and why and recommendations for improving the design and implementation of future AJA initiatives.

[65] Clear Horizon, Evaluation of the partnership arrangement of the Aboriginal Justice Agreement (Phase 3), p.48.

[66] Victorian Government, *Burra Lotjpa Dunguludja* Victorian Aboriginal Justice Agreement Phase 4 – A partnership between the Victorian Government and Aboriginal Community.

established in response to the 1991 Royal Commission into Aboriginal Deaths in Custody and are a key part of the Victorian Government's response to Aboriginal-specific needs in custody.

170 There are currently 11 officers State-wide, who provide ongoing culturally-informed welfare, advocacy and case management support to Aboriginal prisoners. The caseload for each AWO is approximately 45 prisoners. Many prisoners also require additional support from AWOs around mental health, wellbeing, grief and trauma.

Whole-of-government accountability through the Aboriginal Affairs Report

171 The AJA Monitoring, Evaluation and Learning Framework requires the impact of AJA initiatives to be measured through tracking performance of headline and intermediary indicators. Progress in implementing new AJA initiatives is published,[67] and reported to the AJF along with progress towards the AJA4 milestones which indicate the change required to eliminate overrepresentation between rates of Aboriginal and non-Aboriginal youth and adults under justice supervision by 2031. Progress against these indicators is also reported annually in the Victorian Government Aboriginal Affairs Report which is publicly available.

172 Therefore, the effectiveness and the impact of the Aboriginal Justice Agreement is the subject of detailed whole-of-government monitoring and reporting practices in addition to external evaluations and successful programs that have been delivered.

The Aboriginal Social and Emotional Wellbeing Plan

173 As noted in the Statement, the ASEWP was an initiative of the third phase of the AJA. It was developed by Justice Health and Corrections Victoria with the AJC and other Aboriginal justice stakeholders, endorsed by the AJF. It provides the blueprint for social and emotional wellbeing services for Aboriginal people in the justice system.

174 To give effect to the ASEWP, a number of key initiatives have been implemented, including:

(a) an Aboriginal Continuity of Care pilot supporting prisoners on exit to maintain the health gains achieved while in prison;

(b) cultural competency training for custodial healthcare workers;

(c) Aboriginal specialist mental health assessment training for custodial healthcare workers;

---

[67] The publication is available at www.aboriginaljustice.vic.gov.au/.

(d) development of cultural safety standards for prison-based health services;

(e) tertiary scholarships for Aboriginal people wanting to complete qualifications in a health field;

(f) the state-wide Indigenous Arts Program delivered by The Torch supports cultural strengthening and economic development opportunities for Aboriginal people as emerging artists;

(g) Kaka Wangity Wangin-Mirrie: a suite of cultural programs delivered by an Aboriginal Community Controlled Organisation (ACCO) for Aboriginal people in prisons or on community based orders, as well as grants for cultural programs;

(h) Yawal Mugadijna Aboriginal Cultural Mentoring Program which aims to strengthen pre and post release cultural supports for Aboriginal adults.

Supporting the delivery of culturally safe and culturally specific mental health services

175 Broader mainstream policies in the justice system, particularly within the Corrections system, have been adjusted to reflect the need for culturally appropriate and person-centred services to be provided to Aboriginal people in the justice system.

176 The Quality Framework requires health service providers to be responsive to prisoners who are Aboriginal or Torres Strait Islander, culturally and linguistically diverse, and those with specific needs.[68] The Quality Framework includes obligations for health service providers to promote and facilitate access to traditional healing for Aboriginal prisoners and ensure that Aboriginal prisoners are advised of the availability of culturally safe support networks, such as the AWOs and Aboriginal Liaison Officers, who can support them when receiving health care. Health service providers are also obligated to consult with Aboriginal Community Controlled Health Organisations to improve health service delivery for Aboriginal prisoners and support connection and engagement upon transition to the community.

177 Through the ASEWP, the department has provided support for health service providers to understand the expectations in relation to supporting Aboriginal prisoners and how to meet these expectations. As part of the ASEWP in 2018 an additional set of Aboriginal cultural safety standards were developed that provide a higher level of detail for service providers to understand the expectations in relation to supporting Aboriginal prisoners. In addition, an Aboriginal Clinical Governance officer position was created to assist providers to understand these standards and build their competency in this area.

[68] Justice Health Quality Framework 2014, page 22.

178 Further information about the role of Justice Health and the Quality Framework, including how compliance is monitored, is included above at Appendix C.

Yawal Mugadjina Aboriginal Cultural Mentoring Program

179 The Yawal Mugadjina Cultural Mentoring Program commenced in 2018. The Program provides Aboriginal people in prison with cultural mentorship from Elders and Respected Persons and post release-support for Aboriginal prisoners through the Local Justice Worker Program to support their journey transitioning and reintegrating back into their community. Participants also have the opportunity to develop cultural plans with AWOs in prison which can assist with their journey. This phase of the program commenced in March 2019.

Further work on Aboriginal social and emotional wellbeing

180 As noted in my statement, while the ASEWP itself has now expired, the priority areas that it identified continue to guide work on social and emotional wellbeing and a number of the initiatives continue, including the state-wide Indigenous Arts Program, the Kaka Wangity Wangin-Mirrie, the Continuity of Care Pilot, and cultural safety standards for health services.

181 The Rehabilitation and Reintegration Collaborative Working Group (**RRCWG**) oversees and facilitates the implementation and monitoring of AJA4 initiatives and key projects within Corrections Victoria and Justice Health.

182 The RRCWG reports through to the AJF via its Co-Chairs and provides project governance, advice on issues and changes and support, and monitors project progress, using its influence and authority to assist in achieving project outcomes.

183 The RRCWG has an established workplan that includes 14 separate AJA4 initiatives with project planning for each initiative. The initiatives of particular relevance to the Royal Commission include:

(a) Culturally appropriate, holistic health care models in prison are being considered by the Aboriginal Healing Unit sub-committee.[69] Operating models for an Aboriginal healing unit for women at DPFC and in the community are being developed and consulted on.

(b) Cultural safety standards for health services in the adult prison system have been developed. Implementation of the cultural safety standards across the prison health services commenced in 2019.

[69] A subcommittee of the RRCWG

(c) Support for Aboriginal people on CCOs to access culturally safe mental health services. This will ensure that Aboriginal people who have a moderate mental health condition or disorder and who have a CCO with a Mental Health Treatment and Rehabilitation Condition, or are on parole with a mandated mental health order, are able to access culturally appropriate mental health services. The FMHiCH is on track to be fully operational in 2019-2020 and Aboriginal partners have entered resourced partnerships.

184 This work will continue to contribute to and improve Aboriginal social and emotional wellbeing beyond the prescribed plan. It will also continue to embed Aboriginal self-determination and community-led approaches in the government's responses to the mental health needs of Aboriginal people.

Adult Custodial services

185 The Aboriginal social and emotional wellbeing priorities are set out in Part Four of my statement, and the programs implemented through the ASEWP are set out above. Though many of the programs are in their early stages, these programs have demonstrated the supports that can be offered on a small scale, and the potential to provide more intensive and holistic supports.

Screening and culturally valid assessment

186 The mainstream screening and assessment processes upon entry to prison are set out in detail in Part Three of my statement.

187 As part of AJA4, the department has committed to working with the AJF and the AJC to develop a culturally appropriate mental health assessment and screening process for Aboriginal people entering custody.

188 From an Aboriginal Justice perspective, an optimal approach to responding to offenders' mental health needs first requires a culturally valid assessment of those needs (not relying on assessment tools that have not been validated on Aboriginal and Torres Strait Islander populations), and holistic, culturally-based responses capable of addressing all aspects of social and emotional wellbeing. To identify, understand, and respond to distress in Aboriginal and Torres Strait Islander populations requires understanding cultural differences.

189 There are additional patterns of distress that need to be recognised for Aboriginal and Torres Strait Islander people involved in the justice system that may stem from individual and collective experiences of trauma, disruption, discrimination, disconnection, and

dislocation.[70] Therefore, effective responses need to consider and enable culturally-based pathways to healing and recovery that align closely with an individual's needs and world views.[71]

190 Effective responses to mental ill-health among Aboriginal and Torres Strait Islander populations within an in-prison specialist setting requires considering and enabling culturally-based pathways to healing and recovery. They need to align closely with an individual's cultural needs.[72] In practice, this requires the provision of trauma-informed, culturally based programs and services in addition to mainstream offerings.

191 As part of the ASEWP, Aboriginal mental health assessment training was provided to over 250 health service staff across Victorian prisons. The department is currently exploring a pilot of a mental health assessment tool.

192 Corrections Victoria is exploring options for establishing Aboriginal Healing Units in prisons, which could pilot a culturally appropriate mental health assessment and may broaden the scope of culturally appropriate services available in custody.

Culturally safe diversion programs for Aboriginal adults

Culturally safe diversion programs for Aboriginal adults

193 A key finding of the Royal Commission into Aboriginal Deaths in Custody was the need to reduce the rate at which Aboriginal and Torres Strait Islander people are imprisoned by breaking the cycle of imprisonment and diverting people away from prison. In keeping with the principle that imprisonment should be an option of last resort, diversion is one of the four key strategies recognised in the AJA as critical to realising the Agreements' outcomes for Aboriginal young people and adults, particularly those with mental health issues or poor social and emotional wellbeing.

194 Through AJA4 the Victorian Government, in partnership with the Aboriginal community, committed to improving justice outcomes for Aboriginal people and reducing negative contact with the justice system. AJA4 includes an action to deliver community-based, intensive diversion programs for children and young people who have had, or are

---

[70] In relation to Aboriginal and Torres Strait Islander mental health, Dr Tracy Westerman highlights the need to recognise culture-bound disorders (for example, longing for country) that 'often mimic mental health disorders, however, the triggers and maintaining factors lie with the cultural beliefs of the client, and therefore resolution often needs to occur at the cultural level'. Westerman T. Engagement of Indigenous clients in mental health services: What role do cultural differences play. Australian e-Journal for the advancement of Mental Health. 2004; (3):3.

[71] Gee, Dudgeon, Schultz, Hart and Kelly, Aboriginal and Torres Strait Islander Social and Emotional Wellbeing in *Working Together - Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice.*

[72] Gee, Dudgeon, Schultz, Hart and Kelly, Aboriginal and Torres Strait Islander Social and Emotional Wellbeing in *Working Together - Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice.*

vulnerable to, involvement with the criminal justice system, and to address factors contributing to offending.

195 One of the most successful examples of this work is the Koori Women's Diversion Program.

The Koori Women's Diversion Program

196 The community-based Koori Women's Diversion Program helps reduce Aboriginal women's involvement with the justice system and the impacts of incarceration on their families.

197 The program aims to reduce Aboriginal women's involvement with the criminal justice system by providing intensive and holistic case management. This includes practical support to ensure women are connected to the services they need, such as housing and family violence services, and supported to get to appointments, and reconnected to culture as a source of therapeutic strength, healing and self-esteem.

198 During 2018-19, the Koori Women's Diversion Program supported more than 70 Aboriginal women. Outcomes for women in the program vary according to their needs but have included receiving treatment for physical and mental health issues, ceasing alcohol and drug use, improved social and emotional well-being, accessing stable accommodation, reengagement with children and extended family, enhancing confidence to exit violent relationships, reconnecting with culture and community, and ceasing further contact with the justice system.[73]

199 The Koori Women's Diversion Program has experienced extremely high demand since it commenced in 2015. The ACCOs that provide the service have particularly noted that there is potential to broaden the current program to better equip the workforce to provide appropriate mental health supports required, given the high proportion of program participants with mental health and social and emotional wellbeing needs.

200 There is no current equivalent community-based Aboriginal diversion program for men. However, the department has sought to embed health-led responses into diversion programs for Aboriginal men in contact with the justice system. In 2019, the department provided additional funding to ACCO Dardi Munwurro to expand Ngarra Jarranounith Place its Aboriginal men's residential family violence program. The program helps to divert perpetrators from custody and provide an environment where they can engage with critical supports including mental health services. Fundamental to the success of this

[73] While the department does not hold data on clients once women leave the program, community feedback on this program has been positive, as have the evaluations of the program.

service model is a focus on working with perpetrators and their families to ensure service coordination for multiply engaged and complex clients.

Diversion for Aboriginal children and young people

201 As noted in Part Four of my statement, in addition to the diversion programs for adults, there are a number of targeted programs for Aboriginal children and young people, to respond to their specific needs.

Aboriginal Youth Support Service

202 The Aboriginal Youth Support Service (**AYSS**) is a youth outreach and diversion program funded to work with Aboriginal children and young people aged 10 up to 17.5 years at risk of entering the Youth Justice system by addressing the underlying reasons for offending behaviour. The AYSS is currently delivered in two locations; the north-west metropolitan region and Loddon Mallee region.

203 The objectives of the AYSS program is to intervene rapidly to prevent escalation of issues that appear to be emerging for a young person, address the needs of young people who are at risk of entering the Youth Justice system and divert these young people away from the system. This in turns aims to prevent the further progression of young people, who are at the early stages of involvement with Victoria Police, into the Youth Justice system by addressing the underlying reasons for their offending behaviour.

204 The Community Based Aboriginal Youth Justice program works with Aboriginal young people at risk of Youth Justice involvement to provide preventative, early intervention and case management services to divert young people from the system.

Aboriginal Youth Cautioning Program

205 The Aboriginal Youth Cautioning Program, led by Victoria Police, has been implemented for Aboriginal young people to increase and enhance the use of cautioning through a community-led model, based on principles of self-determination, early intervention and harm-reduction, and thus to divert young people from the justice system.

206 As part of AJA4, the program has been piloted in three initial sites in Victoria: Echuca, Bendigo and Dandenong. The program draws upon local Aboriginal culture, knowledge and community to ensure a tailored response for Aboriginal young people coming into contact with police.

207 This program, initially piloted in 2007, enables Victoria Police to issue cautions to Aboriginal young people and divert them to culturally appropriate support services without requiring an admission of guilt. Whilst they are still required to meet other eligibility criteria

for a caution, the move to a "do not deny" model at the pilot sites is expected to improve outcomes for Aboriginal young people by supporting more cautions, enhanced behavioural supports, early intervention and self-determination by way of community ownership and involvement in these processes.

The Aboriginal Youth Justice Program

208 Funding was provided in the 2018-19 budget to strengthen and expand the Aboriginal Youth Justice Programs, to support Aboriginal young people engaged in the justice system.

209 The Koori Youth Justice Program is delivered through 14 funded agencies, supported by a total of 23 positions. 13 of these agencies are ACCOs and one is a community-based agency.

210 The suite of programs provides preventative, early intervention and case management services for Aboriginal children and young people who are at risk of Youth Justice involvement or are in contact with the Youth Justice system. The program suite includes: the Aboriginal Community Based Youth Justice Program, Aboriginal Early School Leavers Program, Aboriginal Intensive Support Program, and an Aboriginal Court Advice Worker.

211 All of these programs are provided to Aboriginal young people engaged with Youth Justice in the community, as the vast majority of Youth Justice clients are based in the community, rather than in Youth Justice custody.

212 There are also specific programs provided for Aboriginal young people in custody, including five Aboriginal Liaison Officers who work to keep Aboriginal young people connected to their culture family and communities; an Elder Support Program which provides cultural mentorship and leadership; an Aboriginal women's leadership program for Aboriginal young women; and the Maggolee Mang program (delivered by Parkville College) which provides cultural storytelling, language, art, and connection to land.

213 These programs are vital to the support needs of Aboriginal young people engaged in the Youth Justice system, however there is not currently targeted Aboriginal social and emotional wellbeing programs for young people, which are specifically targeted towards mental health care needs.

Appendix E. Additional Information for Part Five: Youth Justice and Mental Health

Overview of the legislative framework governing the Youth Justice system

Legislative framework governing mental health care of children and young people in Youth Justice

214 Section 482(2)(c) of the CYF Act provides that young people in custody are entitled to have reasonable efforts made to meet their medical, religious and cultural needs including, in the case of Aboriginal children, their needs as members of the Aboriginal community. This is taken to include mental health care.

215 The CYF Act imposes a duty on the Secretary of the department, to children and young people in custody with mental illness to provide reasonable access to mental health care and treatment. These legislative provisions provide a broad imperative for the State to provide a reasonable standard of mental health care.

216 The Victorian criminal justice system, like other Australian and international jurisdictions, responds to children and young people differently to adults. The CYF Act along with the Child Safe Standards provides the legislative basis for requiring Youth Justice procedures to prioritise young people's health and mental health needs while in Youth Justice custody.

217 The Child Safe Standards are seven standards relating to governance and reporting that apply, among other areas, to the provision of care that health organisations must meet in their delivery of health care and treatment to young people in custody. Health service providers report against the standards to the Commission for Children and Young People. On 1 January 2017, the Commission for Children and Young People became the oversight body for the Child Safe Standards.

218 The Child Safe Standards aim to promote the safety of children, prevent child abuse and ensure organisations and businesses have effective processes in place to respond to and report all allegations of child abuse. The Child Safe Standards work by driving changes in organisational culture, embedding child safety in everyday thinking and practice, providing a minimum standard of child safety across all organisations and highlighting that we all have a role to keep children safe from abuse. The seven Child Safe Standards are governance and leadership; clear commitment to child safety; code of conduct; human resource practices; responding and reporting; risk management and mitigation; and empowering children.

219 The Charter of Human Rights and Responsibilities (**the Charter**) imposes obligations on public authorities to act compatibly with, and to give proper consideration to, the rights of the child. Section 17(2) of the Charter provides all children with the right 'to such

protection as is in his or her best interests and is needed by him or her by reason of being a child.' Section 38(1) states that it is 'unlawful for a public authority to act in a way that is incompatible with a [Charter] right or, in making a decision, to fail to give proper consideration to a relevant [Charter] right', subject to certain exceptions.

Legislative reform

220 As noted in Appendix A, recent legislative reforms have impacted on how young people interact with the Youth Justice system.

221 The *Children, Youth and Families Amendment (Permanent Care and Other Matters) Act* (2014), which took effect in 2016, sought to increase diversionary opportunities for young people appearing in the Children's Court by broadening the eligibility for the Youth Justice Group Conferencing program.

222 The *Children and Justice Legislation (Youth Justice Reform) Act* (2017) is designed to improve supervision options and community safety by:

(a) introducing Youth Control Orders (**YCO**) and intensive bail to provide for the highest intensity supervision and supports in the community for young people. The YCO provides courts with a direct alternative option to a custodial sentence, enabling suitable young people to complete their orders in the community with intensive, wrap-around supports. The YCO includes intensive case management, judicial monitoring, and mandatory participation in education, training or employment. As a direct alternative option to a custodial sentence, the YCO can serve to avoid the adverse effects potentially caused by custodial environments;

(b) increasing penalties for some serious and violent crimes committed by children and young people, including for those who assault Youth Justice officers while in detention; and

(c) creating a presumption in favour of uplifting serious youth offences, such as aggravated home invasion and aggravated carjacking, from the Children's Court to the higher courts, for those aged 16 years or older.

223 The *Crimes (Mental Impairment and Unfitness to be Tried) Act 1977* (**the CMIA**) was amended in 2014 to apply to children and young people and enables a young person on a custodial supervision order (**CSO**) to be detained in a Youth Justice Centre or Youth Residential Centre. This legislative amendment was made in recognition that no therapeutic environment existed. The provision enabled children and young people to be held in a Youth Justice or Youth Rehabilitation Centre and ensured that it was not illegal to accommodate them in custody.

224 However, the department recognises that custody is not a therapeutic environment, and that the the Youth Justice Review (Armytage & Ogloff, 2017) recommended the establishment of a youth forensic mental health precinct to address this infrastructure gap.

225 The remand population is increasing in Victoria's Youth Justice facilities. Of all 10 to 17 year old young people in detention in Victoria in 2018-19, on an average day 70 per cent were on remand.[74] This represents an increase from 2017-18, where Victoria's remand population on an average day was 58 percent of 10 to 17 year old young people.[75]

Diversion programs for young people with mental illness in Youth Justice

Children's Court Mental Health Advice and Response Service (Children's Court MHARS)

226 As outlined in Part Five of my statement, a pilot of the Children's Court MHARS, a service available in the adult court system, commenced at the Melbourne Children's Court in May 2019 and is operated by Orygen Youth Health.

227 The Children's Court MHARS service has three functions:

(a) primary consultation and a report to the court;

(b) secondary consultation; and

(c) advice and Client Management Interface/Operational Data Store checks on the young person's previous involvement with mental health services.

228 Referrals are made to the Children's Court MHARS clinician from Magistrates, lawyers and court advice staff who identify that the young person has mental health issues, and through the clinician's proactive involvement in reviewing court schedules for known young people. The majority of referrals to the Children's Court MHARS are made through the criminal courts; others are made through the family court, particularly for Family Violence Intervention Orders and secure welfare matters.

229 In the eight month period following commencement of the Children's Court MHARS service in May 2019, 80 individual young people were referred to the Children's Court MHARS, with 132 occasions of service.[76] Approximately two thirds of these young people were male, and most were aged 15 to 17 years old. Approximately half of the young people referred had issues with AOD use. Primary and secondary consultations

[74] Australian Institute of Health and Welfare 2020. Youth Justice in Australia 2018–19. Cat. no. JUV 132. Canberra: AIHW, p.16.

[75] Australian Institute of Health and Welfare 2019. Youth Justice in Australia 2017–18. Cat. no. JUV 129. Canberra: AIHW, p.16.

[76] Internal information provided to DJCS by service provider Orygen Youth Health (2020).

compromised almost half of the service provided, with the remainder of service delivery involving liaison, support and Client Management Interface/Operational Data Store checks.

230 The Children's Court MHARS clinician makes recommendations about referrals to other services including tertiary mental health services and headspace. Where an urgent referral is required this will be made by the Children's Court MHARS clinician and other referrals are actioned by Youth Justice. The Children's Court MHARS clinician liaises with the Custodial FYMHS service and primary health service for young people who are going between the Children's Court and a Youth Justice custodial centre.

Youth Justice Case Management Framework

231 The Youth Justice Case Management Framework (the **YJCM Framework**) guides all case management in Youth Justice. It is a comprehensive, evidence-based framework about how to approach the case management of young people in custody or supervised in the community. It contains high-level and operational guidance and covers case management objectives, principles, components and practice.

232 The YJCM Framework aligns with reforms in other areas of Youth Justice, such as risk assessment, classification, community and custodial operations, workforce, and offending behaviour programs. It provides the platform for planning each young person's participation in their statutory order activities, for example, education, work, health and mental health care, and reintegration.

233 As part of the YJCM Framework, Youth Justice is responsible for the following tasks when working with young people with a mental illness:

(a) Responding to the mental health needs identified during the case management of a young person whether formally (through screening and assessment) or informally (when interacting with the young person).

(b) Contacting Mental Health triage when there are acute or immediate mental health risk factors present. Mental Health triage is a central point for making referrals into the Victorian public mental health service. Mental Health triage deals with acute mental health problems where there is an immediate risk to self or others.

(c) Working collaboratively with mental health service providers including by sharing information (with the young person's consent) about the case management of the young person to achieve the best health outcomes for them. Mental ill health is a responsivity barrier that can affect a young person's ability to benefit from interventions addressing their offending behaviour.

(d) Coordinating care team meetings that include the young person's mental health service providers.

(e) Ensuring compliance with any conditions on the young person's statutory order, including if they have a special condition to comply with mental health assessment or treatment conditions. Youth Justice ensures that a young person is complying with conditions of their statutory order through the case plan. The case plan identifies delivery of consistent, targeted interventions, that are in accordance with the young person's criminogenic, non-criminogenic and responsivity needs.

234 Through the YJCM Framework, Youth Justice staff use the Massachusetts Youth Screening Instrument (**MAYSI-2**) to identify potential mental health concerns in children and young people subject to custodial orders, community-based orders, parole orders and non-sentenced matters and then to plan accordingly.

235 Youth Justice staff are required to administer the MAYSI-2 as part of the assessment processes (for young people subject to custodial orders, community-based orders, parole orders and non-sentenced matters). The MAYSI-2 is a responsivity screen that is designed to screen for the presence of mental health symptoms in any young person between 12 years and 17 years of age. The MAYSI-2 is not a diagnostic tool, rather it has been designed to screen for various types of reported and current mental/emotional disturbance, distress or patterns of problem behaviour. The screen outcome will determine whether Youth Justice need to refer a young person for immediate mental health assessment and intervention.

Youth forensic mental health services

Community Forensic Youth Mental Health Services and the Youth Justice Mental Health Initiative

236 Key goals of the Community Forensic Youth Mental Health Service (**Community FYMHS**) is to improve mental health outcomes and divert young people with serious mental illness from the criminal justice system. It does this by delivering early intervention specialist forensic mental health consultation services based in two metropolitan Child and Adolescent Mental Health Service (**CAMHS**) and Child and Youth Mental Health Service (**CYMHS**) sites. This is so the service can better adapt and respond to the specific needs of a young person who demonstrates offending behaviours and is at risk of serious offending or re-offending behaviours.

237 The Youth Justice Mental Health Initiative aims to facilitate delivery of mental health services to young people who require mental health assessment, treatment or referral and are subject to the supervision of Youth Justice (either when leaving custody or

otherwise supervised in the community). The program consists of six clinicians employed by CAMHS/CYMHS and the Victorian Aboriginal Health Service, based in the Parkville Youth Justice Centre as well as the Melbourne metropolitan and Goulbourn regions.

238 The four core functions of Youth Justice Mental Health Initiative are to:

(a) build the capacity of the Youth Justice program;

(b) provide mental health assessments in the community;

(c) facilitate referral pathways and advocate for appropriate service provision; and

(d) engage Mental Health Community Support Services and clinical mental health services before a young person's mental health concerns escalate.

239 These programs are run and funded by DHHS.

Custodial Forensic Youth Mental Health Services

240 As outlined in Part Five of my statement, following the department taking on responsibility for Youth Justice in 2017, we have worked with DHHS to develop and implement the Custodial Forensic Youth Mental Health Service (**Custodial FYMHS**) to improve treatments for young people in custody with acute mental health needs.

241 Custodial FYMHS is available for young people in custody who meet at least one of the following criteria:

(a) experiencing, or at risk of experiencing, a mental health condition with a focus on early intervention and prevention;

(b) experiencing psychological distress while in custody; or

(c) being supervised under the CMIA in custody.

242 Within Youth Justice custodial settings, the Custodial FYMHS is delivered by Orygen Youth Health and comprises of a multi-disciplinary team of consultant psychiatrists, psychiatric registrars and allied health clinicians (psychology, occupational therapy, social work, psychiatric nursing), all of whom (aside from the medical professionals) undertake both assessment, treatment and case management liaison with young people in Youth Justice.

243 Custodial FYMHS can make direct referrals to community mental health providers or recommend that the Youth Justice Community Case Manager makes the referral. Custodial FYMHS participate in care teams and provide reports to the Youth Parole Board. Should any young person require an involuntary inpatient admission while in custody, or transition to supported mental health accommodation (i.e. to a Secure

Exended Care Unit or a Community Care Unit) in the community, Custodial FYMHS staff arranges the admission and liaises with custodial staff to facilitate the transfer of the person to the inpatient facility.

244 There are six acute inpatient units specifically for young people in Victoria including two statewide child inpatient units and four adolescent units. These units are delivered by Orygen Youth Health, the Royal Children's Hospital, Austin Health, Monash Health and Eastern Health. A young person over 18 years of age who needs inpatient care requires admission into an adult inpatient unit. Some young people under 18 cannot be accommodated in a child or adolescent unit due to their risk of violence and the vulnerability of other young people in the unit. Where they instead require admission into an adult unit, the Office of the Chief Psychiatrist is required to approve this admission.

Delivery of primary mental health services in youth justice centres

245 As noted in Part Five of my statement, Justice Health is responsible for delivering health services to children and young people in custody.

246 Primary mental health services in Youth Justice centres are provided by Correct Care Australasia.[77] These services are delivered by mental health nursing staff 24 hours seven days a week, supported by general practitioners who are available four days a week.

247 Justice Health oversees the compliance of these services with the Justice Health Youth Justice Quality Framework,[78] consistent with its whole of system responsibility for the delivery and oversight of health services to young people in Youth Justice custody. The Justice Health Youth Justice Quality Framework operates in the same manner as the Justice Health Quality Framework which applies in the adult justice system. Further detail about the Justice Health Quality Frameworks is provided above in Appendix C.

248 The Justice Health Clinical Advisory Committee and Justice Health Principal Medical Officer may provide clinical guidance and advice on key health issues for patients in Youth Justice custodial settings.

Youth Offending Programs

249 Justice Health is also responsible for delivering Youth Offending Programs to young people involved with Youth Justice, in custody and in the community. The Youth Offending Programs service consists of:

---

[77] Correct Care Australasia provides health services at all public prisons and Ravenhall. More information about Correct Care Australasia is available at https://www.correctcare.com.au/about-us/.

[78] Reflecting the different service needs of children and young people, a separate Justice Health Youth Justice Quality Framework governs the standards of care provided to children and young people in custody (see Part Five of the statement).

(a) a comprehensive clinical and forensic assessment of risk and needs, using validated risk assessment tools;

(b) a suite of criminogenic (offence-specific) group and individual programs addressing offending behaviour (including violence, family violence, sexual offending, AOD related offending, and motor vehicle-related offending); and

(c) a suite of psychosocial and AOD health stream programs for young people in custody aimed at assisting young people to develop skills in areas including emotional regulation and assertive communication.

250 For a young person with mental health issues, the assessment includes consideration of the relationship, if any, between the impact of mental health issues and offending behaviour. The assessment also considers the potential impacts on the young person's capacity to participate in interventions addressing offending behaviour. Programs are tailored to be responsive to the mental health issues of young people, so that they have access to programs that address the underlying causes of offending to reduce reoffending. Young people experiencing acute mental illness may not be able to participate in the Youth Offending Programs assessment or treatment due to the impact of their presentation on their capacity to engage. When symptoms have stabilised or alleviated, or when the condition is being appropriately managed, the young person can be supported to participate in the Youth Offending Programs service.

sign here ►

print name Peta McCammon

date 13/08/2020