

Is there evidence of systematically different outcomes before mental health tribunals depending on whether there is legal representation?

Introduction and overview

At the Productivity Commission's Public Hearing into Mental Health on 18 November 2019, Louise Glanville, CEO of Victoria Legal Aid (VLA), was asked by the Productivity Commission whether there is evidence of systematically different outcomes in Mental Health Tribunal hearings where consumers are legally represented.¹

VLA provides advice and representation to consumers appearing before Victoria's Mental Health Tribunal (**Tribunal**). In 2018–19 in Victoria, 13 per cent of consumers were legally represented before the Tribunal.² VLA is the main provider of representation at the Tribunal, representing consumers at 12 per cent of Tribunal hearings in the 2018–19 financial year.³ VLA also provides around 3,000 advices annually to consumers regarding their Tribunal hearings. Additionally, the Mental Health Legal Centre provides legal advice and representation for consumers, including through pro bono partnerships.⁴

VLA provides access to legal assistance to people with Tribunal hearings in three ways: a regular visiting service to inpatient mental health units across Victoria; a daily telephone advice service for people seeking advice regarding the *Mental Health Act 2014* (Vic) (**the Act**) and other relevant legislation; and on an ad hoc basis for a limited number of consumers outside its visiting service, such as those with long-running matters requiring ongoing advocacy, or for urgent hearings or hearings scheduled on non-serviced days. This includes some consumers on community treatment orders (**CTOs**).

This response to the question taken on notice:

1. Outlines the value of legal assistance in Tribunal matters as described by mental health consumers;
2. Provides and discusses data on differences in outcomes for represented and unrepresented consumers in Tribunal matters;
3. Explains the value that legal advice and representation can bring for individual consumers over and above the difference in legal outcome; and
4. Describes how legal representation can also lead to systemic change.

1. Value of legal representation in Tribunal matters

Access to legal assistance is consistent with the principles contained in section 11 of the Act which mandate least restrictive treatment and include that people receiving mental health services "should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or

¹ Productivity Commission, Public Hearing into Mental Health, Transcript 18 November 2019, Evidence of Louise Glanville, CEO Victoria Legal Aid, 31 (Professor King).

² The difference in rates of legal representation before Mental Health Tribunals in Victoria and New South Wales is further explored in Victoria Legal Aid, *Response to question on notice to the Royal Commission into Victoria's Mental Health System* (30 July 2019) <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-letter-responding-to-question-on-notice-30-july-2019-redacted.pdf>>.

³ Mental Health Tribunal, *Annual Report 2018 – 2019*, 27 (**MHT Annual Report 2018–19**). People have legal representation at 13% of all Tribunal hearings.

⁴ Ibid.

participate in, those decisions, and their views and preferences should be respected.”⁵ As lawyers act on the instructions of their clients before the Tribunal, legal assistance is an effective way of ensuring consumers are involved in decisions, and are supported to make or participate in them.

Notwithstanding the Tribunal’s efforts to create a non-adversarial environment, there is a significant power imbalance between the parties to a Tribunal hearing. On one hand there is the consumer, who has been diagnosed with having current symptoms of a mental health condition, who may be currently detained, and is often heavily medicated. On the other hand there is the mental health service, represented by a doctor or psychiatrist with expert medical training, who usually has experience in appearing at the Tribunal and who may in fact appear at the Tribunal several times per month. Hearings often last for an hour, cover difficult and technical medical and legal issues and often involve complex, inaccessible language. The Tribunal’s determination revolves around a lengthy (often 10 page) report prepared by a medical practitioner, and the Tribunal also has access to the consumer’s clinical file.

All of these factors make the Tribunal an especially difficult jurisdiction to be unrepresented in. The fact that it is constituted by a panel of experts (including a lawyer and psychiatrist or medical member) compounds the way in which it can be experienced as intimidating by consumers.

Consumer experiences of the Tribunal and legal assistance

The value of legal representation at Tribunal hearings is reflected in consumers’ accounts of their experience of the Tribunal. In 2017 VLA commissioned a report of consumers’ experiences of the Tribunal and the role that legal representation can play.⁶

Consumers reported that the presence of a lawyer was a comforting and calming factor:

“I’ve felt vulnerable every time, you don’t feel well and it’s very difficult to negotiate things, but by having a legal representation, at least somebody is on my side.”

“For me it’s comforting that it’s not going to just be me there by myself, especially when you’re in a hospital setting as you can feel very vulnerable. It’s difficult to get out of there, and you’re not well, it’s important to have them there even if it’s not possible to create change.”

Consumers commented on the value that lawyers could add:

“I most definitely felt like I had more control over getting off compulsory treatment, it [having a lawyer] made me feel so much better, I knew how to handle the situation, and what was going to happen after I leave.”

“Oh yes the lawyer helped change the outcome ... Where I fell down was trying to shoot down all the errors in fact, but she helped me prioritise what to talk about.”

“If I hadn’t had a solicitor I wouldn’t have been prepared, I wouldn’t have known my rights, and I wouldn’t have known the process. I was nervous as it was, without guidance you don’t know what you’re walking into. Being unwell and with where you’re at, it’s a very intimidating process, to go into a room of strangers, it’s an incredibly intimidating process, and it would be very frightening if you had to defend yourself on your own.”

2. Differences in hearing outcomes

In order to respond to this question taken on notice, VLA conducted a snapshot analysis of hearings where clients were legally represented by VLA between July 2019 and September 2019. Data was

⁵ *Mental Health Act 2014 (Vic)* s 11(b).

⁶ Quotes are taken from, ‘RedPanther Report – *Legal Advocacy in Mental Health: Exploring the needs, preferences, and opinions of people experiencing treatment under the Victorian Mental Health Act*’ (May 2017).

collated from hearing records where it was readily ascertainable what kind and length of order was sought by the mental health service and what the outcome was.

Some caution needs to be taken in comparing this sample to the outcome rates for Tribunal hearings overall because the VLA sample is in some respects not representative of all consumers with matters before the Tribunal. This is because VLA applies a representation guideline⁷ and cannot represent consumers who do not have capacity to give instructions, or do not want legal representation. It is likely that clients who meet our guideline, want representation and can instruct are already more likely to obtain a less restrictive outcome from the Tribunal than is sought by the mental health service even without legal assistance. This factor would therefore naturally account for some difference in outcomes between VLA clients and consumers overall. However, it is impossible to control for this factor and it is difficult to quantify the extent of the effect, except to say it is likely to account for some but not all of the differences in outcome discussed below.

Treatment order hearings

Our snapshot reviewed 73 treatment order hearings where VLA appeared. Our analysis revealed that in 53 per cent of those hearings, the Tribunal either:

- Made a shorter order than was sought by the mental health service;
- Made a CTO where an inpatient treatment order (**ITO**) was sought by the mental health service; or
- Revoked the order completely.⁸

This means that in over half of all hearings where clients were represented by VLA, a less restrictive outcome was obtained for the consumer than was sought by the mental health service.

Shorter orders

Our analysis revealed that in 41 per cent of the hearings reviewed, the Tribunal made an order that was shorter than was sought by the mental health service.⁹ By way of comparison, in 2018–19 the Tribunal conducted an eight-week study on the duration of orders made by the Tribunal.¹⁰ This study revealed that the Tribunal made shorter orders than sought in 18 per cent of all hearings (whether consumers were legally represented or not).¹¹ This suggests that a consumer is more than two times more likely to receive a shorter order than that sought when they are legally represented (while noting, as stated above, that there is some unavoidable bias in the VLA sample).

This is supported by the Tribunal's analysis that:

"[I]n cases where the Tribunal made a shorter duration, there were higher levels of attendance from the patient, their support person or their legal representative when the Tribunal considered information provided by the participants and congruence with the principles of the Act as factors of their decision. This suggests that participation by consumers and their support people will help provide the Tribunal with the information it needs to meaningfully consider the Act's

⁷ The guideline is: there are reasonable prospects of obtaining a favourable outcome (broadly defined) for the consumer; or the consumer belongs to a priority client group (such as consumers with dual disability, Aboriginal or Torres Strait Islander consumers, consumers from CALD backgrounds, consumers making their first appearance before the Tribunal) and representation is necessary to ensure the consumer can fully participate in the hearing, their views and preferences are properly understood, and/or to otherwise ensure a fair hearing.

⁸ VLA 'Snapshot' of Hearing Data July 2019 – September 2019 (**VLA Snapshot**). 39 out of 73 hearings resulted in either shorter orders made, orders revoked or community treatment orders. The 73 hearings recorded reflect those in which VLA recorded what type of order was sought, the duration of the order sought and the outcome. We note that in some cases the order made will be both shorter than sought and in the community, where an inpatient order was sought. These 73 hearings do not include ECT hearings. We also reviewed a further 9 records from ECT hearings, discussed below.

⁹ Ibid. Shorter orders than sought were made in 30 out of 73 hearings.

¹⁰ MHT Annual Report 2018–19, above n 3, 39, figure 12.

¹¹ Ibid, Tribunal made shorter orders in 165 out of a total 908 hearings.

*principles and objectives when exercising its discretion to determine the duration of Treatment Orders.*¹²

Release on CTO

Our analysis revealed that in 10 per cent of the hearings reviewed, the Tribunal released the consumer on a CTO where the mental health service was seeking an ITO.¹³ The Tribunal does not publish data on whether an ITO or CTO is sought by the treating team, so it is not possible to compare outcomes in cases with and without legal representation.

Revocations

Our analysis revealed that in seven per cent of the hearings reviewed, the Tribunal revoked the consumer's treatment order.¹⁴ This is similar to the rate at which the Tribunal revokes orders overall (seven per cent in 2018–19).¹⁵ However, it should be noted that, due to the design of VLA's duty lawyer service and the prioritisation of consumers held subject to inpatient orders at the time of their hearing, the majority of consumers assisted by VLA are inpatients. Some caution therefore needs to be taken in comparing the revocation rate obtained for VLA clients with the Tribunal's overall outcomes which includes community patients as well.

Electroconvulsive treatment (ECT)

Our snapshot also reviewed records from nine compulsory ECT hearings. Our analysis revealed that in 50 per cent of the hearings that proceeded, the Tribunal refused the application for compulsory ECT.¹⁶ This is similar to analysis undertaken by VLA in 2018, which revealed that the Tribunal refused compulsory ECT applications in 52 per cent of hearings where VLA appeared.¹⁷ By contrast, in 2018–19 the Tribunal's overall refusal rate for ECT applications was 14 per cent.¹⁸ In 2016–17 it was 15 per cent.¹⁹ Again, some caution needs to be taken in comparing these figures as the VLA sample is not representative. However, while the sample bias is likely to account for some of the difference in outcomes, it is unlikely to account for all of it.

3. Other benefits of legal representation in individual cases

The value of providing legal advice and representation in relation to Tribunal hearings does not lie solely in impacting the legal outcome of the hearing. Legal advice and representation can also achieve the following important objectives:

- Ensuring consumers are aware of their rights under the Act and can self-advocate to assert these rights;
- Ensuring consumers are aware of the purpose of hearings, the relevant criteria to be applied and the process that will be followed;
- Enabling consumers to fully understand the case that is being put forward by the mental health service;

¹² Ibid 38.

¹³ VLA Snapshot, above n 8: 7 out of 73 hearings resulted in inpatient orders being varied to community orders.

¹⁴ Ibid: 5 out of 73 hearings resulted in orders being revoked.

¹⁵ MHT Annual Report 2018–19, above n 3, 18.

¹⁶ VLA Snapshot, above n 8: 4 out of 9 applications for compulsory ECT were refused by the Tribunal, and 4 were approved. 1 ECT hearing was adjourned with the ultimate result unknown.

¹⁷ Internal VLA data: VLA appeared in 45 hearings; 23 were refused; 21 were approved and 1 was adjourned.

¹⁸ MHT Annual Report 2018–19, above n 3, 21, table 13. This figure includes the percentage of orders refused in relation to adults being treated as voluntary patients (in which zero orders were refused for voluntary patients).

¹⁹ Mental Health Tribunal, *Annual Report 2016 – 2017 (MHT Annual Report 2016–17)*, 22.

- Enabling consumers to fully participate in hearings – particularly where consumers are distressed, medication-affected, experiencing mental health symptoms, require an interpreter or have a communication impairment;
- Ensuring that consumers' views and preferences are clearly understood by the Tribunal, particularly when the consumer may not be able to attend all or part of the hearing;
- Ensuring that the evidence of the mental health service is properly explored and tested;
- Ensuring hearings are fair, and that consumers' experience is that their hearing was fair (and therefore the outcome legitimate);
- Supporting the Tribunal to make legally sound decisions; and
- Uncovering and highlighting systemic inconsistencies in practice across mental health services.²⁰

As well as the task of representing consumers during hearings, lawyers undertake important work around hearings, including:

- Ensuring mental health services comply with obligations under the Act, including the timely provision of reports under section 191,²¹ access to clinical files, and checking the validity of the underlying admission documentation;
- Thoroughly reading the consumer's clinical file and Tribunal report and seeking corrections to any errors;
- Preparing written statements detailing consumers' views and preferences;
- Liaising with consumers' treating teams prior to the hearing to ascertain if there have been any changes since the Tribunal report was written;
- Negotiating with the treating team outside of the hearing which can result in consideration of whether criteria for compulsory treatment continue to apply, capacity reassessment, withdrawn applications and progress to less restrictive treatment;
- Contacting support people if requested;
- Obtaining supportive medical and other evidence, for example from a consumer's treating private psychiatrist or psychologist;
- Advocating to the Tribunal in relation to the process and attendance at the hearing of people that the consumer does not want their private health information disclosed to;
- Explaining Tribunal outcomes to consumers and advising them in relation to appeal rights; and
- Making appropriate legal and non-legal referrals.

²⁰ See also Victoria Legal Aid, *Submission to the Royal Commission into Victoria's Mental Health System – Roads to Recovery: Building a Better System for Victorians Experiencing Mental Health Issues* (July 2019) (**Roads to Recovery**) part 1 <www.legalaid.vic.gov.au/roadstorecovery>.

²¹ The Act requires that consumers be provided with a report prepared by the mental health service, as well as relevant parts of their clinical file, at least 48 hours prior to their Tribunal hearing. This requirement is to ensure consumers have enough information to understand the application and prepare for their hearing. Neither the Tribunal, nor any other body, has a formal role in ensuring compliance with this obligation, and this requirement is routinely breached by services. VLA collected data on compliance with this obligation, discussed in part 1.3.4 of Roads to Recovery, above n 20, 19.

In addition to the more common treatment order or compulsory ECT hearings,²² lawyers also assist consumers with ancillary matters that can be technical and complex and virtually impossible for consumers to self-represent in relation to, including:

- Applications by health services to withhold from consumers information put before the Tribunal as part of the application;²³
- Jurisdictional issues, including whether the underlying documentation for the application is valid, and therefore whether the Tribunal's jurisdiction has been enlivened; and
- Applications for review of a decision to transfer a consumer to another mental health service.²⁴

4. Systemic changes

As well as improving individual outcomes and increasing consumers' ability to engage with decisions and processes that affect them, provision of legal assistance in relation to Tribunal matters has a role to play in identifying and addressing systemic issues regarding compulsory mental health treatment.

An example of this is VLA's advocacy in relation to compulsory ECT. In 2016 VLA commenced an advocacy project in relation to ECT, particularly in relation to the high incidence of urgent hearings. At that time, 56 per cent of applications for compulsory ECT were urgent applications,²⁵ with the effect that 20 per cent of ECT hearings were being conducted on the same day that the ECT application was made, and a further 31 per cent of hearings were being held on the next day.²⁶ These timeframes were making it virtually impossible for consumers to properly prepare for their hearings, contact supports, and arrange legal advice or representation. Only around six per cent of consumers were being represented in ECT hearings.²⁷ This low representation rate was particularly problematic given the high difference in outcomes for represented and unrepresented consumers in ECT hearings (see above).

As part of VLA's ECT project, we identified matters of systemic importance, including that of our clients PBU and NJE, whose cases we appealed the Supreme Court of Victoria. The Supreme Court's decision in *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 strengthened consumers' rights, clarified the law in relation to mental capacity, and highlighted the issues in relation to the high number of urgent ECT hearings. Following the decision, the Tribunal issued a new guideline on ECT applications, which stated that "the hearing process must be rigorous rather than instantaneous."²⁸ The Office of the Chief Psychiatrist also updated its ECT guideline to reflect the Supreme Court's decision. The Tribunal revised its listing procedures to require registry to take into account the ability of the client, support person, carer or legal representative to participate in the hearing.

Alongside these changes, VLA has worked with mental health services to provide training to mental health staff about the practical impact of the *PBU* decision, and VLA lawyers have incorporated the precedent from *PBU* into day-to-day advice and representation before the Tribunal.

²² *Mental Health Act 2014* (Vic) s 95.

²³ *Mental Health Act 2014* (Vic) s 191 and Mental Health Tribunal, *Practice Note 8 – Access to Documents in Mental Health Tribunal Hearings* 8 <<https://www.mht.vic.gov.au/sites/default/files/documents/201904/Practice-Note-8-Access-to-Documents-in-Tribunal-hearings.docx>>.

²⁴ *Mental Health Act 2014* (Vic) s 66.

²⁵ MHT Annual Report 2016–17 above n 19, 24.

²⁶ *Ibid.*

²⁷ The Tribunal publishes overall rates of legal representation, but does not publish data on the rate of representation for different hearings types (eg, ECT, inpatient or community treatment order hearings). VLA's analysis of our internal data indicates that, between 2014–2017 our lawyers provided representation at, on average, 40 ECT hearings each financial year. When compared with ECT hearings data published by the Tribunal (see Mental Health Tribunal, *Annual Report 2015–16*, 22), this indicates that consumers were represented by VLA in 6% of hearings. This figure does not take into account legal representation by non-VLA lawyers.

²⁸ Mental Health Tribunal, *Guidelines for ECT hearings and orders* 3 <<https://www.mht.vic.gov.au/sites/default/files/documents/201906/MHT%20ECT%20Guidelines.docx>>.

Subsequently, there were 18 per cent fewer urgent applications made by authorised psychiatrists in 2018–19 than in 2017–18,²⁹ and the number of same day hearings has fallen from 14 per cent to eight per cent, while the number of next day hearings has fallen from 28 per cent to 21 per cent.

Similarly, our individual casework helped us identify a not infrequent practice in mental health services, whereby following a decision by the Tribunal (or formerly the Mental Health Review Board) to revoke or vary a person's order, the mental health service would re-start the compulsory admission process. This had the effect of rendering the Tribunal's decision nugatory or of no effect. In order to address this systemic issue, VLA elected to take a test case on the issue to the Supreme Court, *XX v WW* [2014] VSC 564. In its decision the Supreme Court established that it was unlawful for a mental health service to re-start the compulsory admission process following a decision to revoke a person's compulsory order in the absence of a change of circumstances since the Tribunal's decision.

Both of the above are examples of the systemic role legal representation, combined with the work of oversight bodies, can play in promoting greater oversight and accountability in the mental health system.

²⁹ MHT Annual Report 2018–19, above n 3, 23, table 17. There were 79 fewer urgent applications in 2018–19 than in 2017–18, which equates to a reduction of 18% of urgent applications made. Note that the figures cited above at 25 and 26 regarding the ECT project refer to 2016–17; and these figures compare 2017–18 with 2018–19.

Community treatment orders and how they work for Victoria Legal Aid's clients and consumers

Introduction and overview

At the Productivity Commission's Public Hearing into Mental Health on 18 November 2019, Louise Glanville, CEO of Victoria Legal Aid (**VLA**), was asked by the Productivity Commission about community treatment orders (**CTOs**) and, specifically, how they work for clients.¹

Drawing on our practice experience with people subject to compulsory orders, including CTOs, this response:

1. Outlines the relatively high rates of use of CTOs in Victoria and the difficulties presented by lack of transparent data;
2. Describes use of CTOs in practice as part of a crisis-driven mental health system, rather than as a last resort; and
3. Discusses the ways in which CTOs can be experienced as disempowering and restrictive of choice and self-determination,² which can undermine voluntary engagement with services for consumers.

We welcome the Commission's interest in the impact of compulsory treatment, and CTOs in particular, and encourage the Commission to consult with a broad range of consumers with lived experience of CTOs.

VLA's services for people on CTOs

This response is informed by the practice of VLA's Mental Health and Disability Advocacy sub-program in the Civil Justice program, comprising the legal services of Mental Health and Disability Law and non-legal advocacy services of Independent Mental Health Advocacy (**IMHA**).

VLA provides legal and non-legal advocacy to consumers in all designated mental health services in Victoria. In 2018–19, our legal service provided legal representation to people subject to inpatient treatment orders in over 770 hearings and on CTOs in 133 hearings before the Mental Health Tribunal (**Tribunal**). We provided around 3,000 legal advice services annually regarding compulsory treatment orders.

IMHA, our non-legal advocacy service, has been operating since 31 August 2015. IMHA works with consumers and mental health services to embed supported decision-making and recovery orientated practice. IMHA aims to support people to express their views and preferences regarding their assessment, treatment and recovery. IMHA provides people with information, coaching for self-advocacy, referral and advocacy, as well as community education. IMHA also uses systemic advocacy to promote and support the human rights of people subject to compulsory treatment. In 2018–19, IMHA

¹ Productivity Commission, Public Hearing into Mental Health, Transcript 18 November 2019, Evidence of Louise Glanville, CEO Victoria Legal Aid, 30: 'Do you have interface with community treatment orders in Victoria ... And how do you think they work for client[s]?' (Professor Whiteford).

² See, eg, Lisa Brophy, *Formal Submission to the Royal Commission into Victoria's Mental Health System*.

provided over 24,000 occasions of service to people receiving or at risk of compulsory mental health treatment.³

Although the majority of VLA's work is with consumers in inpatient units, this includes working with people whose CTOs have been varied to inpatient orders,⁴ and people being discharged from hospital onto CTOs. VLA also works directly with consumers on CTOs, including people who have been on effectively continuous CTOs for over 10 years.

1. The use of CTOs in Victoria: High rates, variability and a lack of data

This part discusses two features of the use of CTOs in the Victorian and Australian contexts:

- Their use both in Australia and particularly Victoria has remained high by international standards; and
- Their use varies considerably between different services and lack of publicly available data makes it difficult to assess the reasons for variation, understand the impact of CTOs and bring about cultural change to reduce over-reliance on compulsory treatment.

Since the introduction of CTOs, Victoria has maintained high reliance on compulsory treatment in the delivery of community mental health services. Despite variation across states and territories, studies show the rates of people subject to CTOs from 2005 to 2017 in Australia have remained relatively high by international comparison.⁵ Although Victoria's rate of CTOs per 100,000 population fell from 98.8 in 2012 to 76.4 in 2016–17, it is still higher than all other states and territories for which data was reported.⁶

These aggregate figures also mask what is otherwise a high variability of CTO use across metropolitan and regional services, with the percentage of people receiving community mental health services who are on CTOs ranging from five per cent to 27 per cent between services.⁷ The reasons for this variation are not clear. The recent independent evaluation of IMHA (**IMHA Evaluation Report**)⁸ expressed concern about this variation, noting that '[s]ector level data is so poor that it is not possible, using publicly available data, to determine how many people are subject to compulsory treatment in Victoria'.⁹

In the 2018–19 financial year, the Department of Health and Human Services (**DHHS**) reported that 11 per cent of consumers (including 14.4 per cent of adult consumers) receiving community mental health services were on a treatment order and 49.7 per cent of inpatient admissions were compulsory, without specifying how many people these percentages relate to.¹⁰ Reporting from health services indicates that 15 per cent of adult consumers in the community were on CTOs – 18 per cent of community consumers in metropolitan Melbourne and eight per cent in rural areas.¹¹

Whilst the Tribunal publishes data on the number of CTOs made, and the duration of those orders, and has established a research working group to investigate further its approach to setting the duration of

³ Victoria Legal Aid, *Annual Report 2018–19*, 30. IMHA recorded 7,424 high intensity occasions of service (advocacy and self-advocacy) and 17,070 low intensity occasions of service (information and referral).

⁴ That is, people whose CTOs have been varied by an authorised psychiatrist to an inpatient treatment order, resulting in their admission to hospital. This variation triggers an automatic Tribunal hearing within 28 days of the variation (*Mental Health Act 2014* (Vic) s 58(5)).

⁵ Edwina Light, 'Rates of use of community treatment orders in Australia', 64 *International Journal of Law and Psychiatry* (2019), 83-87 (**Light 2019**).

⁶ *Ibid* – the second highest reported rate for 2016-17 was Queensland at 66.1 per 100,000, and the lowest rate for that period was in Western Australia, at 40.9 per 100,000.

⁷ Victorian Agency for Health Information, *Adult Mental Health Quarterly KPI Report July – September 2019* (October 2019) (**VAHI KPI Report**) 3-4.

⁸ Dr Chris Maylea, Susan Alvarez-Vasquez, Matthew Dale, Dr Nicholas Hill, Brendan Johnson, Professor Jennifer Martin, Professor Stuart Thomas, Professor Penelope Weller, *Evaluation of the Independent Mental Health Advocacy Service (IMHA)* (Final Report, November 2018) (**IMHA Evaluation Report**).

⁹ *Ibid* 26.

¹⁰ Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2018–19* (October 2019) 81.

¹¹ VAHI KPI Report, above n 7, 4-5.

orders, there is no published data on the rates at which orders made by the Tribunal expire, are revoked before their expiry, or a further order is applied for and then made by the Tribunal.

Regular public reporting of data in relation to compulsory treatment, including CTOs, is necessary for transparent and accountable mental health services.¹² Despite repeated calls to do so, Australia has no uniform national public reporting of CTOs.¹³ As we noted in our submission to the Commission's Inquiry into the Economic Impact of Mental Ill-Health – *Intersections Between Mental Health and the Legal System and Impacts for People and Communities (VLA Productivity Commission Submission)*, data is critical to service design, evaluation and consumer choice, and essential to ensure accountability,¹⁴ including to determine whether Australia and Victoria are succeeding in reducing the use of compulsory treatment, with a preference for voluntary treatment, supported decision-making and less restrictive approaches.¹⁵

2. Use of CTOs in a crisis-driven system

As a mechanism for compulsory treatment under the *Mental Health Act 2014 (Vic) (the Act)*, CTOs must only be used where they are the least restrictive option available for a person to access the treatment they require.¹⁶

However, in a mental health system under pressure, there is a risk they may be relied on for their perceived ability to facilitate access to community based treatment to prevent crisis and minimise compulsory treatment on an inpatient basis.¹⁷

The Victorian Auditor General's Office recently considered the level of investment in mental health services in its Access to Mental Health Services report (**VAGO Mental Health Report**), noting the impact of funding shortfalls on the delivery of mental health services, in particular community-based services. It found mental health services 'often redirect resources from community to hospital settings to support consumers who need a higher level of care, [and services] have limited capacity to intervene in the earlier stages of mental illness or deliver high quality interventions in the community to promote recovery'.¹⁸ The report noted that between 2009 to 2016 acute admissions grew by 19 per cent, while community mental health contacts decreased by 17 per cent.¹⁹

The VAGO Mental Health Report also noted that a 2017 external report commissioned by DHHS into Victoria's mental health system highlights 'community mental health contacts per 1,000 people declining at a rate of 2.5 per cent per annum over the last 10 years'.²⁰

In this context, this part outlines:

- The use of CTOs, including as a tool for ensuring access to services, instead of less restrictive alternatives and consumers' preferred treatment;
- The use of CTOs to manage potential future risk or disengagement; and

¹² See Light 2019, above n 5.

¹³ See Edwina Light et al, 'Community Treatment Orders in Australia: Rates and Patterns of Use', 20(6) *Australasian Psychiatry* (2012) and Light 2019, above n 5.

¹⁴ Victoria Legal Aid, *Submission to the Productivity Commission's inquiry into the Economic Impact of Mental Ill-Health: Intersections between mental health and the legal system and the impacts for people and communities* (April 2019) 16 (**VLA Productivity Commission submission**). See also IMHA Evaluation Report, above n 8, 26.

¹⁵ See, eg, Minister Wooldridge (former Minister for Mental Health), *Mental Health Bill 2014 (Vic)*, Second Reading Speech (20 February 2014), Hansard, 470, 473 articulating the aims of Victoria's Mental Health Act.

¹⁶ *Mental Health Act 2014 (Vic)* ss 5(d), 55(3).

¹⁷ We note that the effectiveness of CTOs continues to be debated and questioned (see for example Light 2019, above n 5). Rather than comment on their effectiveness per se, we focus our response on what we have seen in our practice working with consumers subject to CTOs.

¹⁸ Victorian Auditor General's Office, *Access to Mental Health Services* (March 2019) 41 (**VAGO Mental Health Report**) <<https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf>>.

¹⁹ *Ibid.*

²⁰ *Ibid* 11.

- Long-term compulsory treatment under CTOs sometimes without meaningful engagement from the treating team or consideration of ongoing application of the treatment criteria under the Act.

a. CTOs as ‘necessary’ for access to services

Through our work, we often see examples of CTOs being used as a gateway to access to services, whether or not the treatment criteria²¹ are met and a CTO is truly needed for the person to access or remain engaged in treatment.

In Tribunal hearings for example, it is not uncommon for the treating psychiatrist to say that a CTO is needed because:

- Community mental health services may not otherwise accept a referral for the person who is being discharged from hospital;
- Clinical teams that provide more assertive treatment (such as the mobile support team) are more likely to provide services;
- It would help ensure access to supported accommodation such as a community care unit; or
- It would help ensure a range of services can be coordinated and additional referrals made, including to drug and alcohol or other non-clinical services.

As was noted by the Tribunal in its submission to the Royal Commission into Victoria’s Mental Health System (**Tribunal Royal Commission Submission**):

“The relative scarcity of available services leads to ... compulsory treatment being used as a tool to ration or determine access [and] results in unfair allocation of resources. It also distorts the effective operation of the Act and leads to irrational responses to risk.”²²

Consistent with the views of the Tribunal, and as identified in the VLA Productivity Commission Submission, we see CTOs relied on in an environment where there is limited availability of outreach mental health services tailored to individual consumer needs and of flexible ‘step up’ and ‘step down’ options between acute inpatient and community services offered in such a way that consumers can take an active role in the direction of their treatment.²³

We also see the way in which the use of CTOs can mean consumers’ preferences for alternative treatment, whether medication or other therapeutic alternatives including psychosocial treatment and peer led models, are not given meaningful consideration by the treating team (discussed further in part 3 below).

b. CTOs ‘just in case’ to manage future risk

We frequently assist consumers whose treating teams recommend a CTO is needed based on concerns that it will be necessary in the event of a crisis or disengagement or non-compliance arising in future. Such ‘just in case’ orders result in different thresholds being applied to the legal criteria under the Act depending on the person’s circumstances, notwithstanding that the criteria for compulsory treatment remain the same.

In Tribunal hearings, for example, it is not uncommon for the treating psychiatrist to say that a CTO is needed because in the past (regardless of the circumstances or context at that time), the consumer had failed to comply with treatment, disengaged, or become unwell (even in the context of treatment compliance).

²¹ *Mental Health Act 2014* (Vic) s 5 – ‘What are the treatment criteria’.

²² Mental Health Tribunal, *Formal submission to the Royal Commission into Victoria’s Mental Health System* (June 2019) 29 (**Tribunal Royal Commission Submission**).

²³ VLA Productivity Commission submission, above n 14, 13.

This tendency is also identified in the Tribunal Royal Commission Submission:

“It is not uncommon in Tribunal hearings... for treating teams to acknowledge that things are going well but to argue that to manage the risk of future relapse a compulsory treatment order is required to be able to ‘act if the need arises’. When asked to elaborate on this, the rationale that is often provided is that if a person is not on a treatment order, intervention will not be possible until a relapse fully plays out ...

This appears to be routinely misunderstood and/or beyond the capacity of services which in a state of constant crisis management operate in salvage rather than prevention mode.”²⁴

As the Tribunal notes, “this misinterpretation of the Act [means] it can be as if there are two different sets of criteria depending on whether they are being considered in relation to a person who is voluntary, in contrast to a person who is a compulsory patient.”²⁵

CTOs are often sought by treating teams on the basis that they could act more swiftly in the event of non-compliance or deterioration of a consumer’s mental health.

This was the case in a matter in which the Victorian Civil and Administrative Tribunal (VCAT) expressed concern about the treating doctor’s view that a CTO was needed because, if voluntary in future, by the time the person met the criteria for compulsory treatment, his mental health would be significantly worse before the service could intervene to compel treatment under an order. The VCAT Member cautioned that “it seemed to me the service was confused about the difference in application of the criteria for compulsory treatment on renewal of an order such as is before me and a fresh order. They are of course the same.”²⁶

It is not uncommon for IMHA advocates to be told by psychiatrists that they are applying for the full length of a treatment order as they can easily revoke it but it is more time consuming to return to the Tribunal.

These considerations can result in consumers being subject to several consecutive CTOs for long periods, even many years in some cases. It also means that the Act is not operating as intended and that resourcing pressures of mental health services, rather than the consumer’s recovery, can influence decisions about whether or not to seek a CTO instead of voluntary, community-based treatment.

c. Long-term compulsory treatment under CTOs

In practice, we see the existence of a CTO over a long period can become the justification for making further orders, with arguments that the person has not been in an inpatient unit for a period of time so the CTO is working, or that the person has been in an inpatient unit and therefore needs to be on a CTO when they are discharged.

Long-term CTOs without meaningful engagement from the treating team or obvious consideration of ongoing application of the treatment criteria to the person were evident in the example of our client, WCH, whose case we took on appeal to VCAT.

WCH was diagnosed with a mental health condition in the early 1990s. At the time he sought assistance from VLA, he had been subject to back-to-back CTOs since his last admission to hospital 16 years earlier. His treating team confirmed that, other than a record of a paranoid delusion around four years prior, WCH had had no other signs or symptoms of illness for at least five years. WCH wished to undertake a carefully managed and slow reduction in his antipsychotic medication, and although he did not agree with the diagnosis made by his

²⁴ Ibid 29-30.

²⁵ Ibid 31.

²⁶ *WCH v Mental Health Tribunal (Human Rights) (Amended)* [2016] VCAT 199 (23 February 2016) at [102] (**WCH**) (discussed further below).

treating team (chronic schizophrenia), he planned to be monitored for a year to ensure he remained well. He wished to do so voluntarily with his treating community mental health service. His treating team argued that the criteria were met for a further CTO but VCAT ultimately found that three out of four of the criteria for compulsory treatment were not met.²⁷

WCH had been on back-to-back CTOs for 16 years before appealing to VCAT, which then found three of the four criteria for compulsory treatment were not met. This suggests his treating team, the Mental Health Review Board and (subsequently) the Tribunal, which had confirmed these CTOs, had not given proper consideration to whether the criteria continued to apply to him.

WCH's case highlighted over-reliance on CTOs, despite the consumer's stated preference for voluntary community-based treatment, willingness to be monitored to ensure he stayed well and the fact that he no longer satisfied the criteria under the Act.

3. Compulsory treatment experienced as disempowering and restrictive of choice and self-determination

In the Victorian Supreme Court case of *PBU & NJE v Mental Health Tribunal*,²⁸ which was run by VLA, Justice Bell stressed the importance of the 'least restrictive' principle as distinct from 'best interests' model of decision-making. He highlighted that, in addition to its mandate under Victorian law, it is more in line with human rights norms, including the *Convention on the Rights of Persons with Disabilities*:

*"The no less restrictive treatment test ... involves a different conception of the relationship between medical authority and the patient: it is one that respects, to a much greater degree, the patient's right to self-determination, to be free of non-consensual medical treatment and to personal inviolability; one that is intended positively to promote patient participation and supported decision-making; and one that, in appropriate cases, incorporates recovery (and not simply cure) as an important therapeutic purpose in a holistic consideration of the person's health (broadly understood)."*²⁹

As part of the recent independent evaluation of IMHA, an expert panel which included people with lived experience of mental health issues was assembled. The panel noted that:

*"[CTOs] are often experienced by consumers as disempowering and limiting choice and agency. The panel identified that people on [CTOs] are in some senses hidden from view, in that they are subject to a level of coercion which is difficult to ascertain and has no physical structure."*³⁰

In our submission to the Royal Commission into Victoria's Mental Health System, *Roads to Recovery: Building a Better System for Victorians Experiencing Mental Health Issues (Roads to Recovery)*, VLA expressed concern about the over-reliance on compulsory treatment in practice, which can limit the offering of voluntary treatment and default to coercive rather than recovery-focussed and rights-oriented practice.³¹ In this context, this part sets out:

- The current limitations on consumer involvement in decision-making about their treatment preferences and less restrictive options; and
- The impact compulsory treatment, including CTOs, can have on consumer trust and engagement.

²⁷ WCH.

²⁸ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564

²⁹ *Ibid* [252].

³⁰ IMHA Evaluation Report, above n 8, 26-27.

³¹ See eg, Victoria Legal Aid, *Submission to the Royal Commission into Victoria's Mental Health System – Roads to Recovery: Building a Better System for Victorians Experiencing Mental Health Issues* (July 2019) 13-14 (**Roads to Recovery**).

a. Supported decision-making and least restrictive treatment

Members of VLA's Speaking from Experience advisory group, which comprises people with lived experience of mental health issues, have highlighted the importance of consumers making and participating in decisions about treatment, even when subject to an order for compulsory treatment like a CTO:

"Even if someone is involuntary, they should still be supported to make their own decision and have the information about what's going to happen, why it might help them and the side effects".

"[Making your own decision about treatment] is important because self-determination has been shown to support recovery."

The disempowerment experienced when services adopt a 'best interests' approach is illustrated by a consumer who said:

"Other people making decisions for you – things are already determined before you have even been asked."³²

Despite the imperative for least restrictive and supported decision-making principles to underpin the delivery of mental health services, including for people subject to compulsory treatment,³³ in practice we see mental health services adopting a 'best interests' model.

We see frequent examples of mental health services' practices that do not support people to play an active role in decision-making. This includes:

- Reluctance to approach decision-making from the starting point of presuming the consumer has capacity to make their own decision about treatment, regardless of whether they are subject to compulsory treatment;
- Assuming the person is unable to make their own decision without providing necessary information and support to enable them to do so;
- Failing to provide the consumer with adequate information about the decision that needs to be made so that they can participate in the decision-making process;
- Not consulting regularly and meaningfully with the consumer to understand their views and preferences about treatment; and
- Applying a 'best interests' rather than 'least restrictive' lens to compulsory treatment decisions.

Limited protections of the rights of consumers were also identified as a key systemic issue in the recent IMHA Evaluation Report:

"The evaluation team identified persistent and consistent breaches of peoples' rights and breaches of the Act, [including] failure to involve people in decision-making processes".³⁴

The IMHA Evaluation Report also identified the role that independent advocacy can play in safeguarding the rights of consumers, including those on CTOs, to make and participate in decisions about treatment. One consumer spoke of the role her advocate was able to play:

"she [the advocate] never took any of the power and control away from me. So, she heard, she gave me options ... and she didn't make assumptions about what I needed."³⁵

³² Daniel Van der Pluym, *Consultation Report - Supported Decision Making under the Mental Health Act 2014: What Consumers Want* (May 2016) 7.

³³ Both under Victoria law (*Mental Health Act 2014* (Vic) s 11) and the *Convention on the Rights of Persons with Disabilities*.

³⁴ IMHA Evaluation Report, above n 8, 18.

³⁵ See *ibid*. See also the accompanying response to the question on notice regarding any difference in outcomes before mental health tribunals when a person has legal representation.

Clients and consumers often tell us that when they do express their views and preferences, these are ignored by their treating team or psychiatrist. Preferences for medication, such as oral medication over the injectable form, or changes to medication due to side effects are issues which are commonly referred to an IMHA advocate to enable the consumer's voice to be heard.

They are also often the basis of submissions that our lawyers make at the Tribunal, where the consumer's treating team is reluctant to accept that the person's preferred medication or treatment regime would be a viable less restrictive alternative.

Importantly, in hearings where the Tribunal ultimately revokes a person's treatment order, the most common reason for doing so is that treatment is able to be provided in a less restrictive manner.³⁶

b. Compulsory orders undermine engagement for some consumers

It is important to appreciate the diversity of consumers' experiences of compulsory treatment. The impact of a CTO on a consumer may vary depending on a range of factors, such as:

- The nature and quality of the relationship with their treating team;
- Their past experiences of compulsory and voluntary mental health treatment;
- Experiences of past trauma or abuse;
- Their recovery goals and the outcomes they want to achieve;
- Their geographical proximity to the community mental health service;³⁷
- The extent to which their cultural, linguistic and other individual needs and circumstances are acknowledged and responded to;³⁸
- The extent to which they have been supported to and are participating in decisions which affect them;
- The extent to which they have had their rights explained and been supported to exercise these rights; and
- The nature of any other supports, clinical or otherwise.

In our experience, CTOs do not necessarily result in better or more therapeutic engagement with mental health services, and can have the opposite effect.³⁹

Trust can be eroded where the service does not trust the consumer to comply or engage with treatment voluntarily, or the consumer does not trust the service to respect their dignity and rights and is therefore reluctant to be open and honest about their circumstances. Most significantly, the fear and trauma associated with compulsory treatment can mean consumers and their families avoid rather than seek out treatment and support from mental health services.

As we highlighted in *Roads to Recovery*:

"We often see consumers who have presented to mental health services voluntarily and have subsequently been made compulsory patients and subject to unwanted and restrictive treatment. These consumers report to us that this experience makes them less likely to seek out

³⁶ Mental Health Tribunal, *Annual Report 2018–2019*. This was a reason cited for revocation of orders in hearings initiated: within 28 days of the person being made subject to a temporary treatment order (69% of cases); by the treating team's application for a further treatment order (78% of cases); and by the person's own application for revocation (59% of cases). Unfortunately the Tribunal does not publish separate data for community and inpatient orders in this respect.

³⁷ See, for example Betty's story in *Roads to Recovery*, above n 31, 61.

³⁸ The need for tailored and culturally safe mental health services is discussed in part 5.2 of *Roads to Recovery*.

³⁹ See, eg, Lisa Brophy et al 'Community Treatment Orders and Supported Decision-Making', *Frontiers in Psychiatry* (2019) and Lisa Brophy et al 'The experience of the use of Community Treatment Orders following recovery-oriented practice training' *International Journal of Law and Psychiatry* (64) (2019) 178-183.

*support from mental health services in the future. Our client PBU is an example of a consumer who initially sought out services on a voluntary basis only to be subsequently made subject to a compulsory order and subjected to highly restrictive treatment in the form of compulsory electroconvulsive treatment.*⁴⁰

In considering people's experiences of CTOs, it is important that the Commission considers the mechanisms for making sure the consumer plays an active role in decision-making, and having their views and preferences heard and respected. As it stands, our practice experience indicates that these mechanisms are not consistently working as they should, which can contribute to over-reliance on more restrictive treatments and to reluctance by consumers and their families to seek out assistance in future.

⁴⁰ Roads to Recovery, above n 31.

Court diversion programs and people getting the mental health or psychosocial support services they need

Introduction and overview

At the Productivity Commission's Public Hearing into Mental Health on 18 November 2019, Louise Glanville, CEO of Victoria Legal Aid (VLA), was asked by the Productivity Commission about VLA's experience with diversion programs and people being able to get the mental health support services they need.¹

VLA provides criminal law services at 15 offices throughout Victoria. Each office, except for the Mallee Regional Office,² provides duty lawyer services to the Magistrates' Courts in their region for people facing criminal charges. As such, VLA's experience with clients' access to mental health or psychosocial supports through court diversion programs varies widely. There are wide differences in the resourcing and staffing of diversionary programs throughout the state. There are some regions where there is little or no access to therapeutic responses to the criminal justice system by way of court diversion programs.³

VLA has a specialist Therapeutic Courts and Programs team within our criminal law practice. This includes lawyers who represent clients before the Assessment and Referral Court (ARC) at Melbourne, Frankston, Moorabbin and Latrobe Valley, Drug Court lawyers based at Dandenong and Melbourne, and lawyers who work at the Neighbourhood Justice Centre (NJC) in Collingwood.

We refer to our submission to the Royal Commission into Victoria's Mental Health System, *Roads to Recovery: Building a Better System for Victorians Experiencing Mental Health Issues (Roads to Recovery)*, and in particular to part 3.2, in which we set out the benefits of people with mental health issues having access to therapeutic responses to criminal offending.⁴

This response focuses on our experience with people being assisted with mental health and psychosocial supports through the following therapeutic courts:

- ARC;
- Drug Court; and
- NJC.

We will also outline our experience with the following court-based services:

- Mental Health and Response Services (MHARS); and
- Court Integrated Services Program (CISP).

¹ Productivity Commission, Public Hearing into Mental Health, Transcript 18 November 2019, Evidence of Louise Glanville, CEO Victoria Legal Aid, 28-29 (Commissioner Abramson).

² The Mallee Regional Office in Mildura is VLA's first Health Justice Partnership, undertaking primarily civil justice and child protection legal work. See Victoria Legal Aid, *Mallee region to benefit from health justice partnership* (2016) <<https://www.legalaid.vic.gov.au/about-us/news/mallee-region-to-benefit-from-health-justice-partnership>>.

³ Productivity Commission, *Mental Health, Draft Report* (October 2019) 592 – 'Definition of key terms - 'Court diversion program: a program that allows magistrates... to adjourn matters while defendants engage in support services. Diversionary programs provide services for people who have been accused or convicted in the summary jurisdiction, who require assistance with addiction or mental health' (**Draft Report**).

⁴ Victoria Legal Aid, *Submission to the Royal Commission into Victoria's Mental Health System – Roads to Recovery: Building a Better System for Victorians Experiencing Mental Health Issues* (July 2019) (**Roads to Recovery**) <www.legalaid.vic.gov.au/roadstorecovery>.

This response does not address the Magistrates' Court Criminal Justice Diversion Program, but we note this program does not provide any support services itself.

Assessment and Referral Court (ARC)

Overview and eligibility

ARC is currently the only dedicated mental health court in Victoria, developed in recognition that individuals with mental health issues are more likely to appear before the courts and be imprisoned.⁵ ARC commenced in 2010 in the Melbourne Magistrates' Court and now sits at additional locations in Frankston, Moorabbin and has recently expanded to courts in Gippsland.⁶ Because of limited coverage across the state, the number of people who have access to ARC remains relatively low.⁷ In some locations there are waiting lists for eligibility assessments and ongoing staffing shortages that can limit both access to ARC and the level and timing of support received by participants.

To be eligible for ARC, a person needs to meet the following criteria:⁸

- the *diagnostic* criteria of having either one or more of the following conditions: a mental illness, intellectual disability, acquired brain injury, autism spectrum disorder, or a neurological condition including dementia;
- the *functional* criteria of having a substantially reduced capacity in self-care, self-management, social interaction or communication; and
- the *needs* criteria that the person would derive benefit from receiving coordinated services.

ARC is a pre-sentence program, with sentencing deferred until after the ARC episode is complete. ARC recognises that recovery takes time and requires a collaborative and multidisciplinary approach that works towards a common goal.⁹

Whilst previously people charged with a serious, sexual or violent offence were not eligible for ARC,¹⁰ the court is now able to accept referrals for people seeking to access ARC and charged with offences of this nature.¹¹

When a person enters ARC, an Individual Support Plan is created that sets out the participant's goals, especially in relation to their offending behaviour, mental health and any substance use. These plans may also include broader life goals such as study and work, community participation, and access and reconnection with family members. This provides a common vision and framework to guide the therapeutic response over a person's involvement in the program (which usually lasts for 12 months).

ARC is a specialist case management list, not an integrated court or a service provider. It relies on linking people with existing service providers in the community and does not provide its own mental health, psychosocial or other support.

⁵ Brianna Chesser and Kenneth H Smith, 'The Assessment and Referral Court List Program in the Magistrates Court of Victoria: An Australian study of recidivism', (June 2016) 45 *International Journal of Law, Crime and Justice* 141 (Chesser and Smith).

⁶ Magistrates' Court of Victoria, *Annual Report 2018 – 2019 22 (MCV Annual Report 2018–19)*. The expansion to the Korumburra, Wonthaggi, Sale and Bairnsdale courts in Gippsland has been delayed due to difficulties recruiting ARC clinicians.

⁷ *Ibid* 47. In 2018-2019, there were 323 referrals to the ARC List, with 124 participants being found suitable. This compares with 3967 referrals to CISP in the same period, with 2112 participants being accepted.

⁸ *Magistrates Court Act 1989 (Vic)* s 4T.

⁹ A more detailed description of ARC is in part 4.2 of Magistrates' Court of Victoria, *Submission to the Royal Commission into Victoria's Mental Health System* (July 2019) 11 (MCV Royal Commission Submission).

¹⁰ See Draft Report, above n 3, 612.

¹¹ There are no legislative exclusions based on offence type. Matters in the Sex Offences List need to first be approved for referral to ARC by a Magistrate in that List. People charged with indictable offences, triable in the committal stream, must first have their application for summary jurisdiction approved before the matter can be referral to ARC.

Our experience

In the 2018–19 financial year, VLA provided 1,029 ARC services across all ARC locations. This is a significant increase on the 615 services provided in the prior financial year, in part due to the expansion of ARC to Gippsland.

VLA sees the way that ARC successfully diverts clients away from deeper entrenchment in the criminal justice system. After successful completion of the program, participants can be discharged by the court,¹² meaning that they can move on with their lives without an order hanging over their head or a criminal record.

Therapeutic courts have the common benefit of more time and stronger relationships between the participant, the Magistrate, the prosecution, support workers and the legal team. This can have strong therapeutic benefits for participants.

VLA has assisted many clients in ARC and has seen a number of people transform their lives over the time they have been participating in the program.¹³ We would encourage the Commissioners to watch this short video of our client Edwin and his mother Jane talking about their experience with the ARC program: <https://www.legalaid.vic.gov.au/about-us/strategic-advocacy-and-law-reform/access-to-justice-for-people-with-mental-illness-and-disability/roads-to-recovery-building-better-system-for-people-experiencing-mental-health-issues-in-victoria/edwins-story>.

Therapeutic courts also have the potential to assist in the resolution of other intersecting legal and social issues.

Evaluation and outcomes

An evaluation concluding that completion of the ARC program results in lower rates of recidivism.¹⁴ External evaluations demonstrate that therapeutic courts are effective in achieving their aims.¹⁵

The Victorian Ombudsman made a recommendation to expand therapeutic courts such as ARC so they are accessible to all people in the criminal system significantly impacted by mental health issues, regardless of their location.¹⁶

Neighbourhood Justice Centre (NJC)

Overview and eligibility

The NJC, founded in Collingwood in the City of Yarra in 2007, refers to itself as a 'one stop justice centre'¹⁷ with mental health, drug and alcohol, financial counselling and other services all co-located with the court. It is the only court of its kind in Victoria.

¹² *Magistrates' Court Act 1989* (Vic) s 4U(2)(d) provides a specific power to discharge the accused.

¹³ See for example the stories of Edwin and 'Belinda' in Roads to Recovery above n 4, part 3.2.2.

¹⁴ Chesser and Smith above n 5.

¹⁵ *Ibid.*

¹⁶ Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria* (September 2015) 153 (**Victorian Ombudsman's investigation into reintegration of prisoners**).

¹⁷ Neighbourhood Justice Centre, 'What we do' (Webpage) <<https://www.neighbourhoodjustice.vic.gov.au/about-us/who-we-are/what-we-do>>.

NJC eligibility requires that a person:

- reside in the City of Yarra, including homeless people in crisis or transitional accommodation in the City of Yarra;
- be homeless and have allegedly committed an offence in the area; or
- be an Aboriginal person who can demonstrate close connection with the City of Yarra and the offence is alleged to have occurred in the City of Yarra.¹⁸

The Neighbourhood Justice Officer engages people including those with mental health issues in a problem-solving meeting. This therapeutically based approach allows clients to be part of the problem-solving approach and there is evidence of its success.¹⁹ NJC clients with mental health issues are managed by the Neighbourhood Justice Client Services Team which comprises expert service providers.²⁰

At the NJC, there is a dedicated Mental Health Liaison Representative from St Vincent's Mental Health Service (**SVMHS**), who is based at the court. To be eligible to receive services it is not necessary that a person be diagnosed with a mental health condition. The SVMHS Representative provides case management, short term counselling, support, assessment and referral to mental health services.²¹ The SVMHS is available to all NJC clients, including those in custody. Because the service is available to support a person in custody, it can be included as a condition of bail in order to support a person on their release from custody.

The SVMHS on-site mental health clinicians are able to provide assessment reports,²² case management, summaries of current and previous treatment at area mental health services and referrals. The availability of such a service empowers the court to divert people away from the criminal justice system and approach the role of sentencing of people in a more therapeutic way. The court can make engaging with the mental health clinician a condition of a diversion, an adjourned undertaking and a deferral of sentence. The service is also available in appropriate circumstances to support a person to satisfy conditions of a Community Corrections Order (**CCO**) in relation to mental health treatment.

The NJC also has an outreach mental health support service provided by NEAMI National which, similarly to the SVMHS role, provides non-time limited case management and support to clients with a history of mental health issues, intellectual disability or cognitive impairment. This role was created by the NJC to provide support for clients who required either additional supports to those provided by clinical mental health services or those with less acute needs who would be best supported in the non-clinical community mental health sector. This role, similarly, to the SVMHS role, is funded by the NJC and provides intensive support and service coordination to clients in both the pre- and post-finalisation period. Our lawyers indicate this role has a significant benefit in supporting successful completion of CCOs for people who might otherwise struggle.

Our experience

In the 2018–19 financial year, VLA provided 518 NJC services, down from 539 services provided in 2017–18.

Our lawyers see first-hand the benefits of integrated services to clients' legal outcomes, as well as other intersecting issues.

¹⁸ *Magistrates' Court Act 1989* (Vic) s 40.

¹⁹ MCV Royal Commission Submission above n 9 details a successful client story at 21.

²⁰ *Ibid* 20.

²¹ <https://www.neighbourhoodjustice.vic.gov.au/our-services/support/mental-health>

²² This saves the delay and cost often associated with obtaining an assessment report.

Evaluation and outcomes

An Australian Institute of Criminology Study compared 187 NJC clients against a control group from another Magistrates' Court.²³ This found that the rate of recidivism for NJC clients was 25 per cent lower than by comparison with Magistrates' Courts where no therapeutic program was available. When comparing the rate of recidivism for NJC clients accessing mental health services, with a matched cohort from the mainstream Magistrates' Court, NJC clients were 22 per cent less likely to re-offend.

The Drug Court of Victoria

Overview and eligibility

In 2018–2019, there were 236 referrals to the Drug Court, with 155 new drug treatment orders imposed at Dandenong and 86 at Melbourne.²⁴

Therapeutic responses are also available through the Drug Court of Victoria for people with addiction to alcohol and drugs. The majority of Drug Court participants also identify as having a mental health condition.²⁵

To be eligible to participate in Drug Court, the person must:

- be dependent on drugs and / or alcohol that contributed to their offending;
- be facing an immediate term of imprisonment not exceeding two years;
- be facing charges that are not sexual offences or involve the infliction of actual bodily harm unless minor in nature;
- not be subject to a parole order or sentencing order of the County or Supreme Court; and
- plead guilty to the offence(s).

Importantly for its success, Drug Court participants are supported to secure stable housing, with dedicated housing pathways. As stable housing is a pre-requisite for many health and wellbeing improvements, the improved housing outcomes that Drug Court facilitates are considered to be a very positive element of Drug Court.²⁶

Drug Court requires intense involvement from participants, including weekly meetings with their Corrections case officer, drug counselling with an addiction medicine specialist, frequent onsite drug testing and engagement with a clinical advisor. If other needs are identified, including housing, physical and mental health and culturally specific supports, referrals and intensive follow-up are provided.

Our experience

VLA provided 4,370 Drug Court services across all locations in the 2018–19 financial year, up from 3,799 services provided in the previous financial year.²⁷

Evaluation and outcomes

The Drug Court can address the underlying causes of addiction, provide strict ongoing supervision and incentive programs, and allow for more flexible and effective sentencing options. It is noted that improvement to overall health (including mental health) is an expected outcome from participation in

²³ Stuart Ross 'Evaluating neighbourhood justice: Measuring and attributing outcomes for a community justice program', 499 *Australian Institute of Criminology: Trends & Issues in crime and criminal justice* (November 2015).

²⁴ MCV Annual Report 2018–2019 above n 6, 22.

²⁵ MCV Royal Commission Submission above n 9, 16.

²⁶ KPMG, *Evaluation of the Drug Court of Victoria* (December 2014) 65 (**Drug Court Evaluation**).

²⁷ The intensive nature of Drug Court requires many more court appearances than mainstream Magistrates' Court matters, which accounts for the high number of services provided compared to the number of Drug Court participants.

Drug Court. An evaluation of the Drug Court in 2014, found that there was declining psychiatric risk in participants in the phase 2 and 3 stages of the program and participants also reported improved mental health.²⁸ The evaluation also found that the two-year recidivism rate for the Drug Court is 34 per cent lower than the mainstream justice system.

Court Integrated Services Program (CISP)

Overview and eligibility

As outlined in the Productivity Commission Draft Report,²⁹ the CISP program is a pre-trial or bail program that is utilised by people in custody, on bail or summons. It can attach as a condition of bail at the time of release from custody at court or be added as a condition of bail to a person who is assessed as suitable and is in the community.³⁰

Currently, CISP is available in eight of 10 metropolitan courts (not available in the Werribee Magistrates Court or the NJC) and 12 of 41 regional courts.³¹ There are no categories of offences that automatically exclude a person's eligibility for the program, however there are situations where leave of the court is required prior to a person being considered for an assessment.³²

CISP provides case management and coordinates referrals to external treatment and support services, but does not provide these services directly.

There are commonly delays of days to weeks for people in custody seeking an assessment as to CISP suitability, although the CISP Remand Outreach Pilot³³ is geared at assessing the eligibilities of remandees. Recent research finds that 'most CISP sites are running at full capacity'.³⁴ There can also be significant delays in referrals to psychosocial supports such as appointments with psychologists, particularly for people in regional Victoria, where there can be a lack of allied services in the region.³⁵

The Atrium Housing and Support Program is a recent pilot program that is coordinated through CISP, currently offering supported housing as part of a pilot operating at Melbourne Magistrates' Court.³⁶ Eligibility is limited to people applying for bail at the Melbourne Magistrates' Court, with high and or complex criminogenic needs and difficulty securing and maintaining housing. The program excludes people charged with offences involving unprovoked serious violence, trafficking or any serious sexual violence. A person needs to be firstly found suitable for CISP to be referred to Atrium. Participants are bailed with a condition to reside at Atrium accommodation with ongoing CISP case management. Eligible participants receive access to supported short term housing, transition to medium- and long-term accommodation, case support and intensive alcohol and drug treatment.

²⁸ Ibid.

²⁹ Draft Report above n 3, 614.

³⁰ Courts tend to attach a CISP condition either at the conclusion of a successful bail application or at the time that pleas of guilty are entered by a person on bail or summons, where a person requires community supports. CISP usually lasts for four months and the person may be required to appear at court each month and a progress report is prepared for the court to update the persons engagement with CISP. Our experience is that the program works best where a Magistrate remains part heard throughout the entire process, noting that this does not always occur pre-trial, in cases where a person is bailed from custody by the court. Ideally, Magistrates should be part heard in CISP matters to ensure there is proper engagement between the court and the client.

³¹ CISP is available at Ballarat, Bendigo, Geelong, Korumburra, La Trobe, Mildura, Portland, Shepparton, Warrnambool, Wangaratta, Wodonga and Wonthaggi <<https://www.mcv.vic.gov.au/find-support/bail-support-cisp>>.

³² This includes situations where a person is currently on a Community Corrections Order. CISP is also unable to case manage people on parole.

³³ MCV Royal Commission Submission above n 9, 14.

³⁴ Angelica Panopoulos, *The recent changes to bail laws in Victoria and the consequences for the justice system*, Victorian Parliamentary Internship Program, (October 2019) 26.

³⁵ Specifically, CISP in Horsham and Warrnambool is noted as having these issues.

³⁶ MCV Annual Report 2018-19 above n 6, 22.

Our experience

Our lawyers regularly refer people to Victoria's CISP for mental health and psychosocial support. Our lawyers see how hard it is for people to rehabilitate from drug use, receive help for mental health issues or find steady employment and housing without having strong holistic supports. CISP provides access to multi-disciplinary supports.

Our experience is that CISP can also be given significant weight as a sentencing consideration by the court and successful completion of the program can result in improved court outcomes.

Evaluation and outcomes

As noted in the Draft Report, a 2009 evaluation of CISP showed recidivism of 35.9 per cent compared to 49.5 per cent in the control group.³⁷ A 2011 audit of the evaluation concluded that the methodology was sound and CISP was shown to reduce recidivism.³⁸

In 2014 the Victorian Auditor-General Report noted that CISP provides the largest number of support places for people with a mental health issues and other needs in the Magistrates' Court, and that substance abuse and mental health issues were the two most common reasons for referral to CISP. The Report found that the number of clients accepted to CISP and CREDIT/Bail has declined from 2009–10 to 2013–14. This was attributed to the increasing complexity of cases correspondingly reducing the number of clients which can be accepted.³⁹

Mental Health and Response Service (MHARS)

Overview and eligibility

MHARS is an initiative developed to provide court-based clinical mental health advice to improve the appropriateness of mental health interventions and referrals for people appearing before the Court, and to reduce delays in court proceedings.⁴⁰ MHARS provides assessments, advice and referrals, not ongoing treatment or support services.

MHARS is delivered by Forensicare at eight metropolitan courts in Melbourne⁴¹ and by local area mental health services in five regional courts.⁴² A MHARS service operated by Orygen Youth Health commenced at the Melbourne Children's Court in May 2019.⁴³

Magistrates, Corrections Victoria staff and legal practitioners refer clients to MHARS to conduct mental health assessments and provide clinical advice to the court. MHARS staff can access mental health databases and an individual's mental health history and compile a summary. This can be used by lawyers in advising clients and Magistrates to inform sentencing decisions and court processes. This can be useful for lawyers wishing to recommend a client for the court diversion program. People being assessed for suitability for a Community Corrections Order may be referred to MHARS to clarify a mental health diagnosis and the appropriateness of attaching a condition for mental health treatment to that order.

³⁷ Department of Justice/Pricewaterhouse Coopers, *Economic Evaluation of the Court Integrated Services Program (CISP)* (2009) cited in the Draft Report above n 3, 614.

³⁸ Victorian Auditor-General's Report, *Problem-Solving Approaches to Justice* (2011).

³⁹ Victorian Auditor-General's Report, *Mental Health Strategies for the Justice System* (2014).

⁴⁰ MCV Royal Commission Submission, above n 9, 24.

⁴¹ These services are available at Melbourne, Ringwood, Broadmeadows, Dandenong, Sunshine, Heidelberg, Frankston and Moorabbin Magistrates Courts. <https://www.forensicare.vic.gov.au/our-services/community-forensic-mental-health-services/court-mental-health-response-service/>

⁴² Ballarat Health Services (Ballarat), Bendigo Health (Bendigo), Goulburn Valley Health (Shepparton), Latrobe Regional Hospital (Morwell) and Barwon Health (Geelong).

⁴³ Children's Court of Victoria, *Annual Report 2018 – 2019*, 12

MHARS serves an important role in providing relevant mental health information to the court. This can be especially pertinent to the court in deciding an application for bail for a person with mental health issues who is in custody. Commonly, people in custody can present with complex issues that require assessment by MHARS. In these situations, the ability of MHARS to access a person's history with the mental health system is invaluable. This can ensure that a person's needs for mental health support can be met if they are to remain in custody.

Our experience

VLA is reliant on MHARS to provide mental health information about people before the court. The capacity for MHARS to provide a summary of a person's past engagement with mental health services can be critical for a matter to dealt with on the day, avoiding delays for further information to be obtained and provided to the court.

However, MHARS only provides a limited information provision service, rather than any case management of clients before the court. While there is widespread acknowledgement of the importance of early intervention through linking people to services,⁴⁴ our experience is that there can be lengthy delays with clients being able to access mental health and psycho-social treatment. A service which could provide care planning and link clients promptly with locally based services that are connected and responsive to the court and the client, could have significant benefits.

Opportunities to increase the impact of therapeutic courts and diversion options in Victoria

There are a number of factors which currently limit the full potential of therapeutic courts and diversion options in Victoria, including geographical limitations, eligibility, resourcing and capacity limitations and reliance on existing services.

None of the therapeutic courts or services outlined are available at all Magistrates' Courts statewide,⁴⁵ despite many having been positively evaluated.⁴⁶ For example, CISP, the most widely available court-based service, is available in fewer than half of all courts across the state. Positively, following a successful pilot in Dandenong, Drug Court has been expanded to Melbourne Magistrates' Court. Similarly, ARC has expanded to Moorabbin and Frankston and is in the process of expanding to multiple courts across Gippsland, however difficulties recruiting suitably qualified ARC case managers has slowed this expansion.

While ARC, NJC, Drug Court and CISP can all provide some case management, our experience is that there are people who fall through the cracks because they are unable to receive ongoing assistance through the local area mental health services.

There could be a real benefit in mental health clinicians being able to provide mental health support through more intensive case management or being more actively involved in following up referrals for people to relevant support services in the community, to prevent them falling deeper into the criminal justice system. As an example we note the success of the locally based youth specialist service Youth

⁴⁴ For example, in its submission to the *Royal Commission into Victoria's Mental Health System* (July 2019), Forensicare stated that there should be a focus on diverting minor offenders early in their contact with the criminal justice system, and that opportunities for diversion into treatment need to be prioritised, 26.

⁴⁵ See MCV Royal Commission Submission, above n 9, Appendix 1 for a list of specialist courts and programs by location.

⁴⁶ For evaluations of other therapeutic courts see for example: Drug Court Evaluation above n 26; Department of Justice, *The Drug Court: an Evaluation of the Victorian Pilot Program* (2005); Zoe Dawkins et al, *County Koori Court* (Final Evaluation Report, County Court of Victoria and the Department of Justice, 27 September 2011); Mark Harris, *A Sentencing Conversation: Evaluation of the Koori Courts Pilot Program, October 2002–October 2004* (Department of Justice Victoria, 2006); Stuart Ross, 'Evaluating neighbourhood justice: Measuring and attributing outcomes for a community justice program', 499 *Australian Institute of Criminology: Trends and Issues in Crime and Criminal Justice*, (2015); Anthony Morgan and Rick Brown, 'Estimating the costs associated with community justice', 507 *Australian Institute of Criminology: Trends and Issues in Crime and Criminal Justice* (2015). See also Victorian Ombudsman, *Investigation into the reintegration and rehabilitation of prisoners in Victoria* (September 2015).

Junction Inc at the Visy Hub in Sunshine, which operates pre-sentence programs for young adults up to 25 years old. An independent evaluation by PricewaterhouseCoopers in December 2018 found that the program was highly successful, with 74 per cent completion rate, compared with the 42 per cent completion rate for a CCO.⁴⁷

Whilst services such as CISP exist to assist clients with community support, we note that there is no specific bail support for people with mental health issues.⁴⁸ In our experience, lack of access to diversionary options through CISP reduces opportunities for our clients to get bail and treatment in the community.

The current eligibility criteria for Drug Court exclude those with both lower level and more serious offending from participating in and therefore benefiting from the Drug Court. The experience of our lawyers is that it is not uncommon for people with substance dependence to cycle in and out of court on low level offences which do not attract imprisonment, such as possession and low value theft or damage. Similarly, many people whose substance dependence-related offending is dealt with in the County Court could benefit from the intensive supervision that Drug Court offers.

Of the courts and services outlined above, only NJC is able to provide mental health support directly. The others rely on referrals to existing external mental health services.

Only Drug Court (and the Atrium pilot, outlined above) provide ongoing housing support, despite housing being persistently recognised as a key factor in improved mental health and rehabilitation. Lack of access to stable housing can keep people in custody, who may otherwise have obtained bail.

⁴⁷ The evaluation also calculated that the cost of the successful completion of the program was about \$3000 per client, compared with \$24741 per client for a successful CCO completion: Kerry Cowling, 'Transitional Transformation: Interventions that Work for Young Adults (18-25 years) Involved in the Criminal Justice System' (Conference Paper, International Criminal Law Conference, 20 November 2019).

⁴⁸ The Magistrates' Court of Victoria recommends the creation of a specialist bail program to be linked with CISP for people with mental illnesses. See MCV Royal Commission Submission, above n 9.

Mental health issues and the experience of civil legal issues

Introduction and overview

At the Productivity Commission's Public Hearing into Mental Health on 18 November 2019, Louise Glanville, CEO of Victoria Legal Aid (VLA), was asked by the Productivity Commission about the experience of civil legal issues for people experiencing mental health issues.¹

Informed by our practice experience, this response sets out information about the experience of the following civil legal issues for people experiencing mental health issues:

1. Housing and eviction;
2. Family violence and family law;
3. Child protection;
4. National Disability Insurance Scheme;
5. Social security;
6. Discrimination;
7. Fines and infringements;
8. Guardianship, administration and compulsory mental health treatment; and
9. Visas and immigration.

Civil legal issues and mental health

During 2018–19, VLA provided legal services to over 100,000 unique clients across the state. One quarter of these people identified as having a disability or mental health issue.²

Our Civil Justice program advocates for equality, enables people to protect their rights and promotes accountability of systems. Together with our partners in the legal and community sectors, and with our clients and consumers at the centre, we use the law so people can access justice and secure better, fairer outcomes in relation to issues that affect their lives, including their housing, income, mental and physical health, visa status and ability to live and work free from discrimination.

Our Family, Youth and Children's Law program assists people to resolve their family disputes to achieve safe, workable and child-focused parenting and care arrangements.

Through our work, we see the two-way relationship between mental health issues and legal problems – not only do legal problems exacerbate mental health issues, but people experiencing mental health issues are significantly more likely to experience legal problems.³ This was supported by the findings of the *Legal Australia-Wide Survey: Legal Need in Australia (LAW Survey)*, which identified that over 60 per cent of participants who reported experiencing at least six legal problems also reported having a mental health issue.⁴

¹ Productivity Commission, Public Hearing into Mental Health, Transcript 18 November 2019, Evidence of Louise Glanville, CEO Victoria Legal Aid, 33: 'Just the civil side of your work. Like we focused on the criminal side in our conversation this morning, but the evidence that we found was that people with mental ill-health were likely to have more issues in the civil side. You touched on housing, so your work in that area would be interesting to us' (Commissioner Abramson).

² Victoria Legal Aid, *Annual Report 2018 – 2019 (VLA Annual Report 2018–19)* <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-2018-19-annual-report.pdf>>.

³ Christine Coumarelos on behalf of the Law and Justice Foundation of New South Wales, *Legal Australia-Wide Survey: Legal Need in Australia* (August 2012) 28, citing Pascoe Pleasence and Nigel Balmer, 'Mental Health and the Experience of Social Problems Involving Rights: Findings from the United Kingdom and New Zealand' *Psychiatry, Psychology and Law* 16(1) (2009).

⁴ Ibid 25.

This response sets out further information in relation to key civil legal issues affecting VLA clients who experience mental health issues. We have not reproduced existing content, but rather identify reports and resources that provide more information about the experience of the following civil legal issues for people experiencing mental health issues:

1. **Housing and eviction.** In 2017–18, VLA assisted over 1,000 people who were experiencing homelessness and identified as having a mental health issue or disability. Through our work with clients at risk of or experiencing homelessness, we see the impact of housing instability and homelessness on people’s mental health, including access to treatment and recovery; the greater risks of eviction for people experiencing mental health issues; and the barriers to getting safe, affordable housing, including because of low incomes, discrimination, and an acute shortage of affordable housing.⁵ Housing and eviction legal issues, and the intersections with mental health, are discussed in:
 - VLA submission to the Commission’s Inquiry into the Economic Impact of Mental Ill-Health, *Intersections Between Mental Health and the Legal System and Impacts for People and Communities (VLA Productivity Commission Submission)*, part 4.1;⁶ and
 - VLA submission to the Royal Commission into Victoria’s Mental Health System, *Roads to Recovery: Building a Better System for Victorians Experiencing Mental Health Issues (Roads to Recovery)*, part 4.1.⁷

2. **Family violence and family law.** Through our work, and extensive research, we know that women with disability and mental health issues are disproportionately victims of family violence.⁸ Consequently, they are more likely to have contact with the family law, family violence, and/or child protection systems if not appropriately supported at an early stage. These legal issues, and the inadequate understanding of the ways in which family violence and mental health issues can intersect, are discussed in:
 - VLA Productivity Commission Submission, part 2;
 - Roads to Recovery, part 4.4;
 - VLA submission to the Joint Select Committee on Australia’s Family Law system;⁹
 - VLA submissions to the Australian Law Reform Commission Family Law Inquiry;¹⁰
 - VLA submission to the Victorian Royal Commission into Family Violence;¹¹ and
 - VLA submission to the Family Law Council – families with complex needs inquiry.¹²

⁵ In 2011, the Victorian Department of Health and Human Services estimated that it costs around \$34,000 in publicly funded support services to rehouse someone following eviction from public housing: Victorian Department of Human Services, *Human Services: The Case for Change* (Report, 2011) 12 <https://www.thelookout.org.au/sites/default/files/1_iwas_human_services_case_for_change_0412.pdf>.

⁶ Victoria Legal Aid, *Submission to the Productivity Commission’s inquiry into the Economic Impact of Mental Ill-Health: Intersections between mental health and the legal system and the impacts for people and communities* (April 2019) 31-33 <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-submission-to-the-productivity-commissions-inquiry-into-the-economic-impact-of-mental-ill-health-april-2019.docx>>.

⁷ Victoria Legal Aid, *Submission to the Royal Commission into Victoria’s Mental Health System – Roads to Recovery: Building a Better System for Victorians Experiencing Mental Health Issues* (July 2019) <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-submission-roads-to-recovery-july-2019.docx>>.

⁸ Women with Disabilities Victoria, *Royal Commission into Family Violence Submission* (June 2015) 4 <[http://www.rcfv.com.au/getattachment/204CC2CA-1899-483F-925E-3DA0F0F348C9/Women-with-Disabilities-Victoria-\(WDV\)>](http://www.rcfv.com.au/getattachment/204CC2CA-1899-483F-925E-3DA0F0F348C9/Women-with-Disabilities-Victoria-(WDV)>).

⁹ Victoria Legal Aid, *Submission to the Joint Select Committee on Australia’s Family Law System* (December 2019).

¹⁰ Victoria Legal Aid, *Submission to the Australian Law Reform Commission Review of the Family Law System Discussion Paper* (May 2018) <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-submission-to-the-alc-review-of-the-family-law-system-discussion-paper.docx>> and Victoria Legal Aid, *Submission to the Australian Law Reform Commission Review of the Family Law System Issues Paper* (November 2018) <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-submission-alc-review-of-family-law-system-issues-paper.docx>>.

¹¹ Victoria Legal Aid, *Submission to the Victorian Royal Commission into Family Violence* (June 2015) 41-43.

¹² Victoria Legal Aid, *Families with Complex Needs - Submission to the Family Law Council’s terms of reference: Number 1* (April 2015) <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-families-with-complex-needs-submission-family-law-council-terms-of->

3. **Child protection.** In 2018–19, VLA assisted over 2,000 clients with child protection legal matters who identified as having a disability or mental health issue. In the child protection system, we have seen that a mental health diagnosis can be cause for a pre-judgement or assumption that parenting capacity is low. Where a parent has a disability, particularly a cognitive disability or mental health issues, children are removed from their family at a rate greater than where parents do not have a disability.¹³ Child protection legal issues, and their intersection with mental health issues, are discussed in:
- VLA Productivity Commission Submission, part 2;
 - Roads to Recovery, part 4.3.1;
 - VLA report, *Care not Custody: A new approach to keep kids in residential care out of the criminal justice system*;¹⁴
 - VLA submission to the Commission Children and Young People’s inquiry into Child Protection permanency amendments;¹⁵
 - VLA submission to the Joint Standing Committee on the National Disability Insurance Scheme;¹⁶ and
 - VLA submission to the Department of Social Services and the National Disability Insurance Agency’s NDIS ‘Thin Markets’ Project, *Ten Stories of NDIS ‘Thin Markets’: Reforming the NDIS to meet people’s needs (Thin Markets Submission)*.¹⁷
4. **National Disability Insurance Scheme (NDIS).** Together with other legal aid commissions across the country, VLA receives funding from the Department of Social Services to provide legal representation in NDIS matters on appeal before the Administrative Appeals Tribunal (AAT). Since 2013 we have provided legal representation to over 100 people with NDIS AAT appeals. In addition to this specialist NDIS appeals work, through our work with people who are – or should be – NDIS participants, we see the issues that the scheme can present for people experiencing mental health issues. More information about NDIS legal issues, and the intersections with mental health, are discussed in:
- VLA Productivity Commission Submission, part 5;
 - Roads to Recovery, part 4.2;
 - Thin Markets Submission;¹⁸

[reference.docx](https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-submission-to-the-family-law-councils-terms-of-reference-number-2.docx) and Victoria Legal Aid, *Families with Complex Needs- Submission to the Family Law Council’s terms of reference: Number 2* (October 2015) <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-submission-to-the-family-law-councils-terms-of-reference-number-2.docx>>.

¹³ Office of the Public Advocate *Rebuilding the village: Supporting families where a parent has a disability* (Report 2, 2015) <<https://www.publicadvocate.vic.gov.au/our-services/publications-forms/241-rebuilding-the-village-supporting-families-where-a-parent-has-a-disability-report-2-child-protection-2015?path=>>>.

¹⁴ Victoria Legal Aid, *Care not custody, a new approach to keep kids in residential care out of the criminal justice system* (August 2016) <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-care-not-custody-report.pdf>>.

¹⁵ Victoria Legal Aid, *Submission to the Commission Children and Young People’s inquiry into Child Protection Permanency Amendments* (November 2016).

¹⁶ Victoria Legal Aid, *Submission to the Joint Standing Committee on the National Disability Insurance Scheme* (March 2018) 9-10 <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-submission-to-joint-standing-committee-on-the-national-disability-insurance-scheme.docx>>.

¹⁷ Victoria Legal Aid, *Ten Stories of NDIS ‘Thin Markets’: Reforming the NDIS to meet people’s needs*, (June 2019) <<http://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-submission-to-the-ndis-thin-markets-project-june-2019.docx>>.

¹⁸ Ibid.

- The National Legal Aid submission to the Review of the NDIS Act and the new NDIS Participant Service Guarantee, *Putting people first: Removing barriers for people with disability to access NDIS supports*,¹⁹ and
 - Independent Mental Health Advocacy resource booklet, *Self-Advocacy for the NDIS (Mental Health)*.²⁰
5. **Social security.** In 2018–19, VLA assisted over 600 clients with social security matters who identified as having a disability or mental health issue.

Recent years have seen a widening gap between the Disability Support Pension (**DSP**) and Newstart Allowance, and significant hurdles to qualification for the DSP.²¹ These include changes to the impairment tables setting out DSP qualification criteria, and the burden of ‘program of support’ requirements. In addition to a lack of access to adequate income, people are burdened by the approach Centrelink has taken to pursuing people for alleged overpayments. The intersection of mental health issues with poverty and social security is discussed in:

- VLA Productivity Commission Submission, part 4.2;
 - Roads to Recovery, part 4.6; and
 - National Legal Aid submission to the Senate Community Affairs References Committee Inquiry into Centrelink’s Compliance Program, *Rethink Robo-debt: Building a fair and accurate system people can trust*.²²
6. **Discrimination.** VLA’s Equality Law Program provides advice and representation to clients who experience discrimination, sexual harassment, victimisation and vilification in all areas of public life. Over a third of people advised by the Equality Law Program in 2018–19 identified as having a disability or mental health issue. The impact of both discrimination on the basis of a person’s mental health issues, as well as how discrimination and sexual harassment can have a negative impact on mental health, are discussed in:
- VLA Productivity Commission Submission, part 6;
 - Roads to Recovery, part 4.5; and
 - VLA submission to the Australian Human Rights Commission National Inquiry into Sexual Harassment in Australian Workplaces, *Change the culture, change the system: urgent action needed to end sexual harassment at work*.²³
7. **Fines and infringements.** In 2018–19, VLA assisted over 1,000 people with their infringements,²⁴ and infringements were among the top five issues people contacted VLA’s

¹⁹ National Legal Aid, *Putting people first: Removing barriers for people with disability to access NDIS supports* (November 2019) <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-submission-putting-people-first-removing-barriers-for-people-with-disability-to-access-ndis-supports-11-2019.pdf>>.

²⁰ IMHA, *Self-Advocacy For the NDIS (Mental Health) – resource booklet* (August 2019)

<<https://www.imha.vic.gov.au/sites/imha.vla.vic.gov.au/files/imha-self-advocacy-for-the-ndis-accessible-version.docx>>.

²¹ See e.g. ‘Over several years, governments have tightened DSP eligibility requirements ... Successful [DSP] claims have dropped from 63 per cent in 2010 to just 25 per cent in 2015’. Australian Council of Social Service, ‘Disability Support Pension cuts bad news for people affected’ (21 February 2018) <https://www.acoss.org.au/media_release/disability-support-pension-cuts-bad-news-for-people-affected/>.

²² National Legal Aid, *Rethink Robo-debt: Building a fair and accurate system people can trust* (September 2019)

<<https://www.legalaid.vic.gov.au/about-us/strategic-advocacy-and-law-reform/challenging-centrelinks-robodebt-system>>.

²³ Victoria Legal Aid, *Change the culture, change the system: urgent action needed to end sexual harassment at work* (February 2019)

<<https://www.legalaid.vic.gov.au/about-us/strategic-advocacy-and-law-reform/change-culture-change-system-end-sexual-harassment-work>>.

²⁴ VLA Annual Report 2018–19, above n 2, 32. This was a reduction on previous years, as Fines Victoria introduced a new system for processing infringements, which temporarily resulted in a significant drop in matters being enforced. By comparison, in 2017–18, VLA provided over 2,000 advices on infringements matters, and representation at the Magistrates’ Court Special Circumstances List in over 3,000 cases for over 2,000 clients.

Legal Help Chat services about.²⁵ Fines and infringements and their disproportionate impact on people experiencing mental health issues are discussed in:

- VLA Productivity Commission Submission, part 4.4; and
- Roads to Recovery, part 4.6.

8. **Guardianship, administration and compulsory mental health treatment.** VLA provides around 3,000 legal advice services annually to people regarding compulsory mental health treatment. In 2018–19, VLA’s Independent Mental Health Advocacy Service provided over 24,000 occasions of service to people receiving or at risk of compulsory mental health treatment.²⁶ People who experience mental health issues are more vulnerable to having their right to make decisions for themselves removed. The making of a compulsory treatment order, or the appointment of a guardian or administrator to manage a person’s health, lifestyle, legal, or financial decisions involves a significant restriction on a person’s rights, autonomy, and dignity. This is discussed further in:

- VLA Productivity Commission Submission, parts 1, 2 and 4.3;
- Roads to Recovery, parts 3, 4.3.2 and 8;
- VLA’s response to the Productivity Commission to a question taken on notice regarding community treatment orders and how they work for VLA’s clients and consumers; and
- VLA’s submission to the Victorian Ombudsman’s investigation into State Trustees, *State of Trust: Making sure State Trustees protects and promotes the rights of Victorians with Disability*.²⁷

9. **Visas and immigration.** VLA’s Migration Program provides advice and representation to asylum seekers and other vulnerable non-citizens primarily in relation to judicial review of administrative decisions. In 2018–19, VLA provided legal advice on over 1,300 migration matters.²⁸ Both pre- and post-arrival stressors can negatively impact on the mental health of asylum seekers and refugees, as discussed in:

- Roads to Recovery, part 5.2.2.

Mental health, civil legal need and legal assistance

One of the key issues with civil legal issues is that they can often go undetected or are not identified as legal issues. For example, they can be seen as issues to do with money, housing, family, personal relationships or health, rather than as legal issues. The ability to identify these issues as having a legal component, and to make sure people have early access to legal assistance, is crucial for preventing the escalation of legal issues and the impact they have on people’s health and wellbeing.

As identified in the VLA Productivity Commission Submission, the escalation of legal issues and the flow-on costs for individuals and the economy were recognised by the Victorian Access to Justice Review:

“Unresolved civil legal problems, such as those related to a community member’s housing, mental health, employment or family, are recognised as having far reaching consequences for both the individuals involved and the state. For individuals, unresolved legal problems can lead

²⁵ Ibid 18.

²⁶ VLA Annual Report 2018–19, above n 2, 30. IMHA recorded 7,424 high intensity occasions of service (advocacy and self-advocacy) and 17,070 low intensity occasions of service (information and referral).

²⁷ Victoria Legal Aid, *State of Trust: Making sure State Trustees protects and promotes the rights of Victorians with disability* (September 2018) <<https://www.legalaid.vic.gov.au/about-us/news/our-report-for-victorian-ombudsmans-investigation-into-state-trustees>>.

²⁸ VLA Annual Report 2018–19, above n 2.

to diminishing health and restrict social and economic participation, as well as triggering further legal problems, including possible criminal legal issues. These consequences for individuals often generate costs which must be borne by the state, whether in the justice system or in other publicly funded systems.”²⁹

As the Commission has identified, the legal assistance sector is not currently adequately funded to meet legal need.³⁰

Together with our community legal centre and Aboriginal legal service partners, we continue to see the role legal assistance has to play in supporting mental health, including through:

- Protecting and promoting people’s rights and building understanding of rights and options.
- Preventing the escalation of legal issues.
- Reducing the stress that so often accompanies legal issues.

In doing these things, legal assistance, together with essential health and community services, contributes to preventing avoidable homelessness, incarceration, and involuntary treatment, keeping people safe and deescalating disputes and issues, all of which carry heavy costs for people and communities.³¹

²⁹ Victoria State Government, *Access to Justice Review: Summary Report* (2016) 4.

³⁰ Productivity Commission, *Access to Justice Arrangements: Inquiry Report* (2014) 30. See also Victoria State Government, ‘Access to Justice Review: Summary Report’ (Report, 2016) 4 <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-engage.files/9814/8601/7130/Access_to_Justice_Review_-_Summary_and_recommendations.PDF>; Law Council of Australia, ‘The Justice Project Final Report: Legal Services’ (2018) 9, which recommended Commonwealth, State and Territory Governments should invest significant additional resources in Legal Aid Commissions, Community Legal Centres, Aboriginal and Torres Strait Islander Legal Services, and Family Violence Prevention Legal Services to address critical civil, family and criminal legal assistance service gaps. The LCA proposed that this would: return the Commonwealth’s share of LAC funding to 50% with States and Territories (based on a cost estimate by PricewaterhouseCoopers of \$190 million per annum); and implement the Productivity Commission’s 2014 recommendation for an urgent interim injection of \$200 million to provide a reasonable level of civil legal assistance services, pending additional work to determine a longer-term sustainable funding model <<https://www.lawcouncil.asn.au/justice-project/final-report>>.

³¹ See eg, Health Justice Australia, *Mapping a New Path: The Health Justice Landscape* (2018) <<https://www.healthjustice.org.au/wp-content/uploads/2018/08/Health-Justice-Australia-Mapping-a-new-path.pdf>>; Victoria Legal Aid, *Mallee region to benefit from health justice partnership* (2016) <<https://www.legalaid.vic.gov.au/about-us/news/mallee-region-to-benefit-from-health-justice-partnership>>; Mental Health Legal Centre, *Bolton Clark: Project Summary* <<https://mhlc.org.au/our-programs/bolton-clarke/>>; Inner Melbourne Community Legal, *Partners in Care: The benefits of community lawyers working in a hospital setting* (2018) <https://imcl.org.au/assets/downloads/IMCL_report_FA_web.pdf>; Justice Connect, *A Just Life: The role for legal help in building fairer, safer and healthier communities* (2018) <<https://justiceconnect.org.au/wp-content/uploads/2018/06/AJustLifeReport.pdf>>.

Access to services for people leaving prison

Introduction and overview

At the Productivity Commission's Public Hearing into Mental Health on 18 November 2019, Louise Glanville, CEO of Victoria Legal Aid (**VLA**), was asked by the Productivity Commission about VLA's experience of access to services for people leaving custody, both on parole and straight released, and the consequent likelihood of coming back into contact with the criminal justice system.¹

VLA provides the following criminal law services:

- Duty lawyer assistance for people in custody or appearing on bail or summons at Magistrates' Courts across Victoria, at the Melbourne Bail and Remand Court during the weekend and evenings 365 days per year. In 2018–19 VLA provided 67,427 criminal duty lawyer services. Our duty lawyers prioritise serious cases, including people who are in custody or at risk of going into custody, and people who have vulnerabilities;
- Specialist therapeutic courts assistance for clients appearing before the Assessment and Referral Court (**ARC**) at Melbourne, Frankston, Moorabbin and Latrobe Valley, Drug Court lawyers based at Dandenong and Melbourne, and lawyers who work at the Neighbourhood Justice Centre (**NJC**) in Collingwood (Melbourne);
- Specialist youth crime duty lawyer services at Children's Court (criminal division) lists across the state, legal representation for children charged with criminal offences, and weekly youth justice centre outreach to children in detention;
- Legally aided criminal casework for summary and indictable matters. VLA is one of the largest criminal law solicitor practices in Victoria; and
- VLA Chambers, a specialist group of in-house advocates who are briefed to provide in-court representation for clients at all stages, mostly in serious indictable matters.

VLA's criminal lawyers represent some of the most disadvantaged people in Victoria. Many of VLA's clients are socially and economically isolated, have a disability or mental health issue and/or are from culturally and linguistically diverse backgrounds. Of VLA's criminal program clients in 2018–19: 6 per cent self-identified as Aboriginal or Torres Strait Islander, 28 per cent disclosed having a disability or mental health issue, 15 per cent identified speaking a language other than English at home (four per cent required an interpreter, 21 per cent were born outside Australia), 11 per cent had a homelessness indicator, and 29 per cent recorded having no income.² These circumstances increase the likelihood and severity of legal problems and make it more difficult for people to navigate the system without help.

VLA does not specifically provide services for people who are released from correctional facilities and we acknowledge that we are not specialists in post-release services. However, our lawyers often see clients who have been in the criminal justice system for extended periods, and often will provide further legal services to past clients where there is alleged new offending.

¹ Productivity Commission, Public Hearing into Mental Health, Transcript 18 November 2019, Evidence of Louise Glanville, CEO Victoria Legal Aid, 31 (Commissioner Abramson).

² VLA internal data.

This response:

1. Provides our perspective on barriers to staying out of the criminal justice system;
2. Outlines changes to parole and post-release support in Victoria; and
3. Provides an overview of supervised and non-supervised release from custody in Victoria.

1. Barriers to staying out of the criminal justice system

Factors contributing to churn in the justice system

Our lawyers see people with mental health issues in the criminal justice system, often charged with low level offences, who continue to reoffend. This 'churn' is due to a number of factors which contribute to the inability of the mainstream criminal justice system to facilitate meaningful long-term rehabilitation, including:

- The influence of homelessness, poverty, intergenerational disadvantage, adverse childhood experiences, mental health issues, cognitive disability, physical ill health and substance abuse;
- Overcriminalisation of minor offending, including drug possession and begging;
- Inappropriate treatment of people experiencing mental health and substance abuse issues from police as first responders;
- Insufficient use of cautions and diversionary options, particularly for people with intersecting issues such as mental health and substance abuse;
- Lack of statewide access to specialist courts including ARC and the Drug Court;³
- Lack of statewide access to appropriate pre-sentence treatment services, including community mental health supports and residential drug and alcohol rehabilitation;
- Insufficient availability of in-custody programs, which often have very long waiting lists that can often exceed a person's sentence;
- Insufficient transition planning, which should start as soon as people enter the correctional system rather than at the end;
- Poor continuity of services and engagement, largely due to poor communication and information continuity between systems and services (which is critical for continuity of care and for engagement);
- Release without housing, a National Disability Insurance Scheme (**NDIS**) plan in place, transition planning or practical supports; and
- Challenges with ongoing engagement with health and mental health services post-release.

The experience of our current and longstanding client, David, illustrates how some of these issues result in churn in the system.⁴

David is 30 years old. David is a long-standing client with a VLA metropolitan office. At 22 years old, David was sentenced to his first period of imprisonment. Since then he has spent some part of every year either serving a sentence or time on remand for various charges. His drug use has continued throughout this period and his mental health deteriorated. David did not get a neuropsychological assessment until he was 27 years old, which found that he had

³ The benefits of therapeutic courts and court-based services is further discussed in Victoria Legal Aid, *Response to question on notice regarding diversion programs and people getting the mental health or psychosocial support services they need* (January 2020).

⁴ David gave VLA permission to share his story in this response, so we have not changed any details apart from his name.

an acquired brain injury due to his significant drug use and history of overdose as well as experiences of head trauma during assaults and accidents.

David has experienced on and off incarceration for many years and has a long history of heroin overdoses. David's loving and supportive mother is fearful for his future and frustrated that despite his addiction to drugs, he is "thrown in jail" every time he does something wrong. She has seen that over 15 years of addiction, this has solved nothing and hides the problem, because he does not recover in custody and reoffends when he is released.

David first used drugs at the age of 12, trying cannabis and then dabbling in speed and ecstasy and became dependent on heroin by the age of 17. His first contact with the criminal justice system was when he was 18 years old. By the age of 20, David had received a community based order from court for breach of an intervention order and other charges.

David most recently spent June to September 2019 in custody for charges which related to a suicide attempt. David was refused bail at his arrest in June because he had no stable accommodation and a pharmacotherapy bed could not be secured at a residential rehabilitation unit earlier than September. David resided at the residential rehabilitation unit for five weeks until October 2019. However, he felt unable to stay, and since he left, has been hospitalised twice; one of those occasions was after a heroin overdose. He told the staff at the mental health inpatient unit of the hospital that he wanted to die. He has been subsequently charged with further offences for conduct which was due to being severely drug affected. As at December 2019, David continues to struggle to receive appropriate treatment for both his mental health and drug addiction.

Disadvantage, prison and mental health

The Victorian-Auditor General noted that:

*"[P]eople from disadvantaged and marginalised backgrounds are significantly over-represented among offenders who repeatedly engage in criminal activities. Repeat offenders commit the majority of all crimes and make up about two in every three prisoners, although this varies for different jurisdictions and demographic groups. The likelihood that a recently released prisoner will reoffend is higher if they experience delays in accessing welfare benefits, housing, health and other social services."*⁵

We see that typically people lose any health improvements made in custody after release from prison, and their health and substance issues can often deteriorate. Studies have found that people released from prison are admitted to hospital at higher rates for mental health issues and substance use disorders than the general population,⁶ and are at risk of poor health outcomes including an increased risk of death by preventable causes compared to the general population. The risk of suicide in people released from prison is approximately seven times higher than in the general population,⁷ and death by overdose is 22 times more likely than the general population.⁸ There is also evidence that incarceration itself can damage mental health, particularly in a context of overcrowding, lack of access to health services and programs, and the use of isolation and restraints.

⁵ Victorian Auditor-General's Office, *Problem-Solving Approaches to Justice* (April 2011) 1.

⁶ Michael Hobbs, Kati Krazlan, Steve Ridout, Qun Mai, Matthew Knuiiman, Ralph Chapman, 'Mortality and morbidity in prisoners after release from prison in Western Australia 1995-2003', 320 *Australian Institute of Criminology: Trends & issues in crime and criminal justice* (July 2006).

⁷ Daniel Jones and Alan Maynard, 'Suicide in recently released prisoners: a systematic review' 17(3) *Mental Health Practice* (2013) 20.

⁸ Simon J Forsyth, Megan Carroll, Nicholas Lennox, Stuart A Kinner, 'Incidence and risk factors for mortality after release from prison in Australia: A prospective cohort study', 113(5) *Addiction* (2018) 937.

Remand, short sentences and transition

Short periods on remand are particularly detrimental for our vulnerable clients, and are a barrier to rehabilitation because they disrupt continuity of mental health treatment, disability supports, training and employment opportunities, family relationships, and community housing and supports. People who serve short periods on remand or receive time-served sentences for low level offending are typically released with no post-release supervision or reintegration assistance. The disruption to people's lives caused by short sentences, particularly combined with lack of post-release support, as well as the stigma associated with time in custody, can all entrench patterns of offending behaviour.

In our experience, proper support upon release is critical to averting relapses, yet our clients are not always released into the community with appropriate supports. A person released directly from court has no time or opportunity to make appropriate arrangements for their release (for example – housing, transport from prison, employment and other support services). The increasingly common practice of hearing bail applications and in-custody guilty pleas by audio-visual links may be contributing to post-release transition barriers. Our lawyers report their clients have been released from custody facilities in these circumstances without a support plan in place, and from a location which may be a significant distance from their home and without ready access to their lawyer or other supports.

The criminal justice system and the Magistrates' Court in particular are under significant pressure because of increased demand and significant reforms to the criminal law in recent years. The significant reforms to the *Bail Act 1977 (Vic)* in 2018 resulted in a substantial rise in the remand population, as more people are being held in custody. Delays in obtaining hearing dates in the Magistrates' Court combined with a reduced number of people granted bail is resulting in people being remanded in custody for extended periods, often released with a 'time served' sentence. While on remand, prisoners are only able to access a limited number of programs and are typically released from prison without a predictable timeframe, allowing limited time to organise transport, housing or services.

2. Changes to parole and post-release support in Victoria

Access to parole has significantly reduced over the past seven years. A number of changes were made to the parole system in 2013, following high-profile cases of offenders committing serious offences while on parole. Changes included:

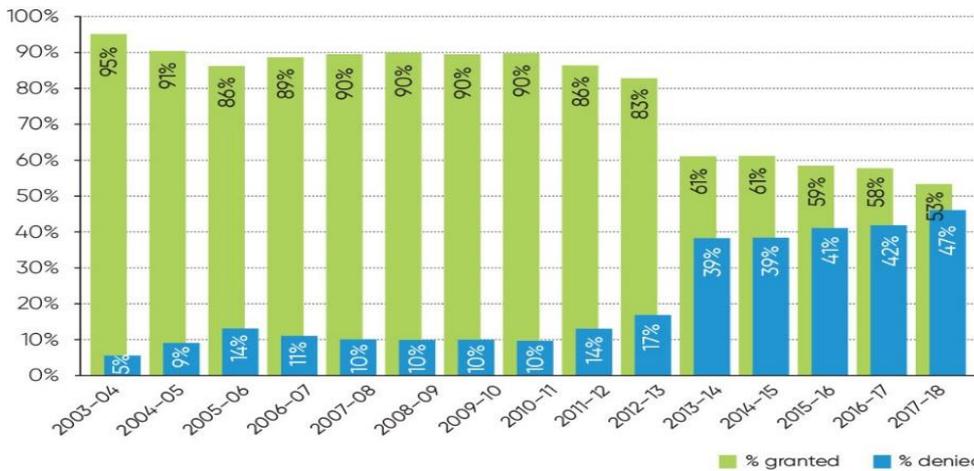
- The default position of automatic consideration for parole after a certain period was changed to a requirement for prisoners to apply;
- Parole eligibility was tightened;
- Parole monitoring requirements were increased;
- Parole conditions became stricter; and
- New penalties for breaches were introduced.

Following these changes there has been an increasing number of prisoners facing straight release from prison without supervision or formal post-release support in the community, even after serving lengthy sentences. The number of parole grants in Victoria has dropped dramatically, there are now at least

1,000 fewer adults released on parole in 2019 than in 2013. The Adult Parole Board Annual Report 2017–18 reported:

“The number of parole orders granted fell dramatically, from a peak of 2,051 in 2012–13 to 757 in 2016–17 (a reduction of 63 per cent). Corresponding to the decline in the number of parole orders granted, in 2012–13 the number of parole denials increased significantly.”⁹

The following graph is extracted from that Report, illustrating the change in decisions to grant and decisions to deny parole, from 2003–14 to 2017–18.



In 2018–19, 803 prisoners were granted parole.¹⁰ In comparison, 14,200 prisoners were discharged from a Victorian Corrections facility, who had served time under sentence at some point during that episode of imprisonment, although they may not have been sentenced at the time of discharge.¹¹

3. Supports available upon release from custody in Victoria

Overall a very small proportion of prisoners are leaving prison with supervision and appropriate support. The Victorian Ombudsman’s investigation into the rehabilitation and reintegration of prisoners in Victoria found that only 700 of the approximately 6,600 people who left prison each year (as at 2015) were provided with transitional support, and that this is typically between three and 22 hours of support.¹² This can be particularly detrimental for young adult offenders leaving adult prisons, as they can often have compromised mental and physical health which contributes to their post-release mortality rate.¹³

Housing is a significant issue, as there is no guarantee of secure housing for people leaving prison. A recent research report by the Australian Institute of Criminology noted the high link between homelessness and contact with the criminal justice system, citing one study which found that nearly a quarter of detainees were homeless or experienced housing stress in the month before arrest. The report concluded that:

“Several recent studies have reinforced the need for housing support for people leaving prison. ... The literature provides further support for the contention that transitional and housing support services have the potential to reduce recidivism, thereby bringing direct benefits to clients, increasing community safety, and reducing criminal justice system costs. ... While supported

⁹ Adult Parole Board, *Annual Report 2017 – 2018*, 24.

¹⁰ Adult Parole Board, *Annual Report 2018 – 2019*, 27.

¹¹ Department of Justice and Community Safety – Corrections Victoria, *Systemwide monthly time series prisoner and offenders* (December 2019) <<https://www.corrections.vic.gov.au/publications-manuals-and-statistics/monthly-time-series-prisoner-and-offender-data>>.

¹² Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria* (September 2015) (**Ombudsman’s investigation into reintegration of prisoners**).

¹³ Jesuit Social Services, *All Alone: Young Adults in the Victorian Justice System* (2018) 36.

housing initiatives can be resource-intensive, there is evidence to suggest that they are nonetheless more cost-effective than imprisonment and can contribute to reduced reoffending.”¹⁴

There are limited crisis accommodation options available and no long-term stable housing options available. If a prisoner is released within business hours and they have means to access public transport they may seek crisis accommodation through a non-government service provider such as the Salvation Army. In some instances, they may be offered a night or two at a motel and anecdotally there are reports of prisoners being given camping swags.¹⁵ We note that offenders released on parole are required to have their housing plans approved by the Adult Parole Board, and therefore lack of housing options limits parole eligibility.

Proper support upon release for people with combined mental health and substance abuse issues is also critical to averting substance relapses, overdoses and recidivism. Co-occurring mental health and substance use issues are significantly higher in people released from forensic services than in the general population. A 2015 Victorian study found that 63 per cent of men who had contact with forensic mental health services, had co-occurring serious mental health issues and substance use disorders. In our experience, prisoners with drug and alcohol rehabilitation needs who are released without supervision also typically enter the community without appropriate supports.

Prisoners subject to short terms of imprisonment are not eligible for parole,¹⁶ and are unlikely to be able to access transition support services given the wait times and length of time taken to organise entry into the limited spots.

The level of supervision available for the majority of prison leavers varies depending on whether the prisoner exits custody on parole or on a straight release.¹⁷ Eighty-one per cent of parole participants successfully complete their parole period.¹⁸ The provision of support by Corrections Victoria and non-profit service providers is critical to this good success rate.

Even so, whether on parole or straight release, we note that the post-release services which provide meaningful assistance to prisoners are limited, and the capacity to deliver services is grossly outstripped by demand. In Victoria, a tiny cohort of the overall population of people leaving prison receive intensive transition support. For example:

- The staged release Judy Lazarus Transition Centre which has been shown to reduce recidivism is limited to 25 beds for men; there are none for women. The Centre has strict eligibility criteria, including serving a minimum term of three years or numerous previous sentences with short period of freedom in between;¹⁹
- Forensicare operates a prison-based psychosocial rehabilitation and reintegration unit, called Tambo, which contains 10 beds in cottage style accommodation. The program is limited to a small number of people seriously impacted by their mental health issues. Since the program commenced in November 2017 there have been 37 admissions. The success of the program lies in its six weeks post release community outreach support, which the service provider

¹⁴ Australian Institute of Criminology, *Supported housing for prisoners returning to the community: A review of the literature* (2018).

¹⁵ Ombudsman’s investigation into reintegration of prisoners, above n 12, 687.

¹⁶ Which requires a minimum term of 12 months imprisonment.

¹⁷ ‘Straight release’ refers to prisoners who were unable to obtain parole because they did not have adequate housing or support externally; and prisoners released on a ‘time served prison sentence’ where, at the point of being sentenced, the length of a sentence of imprisonment imposed on the offender equals the time already spent on remand in custody.

¹⁸ Adult Parole Board, *Annual Report 2018 – 2019*, 30.

¹⁹ Ombudsman’s investigation into reintegration of prisoners, above n 12, 126. See also Corrections, Prisons and Parole, Judy Lazarus Transition Centre: Information specific to Judy Lazarus Transition Centre <<https://www.corrections.vic.gov.au/prisons/judy-lazarus-transition-centre>>.

described as ‘priceless’. Feedback from participants is that they have felt connected and part of community in a way that they rarely have felt before in their lives;²⁰

- Although the NDIS should fund transition supports to facilitate someone’s transition from the custodial setting,²¹ people experience significant difficulties accessing pre-release planning and transition support from NDIS service providers;²² and
- The Australian Community Support Organisation Community Offender Advice and Treatment Services (**COATS**) ‘StepOut’ program coordinates access to drug and alcohol counselling through the community with other drug and alcohol service providers. In 2015 it reported there was a waiting list for its various programs, the wait times varied from 14 days to excess of 51 days with over 100 prisoners on the waiting list. The available services in regional areas are fewer and wait times are longer. Presently, COATS may not accept referrals which are not received within 10 business days of a release date.²³

A further issue compounding the paucity of services is the limited coordination and communication between service providers, as well as structural complexity and difficulty in accessing information about eligibility and capacity. Community mental health services are provided based on geographical regions, which limits referral options for those without a fixed address. Victoria, along with Queensland and Western Australia, does not have an integrated health service which ensures that any treatment which began in prison can meaningfully continue in the community. The experience of our lawyers continues to reflect the Victorian Auditor-General’s findings from 2014 that:

“There is insufficient coordination across agencies allocating support and housing to prisoners of varying levels of need nearing release from prison. Processes for allocating places are not coordinated across the programs or regions, meaning agencies are unable to show that prisoners nearing release with the most significant multiple needs and mental illness are receiving places.”²⁴

²⁰ Danielle Ashley, ‘Psychosocial, Recovery Focused Mental Health Rehabilitation in a Prison: What Does this Look Like?’ (Conference Paper, International Criminal Justice Conference 2019, 20 November 2019).

²¹ National Disability Insurance Agency, ‘Justice’, (Web Page, 11 December 2018) <<https://www.ndis.gov.au/understanding/ndis-and-other-government-services/justice>>.

²² See for more information Victoria Legal Aid, *Ten Stories of NDIS ‘Thin Markets’: Reforming the NDIS to meet people’s needs*, (June 2019) <<http://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-submission-to-the-ndis-thin-markets-project-june-2019.docx>> and National Legal Aid, *Putting people first: Removing barriers for people with disability to access NDIS supports* (November 2019) <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-submission-putting-people-first-removing-barriers-for-people-with-disability-to-access-ndis-supports-11-2019.pdf>>.

²³ Australian Community Support Organisation, *COATS Prison Referral – Step Out* <<http://coats.acso.org.au/forms-referrals/coats-prison-referral-stepout>>.

²⁴ Victorian Auditor-General’s Office, *Mental Health Strategies for the Justice System* (October 2014) 52.