WITNESS STATEMENT OF DR SHAYMAA ELKADI

I, Dr Shaymaa Elkadi, Executive Director of Strategy, Planning and Performance, at the Victorian Institute of Forensic Mental Health, Yarra Bend Road, Fairfield VIC 3078, say as follows:

1 I am authorised by the Victorian Institute of Forensic Mental Health (**Forensicare**) to make this statement on its behalf.

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

BACKGROUND

3 My full name and title are Dr Shaymaa Elkadi PhD, MPA, GradDipPsych, BA.

Qualifications and experience

4 I am currently the Executive Director of Strategy, Planning and Performance at Forensicare. I commenced in this role on 20 March 2020. From May 2019 to March 2020, I held the role of Executive Director of Community Operations at Forensicare.

5 My previous appointments include:

(a) Acting Chief Executive Officer of Forensicare (October 2019);

(b) Clinical Governance and Performance Lead, Beyond Blue (2018 to 2019); and

(c) General Manager, Rehabilitation and Reintegration, Corrections Victoria (2011 to 2017).

6 My professional qualifications include:

(a) Master of Public Administration (2013);

(b) PhD (Psychology), the University of Melbourne (2003);

(c) Graduate Diploma in Applied Psychology, Monash University (1996); and

(d) Bachelor of Arts, the University of Melbourne (1995).

7 Attached to this statement and marked 'SE-1' is a copy of my Curriculum Vitae.

Responsibilities as Executive Director of Community Operations

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

8 During my time as Executive Director of Community Operations at Forensicare, my responsibilities included:

(a) oversight of Forensicare's Community Forensic Mental Health Service, including strategic planning, financial management, workforce planning and service operations;

(b) partnering with Forensicare's clinical leaders to enhance organisation-wide clinical governance;

(c) ensuring delivery of service models in line with Department of Health and Human Service (**DHHS**) standards and funding obligations; and

(d) organisation-wide leadership of the following stakeholder portfolios: Victoria Police, Courts, Area Mental Health Services, Youth, First Nations and Priority Communities.

QUESTIONS FOR THE PANEL

Royal Commission is concerned that young people and adults living with a mental illness are disproportionately represented in the criminal justice system and in prisons and youth justice centres.

Question 1: In your view, what is the reason for this disproportionate representation? Please consider:

a. the capacity of the mental health system to provide care, treatment and support for young people and adults living with mental illness

9 Within the context of the adult mental health and justice systems, I regard a young person as someone aged between 18 and 24 years.

10 The trajectory into the criminal justice system is too often the cumulative result of a reactive and belated mental health system response to mental ill health in young people. The lack of systematic prevention, early identification and treatment interventions for young people is a key contributor to the decline of mental health in young people which over time manifests in serious mental illness, a cycle of offending and reoffending and inevitable contact with the criminal justice system.

11 Over 75% of all serious mental health and substance use disorders commence before the age of 25.[1] Consequently, early screening and assessment must be accessible to children and young people throughout all stages of their development, including at pre-school, primary school, secondary school, and early adulthood. To facilitate this, teachers, families, and carers require education to detect early warning signs of mental

[1] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR and Walters EE, 'Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication' (2005) *Arch Gen Psychiatry* 62(6):593-602.

ill health and support in providing mental health first aid that will yield access to the right services at the right time.

12 Mental illness has wide-ranging impacts on young people and adults, affecting every part of their lives. Effective service responses must necessarily be based on a client-centred and holistic approach that addresses mental health alongside the psychosocial needs of the individual, so as to ensure sustainable positive outcomes in health and wellbeing can be achieved. Addressing one without the other will only compromise these outcomes.

13 Victoria operates a dual-track system that enables young people aged 18-20 years to be sentenced to a youth justice facility. The courts may use this option if there are reasonable prospects for rehabilitation of the young offender, or if the young offender is particularly impressionable, immature or likely to be subject to undesirable influences in an adult prison and thus this option might mitigate further entrenchment in the criminal justice system. According to data from the Youth Parole Board, 48% of young offenders detained on sentence and remand at Parkville and Malmsbury Youth Justice Precincts presented with mental health issues.[2] There is an opportunity to consider how this trajectory can be mitigated by a more proactive service response.

14 Comprehensive (wraparound) care (treatment) plans for children and young people that address their specific mental health needs, including the impact of their mental health on their education, peer relationships and family and community connections, are essential to reduce the burden of disease of mental illness on young people[3] and ultimately divert them away from the risk of contact with the criminal justice system (where such contact might be a corollary of mental ill health).

15 Adverse childhood experiences (including family violence, physical, sexual, and/or emotional abuse, and emotional and/or physical neglect) have been associated with increased rates of mental illness, suicide attempts, and substance use disorder among adults in prison.[4] Responses to mental illness in young people must also recognise the intergenerational transmission of mental health. Young people and adults who suffer from mental illness tend to have a low socio-economic status as compared with others due to both social selection (where downward social mobility leads to greater levels of poverty) and social causation (in which the stress of poverty acts as a trigger to mental illness).[5] A mental health system that is client-centred and supports the social, economic and familial needs of a young person and their families will create an opportunity to break the

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2 Adult Parole Board of Victoria, *Annual Report 2018-19* (Report, September 2019).

3 Correll C U, Galling B and Pawar A, 'Comparison of Early Intervention services vs Treatment as Usual for Early-Phase Psychosis – A Systematic Review, Meta-analysis, and Meta-regression' (2018) *JAMA Psychiatry* 75(6):555-565.

4 Bowen K, Jarrett M, Stahl D, Forrester A and Valmaggia L, 'The relationship between exposure to adverse life events in childhood and adolescent years and subsequent adult psychopathology in 49,163 adult prisoners: A systematic review' (2018) *Pers Individ Dif* 131: 74-92.

5 Cheng T L, Johnson S B and Goodman E, 'Breaking the Intergenerational Cycle of Disadvantage: The Three Generation Approach' (2016) *Pediatrics* 137(6):e20152467.

intergenerational impact of family circumstances, disadvantages and experiences on the mental health and well-being of young people.

16 The current mental health system is geared towards intervention at the serious mental illness stage. This means that they are responding to only the most complex cases of mental illness in young people – that is often at crisis point. By this stage, the prospects of recovery and remediating the long-term detriments of serious mental illness on the young person's broader development and psychosocial wellbeing are significantly reduced. Opportunities for educational attainment, gainful employment, living skills etc. are limited if not lost. A 2015 study of the economic impacts of promotion, prevention, and early intervention found that:

(a) the projected benefits of a 7% decrease in mental illness by 2030 were around $53.4 billion over 25 years from 2015 to 2040; and

(b) community-wide reductions in mental illness of around 10% was expected to yield economic gains of $75.2 billion over the same period.[6]

17 To confront the high representation of young people living with a mental illness in the criminal justice system, a redesigned mental health system must:

(a) seek to limit entry into the criminal justice system, where a welfare response is required,[7] particularly in respect of low-level offending;

(b) include access to diversion, therapeutic courts, and community-based sentencing options[8] as a priority;

(c) look to mitigate the risk of reoffending and escalation from community to prison sentences by offering intensive rehabilitation and reintegration services for adults and young people whilst they are still in the community;

(d) acknowledge the complexity of effective transition from prison back into the community by supporting the outreach of area mental health services into prisons to enable effective care planning and continuity of care;[9] and

(e) ensure that there is greater integration and engagement between the youth and adult mental health systems to better enable continuity of mental health care

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6 Urbis, *Invest now, save later: The economics of promotion, prevention and early intervention in mental health* (Report, May 2015) (**Urbis Report**).

7 See section 3.1 of Victoria Legal Aid, *Submission to the Royal Commission into Victoria's Mental Health System: SUB.0002.0030.0217*, July 2019 (**Victoria Legal Aid Submission**).

8 See Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria* (Report, September 2015) (**Victorian Ombudsman Report**), which identified alternative approaches to imprisonment that are achieving positive results by reducing reoffending.

9 See recommendation 22 of the Victorian Ombudsman Report.

between the youth and adult systems and reduce risk of disengagement in the transfer from one system to another.

18 Currently, Forensicare is one of six organisations delivering the Youth Justice Mental Health Program. This program was established in 2010 to improve youth justice clients' access to mental health services and enhance the capacity of youth justice staff and mental health staff to effectively meet the needs of youth justice clients requiring mental health services. Under the program, six dedicated clinical positions were created in mental health services to work exclusively with custodial and community youth justice services. One of these is the Forensicare Youth Justice Mental Health Coordinator, who provides support at the Parkville Youth Justice Precinct and coordinates the program state-wide. The clinicians provide hands-on training and capacity building for youth justice staff, as well as consultancy to case workers supervising young people on youth justice orders.

19 In redesigning Victoria's mental health system, the Youth Justice Mental Health Program should be repositioned to take on an active leadership role in supporting and building the capability of youth justice staff to understand and respond to the forensic mental health needs of young people in prison and in the community. This program, which is informed by research and best practice, offers an opportunity to set minimum standards of practice in youth forensic mental health and to strengthen the sector to deliver these.

b. changes to police policies and practice

20 Unfortunately, many persons with a mental illness can display behaviours that can often be the entry point into the justice system via policing and police responses.

21 There is no doubt that there is a need for police officers to balance the issues of community safety against their response to offenders living with mental health issues. Police are currently expected to respond to very complex mental health incidents and behaviour based on limited expertise and training. In circumstances where an operational response needs to be made quickly, the default and most intuitive response is often a policing one rather than a mental health or welfare based one.[10]

22 I am aware of mental health training that is provided to new Victoria Police officers that aims to raise awareness of mental illness and strategies to respond to such incidents appropriately. However, mental illness is complex and such training can never be sufficiently nuanced to account for the diverse and complex presentations of mental illness. For this reason, training alone is insufficient. In addition to training, police responses to mental health incidents must be accompanied by a system of differentiated

[10] See section 3.1 of the Victoria Legal Aid Submission, which provides examples of where a welfare response as opposed to a police response would be a better outcome for the individual and the community.

service options to avoid Emergency Departments in hospitals being the only option. International examples exist of mental health ambulances, psychiatric emergency centres, crisis centres, and joint police and mental health response teams, all of which should be considered, piloted, and evaluated to build evidence of the most effective response options[11]. Of note, in 2015, Stockholm became the first city in the world to pilot the implementation of a Psychiatric Emergency Response Team (**PER Team**) to respond to emergency calls for persons in severe mental health or behavioural distress – cases previously traditionally attended by police. The PER Team is staffed by specialist mental health nurses along with a paramedic. In 2017 this pilot was evaluated and found that one third of all cases attended by the PER Team resulted in no further psychiatric intervention. Emergency Departments also experienced a reduction in presentations. This service has now been rolled out on an ongoing basis[12].

23 Recognising mental illness and addressing it appropriately are two distinct challenges. Even with training on the identification of mental health issues, the capacity of police to provide a meaningful mental health response is currently limited. Police officers experience difficulty linking people with appropriate services, especially when there is a perceived or presented risk to community safety. Frustrations are further exacerbated by the temporary nature of these linkages which mean that police are responding repeatedly to the same individuals within the community with the same ineffectual response.

24 An innovative example of how policing and mental health services can be integrated is the Victorian Fixated Threat Assessment Centre (**VFTAC**). The VFTAC began operating in March 2018 with the following two primary objectives:

(a) identify and assess individuals who may have a mental illness and who pose a threat to public safety due to their risk of engaging in potentially violent behaviours arising from pathological fixation or grievances, including where influenced by radicalised beliefs; and

(b) facilitate effective interventions by police, mental health services and other relevant agencies and, through these measures, prevent these individuals from progressing to violent action.

25 The VFTAC team is comprised of a team of senior police officers and mental health clinicians who assess clinical and operational risks of identified individuals ahead of referrals to mental health services and other relevant agencies. The joint case

[11] Mulder, W. & Dekker, Jack & C, Gijsbers. (2005). Psychiatric emergency services in Amsterdam: Experiences with acute admissions in a metropolitan area.

[12] Olof Bouveng, Fredrik A. Bengtsson & Andreas Carlborg (2017) Firstyear follow-up of the Psychiatric Emergency Response Team (PAM) in Stockholm County, Sweden: A descriptive study, International Journal of Mental Health, 46:2, 65-73, DOI: 10.1080/00207411.2016.1264040

management approach across Victoria Police and Forensicare staff is a world first and offers an important precedent in cross sector collaboration

c. the passage of more stringent criminal and sentencing laws over the past 5 to 10 years

26 There has been a significant increase in the number of people on remand and those serving short sentences because of more stringent bail and sentencing laws. This has significant implications for access to services as the very short remand and sentence periods inhibit the assessment of prisoner mental health needs and in turn, the access to services, be it in prison or in the community. To this end, there is opportunity to reduce the increased remand population through further bail reform, particularly for the cohort of offenders who are unlikely to receive a prison sentence when sentenced.[13] Such reform needs to more effectively balance a person's risk to the community against how that risk might be mitigated through more effective mental health treatment coupled with other community-based psychosocial supports. This should be achieved through more proactive therapeutic diversion supported by justice, clinical and psychosocial service integration and continuity of care that captures assessment, treatment and monitoring or supervision.

27 For those prisoners serving longer custodial terms, access to sustained long-term mental health support whilst in prison is essential. Currently, the mental health services available to prisoners target serious mental illnesses. Whilst such services remain essential, earlier and targeted interventions for less acute presentations would offer an opportunity to reduce the overall cost of serious mental illness to the economy and the community as well as reduce the burden of disease on the individual.

d. community attitudes, including the understandings of the community, the police, and the judiciary, of the relationship between mental illness, offending and violent offending

28 Over the last few years, there have been high profile incidents which have led to significant reform driven largely by community emotion rather than evidence. There is often a tension between the response the community expects when a person living with serious mental illness commits a serious crime and best practice treatment. As a community, we have a responsibility to understand this relationship and bring the community with us on the journey of understanding what has occurred, why, and what is in the best interest of the community and individual in terms of response.

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13 Paul Coghlan, *Bail Review: Second Advice to the Victorian Government* (Report, 1 May 2017) 14–28.

29 Community attitudes and stereotypes can create fear and expectations that people will act in a certain way without understanding that this can be driven by mental illness. The gap between community sentiment and evidence-based mental health treatment can be problematic in reconciling our responses to mental illness and offending behaviour. There is often a disparity and a misunderstanding around the purpose of sentencing. For example, is its purpose to punish or reduce reoffending and increase community safety, or both? Community attitudes subject offenders living with a mental illness to multiple layers of stigma that makes it even more difficult to successfully reintegrate them in the community when the time comes. In this context, mental health and justice policy must be grounded in an acknowledgement that the relationship between mental illness and offending is never intended or desired, but rather the culmination of a complex non-linear interaction of psychosocial, health, economic and biological factors.

30 Understanding and responding to the role of mental illness in offending behaviour is critical to shaping an integrated justice, rehabilitation and recovery response that is focussed on achieving the best possible outcomes for both the individual and the community. There has been significant investment in recent years in expanding offence-specific and reintegration services within the prisons; however, this has not been effectively integrated with mental health needs of the same population. The effectiveness of offence-specific interventions in prisons and in Community Correctional Services (**CCS**) for those living with mental illness is contingent on effective concurrent mental health treatment. The siloed operations of these services are prohibitive to achieving meaningful change in recidivism rates.

Can the causes of disproportionate representation be addressed?

31 To address the disproportionate representation of people living with mental illness in the justice system, there is a need to provide holistic and integrated support focused on a range of domains including mental health, housing, education, employment, family and community connectedness, drug and alcohol and living skills (please see paragraph 35 below).

32 There is also a critical need to engage and support families and carers in this journey. Families can have an important role in early identification right through to more intensive intervention and treatment. Involving families early and consistently can have an important positive role in a person's recovery.

33 Services within the current mental health system operate in silos. In many respects, the system sets clients up for failure by overwhelming them during their most vulnerable time with multiple appointments and schemes and services that do not share information and are fragmented. At every stage, individual stories are repeated and retold often to the point of exasperation and disengagement. A far more effective approach would be to

adopt a client-centred and integrated support system which wraps around the individual to identify and respond to their particular needs in a complementary and systematic manner. A key example of this is where a person may have identified needs in relation to housing, mental health, employment and alcohol and other drugs. It goes without saying that housing needs must be addressed first, followed by needs in relation to mental health and alcohol and other drugs, before a person can be gainfully employed. Currently, this service response would involve multiple and disparate services that are less than coordinated. These services need to be geared for assertive outreach in recognition of the significant vulnerability and complexity of people living with mental illness.

Question 2: What reforms would most effectively improve the interaction of, and outcomes for, people living with mental illness with the justice system:

34 The key is to provide a holistic approach across systems and services. We know from the evidence that mental health issues develop over time and there are some vulnerabilities that will put individuals at risk. Thinking about mental health services as a pathway allows us to focus on providing fit-for-purpose supports along this continuum that starts with identification and early intervention through to more intensive and complex care if and when required. A pathway that is holistic integrates mental health care with psychosocial and economic support in a manner that recognises their inter-relationship. Achieving this requires a significant reframing of our current mental health system.

35 Research evidences that intervention in the following seven domains positively impacts an individual's risk of reoffending:

(a) housing;

(b) mental health;

(c) alcohol and other drugs;

(d) education and training;

(e) family and community connectedness;

(f) living skills; and

(g) employment.

36 Forensic mental health services must be supported to provide a service that links across all these needs in understanding the interface with offending behaviour. This requires the work of multidisciplinary clinical and non-clinical teams of psychologists, psychiatrist, social workers and occupational therapists, case workers, housing workers, careers counsellors and employment agents etc.

37 Understanding the complexity of forensic mental health services is often a reactive conversation triggered by catastrophic events. There have been numerous reviews already into forensic mental health, corrections, and justice health. The problems are known and well documented. The intelligence is there. What is now required is a concerted effort to move on from reviews and looking back to genuine reform and innovation to move forward. Genuine reform will undoubtedly be difficult and challenged by the uncertainty it will create for some time, but there is an imperative to be brave and transformational in the best interests of mental health consumers and the broader community.

38 What we do has to be underpinned by research and evaluation. For obvious reasons, forensic mental health is an unpopular and sometimes uncomfortable space and is therefore difficult to research. Australia lacks strong investment in research in this area. More is needed to understand if international models of forensic mental health would work in Australia. There is little research in the Australian context.

a. as offenders?

39 Currently, justice, corrections and mental health services operate in silos. There is a need to provide offenders with a seamless approach that balances risk management and compliance with treatment needs.

40 There is significant research on models of assertive community treatment (including some models in the United States that have been evaluated).[14] Assertive community treatment involves multidisciplinary teams which provide:

(a) mental health treatment coupled with appropriate psychosocial support;

(b) supervision in the community that is adapted to a person's presentation and needs; and

(c) assertive outreach visits where staff proactively visit clients, whether in a public place or another service to promote continuing engagement and connection with clients.

41 Research has demonstrated some positive outcomes associated with the use of assertive community treatment; these are in relation to not only mental health outcomes, but also reoffending rates. The approach is client-centred and adaptive to individual needs. It is

[14] Cuddeback G S, Simpson J M and Wu J C, 'A comprehensive literature review of Forensic Assertive Community Treatment (FACT): Directions for practice, policy and research' (2020) *International Journal of Mental Health*; DeLuca J S, O'Connor L K and Yanos P T, 'Assertive Community Treatment with People with Combined Mental Illness and Criminal Justice Involvement' in Jeglic E and Calkins C (eds), *New Frontiers in Offender Treatment* (Springer International Publishing, 2018); Landess J and Holoyda B, 'Mental health courts and forensic assertive community treatment teams as correctional diversion programs' (2017) *Behav Sci Law* 35: 501– 511.

also wide enough in its scope to integrate mental health treatment with support around the seven domains emphasised in paragraph 35 above.

b. as victims of crime?

42 I prefer not to address this sub-question, as I have limited expertise in this area.

c. as people seeking access to justice?

43 I prefer not to address this sub-question as, I do not have specific expertise in this area.

Question 3: How can innovation in therapeutically oriented justice policy be best facilitated?

44 The opportunities for innovation lie in the investment in action-oriented research, evaluation and continuous quality improvement. Forensicare is funded to deliver a suite of programs that reflect legislative obligations, as well as service reforms arising from shifts in government policy. Like many other organisations, the implementation of these programs and reforms is rarely evaluated to inform future service enhancements or even to determine whether a program or reform has met the intended objective. Fostering and investing in ongoing policy and service evaluation in forensic mental health and mental health more broadly will ensure sound decision-making and create improved learning, accountability, and quality across the sector.

45 Forensicare has embarked on building and strengthening key partnerships in the community to support innovation and best practice. In terms of youth, Forensicare has worked to strengthen its relationship with Orygen over the last 12 months. Forensicare considers those aged 18-24 years to be young people, who would greatly benefit from a stronger collaboration between Forensicare and Orygen. From Forensicare's perspective, there is an opportunity, and a need, to share its unique forensic mental health expertise for the benefit of youth mental health services as well as engage in joint training to build capability across the sector. A strategic workforce and service partnership between Forensicare and Orgyen would be a unique and innovative opportunity to address the long-term mental health treatment needs of many clients whose trajectory has extended across youth through to adulthood.

46 Forensicare has also been working to strengthen its relationship and information sharing with area mental health services. This relationship has traditionally been reactive in that it is driven by having mutual clients. In 2019, Forensicare commenced interface meetings with area mental health services on a regular basis to discuss operational and systemic issues with a view to identifying and working collaboratively on joint priorities. A series of explorations are planned for 2020, the first of which is in relation to the challenges associated with the discharge of prisoners to mental health services and the use of

inpatient assessment orders. These meetings are intended to go beyond operational interface meetings and create a forum for developing a roadmap for system improvements. Positive feedback has been received regarding this more proactive approach with improved relationships, information sharing, collaboration, and consultation.

Question 4: What gaps currently exist in relation to data sharing, research and knowledge translation that would facilitate future innovation?

47 Forensicare has a critical role to play across Victoria in:

(a) imparting its forensic mental health expertise to support area mental health services and clients;

(b) creating and supporting linkages between mental health and justice agencies; and

(c) leading and shaping evidence-based best practice in forensic mental health.

48 There are currently very archaic data and knowledge systems in place in the mental health system. These systems are not integrated and prevent the sharing of information across services in the clients' best interests as well as effective research and innovation.

49 While data sharing raises privacy issues, it is essential for effective service delivery that systems are linked to provide a holistic view of a person's background and relevant mental health history. For example, when an offender is serving a community-based order, it may not be known to the community mental health service that the client has received treatment from, or has previously engaged with, Forensicare services. Sharing information appropriately, and within privacy parameters, can support treatment plans, case management and supervision.

50 The Family Violence sector previously experienced similar data-sharing issues, but has now, to a large extent, overcome these issues with examples like the Risk Assessment Management Panels (**RAMP**). Opportunities to test the RAMP approach across forensic mental health and justice systems for high risk clients would be a positive step to creating a targeted framework for information sharing.

CHANGES OVER TIME

Trends and changes in approaches to diversion, bail and parole law and practice in Victoria over the last decade

51 While I have limited experience in relation to diversion, bail, and parole law and practice in Victoria, I can make some observations on the impact of relevant trends and changes over the last decade on young people and adults living with mental illness.

52 There has been a notable growth in the justice system over the last decade:

(a) over 3000 new police officers have been deployed

(b) weekend courts have been introduced, and

(c) 18 new magistrates have been assigned.

53 The impact of this growth, coupled with significant bail and parole reforms in response to tragic community deaths, have led to a strong risk-averse culture within the community and across the justice and mental health systems. This has manifested in:

(a) a halving of the diversion rate from 25.6% to 12.5%;[15]

(b) an increase in the Victorian prisoner population by over 70%, of which 40% are estimated to be on remand (unconvicted); and

(c) a decrease in parole rates by 61%.

54 In relation to diversion, a study of 29 randomised controlled trials found that entering the justice system had a negative impact on young people's reoffending rates as compared to diversionary responses.[16] The adverse impacts of reduced use of diversion is particularly evident for Aboriginal young people; there have been many cases where diversion would have been indicated but has not been used, creating a pathway into the criminal justice system including incarceration. This contributes to the significant over-representation of Aboriginal men and women in the prison system, leading to further stigmatisation and disadvantage including high levels of morbidity and mortality.[17] This has been a point of contention and discussion at Aboriginal Justice Forums over the years. Diversion is a critical tool for reducing entry into the criminal justice system and preventing the trauma and risk to mental health caused by incarceration. Remaining in the community helps people maintain connection with mental health treatment and protective supports.

55 In relation to the increase in the prison population, the opportunity to provide community equivalent standards of mental health services in prison are impacted by a complex range of factors inherent in prison systems. The delivery of mental health treatment services is confounded by issues of safety and security and the discordant culture of risk and compliance within prisons relative to that of treatment and rehabilitation among mental health workers. I query if the prison environment can be conducive and supportive of mental health interventions and positive behaviour change. In an overcrowded prison

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15 Cowan D, Strang H, Sherman L et al, 'Reducing Repeat Offending Through Less Prosecution in Victoria, Australia: Opportunities for Increased Diversion of Offenders' (2019) *Camb J Evid Based Policy* 3, 109–117.

16 Petrosino, A, Turpin-Petrosino, C and Guckenburg, S, 'Formal system processing of juveniles: effects on delinquency' (2010) *Campbell Collaboration (Crime and Justice) Systematic Review*.

17 Kreig A, Wenitong M and Daniels, 'Custodial health' in Couzos S and Murray R (eds), *Aboriginal primary health care: an evidence-based approach* (Oxford University Press, 3rd ed, 2008) 806.

system, this is even more questionable. There has been recent attention directed to therapeutic communities within prisons. Prison therapeutic communities provide an intensive environment that can facilitate and support change. There are two main types of therapeutic communities: democratic and concept-based or hierarchical. Both types view the community and its members (staff and prisoners) as the agents of change. Therapeutic communities within prison settings have been associated with reductions in offending and improvements in other areas of well-being such as mental health and substance use.[18]

56 In respect of parole, the parole system is an effective means to support successful transition into the community from prison. The Australian Institute of Criminology found that offenders who received parole supervision with a rehabilitation focus took longer to commit a new offence, were less likely to commit a new indictable offence and committed fewer offences, as compared to offenders who were released unconditionally into the community.[19] Recent changes to eligibility requirements and parole application processes have resulted in significantly fewer people being on parole. Scrutiny is required over these processes and systems to ensure they do not disproportionately affect and disadvantage those living with mental illness and their opportunity for community reintegration. There is limited data on the profile of individuals who are granted parole with mental illness.

57 These parole findings provide an evidence base for the integration of community-based supervision with the mental health services to achieve reduced recidivism and positive mental health outcomes. Community-based supervision that is responsive to the needs of those living with mental ill health or serious mental illness also has the promise of improving productivity and quality of life, increasing employment, reducing contact with the criminal justice system and reducing homelessness among other benefits.[20]

58 A relevant example is the experience of Jude, which was discussed in Victoria Legal Aid's submission to the Royal Commission.[21] Jude's case is a prime example of a system in which justice and mental health are misaligned and lack the necessary integration to achieve positive outcomes for individuals and the community through the least restrictive means. Jude's case, like many similar cases, raises the question of how the justice system can provide a suite of options that acknowledges and is responsive to the interface between mental illness and offending behaviour. Consideration should be given to:

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18 Galassi A, Mpofu E and Athanasou J, 'Therapeutic Community Treatment of an Inmate Population with Substance Use Disorders: Post-Release Trends in Re-Arrest, Re-Incarceration, and Drug Misuse Relapse' (2015) *Int J Environ Res Public Health* 12(6):7059-7072; Fortune, C A and Polaschek, D L, 'Therapeutic Communities' in Kerley K R (ed), *The Encyclopaedia of Corrections* (Wiley Blackwell, August 2017).

19 Wan W, Poynton S, Doorn G and Weatherburn D, 'Parole supervision and reoffending' (2014) *Trends & issues in crime and criminal justice* no. 485. Canberra: Australian Institute of Criminology.

20 Urbis Report.

21 Victorian Legal Aid Submission, pp 31 and 40.

(a) the role of diversion as a more humane and trauma-informed response to offending behaviour for people living with a serious mental illness;

(b) the thresholds for the use of charges on summons for people living with serious mental illness;

(c) the role of bail in prioritising rehabilitation; and

(d) where incarceration is deemed necessary, the role of parole in supporting mental health recovery.

59 Another key question to consider is how the legal principles of parsimony, proportionality and parity can be applied not only in sentencing but also in responding to alleged offending.

Addressing recidivism cycles for young people and adults living with mental illness in the criminal justice system

60 Whether a young person or adult living with mental illness is in the community or in prison, there are seven domains that will affect the person's risk of recidivism or requiring forensic mental health services. These domains are discussed above at paragraph 35.

61 The intervention required will depend on a person's needs. The key is to plan interventions around those domains and prioritise them appropriately. For example, a person who has no stable housing cannot receive effective mental health treatment. Likewise, mental health and alcohol and other drug treatment services should be integrated rather than requiring a person to engage with separate services.

62 If intervention in the seven domains is the focus of services from the time a person is first in prison, this would significantly improve not only mental health outcomes but also community safety.

63 The Corrections system is focussed on the risk of reoffending while the area mental health services are focussed on treatment. These two objectives are not always aligned. What is needed is a shared understanding of mental health and offending behaviour risks and how they impact each other. It would be ideal to have a recognition of the interface between mental illness and offending behaviour throughout area mental health services, supported by forensic clinical specialists (please see paragraph 86 below in relation to the Forensic Clinical Specialist Program (**FCSP**).

Impact of increases in the prison population over the last decade on delivery of Victoria's forensic mental health services

64 The high turnover of prisoners over the last decade in Victoria has reduced the ability to effectively deliver forensic mental health services. There is a high number of prisoners

who are on short-term sentences. This raises challenges in being able to quickly access and treat those prisoners.

65 For people serving longer prison terms, the nature of the prison system means that they will move between prisons and unit. While treatment may commence in one place, we then find that we cannot continue to provide that treatment or are required to provide the treatment in a different way. Mental health treatment requires building a rapport with a person. This is difficult if a person is constantly moving to a different prison or unit with access to different services. Such movement can only negatively impact on the quality of the treatment provided.

SENTENCING FOR PEOPLE WITH MENTAL ILLNESS

66 Courts are limited in their ability to facilitate treatment for mental illness to the extent this relies on mental health services providers to provide that treatment. Whilst I understand the *Sentencing Act 1991* (Vic) enables a court to make a 'court secure treatment order' if the criteria for a court secure treatment order are satisfied and there are services available to provide the relevant services, it is my experience that the courts do not commonly utilise this disposition.

67 Where a person is found to be mentally impaired at the time they committed the offence, or is permanently unfit, these matters are dealt with under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (**CMIA**). If a person is found liable to supervision under the CMIA, the court's options are to place that person on a custodial supervision order (ideally in Thomas Embling Hospital subject to bed availability) or in the community on a non-custodial supervision order. The CMIA deliberately diverts this cohort from a punitive pathway into a therapeutic pathway in recognition of the fact that they may not be criminally responsible for their conduct.

68 There is currently a gap in the summary jurisdiction for those people who are mentally impaired or unfit to plead. This gap is well articulated by the Victorian Law Reform Commission in its report on the CMIA.[22] Whilst this gap needs to be addressed, the current CMIA pathway is not considered appropriate given that the indefinite nature of the orders is not proportionate to the summary jurisdiction.

69 Responding to the needs of people with mental illness requires an ongoing sustainable partnership between justice and mental health. Consideration should be given to the establishment of a therapeutic mental health court linked to a network of place-based

22 Victorian Law Reform Commission, *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Report, June 2014) 126–70.

inpatient accommodation options that enables a response to episodes of crisis and step-down support. Key design principles for this pathway should include:

(a) client-centred shared care;

(b) holistic wraparound care encompassing clinical, legal, psychosocial and criminogenic needs;

(c) recovery-focussed;

(d) trauma-informed;

(e) lived experience guided;

(f) family and carer involvement;

(g) diversion into a therapeutic pathway in recognition of the fact that they may not be criminally responsible for their conduct; and

(h) shared accountabilities for key stakeholders and appropriate measures of success.

70 The lack of a strong research agenda across mental health affects our understanding about whether a service is effective. Research in this area is both challenging and limited.[23] Greater investment in this research area is needed to create our own evidence base and innovation towards desired outcomes. Forensicare has an unprecedented opportunity through its partnership with the Swinburne University of Technology's Centre for Forensic Behavioural Science (**CFBS**) to achieve this with the right support.

BEST PRACTICE

Contemporary best practice in community forensic mental health treatment

71 It is important that community forensic mental health treatment incorporate the 'wrap around' domains discussed at paragraph 35 above. Additionally, the following components are important:

(a) assertive community forensic mental health services;

(b) family engagement; and

(c) trauma interventions.

72 It is also essential to have families and carers involved in treatment and planning. The role of families and carers cannot be underestimated.

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[23] Kennedy H G, Simpson A and Haque Q, 'Perspective On Excellence in Forensic Mental Health Services: What We Can Learn From Oncology and Other Medical Services' (2019) *Front. Psychiatry* 10:733; Howner K, Andiné P, Bertilsson G, Hultcrantz M, Lindström E, Mowafi F, et al, 'Mapping systematic reviews on forensic psychiatric care: a systematic review identifying knowledge gaps' (2018) *Front. Psychiatry* (2018) 9:452.

Examples of contemporary best practice in community forensic mental health treatment

73 There are some examples of assertive compulsory treatment programs in the United States that involve multi-disciplinary teams. These programs are not time-limited services and the support will continue if the person needs them. They also enable a person to step in and out of the program as needed depending on their changing risk profile. This has been associated with positive outcomes for mental health and reoffending, as clients are empowered to seek assistance in the absence of fear that their fluctuating mental health could be grounds for breaches.

74 I am not otherwise currently aware of how best practice principles are reflected in community forensic mental health services and programs and consider that this is a gap that could be addressed by investing in targeted research and evaluation in this area.

Delivery of community forensic mental health services in the future

75 In relation to how community forensic mental health services should be delivered in the future, there is an efficiency argument for joint outcome measures between community forensic mental health services and area mental health services, given the relationship between the two. This would require the services to look at pathways, joint key performance indicators and joint outcome measures to enable them to assist mutual clients. Whilst publishable data is not yet available, discussion of the use of inpatient assessment orders between Forensicare and Area Mental Health Services indicates that of all persons discharged from prison on inpatient assessment orders, approximately half are not upheld at the receiving service. This suggests that greater integration, planning and consultation is necessary across services to ensure appropriate reintegration into the community and that linkages with mental health supports are appropriately facilitated. Forensicare is currently working collaboratively with a major area mental health service to interrogate this data in more detail.

76 Joint research between area mental health services and community forensic mental health services would also be an opportunity to strengthen these links.

Current Justice Health arrangements for contracting, delivery and oversight of mental health services

77 Current Justice Health arrangements in adult settings for contracting, delivery and oversight of mental health services are not optimal, as they are provider-focused rather than service-focused.

78 There are both primary and tertiary mental health services available in prisons. However, these are delivered by different providers and the level of service varies across prisons. An individual may move between prisons and move to a different clinician. Transition

from one service to another also creates information sharing difficulties. The challenge in such an environment is to conduct a handover and provide a continuous service pathway for individuals.

79 The focus should be on delivering the best treatment. This requires continuity of care, appropriate transition, and handover between services.

80 The primary way to improve this situation is to bring stakeholders together. Where there are two separate providers in a prison, a joint/shared service delivery model is necessary to ensure common goals and complementary service delivery. Whether this can be achieved depends on the contractual basis in place.

FORENSICARE'S COMMUNITY PROGRAMS

Forensicare's role in supporting area mental health services

81 Forensicare supports area mental health services through both forensic clinics and specialist roles. Forensicare also provides various training opportunities to area mental health services. A key challenge is the need to navigate the varying processes and service pathways in each service.

Forensicare's services and programs in the community

82 Forensicare offers several programs, a small part of which are focused on direct service delivery, such as the VFTAC. A significant part of our work is providing forensic services.

83 The challenge for Forensicare is in delivering programs in a structured and assertive way across Victoria. There is significant merit in supporting Forensicare to provide regional outreach and to operate satellite clinics across metropolitan and regional areas by collocating with area mental health services to provide shared care (particularly for high risk clients). This would support the regional model of Community Corrections, creating a stronger interface between justice and forensic mental health.

Impact of gender of consumers on delivery of Forensicare's community programs

84 Forensicare does not currently deliver community programs differently to male and female consumers. Each clinician may adjust their own practice, but there is no differentiated service response. Similarly, there is no exclusion for males or females to its services, any eligible consumer can access services.

85 Recently, however, Forensicare has established a Priority Communities Advisory Committee which has women's services as part of its portfolio. The committee is seeking advice from stakeholders on how to better offer services to female consumers. In addition,

Forensicare is considering how it can be a gender-responsive service and adjust its practices through the redevelopment of its model of care.

Role of forensic clinical specialists in area mental health services and Forensicare's role in supporting these specialists

86 The FCSP was established to build forensic expertise and capacity in Victoria's specialist mental health services and is designed to improve the clinical skills and expertise of staff working with targeted clients who have offended or are at high risk of offending. Dedicated forensic clinical specialists are embedded within area mental health services to provide specialist clinical, training and service development functions, and to enhance sector capacity to support, manage and treat clients vulnerable to contact with the justice system.

87 There has been a growth in the number of forensic clinical specialists across Victoria – there were 6 to 8 specialists when they were first introduced, and there are now 23 specialists. There have been requests by some area mental health services for additional funding to increase the number of forensic clinical specialists in their services.

88 Forensicare has coordinating responsibility for the FCSP and provides support to a network of forensic clinical specialists across Victoria through training, secondary consultation and advice. Area mental health services receive the funding for each specialist role and Forensicare provides support through forensic clinical specialists. The implementation of the role itself is variable and is based on what each area mental health service determines to be its priorities and needs. Some roles will be assessment-focused, while others are advice-based. This means that, when looking at the outcomes of a role, it is challenging to conduct an evaluation. This also affects the support that can be provided to an area mental health service.

89 Greater consistency in these roles across the State is required to ensure equity of access to forensic mental health expertise across metropolitan and rural areas.

Barriers or challenges associated with effective performance of the role of forensic clinical specialists

90 Forensic clinical specialists provide expertise in managing people with complex mental health needs, often in collaboration with Forensicare. The increasing complexity and number of clients is a significant challenge for forensic clinical specialists. The increasing demand for forensic mental health expertise has created pressures on the extent to which forensic clinical specialists can actively engage in detailed assessments, clinical review, and treatment of clients. To this end, their role is gearing more towards high level advice and consultation rather than the more detailed support to staff that is required.

Enabling the forensic clinical specialist role to function more effectively in the future

91 The forensic clinical specialist role has been critical to embedding specialist forensic mental health expertise in mainstream mental health services. The expansion of this role is much needed to enable area mental health services to cope with the growing acuity and risk complexity of presenting cases. This expansion would benefit, however, from a greater consistency and benchmarking of the operation of the role, so that the outcomes of the role can be evaluated.

Scope for Forensicare to play an expanded secondary consultation and capacity building role for health and related sectors in future

92 Forensicare is in a unique position given it is the only designated mental health service incorporated under the *Mental Health Act 2014* (Vic) (**Mental Health Act**) for the purpose of providing forensic mental health services. Its functions extend to conducting research in the fields of forensic mental health and forensic behavioural science as well as to promote innovations in the provision of forensic mental health services. Consequently, the legislation intended that Forensicare have a leadership role across the State in understanding the interface between mental ill health and offending behaviour, both from a prevention and early intervention perspective, as well as recovery.

93 The challenge faced by Forensicare is how to achieve its multiple roles in an effective way. Currently, Forensicare's focus is on service provision due to the increased demand for our services. However, this has taken us away from capacity building across the mental health sector. There is a need for Forensicare to provide increased assertive outreach to our stakeholders.

94 There is a need for continuity of care and a shared care approach between clinical care and psychosocial supports. The two areas currently operate in silos. If clinical care and psychosocial supports are linked, there can be better mental health outcomes for clients, efficiencies for services and lower rates of recidivism.

95 To achieve this, there is also need for a shared care model with area mental health services. This may require Forensicare to co-locate with area mental health services and have satellite clinics in regional areas. It would assist Forensicare to proactively build relationships with stakeholders and provide assertive outreach. Additionally, many of Forensicare's consumers are also consumers of area mental health services and alcohol and other drugs services. There is a need for Forensicare to have a presence in local conversations to offer specialist consultation and advice, and to avoid consumers simply being referred from one service to another.

Diminished capacity for Forensicare to provide treatment and support for consumers with very complex needs in area mental health services

96 The forensic mental health system is positioned within two complex and strained systems in their own right – the Corrections system and the area mental health services. The growth in the Corrections system can be attributed to a suite of legislative changes but beyond this speaks to a growing complexity and disadvantage in our community; this disadvantage emanates from a range of factors including poverty, poor educational outcomes and minimal employment prospects, all of which manifest in poor physical and mental health outcomes. It therefore follows that area mental health services need to be well positioned to respond to mental ill health in a proactive manner where they are able to be engaged early through schools, primary and community health services, employers etc. to minimise the risk of young people and adults coming into contact with the justice system.

97 Forensicare's role across both systems is critical to ensure that at one end risk can be mitigated ahead of contact with the justice system, as well as to provide specialist mental health and forensic mental health services for those in prison. The rapid growth in demand for Forensicare's services over the last 5 years, coupled with the significant ongoing strain on its bed capacity at Thomas Embling Hospital, has diminished Forensicare's capacity to strategically and innovatively working with area mental health services on the best models of collaboration and support for their workforce and clients. Forensicare's relationships with area mental health services, whilst strong, has focussed on reactive actions and have not allowed for sufficient time and space to proactively innovate, improve service quality and drive best practice.

Responding to consumers with very complex treatment and support needs

98 The biggest challenge to providing appropriate responses to people with very complex treatment and support needs is the lack of suitable models of care.

99 For example, people may stay in Secure Extended Care Units (**SECUs**) for extended periods of time, not because it is the most suitable place from a therapeutic and security perspective, but because there is no other accommodation option that is a step down from SECUs. This is a source of significant frustration among area mental health services and compromises the recovery of patients.

100 The continuum of care between residential care and community-based care requires close examination to ensure that the appropriate intensity and tiers of service are in place for patients as they move out of the Thomas Embling Hospital into the community, or move to a different facility within the community, to accommodate changes in acuity in mental illness. Consideration must be given to more suitable secure accommodation options that are recovery-focussed, gender and culturally responsive, and supported by a step-down approach through to supported accommodation or independent living.

Forensicare Personality Disorder Initiative

101 The Forensicare Personality Disorder Initiative provides assessments, treatment, secondary consultation, education, and supervision to a multi-disciplinary team within Forensicare in relation to personality disorders. As part of this initiative, a range of functions are undertaken including:

(a) assessments and expert secondary consultation to clinicians within Thomas Embling Hospital and the Community Forensic Mental Health Service who are managing consumers with complex and/or severe personality disorder;

(b) developing and/or reviewing treatment and crisis plans;

(c) discussing the treatment and crisis plans at Spectrum meetings;

(d) providing individual and team supervision regarding personality disorder;

(e) participating in case conferences and other clinical meetings;

(f) working closely with Forensicare senior staff to ensure procedural issues are closely followed in relation to clinical risk;

(g) maintaining appropriate records related to the initiative and providing reports as required (in consultation with Forensicare's research unit, the CFBS);

(h) proactively identifying and referring eligible high risk/complex/severely unwell consumers with personality disorder to Spectrum as appropriate;

(i) oversight of the Personality Disorder Clinical Excellence Working Group to provide professional development, education, and training activities (in consultation with the CFBS); and

(j) establishing and maintaining referral pathways to enable consumers with severe personality disorders to access supports.

Forensicare's Problem Behaviours Program

102 The Problem Behaviour Program was established in 2004 as an amalgamation of the Psychosexual Treatment Program and the Problem Behaviour Clinic (established in 2000 and 2002 respectively) in recognition of the need for a specialist service that would target treatment towards these complex problematic behaviours that are often beyond mainstream psychological treatment.

103 The Problem Behaviour Program provides psychiatric and psychological consultation and treatment for adults aged 18 years and over with a range of 'problem' behaviours associated with offending and for whom services are not available elsewhere. The program is specifically directed at people known to have recently engaged in, or are at risk of engaging in, one or more problem behaviours. Problem behaviours include:

(a) serious physical violence;

(b) threats to kill or harm others;

(c) stalking (repeated unwanted contact);

(d) sexual offending, including adult sexual assault and rape;

(e) paedophilia;

(f) collection and possession of child pornography, including internet child pornography;

(g) fire-setting; and

(h) querulous (vexatious) complainants.

104 The program provides primary and secondary Consultations, together with ongoing treatment for clients assessed as having treatment needs that require specialist forensic intervention.

105 Individuals may be referred to the Problem Behaviour Program by justice agencies, area mental health services and private practitioners. Individuals may also self-refer to the service.

106 The Problem Behaviour Program is comprised of a multidisciplinary team of psychology, psychiatry, and social work. In 2016, the Problem Behaviour Program received funding arising from the findings of the Justice Harper Complex Adult Victorian Sex Offender Management Review Panel.

107 The Problem Behaviour Program was evaluated in 2015. Findings of this evaluation include:

(a) 90% of Problem Behaviour Program clients have contact with the public mental health system, despite only 30% of referrals coming from area mental health services;

(b) psychotic disorders were the most prevalent diagnoses (28%), followed by depressive disorders (15%) and paraphilia (13%);

(c) 66% of clients who attended the Problem Behaviour Program for assessment did not have subsequent charges during the follow-up period;

(d) clients averaged 4.9 charges in the two years prior to Problem Behaviour Program contact, which dropped significantly to an average of 2.5 charges in the two years after such contact;

(e) clients who completed treatment reoffended significantly less often and more slowly than clients who either were not recommended for treatment or were recommended but dropped out of treatment.

(f) 25% of Problem Behaviour Program clients are referred for Problem Behaviour Program treatment;

(g) there was a high level of treatment drop out, with only 40% of treatment recommended clients completing treatment satisfactorily;

(h) there was a significant reduction in the number and acuity of mental health contacts by clients after assessment and/or treatment at the Problem Behaviour Program; and

(i) clients reported overall high levels of satisfaction with the service and identified that it assisted them in understanding and managing their behaviour.

Forensicare Serious Offender Consultation Service

108 The Forensicare Serious Offender Consultation Service (**F-SOCS**) is an initiative funded by the DHHS. It aims to support CCS and mental health services in the management of individuals who have a serious mental illness and a history of serious violent and/or sexual offending. The F-SOCS program targets clients of CCS with a serious mental illness where these clients are not currently engaged with area mental health services or where such engagement is problematic. Clients to be considered for referral are those thought to pose a high risk of further serious violent and/or sexual offending. F-SOCS provides forensic mental health assessments and facilitates access to the mental health sector for eligible offenders currently on an order supervised by CCS (Community Corrections, Parole or Supervision Order).

109 The F-SOCS does not provide primary treatment to offenders.

Forensicare's Mental Health Advice and Response Service

110 Forensicare's Mental Health Advice and Response Service (**MHARS**) aims to intervene early in the criminal justice process by identifying mentally ill individuals who are in contact with the court. We then provide specialist clinical mental health advice to Magistrates, Community Corrections Services, and court users, as well as linkage to treatment.

111 The MHARS operates in eight metropolitan courts: Melbourne, Broadmeadows, Ringwood, Heidelberg, Dandenong, Frankston, Moorabbin, and Sunshine.

112 The MHARS provides clinical mental health advice within each court to reduce delays in proceedings and remands, and to improve the appropriateness of mental health interventions and referrals for people appearing before the court. The program enables

clinical services to intervene early in the criminal justice process by identifying where individuals charged with an offence and appearing before the court have a mental illness, and by providing timely advice and linkage with treatment providers. Where needed, immediate psychiatric intervention is provided, and referral is made to appropriate mental health services. Priority is given to providing immediate responses to those presenting to the court who are acutely mentally unwell.

113 Specialist clinical mental health advice is provided to Magistrates, CCS and court users to ensure effective assessment, treatment and management, and that court processes are applied while accounting for community safety and the mental health needs of the individual. Advice is provided:

(a) directly to Magistrates as required, and Magistrates use the advice to inform sentencing decisions or determine whether a person can participate in court processes; and

(b) to CCS on the appropriateness of a mental health treatment and rehabilitation (**MHTR**) condition on a Community Correction Order, which in turn informs the advice CCS provides Magistrates on the application of a MHTR condition on a Community Correction Order.

114 The MHARS also supports the courts to understand mental health, including (but not limited to) in the context of offending. It does this through consultation and education to CCS, Magistrates, and users of the court on mental health services and mental health issues.

Consumers with a disability and mental illness

115 Many of Forensicare's programs (including the Problem Behaviours Program) do not cater for consumers with a disability and mental illness. Whether an individual has a disability forms part of the eligibility criteria for some of Forensicare's programs. For example, if an individual has a disability which is registered with the DHHS, they are ineligible for the Problem Behaviour Program.

116 We have recently been invited by the Disability Forensic Assessment and Treatment Service (**DFATS**) to look more closely at their model of care and examine opportunities for stronger collaboration. Other than DFATS, the Australian Community Support Organisation has 1 Full-time Equivalent position that provides disability support services (funded by the National Disability Insurance Scheme) to those who exhibit problem behaviours.

Impact of gender and diversity of consumers on access to Forensicare's community programs

117 There are no exclusions for Forensicare's community-based programs based on gender. There is, however, a need for more to be done to tailor programs and be more responsive to the needs of particularly vulnerable cohorts including women, Aboriginal and Torres Strait Islander (**ATSI**) people, and culturally and linguistically diverse communities. Forensicare has established a First Nations Advisory Committee which includes membership from key ATSI organisations and community elders to advise on and inform our approaches to service delivery to ensure their cultural safety.

OUTCOMES

Evaluation of Forensicare's community programs and research

118 Forensicare is funded to deliver a range of community forensic mental health programs. Out of these programs, only one has been evaluated (the Problem Behaviour Program) through our collaboration with the CFBS.

119 Forensicare has an obligation to inform its practice through translational research and currently has arrangements with CFBS to conduct research. Greater strategic and financial investment is required in this space to drive a more proactive agenda of research that reflects Forensicare's priority areas. Recently, a Governance Charter between Forensicare and the CFBS has been approved by both the Board of Forensicare and the executive of the Swinburne University of Technology; it will include a renewed governance structure and membership that will provide a stronger strategic focus on strengthening the knowledge base within forensic mental health. This will be informed by stronger service evaluation and practice, as well as research innovations.

Consumer experience outcomes of Forensicare's community programs

120 Consumer experience is evaluated through a yearly consumer and care survey which is reported internally. We also have a consumer advisory group, where consumers meet with, and provide comments to, the Forensicare management, as well as a lived experience leadership team. The aim of these measures is to capture consumer experience in different ways and to ensure that the organisation is accountable to the needs of its consumers. This consumer engagement has been instrumental in the development and implementation of the Forensicare Recovery Model. Also, engagement of consumers in the co-design of Forensicare services is currently underway in Forensicare's Capital, Service and Strategic Planning processes and in the redevelopment of our model of care.

121 Forensicare's workforce can be strengthened to improve consumer experience outcomes through an increased investment in building and supporting the peer worker and consumer consultant workforce. It remains a challenge for a small peer workforce to have input in every area of Forensicare.

Quality and safety outcomes of Forensicare's community programs

122 Forensicare has a significant focus on safety. Given the client cohort, Forensicare has particular vulnerabilities in relation to occupational violence. As a result, we have embarked on a significant program of work in relation to quality and safety including staff safety and wellbeing. Capacity for ongoing evaluation of these initiatives is essential to determine the changes that have occurred and the improvements that have been achieved, and to inform future directions.

Public reporting of patient experiences and outcomes

123 As Forensicare deals with vulnerable people, it is appropriate, and indeed important, that patient outcomes are understood and publicly reported. Public reporting of outcomes can also improve accountability and provide a voice to consumers. Forensicare has a responsibility to be open and transparent to the community. This transparency prevents against complacency in our workforce and drives our ongoing commitment to service improvement.

YOUTH FORENSIC MENTAL HEALTH SERVICES

124 When working with young people early intervention is particularly important. Clinicians also need to be mindful that they are working with young people rather than adults. The treatment must be responsive to the learning style and development stage of that young person.

125 Consideration should be given to youth-specific forensic mental health pathways that ensure intensive and holistic assertive outreach that are not time-limited.

126 Please also refer to paragraphs 9 to 19 and 60 above.

TRANSITIONING BETWEEN SERVICES

Risks posed to people living with mental illness when they transition between services and measures to support these people

127 A significant risk raised by people living with mental illness transitioning between services is the risk of losing engagement. Having to reengage with different services can also affect their level of risk.

128 The sharing and handling of information from one service to another is critical. The current siloed nature of services requires clients to repeatedly tell their stories to different staff and organisation. This is not only inefficient, but also risks frustration and ultimately the disengagement of clients. In many cases, clients are confused as to why they have been referred to different services and how the services differ, and they become overwhelmed

by the need to coordinate appointments and engagement across referrals. Improvements in information sharing will offer significant efficiencies in the system but equally necessitate significant ongoing investment in innovations of Information Technology. While accounting for privacy regulations, systems should be integrated across health and mental health, justice and forensic mental health, and Forensicare and area mental health services in a way that avoids duplication and provides holistic and client-centred care and management.

Mechanisms that can assist to bridge each of the transitions a person living with mental illness may experience

129 The practical mechanisms that can assist people living with mental illness transitioning between services are:

(a) Information sharing (as discussed in paragraph 128 above).

(b) Early reintegration planning – Engaging with clients on entry to prison and building rapport ahead of their release from prison is a significant predictor of service engagement within the community. For this reason, reintegration planning must be holistic and commence from the day of their admission to prison.

(c) Service Integration – Different agencies need to work together more closely to identify and respond to mental health and offending risks from a holistic perspective and to invest in processes for shared care and case management. Psychosocial considerations must be included in this planning. The RAMP is a useful paradigm in considering reform in this area.

Supporting the housing, alcohol and other drug and mental health requirements of people leaving custody

130 As discussed above at paragraphs 34 to 38, there is a need for wraparound services which include alcohol and other drugs, housing, and forensic mental health. The treatment of a person needs to be informed by a holistic assessment of their range of needs. This would include assessment of their housing needs, alcohol and other drug needs and mental health needs.

131 Fundamentally, the system requires a shift on how to access services. We need to assess someone once with the right questions and plan for that assessment. A comprehensive view of the person should be obtained upfront and updated over time. Currently, these assessments happen separately and are not connected. The challenge is to bring them together.

sign here ►

print name SHAYMAA ELKADI

date 25 May 2020

ATTACHMENT SE-1

This is the attachment marked 'SE-1' referred to in the witness statement of Dr Shaymaa Elkadi dated 25 May 2020.

Dr Shaymaa Elkadi

Shaymaa.Elkadi@forensicare.vic.gov.au

Innovative and committed change leader and innovator bringing world class best practice to the Victorian Community.

A high performing leader in Government and Public-sector transformation. Skilled strategist with demonstrated success in translating policy into practice and operations to align with organisational priorities. Exceptional communication skills which foster effective engagement, negotiation and collaboration towards long term sustainable partnerships in service delivery. Builds positive and effective high performing teams which inspires a shared goal and vision in delivering on project outcomes. Takes the initiative in bringing world class and evidence based best practice to organizational policies, practices and service.

EXPERTISE

- Complex, large scale Change Management
- Organisational reengineering
- Policy design & implementation
- Best Practice Implementation
- Transformation and reform
- Strategic planning
- Systems integration
- Building strong, sustainable stakeholder relationships
- Statewide program & project management
- Operational process Analysis
- Performance Management & Benchmarking

KEY ACHIEVEMENTS

- Design, development and implementation of **Corrections Victoria's Family Violence Strategy and Service Response to Royal Commission into Family Violence**.
- Transformation and reform of **Corrections Victoria's policy and practice for the reintegration of prisoners into the community**.
- Design, development and implementation of a new **Offending Behavior Programs Service Delivery Model** in response to the 2003 Callinan review of Victoria's Adult Parole System and Serious Violent Offender legislation.
- Development of **Workforce Capability Framework** across key Corrections service role.
- Development of **Statewide Performance Measurement** Framework across Corrections Victoria's rehabilitation service models.
- Evaluation of inaugural **Family Violence Specialist Courts.**
- Successful **negotiation of $15 million project with the Commonwealth for a national training** program for the education and training of collaborative mental health care models.
- **Development of a** national training tool **for collaborative mental health care.**

PROFESSIONAL EXPERTISE

ACTING CHIEF EXECUTIVE OFFICER

FORENSICARE

23 October – 5 October 2019

Acting for Forensicare CEO during leave.

EXECUTIVE DIRECTOR, COMMUNITY OPERATIONS
FORENSICARE
May 2019 – Present

Responsibilities

Oversight of the Forensicares' Community Forensic Mental Health Service including strategic planning, financial management, service and workforce planning and service operations.

Partnering with Clinical Leaders of the Organisation to enhance organisation wide clinical governance of Forensicare

Organisational wide leadership of the following stakeholder portfolios:
Victoria Police, courts, Area mental Health Services, Youth, First Nations and Priority Communities

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CLINICAL GOVERNANCE AND PERFORMANCE LEAD
BEYOND BLUE
September 2018 to May 2019

Responsibilities

Establishment of an organisation wide Clinical Governance to inform the ongoing quality assurance of Beyond Blue programs and services nationally. An overarching Clinical Governance Framework was developed and endorsed by the Beyond Blue Board in December 2018.

Establishment of strategy and infrastructure for the national implementation of a commonwealth funded suicide prevention program.

GENERAL MANAGER, SENTENCE CALCULATION AND WARRANT ADMINISTRATION UNIT
SENTENCE MANAGEMENT DIVISION, CORRECTIONS VICTORIA
Nov 2017 to August 2018[1]

Responsibilities

Oversight of the operational processing of all legal instruments for the holding and discharge of prisoners statewide across Victoria's prisons. This includes the coordination of court attendance, bail applications and sentence calculations.

Review of operations to inform the development of strategic objectives and plans that will form a foundation for future policy, practice, process and workforce requirements.

ACTING/DEPUTY COMMISSIONER,
OFFENDER MANAGEMENT DIVISION, CORRECTIONS VICTORIA
December 2016, April 2017

Responsibilities

Portfolio responsibilities include Sex Offender Management Branch inclusive of Serious Offender Reform and Supervision Order Scheme, Adult Parole Board, Rehabilitation and Reintegration, Offender Management Development.

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[1] *Appointed to this role to support the transformation and reform of the Sentence Calculation and Warrant Administration Unit following a number of independent reviews and recommendations.*

Acting Deputy Director – North West Metro Area
Regional Services Network, Department of Justice and Regulation
May to July 2016

Responsibilities

Portfolio responsibilities included Metropolitan Remand center, Melbourne Assessment prison and Dame Phyllis Frost Centre, Regional Prisons and Offending Behavior Programs and services.
During this time, I initiated a key reform program for the regional Offending Behavior Programs Team which has been sustained and contributed to a significant improvement in performance.

General Manager, Rehabilitation and Reintegration Branch
Offender Management Division, Corrections Victoria
July 2011 – Nov 2017

Responsibilities

Leading the design, development, implementation and monitoring of high level and complex rehabilitation and reintegration policy, projects, service models and processes across Corrections Victoria for: Family Violence, Violence and general offending, Specialist vulnerable cohorts including women, youth, those with cognitive impairments, culturally and linguistically diverse cohorts and the ageing, and Aboriginal and Torres Strait Islanders (inclusive of Aboriginal Justice Agreement).
All project management occurs in accordance with the Project Management Excellence (PME) Framework

Principal Workforce Advisor
Modeling and Spatial Analysis, Business Planning and Communications Branch
Department of Health
July 2008 – July 2011

Responsibilities

Provision of high-level authoritative advice to Ministers and the Health Executive regarding key statewide workforce issues and challenges.
Stakeholder engagement of educational, health, training and unions in key workforce initiatives.
Strategically inform statewide workforce planning in line with community health priorities.
Redevelopment and oversight of Department wide a workforce modelling and collections.

Deputy Director of Policy and Projects,
Royal Australian and New Zealand College of Psychiatrists (RANZCP)
2007- 2008

Responsibilities

Provision of high-level expert advice expert to the College General Council, Boards, Branches, Faculties and Sections on key policy, projects and research
Lead and manage policy, research and project teams
Building strong stakeholder networks including with Commonwealth and State Governments.
In partnership with the CEO negotiate major policy issues and projects within and between RANZCP, stakeholders and Governments.
Complex policy and impact analysis in response to recommendations and reviews in relation to health service delivery and operations, funding, education, workforce, community and broader issues.

Research Development & Projects Manager/ Manager of Clinical & Workplace Support
Caraniche
2005 – 2007

Responsibilities

Implementing and monitoring and development of forensic assessment programs in line with evidence based best practice principles.
Provision of authoritative advice to Company directors to inform Strategic and Service directions.
Leadership of clinical service delivery, service delivery research as well as implementation of new initiatives and service innovations.
Engagement of key stakeholders The Department of Justice and Regulation, Department of Health and Human Services and Victorian Courts.

Programs Manager, Clinical Epidemiology and Health Service Evaluation Unit, Melbourne Health
2005

Responsibilities

Project management and stakeholder engagement across key multidisciplinary projects including: The review of clinical treatment guidelines for arthritis treatment (Arthritis Foundation) and The Development of a National Patient Safety Toolkit (Australian Quality Council).

Research Neuropsychologist
Department of Neuroscience, The Alfred Hospital.
2003-2006

Responsibilities

Management of statewide delivery of research grants including:
Engaging and communicating with private and public practicing health professionals for recruitment, Neuropsychological assessments and statistical analysis.
Presentations at national and international conferences (see below).

Research Fellow
Department of General Practice, Monash University
2004

Responsibilities

Supervising general practitioners enrolled in the program for the delivery of their primary care research projects and the training of general practitioners in research methods and data analysis.

Education

Company Directors Course
Australian Institute of Company Directors
4-11 February 2020

Executive Masters of Public Administration
Australian and New Zealand School of Government
2010-2013

Cranlana Program for Future VPS Leaders
Myer Foundation
2009

Leadership and Management, Performance Management
Monash University
2004

PhD (Psychology)
University of Melbourne
2003

Graduate Diploma in Applied Psychology
Monash University
1996

Bachelor of Arts (Majoring in Psychology & Criminology)
University of Melbourne
1993-1995

Referees

Available on request

CAREER ACHIEVEMENTS

Key Achievements

Services and Programs

Pilot of Aboriginal Disability Program

Redevelopment of Corrections Victoria's Approach to driving and supporting the reintegration of prisoners in the community through the development of a new unprecedented innovative pathway that commences on entry to prison through to post release.

Leading the development of the inaugural Corrections Victoria Prisoner Reintegration System that would change the way programs are recorded, monitored, reported to inform service delivery

Development of a new Remand Service Delivery Model for unsentenced prisoners

Development of a new Individual Service Delivery Model for unsentenced prisoners

Development and implementation of a new Family Violence (FV) Specialist Pathway including leading the development of:

Corrections Victoria's strategic policy response to FV

Innovative practices and services including:

- Men's Behavior Change Programs (MBCP)
- Family Safety Contact Service,
- FV Flags,
- Culturally and Linguistically Diverse MBCPs.
- CALD FV Information Sessions
- Respectful relationships program
- Development and Introduction of Change About Program (Tailored FV intervention for medium and high-risk offenders)

Expansion of CASA service in prison and community-based offenders

Kaka Wangity Wangin Mirre Grants (Aboriginal Program Grants)

State-wide introduction of Aboriginal yarning circles

Review and redevelopment of the following high-profile Offending Behaviour Programs (OBPs)

- Violence Intervention Programs
- Making Choices
- Talking Change
- Remand programs

Review of Mother and Children's program

Key Achievements
Introduction of Family Engagement Program
Scoping of cognitive screening and assessment tools
Development, introduction and implementation of: • OBP panel of preferred providers $28.1m • MBCP Panel of preferred providers $16m
Redevelopment of programs for low functioning prisoners
Review of OBP assessment process
Aboriginal Transitional Housing Project
Review and Introduction of Triple P parenting program
Relink and ReConnect Service Audits
Implementation of Links program
Transfer of YMCA program
Policy and Strategy (Systems thinking)
Realignment and expansion of the Nalaamba Ganbu Nerrlinggu Yillam
Development of and delivery on CV Aboriginal Justice Agreement Objectives
Introduction of Youth Practice Guidelines for Prison and Community Corrections.
Integration of risk assessment, parole application and reintegration services as a single pathway.
Review of Disability Programs Pathway
Development of Aboriginal Generals Policy
Leading the programmatic effort as part of parole system reform program through: • Redevelopment of OBP service delivery model • Integration of program delivery and case planning and case management • Linking program participation to parole
State-wide Women's Services Review which included: • Development of design principles • Three-tiered service model

Key Achievements

Performance monitoring model for Private prisons

Systematic reporting of state-wide programmatic effort

Development of performance measurement framework

MACNI MOU

Youth Justice MOU

Development of Aboriginal Cultural Guidelines

Development of national Patient Safety Toolkit

Translation of research into practice (North Western Mental Health)

Proposed combined AOD- OBP assessment model

Leading the implementation of serious violent offender service response including:

Informing legislative change

Serious Violent Offenders waitlist project

Leading CVs participation in the Koori Cultural Inclusion Action Plan

Redevelopment of central-regional governance framework

Leading the impact assessment of Community Correctional Services reform on programmatic participation and pathways

Development of the Beyond Blue Clinical Governance Framework

Stakeholder Management and Workforce

Introduction of a new workforce of regional Program facilitators state-wide to contribute to OBP service delivery. Delivery included:

- ADAPT
- Step Up
- Psych Ed

Introduction of Contract Coordinator role

Creation of a new workforce in the form of a state-wide central intake team that would manage all programmatic referrals state-wide to support regional service delivery and the introduction of the Corrections Victoria Intervention Management System.

Sponsorship of Somebody's Daughter Theatre Company

Key Achievements

Regionalisation of Aboriginal Wellbeing Officers

Introduction of Remand Program Facilitator Model

Development of an Aboriginal Cultural Advisor role within CV

Use of DJR Graduate Program to expand the business and achieve natural growth in capacity

Improving system wide visibility of programs and their role in the pathway of the correction system

State-wide professional development of the OBP, Assessment and Transition Coordinator and Aboriginal Workforce through:

- The introduction of standard new starter training
- Annual OBP forum

Development of a capability framework for clinical staff.

Development of Karreenga Prison Annex Service Delivery Model

Restructure of regional OBP workforce (NWMA)

Introduction of facilities management at the Dame Phyllis Frost Centre

Development of a program Compendium for stakeholders and other communication materials

Workforce Modelling

Two major workforce restructures

- Sentence Calculation and Warrant Administration
- Offending Behaviour Programs Statewide

Information Management

Leading the development of the inaugural Corrections Victoria Intervention Management System that would change the way programs are recorded, monitored, reported to inform service delivery

Introduction of SharePoint

Reports and investigations

Ombudsman Own motion investigation

Unfinished Business

VAGO review

Treasury Base review

Key Achievements
Internal Management Reviews
Committees
Ministerial Women's Correctional Advisory Committee
EACPI
Women's services review Steering committee
Movement of Offenders
Correctional Services Advisory Committee