Peer Mentoring In Mental Health

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Aim

To express the use of peer mentoring within the mental health space as a way to respond to mental health conditions and eliminate the use of forced medication.

Executive Summary

Peer Mentoring is an effective social solution for those presenting difficulties in re-integrating and contributing to the wider community due to their psychosocial challenges. It enables people to express their shared experiences in mental struggles, and thus, can better relate, offering more authentic empathy and validation to mentees. It is a valuable resource for building strong relationships, instilling confidence and importantly, curtailing reoffending. A 'Peer Mentor' is defined as a professional care worker who has lived experiences relevant to the challenges faced by the people they care for. Peer mentoring allows mentees to feel understood by their mentors and other individuals who have experienced similar challenges with their mental health. For example, individuals undergoing mental health struggles, substance abuse issues, trauma, detention, prior detention, or other experiences can be vastly helped by the advice and support of their peer mentors.

Peer Mentoring was first implemented in the USA in the 1970s, and is now practised across the globe, including nations such as the UK, New Zealand and South Africa.[1] In Australia, peer mentoring has been accepted nationally, with multiple organisations providing mentoring programs for those with psychosocial challenges.

By implementing the sharing of lived experiences, mentors can model and empower future pathways that the mentee could envision for themselves as well as assist in navigating the complex mental health system. Further, mentors can be empowered to assist mentees in understanding the services that are available to them, how these services can be accessed, and guidance on how to use them.

Peer mentoring provides a client-centred approach to mental health care through empathy, trust and community. During peer mentoring sessions, mentors are required to consciously implement these three principles. Mutual trust is achieved by communicating honestly and vulnerably while withholding judgement and fostering a sense of connection, community and credibility. Furthermore, connections made within a community can act as a "safety net" for an individual's mental health, providing greater self esteem, connectedness and sense of purpose.

Existing mentorship programs in Australia emphasise the importance of finding a mentor that can relate to the mentee in a way that facilitates empathy, understanding, and sensitivity. For example, the Women's Justice Network takes a gender-responsive approach, with mentorship programs provided by women for women.[2] Another peer mentoring service

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[1] N Coleman, W Sykes and C Groom, 'Peer Support and Children and Young People's Mental Health: Research Review' (2017) *Department for Education,* London.
[2] 'About WJN', Women's Justice Network (Web Page) <https://www.womensjusticenetwork.org.au/our-mission/>

Deadly Connections provides a culturally-responsive approach, whereby young Aboriginal individuals are paired with Aboriginal elders.

There is evidence suggesting peer mentoring is effective in preventing the formation of mental illness in those at risk. This is important within the incarceration environment and youth detention centres due to the high rates of mental health issues.This form of treatment has also shown to be successful in hospitalisation environments. A randomised controlled trial, Glazzard et al (2021), conducted with individuals with clinically significant psychotic and mood disorders found that those who were assigned a peer mentor had significantly reduced hospitalisation rates when compared to the treatment as usual group[3].

Additionally, peer mentoring is successful in improving the wellbeing of older adults with psychosocial concerns by assisting them in learning useful skills and increasing their self-awareness. Assistance can come in the form of employment or education support including resume building and in obtaining government documents needed upon release (such as medicare and transport cards).

National and state policies have also proven the efficacy of peer mentors and commended the role peer navigators have played in mitigating distress and encouraging help-seeking when individuals transition from mental health hospitals to everyday life. In 2021, the National Mental Health Commission ('NMHC') released guidelines for peer mentors, and presented a range of evidence demonstrating the efficacy of consumer workers. Moreover, the Victorian Department of Health released a framework for lived-experience workers, and consumer engagement in mental health policy with Western Australia publishing their own state guidelines.

In the facilitation of Peer Mentoring in mental health, it is vital for there to be effective incorporation that focuses on the betterment of the mentees and mentors. This is underpinned by how accessible, supportive and extensive the quality of training is. In order to be an effective alternative to forced medication, peer mentorship should uphold basic human rights and transparency by providing balanced information for individuals with psychosocial challenges on its benefits. In addition, the opportunity for people with the experience of coping with psychosocial challenges to become peer mentors promotes their active community engagement, work experience and career satisfaction by helping others in relatable situations.

For a peer mentoring program to be considered 'successful' or 'effective', it is argued that the following criteria must be met. Firstly, peer mentors must have adequate training to deal with various mentees and situations, focussed on professionalism. The success of peer mentorship within the mental health system partly relies on training that identifies lived experience as a priority. Central to being a peer mentor should be the ability to translate lived experience into effective support and guidance material for the mentees. Following, the place where peer mentoring is undertaken is appropriate, safe and that peer mentoring services themselves are accessible to a diverse audience of individuals. Another criterion for

[3] Jonathan Glazzard, Anthea Rose, Paul Ogilvie, 'The impact of peer mentoring on students' physical activity and mental health', (2021) 20(2) *Journal of Public Mental Health* 122

effective peer mentoring is adequate status within the workplace. Affording peer mentors status within the workplace will ensure their voice is respected by other mental health professionals. Peer mentors' unique set of insights and experiences are a priceless asset to the mental health industry, and deserve to be respected. Respecting the role of peer mentors is also something included in the guidelines released by the National Mental Health Commission (NMHC). The last criteria is that there is sufficient funding to support the continued operation of peer mentoring services for the long-term.

Currently, peer mentoring is supported by the NSW Ministry of Health, providing $2.7 million annually towards the peer supported transfer of care initiative. In an independent review it was found to reduce 28-day and 12 month readmission rates and increase consumers' interaction with community services[4]. Additionally, the Australian Department of Health has partnered with The Australian Centre for Social Innovation to invest $7.5 million of the fund into the development of two mental health lived experience peak bodies to support both consumers and their families, carers and kin.

There are currently various peer mentoring programs in Australia catering to people from different backgrounds. Some examples include SANE's Peer Guide program that has run for 5 years since 2023.[5] The program primarily seeks to ensure that people with complex mental health issues have access to practical work experience, ultimately closing the gap between mental health inequities and social and economic exclusion. Furthermore,the Women's Justice Network also has an Adult Mentoring Program that provides one-to-one social support for women and girls who have either exited custody or are at risk of involvement in the Criminal Justice System. Justice Action also has published a Mentor's Handbook on the JA Mentor Project to establish practical mentoring strategies.

Overall, it is clear that peer mentoring is a well established and successful practice across the mental health industry, with both federal and state governments providing extensive funding into training and establishing these practices. Peer mentoring within the mental health space has also been proven a highly effective response to mental health conditions that upholds greater benefits for the mentee, mentor and wider community. It is the solution to eliminating forced medication.

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[4] N Hancock et al, 'Independent Evaluation of NSW Peer Supported Transfer of Care initiative (Peer-STOC): Final report' *The University of Sydney & Australian National University, Australia* (Report, July 2021) <https://www.nswmentalhealthcommission.com.au/sites/default/files/2022-03/Peer%20StoC%20eval.pdf>.

[5] '2023 Annual Report', *SANE Australia* (Web Page, 2023) <https://www.sane.org/images/Annual_Reports/SANE_Annual_Report_2023_DIGITAL.pdf>.

Recommendations

1) Support the use of peer mentors as a response to people with psychosocial challenges – more effective and a safer/comfortable experience for mentees
2) Better alternative to forced medication and inadequate crisis intervention, provides better opportunity for reintegration and rehabilitation
3) People are able to leverage their experiences with mental illness into a pathway to employment, engagement and participation in the community
4) Mental health patients can recover and regain control over their life and have a meaningful role in society, despite experiencing mental illness, including its negative and sometimes disabling consequences
5) Provides attainable and meaningful support to prisoners, aiding rehabilitation

1. Definition of ‘Peer Mentoring’

The idea behind peer mentoring is that people who have had similar experiences can better relate and consequently offer more authentic empathy and validation to mentees (Repper and Carter, 2011). A ‘peer worker’ in this paper refers to a care worker who has lived experiences relevant to the challenges faced by the people they care for. Preferably, all peer support workers would be paid members of staff, providing an employment opportunity for people leaving custody. However, peer workers may also be volunteers, contributing their time and expertise to our most vulnerable. Those undergoing mental health struggles, substance abuse issues, trauma, detention, prior detention, or other experiences can be vastly helped by the advice and support of those either in, or having been in similar situations. While terms such as ‘peer support’ apply to group mentoring or lived experience forums, a ‘mentorship’ would be a one-on-one relationship between mentor and mentee. Therefore, a ‘Peer Mentor’ is an individual with lived experience working in a one-on-one mentorship role. The role of the mentor is a “non-judgemental” and “non-directive” individual who fosters an “equal relationship” with the mentee.[6]

Greens Party MLC Amanda Cohn, chair of the Mental Health Inquiry, stated that the inadequate resources in hospitals and prisons left doctors “no choice but to provide medical restraint”. Peer mentoring has the potential to spearhead recovery-focused changes in service (Repper and Carter, 2011) and offer a gateway solution to the dehumanising use of forced medication. As stated by Glenn Martin, ‘Those closest to the problem are closest to the solution, but furthest from resources and power’, peer mentoring values and centres lived experience of prisoners and is the missing link to the treatment process.

It is important to avoid unnecessary labelling of people involved in peer services and be careful of potential stigmatisation. individuals affected by psychosocial challenges have commonly been referred to as ‘consumers’ in literature concerning training programs for peer mentorship. However, ‘people with psychosocial challenges’ has become the accepted term over “consumers" by the World Health Organisation. With regards to mentors, ‘‘Peer worker’ is the preferred term over ‘Consumer worker’. A lived experience worker also provides another alternative’.[7] The use of appropriate terminology may mitigate the potential for a power imbalance between mentor and criminal justice client.

Dr David Murphy has made a statement regarding the legality of chemical restraints, and the circumstances in which forced medication is permissible[8]. He stated that providers who use chemical restraints are actively violating the Mental Health Act[9], citing sections 41[10], 68[11], and 195[12]. Additionally, section 68(d) states that medication can only be prescribed for treatment, not as a punishment, or for the convenience of others. Despite this, consumers

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[6] Gillian Nisbet et al, ‘A Peer Group Mentoring Framework for the Development of Student Supervisors’ (2014) *Mental Health Coordinating Council*, Sydney

[7] Australian Government, Department of Health, ‘Peer workforce role in mental health and suicide prevention’ (2019)

[8] Ibid.

[9] *Mental Health Act 2007* (NSW) s 1 (‘*MHA*’).

[10] Ibid s 41.

[11] Ibid s 68.

[12] Ibid s 195.

are continually forced to take medication which is not in their best interest, but is instead, taken to convenience others. Additionally, section 69[13] makes it an offence to wilfully strike, wound, ill-treat, or neglect a person detained at a mental health facility. However, consumers are ill treated via the use of chemical restraint, and malpractice. The overreliance on chemical restraints for mental health patients who suffer from psychosocial challenges and who would benefit from peer mentoring is unacceptable.

2. Principles of Peer Mentoring

Peer mentoring provides a client-centred approach to mental health care through empathy, trust and community. Peer mentoring is an alternative to forced medication which addresses ineffective crisis intervention programs due to inadequate resources. Consequently, mentors require either lived experience or extensive history working within the mental health sphere to provide informed guidance to mentees.

Peer mentors use their lived experiences to approach and help mentees with understanding and respect. A mentor-mentee relationship requires human connection, empathy and mutual trust to establish a safe space for mentees to open up to their mentors during peer mentoring sessions. Ultimately, a peer worker would be a role model and provide guidance and strategies for progression.

Prisoners in NSW correctional centres have little chance to participate in formal professional psychological counselling. In 2018, 40% of the prison population had reported being diagnosed with a mental health condition and 18% were referred to a mental health service for further treatment,[14] highlighting peer mentoring will benefit a large proportion of prisoners. The value of receiving assistance from people who are trained, willing to listen to their problems and provide guidance is invaluable in an isolated prison environment. The three pillars of peer-mentoring experience are empathy, trust and community.

[13] Ibid s 69.
[14] 'Health of People in Prison', Australian Institute of Health and Welfare (Webpage, 17 July 2022) <https://www.aihw.gov.au/reports/australias-health/health-of-people-in-prison>.

2.1 Empathy

"To my mind, empathy is in itself a healing agent. It is one of the most potent aspects of therapy, because it releases, it confirms, it brings even the most frightened client into the human race"
treatment– Carl Rogers

'Empathy' is a multidimensional understanding of others' emotional experiences, allowing people to put themselves in others' shoes and perceive the world through differing perspectives.[15] Empathy utilises an emotion-focused approach to provide support, form relationships and to show understanding and compassion towards others' situations.

The notion of 'empathy' displays that humans are not simply contained within our own bodies and minds. Rather, we possess an inherent connection to the world and others around us.[16] Helping others and understanding what they are going through benefits the emotional development of the self, which in turn, contributes to overarching social unity.

The ability to form meaningful relationships between a peer mentor and mentee is largely guided by the principle of empathy. A *peer* can be defined as 'one that is of *equal* standing with another',[17] reflective of how peer mentoring as a practice functions on the premise of establishing an understanding of an individual's experience through connection, openness and responsiveness. Resultantly, empathy is undeniably one of peer mentoring's essential virtues.

Empathy is vital when working with people who experience psychosocial conditions, especially following forced medication which disempowers and isolates the client. Further, individuals with lived experience are more likely to have empathy toward their mentees who are struggling with psychosocial issues. Such individuals can offer support, validate and offer valuable advice and strategies for overcoming shared challenges. An empathetic approach, built on genuine understanding, sensitivity, and goodwill is a core tenet of peer mentoring, facilitating a safe environment for mentees to share their experiences.

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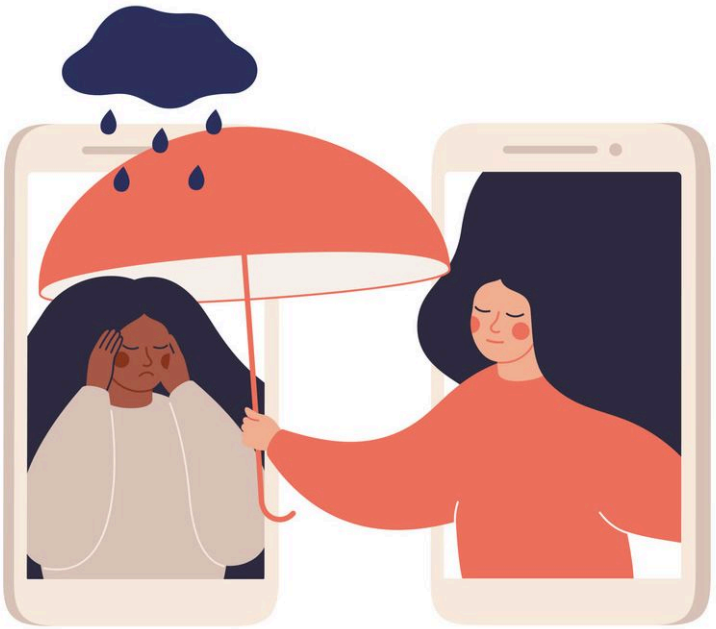
[15] Ronald Wayne Hochstatter, 'Peer Mentoring and Empathy', (2012) *UND Scholarly Commons* <https://commons.und.edu/cgi/viewcontent.cgi?article=2293&context=theses> 13.
[16] Ibid (n 5).
[17] Merriam-Webster, 'Peer Definition & Meaning' (Webpage, n.d.) <https://www.merriam-webster.com/dictionary/peer>

2.2 Trust



"Mistrust begets mistrust; trust begets accomplishment"
– Lao Tzu

By necessity, trust is a key agent in a successful peer mentoring session. A *mentor* is a '*trusted* counsellor or guide'.[18] Evans emphasises specific characteristics such as being a good listener and respecting confidentiality, as promoting trust in a mentor-mentee relationship.[19] Mutual trust is achieved by creating equitable relationships between mentors and mentees, fostering a sense of connection and credibility. Credibility is derived from the ability to understand the inner pains caused by the experience of incarceration.[20] With credibility comes trust. Trust ensures that mentors and mentees communicate honestly, displaying vulnerability and withholding judgement, encouraging active engagement and opportunity for recovery.

[18] Merriam Webster, 'Mentor Definition & Meaning' (Web Page, n.d.). <https://www.merriam-webster.com/dictionary/mentor>.
[19] Catherine Evans, 'Trust and connection in formal, virtual mentoring', (2018) (12) *International Journal of Evidence Based Coaching and Mentoring* 154
[20] Esther Matthews, 'Peer-focused prison reentry programs: Which peer characteristics matter most?' (2021) 2(2) *Incarceration* <https://journals.sagepub.com/doi/full/10.1177/26326663211019958>

2.3 Community

"We cannot live only for ourselves. A thousand fibers connect us with our fellow men"
– Herman Melville

A 'community' is a group of individuals living in social cohesion because of their shared experiences, concerns, and physical environments. Connections made within a community can act as a "safety net" for an individual's mental health, providing greater self esteem, connectedness and sense of purpose.[21] Ideally, members of a community have the opportunity to actively participate in society, however, prisoners' long-term exposure to hostility may impact their mental health and prevent them from actively participating.
Peer mentoring provides the opportunity to mitigate the impact of mental health conditions and promote active participation upon reentry into society. Empathetic peer mentors who are likely to share similar experiences with their mentees, can form a community with their mentees. Additionally, mentees can provide further support for each other alongside their mentor, providing clear, nonjudgmental and informed guidance to improve their mental health. Giving support through peer mentoring and making positive impacts on others, in return, brings fulfilment and enriches the life of not only the receiver, but the giver too.

2.4 Principles in Practice

During peer mentoring sessions, mentors are required to consciously put the three principles mentioned above in use. In order to accomplish the goal of peer mentoring, they have to rid themselves of any established prejudice and recognise the value of the lived experience of mentees. Mentors must ensure the mentee confidentiality is protected, and their practice is ethical to ensure the safety of all parties. Privacy of personal information is vital considering the unique position of peer mentoring programs catering for prisoners. There exist several important and famed paradigms concerning peer support, which will be discussed thoroughly in Section 3 below.

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[21] 'Connecting with others', *Head to Health* (Web Page) <https://www.headtohealth.gov.au/living-well/connecting-with-others>.

2.5 Benefits of Peer Mentoring

Peer mentoring, along with other social support solutions, can also assist with particular, practical challenges faced by people in custody. Assistance can come in the form of employment or education support, including resume building, as well as support in obtaining documents needed upon release (such as medicare and transport cards). The breadth of support services provided by a peer mentor allow for long term benefits for mentees in custody. Research has shown that people who have accessed consumer-operated services achieve improved housing, employment and social inclusion.[22] Further, it has been demonstrated that peer mentors may also clarify or point out specific factors pertaining to a mentee's situation more so than institutional figures, providing signposts of their recovery which has subsequently led to a higher level of trust between a mentee and their mentor.

SANE's National Stigma Report Card[23] has identified that people with complex mental health issues require workplaces that are sensitive, flexible and equipped to respond to their needs. Those with mental health issues are reportedly more prone to experiencing unfair treatment based on stigma and discrimination. Consequently, the opportunity to become a peer mentor enables individuals who have experienced psychosocial conditions to gain work experience that enables positive reintegration into the community.

[22] Flick Grey and Mary O'Hagan, 'The effectiveness of services led or run by consumers in mental health' (2015) *Evidence Check,* Sax Institute for the Mental Health Commission of New South Wales.
[23] 'The National Stigma Report Card', *The National Stigma Report Card* (Web Page) <https://www.nationalstigmareportcard.com.au/national-stigma-report-card>

3. Peer Mentoring as a Solution

Existing mentorship programs in Australia emphasise the importance of finding a mentor that can relate to the mentee in a way that facilitates empathy, understanding, and sensitivity. For example, the Women's Justice Network takes a gender-responsive approach, with mentorship programs provided by women for women.[24] Another peer mentoring service Deadly Connections provides a culturally-responsive approach, whereby young Aboriginal individuals are paired with Aboriginal elders.[25]

In the environment of imprisonment, violence to the self and to others occur almost on a daily basis. There is also a lack of physical and social interactions leading to isolation and other maladaptive coping mechanisms. Traumatic conditions of prison and lack of inside support can foster a negative environment for individuals to inhabit and be heavily influenced to stimulate negative actions. Moreover, forced medication dismisses the capacity of prisoners to actively participate in decision making, and denies their autonomy. Observing is a great way to learn from someone who has previous lived experience and acts as a model. Mentees can feel connected and understood by those who experienced similar instances as them.[26]

Chemical restraint and its indefinite use should be discouraged because of the negative effects on those with psychosocial challenges. A common consensus at the 'Mental Health is a Universal Right' discussion,[27] was that a lack of resources lead to medical professionals and care workers being overburdened, in turn causing a greater probability for chemical restraints to be used. In order to minimise the use of chemical restraint more funding needs to be allocated to mental health services along with increased social support for patients.

3.1 Mental Health

3.1.1 Current Australian Peer Mentoring Initiatives

Peer Mentoring was first implemented in the USA in the 1970s, and is now practised across the globe, including nations such as the UK, New Zealand and South Africa.[28] In Australia, peer mentoring has been accepted nationally, with multiple organisations providing mentoring programs for those with psychosocial challenges. Additionally, following the

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[24] 'About WJN', Women's Justice Network (Web Page) <https://www.womensjusticenetwork.org.au/our-mission/>
[25] 'Youth Frontiers', *Deadly Connections Community and Justice Services* (Web Page) <https://deadlyconnections.org.au/youth-frontiers/>
[26] David Adair, 'Peer Support Programs Within Prisons' (2005) *School of Sociology and Social Work, University of Tasmania* <https://www.aph.gov.au/~/media/wopapub/senate/committee/mentalhealth_ctte/submissions/addinfo022_pdf.ashx>
[27] Justice Action, *Australian Human Rights Commission and Being Discussion 17/10/23* (Report, 2023) <https://justiceaction.org.au/report-on-australian-human-rights-commission-being-discussion-17-10-23/ >
[28] N Coleman, W Sykes and C Groom, 'Peer Support and Children and Young People's Mental Health: Research Review' (2017) *Department for Education,* London.

Mental Health Equity and Access Forum held in 2023, the Federal Government has announced they will be investing 8.5 million dollars into elevating the role of those with lived experience within the mental health system[29]. The Australian Department of Health has partnered with The Australian Centre for Social Innovation to invest $7.5 million of the fund into the development of two mental health lived experience peak bodies to support both consumers and their families, carers and kin.[30] This significant investment by the federal government highlights the importance of utilising those with lived experience to reform our mental health practices.

Peer mentoring is supported by the NSW Ministry of Health, providing $2.7 million annually towards the peer supported transfer of care initiative. In an independent review it was found to reduce 28-day and 12 month readmission rates and increase consumers' interaction with community services.[31] The NSW government is also providing 100 scholarships for those with lived experience to complete a Certificate IV in Mental Health Peer Work.[32] Additionally, the Victorian government has invested $1.3 million as part of the peer cadet program into a number of organisations that provide mentoring support, which due to its success is being expanded across more mental health services.[33] Funding has also been offered by the South Australian Government who have committed to funding advocacy groups for peer mentors over a four year period.[34]

It is clear that peer mentoring is a well established and successful practice across the mental health industry, with both federal and state governments providing extensive funding into training and establishing these practices. Additionally, there is a wealth of research which shows that peer mentoring is a non-restrictive practice and is effective in helping those with psychosocial challenges (see section 3.2.2). Therefore, the question remains as to why peer mentoring is not offered as an alternative to medication, especially given the funding available.

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[29] Mark Butler, 'Elevating people with lived experience of mental ill-health to drive reform *Ministers Department of Health and Aged Care* (Web Page, 30 January 2023) '<https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/elevating-people-with-lived-experience-of-mental-ill-health-to-drive-reform>

[30] 'National mental health lived experience peak bodies' *Australian Government Department of Health and Aged Care* (Web Page, n.d.) <https://www.health.gov.au/topics/mental-health-and-suicide-prevention/what-were-doing-about-mental-health/national-mental-health-lived-experience-peak-bodies>

[31] N Hancock et al, 'Independent Evaluation of NSW Peer Supported Transfer of Care initiative (Peer-STOC): Final report' *The University of Sydney & Australian National University, Australia* (Report, July 2021) <https://www.nswmentalhealthcommission.com.au/sites/default/files/2022-03/Peer%20StoC%20eval.pdf>.

[32] 'Peer workers', *NSW Health* (Web Page, n.d.) <https://www.health.nsw.gov.au/mentalhealth/professionals/Pages/peer-workers.aspx>

[33] Gabrielle Williams, 'Bolstering Our Mental Health Lived Experience Workforce', *Premier of Victoria* (Web Page, 24 March 2023) <https://www.premier.vic.gov.au/site-4/bolstering-our-mental-health-lived-experience-workforce>

[34] Peter Malinauskas, 'Supporting community input on mental health care', *Premier of South Australia* (Web Page, 6 May 2023) <https://www.premier.sa.gov.au/media-releases/news-items/supporting-community-input-on-mental-health-care>

3.1.2 The Effectiveness of Peer Mentoring

Peer Reviewed Research on the effectiveness of Peer Mentors

In support groups and consumer-run programmes, there exists a mutually beneficial relationship between peers and mentees. Those who are involved in consumer-run programs share their lived experience, which aids in the recovery of the consumer, and improves the wellbeing of the mentor.[35] Additionally, peer support workers can empower consumers by being a role model and helping develop the framework for recovery. The marked improvements afforded to consumers, highlights the importance of peer mentors in supporting those with psychosocial challenges. Peer mentoring has been found to be vital in the treatment process of prisoners and individuals that have been hospitalised.

Moreover, Ochocka, Nelson, Janzen, and Trainor (2006) longitudinal study of mental health consumer/survivor initiatives (CSIs) found that participation in peer support as both provider and recipient resulted in improved mental health, enhanced social support, and increased sense of independence. Among the intervention group, 62.5% individuals reported experiencing mental struggles at baseline which reduced to 12.5% individuals after 18 months of treatment. In contrast, the control group maintained a constant level of mental health issues with 50% individuals reporting declined mental health at 18 months (75% at baseline). Additionally, both groups at baseline reported having a social support group, however, the CSI group were more likely to maintain and strengthen social relations (80% individuals at 18 months)[36]. Those who participated in the CSI treatment felt more independent as they were provided with sustainable work and income, education and training. Within the CSI group, 73% individuals were employed after 18 months in comparison to the non-CSI group, with only 33% being employed. Thus, adapting a social approach to treating mental illnesses has been profound.

The prevalence of mental disorders among adolescents in juvenile detention and correctional facilities prisoners is evident, thus, researching different treatment methods and their effectiveness is essential. An international systematic review conducted by Fazel, Doll and Langstrom (2008) concluded that young offenders strongly correlate to having poor physical health, mental disorders, substance abuse and externalising disorders in comparison to the general population of young adults. Amongst boys, 3.3% are diagnosed with psychotic illnesses, 10.6% with major depression, 11.7% with ADHD and 52.8% with conduct disorder. Moreover, 2.7% girls were diagnosed with psychotic illnesses, 29.2% with major depression, 18.5% with ADHD, and 52.8% with conduct disorder. These results concluded that prisoners within these facilities are 10 times more likely to suffer with mental disorders than the general population[37]. In addition, these findings correlate to the prevalence of mental disorders and drug and substance abuse in Australia, with over 42% of prisoners presenting with a mental disorder and 55.3% of

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[35] Larry Davidson, Matthew Chinman, Bret Kloos, Richard Weingarten, David Stayner and Jacob Kraemer Tebes, 'Peer Support Among Individuals With Severe Mental Illness: A Review of the Evidence' (2006) 6(2) *Clinical Psychology, Science and Practise* 165

[36] Joanna Ochocka, Geoffrey Nelson, Rich Janzen, John Trainor, 'A longitudinal study of mental health consumer/survivor initiatives: Part 3- A qualitative study of impacts of participation on new members' (2006) 34(3) *Journal of community psychology* 273

[37] Seena Fazel, Helen Doll and Niklas Langstro, 'Mental Disorders Among Adolescents in Juvenile Detention and Correctional Facilities: A Systematic Review and Metaregression Analysis of 25 Surveys' (2008) 47(9) *Journal of the American Academy of Child and Adolescent Psychiatry* 1010

substance abuse disorder (Butler et.al, 2011)[38]. Therefore, this report details the importance of peer mentoring for prisoners and its efficacy of improving overall wellbeing and mental struggles.

Furthermore, a recent review of the effectiveness of a number of peer mentoring programs for at-risk and delinquent youth demonstrated that this is an effective approach not only for improving the mental health outcomes of delinquent youths but also in reducing recidivism.[39] Jarjoura (2007) study replicated these findings, reporting that 1 year recidivism rates were reduced from 39% to 13% when prisoners were a part of the peer-mentoring program[40]. Robbins et al (2009) report on peer-driven mentoring within women cells found that 70% were not re-arrested at 12 months postrelease[41]. Implementing peer mentoring within detention cells and prisons is essential to improving mental health and reducing re-conviction and imprisonment.

This form of treatment has also shown to be successful in hospitalisation environments. A randomised controlled trial conducted with individuals with clinically significant psychotic and mood disorders found that those who were assigned a peer mentor had significantly reduced hospitalisation rates (F=3.07, df=1 and 71, p=.042 and $\eta 2$=.04) when compared to the treatment as usual group.[42] This finding was also replicated in the Chinman et al pilot study which also found a reduction in hospitalizations for patients receiving support from peer mentors, with only 15% of patients being readmitted to the hospital, reducing re-hospitalisations by 50% in comparison to the general population.[43] Moreover, a randomised clinical trial by Forchuk et al observed that consumers who received peer support used as part of the patient discharge process significantly reduced readmission rates and increased discharge rates.[44] These findings have been replicated by a systematic review and meta analysis published in 2023, which found social network interventions such as peer mentoring can improve many aspects of general functioning and mental health.[45] These results highly suggest that peer mentoring can be fundamental in improving mental health for a hospital environment.

These findings suggest that consumer-run programmes have the potential to improve mental health and reduce recidivism within public institutions such as hospitals and incarceration systems.

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[38] Tony Butler, Devon Indig, Stephen Akknutt and Hassan Mamoon, 'Co-occurring mental illness and substance use disorder among Australian prisoners', (2011) 30(2) *Drug and alcohol review* 188
[39] Allyson Pitzel, Alison Kearley, Kristine Jolivette and Sara Sanders, 'Contextualizing Mentoring Programs Into Juvenile Justice Facilities' (2021) 72(2) *Journal of Corrective Education* 5
[40] Jarjoura, G. R., 'Evaluation report: Aftercare for Indiana through mentoring' (2001), Indiana University School of Public and Environmental Affairs.
[41] Earl H. Goldstein, Carmen Warner-Robbins, Christopher McClean, Liza Macatula, Richard Conklin, 'A Peer-Driven Mentoring Case Management Community Reentry Model: An Application for Jails and Prisons' (2009) 32(4) *Family and Community Health* 309
[42] William H Sledge, Martha Lawless, David Sells, Melissa Wieland, Maria J. O'Connell, and Larry Davidson, 'Effectiveness of Peer Support in Reducing Readmissions of Persons With Multiple Psychiatric Hospitalizations' (2011) 62(5) *Psychiatric Services* 541
[43] Matthew J Chinman, Richard Weingarten, David Stayner and Larry Davidson, 'Chronicity reconsidered: improving person-environment fit through a consumer-run service' (2001) 37(3) *Community Mental Health Journal* 215
[44] C Forchuk, M-L Martin, Y L Chan and E Jensen, 'Therapeutic relationships: from psychiatric hospital to community' (2005) 12(5) *Journal of Psychiatric and Mental Health Nursing* 556
[45] Lise Swinkels, Machteld Hoeve, Annemieke ter Harmsel and LJ Schoonmade, 'The effectiveness of social network interventions for psychiatric patients: A systematic review and meta-analysis' (2023) 104(11) *Clinical Psychology Review* 1

Policy on the Efficacy of Peer Mentors

New South Wales Policy

The Mental Health Commission of NSW commented on the importance and necessity of 'peer navigators'. In their submission to the Inquiry to Parliament, they commended the role peer navigators have played in mitigating distress and encouraging help-seeking when individuals transition from mental health hospitals to everyday life. Furthermore, the 'Living Well in Focus 2020-2024' strategy proposed by the Commissioner, which arose after the NSW Mental Health Commission, supports the need for an 'increase [in] the mental health workforce to support people in, and released from, custody'.

National Policy

The Royal Australian and New Zealand College of Psychiatrist (RANZCP), the peak psychiatric organisation, gave evidence to the inquiry parliament on 16th October 2023. They supported the use of peer workers as a key response pertaining to the people with psychosocial challenges. RANZCP states that peer mentor programs created by Headspace and Safeguard provide lived experience advice as they have 'been there' before, with increase from these organisations during the COVID-19 pandemic.

Victorian Policy

The Victorian Department of Health released a framework for lived-experience workers, and consumer engagement in mental health policy[46]. The Victorian department guideline points to a need for democratic and transparent policy making in the mental health industry. Whereby those affected by the relevant legislation, and policy, are also active participants in the decision making process. One step policy makers can take to enhance transparency, is to utilise the expertise of peer mentors and engage them on the relevant issues. For instance, peer mentors will be able to empathise with patients, and also understand the demands that are placed on staff. This dual perspective may be incredibly useful for policy makers, as peer mentors will be able to advocate for both consumers and workers.

Western Australian Policy

Along with the Victorian framework for peer mentors, Western Australia have published their own state guidelines[47]. Western Australia's guidelines highlight the role of peer mentors in implementing the psychosocial model of mental wellbeing. Within most mental health settings the biological determinants of mental health receive a disproportionate amount of attention. This often means the social determinants are ignored. The use of peer mentors will hopefully allow for social factors such as childhood trauma, distressing life circumstances, and systemic injustice to be addressed. That is due to the candid relationship

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[46] Victorian Department of Health, 'Mental health lived experience engagement framework' (WebPage, 9 December 2021)<https://www.health.vic.gov.au/publications/mental-health-lived-experience-engagement-framework>

[47] Government of Western Australian Mental Health Commission, 'Lived Experience (Peer) Workforces Framework' (Submission, n.d.) <https://livedexperienceworkforces.com.au/wp-content/uploads/2022/10/mhc-lived_experience-pw-framework-oct2022-digital.pdf>

between peer mentors and consumers, discussions pertaining to trauma and injustice may be more likely to take place. Discussions surrounding these topics are likely to be therapeutic to the consumer, and may result in faster recovery.

3.1.3 The Mental Health Commission of NSW

The Mental Health Commission of NSW advocate towards the proper allocation of resources towards peer support workers and ensuring they may function effectively through their 'Living Well in Focus 2020-2024' report. In their submission to the recent mental health Inquiry,[48] the Commission stated that 'Redirecting resources towards community-based services can effectively broaden the spectrum of support options available to individuals, thereby enabling them to maintain their wellbeing and remain in their community'.[49] Thus, the view taken by the Commission in favour of investing into peer support services strongly aligns with the necessity of implementing programs such as peer mentoring into core mental health systems.

3.1.4 The Royal Commission into Victoria's Mental Health System

The Royal Commission into Victoria's Mental Health System was called upon concerns that "the state's mental health system was failing to support those who needed it."[50] One of the reasons for the proposed reforms to Victoria's current system is the impact of compulsory treatment on patients' human rights and freedom[51]. The final report of the Royal Commission into Victoria's Mental Health System outlines that the current system focuses on a primary goal of 'clinical recovery'.[52] This, to an extent, dehumanises the patient and identifies their condition and quality of life with a cluster of symptoms. 'Personal recovery', on the other hand, is a concept "developed by those with lived experience" which centralises the creation of "a meaningful and contributing life".[53] Ms Erandathie Jayakody, provided an explanation to the Commission outlining that a "recovery-oriented approach" recognises that one's desire to choose and have autonomy over their life's decisions is central to 'personal recovery'.[54] Furthermore, the Commission has also recommended that the Victorian government expand on the areas of "clinical and non-clinical" support "like peer workers".[55]

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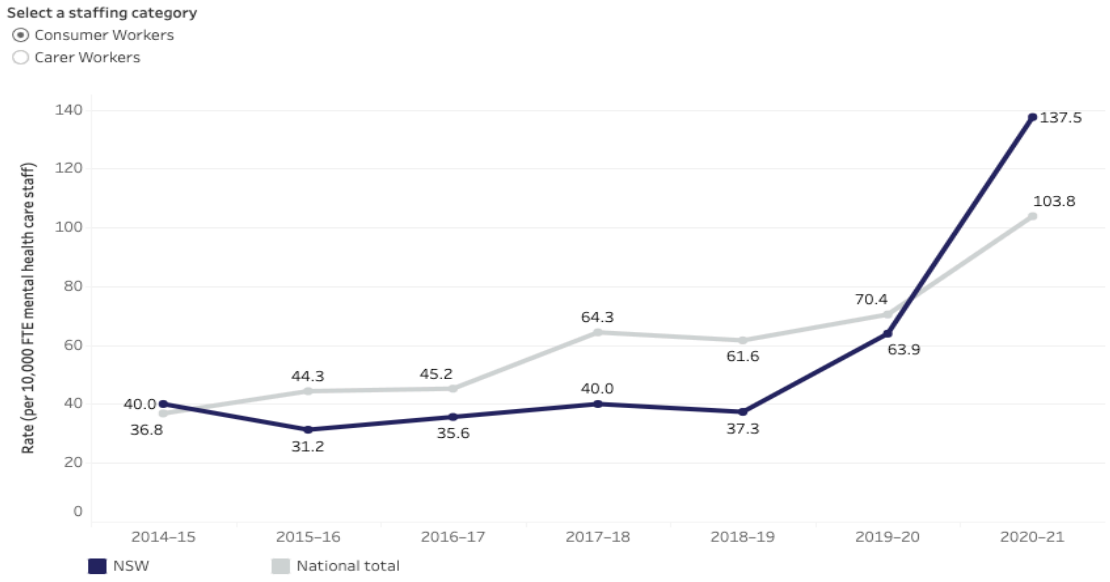
[48] Inquiry into Equity, Accessibility and Appropriate Delivery of Outpatient and Community Mental Health Care in New South Wales Submission no 147.
[49] Ibid 8.
[50] Royal Commission into Victoria's Mental Health System 'Final Report - Summary and recommendations' (Submission, February 2021) <https://content.vic.gov.au/sites/default/files/2024-01/RCVMHS_FinalReport_ExecSummary_Accessible.pdf>.
[51] Ibid.
[52] Ibid.
[53] Ibid.
[54] Ibid.
[55] Ibid.

Figure: Public mental health workforce who are consumer and carer workers



Source: AIHW 2023. Mental health services in Australia: Specialised mental health care facilities 2020-21 tables. Table FAC.7. Canberra: AIHW.

The number of paid full-time equivalent (FTE) consumer and carer workers per 10,000 mental health care staff FTE, in specialised mental health services in NSW as of May 2023. Source: https://www.nswmentalhealthcommission.com.au/measuring-change-indicator/mental-health-consumer-and-carer-peer-workers

3.1.5 The National Mental Health Commission on Peer Mentors

"*Lived experience workers [peer mentors] provide a resource for change: the personal and social change that provides the necessary foundation for individual recovery, and the cultural and practice change that can move health care services towards recovery-oriented practice*."

– The National Mental Health Commission

In 2021, the National Mental Health Commission ('NMHC') released guidelines for peer mentors, and presented a range of evidence demonstrating the efficacy of consumer workers.[56] Here, the NMHC posits that peer mentors have "lived experienced expertise", gathered as a result of their experiences with psychosocial challenges.[57] As such, the guidelines call for peer mentorship to be available at every level of the mental health system, from psychiatric settings to community reintegration, which will assist in the development of trusting relationships during all stages of their recovery. As a result, peer mentors have been positioned by the NMHC as therapeutic and useful for individuals.

The benefits of peer mentors for those accessing services outlined by the NMHC include; hope, empowerment, social functioning and self care. The NMHC suggested the inclusion of peer mentors would provide hope for those undergoing treatment, as their mentors' lived experience may be an example of how their circumstances can be overcome. Additionally,

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[56] L Byrne, L Wang, H Roennfeldt, M Chapman, L Darwin, C Castles, L Craze, M Saunders, National Lived Experience Workforce Guidelines (2021), National Mental Health Commission <https://www.mentalhealthcommission.gov.au/getmedia/a33cce2a-e7fa-4f90-964d-85dbf1514b6b/NMHC_Lived-Experience-Workforce-Development-Guidelines>

[57] Ibid 8.

the NMHC highlighted how peer mentors' lived experience could be utilised to create a therapeutic relationship between the mentor and the individual seeking treatment. This relationship would then serve to empower both parties, and fastrack recovery. Once more, the NMHC suggested that peer mentors would be useful for social functioning, as the communication between mentors and consumers will encourage the usage of social skills.

3.1.6 Mental Health Australia

Mental Health Australia is an advocacy body for the mental health sectors that have focused their mission on providing social-psychological services for communities within NSW. The Peer Navigation Project 2021-2023 formed by the Mental Health Commission (MHC) of New South Wales aims to identify the "critical need to enhance referral pathways, facilitating individual's connections to appropriate services and supports to improve their mental health and wellbeing" (Mental Health Commission of NSW, 2023). This project was a major success, due to its adaptability and effective module that highlights the importance of shared lived experiences. Furthermore, the director of the Integrated Mental Health Drug and Alcohol Services within the Western NSW Local Health District, Jason Crisp, states the significance of peer navigators within the mental community space, as they are the central key to providing empathy that allows people to *"feel comfortable engaging with them"*, thus, the program has exceeded expectations and is hoping for further expansion of '*'to other communities throughout the LHD"*[58].

3.2 Criminal Justice

3.2.1 Recidivism

Research suggests that Peer mentoring can have positive effects on the recidivism rates[59]. Many mentees indicated that it was easier to avoid coming back to prison with the help of a mentee.[60] Hearing specific examples about others getting out and staying out, provided a roadmap for success. The ability to call and ask their mentor for advice was one of the most valuable components of the peer relationship.[61] Analysis revealed that mentees often look to mentors for advice regarding one of the biggest obstacles: disconnecting from a violent lifestyle.[62] Where prison staff lack credibility and relatability, mentors provide. Peer Mentoring provides emotional and social support to the mentees which has been shown to reduce community isolation. A study conducted at Yale concluded that the participants who received standard re-entry services plus peer mentorship showed significantly lower levels of

[58] Mental Health Commission of New South Wales 'Peer navigation project 2021-2023' (Web Page, 15 September 2023) <https://www.nswmentalhealthcommission.com.au/content/peer-navigation-project-2021-2023>
[59] Amanda Claire Workman (2018) 'Can Mentoring Help Reduce the Risk of Recidivism? An Analysis of the Serious and Violent Offender Reentry Initiative (SVORI Data)' (2018) *BYU ScholarsArchive* 6827
[60] Matthews (n 15).
[61] Ibid.
[62] Ibid.

recidivism than those receiving standard reentry services alone[63]. For individuals returning to their community after being incarcerated, social support plays an essential part in their reentry experience and can help prevent re-offending during the first couple of months[64]. Therefore, peer mentoring is beneficial for the individual and the wider community.

3.2.2 Prisoners with Psychosocial Challenges

The portion of people with disabilities in detention far precedes the portion of them in Australia, making up almost 30% of the prison population, and 95% of First Nations people arriving in court have intellectual disabilities or mental illnesses.[65] Many prisoners with mental health issues are also victims of crime, such as sex violence. To make it worse, such problems are not reported and addressed in time.[66] Multiple academic studies have revealed that peer mentoring plays a positive role in assisting disabled people. In general, mentees reported to feel happy and content with the peer mentoring program. They claimed that they learned several useful skills and their self-awareness was increased.[67] Several case studies also show that people with mental disabilities are more comfortable with other people from similar backgrounds.[68]

3.3 Youth Justice

Throughout the Budgets Estimate Comic mentioned peer mentoring as a social solution to committee hearing, the Minister for Youth Justice Jihad Derns over youth justice. As approximately 90% of youth in detention are struggling with their mental health, it is essential that these concerns are urgently addressed through appropriate means. In order to address these concerns, then, mechanisms such as youth mentoring is vital and may form the foundation for future prevention of youth involvement with justice systems.
Youth mentoring is an approach that requires a 'consistent, prosocial relationship' between a youth individual and an older adult figure is maintained,[69] with the goal of diverting behaviours such as involvement with the justice system and criminal activity.[70] Although

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[63] David Sells et al, 'Peer-Mentored Community Reentry Reduces Recidivism', (2020) 47(4) *Criminal Justice and Behavior* 437
[64] Jean Kjellstrand, Miriam Clark, Celia Caffery, Joanna Smith & J. Mark Eddy, 'Reentering the Community after Prison: Perspectives on the Role and Importance of Social Support' (2022) 47 *American Journal of Criminal Justice* 176
[65] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Final Report - Volume 1, Voices of people with disability - Book 1* (2023)
[66] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 'People with disability over represented at all stages of the criminal justice system' (Web Page, 23 December 2020) <https://disability.royalcommission.gov.au/news-and-media/media-releases/people-disability-over-represented-all-stages-criminal-justice-system>
[67] Ariel E Schwartz and Melissa Levin, 'Feasibility of a peer mentoring programme for young adults with intellectual and developmental disabilities and co-occurring mental health conditions' (2021) 50(3) *British Journal of Learning Disabilities* 433
[68] Royal Commission (n 56)
[69] 'Youth Mentoring: diverting young people from justice involvement' *NSW Government* (Report, June 2021) <https://www.nsw.gov.au/sites/default/files/2022-05/Youth_Mentoring_diverting_young_people_from_justice_involvement.pdf>
[70] Ibid.

youth mentoring has existed in schools and in at-risk youth districts for a long time now; however, such programs for youth in custody are lacking.[71] The developmental status of adolescence creates inherent vulnerability, because of the lag in their psychosocial maturation, in particular their impulse control, future orientation, and resistance to peer influence, all crucial in their decisions to engage in risky and criminal behaviours. Thus, given that adolescence is a fundamental period in life that shapes the future of young people, whereby decision-making processes, actions and support throughout this period can impact both their present and future livelihoods significantly, it is crucial that they are provided with the right guidance and support to effectively navigate their education, employment and community involvement. Youth mentoring, similar to the likes of peer mentoring, can provide this form of solution.

Core components that form these mentoring programs include: social networks and community engagement, mentor screening and matching, mentor training and supervision, engagement, personal and life skills development. However, development of a more effective and targeted model is necessary as the current framework harbours significant limitations, notably in its failure to consider the effectiveness or impact of youth mentoring among a diverse group of individuals. For example, the lack of consideration for Aboriginal or Torres Strait Islander young people is problematic as young Indigenous individuals currently represent 46% of all young people under youth justice supervision[72] and were 16 times likely to be under supervision on a daily basis.[73] Thus, it becomes necessary to provide mentoring strategies that address specific concerns that communities may have with a limited or rigid youth mentoring system.

3.4 Addiction and Drug Users

Studies have shown that peer mentors help reduce relapse rates, and improved treatment retention[74]. Additionally, one randomised trial found that socially focused treatments, such as peer mentoring, can produce helpful changes to the patient's social network[75]. These changes then increase rates of abstinence[76]. For example, the presence of one non drinking friend translated to a 27% increase in the probability of reporting abstinence on 90% of days or more at all follow-up visits.[77]

Recovery and rehabilitation from drug addiction require a compassionate and client-centric approach in order to be effective. Peer mentorship for individuals with drug use and

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[71] Adair (n 21).
[72] '2.11 Contact with the criminal justice system' *Aboriginal and Torres Strait Islander Health Performance Framework* (Web Page, 30 January 2023) <https://www.indigenoushpf.gov.au/measures/2-11-contact-criminal-justice-system#:~:text=On%20an%20average%20day%20in,population%20aged%2010%E2%80%9317>
[73] Ibid.
[74] Sharon Reif et al, 'Peer recovery support for individuals with substance use disorders: Assessing the evidence' (2014) 65(7) *Psychiatric Services* 853.
[75] Reham A Hameed Shalaby and Vincent IO Agyapong 'Peer Support in Mental Health: Literature Review'(2020) *JMIR Mental Health* 7(6) <https://mental.jmir.org/2020/6/e15572/>.
[76] Ibid.
[77] Ibid.

addiction challenges can aid the management of triggers and prevention of relapse.[78] The element of lived experience in peer mentorship allows for a practical and collaborative approach to recovery and rehabilitation. Not only can mentors guide mentees through the challenges of relapse and problematic triggers, but this responsibility can help mentors stay on track with their own journey as well.

3.5 Older Adults

Traditional mental health services are not used by the majority of older adults. As people grow older, it is more unlikely that they'll seek help, and wellbeing often declines as the elderly grow isolated due to living conditions and loss within social support networks. Peer mentoring, specifically client-centred conversation, in which the mentee leads the discussion, has shown to be an effective strategy in improving the wellbeing of older adults with psychosocial concerns, such as depression.[79] A Java program in Ontario found that in nursing homes, mentorship reduced depression by 30%, loneliness by 12%, and increased activity participation by 60%. This is an immensely positive step towards determining non-pharmacological alternatives to mental health issues.[80]

[78] The Howard League for Penal Reform, 'Takes one to know one? An evaluation of peer mentoring in the drug dependency treatment sector' (Report, September 2015) <https://www.drugsandalcohol.ie/24565/1/Peer_mentoring_Takes_one_to_know_one.pdf>.
[79] Jin Hui Joo, Seungyoung Hwang, Joseph J Gallo and Debra L Roter, 'The impact of peer mentor communication with older adults on depressive symptoms and working alliance: A pilot study' (2018) 101(4) *Patient education and counselling* 665
[80] Kristine A Theurer et al 'The Impact of Peer Mentoring on Loneliness, Depression, and Social Engagement in Long-Term Care' (2021) 40(9) *Journal of Applied Gerontology* 1144

4. Criteria for Effective Peer Mentoring

4.1 Proposed Criteria for Effective Peer Mentoring

For a peer mentoring program to be considered 'successful' or 'effective', it is argued that the following criteria must be met:

1. That peer mentors have adequate training to deal with various mentees and situations, focussed on professionalism;
2. That there is sufficient funding to support the continued operation of peer mentoring services for the long-term;
3. That the place where peer mentoring is undertaken is appropriate and safe; and
4. That peer mentoring services themselves are accessible to a diverse audience of individuals.

In the facilitation of peer mentoring in mental health, it is significant for there to be effective incorporation that not only focuses on the betterment of the mentees, but also benefits the mentors. The proposed criteria for effective implementation of peer mentoring in mental health below aligns with the best interests of both parties as well as the basic human rights that forced medication violates.

Accessibility

The link between mental illness and socioeconomic status places individuals with psychosocial challenges at a great disadvantage. Isaacs (et al., 2018) found that individuals who had lower incomes in Australia struggled with factors like "unemployment" which "...can result in increased psychological distress".[81] Furthermore, mental health consumers who have gone through the prison system are more likely to experience difficulty in reintegrating back into society, particularly employment. **See section 3.3 for more on this issue.** Due to the complexity of this issue, the accessibility of becoming a peer mentor, as well as accessing the service as a mentee, must be clear and welcoming to uphold effectiveness. Knowledge, guidance and inclusion are fundamental pillars for the accessibility of peer mentorship.

Individuals with lived experience in matters of mental illness should be provided with adequate knowledge on the opportunity to become a peer mentor. Psychosocial rehabilitation is particularly concerned with the intervention of challenges that individuals face when "enduring mental illness" (Mental Health Coordinating Council, n.d.).[82] It focuses on the reintegration of individuals into the community that not only emphasises their role as a member of it, but also their personal recovery. As such, a key issue that those with psychosocial challenges face is the ability to find a meaningful role within society. The benefit of finding this role is expressed by Salzer and Shear (2002)[83] who found peer support

[81] Anton N. Isaacs et al, 'Lower Income Levels in Australia Are Strongly Associated With Elevated Psychological Distress: Implications for Healthcare and Other Policy Areas' (2018) 9 *Front Psychiatry* 536
[82] Mental Health Rights Manual, 'Psychosocial rehabilitation' (Web Page, n.d.) <https://mhrm.mhcc.org.au/glossary/psychosocial-rehabilitation/>
[83] Julie Repper and Time Carter, 'A review of the literature on peer support in mental health services' (2011) 20(4) *Journal of Mental Health* 392

workers felt appreciated and increased levels of confidence and self-esteem which aided their own recovery.

In order to be an effective alternative to forced medication, peer mentorship should uphold basic human rights, and individuals with psychosocial challenges should be provided with balanced information on its benefits. As opposed to maintaining the lack of consent evident within forced medication, the alternative of peer mentorship should come with encouragement that allows the mentee to hold autonomy over their decision to engage with the service.

Guidance is a significant tool in ensuring the accessibility of peer mentorship as a rehabilitative avenue to reintegrating into the community. While providing individuals with knowledge on the pathway of mentorship is useful, it is important to consider encouraging the practice as well. Reintegration into the community with a role like mentorship may be perceived as daunting if adequate guidance is not provided.

As the final pillar of accessibility, inclusion is vital in ensuring that peer mentorship is a diverse network through which individuals with lived experience can mentor those who currently struggle with similar challenges. The diversity of peer mentorship enables a diverse range of mental health consumers who can experience the support and empathy of those who relate to them. Inclusion not only fosters accessibility for the mentor, but it also fosters accessibility for the mentees. As SANE's National Stigma Report Card expresses, those with complex mental health issues, as opposed to common mental health conditions, continue to experience substantial discrimination and stigmatisation.[84] The prevention of this stigmatisation should begin with inclusion within the realm of peer mentorship programs.

Training

The optimal position of a peer mentor is someone who has lived experience, can relate to the mentee from a place of empathy, and someone who can foster an approach to community membership that prioritises personal growth and development. The effectiveness of such peer mentorship rests on a structure and organisation that is essential all peer mentors receive training for. Pfeffer (1998) suggests that "effective training and development" is indicative of a "successful organisation".[85]

The success of peer mentorship within the mental health system partly relies on training that identifies lived experience as a priority. Central to being a peer mentor should be the ability to translate lived experience into effective support and guidance material for the mentees.

A challenge that may arise from qualified professionals training mentors on how to use their personal experience to relate with the mentees is the lack of clarity in their role. The formalisation of mentorship may lead to power imbalances in which the mentor may instead

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[84] Christopher Groot et al, 'REPORT ON FINDINGS FROM THE OUR TURN TO SPEAK SURVEY: Understanding the impact of stigma and discrimination on people living with complex mental health issues' *National Stigma Report Card* (Report, 12 October 2020) <https://www.nationalstigmareportcard.com.au/sites/default/files/2021-06/NSRC_Full_Report.pdf>.
[85] Mike Pedler, John Burgoyne and Cheryl Brook, 'What has action learning learned to become?' (2005) 2(1) *Action Learning Research and Practice* 49.

be perceived as a supervisor. However, a lack of training can risk the inability of the mentor to foster an environment of rehabilitation and reintegration, lacking significant structure and discipline within the practice. As such, a solution to this is the recognition of and training for vicarious trauma. Vicarious trauma is defined as ”disruptive and painful…profound psychological effects” that a “helper” experiences when assisting victims of trauma (McCann and Pearlman, 1990)[86]. Vicarious Trauma Training (VTT) should be implemented within peer mentorship organisations to ensure an effective and healthy avenue to providing social support. Managing the demands of the role, such as empathy, with one’s own self care is crucial to the operational features of peer mentorship.

Funding

Sufficient funding is required for peer mentors to work effectively in the mental health industry. A lack of funding will result in peer workers not being able to receive the financial, and professional support they need, and therefore will diminish the quality of care for consumers. Justice Action proposed in the Our Pick report of July 2010, that 0.1% of the mental health budget should be allocated to independent consumer groups. This additional funding would allow for adequate support for peer worker organisations. The call for increased funding is not only advocated by Justice Action, but is also something recommended by The National Mental Health Commission (NMHC). The NMHC suggested that peer worker organisations are in need of additional funding to develop and train staff[87]. Providing adequate funding will allow for peer mentors to work effectively, and will also allow long term implementation of peer mentoring.

Support

The avoidance and management of emotional burnout is significant in a role such as peer mentorship. A firm framework designed to foster an effective process of giving and receiving support is vital. This can be achieved through action learning, a framework through which individuals learn through their experience and reflect on them (National Institute for Health and Care Research, 2022)[88]. The purpose of a reflective approach enables mentors to share the emotional weight of their role with those who understand and empathise with their work. A support network amongst mentors not only benefits their emotional capacity when dealing with mentees’ trauma, it also creates a sense of community.[89] For peer mentors who have experienced the alienation and stigma of being incarcerated, this can have a positive impact on their journey of rehabilitation. Furthermore, another key role of action learning is its dialogical nature which allows mentors to collaborate and exchange experiences to better their individual approach to providing support for mentees. Mentors can draw on their own

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[86] Lisa McCann and Laurie Ann Pearlman, ‘Vicarious traumatization: A framework for understanding the psychological effects of working with victims’, (1990) 3 *Journal of Traumatic Stress* 131.
[87] Byrne (n 47) 66.
[88] National Institute for Health and Care Research, ‘Peer mentor support and action learning’ (Web Page, 19 December 2022) <https://www.nihr.ac.uk/documents/peer-mentor-support-and-action-learning/32286>.
[89] Sonia Chanchlani, *The value of peer mentoring for the psychosocial wellbeing of junior doctors: a randomised controlled study* (Report, 22 October 2018) <https://www.mja.com.au/journal/2018/209/9/value-peer-mentoring-psychosocial-wellbeing-junior-doctors-randomised-controlled>.

values and beliefs to converse with each other and develop mentorship skills as they perform.

Another way to support peer mentors is to establish supervision and management to oversee the work being put in.[90] Along with training and group mentoring for the mentor, it is important to maintain structure within the organisation so that peer mentors feel supported and feel as though they also have someone to turn to.

The facilitation of peer mentorship must be effective. This is underpinned by how accessible, supportive and extensive the quality of training is.

Status

Another criterion for effective peer mentoring is adequate status within the workplace. Affording peer mentors status within the workplace will ensure their voice is respected by other mental health professionals. Peer mentors' unique set of insights and experiences are a priceless asset to the mental health industry, and deserve to be respected. Respecting the role of peer mentors is also something included in the guidelines released by the National Mental Health Commission (NMHC). The NMHC frequently refer to the lived experience of peer mentors as a form of expertise[91]. Valuing peer workers and their expertise will not only ensure peer mentors are treated with respect, but will also allow for consumers to receive better care. Therefore Justice Action makes a strong recommendation for providing peer mentors with adequate status within the mental health industry.

5. Current Mentorship Programs

There are currently various peer mentoring programs in Australia catering to people from different backgrounds. The following section will explore their effectiveness and limitations in detail.

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[90] NSW Mental Health Consumer Workers' Committee, 'Consumer Workers' Project Framework for the NSW Public Mental Health Consumer Workforce' (Report, September 2013) <https://being.org.au/wp-content/uploads/2015/06/Framework-2013-sent-to-CAC-270913.pdf>.
[91] Byrne (n 47) 9.

5.1 SANE's Guided Service

SANE's Guided Service is an approach to psychosocial support for people aged over 18 years old that puts the consumer at the centre and in control of their own programme; including 1-2-1 digital and telehealth support with counsellors and peer workers as well as access to a programme hub and SANE's existing forums (for instance, 'Our Lived Experience Forum' allows for people to pass on tips, share stories and explore issues of mental health and recovery').

SANE's Peer Guide program has run for 5 years since 2023.[92] The program primarily seeks to ensure that people with complex mental health issues have access to practical work experience, ultimately closing the gap between mental health inequities and social and economic exclusion.[93] To become a peer mentor, 10 weeks of online training are provided for applicants to ensure credibility and legitimacy. As of 2023, there are 20 trained peer workers. Among this cluster, more than 85% of staff have disclosed living with mental health challenges or neurodiversity. This demonstrates not only the success of the program, but the possibility of workforce engagement and career satisfaction in spite of mental illness issues.[94]

SANE also offers further resources, including a Peer Group Chat which allows for those with mental health issues to chat in real-time with others living with complex mental health issues, in addition to family, friends and carers. The organisation ensures that services have undergone extensive consultation with people with complex mental health issues, as well as counsellors and other experts and organisations in the mental health sphere.[95]

However, SANE's Guided Service does not come without its limitations. First, the service requires individuals to live within an 'eligible Primary Health network', which may result in limited accessibility. Secondly, the team can decide if one's condition is not suitable for the service. If the service chooses that they are not fit, it may deter one from seeking help again.

Contact Details

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[92] '2023 Annual Report', *SANE Australia* (Web Page, 2023) <https://www.sane.org/images/Annual_Reports/SANE_Annual_Report_2023_DIGITAL.pdf>.
[93] 'Peer Guide Program', *SANE Australia* (Web Page, 2022) <https://www.sane.org/peer-support/peer-guide-program>.
[94] *SANE Australia* Annual Report (n 79).
[95] 'Sane Support Services FAQs, *SANE Australia* (Web Page) <https://www.sane.org/images/sane-support/SANE-Support-Services-FAQs.pdf>.

5.2 Women's Justice Network

The Women's Justice Network has an Adult Mentoring Program that provides one-to-one social support for women and girls who have either exited custody or are at risk of involvement in the Criminal Justice System.[96]

The Adult Mentoring program recognises the more substantive impact of a mentor compared to a case manager or a counsellor.[97] Emphasis is placed on developing a mutually valuable relationship between mentor and mentee, such that there is less of an "obligation" on the mentor.[98] Additionally, this system prioritises proactive and positive coping mechanisms. While individuals can open up about their problems to their mentors, they can also learn to build resilience and other coping mechanisms for future challenges.[99]

The Women's Justice Network states that 93% of mentees involved in the program for a year or longer have not reoffended or returned to prison.[100]

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5.3 Deadly Connections Youth Frontiers Project

Funded by the NSW Department of Communities and Justice, the Deadly Connections Youth Frontiers Project ('YF') responds to Aboriginal children and young people, ages 10-17, who are entangled or at risk of being entangled with the criminal justice system or child protective services. Youth Frontiers are delivered by Aboriginal Youth Mentors who understand the challenges Aboriginal people face. Therefore, they can form deep connections with the children and young people, as they share the sentiment of being inextricably connected to the land, Aboriginal community and culture. Once the mentor and mentee are matched, the mentors are positive role models for the children, showcasing the possibility of healing, learning and opportunity. They do this by encouraging prosocial skills and activities and participation with external services to develop personal and professional skills.

Contact Details
Email: info@deadlyconnections.org.au
Phone: +61 1800487662

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[96] 'Adult Mentoring Program', *Women's Justice Network* (Web Page) <https://www.womensjusticenetwork.org.au/mentoring-program/> .
[97] Ibid.
[98] Ibid.
[99] Ibid.
[100] Ibid.

5.4 SHINE for Kids with Youth Justice

SHINE for Kids delivers the Stand As One mentorship program for children leaving the Youth Justice Centre, preparing them for transition back into the wider community and the rebuilding of their lives.

A young person is matched with a mentor who supports them while they are in custody. The mentor meets with the young person regularly, to encourage a robust and trusting relationship and discourage a cycle of reoffending. In turn, young people can then harness resilience, motivation and encourage a positive outlook to life in general, during a time of uncertainty. The program helps to build a repertoire of essential life skills by empowering young children to enrol in education and training, look for a job and housing, amongst other services.[101] Recently, Stand As One provided young boys with the chance to learn barista and hospitality skills at Hope Cafe.[102]

Other programs include the SFK Mentoring Program[103], designed for young people between the ages of 12 and 21, who have had or have a parent in custody. This program includes fortnightly mentoring sessions and monthly group activities curated to inspire resilience, confidence, a sense of belonging and identity within them.

Contact Details
Email: enquiries@shineforkids.org.au
Phone: +61 2 9714 3000

5.5 Success Works

Success Works is a nonprofit, with many of its female staff having undergone the criminal justice system. Success Works creates opportunities for women affected by the criminal justice system through Mentoring Programs which provide support and empowerment to women who are seeking, securing and maintaining employment. The mentors specifically focus on building essential skills, navigating barriers, boosting confidence, setting career goals and fostering positive connections. These of which are all built on the elements of their model – listen, guide, encourage, inspire.[104]

Contact Details
Email: info@successworks.org.au

Eleni Psillakis - Manager
Phone: 0467 767 076

Juanita Schaffa - Peer Support Coordinator
Phone: 0490 810 459

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[101] 'Programs', *Shine for Kids* (Web Page) <https://shineforkids.org.au/programs/stand-as-one/>.
[102] 'News', *Shine for Kids* (Web Page) <https://shineforkids.org.au/allnews/young-people-in-youth-justice-mentoring-give-back-to-our-kids/>.
[103] 'SFK Mentoring Program', *Shine for Kids* (Web Page) <https://shineforkids.org.au/programs/sfk-mentoring-program/>.
[104] 'Mentors', *Success Works* (Web Page, 2024) <https://successworks.org.au/mentors/>.

5.6 Confit Pathways Program

Confit is a mentoring program for those in youth detention and is intended to encourage employment and education, while providing pathways to reintegration, post release.[105] The program is delivered by mentors with lived experience who are currently either working or studying in the community.[106] Confit seeks to address root causes behind the behaviour of its participants, especially in relation to violence and community identity.[107] These objectives are primarily achieved through fitness activities and mentorship.[108]

Presently, Confit is working with the University of New South Wales to develop methodologies for assessing the effectiveness of their programs, both in shorter (9 weeks) and longer (6-12 months) timeframes.[109]

Contact Details
Email: info@confitpathways.org

5.7 Australian Red Cross

The Australian Red Cross have created programs for people in prisons, with the input and active involvement of those with lived experience[110]. The Community Based Health and First Aid program currently runs in three correctional centres, and trains prisoners to be 'Special Status' Red Cross volunteers from within the facility. "Inmates could come to us with their problems and we could work towards solving them. And when we got projects done inmates started looking up to us, like we were someone… it gave me a reason to do the right things, to fall on the right side of the fence".[111]

The Sisters Making Change Report released by the Red Cross suggests that 75% of the volunteers felt they had changed as a person since engaging in the mentoring service, and 50% said they felt more hopeful about the future.[112]

Contact Details
Email: contactus@redcross.org.au

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[105] 'Confit Pathways', *Waratah Education Foundation* (Web Page) <https://www.waratahеducationfoundation.org.au/confit>.
[106] Ibid.
[107] 'Our Services', *Confit Pathways* (Web Page) <https://confitpathways.raisely.com/our-services>.
[108] 'Our Mission', *Confit Pathways* (Web Page) <https://confitpathways.raisely.com/our-mission>.
[109] Ibid.
[110] 'Prisoners As Change Makers', *Australian Red Cross* (Web Page) <https://www.redcross.org.au/justice/prisoners-as-change-makers/>.
[111] Ibid.
[112] Australian Red Cross, *Sisters for Change at Townsville* (Report Summary) <https://www.redcross.org.au/globalassets/cms-assets/documents/news/cbhfa-summary-report-a4-4pp-final.pdf>

5.8 Justice Action Peer Mentoring Programs

Justice Action has published a Mentor's Handbook on the JA Mentor Project to establish practical mentoring strategies. The project underlined the idea that ex-prisoners are the best people to offer support and advice to other prisoners, ex-prisoners and people caught up with the justice system. The JA Mentor Project was set up in response to a paper presented by Margaret Lamont at the First National Conference of Community Based Criminal Justice Activists hosted by Justice Action.

Basis of JA Mentoring Project:

- Mentor is ideally someone with a similar background/personal experience to the mentee, providing a one to one relationship on a daily basis to give support and guidance on a fee
- Relationship with mentor built on trust, similar to a contractual agreement (both have rights, responsibilities and remedies)
- Reduces recidivism rates and increase community participation

Justice Action Mentoring Group

- Project set up in response to a paper presented by Margaret Lamont at the First National Conference of Community Based Criminal Justice Activists hosted by Justice Action
- Made up of graduates and non-graduates of the Mentoring in the Community course, the majority of whom are ex-prisoners
- Maintains ongoing communications with prisoners and monitors their complaints
- Over the past 20 years Justice Action has had a mentoring relationship with thousands of criminal justice clients both in the prisons and the general community.

5.9 Flourish Australia

Focusing on lived experience as half of their peer workers have experiences with mental health, Flourish Australia provides people with mental health issues with sincere support in an appropriate way chosen by their customers. They claim to be an outcome-focused and recovery-oriented service by assisting their customers with flourishing in their communities.

Furthermore, they have various diverse methods on mental health support. Aside from conventional counselling sessions, their disability employment services provide mentees with community business opportunities so that they can truly strive in their communities.

- employment as a peer worker is focused on personal development and training
- one on one mentoring with a peer worker who can help the integration into employment

Contact Details
Phone: +61 1300 779 270

Additional information

Potential organisations for feedback

- One door mental health
    - Contact: Robert Ranjam
    - Associated group: Pioneer clubhouse
- Long Bay Correctional Facility (specifically their forensic hospital)
    - 02 8304 2000
- Justice Health and Forensic Mental Health Helpline
    - 1800 222 472, 02 9700 3000 (Justice Health Office)
    - jhadmin@justicehealth.nsw.gov.au
- Emu Plains Correctional Centre for Women (they also have a Justice Health Clinic)
    - 02 4735 0200
- Alexander Maconochie Centre
    - 1300 286 583
    - AMCExecSupport@act.gov.au
- Toora Women Inc
    - 02 6122 7000
    - tooraadmin@toora.org.au
- Grow (focus on recovering from mental illness)
    - 1800 558 268 (Option 2)
    - eastregion.admin@grow.org.au
- Sisters Inside
    - 07 3844 5066
    - admin@sistersinside.com.au
- Community Restorative Centre
    - (02) 9288 8700
    - info@crcnsw.org.au
- Black Dog Institute
    - (02) 9382 4530
    - blackdog@blackdog.org.au
- Mental Health Australia
    - 02 6285 3100
    - info@mhaustralia.org
- Flourish Australia
    - 1300 779 270
    - info@flourishaustralia.org.au

Medicating against Recidivism

This is in response to the Hon. Susan Carter's question during evidence at the Parliamentary Inquiry into Mental Health on February 15, 2024, about forced medication happening not for people's own benefit but for reducing recidivism.[1]

The Hon. SUSAN CARTER: Do you have any evidence of the fact they're being wrongly medicated?

BRETT COLLINS: Do I have any evidence of the—

The Hon. SUSAN CARTER: Of the fact that they're being wrongly medicated.

BRETT COLLINS: As I say, we had significant consultation about three years ago where that was definitely an attempt to reduce recidivism by in fact some—

The Hon. SUSAN CARTER: So you have evidence that NSW Health is forcing people to take medication not for their own benefit but to avoid recidivism?

BRETT COLLINS: Oh, absolutely. That was the whole basis of the consultation. I'm very happy to show you the documents that are the basis for that consultation.

The Hon. SUSAN CARTER: Yes, thank you. I would be interested to see that.

BRETT COLLINS: It was very significant, only a short time ago, three years ago, run by the Kirby Institute. We also think that the support given by those community transition teams shouldn't just only be for people who have mental health problems. It should be also for everyone. To accept that you're mad, a "spinner" in prison, makes you a person of little worth, according to the culture of prisons. That's a shame if people have to be released in order to get that sort of support when they're released. The other thing I'd like to raise in response to the question of outlying areas. We're really keen that e-health should be available widely, also including inside prisons, but also out in the community. Having access to a psychiatrist by e-health we've found is a very useful thing.

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[1] Portfolio Committee No. 2 - Health, Legislative Council, Parliament of New South Wales, *Equity, accessibility and appropriate delivery of outpatients and community mental health care in New South Wales*, (Report, 2024), p37.

Contents

1. Committee's Terms of Reference compliance

The matter addressed in this submission conforms to the Committee's Terms of Reference[2] such as the following:

> *(a) equity of access to outpatient mental health services; [...]*
> *(d) integration between physical and mental health services, and between mental health services and providers;*
> *(e) appropriate and efficient allocation of mental health care workers, including psychiatrists, nurses, psychologists, GPs, counsellors, social workers, allied health professionals and peer workers;*
> *(f) the use of Community Treatment Orders under the Mental Health Act 2007;*
> *(j) any other related matter.*

2. Kirby Institute Delphi Consultation Analysis

Justice Action received an invitation from the Kirby Institute on July 7, 2020 to participate in a virtual consultation process, with the aim of defining and developing an 'Optimal Treatment Model for people with psychosis who are leaving custody'. This consultation process was in response to the NSW Premier's 2019 initiative to

[2] Portfolio Committee No. 2 - Health, Legislative Council, Parliament of New South Wales, *Terms of Reference* (12 July 2023).

'reduce adult reoffending following release from prison by five per cent by 2023'. That priority aim followed the Premier's 2015 attempt to do the same, which failed and was followed by an 8 per cent rise in recidivism.

At the request of the Stronger Communities Cluster, the Kirby Institute was given the task to propose a model focussing on that group of ex-prisoners.

The Delphi consultation comprised three workshops as well as online surveys with feedback processes. The thirty six people participating included senior interstate bureaucrats in Corrections and Health, forensic psychiatrists, academics and three people with lived experience representing the focus group.

After it ended we received a detailed Report which is linked here. The Kirby Institute then released a published report titled '*Defining Optimal post-prison care in New South Wales for those with psychosis'* in 2020 ('The Kirby Report') which aimed to uncover the optimal model of care for individuals with prior episodes of psychosis being released from NSW prisons.[3]

Email expressing concern

Justice Action sent its concerns to all the participants through the organisers. The email is below.

> *From: Brett Collins <brett@justiceaction.org.au>*
> *Date: Monday, 19 October 2020 at 9:04 pm*
> *Subject: Concern/Optimal care model for people with psychosis leaving prison*
>
> *Dear Kirby Institute,*
>
> *We are concerned that a preliminary matter defining the focus of the consultation hasn't been directly addressed, although we have raised it during our contributions. Would you mind putting it to participants please?*
>
> *The prima facie position is that all prisoners are mentally fit at the time of being sentenced or they would be transferred to hospital. A pre-existing mental health problem causing delusions would be identified by lawyers and the person likely to get the benefit of a not guilty result. No prisoners should be psychotic upon entry to prison. They would be diverted to hospital under special conditions.*

[3] Paul L. Simpson et al, 'Defining optimal post-prison care in New South Wales for those with psychosis' *School of Population Health, University of New South Wales, Sydney and the New South Wales Department of Communities and Justice* (Report, 2020) (ISBN 978-0-7334-3951-3) 6 ('*Kirby Report*').

However we know many people who have been degraded by their prison experience. They are isolated from support, feeling guilty for abandoning their vulnerable children, shocked, frightened, sexually abused, bored and often becoming drug addicted.

The conditions of imprisonment through trauma, possibly exploiting pre-existing weaknesses, cause psychosis. We have attached a draft paper on prison induced psychosis. It is an accepted phenomenon. Here is also a link. We would appreciate comments.

We feel that a primary focus of the consultation to support the NSW Premier's priority to 'Reducing recidivism in the prison population' should be lessen the damage of imprisonment itself. Where diversion is not to be applied, then the use of the proven computer tablets in cells for rehabilitation services, education and communication with families is urgent and had already been agreed three years ago.

We are arguing that fixing a road is better than building a hospital for the victims of accidents.

We also identify the wrongly expressed law on forced medication which will limit its use in future, and the empowering alternatives available to assist ex-prisoners.

We appreciate the goodwill of participants and look forward to working with you for the good of our community.

Kind regards,

Brett
Brett Collins
Coordinator
JUSTICE ACTION

We then sent a Report on the Consultation to the organisers. See below:

Kirby Consultation Report

Draft 091120

Justice Action received an invitation from the Kirby Institute to participate in a virtual consultation process, with the aim of defining and developing an 'Optimal Treatment Model for people with psychosis who are leaving custody'[1]. This consultation process was in response to the NSW Premier's 2019 initiative to 'reduce adult reoffending following release from prison by five per cent by 2023'.[2] That priority aim followed the Premier's 2015 attempt to do the same, which failed and was followed by an 8 per cent rise in recidivism.

At the request of the Justice super ministry cluster, comprising the Attorney General, Police, Corrections, now referred to as the Stronger Communities Cluster, the Kirby Institute was given the task to propose a model focussing on that group of ex-prisoners.

The Delphi consultation comprised three workshops as well as online surveys with feedback processes. The thirty six people participating included senior interstate bureaucrats in Corrections and Health, forensic psychiatrists, academics and three people with lived experience representing the focus group.

A number of concerns were raised by Justice Action during the consultation as well as in separate emails to the organisers. The JA Mental Health Team produced research papers around the issues and distributed them to participants through the organisers.[3] They focused on matters that were not being raised: conditions during imprisonment causing mental illness for those who had been found guilty and therefore mentally responsible; the likely forced medication of people who instead needed ongoing social support; the use of the term "lifetime diagnosis of psychosis" to label a target group that would make their resettlement more difficult, and the illegal abusive culture of forced medication.

At the last workshop on October 20th Justice Action was given the opportunity to address the consultation about its concerns. Several other participants agreed that there were vital points still to be considered. Concerns were also raised about the use of forced medication inside NSW prisons rather than transfer to the Health Department, and the labelling of the target group. There has been no report to participants about what is intended or what action shall be taken following that consultation.

Several research papers were referred to during the consultation, and were sent to Justice Action at the end of the process. They had been produced by several of the participants in the period before the consultation using internal statistics from Corrections and Health. They purport to analyse the links between criminal offending and mental health with the target group being offenders with a psychosis diagnosis. The papers are Association between Early Contact by Adily et al (Paper 1), Court diversion by Albalawi et al (Paper 2), and Psychosis and Criminal Offending by Chowdhury et al. (Paper 3),

The research papers interlink to prove the increased rate of criminal offending in those with diagnoses of psychosis in an attempt to justify medicating vulnerable individuals who have suffered trauma and need assistance to find a safe place in the community for optimal outcomes. The papers show no effort at consumer engagement, interest in post-release social reintegration or concern with therapeutic outcomes. They fail to take into account the perspective or feedback from the individuals or the community on the treatment of "released prisoners with psychosis".

The papers used the term "treatment" in a broad and undefined manner but implied it should constitute medication via monthly injection regardless of the consumer's wishes. The papers did not consider the bodily autonomy of individuals and did not disclose whether consent was given. They do not disclose whether the individuals were informed of the long-term consequences of the treatment or if they were given the right to refuse medication. The papers claim only a cause and effect approach; that medication leads to lower recidivism rates; but offer nothing about the mechanism.

Justice Action's email that was distributed to participants is ***Appendix A*** to this Report. It has links to **Prison Induced Psychosis** paper, **Limits of Forced Medication** and "**Survival Manual for Health Department Escapees**". Additional research reports examining the focus issues were created on potential **abuse of s.32/33** of the Mental Health Act, statistical **problems with the s.33 Albalawi analysis**, and the abuse represented by **Forensic Community Treatment Orders**.

Justice Action's concern is that, instead of assisting people into recovery, the Institute is promoting forced medication as a dangerous form of chemical restraint.

(1) Preconception of a conclusion

The research papers link together to provide justification for medicating vulnerable individuals who have suffered trauma and need assistance to find a safe place in the community. The label of "mad crims" would see them shunned in all communities, regarded as mad and dangerous rather than recovered and functioning. Indigenous people would be especially affected.

Albalawi (2019: p. 3) found that the most common offence among the individuals was 'acts intended to cause injury'. Those charged with violent offences are more likely to get treatment orders (56%) rather than a punitive sanction (38%, these include bail and fines) [4](Paper 2, p. 3). Those committing drug-related offences are more likely to receive a punitive sanction (12%) rather than a treatment order (2%). The cohort did not include many individuals charged with homicides and sexual offences as it is likely that these were heard in higher courts. It was found that reoffending in the treatment group was 12% lower than the group receiving punitive sanctions.

1.1 Target group

The target group of the consultation of the Kirby Institute is a person who has a lifetime diagnosis of one or more of the following:

- Schizophrenia, schizotypal and delusional disorder;
- Mood [affective] disorders (mania with psychotic symptoms, bipolar affective disorder, current episode manic with psychotic symptoms);
- Bipolar affective disorder, current episode severe depression with psychotic symptoms, severe depressive episode with psychotic symptoms, recurrent depressive disorder, current episode severe with psychotic symptoms;
- Psychotic disorders due to psychoactive substance use; amnestic syndrome; residual and late-onset psychotic disorder

(From Kirby Institute Optimal Care Model Invitation Information, 24 June 2020).

The Kirby Institute has based this definition on their research, however Justice Action's concern is that this definition is contrary to the modern approach in relation to mental health, which is centred on recovery, instead diagnosing an individual for their lifetime for what may be only a transient psychosis diagnosis. This also does not take into account the stigma and negative social consequences of such a diagnosis.

The research papers provided by the Kirby Institute each study and make findings in relation to different types of target groups. In Paper 1 (Adily et al.) the cohort is individuals diagnosed with psychosis before their index offense from July 1, 2001, to December 31, 2012, and who received a noncustodial sentence (Paper 1, p. E1). Paper 2 (Albalawi et al.) studies individuals with a pre-existing diagnosis of psychosis prior to their court finalisation date for the first offence (Paper 2, p. 2). In Paper 3 (Chowdhury et al.) the target group is all individuals diagnosed with psychosis in either the New South Wales Ministry of Health's Admitted Patient Data Collection (APDC) between July 2001 and December 2012, or in the NSW Emergency Department Data Collection (EDDC), between June 2005 and December 2012 (Paper 3, p. 4). No study is directly focused on re-offending following a custodial sentence, and the effect that any psychosis treatment may have on this possible re-offending.

1.2 Point of Intervention

Paper 1 focuses on the effect that clinical contact with mental health services has on the level of recidivism (Paper 1, p. E3). Paper 2 focuses on the rate of recidivism following either a court treatment order, or a punitive sanction, and found that re-offending in the treatment order group was 12 per cent lower than the punitive sanction group (Paper 2, p. 3).

Paper 3 studies the effect on psychosis on offending, finding that individuals with a diagnosis of psychosis were approximately 5 times more likely than those without a diagnosis to have a criminal conviction (Paper 3, p. 11). The authors in Paper 3 argue that the results suggest that interventions and measures targeting the health and criminogenic needs of those diagnosed with psychosis are likely to have significant impact on crime in the state (Paper 3, p. 15), however do not provide results which suggest a proven method of treatment for individuals with psychosis diagnosis to receive medical treatment. This exposes a limitation in the paper's findings, which do not shed conclusive light on the effect of clinical treatment on offenders once upon completion of their sentences, or as a result of conditional release orders.

Dot points indicate draft comments not yet incorporated into the Report.

Paper 1 (p. E2): 7030 offending individuals who received a psychosis diagnosis before their index offence during the July 2001 - December 2012 period - noncustodial sentences

- Only showed reduced offending in the male demographic as a result of 'clinical contact' - further study into female offenders required
- Multiple types of psychoses were classed under the one group, thus not allowing for proper consideration of different diagnoses

(p. E3): Most (61.3%) were nonviolent index offenders, most frequently (12% of those) convicted for theft

(p. E5): 66.8% of repeat offenders were also nonviolent - the most frequent (17.6%) of these against justice procedures, govt security, etc.

- Overall mostly nonviolent offenders, questioning the need for forcible medication

Paper 2 (pg. 1): 7743 individuals who had been diagnosed with a psychotic disorder prior to their court date for their first offence

- Included people diagnosed with schizophrenia, affective psychosis and substance-related psychosis → these types of psychosis do not warrant a labelling of a lifetime diagnosis

Paper 3 (p. 1): 86,461 individuals diagnosed with psychosis between 2001 and 2012, contrasted with a control group with no diagnoses

- (p. 11): Schizophrenia, substance related, and other psychoses analysed
- Association between psychosis and violent and nonviolent offenses in NSW between 2001 and 2015 using data linkage of health and justice administrative data collections - also the association between criminal convictions and psychosis due to psychoactive substance use (p. 3)
- Used definition of psychosis: schizophrenia and related psychoses, affective psychoses (with no diagnosis of schizophrenia and related psychoses), and substance-related psychoses (p. 4)
- Finding: conviction types in the cases and controls were similar in terms of those classified as violent (29% and 31%) and nonviolent (71% and 69%) (p. 11) (p. 7): 81% only non violent offences committed, again questioning the need for extreme treatment measures that limit liberty

(2) Consumer Involvement

The research papers provided by the Kirby Institute have an inherent problem impacting and subsequently limiting their findings. Papers 1, 2 and 3 do not consider the individual's perception on the treatment of released prisoners with psychosis. Individuals may include prisoners, people charged with an offence and those experiencing conditional releases. While these papers mention factors that may influence the effectiveness of psychosis treatments, none mention how individuals themselves perceive their treatment, raising the question of who objectively determines the efficacy of such treatments and whether such declarations can be a way to speak over mental health consumers.

<u>No consultation with individuals diagnosed with psychosis</u>

- Including: prisoners, charged persons, people experience conditional releases- under orders
- They are not involved in the treatment they receive→ not tailored towards them; idiosyncrasies are not considered
- Infringes on their human rights
    - Were the human rights of the individuals respected as per their rights to personal bodily autonomy? Personal control of body and mind, right to self-determination and therefore personal responsibility.
    - Were they informed of the long-term consequences of the treatment and were they given the right to refuse?
    - No consultation with patients about what kind of diagnosis they should receive. It is likely that they would have received prior treatment if they have received diagnosis before.

<u>Community is not involved</u>

- Does not consider the consequences on individuals or on the community
- Papers make some mention of consumer background but no mention of consumer involvement.
    - Does not involve or adapt treatment according to individual consumer needs and whether they would differ based on different socio-economic/cultural etc. backgrounds

Paper 1:

- References to unspecified treatments and future plans with no reference to autonomy (i.e. p. E9: refers to positives of medication, or medication + other treatment, with no clarity as to whether this would be voluntary or involuntary)

- No comments made regarding individuals being informed of consequences of treatment or gaining autonomy with regards to their treatment process.

Paper 1 (p. E3): Mentions socioeconomic and other disadvantages in passing

- No analysis of or references to addressing these issues before intervening with medical treatment
- Mentions: marital status, offending history, offense/type of offense

Paper 2:

- Adjusts results for age, marital status, country of birth and psychosis types. Also considers people of Aboriginal heritage.
- However, no comments were made regarding individuals being involved with their treatment.
- People do not have autonomy over their ability to receive treatment, as this decision is left up to the magistrate, who may hold personal biases against various social groups.
- A significantly lower proportion of Aboriginal people received a treatment order compared to non-Aboriginal people (7% vs 11%).
- Only those charged with summary offences and not strictly indictable offences are given the opportunity for diversion to the community

Paper 3:

- (p. 15): Study did highlight that those with psychosis are more likely to receive convictions for nonviolent crimes compared to control group counterparts.
- Also acknowledged other groups within the larger group which are subject to this; i.e. Aboriginal people.
- No input from these groups themselves referenced however.
- No reference to individual autonomy or informing of consequences.
- Furthermore, no clarity as to the nature of treatment.

The lack of consideration for consumers' opinions regarding their own treatment is an intrinsic flaw in these research papers. This lack of consumer involvement within a treatment plan infringes on an individual's human rights as they have no autonomy over their own treatment and the bodily, mental or emotional effects it may have.

(3) Treatment

Adily et al (2020: p. E2) focuses on ‘clinical contact with mental health services’ but does not explain whether this consists of medication or counselling. The study finds that the risk of reoffending was 30% less in male offenders with 5 or more clinical contacts compared with male offenders with no clinical contact. However, ‘clinical contact’ is not defined and offers a vague understanding throughout the paper.

In Paper 1, the treatment that was used to suggest that treatment reduced recidivism was contact with mental health services during the follow-up period, being 30 days following their index offence (Paper 1, p. E3). No further definition of ‘clinical contact’ was provided, however it is provided it most often occurred at community mental health services rather than hospital admissions or emergency departments (Paper 1, p. E3).

Paper 1 (p. E2): Reference to treatment orders and psychotropic medication reducing “violent and non-violent offences”

- Also comments on benefits of frequency of clinical contact with no reference to what clinical contact entails (counselling? medication?)

(p. E3): Contact with “mental health services”

- No specifics as to treatment type

(p. E9): Mentions that previous studies have advocated for antipsychotic medication, and that perhaps future work could examine medication in combination with other mental health service contact

- “Early treatment” - again no specifics

Paper 2 (pg. 8): When a person is diverted into the general psychiatric mental health system, they are not referred to a specialist service, and instead become general mental health patients

- No mention of counselling or treatment from psychologists, just refers to ‘treatment orders’ and ‘mental health services’ without specificity
- Raised point that treatment orders may be given out as a means of disposing of cases quickly (pg. 8)
- Paper doesn’t mention unique treatment orders dependent on the person’s type of psychosis, which may explain why treatment for substance-based psychosis was shown to be the least effective
    - This is especially significant since Paper 3 (pg. 15) found that individuals with substance-related psychoses have the strongest association with having a criminal conviction

- Re-offences for people with substance-related psychoses could simply be acquisitive crimes to fund drug use, and hence treatment must address problem drug use.

Paper 3 (p. 3): Data from hospitals and day centres

- No reference to specific treatments

(p. 15): “population level interventions” and addressing “criminogenic needs” referred to

- No clarity in regard to what the former interventions should entail
- Does mention mental health services for Aboriginal individuals specifically

(p.17): Advocates a multi agency approach and culturally appropriate services

- No specifics

Other concerns:

Paper 2:

Pg5

- After adjusting the results for age, marital status, country of birth and psychosis types, the treatment order group were less likely to commit a second offence compared with the punitive sanction group

Paper 2 (pg. 8): Diversion into treatment under Section 32 and 33 is discretionary and subjective to the magistrate

- Low diversion rate of 32% shows the difficulty of this decision, as magistrates have to weigh up numerous factors and ultimately still display a tendency towards punitive measures (e.g. the seriousness of the offence, the degree to which the condition contributed to the offence, the need for punishment and deterrence etc.) (pg. 8)
- It was shown that engagement with treatment has a positive impact on reducing subsequent offending, and as such, offenders should have some discretion into their method/place of treatment, as this will likely cause them to engage more positively with the treatment (pg. 8)
- The average time between the court finalisation date and the most recent diagnosis was much shorter for people in the diversion group compared to the punitive sanction group (pg. 3). This stat may show that magistrates do possess a level of accuracy when deciding between a treatment order and punitive sanction.
- Only compares treatment order with punitive measures- what about other methods of treatments?

[1] Email from Tony Butler to Justice Action, 7 July 2020.

[2] NSW Government, *Reducing Recidivism in the Prison Population*, < https://www.nsw.gov.au/premiers-priorities/reducing-recidivism-prison-population >

[3] See Appendix A

[4] Olayan Albalawi et al., 'Court diversion for those with psychosis and its impact on re-offending rates: results from a longitudinal data-linkage study' (2019) 5(1) Journal of Law and Medicine 736, 738.

Kirby Institute Delphi Consultation Analysis (continued)

The Delphi model was used to investigate this aim, consisting of a selection of 25 experts and consumers judging a series of 'treatment' models to reach an eventual consensus. Of these experts, 9 were a part of NSW Health. Within the aim it also clearly states that the purpose of this process was to address one of the NSW Premier's priorities - reducing the rate of recidivism.[4] The study was commissioned by 'The Coordinated Continuous Model of Care (CSNSW) who alongside the Community Transitions Trial (JH&FMHN) are leading pilot programs in reducing recidivism in those with serious mental illness[5]. This Delphi Consultation did not progress to Round 3 as it did not achieve the required consensus criteria. Subsequently, there were published papers that relate to the foundational data-linkage study or refer to the Delphi Consultation process that had previously occurred. They were clearly identifiable either through the grant number that the report cited, or by the specific content and authorship. All reinforce the aim and focus was of reducing recidivism/reoffending.

The Report's Executive Summary stated upfront its post-release, recidivism aim:

> *UNSW Sydney found that significant numbers of those with histories of psychosis are released from New South Wales' (NSW) prisons each year, and that increased treatment (defined as contact with community mental health services), retention in treatment, and early commencement of treatment following an offence were associated with reduced reoffending. These findings suggest that if treatment is an important factor in reducing reoffending, what attributes of care and support are required to best achieve this in those exiting prison.* (pp. 1)

[4] Ibid.
[5] Ibid.

Furthermore, substantial NH&MRC grant-funded work was conducted, and publications were tagged to this grant that were specifically oriented at reducing reoffending - not focussed on benefitting the prisoners while in prison care, nor post-release care, nor post-release wellbeing and recovery.

2.1. Definition of 'Psychotic' Episodes

The Kirby report targets patients who leave NSW prisons with experience of psychotic episodes prior.[6] The report itself did not define psychosis. According to the DSM-5, the primary symptoms of psychosis, including delusions, hallucinations, disorganised speech, abnormal psychomotor behaviour, and negative symptoms. The psychotic episode refers to the period of time when a person experiences psychosis symptoms. It is a mental illness therefore only medical practitioners or accredited persons have the authority to certify a patient.[7]

The Kirby Report also refers to its base study that reported on the Delphi Consultation and a data-linkage study, which defined in the broadest terms 'psychotic disorders' the Kirby Report utilised, that included any psychotic reaction, including reactions to anxiety and substance use:

> *Psychotic disorders for the purpose of this study included schizophrenia and related psychoses, affective psychoses, and substance-related psychoses.*[8] (pp. 59)

Wallace et al.[9] found that people with comorbid diagnoses of schizophrenia and substance use disorder had significantly higher rates of conviction and recidivism than those only diagnosed with psychoses but no substance use disorder. Substance induced/related psychoses are a form of psychosis brought on by alcohol or drug use and can also occur from a withdrawal of these substances (onset during intoxication or onset during withdrawal).[10] Additionally, people with psychotic disorders statistically use substances to cope with pre-existing symptoms of psychosis. Often known as 'self-medicating', this leads to a cycle of an interconnected relationship between substance use and psychoses that provides short-term relief but results in a great dependence on substances.[11]

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[6] *Kirby Report* (n 3) 6.
[7] *Mental Health Act 2007* (NSW) s 4 ('*Mental Health Act*').
[8] Chowdhury, N.Z. (2021). The relationship between psychosis and offending behaviour in New South Wales - a data-linkage study. *UNSW Medicine and Health*. Doi: https://doi.org/10.26190/unsworks/22707
[9] Wallace, C., Mullen, P. E., & Burgess, P. (2004). Criminal offending in schizophrenia over a 25-year period marked by deinstitutionalization and increasing prevalence of comorbid substance use disorders. American Journal of Psychiatry, 161(4), 716-727.
[10] National Drug and Alcohol Research Centre (2011). *NDARC PSYCHOSIS FINAL*. [online] Available at: https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/NDARC_PYCHOSIS_FINAL.pdf.
[11] Ibid

The Kirby report reiterates the necessity for substance abuse specialists in the treatment plans for incarcerated people and prisoners who have been released. Almost 75% of people in prison are diagnosed with more than one mental health disorder, however, information regarding what percentage of this is substance-induced has not yet been clarified.

2.2 Definition of Treatment

The term ‘treatment’ is commonly recognised as a means of preventing, alleviating, or curing specific health problems.[12] The Kirby report clarifies that the top three most important attributes for the “treatment” theme were , 24-hour access to mental health care, having not just medications but also other, kinds of help, and access to culturally safe mental health care such as an Aboriginal Health Service[13]. In specific, there are fourteen attributes related to the *treatment in community* theme other than medications, including case management approach, team composition and lead, treatment access, working with consumer’s informal support network, contact frequency with consumer, 24-hour crisis response, team involvement in hospital admission & discharge decisions, case load, treatment types, stakeholder treatment delivery, treatment locations, supervision arrangement of those assessed as medium to high reoffending risk, and forensic mental health expertise/training of team[14].

The report has utilised the term ‘care’ in their report title and use ‘treatment’ and ‘care’ interchangeably throughout. During the consultation, the papers which were referred to used the term treatment in a broad and undefined manner but they implied it should constitute medication against the consumer’s wishes. The major focus of the resources in the consultation was on a cause and effect relationship rather than the mechanism. Using the term “treatment” in a report for developing a post prison care model indicates the model is dominantly medical in nature, rather than social, as claimed.

The Kirby report, by referring to data-linkage research, states that increased treatment following an offence was associated with reduced reoffending. It defines treatment as contact with community mental health services.[15] Additionally, the report defines the theme (of the model of care) of the treatments as integrated, comprehensive, and specialised treatments/services that address the psychological, medical, and social needs of the person.[16] Clearly, within the report, the definition of the theme of treatment is broader than the definition of treatment, the latter one is with medical nature only and can be received voluntarily and involuntarily.

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[12] Felicity L Bishop, Lucy Yardley and George T Lewith, ‘Treat or Treatment: A Qualitative Study Analyzing Patients’ Use of Complementary and Alternative Medicine’ (2008) 98(9) *American Journal of Public Health* 1700.
[13] *Kirby Report* (n 3) 16.
[14] Ibid 28.
[15] Ibid 1.
[16] Ibid 12.

Participants of the report were resolute that involuntary treatment for psychosis in prison must not be standard practice due to its unethical and inefficient nature.[17]

2.3 Medication Purpose

The report failed to take into consideration 'bodily autonomy' and whether individuals are made aware about the long term consequences of the medication. It was noted that The Kirby Report also notes that 'involuntary treatment' can be the legal order for the compulsory medication, or other treatments, to treat an individual.[18] Involuntary treatment therefore includes the making of community treatment orders (CTOs) or forensic community treatment orders (FCTOs) under s 51 of the *Mental Health Act 2007* (NSW). Within that Act, medication is not defined but is generally understood to be any medicine or drug for the purposes of treating conditions or illnesses.[19] Further, FCTOs are issued in the hope that they will reduce the risk of readmission. Thus, the Mental Health Act has wide discretion to administer any medication they wish onto consumers with no accountability mechanism ensuring they adhere to the requirement that the treatment plan is for the benefit of the consumer as per s 53(3)(a).[20]

There is other substantial evidence outside of the Kirby report which supports the claim that medications are being involuntarily administered to reduce recidivism. The Harper v State case in 1976 demonstrated that The Washington Supreme Court had the same standing as the Kirby report whereby they acknowledged that the administration of antipsychotic medication to Harper was of a "highly intrusive nature". Alongside stating that, The American Medical Association journal elaborates on the fact that physicians sought to treat Harper, despite his objections, as per following prison policy. Prison policy permitted involuntary treatment if the individual suffered from a mental disorder and was subsequently gravely disabled or posed a likelihood of serious harm to himself.[21] Prisoners are entitled to a hearing before a non treating psychiatrist and in the case of Harper, this procedure was followed prior to forcibly receiving treatment, however, the problem lies in the fact these procedures were insufficient at protecting their constitutional rights. He argued that a court hearing should have occurred before the involuntary administration of antipsychotics.

3. Prevalence of Psychotic NSW Prisoners on Release

The report does not directly refer to the number or even the percentage of individuals involved or estimated as a target group. Though it clearly stated that it was based on a data-linkage project that examined a NSW cohort from 2001-2012, and the citation

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[17] Ibid 15.
[18] Rajesh Mohan, Mike Slade and Tom A Fahy, 'Clinical characteristics of community forensic mental health services' (2004) 55 *Psychiatric Services* 1294.
[19] Cambridge Dictionary y (online at 4 March 2024) 'medication'.
[20] *'Mental Health Act'* (n 7).
[21] AMA Journal of Ethics, *Forced Medication of Prison Inmates,* (Web Page, February, 2018) <https://journalofethics.ama-assn.org/article/forced-medication-prison-inmates/2008-02>

reference for the Kirby Report was: 'Psychosis and criminal offending a Population-Based data-linkage study' authored by Chowdhury et al. (authors included Tony Butler, who took part in the Kirby Delphi Consultation Process). Associated details were also published in: ''The relationship between psychoses and offending in New South Wales (NSW) – a data-linkage study', focused on finding an association between psychosis and criminal convictions.

The Report connected to a data-linkage study, and it was the study that specified case number details for NSW, as published in a 'A Population-Based data-linkage study'[22] as well as in a 'Psychosis and criminal offending a Population-Based data-linkage study' authored by Chowdhury et al (authors included Tony Butler, who took part in the Kirby Delphi Consultation Process). Based on data from one to two decades ago, the data-linkage study detailed that '**Cases were individuals diagnosed with psychosis between 2001 and 2012 (n = 86,461)**... [and] Cases were approximately 5 times more likely to offend compared with controls', and the prevalence of at least one criminal conviction was 30%, accounting for 10% of all criminal convictions in NSW between 2001-2015[23]. **Using adjusted data from the NSW Reoffending Database, this indicated that per year, 7860 cases were identified in NSW for individuals with a criminal conviction.**

The 'Optimal' Report' paper that relates to this Report noted the complex relationship and mechanism, while acknowledging international studies conclusions' that:

> *'Serious mental illness is associated with an increased likelihood of having criminogenic factors, such as homelessness, poor social relationships, being unmarried, unemployment, substance use, poor education, and antisocial behaviours…*
> *Bonta et al. (2014, p. 278) states that "From both a risk prediction and a recidivism reduction perspective, symptoms of mental illness do not appear to play a major role'...*
> *There is evidence that treatment in prison significantly delayed the time to reoffending following release among individuals with schizophrenia (18% reduction)'*.[24]

[22] Nabila Z Chowdhury et al, 'Psychosis and Criminal Offending: A Population-Based Data-Linkage Study' (2021) 48(2) *Criminal Justice and Behavior* 157.
[23] Ibid.
Note that this was described in Results section as '86,461 individuals were as having at least one record of a diagnosis of psychosis on admission' to hospital or Emergency department, as compared to matched controls with no psychosis as a diagnosis record, noting age was not well matched, and cases were more likely to be from disadvantaged areas (50% vs 42% for controls).
[24] *Kirby Report* (n 3) 158.

3.1 Kirby Report's target group & the Delphi Consultation's Agreed Attributes of a Model of Care

The target group of the consultation of the Kirby Institute is a person who has a lifetime diagnosis of one or more of the following[25]:

- Schizophrenia, schizotypal and delusional disorder;

- Mood [affective] disorders (mania with psychotic symptoms, bipolar affective disorder, current episode manic with psychotic symptoms);

- Bipolar affective disorder, current episode severe depression with psychotic symptoms, severe depressive episode with psychotic symptoms, recurrent depressive disorder**,** current episode severe with psychotic symptoms;

- Psychotic disorders due to psychoactive substance use; amnestic syndrome; residual and late-onset psychotic disorder

Within the discussion section of Dr Butler's study, it was stated that the present Delphi study was commissioned by the DCJ to address the local NSW context. Further, the funding section of this study acknowledged that work was supported by a grant from the NSW DJC, and AA reports receiving support from a National Health and Medical Research Council grant APP1057492. BT reports receiving support from a grant from the New South Wales Department of Communities and Justice' and declared no conflict of interest.[26] (Articles were produced associated with this grant, and are listed at the end of this document.)

The study anticipated a NSW cohort of diagnosed people in 2001-2012, finding increased offending rates for people with psychosis and that those diverted into treatment under Forensic Provision of the Mental Health Act had relatively reduced reoffending: 'in 2016, the Justice Health Research Program, School of Population Health, UNSW Sydney commenced a data-linkage project entitled: 'The relationship between psychoses and offending in New South Wales (NSW) – a data-linkage study'.[27]

While not defined within the report, the Kirby Report does refer to an associated NSW data-linkage study that was published, as well as refers to the specific NH&MRC Grant APP1057492 (from which several publications were produced, funded to address Recidivism).

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[25] Kirby Consultation Report, p3, target group.
[26] Paul L Simpson et al, 'Defining optimal post-prison care in New South Wales for those with psychosis' (2020) 12(760904) *Frontiers in Psychology* 1, 10.
[27] Ibid 4.

Furthermore, the Kirby Report did not directly specify the target numbers or how many prisoners were being released who were 'psychotic prisoners' intended for any 'optimal model of care'. **The Kirby Report did link for any supplementary information to another publication[28] which did report on the examination of NSW data where:**

> ***Cases were all individuals diagnosed with psychosis between 2001 and 2012 (n = 86,461).[29]***

The Delphi Study drew from a data-linkage study that reported on the investigated cases of individuals diagnosed with psychosis and with criminal convictions, claiming this startling, large number of cases. This is especially concerning as NSW prisons latest average prison population is approximately 12,091 (of which 5055 are on remand, and 3674 in custody are Aboriginal; and 174 are youth, of which 129 are on remand, and 61.5% in custody are Aboriginal) [30]. The Delphi Study published the consensually- agreed attributes for a model of care[31], which is described later in this document.

The Kirby Institute study sought to identify themes about the kind of model of care, using the Delphi Model. The article refers in the Delphi Scoring Rounds to two rounds in a consensus process, where it is expected that consensus is reached by Round 3. It involved deliberating with different experts and stakeholders in the issue, then, online surveys were also conducted to gather opinions on different models of care. A 'stress test' was used to evaluate the models of care. This involved experts and consumers outlining reasons for a specific model's failure. Similarly, individuals who had lived in prison and experienced past episodes of psychosis along with their family members were asked to share their views on the support available to those who had left prison in the online consumer poll. Brett was an unidentified consumer of 3 consumer participants of the total 25 experts/consumers, 4 from CSNSW, 7 from JH or FMHN.[32]

3.2 Kirby's Delphi Consultation Consensus Process

While JA received a copy of this Kirby Report, it is surprising that it cannot be found directly on any website links including projects, nor reference to the Grant in the annual reports https://www.kirby.unsw.edu.au/about/annual-reports. Nor is it found on the Kinnford Consulting website & subsequent publications by Dr Butler.

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[28] Simpson et al (n 21).
[29] Ibid.
[30] NSW Bureau of Crime Statistics and Research,'Custody Statistics' (Web Page, 7 February 2024) <https://www.bocsar.nsw.gov.au/Pages/bocsar_custody_stats/bocsar_custody_stats.aspx>
[31] Simpson et al (n 21).
[32] *Kirby Report* (n 3) 1.

However, the content appears in a Delphi Study published in 2021 with author Tony Butler.

Despite the process being aborted due to lack of consensus progress, the Delphi Consultation details were published, identifying themes that had achieved consensus. Key post release themes that gained at least consensus rating of >71%, are detailed in Table 2: all prisoners to be involved in pre-release planning & Coordination; information sharing between agencies occurs with confidentiality provisions; a specialised case manager team deliver treatments with brokered services; a case manager from a new independent team/service be created to operationalise plan, and that this Not be a Community Corrections Officer; consumer contact is frequent at least weekly, with 10 as a maximum caseload; for treatment priorities of independent living skills as well as social & economic supports to be obtained by an ATSI controlled health organisation, pharmacotherapy provided by Health NSW; drug and alcohol support by an independent specialised service; psychological support counselling provided by a new independent specialised service. It was recognised that to prevent model failure, alternatives to authorities was important, being the use of Consumer/carer/family member/guardian/peer to be involved in planning and as stakeholders.

When considering the question of medication, the Kirby report outlines that during the 'stress testing' meeting, some of the patients were adamant that involuntary treatment for psychosis should not be normalised "as they consider that is unethical [and] inefficient".[33] There was strong emphasis placed on having access to support and treatment services that was not just medication as evidenced by the Consumer poll issue.

[33] *Kirby Report* (n 3) 15.

Response to NSW Mental Health Inquiry: Crisis Intervention CAHOOTS Model

At the Parliamentary Inquiry into Mental Health, Hon Susan Carter asked Justice Action;[1]

> "*Is there anywhere that you're aware of where this type of program [CAHOOTS] has been rolled across something as big as the State of New South Wales, as opposed to two individual cities in two different states*?"

Responding to Hon Susan Carter's Question To Justice Action

This document should not be read as a definitive list of effective Community Response Programs but rather as a basis and encouragement for further research. The research should focus on making sure each NSW community implements the best CRP model for their local needs.

Community Response Programs (CRPs) are run independently from the Police force (CAHOOTS is one type of CRP model). They aim to evaluate and provide interventions in Mental Health emergencies. CRPs work alongside/with healthcare professionals and peer workers.

Every CRP has a slightly different set of criteria for what they can and cannot respond to, in accordance with the local culture, needs and resources of that community. For instance, CAHOOTS, responds to calls regarding suicidal patients, whereas Portland Street Response will not. The underlying principles of CRPs remain the same, and centre around diverting those suffering acute mental stress from the criminal justice system and facilitating their access to local support services.

In the United States, CAHOOTS and models like it, do not extend beyond city limits, due to the nature of the CRP models stressing the importance of community based responses to community based problems. In the UK, Humberside Police and the London Metropolitan Police, which collectively serve as many people as the NSW

[1] Transcript, "EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES", 2024, p 35.

Police Force, are currently implementing the CRP inspired 'Right Person, Right Care' model. However, this program is new and still in the early stages of assessment.

It is also important to emphasise the importance of peer-led crisis response, which contributes to the success of CAHOOTS. The majority of their responders identify as "peers with lived experience of incarceration, substance use, neurodivergence, houselessness, and other forms of oppression."[2] Their lived experience of mental health crises gives them unparalleled empathy and insight into the suffering of those they serve and enhances development of the rapport crucial to de-escalating stressful situations. There has never been a serious injury to anyone involved in the hundreds of thousands of call-outs responded to by CAHOOTS teams.

Other programs, such as Portland Street Response, also despatch teams with peer support specialists, where they use both professional and personal experiences in their work. They can refer clients to pre-existing support systems and establish new connections with other service providers. Peer support specialists can build trust with the person in distress by sharing their own stories, reassuring them that help is just around the corner.

The core features of CRPs are as follows: (1) police have no role in the response teams, though they may be called to assist if needed; (2) they are an alternative to traditional emergency responders such police and ambulance, not attempts to reform their responses to mental health crises; (3) they draw primarily upon the local community for design, implementation and staffing as they are the ones most in touch with local needs and challenges as well as the resources available or required to address them.

It's important to note that for such programs to succeed in reducing violence and criminalisation during mental health crises the initial involvement of police must be minimised. There have been numerous failed attempts, both in Australia and overseas, to reduce the tendency towards arrest, imprisonment and violent escalation the presence of armed, uniformed law enforcement officers produces. Even after extensive training police quickly revert to the culture and methods which serve them in their roles as enforcers of public order. It is neither reasonable nor realistic to expect them to become health or social workers when faced with someone displaying extreme emotional and behavioural dysfunction. The price for such expectations is steadily increasing and is denominated in human lives.

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[2] "Peer-led mobile crisis response: How it works," *Greenfield People's Budget*, 2021, https://peoplesbudgetgreenfield.com/cahoots/.

Justice Action Recommendations

The NSW government should use their state resources to research Community Response Programs globally and how they pertain to those communities. Using this data to develop a toolkit that will aid each individual community in building up their own CRP. Each program should be built from the ground-up with the members of the community so that it can pertain to the area's specific mental health needs. The NSW government should aid them in creating their programs, with their government research, resources and funding.

Justice Action urges the NSW government to provide CRPs with independence, to ensure that CRPs are able to respond quickly and effectively to challenges unique to each community. Therefore, Justice Action argues the NSW government should not create a top-down regulatory structure for CRPs, as it undermines the purpose, and efficacy of CRPs.

Community Response Programs (CRPs)

Crisis Assistance Helping Out On The Streets (CAHOOTS)

Crisis Assistance Helping Out On The Streets' (CAHOOTS) is a CRP based in Eugene, Oregon and Springfield. CAHOOTS was established over thirty years ago and currently operate as emergency services that dispatch from a local crisis centre. The CAHOOTS team consists of support workers and medics who respond to a variety of incidents including psychological distress and suicidality, adequately providing the appropriate services individuals require[3]. This expertise in behavioural-related de-escalation ensures unnecessary police transportation, removing indignant dissatisfaction with police services.

Portland Street Response

Portland Street Response (PSR) is based in Portland Oregon, and is inspired by CAHOOTS. The PSR works with Portland Fire and Rescue to provide emergency care for those suffering from a mental health crisis. Their services can be requested via 911, who determine whether to alert PSR or other emergency services. Unlike other community response programs, PSR does not attend incidents where there is an individual suffering from suicidal ideation.

[3] "Cahoots," *White Bird Clinic,* https://whitebirdclinic.org/cahoots/.

However, there are suggestions from staff to expand the criteria to which their calls will respond, as to include calls involving suicidal attempts or ideation. They felt like this is one of the primary objectives of the program mission and should be expanded to include in the call criterias.[4]

Support Team Assistance Response (STAR)

The Support Team Assistance Response (STAR) is a CRP based in Denver. STAR responds to low risk mental health and drug related incidents, and their team consists of mental health professionals and paramedics.[5] This program was shown to reduce drug related arrests by 34% in the Denver area.[6] In its inaugural year, STAR responded to over 1,000 calls and there were no arrests made, calls for police backup or injuries.[7] This is promising preliminary evidence for the efficacy of community response programs, as STAR directs people in crisis to appropriate mental health care rather than directing them to the criminal justice system, leading to a prevention of future criminal activity.[8]

The Behavioural Health Emergency Assistance Response Division (B-HEARD)

The Behavioural Health Emergency Assistance Response Division (B-HEARD) is a community response program based in New York City. The team members include paramedics, medical technicians from FDNY, and mental health professionals working with the New York Health Department. The team members are dispatched when 911 receives mental health related calls. This program was trialled in Harlem and is now being implemented across Manhattan. The B-HEARD team aims to de-escalate and provide care for those suffering from drug and/or mental health crises.[9] However, B-HEARD is not dispatched when there is a weapon present, or a threat of violence.

B-HEARD has also received a lot of criticism from the local community who feel the program is ineffective, as it is under-resourced, and therefore unavailable for eight hours of the day. Secondly, B-HEARD passes on 80% of

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[4] Townley, G., & Leickly, E., "Portland Street Response: Year One Evaluation," *Portland State University,* 2022.
[5] "Support Team Assisted Response (STAR) Program," *Denvergov.org.*
[6] Thomas S. Dee, Jaymes Pyne, "A community response approach to mental health and substance abuse crisis reduced crime", Sci.Adv.8, eabm2106 (2022). DOI:10.1126/sciadv.abm2106.
[7] "Support Team Assisted Response (STAR)," *Well Power,* www.wellpower.org/star-program/.
[8] Krysten Crawford, "A new Stanford study shows benefits to dispatching mental health specialists in nonviolent 911 emergencies," 2022. https://news.stanford.edu/press/view/43952.
[9] FDNY, "Re-imaging New York City's mental health emergency response," https://mentalhealth.cityofnewyork.us/b-heard.

their referrals to the New York Police Department (NYPD), meaning a majority of those suffering a mental health crisis are not treated, or attended to.[10]

The Mobile Assistance Community Responders of Oakland Program (MACRO)

In 2019, the City Council in Oakland, California initiated a program under the model of CAHOOTS to adhere to the needs of a compassionate care first response model. The program was created to decrease the rate of emergency responses and improve community-based services and resources to individuals, especially for Black, Indigenous and other people of colour[11]. The eighteen month pilot program was launched in April 2022, within the Fire Department, which responded to nonviolent, non-emergency calls to 911 and diverted the calls away from police and fire departments that can be handled by civilians.[12] MACRO will respond to calls falling under three categories: (1) Behavioral Health Issues (2) Individual Well-Being (3) Community Disturbance. The program came to an end in October 2023, but the City Council is mapping out the potential of expanding the program further[13]. The main limitation during the program's pilot was that MACRO did not have a direct phone-line, so it is crucial that in the program's re-introduction that this is implemented.

Crisis Response Units (CRUs)

The CRP is not to be confused with the Crisis Response Unit (CRU) which is a co-responder service. Police are involved in CRU, though some programs are informed by CRP practice.

Crisis Response Unit, Olympia, Washington

CRU provides mobile responses to community members experiencing problems related to mental health, poverty, homelessness and substance abuse.[14] CRU is a co-responder service to the Olympia Police Department. CRU teams also use police radios to identify and respond to calls which otherwise go to the police.[15]

[10] Ibid.
[11] "The Mobile Assistance Community Responders of Oakland (MACRO) Program," *Oaklandca.gov,* 2021, https://www.oaklandca.gov/projects/macro-mobile-assistance-community-responders-of-oakland.
[12] Eli Wolfe, "What's next for Oakland's MACRO civilian first responder program?," *The Oakland Side,* 2023, https://oaklandside.org/2023/10/24/oakland-macro-911-civilian-first-responders/.
[13] "The Mobile Assistance Community Responders of Oakland (MACRO) Program," *Oaklandca.gov,* 2021, https://www.oaklandca.gov/projects/macro-mobile-assistance-community-responders-of-oakland.
[14] "Crisis Response & Peer Specialists," olympiawa.gov, www.olympiawa.gov/services/police_department/crisis_response.
[15] Ibid.

Calls are shared through Olympia's non-emergency police line, and CRU respondents can respond to incoming calls or officers refer calls to CRU if they determine the apparent threat to first respondents is minimal.

The CRU within the Olympia Police Department implemented a peer support program in 2018 named 'Familiar Faces' in which clients interact with peers who they identify with. The peers bring lived experience with poverty and substance use to their roles, including their personal histories with the criminal legal system.[16] Although Familiar Faces is informed by CRP practices, they receive their training through the police department and are only available by referral from the police-led department CRU.

Ambulance Centred Non-Police Response

There are also Ambulance Centred Non-Police Response, which are also not to be mistaken for CRPs.

Mental Health Acute Assessment Team (MHAAT)

The Mental Health Acute Assessment Team (MHAAT) is a program located in Western Sydney that seeks to help those in need of mental health clinical support. A mental health clinician is sent in ambulances alongside paramedics for mental health support. An aspect of the program is not always delivering those in crisis to the emergency department and instead to the appropriate care facilities. It reduces the number of those in emergency departments who are dealing with mental crises. People are instead receiving the correct care needed for their situation at appropriate facilities, instead of wasting resources in an emergency department[17].

Mental Health, Ambulance and Police Project (MHAPP)

Mental Health, Ambulance and Police Project (MHAPP) is a trial partnership with the involvement of Illawarra Shoalhaven Local Health District (ISLHD) Mental Health Service, NSW Ambulance and Wollongong Police District. There will be an experienced mental health clinician in corporation with the

[16] Jackson Beck, Melissa Reuland & Leah Pope, "Case Study: CRU and Familiar Faces," *Vera*, 2020, www.vera.org/behavioral-health-crisis-alternatives/cru-and-familiar-faces.
[17] "Mental Health Acute Assessment Team," *Mental Health Commission of New South Wales,* 2020, https://www.nswmentalhealthcommission.com.au/content/mental-health-acute-assessment-team.

police and ambulance to respond to the situation, either through telephone or on-site support. In person support will provide a mental health assessment by the clinician, physical examination by paramedics, advice on de-escalation, transport and referral options. The clinician can also refer to a psychiatrist on a call for further consultation with the client. MHAPP's goals are to provide early access to relevant assessments and services in the community as well as limit the experience between the client and the Emergency Department. However, MHAPP's response is restricted from children under fourteen, persons under influence of alcohol or other drugs, persons with acute medical concerns requiring urgent hospital transport, and persons with no previous documented mental health history with ISLHD Mental Health Services.[18]

Psychiatric Emergency Response Team (PAM)

Psychiatric Emergency Response Team (PAM) is a 2015 project run in Stockholm County, Sweden. Intended to respond to emergency calls concerning persons in severe mental health or behavioural distress, there will be a team of two nurses, specialised in psychiatry and a paramedic. It is also in cooperation with the police, ambulance, rescue service, and the somatic emergency departments, and a psychiatrist on call if needed. PAM will respond on-site, when the Emergency Call Centre identifies the situation as a mental health crisis. The patient will be assessed in the PAM vehicle with their medical records already made available. The positive aspect of PAM is that all ages are considered and suicide attempts/threats are classified as first priority.[19]

List of Community Response Programs and Advocacy Groups

Programs in operation for more than 3 years

1. MH First, Sacramento, California

https://www.antipoliceterrorproject.org/mh-first-sac
→ operating since January, 2020
There is a second city that this program is in operation, Oakland
https://www.antipoliceterrorproject.org/mh-first-oakland

[18] "Mental Health, Ambulance & Police Project (MHAPP) fact sheet," *NSW Health*, https://www.coordinare.org.au/assets/MHAPP-fact-sheet.pdf.
[19] Olof Bouveng, Fredrik A. Bengtsson & Andreas Carlborg, "First-year follow-up of the Psychiatric Emergency Response Team (PAM) in Stockholm County, Sweden," 2017, 46:2, 65-73, DOI: 10.1080/00207411.2016.1264040.

2. Person in Crisis Team, Rochester, New York
https://www.cityofrochester.gov/person-in-crisis-team/
→ stared since September 2020

3. Street Crisis Response Team, San Francisco, California x
https://www.sf.gov/street-crisis-response-team
https://www.sf.gov/sites/default/files/2022-06/SCRT%20Final%20Report_FINAL-%201%20year.pdf
→ first launch in 2020

4. Specialized Care Unit, Berkeley, California
https://berkeleyca.gov/community-recreation/news/new-program-launches-non-police-mental-health-crisis-response
→ launch May 2020

Programs established as pilot programs or less than 1 year

1. Aurora Mobile Response Team, Aurora, Colorado
https://www.auroragov.org/residents/neighborhood_resources/aurora_mobile_response_team
→ pilot program ended 2022

2. COMPASS, New Haven, Connecticut
https://www.elmcitycompass.org/about
→ launch since 2022, still ongoing, within city of New Haven

Organisations advocating for greater rollout of CRPs who provide further information include

CCIT-NYC, NYC, New York
https://www.ccitnyc.org/

The Vera Institute, NYC, New York
https://www.vera.org/civilian-crisis-response-toolkit

Reach Out, Toronto, Canada
https://reachouttoronto.ca

The Anti Police-terror Project, Sacramento, California
https://www.antipoliceterrorproject.org/