Submission No 76

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Organisation: Justice Reform Initiative

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JUSTICE REFORM INITIATIVE

SUBMISSION TO NEW SOUTH WALES PARLIAMENT LEGISLATIVE COUNCIL PORTFOLIO COMMITTEE NO. 2 – HEALTH

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ABOUT THE JUSTICE REFORM INITIATIVE

The Justice Reform Initiative is an alliance of people who share long-standing professional experience, lived experience and/or expert knowledge of the justice system, further supported by a movement of Australians of goodwill from across the country who believe jailing is failing and that there is an urgent need to reduce the number of people in Australian prisons.

The Justice Reform Initiative is committed to reducing Australia's harmful and costly reliance on incarceration. Our patrons include more than 120 eminent Australians, including two former Governors-General, former Members of Parliament from all sides of politics, academics, respected Aboriginal and Torres Strait Islander leaders, senior former judges including High Court judges, and many other community leaders who have added their voices to end the cycle of incarceration in Australia.

We seek to shift the public conversation and public policy away from building more prisons as the primary response of the criminal justice system and move instead to proven alternative evidence-based approaches that break the cycle of incarceration.

We are committed to elevating approaches that seek to address the causes of contact with the criminal justice system including responses to housing needs, mental health issues, cognitive impairment, employment needs, access to education, the misuse of drugs and alcohol, and problematic gambling. We are also committed to elevating approaches that see Aboriginal and Torres Strait Islander-led organisations being resourced and supported to provide appropriate support to Aboriginal and Torres Strait Islander people who are impacted by the justice system.

New South Wales patrons of the Justice Reform Initiative include:

- **Professor Eileen Baldry AO.** Deputy Vice-Chancellor Equity Diversity and Inclusion and Professor of Criminology, University of New South Wales
- **Professor Larissa Behrendt.** Professor of Law and Director of Research at the Jumbunna Indigenous House of Learning at the University of Technology Sydney
- **Jody Broun.** Inaugural female co-chair of the National Congress of Australia's First People
- **Nicholas Cowdery AO KC.** Former Director of Public Prosecutions NSW
- **Bill Crews AM.** Founder of the Rev. Bill Crews Foundation, broadcaster and National Living Treasure
- **The Honourable Bob Debus AM.** Former Attorney General of NSW and former Federal Minister for Home Affairs
- **The Hon John Dowd AO KC.** Former Attorney General of NSW, former Justice of the Supreme Court of NSW and Vice President of the International Commission of Jurists
- **John Feneley.** Former Mental Health Commissioner NSW
- **The Hon Geoff Gallop AC.** Former Premier of Western Australia and currently Emeritus Professor in the Faculty of Arts and Social Science at the University of Sydney
- **The Hon Katrina Hodgkinson.** Former Minister for Primary Industries (including lands and water), former Minister for Small Business, former Assistant Minister for Tourism and Major Events

- **Dan Howard.** Former President, NSW Mental Health Review Tribunal. Former Commissioner, Special Commission of Inquiry into the Drug 'Ice'
- **Ken Marslew AM.** CEO of Enough is Enough (community support group for victims and offenders).
- **The Honourable Ruth McColl AO SC.** Former Justice of the NSW Court of Appeal
- **Dr John Paget.** Former Assistant Commissioner NSW Corrective Services, CEO SA Correctional Services and NSW Inspector of Custodial Services
- **The Honourable Greg Smith SC.** Former Attorney General of NSW and former Minister for Justice (including Juvenile Justice and Corrective Services)
- **Dr John Vallance.** NSW State Librarian.

KEY RECOMMENDATIONS

1. **That the NSW Government develop a health-led focus to response to people with mental illness in crisis with the following elements:**
   - **Alternative first-responder models where specialist mental health support workers respond to people in mental health crisis instead of police, unless there is a clear risk of harm;**
   - **Where there is need for police to also be involved that health professionals lead the response wherever possible (with the police there as support);**
   - **Ensuring that all police members are adequately trained to work effectively and safely with people experiencing mental illness, and in a way that carries minimal risk of harm to any person.**
2. **Reinstate the presumption in favour of bail for all offences, with the onus on the prosecution to demonstrate that bail should not be granted due to there being a specific and immediate risk to the physical safety of another person, a serious risk of interfering with a witness, or the person is posing a demonstrable flight risk.**
3. **That the NSW Government review and amend the Bail Act to ensure that bail provisions do not operate to make it more likely that a person with mental illness is denied bail. In particular:**
   - **Ensure that bail conditions, particularly those relating to residency, curfew and non-association, are not excessively onerous.**
   - **Include a specific provision in the Bail Act that a person may not be remanded for an offence that is unlikely to result in a sentence of imprisonment.**
4. **That the NSW Government establish and appropriately resource bail support services including accommodation support and pre-trial diversionary and bail support services for people with mental illness.**
5. **That the NSW Government establish specialist in-court diversion programs to respond to the particular needs for people with mental illness who face criminal charges, and to address the underlying mental health issues which have contributed to criminal offending.**
6. **That the NSW Government review and amend the *Crimes (Sentencing Procedure) Act 1999* to enable more tailored community corrections orders for people who have mental illness or cognitive disability, and for more options for community-based sentencing, including options that incorporate psychological and psychosocial support, education and vocational counselling, and partnerships with organisations for paid and volunteer work.**
7. **That the NSW Government provide necessary resources to enable people with mental illness who are convicted of criminal offences to access appropriate community corrections orders and other community-based sentencing options that provide the necessary supports to enable that person to live and thrive in the community.**
8. **Practices such as solitary confinement, strip-searching and the use of physical restraints should only ever be used in exceptional circumstances, where there is a need to prevent an imminent and serious threat of injury to the incarcerated person or others, and only ever as a last resort.**

9. **All people in prison should have access to Medicare services and the Pharmaceutical Benefits Scheme (PBS) subsidies.**
10. **Prison reception and assessment processes need to include a comprehensive assessment of people entering custody to identify and assess mental illness. Such an assessment must also be undertaken for people who are currently incarcerated.**
11. **Improve access to specialist services and programs for people with mental health needs who are incarcerated. All programs should be trauma-informed, culturally safe and readily available, including for people on remand and serving short-term sentences.**
12. **That the NSW Government increase funding and other resources to community-based services that provide mental health, alcohol and other drug treatment, disability support, education and training, and culturally appropriate support, to assist people exiting prison to reintegrate back into the community.**

INTRODUCTION

People living with mental illness are significantly over-represented amongst those who have contact with the criminal justice system.[1] They comprise a disproportionate number of the people who are arrested by police, who come before the courts and who are imprisoned. This does not mean that people who live with mental illness are more likely to commit crimes or are more pre-disposed to criminal behaviour. What it indicates is that having a mental illness is often related to various other factors of disadvantage and hardship, and that in the absence of appropriate and tailored support and mental health medical services, these factors make it more likely for such people to come into contact with the criminal justice system. They may include factors such as disrupted family backgrounds, family violence, sexual and other abuse, use of drugs or alcohol, poverty and homelessness. Many will have experienced institutional child sexual abuse as revealed by the Royal Commission into Institutional Responses to Child Sexual Abuse.

The over-representation of people with mental illness in the criminal justice system is most conspicuously illustrated in the fact that 40% of people incarcerated in Australian prisons have a history of mental illness and 21% have a history of self-harm.[2] Not only are prisons across Australia disproportionately filled with people who experience mental illness. These same institutions also cause mental illness in people who did not previously experience it and exacerbate mental illnesses for those people in prison who previously were managing their illness.

A major cause for the over-representation of people with mental illness in the criminal justice system is the inability to access appropriate and tailored mental health services to meet their particular needs and to support them to live and thrive in the community. A lack of crisis mental health services contributes to an increased reliance on the police to respond to people experiencing mental illness or psychological distress. A lack of supported accommodation options contributes to increased reliance on the prison system to house people whose conduct might be considered by some to pose a threat to community safety.

The JRI submits that the focus in addressing mental illness needs to shift from a punitive law and order approach to a therapeutic response that focuses on individual and community health and wellbeing. This can occur at all stages of contact with the criminal justice system, from initial interactions with police, through to consideration of eligibility for bail and the opportunity to divert a person to receive treatment, the opportunity for in-court diversion to mental health treatment, and alternative sentencing options allowing for referral to community-based treatment services.

Given that people in prisons are more likely to experience mental illness than the general population, and that incarceration is often a cause or an exacerbating factor of mental illness, there is a need for accessible, culturally appropriate, strengths-based mental health programs in custodial settings that are tailored to each person. As the transition from prison to the community is particularly difficult for people with mental illness, the provision of effective post-release reintegration programs that work with people holistically around a range of issues, including housing, drug and alcohol treatment, employment, mental health and disability, is of vital importance.

Mental illness is a significant health and social issue in Australia and requires a health and social policy response. The lack of adequate, appropriate mental health services in the

[1] Mental Health Commission of New South Wales, 'Towards a just system: Mental illness and cognitive impairment in the criminal justice system' (July 2017) 4.

[2] AIHW 2019. The health of Australia's prisoners, 2018. Cat. no. PHE246. Canberra: AIHW.

community has resulted in the criminal justice system becoming the default option to respond to a serious community health issue. Tragically this is too often in a cruel and punitive manner, which only serves to exacerbate existing mental health problems for affected individuals, and ultimately undermining community safety. A punitive law and order approach is not appropriate to deal with mental illness.

OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NSW

The provision of mental health care in NSW is governed by the *Mental Health Act 2007* ('the Act'). Section 3 sets out the objects of the Act, which include:

a) to provide for the care and treatment of, and to promote the recovery of, persons who are mentally ill or mentally disordered,
b) to facilitate the care and treatment of those persons through community care facilities,
c) to facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis,
d) while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care and, where necessary, to provide for treatment for their own protection or the protection of others, and
e) to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care and treatment.

The Act also sets principles for care and treatment of people with a mental illness in section 68. These include the following:

- people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given,
- people with a mental illness or mental disorder should be provided with timely and high quality treatment and care in accordance with professionally accepted standards,
- the provision of care and treatment should be designed to assist people with a mental illness or mental disorder, wherever possible, to live, work and participate in the community,
- any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances.

Chapter 3 of Part 3 of the Act sets out a framework for authorising compulsory treatment in the community of a person who has mental illness or is in mental distress. Under section 51 the Mental Health Review Tribunal may make a Community Treatment Order ('CTO') authorising the compulsory treatment in the community of a person. The CTO must include a treatment plan which consists of an outline of the proposed treatment, counselling, management, rehabilitation or other services to be provided to implement the CTO (s54). If the CTO is breached and reported to police, a police officer must apprehend and assist in taking the person the subject of the order to the mental health facility (s59(1)).

CONCERNS WITH THE OPERATION OF THE ACT IN NSW

LACK OF ACCESS TO MENTAL HEALTH SERVICES

The JRI supports the principle of community treatment and the importance of people with mental illness not being detained and denied their liberty unless there is strong evidence that protection of the community cannot be otherwise achieved. However, for the CTO framework to function as intended and as a priority for the treatment of people with mental illness it is essential that there are appropriate and well-resourced mental health psychiatry services (including child psychiatry services) across NSW, particularly in rural, regional and remote areas.

There is also a concern that where services are limited, priority is given to those people on a CTO. This results in people who have mental illness who are not subject to a CTO being unable to access the necessary support treatment and services.

Finally, there is also a need for strategies in regional and remote areas that avoid the unnecessary transfer of a person with mental illness to a mental health hospital which is a long distance from their home. This is particularly important for First Nations people who face the prospect of being removed from family and community supports, and country. In these circumstances the use of “calm rooms” or de-escalation spaces can serve as a suitable alternative that can result in an apparent mental health crisis being resolved without the need for an admission.

LACK OF CONNECTION BETWEEN HOSPITAL MENTAL HEALTH AND COMMUNITY MENTAL HEALTH

For people with severe and persistent mental illness who transition between community treatment and hospital admission, and vice-versa, there is often a lack of connection between the hospital mental health team and the community mental health team and related NDIS funded psychosocial services. The transition from hospital to community treatment requires strategies to ensure continuity in treatment.

One model that could be employed for mental health treatment could be based on the Hospital in the Home model, which provides clinical care for a range of health conditions that can reduce the length of stay in hospital or even avoid admission altogether. Benefits from such a model include remaining in one’s home environment and being close to family and friends.

COST OF COMPULSORY MEDICATION

Many people on CTOs will have severe and persistent mental illness. As part of their CTO treatment plan they may be required to be subject to a compulsory medication regime. Even though many people are reliant on a Disability Support Pension they still have to pay for their compulsory medication. A failure to do so may place them in breach of their CTO and subject to police intervention and involuntary hospital admission. The reality is that many people on CTOs will also be paying for medication for related physical health issues associated with metabolic syndrome such as diabetes, as well as food and other outgoings.

INVOLVEMENT OF POLICE IN CTO BREACH

The requirement under s59 for police to apprehend a person with mental illness who breached their CTO places police in the role of first responder to a situation involving a person with mental illness. This requirement has the potential to escalate into a punitive response rather than providing a health-focused response that ensures that the person receives appropriate care and treatment. As discussed below, the JRI considers that it is more appropriate that specialist mental health support workers respond to people in mental health crisis or have breached a CTO, rather than police, unless there is a clear risk of harm.

RELIANCE ON POLICE TO RESPOND TO PEOPLE EXPERIENCING MENTAL ILLNESS

There is often a reliance on the police to respond to people experiencing mental illness or psychological distress due to a lack of mental health services. Given that most people experiencing a mental health crisis have done nothing illegal the involvement of police can be humiliating, traumatic and confusing.[3]

As noted above, under s59 of the Act, where a CTO has been breached police are required to apprehend and assist in taking the person the subject of the order to the mental health facility. It should be noted that the vast majority of people with mental illness are not subject to a CTO. Police are also often called upon to assist these people who may be experiencing a mental illness episode, particularly where they pose a risk of harm to themselves or others. The need to adopt a health-focused response to these people, rather than a punitive response, is critical in ensuring that they are not drawn into the criminal justice system.[4] The starting position should always be that all other alternatives should be explored before police become involved, whether in response to a breach of a CTO or otherwise. However, due to an under-resourced social sector people with mental health conditions are often 'criminalised' in their interactions with police. These people should be able to access the required care, support and assistance in the community so they are not drawn into the criminal justice system.

The current nature of policing results in many people with mental illness often being unnecessarily or inappropriately funnelled into the criminal justice system, rather than receiving the supports, care and connection they require in the community.[5] Too often people with mental health conditions are 'criminalised' in their interactions with police, when alternative pathways outside of the criminal justice system are not available. Additional resources should be provided to community sector supports and other programs and services that operate outside of the justice system.

THE NEED FOR A HEALTH-FIRST RESPONSE

A lack of mental health services across Australia results in increased reliance on the police to respond to people experiencing mental illness or psychological distress. The Royal Commission into Victoria's Mental Health System found that police are often on the frontline due to a lack of alternative services and that as a result, the mental health system defaults to police as the first responders to mental health crises. This has the natural flow on effect that people with mental illness become more likely to become involved in the criminal justice system.[6]

Police are not clinicians and should not be expected to be experts in responding to people experiencing mental illness or crisis. In such circumstances a health-led response involving specialist mental health support workers, rather than a police-led response, is more appropriate.[7] According to the Royal Commission, greater emphasis on mental health interventions in community and primary care could both reduce the reliance and prevent the

[3] Royal Commission into Victoria's Mental Health System (RCVMHS). Final Report Volume 1. 2021. 514-515.

[4] Legislative Council, Legal and Social Issues Committee, Parliament of Victoria (Victoria Parliament CLSIC), *Inquiry into Victoria's criminal justice system'* (Report, March 2022). 198.

[5] Leanne Dowse, Simon Rowe, Eileen Baldry and Michael Baker. 2021. *Police Responses to People with disability,* (Research Report for the Disability Royal Commission, 2021).

[6] RCVMHS, n 3, 558.

[7] Victoria Parliament CLSIC, n 4, 201.

escalation of circumstances that result in an emergency law enforcement intervention.[8] The Royal Commission recommended the following to implement a health-led response for people in mental health crisis:

- Alternative first-responder models where specialist mental health support workers respond to people in mental health crisis instead of police. Unless there is a clear risk of harm, all alternatives should be explored before police are involved.
- Where there are co-first responder models, health professionals should 'lead' the response wherever possible (with the police there as support). Police have a role in terms of referral to appropriate services and supports, but should not be responsible for the provision of mental health support.
- Cultural change within the police through a commitment to diversity in employment and promotion, cultural awareness training, and public reporting on community engagement initiatives, to ensure that policing practices and procedures do not disproportionately contribute to the incarceration of people with mental illness.[9]

With a view to developing a health-first response framework to improve the quality and accessibility of services for someone experiencing a mental health crisis, the UK National Health Service developed the Mental Health Crisis Care Concordat. The Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. The Concordat focuses on four main areas:

- Access to support before crisis point - making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
- Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.[10]

POLICE DISCRETION – AN OPPORTUNITY TO DE-ESCALATE AND DIVERT

Nearly all contact with the criminal justice system starts with police contact. Police discretion can work in favour of, or against, a person suspected of criminal conduct.[11] It is inevitable that police will be needed at some events involving people experiencing mental illness or psychological distress. As is the case currently, police in these situations will have to make difficult decisions that balance the rights and needs of the person in crisis with the safety of others at the scene. How police use their powers and discretion determines whether - and how far - a person with mental illness further progresses in the criminal justice system. Every

[8] RCVMHS, n 3, 560.

[9] Ibid, 564-567.

[10] https://www.crisiscareconcordat.org.uk/

[11] Australian Law Reform Commission 'Pathways to Justice–Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples', Report No 133 (2017) (ALRC Report 2017), paragraph 14.23.

decision made (such as whether to investigate, question, search, arrest, caution, charge and prosecute) involves an element of discretion on the part of the officer, which can be exercised either to escalate or de-escalate.

There is considerable evidence to suggest that police discretion is often used in ways that discriminate against particular groups including people with mental illness. The adverse effects for police exercising their discretion in a manner that results in targeted policing of homeless people, or overcharging a defendant, can be exacerbated for people with mental illness.[12]

The JRI considers that arrest and charge should not be the default discretionary option for police when responding to a person in crisis or having a mental illness episode. Rather, police should utilise other discretionary options available to them, including issuing a caution or warning, or calling emergency mental health services for assistance. The introduction of a 'specific mental illness caution' to manage low-level offending attributable to mental illness would assist police being able to respond appropriately in such circumstances.[13]

In addition, all police services need to ensure that their members are adequately trained to work effectively and safely with people experiencing mental illness, and in a way that carries minimal risk of harm to any person. This includes the ensuring that the use of minimum force and preservation of life are top priorities when responding to mental health crises, and ensuring police officers are accountable for their interactions with vulnerable members of the community.

POLICE AND MENTAL HEALTH CO-RESPONDER MODELS

In Australia and internationally, models of police and mental health clinician partnership have consistently demonstrated considerable improvements in response times to people experiencing a mental health crisis, and interactions with and the outcomes for people in crisis, when compared with usual services. Several of these models are listed in Appendix A.

Bail Refusal For People With Mental Illness

According to the Australian Institute of Criminology (AIC) people with particular complex vulnerabilities such as mental illness and disability are over-represented in terms of being refused bail. While this may be due to being perceived as being a greater risk to community safety, it also reflected the limited availability of and access to appropriate support services that would have enabled these people to remain in the community pending their court hearing.[14] Many people are refused bail not because they are 'dangerous', but because they are homeless, have mental illness, or disadvantaged, or experiencing a combination of vulnerabilities which influences court decisions around their reliability in terms of attending court when required.

Increasingly restrictive bail laws in all States and Territories often have unintended consequences on populations that were not the target of the legislative changes. For example, when the Victorian Government restricted access to bail in response to the 2017 Bourke Street

[12] Ibid paragraphs 14.41, 14.46.

[13] Victoria Parliament CLSIC, n 4, 215.

[14] Max Travers, Emma Colvin, Isabelle Bartkowiak-Théron, Rick Sarre, Andrew Day, Christine Bond. 2020. *Bail decision-making and pre-trial services: A comparative study of magistrates courts in four Australian states*. Report to the Criminology Research Advisory Council Grant: CRG 34/16–17, October 2020. 19-20.

Mall attack[15] the consequence was that some of the most vulnerable members of society who were charged with criminal offences were remanded in custody, including those with mental illness or cognitive impairment.[16]

Bail laws should be informed by an evidence-based approach that genuinely centres community safety. Remanding people in custodial settings should only be used as a last resort for people who are waiting for their court hearing. There is a particular need for evidence-based diversion alternatives such as access to drug and alcohol services, mental health and disability support, holistic wrap-around case management, and safe and secure accommodation.

It is extremely important that the NSW Government establish and appropriately resource bail support services including accommodation support and pre-trial diversionary support options. Provision of appropriate diversion and bail support services (such as drug and alcohol services, mental health and disability support and accommodation) assists in addressing the needs of people charged with criminal offences with vulnerabilities, reduces the likelihood of reoffending while on bail or not appearing in court, and provides alternatives to detention. Providing support and accommodation services to people in need who have been charged with a criminal offence serves to enhance both community safety and the interests and welfare of the person facing criminal charges.

A NSW Local Court based program similar to the Magistrates Court of Victoria Bail Support Court Integrated Services Programs (CISP) could provide support for a person who on bail awaiting their court hearing. The CISP provides such support by coordinating referrals to drug and alcohol treatment services, crisis and supported accommodation, disability and mental health services, acquired brain injury services, or Koori specific services. CISP is available in 20 Magistrates Courts across Melbourne and regional Victoria. The accused person is assigned a case manager with whom they meet regularly to help them through the program, review their progress and provide updates to the magistrate. To be eligible the accused person must be charged with an offence, consent to be involved with CISP, and is experiencing: physical or mental disabilities or illnesses; drug and alcohol dependency and misuse issues; inadequate social, family and economic support; or homelessness.

In 2009 CISP was favourably evaluated for its effectiveness and cost benefit. People involved in CISP showed a 33% reduction in reoffending. Where a person did reoffend the offending was less frequent (30.4% less) and less serious. According to a 2009 evaluation, for every $1 invested in CISP the economic benefit to the community is $2.60 after five years and the long-term benefit is $5.90 after thirty years.[17]

Court Diversion For People With Mental Illness

In-court diversion to practical, alternative programs provide an opportunity to address some of the underlying causes of offending including mental illness, cognitive impairment, poverty and

[15] Gareth Boreham, 'How Victoria's bail laws are changing following the Bourke St deaths', *SBS News*, 23 January 2017, <https://www.sbs.com.au/news/article/how-victorias-bail-laws-are-changing-following-the-bourke-st-deaths/x551pua8k> (accessed 11 Mary 2023).

[16] Emma Russell, Bree Carlton and Danielle Tyson, '"It's a gendered issue, 100 per cent": How tough bail laws entrench gender and racial inequality and social disadvantage' (2022) 11 *International Journal for Crime, Justice and Social Democracy* 107.

[17] Ross, S., *Evaluation of the Court Integrated Services Program: Final Report* (December 2009); Price Waterhouse Coopers, *Economic Evaluation of the Court Integrated Services Program (CISP): Final Report on economic impacts of CISP* (November 2009).

disadvantage. These programs reduce the prospect of continuing contact with the criminal justice system. The effectiveness of these programs for people living with mental illness relies on the early identification of people with mental illness to enable appropriate assessment and referral. Examples of such services include:

- **The Victorian Mental Health Court Liaison Service** - The service aims to provide early intervention within criminal justice processes by identifying individuals with mental illness at the post-charge, pre-sentence stage. It provides assessment and advice to courts and referrals to treatment providers. The service is funded by the Victorian Government and provided by Forensicare.
- **The Victorian Mental Health Advice and Response Service** - The service provides advice and support to individuals within the court system as well as specialist clinical mental health advice to judges and community corrections services regarding appropriate mental health interventions. The service currently operates in the Magistrates Court of Victoria.

Diversion can form part of the court system itself through specialist courts specifically set up to responds to particular needs for people facing criminal charges. These courts work on the principle of 'therapeutic jurisprudence', that positively impacting the psychological well-being of an accused person will result in better outcomes. The aim of these specialised problem-solving courts is to overcome the inadequacies of traditional court systems by providing long-term solutions to drug use and crime, and to address the underlying mental health and drug dependency issues which have contributed to criminal offending.[18]

There are a variety of models for specialist court for people with mental health issues and/or cognitive disability. These specialist courts combine intensive judicial monitoring and treatment in order to ensure that offenders with mental health illness access treatment while being subject to proceedings and supervision. Some are specifically targeted at mentally ill offenders with co-occurring substance misuse issues and seek to stabilise offender's mental health while targeting addiction in a drug-court style treatment and testing regime. In some mental health courts, this approach includes being a specific alternative to custody. International evidence suggests that mental health courts are likely to reduce reoffending and facilitate access to support and treatment services.

Community justice courts or community justice centres aim to provide a broad range of therapeutic justice services to victims of crime, persons who have committed an offence, civil litigants and the community. A key feature of these courts are the specialist services and processes made available to people with mental illness. This model has been implemented in Australia with the Neighbourhood Justice Centre located in inner-Melbourne.

Details of these specialist courts for people with mental illness and community justice courts are included in Appendix B.

Sentencing People With Mental Illness

The over-representation of people with mental illness in custodial settings is also a product of the lack of alternative criminal justice programs and sentencing options for people with a mental health issue or disability. The absence of sufficient diversionary programs for people with mental illness means that judges and magistrates have limited options in terms of sentencing, resulting

[18] Lacey Schaefer and Mary Beriman. 2019. Problem-Solving Courts in Australia: A Review of Problems and Solutions. Victims & Offenders, 14:3, 344-359 at 344.

in many people with mental illness convicted of criminal offences being sentenced to a term of imprisonment.[19]

The lack of appropriate, diversionary sentencing options was recognised in the Victorian parliamentary *Inquiry into the criminal justice* system in 2022. The inquiry noted that if a person is not considered suitable for a community corrections order (CCO) (for example, because they have breach an earlier CCO, or because Community Correctional Services cannot provide the necessary supports and resources for that person), then the next alternative in the sentencing hierarchy is imprisonment. If the Court deems that a CCO is not warranted, the next step 'down' in the sentencing hierarchy is a fine. There is no intermediate sentencing option with a focus on rehabilitation. [20]

The inquiry recognised a need for more tailored CCOs for people who have mental illness or cognitive disability, and for more options for community-based sentencing outside of just CCOs. This would include additional options that incorporate psychological and psychosocial support, education and vocational counselling, and partnerships with organisations for paid and volunteer work. Judicial officers would then have greater flexibility to tailor community-based sentences, to promote greater use of alternatives to full-time imprisonment, and to allow for the imposition of treatment and programs which aim to address underlying causes of offending.[21]

People With Mental Illness In Prison

As noted above, prisons in Australia are disproportionately filled with people who experience mental illness, with 40% of people incarcerated in Australian prisons reporting a history of mental illness and 21% with a history of self-harm.[22] People in prisons are more likely to be experiencing mental illness than the general population. In many cases the experience of incarceration is either the cause of their mental illness, or a major factor in exacerbating their pre-existing mental illness, which they were previously managing.[23] Of prison dischargees surveyed in 2018, 1 in 10 males (10%) and 1 in 12 females (8%) reported their mental health had deteriorated during their time in prison.[24]

Prison conditions and practices such as solitary confinement, strip-searching and the use of physical restraints are likely to exacerbate existing mental illness and cause new illnesses among people incarcerated. This is particularly the case given that people in prison with mental illness or physical disabilities are more likely to be subjected to solitary confinement as part of behaviour management. Extended periods of incarceration can lead to further trauma and lead to challenging behaviour patterns that will make it more difficult for a person to engage with support and integrate back into the community upon release.[25]

In addition, for people denied bail the experience of remand is one that is often characterised by high levels of frustration and stress due to sudden separation from family, uncertainty about

[19] Victoria Parliament CLSIC, n 4, 499, 558

[20] Ibid 558; ALRC Report 2017, n 11, paragraphs 7.57, 7.68.

[21] Victoria Parliament CLSIC, n 4, 558.

[22] AIHW 2019, n 2.

[23] Victoria Parliament CLSIC, n 4, 581-582.

[24] Australian Institute of Health and Welfare (AIHW). 2022. The health of prisoners. 7 July 2022. <https://www.aihw.gov.au/reports/australias-health/health-of-prisoners#_Toc30748009> (accessed 11 May 2023).

[25] Victoria Parliament CLSIC, n 4, 593.

their future, loss of employment and housing, and sudden loss of existing mental health support.[26]

Incarcerated women are particularly vulnerable to mental illness. Women are the fastest growing cohort of Australia's prison population According to the AIHW, based on information collected from 117 women as they entered prison, 65% said that they had one or more diagnosed mental illnesses and 31% reported a history of self-harm.[27]

Sexual and gender minorities are also over-represented in the Australian criminal justice system, with evidence suggesting that LGBTQI people in prison experience much higher rates of mental illness.[28]

ACCESS TO HEALTHCARE AND MENTAL HEALTH PROGRAMS IN PRISON

According to the AIHW almost 1 in 4 people in prison are currently taking mental health-related medication.[29] However, people in prison lose access to Medicare services and the Pharmaceutical Benefits Scheme (PBS) subsidies under s19(2) of the *Health Insurance Act 1973* (Cth). This means that when people go into prison they cannot access Medicare funded services such as mental health plans (and counselling), and they cannot access particular medications that they may have had access to when they were in the community.

Given the over-representation of people with mental illness in adult prisons and youth detention centres, incarceration for these individuals presents as an opportunity to connect them to mental health services. This should not be seen as a justification for the incarceration of people with mental illness, as they would be better served by accessing mental healthcare in the community. However, the criminal justice system provides the opportunity to identify and commence treatment for mental health needs which had not been met prior to incarceration. The Melbourne University based Justice Health Unit has noted that most jurisdictions fail to take this opportunity and poor transition planning and inadequate resourcing of transitional programs creates a risk that any health gains may be lost after release.[30]

While all Australian jurisdictions provide mental health treatment to people in prison, there is limited information about how prison mental health services are structured, funded and delivered. There is also a lack of reliable and publicly available information about the scale of mental health services provided in correctional settings. What is clear is that there is an apparent inadequacy of prison mental health services in almost all jurisdictions.[31]

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[26] Ibid 586.

[27] Ibid 611.

[28] The Fenway Institute, 'Emerging Best Practices for the Management and Treatment of Incarcerated Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) Individuals' (November 2019), 50.

[29] Australian (AIHW) 2018. *The health of Australia's prisoners 2018*, 4, <https://www.aihw.gov.au/getmedia/2e92f007-453d-48a1-9c6b-4c9531cf0371/aihw-phe-246.pdf.aspx?inline=true> (accessed 11 May 2023).

[30] Justice Health Unit, Melbourne School of Population and Global Health, The University of Melbourne. 2019. *The role of incarceration in addressing inequalities for people with mental illness in Australia*. Submission to the Productivity Commission's Issues Paper on The Social and Economic Benefits of Improving Mental Health. 5 April 2019.

[31] Fiona Davidson, Bobbie Clugston, Michelle Perrin, Megan Williams, Edward Heffernan, Stuart A Kinner. 2020. Mapping the prison mental health service workforce in Australia. *Australian Psychiatry* 2020, Vol 28(4) 442-447 at 443.

Of particular concern is the lack of mental health services for those who spend only a short time in custody or on remand, who make up the vast majority of people who are incarcerated with mental illness.[32]

There is a need to ensure that specialist mental health services in prison are adequately resourced, and that all people entering into a custodial setting are assessed to systematically identify and target their mental health needs. Appropriate access to mental healthcare treatment must be available for all people incarcerated, including those on remand and short sentences, and those with mild or moderate mental illness as well as people with substantial and complex mental health needs.

In addition, responsibility for delivery of mental health services in custodial settings should rest with the respective Government Health Departments rather than the departments responsible for justice, as recommended by the World Health Organisation.[33] This would support incarcerated people to arrange continuing access to mental health services when they are released from custodial settings and re-enter the community.[34]

Dedicated funding should also be provided for dual diagnosis and co-morbidity services for people in prison with co-morbid AOD and mental illness issues and also for those with both intellectual disability and mental illness.[35]

THE NEED FOR TAILORED MENTAL HEALTH PROGRAMS

The prison system needs to provide access to culturally appropriate, strengths-based mental health programs that are tailored to each person and that promote connection to family and community. These programs should include the following elements:

- Reception and assessment processes need to include a comprehensive assessment of incoming prisoners to identify and assess mental health;
- Improved access to specialist services and programs for prisoners with mental health needs;
- Mental health programs that are culturally safe and readily available for all prisoners, including those on remand and serving short-term sentences.

There is a particular need to provide tailored mental health programs for women in prison. As part of this, it is essential that programs assist people in prison to maintain meaningful contact with their families as this is critical for their mental wellbeing and ability to reintegrate into the community.[36] Many women entering the prison system have carer responsibilities that they are forced to relinquish while in custody, and separation often detrimentally impacts their mental

[32] Justice Health Unit, 2019, n 30.

[33] United Nations Office on Drugs and Crime, World Health Organization. 2013. Good governance for prison health in the 21st century: A policy brief on the organization of prison health' (2014) <https://www.unodc.org/documents/justice-and-prison-reform/WHO_Europe.pdf> (accessed 11 May 2023).

[34] Stuart Kinner. 2020. Witness Statement, Royal Commission into Victoria's Mental Health System. <http://rcvmhs.archive.royalcommission.vic.gov.au/Kinner_Stuart.pdf> (accessed 11 May 2023).

[35] Ibid.

[36] Dr Lorana Bartels and Antonette Gaffney, 'Good Practice in Women's Prisons: A literature Review' (AIC Reports Technical and Background Paper 41, 2011) 58 citing Ian Mulheirn, Barney Gough and Verena Menne 'Prison Break: Tackling recidivism, reducing costs' (The Social Market Foundation, 2010).

and emotional wellbeing.[37] Relationships between parents in prison and their families can be difficult to maintain leading to feelings of anger, anxiety, depression shame, guilt and grief.[38] Maintaining familial and parental connections whilst in prison delivers psychosocial benefits for parents and children, and can reduce parental recidivism.[39]

POST PRISON

The transition from prison to the community is particularly difficult for people with mental illness. In NSW people who are identified and treated for chronic/complex mental illness are covered by the Integrated Care Service which monitors their transition to community. They may be placed on an involuntary Forensic Community Treatment Order by the Mental Health Review Tribunal while in prison and this can transition with them to a community mental health team in their Local Health District when they are released.

Transition support for this cohort is inadequate with people who commenced treatments in prison not being provided with assistance or referrals to continue treatment post-release. In addition, multiplicity and complexity of need means many people from prison are excluded from support. For instance, many people are not able to access drug and alcohol services if they have a complex mental health condition. Many people are not able to access mental health services if they have an ongoing drug and alcohol problem.[40] In 2021, around 9,000 clients of specialist homelessness services (SHS) were people exiting from custodial arrangements (or 3.3% of all SHS clients). Of these 44% had mental health issues and 27% had drug and alcohol issues.[41]

Successful post-release reintegration programs work with people holistically around a whole range of issues, including housing, drug and alcohol treatment, employment, mental health, disability, and cultural and community connection alongside the formulation of a sense of identity and belonging outside of the justice system.

Of vital importance for people with mental illness leaving prison is the availability of supported accommodation. Over the last decade the availability of housing for formerly incarcerated people has significantly reduced.[42] As prison populations have increased the need for housing and assistance post-release has likewise increased.[43] There is considerable evidence to indicate the

[37] Victoria Perry, Catherine Fowler, Kyleigh Heggie and Karen Barbara. 2011. 'The Impact of Correctional-based Parenting Program in Strengthening Parenting Skills of Incarcerated Mothers' (2011) 22(3) *Current Issues in Criminal Justice* 457, 459; Penal Reform International, 'The rehabilitation and social integration of women prisoners: Implementation of the Bangkok rules' (Thailand Institute of Justice, May 2019), 26.

[38] Victoria Parliament CLSIC, n 4, 664.

[39] Bartels and Gaffney, n 37, 58, citing Ian Mulheirn, Barney Gough and Verena Menne 'Prison Break: Tackling recidivism, reducing costs' (The Social Market Foundation, 2010).

[40] Victoria Parliament CLSIC, n 4, 654.

[41] AIHW. 2022. Specialist homelessness services annual report 2021-22. Clients exiting custodial arrangements. 8 December 2022.

[42] UNSW Sydney. 2020. *Obstacles to Effective Support of People Released from Prison: Wisdom from the* Field, 25.

[43] Chris Martin, Rebecca Reeve, Ruth McCausland, Eileen Baldry, Pat Burton, Rob White, Stuart Thomas. 2021. *Exiting prison with complex support needs: the role of housing assistance*. AHURI Final Report No. 361.August 2021. 24.

social and economic effectiveness of supportive housing models for those people who also experience mental health and drug and alcohol problems.[44]

The JRI considers that it is essential for people exiting prison to have access to appropriate models of supportive housing that will facilitate their transition back into society, assist them to address particular identified needs such as mental illness or drug and alcohol problems, and to provide them with the necessary supports and assistance to make re-offending less likely. The JRI sees the value of supportive housing to assist people exiting prison and the opportunity for that model to provide the specific needs support and assistance for people exiting prison.

Two examples of supportive housing models for people exiting prison are the Aspire Program in South Australia and the Community Restorative Centre In NSW. Details of these two programs are provided in Appendix C.

CONCLUSION

The over-representation of people living with mental illness in the criminal justice system represents one of the system's most tragic failings. The lack of mental health services in the community combined with a criminal justice system that is not sufficiently resourced to support recovery is the major cause for this over-representation, which occurs at every stage of the criminal justice process. People living with mental illness are more likely to come into contact with police than those who do not have mental illness. They are more likely to be the subject of arrest and criminal charges. They are more likely to be refused bail. They are less able to access community-based sentencing alternatives and consequently they are more likely to be sentenced to a term of imprisonment. And upon release, they are more likely to reoffend and come back into contact with the criminal justice system.

A failure to adequately resource mental health services in the community has meant that the criminal justice system has become the default mechanism to respond to people living with mental illness who experience crisis.

There are a range of measures that the NSW Government can implement to develop a health-led response (as distinct from a punitive law and order response) to people living with mental illness who may be experiencing crisis. This includes ensuring that mental health professionals rather than police become the first option to respond to people in crisis. In addition, where police need to assist in response, ensuring that all police members are adequately trained to work effectively and safely with people experiencing mental illness, and in a way that carries minimal risk of harm to any person. Police must also exercise their discretion in a way that places a priority on diverting people with mental illness away from further contact with the criminal justice system, through the use of cautions and warnings, rather than resorting to arrest and charge.

Where people living with mental illness are charged with a criminal offence it is vitally important that these people are not by default denied bail. The Government needs to establish and appropriately resource bail support services including accommodation support and pre-trial diversionary services for people with mental illness. Likewise, the NSW Government should establish specialist in-court diversion programs to respond to the particular needs for people with mental illness who face criminal charges, and to address the underlying mental health issues which have contributed to criminal offending.

[44] Parsell C, Moutou O, Lucio E & Parkinson S. 2015. *Supportive housing to address homelessness*. AHURI final report no. 240. Melbourne: Australian Housing and Urban Research Institute. 11.

For those who are found guilty of a criminal offence there is a need for people living with mental illness to be able to access tailored community corrections orders and community-based sentencing alternatives, so that there is not a default option of a term of imprisonment.

Finally for those people with mental illness who are incarcerated it is vitally important that they are able to access specialist services and programs whilst in prison, including those people who are on remand or serving short-term sentences. The NSW Government must also increase funding and other resources to community-based services that provide mental health, alcohol and other drug treatment, disability support, education and training to assist people exiting prison to reintegrate back into the community.

Ultimately, the key element in recalibrating the emphasis from a punitive law and order focus to a health focus, is to ensure that there are accessible, culturally appropriate, well-resourced mental health services in the community. The availability of such services will make an important difference in ensuring that the criminal justice system does not continue to be the default option to respond to those people living with mental illness.

APPENDIX A

POLICE/MENTAL HEALTH ALTERNATIVE AND CO-RESPONDER MODELS

POLICE FORCE MENTAL HEALTH CO-RESPONSE TRIAL (WESTERN AUSTRALIA)

In January 2016, the Western Australia Police Force implemented the Western Australia Police Force Mental Health Co-Response (MHCR) Commissioning Trial. The MHCR involved mental health practitioners co-located with police at the Police Operations Centre, and two mobile teams operating in north-west metropolitan and south-east metropolitan districts and the Perth Watch House. Mental health practitioners were involved at each stage of a police response to and management of people experiencing a mental health crisis. An independent evaluation of the trial found that it had improved the safety and wellbeing of police and mental health consumers and increased collaboration between the relevant services. Mental health consumers and families, carers and supporters saw the model as a considerable improvement over the traditional police crisis response. Based on the success of the trial, in 2019 the model was expanded to cover the whole Perth metropolitan area.[45]

MENTAL HEALTH CO-RESPONDER (QUEENSLAND)

In partnership with the Queensland Police Service (QPS), mental health co-responder models were established in Cairns in 2011[46] and in the West Moreton region in 2017. In 2019, the model was expanded to service the metropolitan south region and include Queensland Ambulance Service (QAS). Under this model, a team of experienced mental health clinicians are integrated either into a QPS or QAS first responder unit, which enables people experiencing a mental health crisis to be assessed and receive onsite intervention in the community.

A 2022 Queensland Government review of this program found the mental health co-responder model enabled timely and appropriate mental health care to be provided to people presenting to QPS and QAS in a mental health crisis, and that the program builds the capacity of QPS and QAS to respond to mental health crises when co-responder clinicians are not available. This evaluation further found the majority of participants (74%) were diverted from custody and the emergency department. Of the people who interacted with the program, 45% did not require further assistance after the crises was resolved, 17% were referred to primary care or community-based services, and 12% were referred to mental health services. Only 2% of people were taken in custody, while the remaining 24% of people were transported to the

[45] Henry, P. & Rajakaruna, N. (2018). *WA police force mental health co-response: Evaluation report*. The Sellenger Centre for Research in Law, Justice and Social Change, Edith Cowan University, https://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypaper/4011830c6f17958a776124a04825830d0003e135/$file/tp-1830.pdf; Blagg, H. (2015). Models of best practice: Aboriginal community patrols in Western Australia. https://www.researchgate.net/publication/282866234_Models_of_Best_Practice_Aboriginal_Community_Patrols_in_Western_Australia.

[46] Robertson, J. A., Fitts, M. S., Petrucci, J. & McKay, D. (2019). 'Cairns Mental Health Co-Responder Project: Essential elements and challenges to program implementation', *International Journal of Metal Health Nursing*, 29(3), https://www.researchgate.net/publication/337947266_Cairns_Mental_Health_Co-Responder_Project_Essential_elements_and_challenges_to_programme_implementation.

emergency department.[47] This model has since been expanded to cover other regions in Queensland such as Townsville[48] and Mackay.[49]

PACER PROGRAM (ACT, TAS, NSW, VIC)

The PACER program is designed to provide a specialist mental health early response to people experiencing a mental health crisis. It embeds mental health experts with first responders to support them to appropriately recognise, assess and respond to psychiatric incidents. It usually includes a police respondent, a paramedic and a mental health respondent working together. The paramedic is there to assess and treat any physical health emergencies. The police officer is there to make sure the PACER team, the person, and the community are kept safe. The mental health clinician is there to assess mental health needs and support the person in crisis. During the ACT pilot, of the 1,200 callouts to the PACER team, 900 people seen by the PACER team were able to stay in the community. 300 people still required hospitalisation either because PACER was unavailable at their point of distress, or they needed high level of care from the Emergency Department. The program is being continued and has now expanded to 7-days per week.[50]

In Tasmania, PACER was launched as a two-year pilot in January 2022 By September it had assisted 1,000 people experiencing an acute mental health issue. Of these, almost 80% were supported to remain in the community. On average there were 45 fewer mental health related presentations to the Royal Hobart Hospital emergency department every month.[51] The NSW model has seen cross-agency response to people experiencing mental health crisis, avoidance of emergency Department presentations, provision of alternate pathways to care and avoidance of coercive measures. From November 2018-September 2020 of the more than 1,500 PACER contacts, only 500 required further hospital-based assessment or treatment.[52] In Victoria the PACER program has operated for several years. In 2014 the name of the initiative was changed to Mental Health and Police. A 2019 departmental evaluation indicated the effectiveness of the program, reporting that PACER units are effective in diverting people from emergency departments and that the co-response model helps improve the skills and knowledge of the police who work alongside mental health clinicians The evaluation also noted that the effectiveness of the program is hampered by workforce shortages, especially in rural areas.[53]

CAHOOTS (CRISIS ASSISTANCE HELPING OUT ON THE STREETS) (EUGENE, OREGON, UNITED STATES)

CAHOOTS is a different first responder model that has been running for more than 30 years. It is a mental-health-crisis intervention program founded in 1989 by the Eugene Police

[47] Wyder, M. & Powell, S. (2022). *Metro South Addiction and Mental Health Services QPS and QAS Co-responder program evaluation*, Metro South Addiction and Mental Health Services, https://metrosouth.health.qld.gov.au/sites/default/files/content/msamhs_qas_and_qps_coresponder_evalution.pdf.
[48] The Queensland Cabinet and Ministerial Directory (2 June 2022). 'Mental health co-responder launch, Townsville', media statement, https://statements.qld.gov.au/statements/95298.
[49] Queensland Government (2023). *Job Search*, webpage, https://smartjobs.qld.gov.au/jobs/QLD-479330.
[50] Cassandra Power. 2021. 'ACT Government recommits to PACER mental health election promise'. *Canberra Weekly*. 3 February 2021. <https://canberraweekly.com.au/act-government-recommits-to-pacer-mental-health-election-promise/> (accessed 25 November 2022).
[51] Megan Whitfield. 2022. 'New Tasmanian PACER program aims to ease ED pressure with mental health aid'. *ABC News*, 14 September 2022. <https://www.abc.net.au/news/2022-09-14/pacer-program-aims-to-ease-ed-pressure-with-mental-health-aid/101440808> (accessed 25 November 2022).
[52] Robert Fedele. 2020. 'On the beat: Mental health nurses join forces with NSW police to improve care'. *Australian Nursing & Midwifery Journal*. 11 September 2020. <https://anmj.org.au/on-the-beat-mental-health-nurses-join-forces-with-nsw-police-to-improve-care/> (accessed 25 November 2022).
[53] Royal Commission into Victoria's Mental Health System. Final Report Volume 1. 2021. 565.

Department and White Bird Clinic, a non-profit mental health crisis intervention initiative. Calls to 911 related to drug use, disorientation, mental health crises and homelessness are routed to CAHOOTS. Staff members respond in pairs; usually one has training as a medic and the other has experience in street outreach or mental health support. Responders attend to immediate health issues, de-escalate, and help formulate a plan, which may include finding a bed in a homeless shelter or transportation to a healthcare facility. The service operates 24 hours a day. Cahoots diverts close to 8% of all police calls, reducing the load on the police department. Evaluations of CAHOOTS have found it to improve access to health and welfare services[54] as well as saving an estimated $8.5 million annually in public safety spending.[55]

PORTLAND STREET RESPONSE (OREGON, UNITED STATES)

Portland Street Response (PSR), a program within Portland Fire & Rescue (PF&R), assists people experiencing mental health and behavioural health crises. The team is made up of mental health crisis responders, community health medics, community health workers, and peer support specialists. In their outcome evaluation it is noted that, in the six months between April and September 2022, PSR responded to 3228 incidents. This represented a reduction of more than 3.2% of total calls to police; an 18.7% reduction for the police in non-emergency responses and reduced the numbers of people called out to emergency departments. Most people were responded to by PSR, with only 1.9% of all calls resulting in a hospital admission.[56]

THE BEHAVIOURAL HEALTH EMERGENCY ASSISTANCE RESPONSE DIVISION, B-HEARD (NEW YORK CITY, UNITED STATES)

The B-HEARD Team is an alternative first responder model in New York City. Responders use their mental health expertise in crisis response to de-escalate emergency situations and provide immediate care. Evaluation of the pilot has found that the project reduces unnecessary transports to hospitals, increases connection to ongoing mental health care and reduces the number of times police respond to 911 mental health calls. In the 12 months to June 2022, there were approximately 11,000 mental health 911 calls in the pilot area. Of people assisted by B-HEARD:

» 54% were transported to a hospital for additional care – (compared to 87% under the traditional response)
» 36% were served in their community
» 24% were served onsite, including de-escalation, counselling, or referral to community-based care
» 12% were transported to a community-based healthcare or social service location.[57]

STREET CRISIS RESPONSE TEAMS, SAN FRANCISCO, CALIFORNIA

The street crisis response teams are a community health approach for people who are experiencing mental health and/or substance abuse crises in San Francisco. Early evaluation shows 5,338 calls were responded to in the six-month evaluation period. The evaluation reported successful diversion of 911 calls for mental health matters, only 3% of interactions

[54] Waters, R. (2021). 'Enlisting mental health workers, not cops, in mobile crisis response', *Health Affairs*, 40(6), https://www.healthaffairs.org/doi/10.1377/ hlthaff.2021.00678.
[55] What Works Cities (2021). *Alternative emergency response: Exploring innovative local approaches to public safety*, https://whatworkscities.medium.com/ exploring-innovative-emergency-responses-with-cahoots-499c5b8920c8.
[56] Townley, G. & Leickly, E. (2022). *Portland Street Response: Year two mid-point evaluation*, Portland State University Homelessness Research & Action Collaborative, https://www.pdx.edu/homelessness/sites/g/files/znldhr1791/files/2022-12/PSR%20Year%20Two%20Mid-Point%20Evaluation%20Report_For%20 Public%20Release.pdf.
[57] New York City Mayor's Office of Community Mental Health (n.d.). *Re-imagining New York City's mental health emergency response: A new health-centered approach to mental health emergencies*, https://mentalhealth.cityofnewyork.us/b-heard.

required police involvement, and only 7% of matters required further urgent medical attention. The evaluation also reported high levels of engagement and referrals to other services. [58]

[58] https://sf.gov/sites/default/files/2022-06/SCRT%20Final%20Report_FINAL-%201%20year.pdf

APPENDIX B

SPECIALIST COURTS FOR PEOPLE WITH MENTAL ILLNESS AND DISABILITY AND COMMUNITY JUSTICE COURTS

Specialist Courts for mental illness and disability – Australian Models	
Victoria - Assessment and Referral Court	The Assessment and Referral Court (ARC) is a court list for persons accused of an offence who have a mental illness and/or cognitive impairment. Sitting within the Magistrates' Court, it aims to help people address underlying factors that contribute to their offending behaviours. For a person to be referred to the ARC, the following steps must be followed: • **Confirm availability**—The person must be charged with an offence within the catchment area of an existing ARC (i.e. Frankston, Latrobe Valley, Korumburra, Melbourne and Moorabbin) and be on bail at the time of referral. • **Check eligibility**—The person must be diagnosed with a mental illness, intellectual disability, acquired brain injury, autism spectrum disorder, or neurological impairment. The diagnosis must cause a 'substantially reduced capacity' in the areas of self-care, self-management, social interaction or communication. The person must also be able to benefit from receiving services through a support plan, such as psychological or welfare services. • **Seek a referral**—A referral can be made at a bail hearing or mention hearing by the person accused of an offence or their family, a community service organisation, magistrates, Victoria Police, or lawyers of the Court Integrated Services Program (CISP). The accused individual must consent to being referred to the ARC. • **Attend an assessment**—Eligibility must be assessed by a case manager at the ARC. If accepted, the accused person must enter a formal plea in order to access a support plan. If a guilty plea is entered, sentencing will occur within the ARC.[59] The ARC delivers mental health treatment and case management under the supervision of the court. This produces substantial reductions in both the frequency and seriousness of offending that persist over time, reducing incarceration rates. Recommendations for improvements have included: • Expanding the ARC to additional locations, particularly in rural and regional areas; • Additional therapeutic support and treatment services in regional areas; • Expanding the eligibility criteria for the ARC as people are required to be on bail in order to be referred to ARC.[60] The ARC has been found to provide a therapeutic response to persons accused of an offence who have a mental illness and/or cognitive impairment, and has demonstrated success in supporting them to address the underlying causes of their offending.[61] The Royal Commission into Victoria's Mental

[59] Magistrates' Court of Victoria, *Assessment and Referral Court (ARC)*, 2018, <https://www.mcv.vic.gov.au/criminal-matters/assessment-and-referral-court-arc> (accessed 11 May 2023).

[60] Centre for Justice Innovation. *Problem solving courts: An evidence review*. June 2016. 15.

[61] Victoria Parliament CLSIC, n 4, 482.

	Health System recommended that the Assessment and Referral Court list be expanded to each of the 12 Magistrates' Court locations by 2026. [62]
Special Circumstances List, Melbourne Magistrates' Court	The creation of the Melbourne Magistrates' Court special circumstances list was initiated by the court and the Sheriff's office and commenced operation in June 2002. The list is presided over by a single magistrate who has a personal commitment to the goals of the program. The list was initially only targeted at persons with mental illness, intellectual disability, acquired brain injury, physical disability or drug or alcohol addiction. The definition of "special circumstances" was also extended to include homelessness, where it results in a person being unable to control conduct which constitutes an offence. A person with special circumstances can only be dealt with under the special circumstances list if s/he has received one or more infringement notices for an offence, has failed to pay the infringement penalty, has forwarded an application for revocation of these fines, and the infringements registrar is satisfied that the matter would be more appropriately dealt with by the court. Cases involving "special circumstances" in Melbourne most often result in an adjournment or dismissal, often with an undertaking to be of good behaviour and/or to comply with a treatment regime. The list has been heralded a great success, with most defendants taking their undertakings to the court seriously and continuing their treatment as ordered.[63]
WA - Start Court	Start Court is a Magistrates' Court that specialises in dealing with people who have mental health issues. It is an holistic support program that seeks to address the underlying causes of offending behaviour. Referrals to the Start Court are made by Magistrates in general court lists and can be suggested by the individual, family members, the defence lawyer or a dedicated duty lawyer. To be eligible the individual must have a mental health condition, plead guilty and be eligible for bail.[64] A review of the Start Court found that between March 2013 and 30 September 2015: • 92% of participants demonstrated clinical improvement; • 80% of participants who completed the Start Court program in that period either ceased offending or committed less serious offences; • 49% of Start Court program participants reoffended. The rate of reoffending for individuals who were not processed through the Start Court program was 62%. • 58% of Start Court participants were assessed as posing a lower risk of violence after engagement with the program.[65] Engagement with the Start Court was also often perceived as a mitigating factor in sentencing, leading to higher rates of diversion from incarceration.[66]
Special Circumstances Court, Brisbane	In 2006 a "special circumstances list" was established at the Brisbane Magistrates' Court. The list was aimed at finding an alternative way of dealing with defendants charged with public order-type offences who had impaired

[62] Ibid 85.

[63] Tamara Walsh, 'The Queensland special circumstances court' (2007) 16(4) *Journal of Judicial Administration* 225.

[64] Magistrates Court of Western Australia, Start Court, <https://www.magistratescourt.wa.gov.au/S/start_court.aspx> (accessed 11 May 2023).

[65] Mental Health Court WA. 2015. Summary of Mental Health Court Diversion Program, 2. <https://www.mhc.wa.gov.au/media/1557/summary-of-court-diversion-evaluation-2015-for-mhc-website.pdf>

[66] Ibid.

Magistrates' Court	capacity at the time of the offence, as a result of mental illness or intellectual disability, and homelessness. A person is eligible to be dealt with under the special circumstances list if s/he is 17 years of age or older, homeless, and appears to be suffering from impaired decision-making capacity as a result of either mental health issues, intellectual disability or brain/neurological disorder. Further, s/he must have been charged with, and pleaded guilty to, an "eligible offence" (i.e. an offence which arises from circumstances which have an aspect of "public order", including offences such as failing to appear, breach of bail, etc in respect of another eligible offence). This also includes offences like public nuisance, begging, public drunkenness and failing to properly dispose of a syringe. Serious drug offences, sexual offences and serious offences of personal violence are disqualifying offences.[67] Court observation of the Brisbane special circumstances list was conducted for a period of nine weeks between August and October 2006. The penalties imposed on participants for the designated offences were more likely to be aimed at addressing the underlying causes of offending (i.e. court supervision, referral to for psychiatric or drug/alcohol treatment, referral to cognitive/life skills course) than for defendants facing similar charges in the generalist courts.[68]
Specialist Courts for mental illness and disability – International Models	
United Kingdom – Brighton Mental Health Court **Stratford Mental Health Court**	Two dedicated mental health courts (MHCs)were set up in England, in Brighton and Stratford, for one year only. Both Brighton and Stratford operated within regular magistrate court provisions. The key elements of the MHCs were to: • Identify defendants with mental health and/or learning disability issues through screening and assessments; • Provide the court with information on a defendant's mental health needs to enable the court to effectively case manage the proceedings; • Offer sentencers credible alternatives to custody to support an offender with mental health/learning disability needs by way of a Community Order with a supervision requirement or mental health treatment requirement; • Offer enhanced psychiatric services at court; • Implement regular reviews of orders; and • Signpost those individuals not suitable for the MHC community order to mental health and other services that could appropriately address their needs. The pilots were subject to a process evaluation. This indicated that extensive multi-agency collaboration and data sharing arrangements were achieved on both sites but that the caseload was low. Out of 180 offenders identified as having mental health issues, 55 offenders were given Community Orders with mental health requirements. Of these, nine breached their orders. The evaluation also noted that the eligibility could be widened to also include those with dual diagnosis.[69]
United States Mental Health Courts (MHCs) first began operations in the US in the late 1990s and there are now over 250 MHCs operating across the US. A 2011 meta-analysis showed that US mental health	

[67] Walsh, n 59, 223.

[68] Ibid 228-229.

[69] Winstone, J. & Pakes, F. (2010). *Process evaluation of the Mental Health Court Pilot.* London: Ministry of Justice.

court participants had better criminal justice outcomes such as reoffending and further imprisonment than similar comparison groups. The analysis found that a number of studies had shown that MHCs can reduce recidivism, MHCs link individuals to mental health treatment and provide significant savings for governments. The studies also suggested that individuals with severe mental illnesses who participate in MHC programs are less likely to commit and be arrested for offenses caused by untreated illness symptoms.[70]	
The Bronx Mental Health Court	The Bronx Mental Health Court (Bronx MHC) began as a pilot in 1999 and started taking case referrals in 2001. It is a collaboration comprised of criminal justice personnel (judge, defence attorneys, and prosecuting attorneys), a clinical team and coordinating staff. Defendants are referred to the program, screened for eligibility, enter the court through a formal plea process, are matched with community-based treatment, and then participate in court monitoring, case management, and treatment services. Duration of participation can vary based on charge and mental illness characteristics, with a minimum six-month treatment mandate for misdemeanour crimes. Treatment mandates for felony crimes typically last 18-24 months. The mandated length of treatment begins upon entry into a treatment program, rather than the plea date. Defendants are eligible to participate in the MHC if they meet both clinical and legal criteria. Potential participants must have mental health problems that cannot be handled adequately in other traditional or alternative justice venues. The mental health court does not accept defendants who are unstable or need hospitalization. Cases are typically identified for referral between arraignment and the plea or trial. Cases can be referred to the mental health court through various sources, including prosecutors, defence attorneys, judges, family members, community providers, jail mental health staff, probation officers, competency hearings, other case management or diversion programs, or by the defendant. The Bronx MHC was intended for felony and misdemeanour offenders (primarily nonviolent) with serious mental illness. MHC personnel reported a mix of crime types within the program, including both violent and nonviolent crimes at both felony and misdemeanour levels. MHC participants often had extensive criminal histories. According to program data from 2002-2006, 81% who pled into the Bronx MHC were successfully placed into treatment. Of these: • 52% of clients successfully completed their treatment mandates; • About one-quarter of program failures were due to rearrest, having a warrant, or violation of conditions.[71] Participants in the MHC were less likely to experience recidivism than those who did not participate. The evaluation found that: • Being in the Bronx MHC program would reduce the chance of re-arrest by approximately 29%; • Arrestees diagnosed with mental disorders and charged with violent offences are associated with positive recidivism outcomes compared to similar arrestees charged with other offences;

[70] Christine M. Sarteschi, Michael G. Vaughn, Kevin Kim. 2011. Assessing the effectiveness of mental health courts: A quantitative review. *Journal of Criminal Justice* 39 (2011) 12–20.

[71] Shelli B. Rossman, Janeen Buck Willison, Kamala Mallik-Kane, KiDeuk Kim, Sara Debus- Sherrill, P. Mitchell Downey. *Criminal Justice Interventions for Offenders with Mental Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn, New York – Final Report*. 2012. 32-33, 37, 42, 55.

	• Individuals diagnosed as hard drug users may be at a greater risk of recidivism, thereby necessitating more attention in MHC.[72]
Brooklyn Mental Health Court	Established in 2002, the Brooklyn MHC was developed collaboratively by the Centre for Court Innovation and the New York State Office of Court Administration, in partnership with the New York State Office of Mental Health. The Brooklyn MHC is a post-indictment problem-solving court that handles primarily felony offenders (roughly 80%). It links defendants with serious, persistent mental illness to long-term treatment as an alternative to incarceration and, by doing so, works to effectively address both the needs of defendants with mental illness and the public safety concerns of the community. The goals of the Brooklyn MHC program are: • Improving the court's ability to identify, assess, evaluate, and monitor offenders with mental illness; • Creating effective linkages between the criminal justice and mental health systems; • Engaging participants in treatment and ensuring they are linked to high-quality services; and, perhaps of foremost importance; • Improving public safety by reducing recidivism among offenders with mental illness. The underlying assumption of the Brooklyn MHC is that defendants' criminal behaviours are the result, at least in part, of untreated or inadequately treated mental illness. Program operations are guided by the supposition that treating a defendant's mental illness leads to stability, which, in turn, leads to a reduction in criminal behaviour and improved psychosocial functioning.[73] Defendants are referred to the Brooklyn MHC program, screened for eligibility, matched with community-based treatment, enter the court through a formal plea process, and then participate in court monitoring, case management, and treatment services. Duration of participation in the program varies based on charge and mental illness characteristics. Participants enter the court by agreeing to a guilty plea with a sentence comparable to what they would have received in a traditional courtroom. Although a sentence is agreed upon at the time of the guilty plea, formal sentencing is suspended while the defendant participates in the court and associated treatment. The Brooklyn MHC targets both adult misdemeanour and felony offenders, including predicate felons and, in some cases, violent offenders, whose mental illness is believed to have contributed to their current criminal justice involvement. Participation in the MHC is voluntary. Potential cases must meet both the clinical and legal eligibility criteria of the program in order to participate. Clinical eligibility rests on a diagnosis of serious and persistent mental illness (SPMI) for which there is a known, effective treatment. Defendants with substance disorders may be eligible as long as they have an additional SPMI. Individuals with personality disorders, cognitive impairment, developmental disabilities, brain damage, and dementia are not eligible for the MHC program unless they also are diagnosed with an eligible major mental illness. The program's formal criminal justice eligibility guidelines are as follows: • **Felonies.** All nonviolent felonies are eligible. Felonies involving assault, robbery, and burglary are presumed eligible, but are reviewed by the clinical team and the ADA. Other violent felonies are presumed ineligible,

[72] Ibid 101-112.

[73] Ibid 57.

	but are reviewed on a case- by-case basis, if referred. Murder and rape are excluded. • **Misdemeanours.** All offences are eligible, but the court is not intended for offenders who would spend only a short amount of time in jail. Individuals may participate in Brooklyn MHC more than once.[74] A total of 519 individuals were referred to the Brooklyn MHC program between 2002 and 2006, of whom, 327 participated in the program. Of these: • 74% successfully completed the program; • Nearly 40% of graduates had their charges dismissed, and about one-half had their felony cases reduced to misdemeanour sentences. • In 21% there were no further supervision requirements.[75] The evaluation found that MHC participation lowers the chance of recidivism. The odds of being re-arrested are 46% lower for the Brooklyn MHC treatment groups than for non-participants. Similarly, having participated in the Brooklyn MHC treatment lowers the chance of re-conviction. Violent offenders who participated in the MHC program were much less likely to recidivate than other offenders in the MHC program.[76]
The Neighbourhood Justice Centre, Melbourne	
The Neighbourhood Justice Centre (NJC) was established in the City of Yarra in Melbourne in 2007. The NJC provides place-based justice for the local community. In its premises located in inner-city Collingwood, it hosts Client services in relation to mental health, housing and homelessness, drug/alcohol addiction, financial, and family violence, as well as specific services for Aboriginal Victorians, the LGBTIQ+ community, and refugees and migrants. The premises also hosts multi-jurisdictional courts and tribunals (including the Magistrates' Court, Children's Court, Victorian Civil and Administrative Tribunal and Victims of Crime Tribunal) and legal aid and justice agencies (including Victoria Legal Aid, Fitzroy Legal Service and Community Correctional Services).[77] A 2015 evaluation conducted by the Australian Institute of Criminology (AIC) found: • the NJC had 25% lower rates of reoffending than other Magistrates' Courts; • participants who went through the NJC were 3-times less likely to breach Community Corrections orders; • participants who went through the NJC demonstrate lower breach rates for intervention orders.[78]	

[74] Ibid 58, 61, 63.

[75] Ibid 77.

[76] Ibid 118-119.

[77] Neighbourhood Justice Centre, *What we do*, 2021, <https://www.neighbourhoodjustice.vic.gov.au/about-us/our-story/what-we-do> (accessed 11 May 2023).

[78] Stuart Ross. 2015. *Evaluating neighbourhood justice : Measuring and attributing outcomes for a community justice program*. Trends and Issues in crime and criminal justice. Australian Institute of Criminology. No. 499 November 2015. 3-6.

APPENDIX C

MODELS OF SUPPORTIVE HOUSING PROGRAMS FOR PEOPLE LEAVING PRISON

Aspire Program, South Australia	The Aspire case management program is a homelessness intervention that commenced in Adelaide, South Australia, in 2017. It provides intensive case management over a three-year period for people who have been experiencing chronic or recurrent homelessness or are at risk of returning to homelessness after being discharged from a health or correctional facility. Most Aspire participants have complex needs (such as mental or physical health issues, disability and/or drug or alcohol use). Between mid-2017 and mid-2021 Aspire enrolled 575 participants. Aspire aims to provide a rapid housing (and rehousing) service and wraparound supports to maximise the chances of participants maintaining their tenancies rather than returning to homelessness. It provides a distinctive homelessness response in terms of the intensive and sustained nature of supports. A 2022 evaluation concluded that Aspire is a highly effective homelessness intervention, especially for people with complex needs and/or experiencing chronic or recurrent homelessness. The analysis indicated that Aspire participation is associated with people successfully exiting homelessness and sustaining their tenancies over the medium term, alongside a reduction in accessing emergency accommodation services, decreased use of hospital services and less interaction with justice services, delivering significant cost savings to government. Aspire participants reported reductions in substance abuse, and suicide risk. They also described enhanced personal wellbeing, improved employment prospects, stronger family relationships and community connections, and better mental and physical health. The participants who were interviewed said that without Aspire, they would still be sleeping rough, in jail, or possibly no longer living. Instead, these participants were securely housed, had stabilised their lives and were accessing government services much less frequently. Participation in the Aspire program was also associated with decreased interaction with justice services, including fewer offences committed, fewer court appearances, fewer convictions recorded, fewer custodial sentences and less time spent in custody. In the first five years of Aspire, it saved $12 million in justice and other services and is projected to save $25 million once all 575 participants have completed their three years of intensive wrap around supports. Of the 575 participants since 2017, criminal convictions have reduced by 28%.[79]
Community Restorative Centre (CRC) NSW	The Community Restorative Centre (CRC) is a non-government organisation providing a range of specialist services to people involved in the criminal justice system and their families. Based in NSW, all CRC programs aim to break entrenched cycles of disadvantage and imprisonment. CRC aims to do this by addressing the drivers of incarceration, including homelessness, substance use, poor mental and physical health, lack of education and employment, social

[79] Coram, V., Lester, L., Tually, S., Kyron, M., McKinley, K., Flatau, P. and Goodwin-Smith, I. (2022) Evaluation of the Aspire Social Impact Bond: Final Report, Centre for Social Impact, Flinders University, Adelaide and Centre for Social Impact, University of Western Australia, Perth, https://doi.org/10.25916/202z-ey67. ix, x, xiii, 1.

	isolation, breakdown of family relationships, financial hardship and histories of trauma, including the trauma of imprisonment.[80] In 2021 the efficacy and impact of support provided by CRC to people leaving custody or at risk of incarceration was independently evaluated, with a particular focus on populations requiring support around the use of drugs and alcohol. The evaluation found a significant improvement in the criminal justice outcomes of 483 CRC clients who participated in Sydney-based transition and AOD programs between 2014-17. The analysis showed that on average for people after they engaged with CRC: • their number of days in custody fell by 65.8% • their number of new custody episodes fell by 62.6% • their number of finalised court appearances fell by 47.8% • their number of proven court appearances fell by 51.2% • their number of proven offences fell by 62.1%. In addition, the evaluation undertook a comparison analysis with clients from the Mental Health Disorders and Cognitive Disabilities linked administrative dataset at UNSW, comparing their outcomes to CRC clients. This analysis found engagement in CRC programs dramatically reduced contact with the justice system when compared to a similar group who did not receive support.

[80] Community Restorative Centre, CRC Our Services, <https://www.crcnsw.org.au/services/> (accessed 11 May 2023).