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PROTOCOL BETWEEN MENTAL HEALTH, DRUGS AND REGIONS DIVISION AND COMMUNITY CORRECTIONAL SERVICES

DEPARTMENT OF JUSTICE AND
DEPARTMENT OF HEALTH





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PREFACE

The Mental Health, Drugs and Regions Division (MHDR), Department of Health and Community Correctional Services (CCS), Department of Justice, have jointly developed this protocol recognising the need to enhance coordination and improve communication between staff of the respective sectors to better meet the mental health needs of adults within CCS with a mental illness or mental disorder.

People with a mental illness or mental disorder who are also engaged with CCS will often have multiple problems requiring intervention and support from health and community and social services. More specifically, providing a comprehensive and coordinated mental health response presents a number of challenges including:

- > Managing the response when an urgent mental health assessment and intervention is considered necessary.
- > Providing streamlined access to assessment and treatment services for CCS clients who have varying levels of complexity and severity in relation to their mental illness/disorder.

- > Managing the complexities of engagement, assessment, diagnosis and/or treatment of some offenders with mental health problems, particularly those with co-morbid personality and/or substance use problems as well as social isolation.
- > Managing the differing understandings and expectations of mental illness/disorder among CCS workers, non-government agencies, primary care practitioners and area mental health service (AMHS) staff.
- > Enhancing communication between CCS and AMHS.

It is recognised by all parties that the programs offered by mental health services and Community Correctional Services are dynamic in nature and that the protocol will require review and update on a regular basis. The protocol will be monitored regularly through meetings between the MHDR and CCS.

Signed November 2012

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1. INTRODUCTION AND BACKGROUND

Corrections Victoria is a business unit within the Department of Justice that manages and provides correctional services in Victoria, including a wide range of community and prison based services. Community Correctional Services (CCS), within Corrections Victoria, supervises adults who are sentenced by the courts to serve Community Correction Orders (CCO) or are conditionally released from prison on parole by the Adult Parole Board (APB). CCS's purpose is to promote community protection by providing effective supervision and opportunities for the rehabilitation of offenders. It also provides assistance to the courts and the Adult Parole Board.

The Department of Health is responsible for coordinating the provision of health services across Victoria, including Area Mental Health Services (AMHS), which provide programs for the care, treatment and management of the seriously mentally ill, in both inpatient and community settings. Treatment services are designed to be appropriate to the individual needs of the client and to be provided in the least possible restrictive environment and the least possible intrusive manner consistent with the effective giving of care and treatment.

The Department of Health is also responsible for coordinating the provision of community-managed mental health services, provided by Psychiatric Disability Rehabilitation Support Services (PDRSS). PDRSS are managed by non-government organisations and focus on addressing the impact of mental illness on a person's daily activities and the social disadvantage resulting from illness.

The Victorian mental health service system is currently undergoing a process of reform. Reform directions will position state-funded providers of community-based mental health services to deliver person-centred, client-directed disability support, driven by and tailored to the individual's changing support needs.

In many instances, clients of CCS may require support from a range of health and community services and may also receive support from a Department of Health funded service, such as mental health (both AMHS and PDRSS). Effective support for these people requires good communication and the coordination of roles and responsibilities between the service providers.

The development of this protocol was informed by the views, opinions and experience of people across CCS and public mental health services. Themes that emerged from these discussions included:

- > many offenders who are in contact with CCS have multiple problems;
- > there is a range of significant disorders in this population, including a high rate of dual diagnosis (mental health and drug/alcohol);
- > there can be impediments when accessing AMHS, especially in crisis situations; and
- > there is scope for collaboration between agencies to provide effective responses to mental health care, including crisis care.

It should be noted that this protocol does not attempt to address the relationships between CCS and other sectors that assist people with mental health problems, such as the primary health services provided by general practitioners or Community Health Services. It should also be noted that specific protocols have been developed for:

- > Department of Health and CCS and the Community Offenders Advice and Treatment Services (COATS) Drug Treatment Services. www.health.vic.gov.au/drugservices/pubs/coats; and
- > Mental Health Drugs, and Regions Division and Youth Justice Program, Department of Human Services http://intranet_2.csv.au/ccd/youthjustice/protocol.htm. (under review)

2. PREVALENCE OF MENTAL ILLNESS

2.1 Mental illness among adults in the general community

Almost half of all Australian adults (45 per cent)¹ are affected by mental illness at some stage in their lives. While some people experience mental illness only once, others experience mental illness intermittently throughout their lives. Mental illness is the single largest cause of disability, accounting for 27 per cent of all years lived with disability and 45 per cent for those aged 25 to 44 years².

One in five Australian adults (defined as people aged 16 to 85) are estimated to be affected by mental illness at any one point in time.³ Many of these people will experience mild mental illness, such as mild depression and anxiety disorders.

However, about three per cent of adults are severely affected by mental illness, with high levels of associated psychosocial disability. People with severe mental illness are more likely to be diagnosed with psychotic or bipolar disorders, severe anxiety and depression and severe eating disorders.

People who have been incarcerated during their lifetime are about twice as likely as people who have never been incarcerated to have experienced symptoms of a mental illness within the previous twelve months⁴.

2.2 Mental health problems among adult offenders

Research findings consistently show that a large percentage of prisoners have some form of mental disorder. In Victoria, a study in 2003 noted that 26 per cent of prisoners met criteria for at least one of the diagnostic categories of schizophrenia, manic depression and depression. The *Victorian Prisoner Health Survey* found that of the respondents:

- > About half had been assessed for emotional problems by a psychiatrist or doctor and more than 15 per cent had been admitted to a hospital for these problems.
- > Fifteen per cent said that they were taking medication for these problems, with anti-depressants the most common type of medication.
- > Approximately 40 per cent stated that they had received intervention from a psychologist or counsellor for emotional or mental health problems.

1 ABS National Survey of Mental Health and Wellbeing 2007

2 Boston Consulting Group 2006 Improving Mental Health Outcomes in Victoria: The next wave of reform Department of Premier and Cabinet, Victorian Government

3 ABS National Survey of Mental Health and Wellbeing 2007

4 ABS National Survey of Mental Health and Wellbeing 2007

The mental health status of newly-remanded prisoners suggests that 28 per cent suffer from some form of mental illness, with approximately 8 per cent suffering from schizophrenia or bipolar disorder. The prevalence of depression is at least 50 per cent higher than that in the general population and the prevalence of schizophrenia and bipolar disorder is almost 10 times greater⁵. Research in the UK has further identified the first month following discharge from a correctional setting as being a high-risk period for suicide⁶. American research further suggests that access to community mental health services after discharge from a correctional setting reduces the likelihood of reincarceration and other adverse events, such as hospitalisation and presentation at Emergency Departments⁷.

Studies also show markedly higher rates of mental illness for aboriginal than non-aboriginal prisoners and for female compared to male prisoners. A number of reports document high co-morbidity of mental health and drug and alcohol problems for prisoners, with a NSW report noting that the increased use of illicit drugs among people with mental illness is likely to significantly contribute to re-offending.⁸

2.3 Mental health problems in Community Correctional Services clients

The prevalence of mental health problems and suicide risk in the CCS offender population is indicated by a set of associated data:

- > the Andersen Review of CCS in Victoria concluded that approximately one quarter of offenders with a community-based order or a combined community and treatment order were identified as having a psychiatric or psychological problem. That proportion had doubled from 1996-2000 (12 to 23 per cent).⁹
- > the Department of Justice recognises the complex impact of mental illness, substance abuse and trauma as integral to women's offending, with higher rates of all three factors among women than for men.¹⁰
- > in that review, 15 per cent of high-risk offenders were identified as having 'antisocial personalities, procriminal attitudes and poor problem solving skills and thus require psychological counselling'. Out of the 15 per cent of high-risk offenders who 'may be at risk of self-harm or harm to others, almost 40 per cent cannot be successfully and appropriately referred to psychological counselling'.¹¹
- > with reference to both prisons and community correctional services, a State Coroner's Office report in 2000 found that approximately 10 per cent of those who committed suicide were known to have committed criminal activity.
- > Corrections Victoria estimates that during the period 2001-2002 to 2003-2004 people under the supervision of CCS were between 18 and 22 times more likely to die from suicide than the general population.¹²

5 Boston Consulting Group 2006 Improving Mental Health Outcomes in Victoria: The next wave of reform Department of Premier and Cabinet, Victorian Government

6 Shaw 2006 accessed at www.medicines.manchester.ac.uk/aboutus/news/suicide 28 March 2007

7 Hawthorne et al 2012 'Incarceration among adults who are in the public mental health system: rates, risk factors, and short-term outcomes' *ps.psychiatryonline* January 2012 Vol 53. No. 1

8 New South Wales Justice Health 2003 study

9 Andersen A 2000 *Review of Community Correctional Services in Victoria*. Department of Justice p.33

10 Department of Justice 2007 *Better Pathways in Practice: the women's correctional services framework*

11 Andersen A 2000 *Review of Community Correctional Services in Victoria*. Department of Justice p.77

12 Department of Human Services 2006 *Next Steps Victoria's suicide prevention forward action plan. A public statement*, p.6

3. BEST PRACTICE PRINCIPLES

In addition to existing core values underlying each department and health service including demonstrating a commitment to human rights, a set of principles have been adopted for this protocol to guide the provision of mental health care to CCS clients.

Access related to individual need: a person's offending behaviour or co-occurring substance use will not exclude them from mental health treatment. At times this has been identified as an obstacle to service provision.

Shared care: the Department of Health meets its obligations through its funded services, whilst CCS has a statutory role and retains primary case management responsibility. The needs of the person are paramount, and can best be met through a collaborative approach emphasising shared responsibility, with each service sector contributing their expertise to an integrated model of care. The two systems, therefore, have a shared responsibility for CCS clients who have a serious mental illness.

Confidentiality and exchange of information: confidentiality between a person and service staff is fundamental to the relationship and is enshrined in relevant legislation and professional codes of conduct. AMHS and PDRSS staff should make every effort to seek informed consent from the person to share information. CCS, AMHS and PDRSS staff are obliged to keep information confidential unless the person consents to the disclosure of that information. For disclosure *without* the person's consent, specific requirements exist, for instance under the *Mental Health Act 1986*, and must be followed (for further detail see Section 4.2). It should be noted that the *Mental Health Act* is currently under review.

A coordinated approach: where a person is engaged with both CCS and AMHS or PDRS services, it is expected that staff in each system will work together for the benefit of the person. In many instances, a number of other services may also be involved in providing services, including housing and vocational support services. Communication, collaboration and service coordination between all parties is essential.

Assertive engagement: there can be particular challenges associated with engaging people in a casework relationship. CCS clients may bring with them additional issues such as a history of offending behaviour, substance use, complex health problems and possible resistance to authority. Successful therapeutic intervention is, in part, dependent on the quality of the relationship between worker and client. Mental health services need to take a proactive and flexible approach to engaging CCS clients in treatment.

Least restrictive service option: when mental health assessment or treatment is required from AMHS, consideration should always be given to identifying the service and the treatment option that can provide care in the most accessible and least intrusive manner. Where it is appropriate for the person to receive their mental health care from primary health services, such as a GP and Community Health Service, this should be actively explored. Support from a community-managed mental health service may also be more appropriate should also be considered. Whilst the individual's right to self-determination and their acceptance or non-acceptance of psychiatric treatment and support should be respected, this right needs to be considered within the framework of any treatment conditions attached to their order and options for involuntary treatment subject to the provisions of the *Mental Health Act*.

Coordinated care: when AMHS provides direct care for people with a serious mental illness, this will often be time-limited, focused on alleviating symptoms of mental illness and promoting maximum recovery. It is important that AMHS establish and maintain links with the other services that support the person, including CCS and PDRSS (which often provide longer-term support to people with a mental illness), to ensure these are available once the person no longer requires AMHS case management. If a relapse occurs, referral to an AMHS should not be viewed as a new referral but as providing continuity of care.

4. ACCESS FOR COMMUNITY CORRECTIONAL SERVICES CLIENTS TO AREA MENTAL HEALTH SERVICES

4.1 Who should be referred?

The most appropriate service for people, including CCS clients, who are experiencing mental health problems is decided by the severity and complexity of the presenting symptoms. Many offenders involved with CCS who experience mental health problems can be managed by a service provided by a General Practitioner, private practitioner under the new rebateable Medicare Benefits Schedule (MBS) items, headspace (for young people aged under 25 years) or a Community Health Service counsellor. Many people who are involved with CCS will also receive support for a mental health problem from a PDRS service. They will generally respond well and require little further intervention. In a smaller percentage of more serious cases, referrals to the AMHS will be required. Involvement of an AMHS may be required for problems that:

- > cause moderate to severe distress and impairment;
- > are associated with a greater risk of enduring disability;
- > are associated with a moderate to high risk of harm;
- > may involve the presence of a complicating co-morbidity; and
- > require specialist psychiatric treatments or psychosocial interventions.

Importantly, clients of CCS should have the same access to AMHS as others in the community, while recognizing that for many CCS clients there is an increased vulnerability to mental health problems. A collaborative approach between the two service sectors, emphasising shared care, is vital. It is also recognised that CCS case managers develop a sound understanding of their clients through the offender management process and are generally well placed to make judgements about their potential need for mental health care.

In cases where referral to mental health services is urgent, or access to other health services is limited, direct referral from CCS staff to AMHS triage is encouraged.

AMHS assess and provide treatment for people with a serious mental illness or disorder. The following indicators will assist CCS case managers to determine whether a person appears to have a serious mental illness and whether AMHS assessment should be considered. They serve as a guide rather than as factors confirming the presence of a serious mental illness or disorder. Specific symptoms and signs will vary depending on the mental disorder and the person's age. Psychiatric assessment is required to confirm the diagnosis of mental disorder and determine the level of impairment and treatment needs. The presence of any of the following may be indicators of mental illness:

- > bizarre or unusual thinking
- > hallucinations
- > significant changes of mood, such as pronounced depression, pronounced anxiety or pronounced elevation in mood
- > restless, agitated and disorganized behaviour, or marked decrease in activity
- > significant impairment of social, educational and/or occupational functioning
- > significant impairment in self-care
- > suicidal thoughts or acts of self-harm
- > destructive or high risk behaviour
- > significant memory impairment
- > confusion and disorientation.

4.2 Confidentiality and exchange of information

Mental health clinicians, including both AMHS and PDRSS staff, and CCS case managers are generally obliged to keep identifying information confidential unless the person consents to the disclosure of their information. Consent is therefore the starting point when considering disclosure. Part of clinical/casework work is helping a person understand the benefits or reasons for sharing information in a particular circumstance. This understanding helps the person to decide what they may be willing to allow to be disclosed, and to whom. Disclosing any information is a judgement for AMHS and CCS, based on what the law permits, and should take into account the following factors:

- > the purpose of the disclosure
- > the legal authority for disclosing the information
- > whether it can be met in any way other than revealing personal information
- > whether the requester is entitled to receive information
- > the minimum amount of information that needs to be disclosed to achieve the purpose
- > that people are informed that information about their needs may be communicated.

Confidentiality between a person and mental health clinician is fundamental to the therapeutic relationship and is part of relevant legislation and professional codes of conduct. Mental health clinicians are obliged to keep identifying information confidential, unless the person consents to the disclosure of that information to another person or service (in this case CCS), or where there are specific grounds under the Mental Health Act for disclosure without the person's consent. The Mental Health Act lists general and specific circumstances in which information may be disclosed with and without consent. Disclosure means AMHS giving information to an external individual or organisation.

Where there is a serious and imminent risk to a person's life, health or safety, or where a person is showing suicidal intent or behaviour, staff should consider whether sharing relevant information would assist in minimising risk. AMHS staff should refer to the clinical practice guideline *Working with the suicidal person*, available at www.health.vic.gov.au/mentalhealth/suicide/suicidal-person-book2010.pdf. It is good practice for triage to follow up with a person after a suicide attempt, to ensure the person's support needs are being met.

The *Corrections Act 1986* provides that CCS case managers must not disclose information except to the extent necessary to perform their official duties (for instance, compliance with a relevant court order). It also specifically preserves the operation of the Health Records Act. Specific circumstances exist that allow for certain information to be disclosed without the consent of the person. This includes, for example, lessening or preventing a serious and imminent threat to the life, health, safety or welfare of a client or any other person. A useful distinction in deciding which law applies is that:

- > the *Mental Health Act* is the principal law regulating the disclosure of health information by specialist mental health services
- > the *Health Records Act* is the principal law regulating the collection and use of health information by mental health services
- > the *Corrections Act 1986* is the principal law governing general disclosure of information in the course of official CCS case manager duties
- > the *Charter of Human Rights and Responsibilities Act* includes the right to privacy and reputation.

4.3 How to make contact with an AMHS

All AMHS have a 24-hour-a-day/seven-day-a-week triage function that provides an initial clinical assessment over the telephone and the mobilisation of a crisis response if required.

Local AMHS details and contact information are located at: www.health.vic.gov.au/mentalhealth/services/index.htm. The first contact with AMHS can be made directly to the service's triage worker. Medical or court referrals are not necessary. The role of the triage clinician is to conduct a preliminary assessment to determine whether it appears that a person has a mental illness or disorder, and the nature and urgency of the response required. Triage and intake assessment are conceptually two different functions, however they may occur concurrently.

It is expected that AMHS will have procedures for ensuring timely and appropriate responses to referrals and enquiries. Where it is determined that the mental health service is not the most appropriate service, every effort should be made to link the person or referrer to a more suitable service (including PDRSS and GPs). Where appropriate, the clinician should make contact with this service on behalf of the person requesting the service. Following this triage assessment, one of the following responses will occur:

Arranging a more detailed assessment: when triage assessment indicates that AMHS are required, or could possibly be required, the triage worker will arrange or provide a more detailed intake assessment. In most cases, this will involve a face-to-face assessment of the person.

or

Crisis intervention: where intervention is time critical, the triage clinician may arrange for acute assessment and community treatment or, if this is not possible within an appropriate timeframe, will advise that the person be brought to a hospital emergency department. Major Victorian emergency departments have mental health clinicians available on site or on-call to respond to people in psychiatric crisis. Where there are immediate concerns about the safety of the person or of other people, the triage clinician may call 000.

or

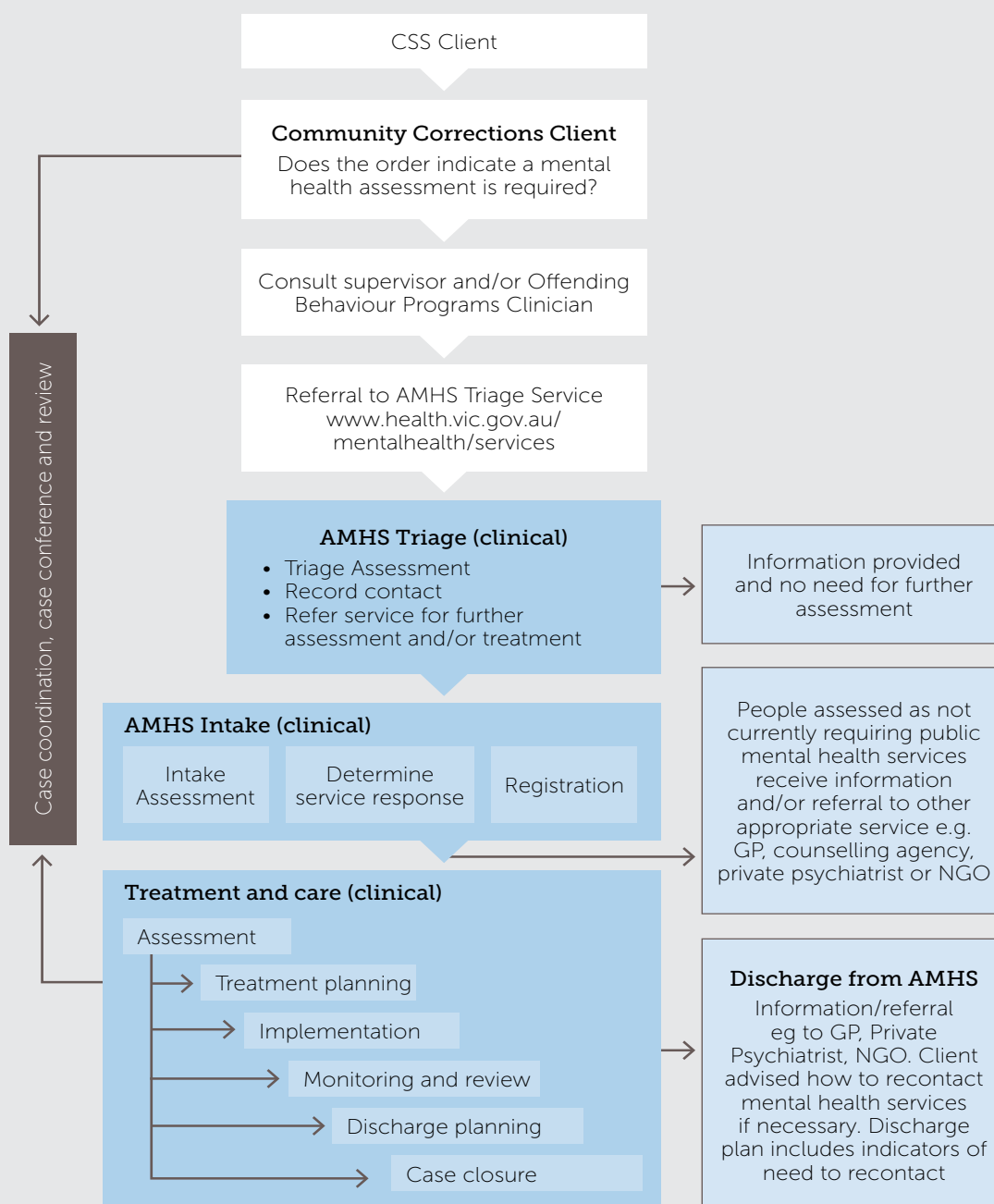
Telephone advice and referral: may be given where, on the basis of the information provided to them, the clinician determines that a response from AMHS is not required, or alternative mental health care is more appropriate. Advice about the alternative service options should be given at this point.

Once a person is accepted for assessment, decisions about treatment will be subject to the outcomes of this clinical assessment. The intake assessment may ultimately result in:

- > information and advice only
- > referral to another organisation within the provisions of Section 120A of the *Mental Health Act*
- > secondary consultation and support to the original referrer
- > acceptance for treatment within AMHS for short or longer-term treatment.

4.4 What is the AMHS referral pathway?

The following flowchart depicts the pathway for CCS clients' referral to AMHS



4.5 What referral information will AMHS need?

CCS case managers can help the mental health clinician make the most informed decision about the referral request by providing as much information as possible, with the client's consent, about the client, their family and service provider involvement. In the absence of client consent to share information, a referral can still be made in certain situations, with limited information only provided. This may include where the matter is urgent or when case managers seek advice about a situation without disclosing identifying information. Wherever possible, the following information should be presented with the referral:

- > **Demographic information** – name of person, current address, date of birth, current living situation, family relationships, school/employment status.
- > **Person's knowledge of referral** – has the person been informed about the referral for assessment, and is the person willing to be assessed? It should be noted that this is not necessarily a condition of referral.
- > **Presenting problems** – a clear description of the nature of the presenting concerns, their severity and impact and the length of time that they have been present. It may be appropriate for the referrer to give his or her assessment of the risk to the person and/or others as a consequence of these problems.
- > **Mental health history** – has there been previous contact with AMHS? Is the person currently in contact with any other mental health professionals? Has the person presented previously with similar problems? If so, what was the management plan, who was involved, how was it resolved? Has the person been diagnosed previously with a mental illness?
- > **Medication** – has the person been prescribed medication and, if so, what type and what dosage (if known)? Are they complying with the prescription? Have there been any recent changes to their medication?
- > **Drug and alcohol use** – is the person using alcohol or other drugs in a problematic way? Have they recently changed their alcohol or drug use patterns?
- > **Forensic history** – does the person's mental health problems relate to their offending history, if so how? What are the relevant arrangements in place with CCS or the courts?
- > **Involvement of other services** – what other services are currently involved with the client and/or their family? What intervention has already occurred, and what was the outcome? Do these services plan to stay involved with the person?
- > **Relevant medical history** – does the person have any other medical conditions (if known)? What treatment are they receiving? Providing relevant medical/health documents, subject to consent provisions, may be beneficial.

4.6 What if the need for assessment is urgent?

Case managers sometimes need to access AMHS when they perceive the need for assessment and treatment to be urgent. Case managers often experience difficulty when offenders attend in mental health 'crisis', such as expressing serious suicidal tendencies. In general, case managers are not equipped to make accurate assessments regarding the client's actual status or to determine whether they are 'at risk'. Trying to access immediate services for offenders in crisis is one of the most difficult tasks undertaken by case managers. Often case managers have concerns not only for the immediate welfare of their client but also for the expected duty of care that is to be extended to offenders under these circumstances.

The case manager can generate referrals for assessment and treatment. This may be in consultation with Offending Behaviour Program (OBP) who can assist by suggesting referral pathways at any relevant stage. This means that crisis situations may be pre-empted. In general, OBP does not provide direct suicide risk assessment and crisis management services; their key responsibility is the provision of programs and treatment of offenders and prisoners under the supervision of CV.

Depending on the presentation there are several options for action:

- > the case manager assists to de-escalate the level of distress by identifying previous circumstances and by problem solving with the person. This is followed by a management plan that may include contact with the AMHS if he/she is unable to manage their distress.
- > referral to a General Practitioner.
- > contact AMHS telephone triage. AMHS triage will determine the most appropriate mental health response for the CCS client. This may include calling 000, directing the person to attend an emergency department immediately, or arranging a face-to-face assessment by a community mental health team. Triage may also refer the CCS client to other services, including primary care, headspace (for clients aged less than 25 years), PDRSS or other support services.

- > contact police if:
 - > the CCS client is threatening violence and there is a genuine and immediate risk of self-harm or harm to other people;
 - > the CCS client is armed with any weapon;
 - > a police presence is reasonably necessary for personal safety.

Crisis intervention may be required when CCS clients attend or contact CCS locations whilst appearing to be in mental health 'crisis', or distress, or when expressing suicidal tendencies. In these situations, AMHS triage should be called. Triage services will conduct a preliminary assessment and determine the most appropriate response. As noted in 4.3, this may include calling 000, directing the person to attend an emergency department immediately, or arranging an urgent face-to-face assessment by a community mental health team. It is important to note that mental health services are not an emergency service and, unlike ambulances, may not always be able to provide an immediate response. In the event of a medical emergency ambulance services should be contacted.

For urgent referrals, the referring case manager will be requested to provide as much information as possible to triage clinicians regarding the situation. The information should include:

- > the person's current location
- > presenting problem
- > behaviour of the person
- > relevant risk issues to self or others
- > evidence of drugs or alcohol use
- > other services and people involved
- > presence or availability of family members.

Where it is decided that an urgent face-to-face assessment is appropriate, specific arrangements will need to be discussed with a CCS senior officer or case manager. These will include:

- > the location where the assessment will take place
- > the workers who will be involved
- > the anticipated time of the assessment
- > management of risk for clinicians.

4.7 Community treatment from Area Mental Health Service

Where ongoing mental health treatment is required, CCS is to maintain responsibility for the overall case management incorporating a statutory supervision role. AMHS are responsible for providing clinical case management services and for utilising their expertise to meet the specific mental health needs of the person.

When a CCS client is accepted for treatment within AMHS, the CCS case manager and the AMHS clinical case manager should establish a clear plan for communication and collaboration. This will be subject to the relevant confidentiality provisions of *the Mental Health Act*, the *Health Records Act* and the *Information Privacy Act 2000* (For further detail refer to Section 4.2, Confidentiality and exchange of information). AMHS are responsible for identifying treatment needs, rather than CCS. Supervision, support, treatment and rehabilitation needs should independently form part of both the mental health and the CCS case management plans.

It is particularly important that CCS case managers and mental health clinicians clarify their respective roles and responsibilities, particularly their statutory obligations, as these may differ. While communication by telephone may be sufficient in many instances, more formal approaches to information sharing and case planning, such as case conferences, may be required from time to time. Active participation by the person and their family or support person is essential to this coordinated care process.

The emphasis of AMHS management is towards community-based treatment, wherever possible, under the direction of a Consultant Psychiatrist with the majority of receiving people receive care from community mental health clinics. People with substantial and prolonged mental illness associated with high levels of disability and vulnerability to repeated inpatient admissions could be seen by a more intensive outreach service such as the Mobile Support and Treatment Service (MSTS). MSTS provides clinical case management, assertive outreach, intensive support, treatment and rehabilitation service to a smaller group of high-needs people. Many CCS clients could also receive ongoing support from PDRSS services. For more information about the different elements of the mental health service system, see www.health.vic.gov.au/mentalhealth/services/service-components.pdf or Appendix 2 of this document.

Each person receiving community mental health treatment is allocated a primary clinician, often known as a clinical case manager. Key functions of the clinical case manager include:

- > ensuring that each person is provided with a comprehensive psychiatric and needs assessment as the basis for their individual care plan
- > developing an individual care plan outlining goals, strategies and responsibilities in
- > collaboration with the person
- > working collaboratively with the person in relation to their treatment and to facilitate the implementation of the person's individual care plan
- > monitoring the person's emotional and social well-being and review the individual care plan
- > identifying and respond to the information and support needs of families and other support people
- > finalising involvement when the person no longer requires treatment from AMHS and that appropriate transitional arrangements and discharge plans are in place.

The clinical case manager will provide direct treatment and support to the person, as well as facilitating access to other services directed at the person's expressed practical, recreational, vocational and emotional support needs. The person's doctor (psychiatrist, psychiatric registrar or psychiatric medical officer) is responsible for monitoring the person's physical and mental well-being and for their psychiatric management, including supervision of any medication that the person may require. There is a growing emphasis on ensuring strong links between AMHS and primary care providers (for example, General Practitioners) as well as better links with private psychiatrists, to ensure a holistic approach to the person's wishes, aspirations and needs and continuity of care. Treatment may include:

- > psychoeducation (aimed at fostering an individual's understanding of their condition and enhancing their ability to manage their condition more effectively)
- > medication or other physical therapies
- > counselling and psychotherapy
- > goal planning and structured problem solving
- > stress management
- > attention to social and welfare issues

- > monitoring physical health needs
- > working with families and other support people
- > liaison and collaboration with other service providers.

People generally receive community mental health treatment on a voluntary basis, therefore it is not possible for AMHS clinical staff to insist on their attendance. Some people, however, may be required to receive psychiatric treatment under the *Mental Health Act* either in an inpatient setting or in the community under a Community Treatment Order (CTO) or a Restricted Community Treatment Order (RCTO) when they are unable or unwilling to consent to treatment. CTOs offer a less restrictive, community-based environment for involuntary treatment than in an inpatient setting.¹³ Further information is available from: www.health.vic.gov.au/mentalhealth/cpg/comm_treat_order_guidelines.pdf

CCS clients who are required to attend treatment services as a condition of their community based dispositions and do not meet the criteria for involuntary treatment under the *Mental Health Act* will have their attendance monitored by their CCS case manager. CCS clients who do not attend as required by their order may be in breach of their order and liable to a return to court or prison at the discretion of the Adult Parole Board. It should be noted AMHS do not routinely provide court reports.

Statewide specialist service – Forensicare

Forensicare's Community Forensic Mental Health Service (CFMHS) is a highly targeted specialist statewide service that provides expert forensic assessment and multidisciplinary treatment services to high-risk people referred from correctional providers, courts, the Adult Parole Board, the Thomas Embling Hospital, the Acute Assessment Unit at Melbourne Assessment Prison, the Maarmak Unit at Dame Phyllis Frost Centre, police, area mental health services, private psychiatrists and general practitioners.

The CFMHS provides community based clinical, liaison, assessment and consultation services in relation to the treatment of high-risk people who have a serious mental illness and or present with significant forensic issues. This includes specialist psychiatric and psychological assessment and treatment services specifically focused on individuals with

"problem behaviours" which may be associated with offending such as stalking, threatening, fire setting, violence, and problematic sexual behaviour including paedophilia, adult sexual assault and internet child pornography. Time limited support and linkage assistance is also provided to people with a serious mental illness leaving prison in their engagement with area mental health services. In addition, the CFMHS provides intensive case management for those people who receive a Custodial Supervision Order under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* upon their re-entry to the community, and supervises all people on Non-Custodial Supervision Orders.

Forensicare provides psychiatric and psychological pre-sentence reports to courts, both to offenders in custody and those remanded on bail. This includes reports to Magistrates' Courts, the County and Supreme Courts, and the Adult Parole Board. Reports provide specialist input that informs the sentencing process of people with a mental illness, as well as the review and release determinations of prisoners with a mental illness,

Referrals to CFMHS can be made directly by contacting the intake worker Monday to Friday between 9am and 5pm. Referrers from Criminal Justice Services are requested to provide the following in order for the referral to be considered:

- > signed Authority to Exchange Information (for Corrections)
- > copy of current court order
- > copy of Victoria Police summary of charges
- > copy of judge's sentencing comments
- > copy of a criminal history report
- > for sexual offenders: clarify whether the offender has been assessed by Corrections Victoria Sex Offender Program (SOP) and a copy of SOP's reports and recommendations.

Forensic Clinical Specialist Initiative

The CFMHS also coordinates the Forensic Clinical Specialist (FCS) initiative. This pilot program aims to build forensic expertise and capacity into existing community-based public specialist mental health services (including AMHS and PDRSS) by funding dedicated forensic mental health clinical specialists in ten selected AMHS across Victoria. This program is expected to ensure better continuity of care, as well as improved early recognition of and response to forensic issues in mental health clients.

13 Chief Psychiatrist's Guideline November 2005
Community treatment orders

4.8 Consultation with an Area Mental Health Service

In many cases, an appropriate step towards obtaining assistance from AMHS will be to request a one-off, or a series, of primary or secondary consultations between mental health clinicians and other service providers involved with the person's care. This can be discussed with the triage service or the person's primary clinician if they are already registered with the AMHS. Once again, it is important to reiterate that all communication is subject to the relevant confidentiality provisions of the *Mental Health Act*, the *Health Records Act* and the *Information Privacy Act 2000* (For details, refer to Section 4.2, Confidentiality and exchange of information).

- > **Primary consultation** – an AMHS clinician conducts a direct assessment of the CCS client and provides CCS with management advice.
- > **Secondary consultation** – CCS is given an opportunity to discuss the offender's issues with an AMHS clinician in order to obtain management advice.

As well as providing a mechanism for understanding and managing the concerns relating to the CCS client's current presentation, consultation support provides the basis for future contact between the service providers. Collaboration between AMHS and CCS staff may result in one or more of the following outcomes:

- > AMHS advice on the nature and management of the person's condition
- > further assessment by AMHS
- > establishment of ongoing collaborative care between CCS and AMHS staff
- > planning for future contact between services, including a management plan setting out respective roles and responsibilities, should a person's mental health problems become more severe or complex.

4.9 Transition points

Given the CCS client group's vulnerability to mental health problems and the complexity of the issues with which they often present, continuity of mental health care is vital. It is also known that for people with mental health problems there is increased vulnerability to relapse and self harm at points of transition. It is therefore important that workers communicate at transition points to ensure services continue to be provided consistently. Transition points may include:

- > movement between prison and CCS
- > movement between AMHS and CCS
- > completion of court orders
- > other relevant changes in treatment circumstances.

Planning for transitions should ideally be part of the case management process for both CCS and AMHS, with appropriate notifications of client movements made to relevant services in a timely manner.

In the case of the person's mental health intervention continuing beyond the expiration of any statutory orders, CCS no longer has a mandate to work with the person concerned. It is therefore essential that handover of case responsibility occurs in a planned manner. It is likely that a person involved with a mental health service beyond the expiration of a court order will require some extra support at the time the order finishes. This should be part of the case coordination process between the two systems.

4.10 Working together and collaboration

Given the potentially complex nature of service collaboration and variations in local circumstances, it may be necessary to establish local liaison committees or identify a local contact person in CCS and AMHS. This could assist in improved communication between AMHS and CCS and lead to the development of local protocols regarding the coordinated care of mutual clients.

Successful case collaboration and coordination occurs when there is an awareness of a client's involvement with other service providers. It is therefore important that clinical case managers working within AMHS and CCS are aware of each other's involvement, and that of other agencies such as Drug Treatment Services.

It is expected that clinical case managers working in AMHS routinely ask people whether they are involved with other services, including CCS. Similarly, CCS staff should routinely seek information from clients regarding whether they are in receipt of treatment by health services (including mental health services), regardless of whether it is a requirement of their orders.

4.11 How to resolve differences

At times, different views may arise as to the suitability of a CCS client receiving clinical care from AMHS. The dispute resolution process should be undertaken in a manner that ensures that:

- > the person's safety and wellbeing is paramount
- > differences are resolved at the most immediate level possible within the system's processes, however, line management support and decision-making should be used if initial attempts to resolve the dispute are not successful
- > differences are addressed as soon as possible after they arise.

In the first instance, attempts should be made to resolve any differences of opinion by the staff involved. The local liaison committee (where relevant) might have a role to play in resolving disputes. If the dispute is not able to be resolved at this level, then it should be referred to line management including, where appropriate, the Director of Clinical Services within the respective services.

The overall aim of this process is to resolve the case specific issues and problems. All information should be clearly recorded with an outline of the process taken to resolve the issues, roles and responsibilities of each service and further action plans to address issues and maintain the safety and wellbeing of the person.

If concerns arise in relation to any aspects of service delivery by AMHS, the preferred action is to speak directly to the staff involved, the clinical case manager or the service manager. If concerns still exist, all services have formal mechanisms to address any complaints or concerns. Most commonly these involve contacting the CCS regional general manager or the Director of Clinical Services or complaints liaison officer within the health services or hospital. If local complaints resolution mechanisms fail, other options include contacting the:

Office of Chief Psychiatrist

Department of Human Services
Telephone: (03) 9096 7571
Toll free: 1300 767 299

Health Services Commissioner

Telephone: (03) 8601 5200
Toll free: 1800 136 066

APPENDIX 1: DEFINITIONS

1.1 Definition of key terms

Mental health has been described as not simply the absence of mental illness, but 'the capacity of individuals and groups to interact with one another and their environment in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals...'¹⁴

The term **mental health problem** is used to describe a broad range of emotional, cognitive and behavioural problems that generally arise in response to life stressors, are mild in severity and generally short term in duration.

Mental disorders or **mental illnesses** are clinically diagnosable conditions that interfere with an individual's thoughts, perception, memory, mood or behaviour and are associated with distress or impaired functioning.

Serious mental illnesses are conditions in which 'a person's ability to think, communicate and behave appropriately is so impaired that it significantly interferes with his or her ability to deal with ordinary demands of life. Without effective treatment and support, the outcome for the person may be significant disability and/or disadvantage'¹⁵.

Adult offenders are subject to diversionary dispositions imposed by the court or the Adult Parole Board. These dispositions include community-based orders, intensive correction orders, combined custody and treatment orders, parole orders and interstate orders.

1.2 CCS orders

The parole order. When a prisoner is sentenced to more than 12 months imprisonment, the sentencing judge or magistrate may set a minimum period to be served before they are eligible for release on parole, known as the earliest eligibility date (EED). At the EED, the APB, on the advice of CCS, considers the prisoner's case and may grant them conditional release on parole.

While on parole, an offender is subject to a number of core and special conditions, which they are required to comply with in order to complete their parole successfully. CCS regularly updates the APB on offender compliance, and the APB maintains the discretion to cancel any parole order and return the offender to custody where it deems the non-compliance to be of an unacceptable level.

Parole ensures that, upon release, offenders receive the management and supervision required to support their reintegration from prison into the community, and provided the important function of monitoring the parolee's behaviour and compliance while on conditional release in the community.

Structure of the Community Correction Order (CCO) The maximum length of a CCO in the Magistrates Court is two years.

In the higher courts, maximum duration of a CCO is determined in each case by the maximum term of imprisonment for the relevant offence.

14 Australian Health Ministers 1991 p.24

15 www.health.vic.gov.au/mentalhealth

'Terms and Conditions' – Existing core conditions will still apply to the CCO, however they are now referred to as 'terms' with optional 'conditions'.

Optional Conditions Under the CCO, courts are able to draw on a broad range of new and pre-existing powers to tailor the order to address the circumstances of the offence and the offender, in order to reduce the likelihood of further offending or to protect those affected by the crime.

At least one optional condition must be attached to the CCO by the court.

Optional conditions can be for a period specified that is less than the order duration. While the CCO has replaced the orders listed below from 16 January 2012, existing orders will continue until their end date.

The Community-Based Order (CBO) is the most commonly imposed order by magistrates and judges. It allows for the inclusion of both core conditions (generic compliance conditions that are attached to every order) and program conditions (including unpaid community work or other programs which are suitably tailored to address the offending behaviour). Every order must have at least one program condition attached. The maximum duration of a CBO is 24 months.

Offenders subject to CBOs with unpaid community work as the only program condition or CBOs relating to default of fines are required to undertake community work hours imposed by the court and report to a Community Corrections Officer when issues arise regarding attendance.

The Intensive Correction Order (ICO) is a sentencing option available to magistrates and judges that is a direct alternative to a period of incarceration. The ICO is a term of imprisonment that the offender is allowed to serve in the community rather than in custody. However, if an offender fails to comply with an ICO, the expectation is that the remainder of the sentence will be served in custody. The ICO generally imposes more intensive reporting requirements than a CBO. Unless otherwise stipulated by the court, the offender is required to report to their supervising CCO twice per week during the operational period of the order. They are also required to undertake 12 hours per week of unpaid community work, of which up to four hours can be constituted by participation in educational programs. Current legislation however makes provisions for the court to alter these programmatic requirements under certain circumstances. The maximum duration of an ICO is 12 months.

The Combined Custody and Treatment Order (CCTO) is a relatively new sentencing alternative that was designed to best suit the needs of offenders with substance abuse concerns. The order incorporates a period of imprisonment (no less than six months) during which time the offender undertakes drug or alcohol treatment whilst in custody, followed by a period of community supervision (to a total of no more than 12 months) where follow up treatment and supervision may occur. Similarly to an ICO, it is an expectation that where an offender fails to comply with the community component of a CCTO, the community portion of the order will then be required to be served in custody. A combined custody and treatment order does not have an unpaid community work component.

APPENDIX 2: THE SERVICE SYSTEM – A BRIEF OVERVIEW

2.1 Clinical mental health service system (AMHS)

In Victoria, public mental health services focus on people with the most complex and severe mental health problems across the following groups: children and adolescents (0-18), adults (16-64) and aged persons (65+). In addition, some services have moved towards a 0-25 child and youth service model. Public mental health services are area-based and grouped into entities known as area mental health services. There are 21 adult mental health services (AMHS) across Victoria with defined geographic boundaries, 13 Child and Adolescent Mental Health Services (CAMHS), 10 Youth Early Psychosis services (YEP), 17 Aged Persons Mental Health Services (APMHS) and an increasing number of youth services statewide.

Redevelopment of specialist mental health services for children and young adults (aged 0–25 years) has commenced in various ways across a range of sites. As part of ongoing reform and service improvement endeavours, CAMHS and Adult MHS are working together to deliver a new 0-25 response - Child and Youth Mental Health Services (CYMHS), that aims to provide seamless care across this important age range. These services are not yet available across the state but operate in all metropolitan and some regional centres.

Each adult AMHS comprises a number of service elements. These include acute inpatient units, residential units and a continuum of community treatment options. Acute inpatient units provide short-term treatment during an acute phase of a mental illness until a person is well enough to be treated in the community. Secure Extended Care Units (SECU) are units designed for people who require an increased level of clinical assistance or supervision than offered by other service components. Residential service options include Community Care Units (CCU) and Prevention and Recovery Care (PARC) services. CCUs provide medium to long-term accommodation, clinical care and rehabilitation services for people with a serious mental illness and psychosocial disability.

PARCs provide short-term residential (up to 28 days) treatment and support in the community and operate with a step-up (from the community), step-down (from an inpatient stay) model to avoid unnecessary inpatient admissions and enable earlier discharge from hospital. Community teams perform a range of functions including acute community assessment and treatment, assessments, treatment, support and case management to people living in the community. Community teams work with a range of people, from people in need of short-term acute intervention, to people requiring long-term case management and support. These elements may function as discrete services or are integrated into one or two service components, particularly in rural areas. In addition, 10 adult AMHS have a Forensic Clinical Specialist, who work to build forensic capacity and expertise within AMHS. The target group of the adult AMHS are adults with serious mental illness, such as psychotic disorders (such as schizophrenia), severe mood disorders, severe anxiety disorders and severe personality disorders.

The legislative framework sets out the objectives and principles of service delivery in the Mental Health Act. In short, the objectives of the adult AMHS are:

- > to assess and treat adults with a serious mental illness in a timely and effective way
- > to minimise the adverse effects of mental disorders on the individual and his/her family and community
- > to monitor and coordinate the provision of services to clients to ensure continuity of care in the least restrictive environment
- > to deliver a range of community and residential treatment and care programs on a continuous or intermittent basis
- > to undertake prevention activities and community education to increase public awareness and understanding of mental illness.

The Mental Health Act is currently under review.

AMHSs are staffed by multidisciplinary teams, which include clinicians from psychiatry, psychology, nursing, social work and occupational therapy, although the actual team composition and structure will vary from one AMHS to another. Multidisciplinary team members have a set of common core skills and a number of clinical tasks overlap, including case management responsibilities. Different disciplines also provide specialist assessment and treatment services specific to their training.

The first AMHS contact is often with the service's triage service where the mental health practitioner determines if the client requires specialist mental health intervention. A range of responses may be provided by the AMHS, including:

- > assessment (either urgent or non-urgent)
- > short-term treatment
- > continuing care.

Telephone advice may be given where the clinician makes an assessment that the person does not suffer from a mental illness or disorder requiring a response from AMHS. The clinician is responsible for providing advice to the referring service provider about the most appropriate course of action, or directly linking the client with a more appropriate service.

People who do not meet the criteria outlined in Section 8(1) (criteria for involuntary treatment) of the Mental Health Act are not compelled to attend an AMHS. Attendance is on a voluntary basis. Once the person has been accepted into the AMHS, he or she will generally be assigned a clinical case manager. The clinical case manager will coordinate the person's mental health treatment and care and will be the contact point for any enquiries about the person. Wherever possible, mental health clinicians will work collaboratively with other services involved with the person.

AMHS are able to provide a treatment response, where possible in partnership with the person's General Practitioner, using a range of evidence-based individual, family, and group interventions that are specific to the needs of the person.

The focus of treatment is on control of symptoms and optimising psychosocial recovery or adaptation, with a view to minimising impairment or disability. Two of the most common treatment modalities are medication and counselling/psychotherapy or a combination of both. A multidisciplinary and multi-systemic approach to care is often required to simultaneously address the biological, personal, family and social risk factors that may contribute to poor recovery from a mental health problem, enduring impairment or disability.

In many instances people with a serious mental illness will have a range of needs that extend beyond their need for core mental health treatments. Many people also require assistance with living skills, relationships and support networks, education or employment, housing and general health care. Referral to Psychiatric Disability Rehabilitation and Support Services (PDRSS) or mainstream community-based services may be required to provide additional support.

While each AMHS offers a comprehensive range of services it is recognised that, at times, more specialised statewide services are required. Some of these services include:

- > Victorian Institute of Forensic Mental Health (Forensicare), which provides assessment and ongoing treatment for people with significant offending and psychiatric histories.
- > Spectrum, the Personality Disorder Service for Victoria, located at Maroondah Hospital, which provides secondary consultation and some ongoing treatment for people with a severe personality disorder.
- > The Victorian Dual Disability Service, located at St Vincent's Hospital, provides secondary consultation to AMHS clinicians, for people with an intellectual disability and a mental illness.
- > Dual Diagnosis Teams, located at four lead agencies in metropolitan AMHS with established links to rural areas, providing training, secondary consultation and limited direct consultation for people with a dual diagnosis of drug and or alcohol abuse and mental illness, who are engaged with either AMHS or Alcohol and Drug Services.

2.2 Psychiatric Disability Rehabilitation Support Services (PDRSS) service system

The community managed PDRSS sector is a core component of specialist mental health services complementing clinical mental health services. PDRSS are managed by non-government organisations and focus on addressing the impact of mental illness on a person's daily activities and the social disadvantage resulting from illness. They work within a recovery and empowerment model to maximise people's opportunities to live successfully in the community.

Psychiatric disability support services are aimed at people with serious mental illness and associated significant psychiatric disability. Services cater primarily for people aged between 16 and 64 years. The precise eligibility criteria will depend on the type of service or program being offered. People receiving case management services from the public mental health service who are referred by the service are automatically eligible for support from the PDRSS.

Program streams include:

- > **Home-based outreach support (HBOS) (including intensive, moderate and standard levels of support)** – HBOS provides support to consumers living in their own homes, or other community residential settings. Training in social and living skills is provided in the person's home, with a focus on the activities and interactions of everyday life.
- > **Day programs** – rehabilitation day programs assist people with severe psychiatric disabilities to improve their quality of life, participate in everyday living activities, and function as independently as possible in the community. This may involve the development of social and living skills in a group context, through centre-based and community access programs.
- > **Care coordination** – care coordination works to support the mental health, wellbeing and long-term recovery with people with severe mental illness and multiple needs, by assisting them to access the range of health, community and social support services they need.
- > **Youth and adult residential rehabilitation services** – residential rehabilitation services provide intensive psychosocial rehabilitation and support in group accommodation preparatory to residents living independently in their own setting. Emphasis is placed on developing or regaining skills to enable each resident to deal with daily living activities, developing confidence to commence or continue schooling, training or employment, as well as supporting positive contact with their family and friends.
- > **Mutual support and self help (MSSH) programs** – MSSH services provide information and peer support to people with a mental illness and/or their carers. This can involve the sharing of experiences and coping strategies, the provision of information and referral services, and the promotion of community awareness.
- > **Planned respite services** – planned respite services provide a short-term change in environment for people with a mental illness and a break for carers, and include both formal and informal psychosocial rehabilitation components. Planned respite services may involve social and recreational day activities, including in-home support, holiday and adventure activities, and residential components.
- > **Support and accommodation services.**
- > **Other services, including funding for peak agencies.**

Further details and contact information of mental health services are located at: www.health.vic.gov.au/mentalhealth

2.3 Community Correctional Services: Service outline

Victoria's Community Correctional Services (CCS) was established in 1984. CCS plays a vital role in community safety by rehabilitating offenders and diverting low-risk offenders from jail in order to break the cycle of re-offending. It supervises adult offenders (aged 18 years or over) who are sentenced by the courts to serve community-based dispositions or who are conditionally released from prison on parole by the Adult Parole Board. Victoria's juvenile corrections management system is managed by the Victorian Department of Human Services.

CCS plays a vital role in community safety by rehabilitating offenders and diverting low offenders from jail, which helps to break the cycle of re-offending. The system actively engages offenders and the community to promote positive behaviour change.

Supervising Officers, manage offenders and are responsible for ensuring they comply with the conditions of the various courts or parole orders. These may include participating in appropriate educational programs, unpaid community work, assessment and treatment programs and drug and alcohol testing which are focused on rehabilitation while enabling offenders to make suitable reparation to the community.

There are more than 50 Community Correctional Services offices located throughout metropolitan and regional Victoria. See www.justice.vic.gov.au for more details.

CV, through OBP, deliver a range of clinical offending behaviour programs. It also consults with community agencies to:

- > identify programs that meet the particular needs of offenders and attempt to access these programs for offenders within the general community; and
- > CV designs programs to provide risk reduction, rehabilitation and harm minimisation opportunities where an agency provides the delivery of such programs.

CCS operates by way of a brokerage model to provide particular programs. These include the Community Offenders Advice and Treatment Service (COATS) program for drug and alcohol services, the contracting of urinalysis testing and the internal Sex Offender Program.

Each individual CCS location has staff with a different blend of experiences and backgrounds, generally from either a social welfare background or a legal studies/justice administration background. Each team is led by a Senior Community Corrections Officer (SCCO) who has the responsibility for the professional supervision and development of staff within his or her team. The SCCO reports to the Operations Manager.

CCS employs therapists within the Sex Offender Program and clinicians within the Offending Behaviour Programs and Disability Pathways stream of the Targeted Programs Branch. The key objective of this service is to reduce offending behaviour for medium to high-risk offenders through group work programs and limited individual therapy. The expertise of clinicians also enhances the role of the CCOs as case managers via case consultation and through specialist training development. Targeted programs clinicians are not available for crisis response work and have limited capacity for individual referrals, which need to specifically focus on needs that relate to offending behaviours.

When offenders present with mental health issues, OBP clinicians may assist CCOs in referring offenders to appropriate services within the community. This can occur through informal consultation as well as a formal process known as Case Management Review Meeting (CMRM). Crisis management (such as dealing with suicidal or psychotic clients) is responsibility of the Case manager (CM) and can occur in consultation with OBP. Similarly, referral to AMHS is co-ordinated by the CM. There are a number of paths to such a referral, including initial court assessment, the development of individual management plans or when treatment becomes necessary through the course of the order. CMs have historically managed and undertaken this dimension of work, supported by appropriate training.

CMs conduct general pre-sentence report assessments as requested by the courts and may be directed to organise a psychiatric/psychological assessment by an external health professional. They can also direct offenders to undergo medical, psychological or psychiatric assessment. This can include attendance at Forensicare-Community Forensic Mental Health Service for assessment and treatment.

This role includes gathering information about the offenders life circumstances/relationships, offending history, physical/emotional health and social wellbeing, and the degree of social connectedness in their family, peer groups and broader community.

Such an assessment also includes careful screening for risk, mental health problems and alcohol and other drug issues. When an offender with moderate to high-risk needs in the area of general offending commences a community-based disposition they are referred to CCS Clinical Services. Depending on the primary needs of the offender, the clinician determines whether or not a psychological and/or program assessment is required. The clinician may also determine that a referral to an external agency (for example, AMHS or Forensicare) is appropriate.

CMs provide progress reports to the APB for those offenders on parole orders. These reports can include considerations relating to how well the offender has responded to any external treatment, counselling or programs for mental health. CMs also report to the APB on any relevant mental health issues arising for all offenders in the course of their parole period. There are three instruments used by the CCS non-clinical staff to assist with the identification of potential issues and for planning: the Victorian Intervention Screening Assessment Tool (VISAT) and the Suicide Assessment Checklist.

A CCS assessment may not indicate any mental health problems, however for some people symptoms may emerge or be more apparent later. In these cases, referral for a further assessment, following consultation with the supervisor, is the appropriate action.

APPENDIX 3: FURTHER INFORMATION

3.1 Community Correctional Services

Information about Community Correctional Services is available at:

www.justice.vic.gov.au

3.2 Mental Health, Drugs and Regions Division

Information about the Victorian mental health services is available at:

www.health.vic.gov.au/mentalhealth

This website provides up-to-date contact details of all public mental health services across Victoria and information about mental health and mental illness, including treatments and consumer rights.

3.3 Primary Care Services

Information about primary care services is available at:

www.betterhealth.vic.gov.au

www.health.vic.gov.au/services

<http://pcp.serviceseeker.com.au/index.shtml>References

APPENDIX 4: REFERENCES

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