Martin Foley MP

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BAC-5498

Kate Sanderson
Coroner's Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Ms Sanderson

Court reference: COR 2017 5779

Thank you for your letter of 12 November 2019 regarding Acting Coroner Caitlin English's *Finding without inquest into the death of Tre Leigh Lawson*.

In her finding, Acting Coroner English recommended that the Forensic Mental Health Implementation Plan and corresponding Mental Health Advice and Response Service be expanded to operate in regional areas that have been identified with high rates of indigenous suicide, in particular, to the Mildura Magistrates' Court.

A combination and expansion of the Mental Health Court Liaison Service and the Community Correctional Services Mental Health Court Advice Service, the Mental Health Advice and Response Service facilitates mental health assessment and treatment responses for people involved in the justice system, often at a critical point in their lives.

The Department of Health and Human Services and the Department of Justice and Community Safety has worked in partnership with the Victorian Institute of Forensic Mental Health, Forensicare, along with five local area mental health services in Geelong, Bendigo, Latrobe, Goulburn Valley and Ballarat to deliver the Mental Health Advice and Response Service at 13 Magistrates' Court of Victoria locations across the state.

The Mental Health Advice and Response Service is a valuable service, but we know that more broadly our mental health system is failing Victorians. Every year, one in five Victorians experience mental illness. Sadly, suicide is the leading cause of death for Australians aged 15–44 years and the annual suicide rate is about 40 per cent higher in rural and regional Victoria than in metropolitan Melbourne.

That is why we established the *Royal Commission into Victoria's Mental Health System*. The Royal Commission is a once in a generation opportunity to find out what's working and what's not. It will give us the answers we need, so we can build a coordinated, quality mental health system that supports Victorians and their families when they need it most.

On 28 November 2019, the Royal Commission released its interim report, which contains nine priority recommendations that address immediate needs and lay the foundations for a new approach to mental health. Some of these recommendations address suicide prevention and Aboriginal social and emotional wellbeing.

The Royal Commission has recommended an expansion of follow-up care and support for people after a suicide attempt through the Hospital Outreach Post-suicidal Engagement (HOPE) program, including to Mildura. It also recommended the state-wide roll out of Aboriginal social and emotional wellbeing teams, supported by a new Aboriginal Social and Emotional Wellbeing Centre.

The important work of the Royal Commission continues through 2020 and will consider in detail issues relating to people living with mental illness and the forensic mental health system and the criminal justice system.

I am proud to say that the Victorian Government is committed to implementing each and every one of the Royal Commission's recommendations. This will include those related to forensic mental health in its final report, due to be delivered by 31 October 2020.

Thank you again for writing to me about this important matter.

Yours sincerely

Martin Foley MP
Minister for Mental Health

9 /12 /2019