IN THE CORONERS COURT OF VICTORIA
AT MELBOURNE

IN THE MATTER OF:
INQUEST INTO THE DEATH OF BRENT REKER **COR 2019 006797**

RESPONSE TO RECOMMENDATIONS

Date of document: 14 October 2025
Filed on behalf of: GEO Group
Prepared by:
Hall & Wilcox
Level 31, Queen & Collins Tower
376-390 Collins Street
MELBOURNE VIC 3000

[redacted]

1. GEO Group Australia (GEO) welcomes the opportunity to respond to the recommendations made by the Coroner in his finding dated 4 July 2025.

Summary of this response

2. Recommendation 1 is directed at the Secretary to the Department of Justice and Community Safety. GEO supports in particular the recommendation in sub-paragraph (a). As set out in its response to recommendation 2, GEO is comfortable that its training provided to custodial supervisors and custodial officers is already achieving the requirements of sub-paragraph (b).

3. Recommendation 2 is directed to GEO, and is the focus of these submissions. GEO supports recommendation 2 and it has reviewed its systems and procedures and considers that it achieving aims of this recommendation. Attached to this response is a copy of the following supporting documents:

   (a) 2023 SASH Presentation to New Recruits;

   (b) Separation Assessment form;

   (c) Moroka Program Joint Operations Manual.

4. Recommendation 3 is also directed at the Secretary to the Department of Justice and Community Safety. GEO notes that management cells are used not only for patients with a high SASH risk and there are competing issues, such as in relation to privacy, when considering installation of cameras in all such cells. The Ravenhall Correctional Centre currently has 16 Observation cells ('safe cells')

which are predominantly used for prisoners with SASH risks of S1 or S2 and have CCTV installed. Further to this, 10 cells in the Forbes Management Unit have cameras in regular cells.

5. Recommendation 4 is also directed at the Secretary to the Department of Justice and Community Safety. GEO supports recommendation 4. Since Mr Reker's passing, such cameras have been made available at Ravenhall and custodial staff have been trained in their use.

Response to recommendation 2

That, in order to promote an increased awareness by custodial managers and custodial officers of the essential details of previous episodes of suicidal or self-harming behaviour by a prisoner, and to prominently convey meaningful context associated with a SASH rating, GEO Group Australia Pty Ltd:

(a) review the manner in which the details of previous episodes of suicidal or self-harming behaviour are contained in GEO prisoner information systems with the aim of making this information more prominent in an operational setting; and

(b) review its training of custodial supervisors and custodial officers to reinforce the need for a thorough examination of prisoner information relating to any SASH rating, in order to properly inform prisoner assessment processes and relevant operational decisions concerning the prisoner.

6. The Ravenhall Group Operations Manager and Acting National Health Services Manager have reviewed the Coroner's recommendations and considered if practice could be improved or has improved since Mr Reker's unfortunate death.

Sub-paragraph (a)

7. In early 2021, a Separation Assessment Model was introduced after a prolonged and in depth development process.

8. When men at Ravenhall are separated, they go through a thorough Separation Assessment before being transferred to ensure all potential risks and any risk history is known to all staff and this information is handed over to the staff receiving the man. This assessment highlights any past self-harm behaviour or incidents so staff can be made aware of the potential for this to occur. This separation assessment is completed by both custodial and clinical staff to ensure all relevant information is considered so we can then ensure we are managing these risks appropriately.

9. A prisoner's separation assessment document is uploaded to the prison 'Gateway system', where it is available for all staff to access and view.

10. The Moroka Program Joint Operations manual (February 2024) includes the factors, such as a prisoner's history and triggers, to be considered in the approach to suicide and self-harm risk assessment and management and the documentation of any atypical risk management plan. It also sets out the requirement for a suicide assessment for men being transferred from Moroka to Forbes to ensure they are adequately assessed upon transfer. This includes the requirement that staff at the receiving unit receive a handover about the prisoner, including SASH and IPV risk prior

to the move being actioned. This should be undertaken through the Transfer Case Management Review Committee process.

11. In relation to the transfer of prisoners from the Moroka program, a Consultant Psychiatrist will review this move prior to the move being implemented.

Sub-paragraph (b)

12. GEO has reviewed both the training given to custodial staff and the refreshers training that is delivered, and believes it is sufficient to ensure that staff know and can adequately identify any potential SASH risks for the men in our care. It also sets out the At Risk Process if someone does identify a prisoner at risk. A copy of the SASH presentation for new recruits is provided with this response.

13. The Ravenhall Operations Manager and Director of Health Services have reviewed the SASH training provided at Ravenhall and are comfortable with the present training for identifying and management of a prisoner with these risks.

14. In relation to transfers from any of the FMH units to a regular unit, all staff have been made aware of the process which is managed by Forensicare and the unit Custodial Supervisor, as follows:

- a weekly clinical review of prisoners on FMH;
- receiving units are communicated with all risks;
- Case Management Review Committee (CMRC) is convened with clinical Forensicare custodial representatives to discuss and consider the risks which include both recent and historical SASH risks;
- Corrections Victoria Sentence Management department advised of the outcomes to CMRC;
- prisoner transferred.

Conclusion

15. GEO thanks the Coroner for the opportunity to respond to the recommendations, and again expresses its sympathy to and acknowledges the loss felt by Mr Reker's family and friends.

Hall & Wilcox

……..

Hall & Wilcox

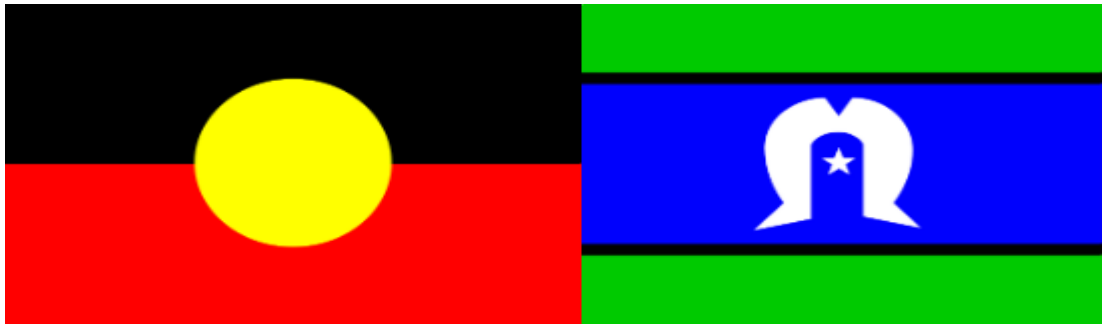
Solicitors for GEO

Forensicare

Suicide & Self Harm Prevention Training

Acknowledgement to Country.

We would like to acknowledge the Traditional Owners on the land of which we stand here today. We pay our respects to Elders from all nations here today—and to their Elders past, present and emerging.



Forensicare

Statement of Lived Experience

We recognise and value the knowledge and wisdom of people with a lived experience of mental ill health, their families, and supporters.

We celebrate their strengths in facing the challenges associated with Recovery and include the voice of Consumers and Carers in the development, delivery and evaluation of Forensicare Services and Care.

LIVED EXPERIENCE
WORKFORCE

Safe Space Statement

We would like to recognise that all of us are here because we want to create a workplace that is respectful, accountable, and safe for everyone.

To make sure we achieve this together, I want to declare this meeting as a safe place – a space where participants are respectful of one another, can be open and honest and can put forward ideas and feedback without fear of reprisal.

Support Services

Mental Health Services and Support

Beyond Blue

24/7 mental health support service

1300 22 4636
beyondblue.org.au

headspace

Online support and counselling to young people aged 12 to 25

1800 650 890
(9am-1am daily, AEDT.)

For webchat, visit:
headspace.org.au/eheadspace

Kids Helpline

24/7 crisis support and suicide prevention services for children and young people aged 5 to 25

1800 55 1800
kidshelpline.com.au

1800 RESPECT

24/7 support for people impacted by sexual assault, domestic violence and abuse

1800 737 732
1800respect.org.au

Lifeline

24/7 crisis support and suicide prevention services

13 11 14
lifeline.org.au

Suicide Call Back

24/7 crisis support and counselling service for people affected by suicide

1300 659 467
suicidecallbackservice.org.au

Mensline

24/7 counselling service for men

1300 78 99 78
mensline.org.au

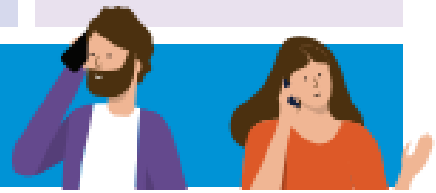
QLife

LGBTI peer support and referral

1800 184 527
(6pm - 10pm daily)

qlife.org.au
(online chat 3pm - 12am local time, including over holidays.)

If you are concerned about someone at risk of immediate harm, call 000 or go to your nearest hospital emergency department.



icare

Support services for Aboriginal and Torres Strait Islander peoples

- 13Yarn 13 92 76
- eheadspace provides free online and telephone support and counselling to young people 12 – 25 and their families and friends, including fortnightly yarn circles.
- The National Indigenous Postvention Service – After Suicide Support 24/7 1800 805 801
- Brother to brother 24-hour crisis line 1800 435 799

The Cent
Aborigin
Suicide P

Forensicare

Support services for Aboriginal and Torres Strait Islander peoples

- The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP) is Australia's leading authority on Indigenous suicide. The Centre promotes evidence-based suicide prevention practice that empowers individuals, families, and communities and respects their culture.
- WellMob brings together online resources made by and for our mob. Here you will find websites, apps, podcasts, videos, helplines, social media, and online programs all with a focus on social and emotional wellbeing.

Employee Wellbeing Program

Provide free and confidential counselling

Contact details:

1300 687 327 (1300 OUR EAP)

Converge international

Forensicare

Learning Objectives

- To identify prisoners at risk of suicide or self-harm
- Effectively communicate with an "At Risk" prisoner
- Manage 'At Risk' prisoners according to relevant Operational Instructions
- Complete an 'At Risk' assessment referral form
- Roles and responsibilities on discovering a death in custody
- Identify ways to maintain your health and wellbeing

Forensicare

Session 1

Understanding Suicide & Self-Harm

Forensicare

Who we are: Forensicare
Leadership in treatment of mental disorders associated with criminal behaviours

Thomas Embling Hospital

- High security
- 134 beds
- 8 units

2024
Completion
Of 82 bed
expansion project

Prisons

- DPFC
- MAP
- MRC
- PPP
- Ravenhall

Community Services

- Court Liaison MHARS
- CTT, NCSO, CIP
- PBP
- VFTAC
- FCS Program
- Youth Justice Services
- Court Reports & Risk Assessments

Research and Education

- Swinburne

Forensicare

Quiz

Quiz Questions	True/ False
1. Suicide is the leading cause of death for people aged 15 – 44 years in Australia?	True
2. People who take their own lives are selfish & weak?	False
3. Aboriginal & Torres Strait Islanders and young LGBTQIA+ people have higher rates of suicide?	True
4. Self-harm a risk factor of suicide?	True
5. Only seniors or supervisors can complete an “AT Risk” referral for a prisoner?	False
6. S2 prisoners must be reviewed by RRT/HRAT every 3 days?	False
7. The quality of staff-prisoner relationships is critical in reducing prisoner stress levels and increases the likelihood that they will trust staff to disclose when they are not coping	True
8. Talking to people about their suicidal thoughts will increase their risk of acting out these thoughts?	False

No script of what to say…

- Talking to someone about suicide will NOT increase suicide risk.
- Empathy and positive interactions.
- Invitation to suicidal person to tell their story.
- Can provide validation, connection, hope and show you want to understand
- "What can I do to help?"

Forensicare

Talking About Suicide Respectfully

Problematic	Preferred
Committed Suicide	Died By Suicide
Successful Suicide	Suicided
Completed Suicide	Ended his/her life or Took his/her life
Failed Attempt	Suicide attempt
Unsuccessful Attempt	Attempted Suicide/ Attempted to end his/her life

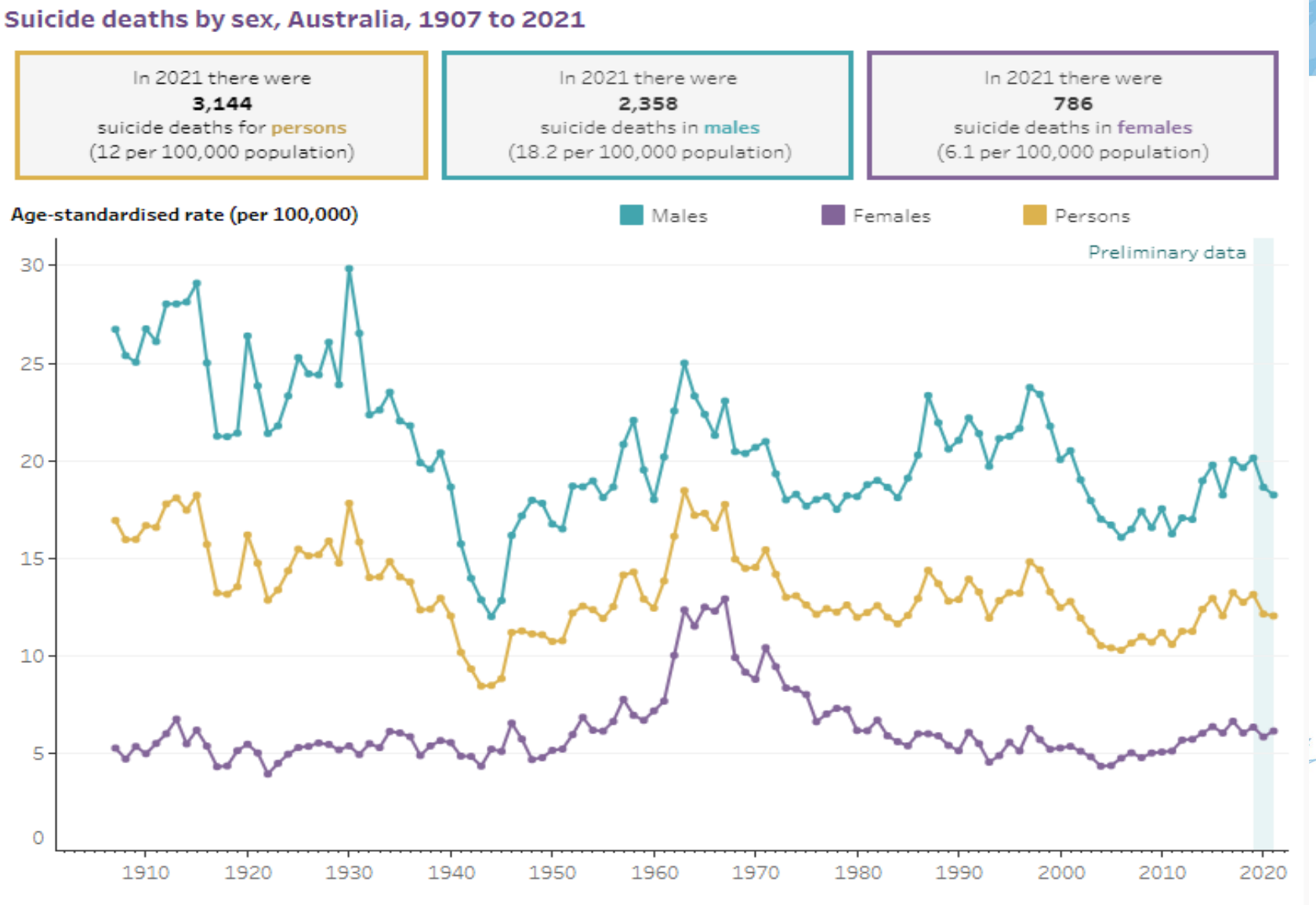
The Coroner

The Coroner needs to determine three criteria for a death to be a suicide:

- **Unnatural**
- **Self inflicted**
- **Intent to die**

Forensicare

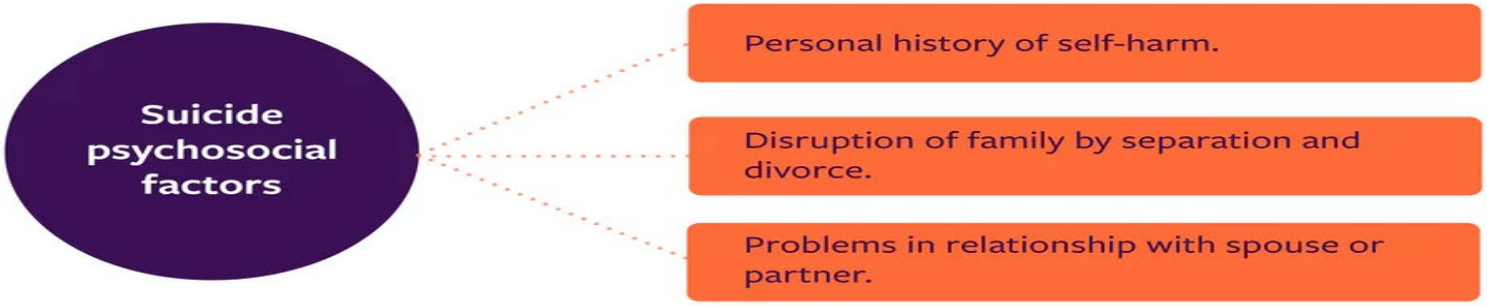
Statistics – Australia



Statistics – Australia

Psychosocial factors summary

Top three psychosocial factors (across all age groups).



All data sourced from the Australian Bureau of Statistics (ABS) Causes of Death data, on 23.10.20. 2019 total occurrences. Factors can be co-occurring.

Aboriginal and Torres Strait Islander People in the Community

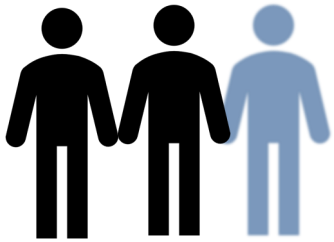
Mindframe National Media Priority Population Groups
Identifying the prevalence and predictors of suicidal behaviours for indigenous ales in custody. Shepard et al. 2018

Aboriginal and Torres Strait Islander people are 2x more likely to take their own lives compared to general population.

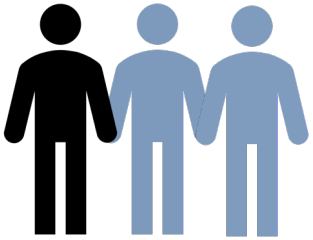
1 in 18 Aboriginal and Torres Strait Islander people die from suicide*
Suicide is leading cause of death for Aboriginal and Torres Strait Islander children (5-17 years old)

Aboriginal and Torres Strait Islander People in Custody

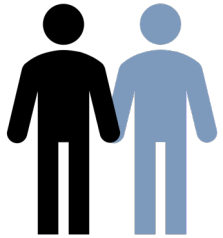
Mindframe National Media Priority Population Groups
Identifying the prevalence and predictors of suicidal behaviours for indigenous ales in custody. Shepard et al. 2018



Thought about suicide in their lifetime



Thought about suicide - past 12 months



Attempted suicide (typically in the community)

Aboriginal and Torres Strait Islander People in the Community

Mindframe National Media Priority Population Groups
Identifying the prevalence and predictors of suicidal behaviours for indigenous ales in custody. Shepard et al. 2018

Risk Factors

- Transgenerational feelings of loss and grief
- Trauma
- Separation from culture
- Racism and discrimination
- Social disadvantage
- Mental illness
- Substance abuse

Aboriginal and Torres Strait Islander

Aboriginal and Torres Strait Islander people are

13 times more likely

to be incarcerated than non-Indigenous Australians[1]

Although we make up just 3% of the Australian population, Aboriginal and Torres Strait Islander people account for:

27% of the adult prison population

34% of the adult female prison population

55% of young people held in detention

Forensicare

Suicide within priority populations

Mindframe National Media Priority Population Groups

LGBTQIA+ Populations

- Increased rates of mental illness, self-harm & suicide attempts
- Suicide attempts have been found to be **2.5 times higher**
- Elevated risk more associated with bullying, discrimination and negative responses from others.

Migrant & Refugee Communities

- People born overseas account for 25.1 % of all suicides in Australia.
- Rates are higher in people born in countries that have higher suicide rates (notably, English-speaking countries, countries from western, northern and eastern Europe)

Understanding why people suicide

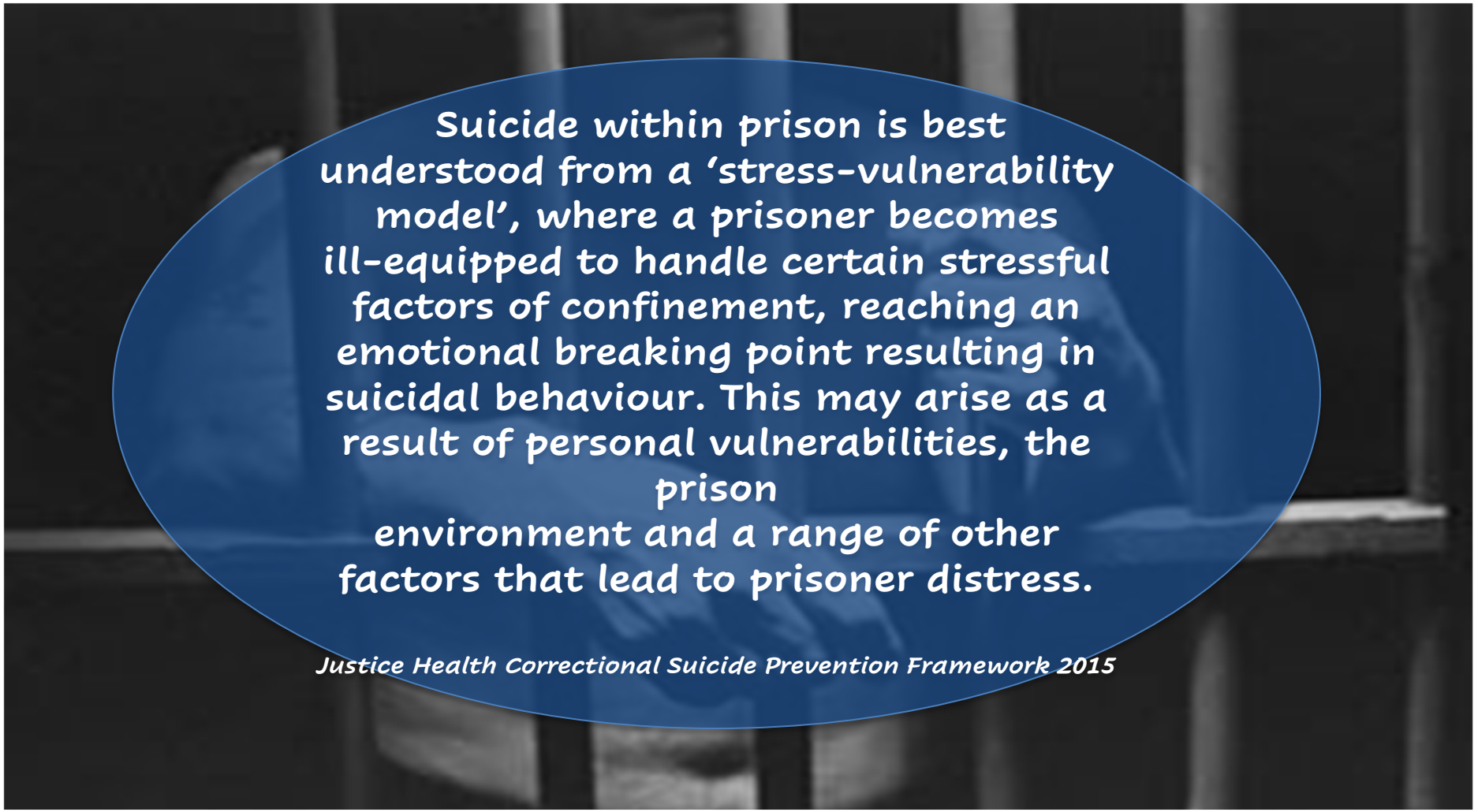
- Why do you think people suicide?
- Do you think this is any different for people in prison?

Forensicare

Suicide in prisons…

- Incarcerated individuals have a higher rate of suicide than their counterparts in the general community.
- Rates typically **three to five times** those of the general community.
- Offenders enter the prison system with more risk factors for suicide than those that apply to members of the general community and remain at elevated risk of suicide following their release

Suicide in prison

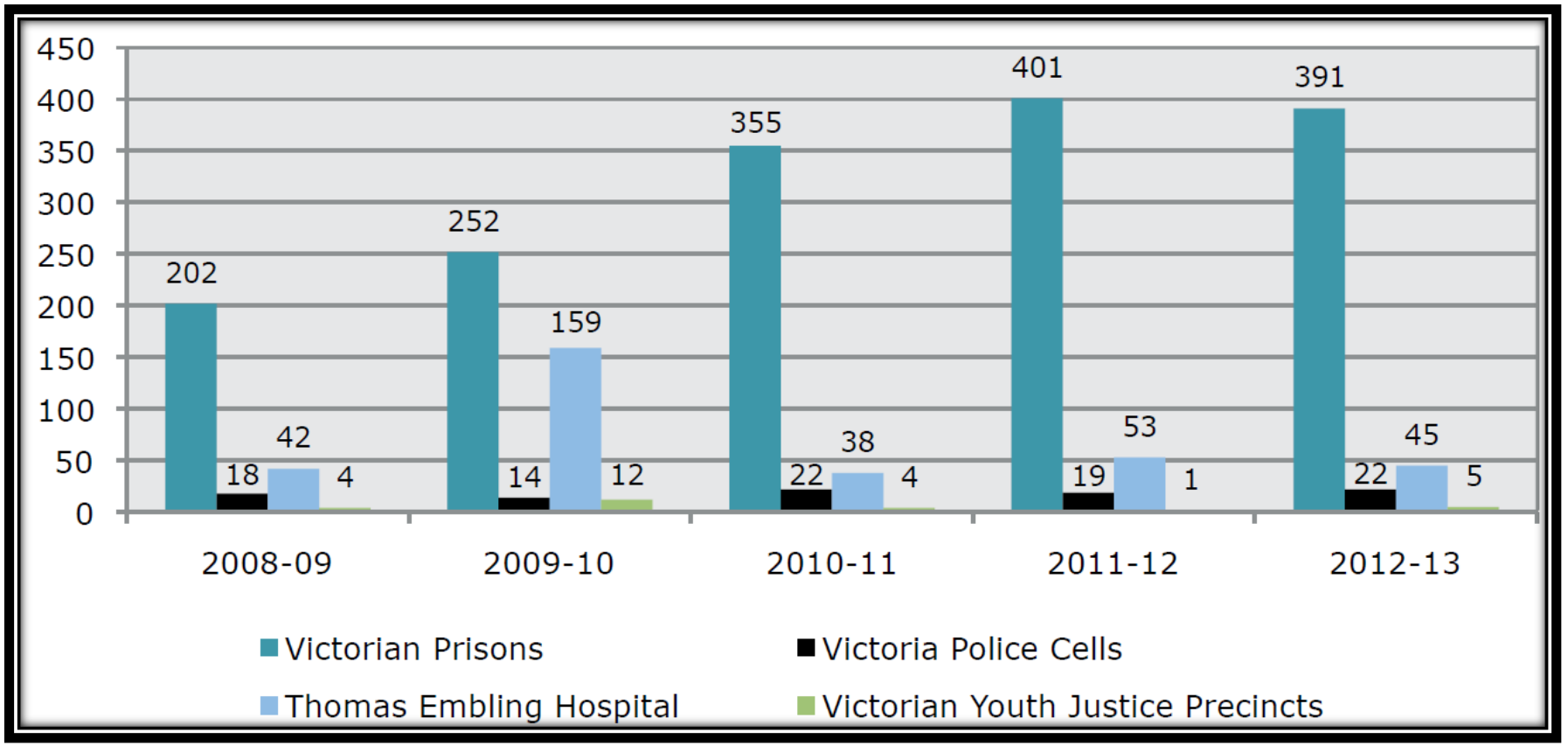


Suicide within prison is best understood from a 'stress-vulnerability model', where a prisoner becomes ill-equipped to handle certain stressful factors of confinement, reaching an emotional breaking point resulting in suicidal behaviour. This may arise as a result of personal vulnerabilities, the prison environment and a range of other factors that lead to prisoner distress.

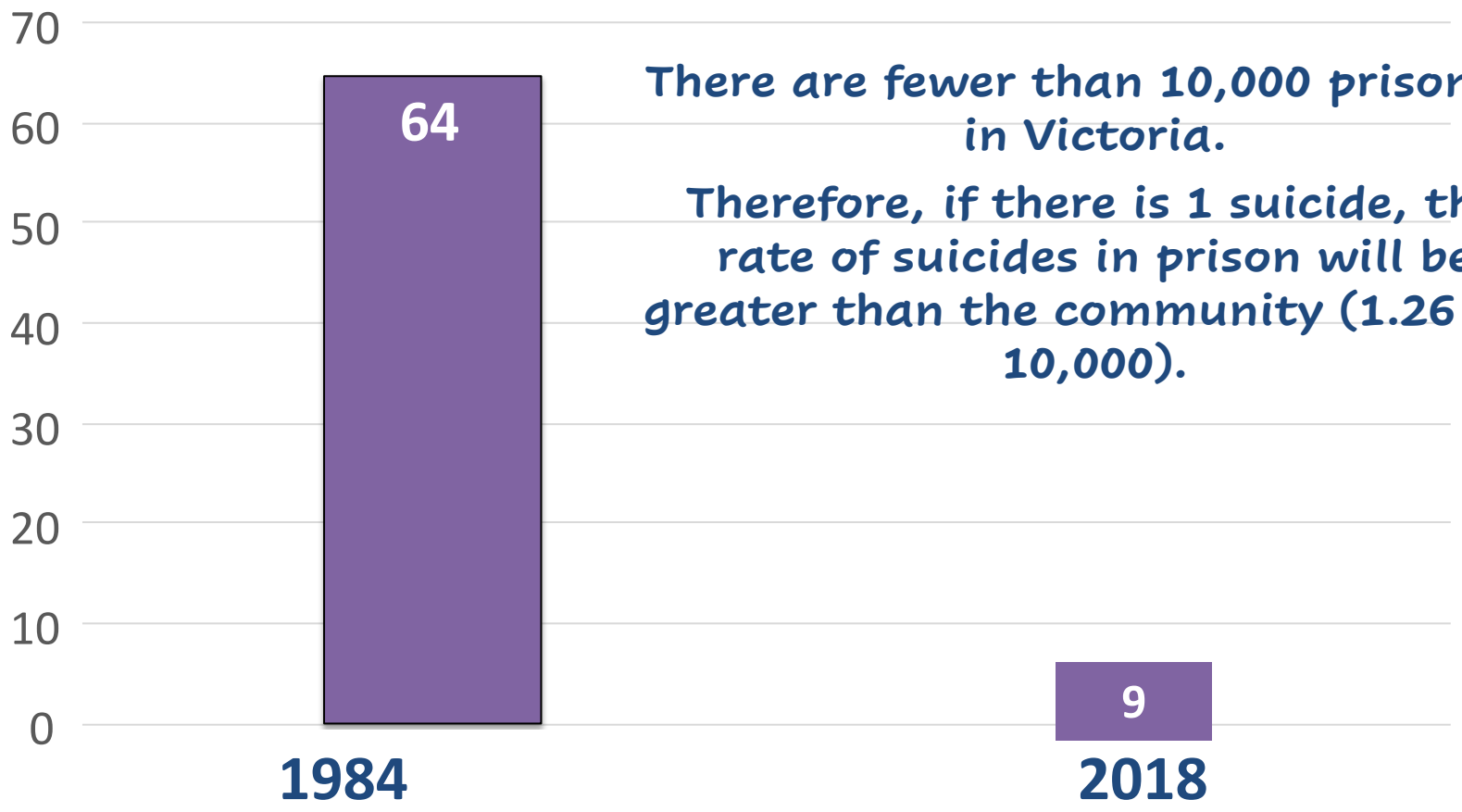
Justice Health Correctional Suicide Prevention Framework 2015

Reported Incidents of Self-Harm & Attempted Suicide in Victorian Custodial Facilities 2008 – 2013

Victorian Ombudsman Report Investigations into deaths and harm in Custody 2014



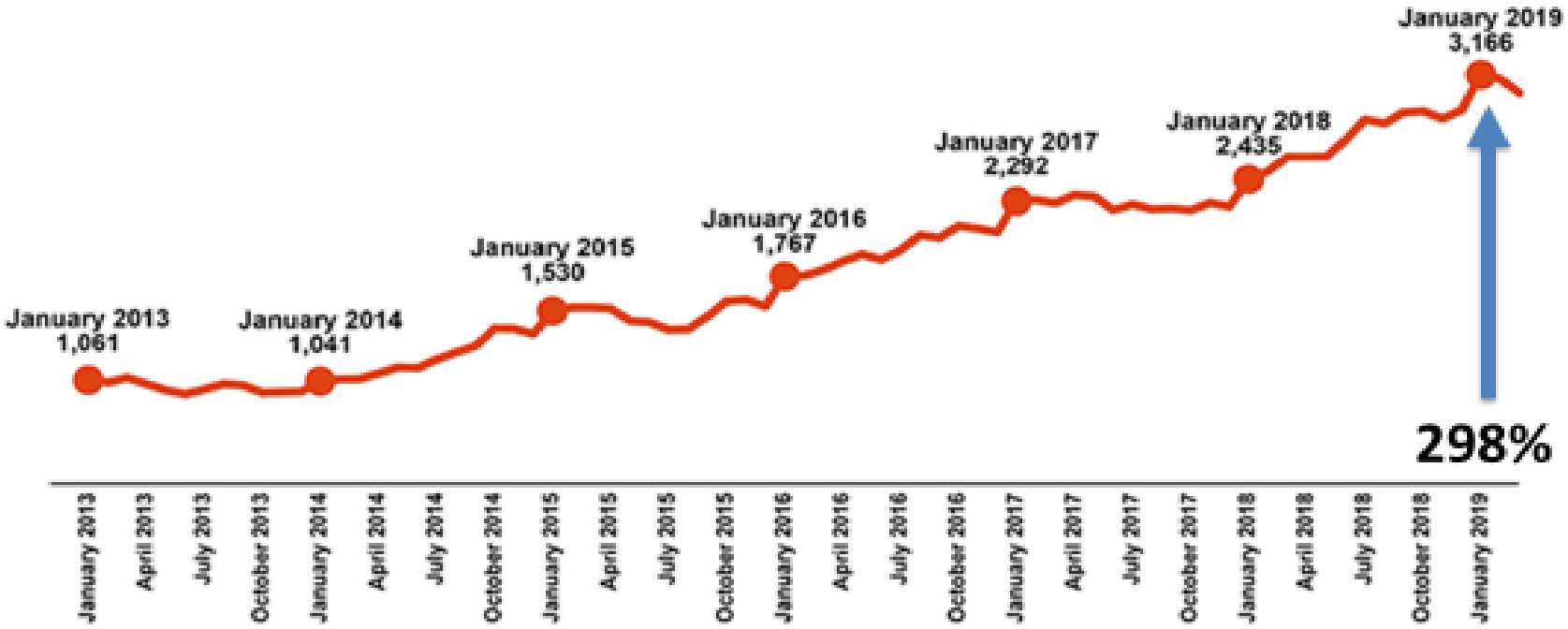
Rate of Victorian Prisoner Suicides 1984 -2018 Per 10,000 prisoners



There are fewer than 10,000 prisoners in Victoria.

Therefore, if there is 1 suicide, the rate of suicides in prison will be greater than the community (1.26 per 10,000).

Increasing Remand Population



Source: Corrections Victoria, *Monthly Prisoner and Offender Statistics*

Snap Shot of Victorian Prisons
10th September 2019

Total No. of prisoners in Vic: 7925

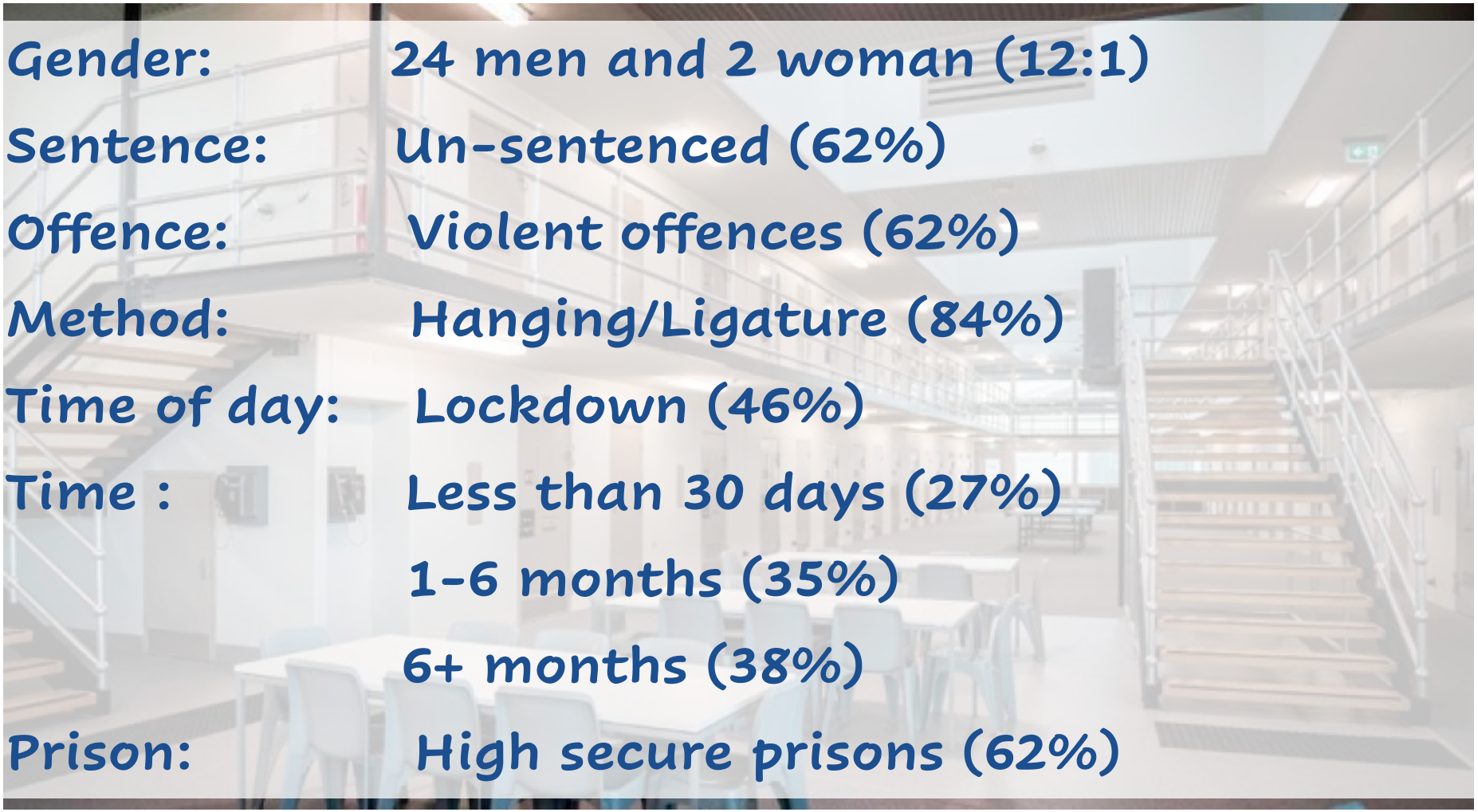
No of S rated prisoners 4359 (55%)

- S1- Immediate Risk 5
- S2 - Significant Risk 11
- S3 - Potential Risk 64
- S4 - Previous Risk 4279

No of P rated prisoners 3349 (42%)

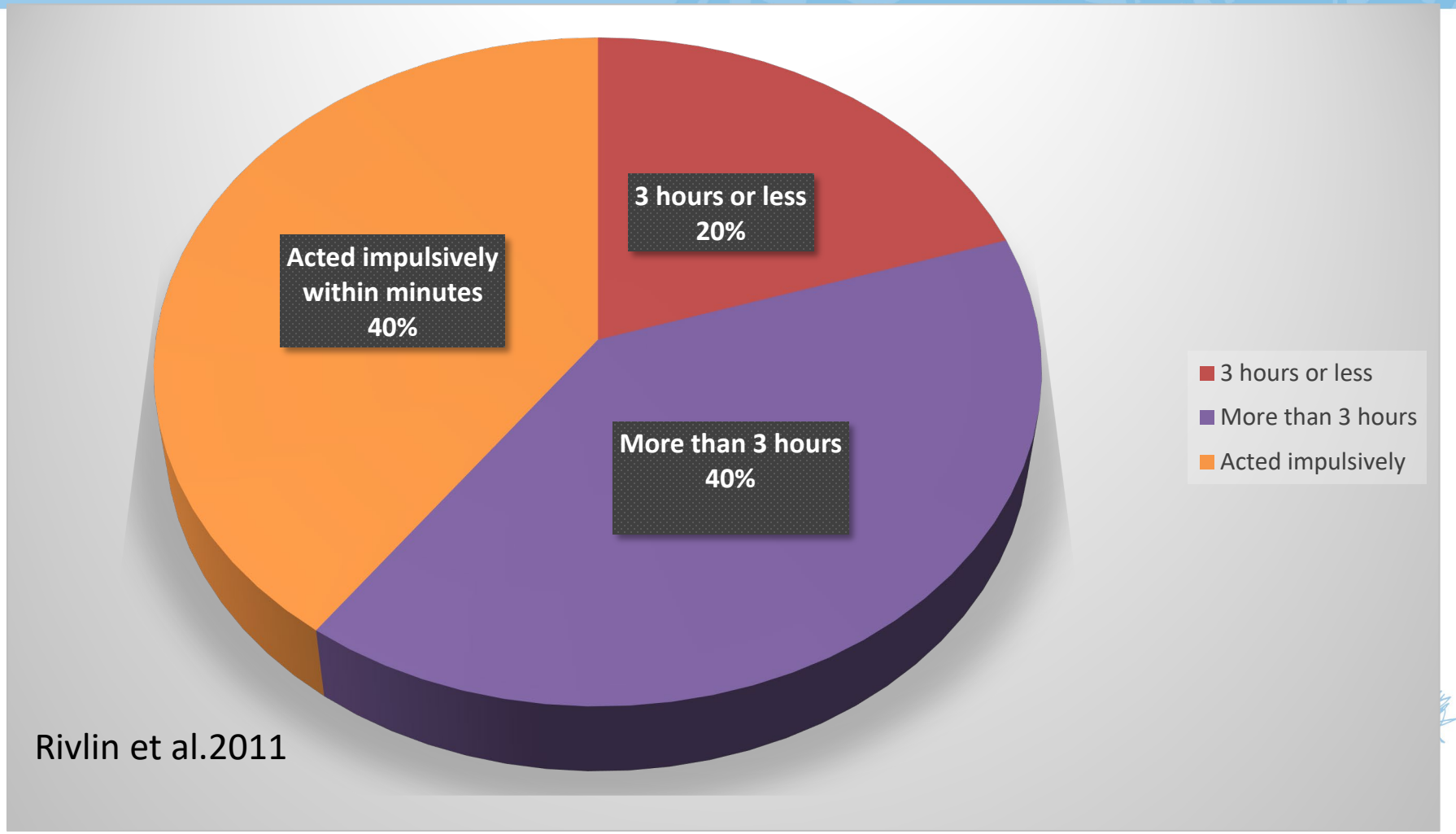
- P1 - Serious psychiatric condition /immediate care 130
- P2 - Significant /ongoing psychiatric condition requiring treatment 402
- P3 - Stable psychiatric condition requiring continuing treatment 2817

Patterns of Custodial Suicides 2009 - 2019



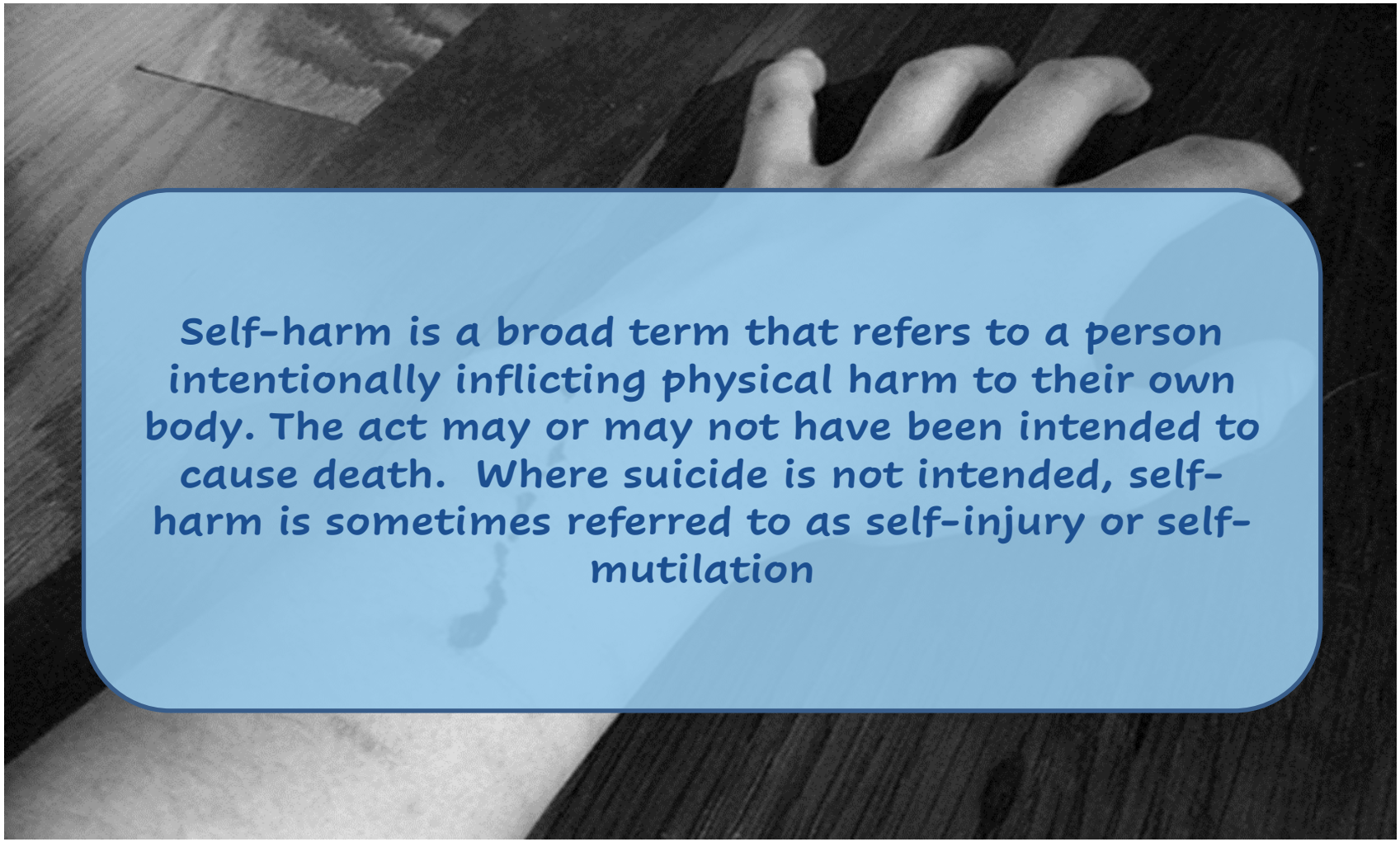
Gender:	24 men and 2 woman (12:1)
Sentence:	Un-sentenced (62%)
Offence:	Violent offences (62%)
Method:	Hanging/Ligature (84%)
Time of day:	Lockdown (46%)
Time :	Less than 30 days (27%)
	1-6 months (35%)
	6+ months (38%)
Prison:	High secure prisons (62%)

Time Lapse Between Suicide Ideation and Suicide



Rivlin et al.2011

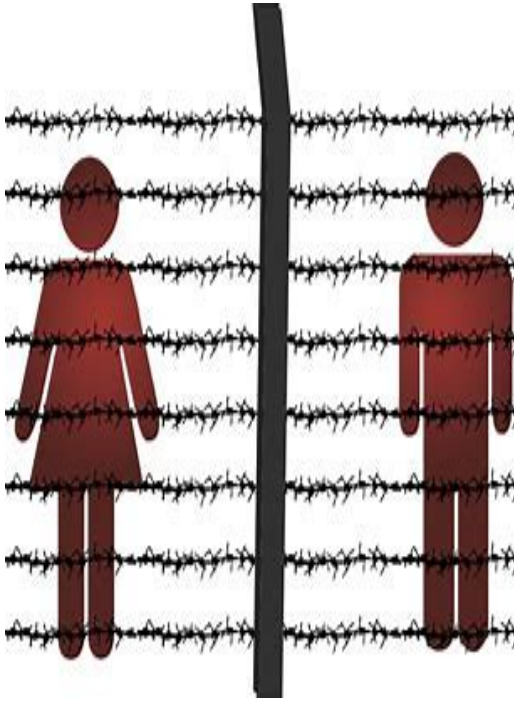
Deliberate or intentional self-harm terminology



Self-harm is a broad term that refers to a person intentionally inflicting physical harm to their own body. The act may or may not have been intended to cause death. Where suicide is not intended, self-harm is sometimes referred to as self-injury or self-mutilation

Understanding Self Harm

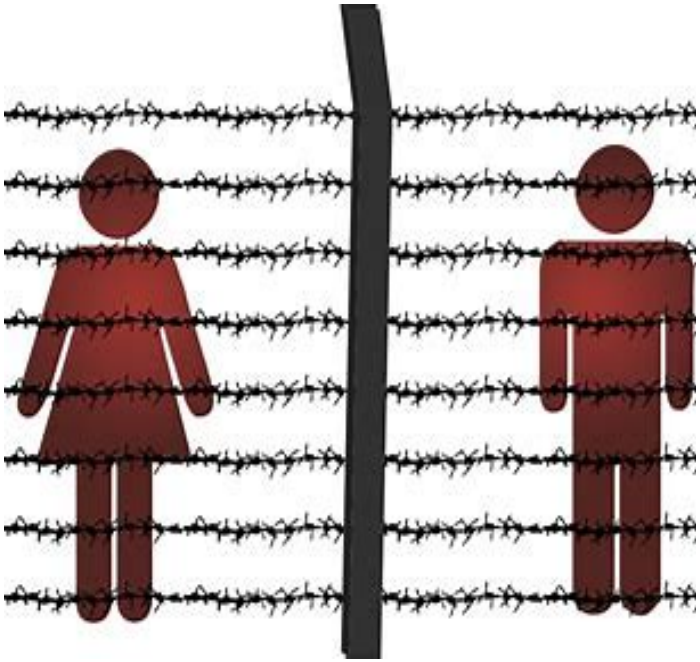
- Typically involves cutting, bruising, burning, head banging, biting.
- Usually occurs in private.
- A response to intense emotional pain.
- Lack of alternative coping strategies.
- Can be addictive.
- Usually preceded by a 'triggering' event
- Prisoners may use self-harm to meet their needs.
- Is associated with an increased suicide risk (death by misadventure).



Forensicare

High Risk Groups

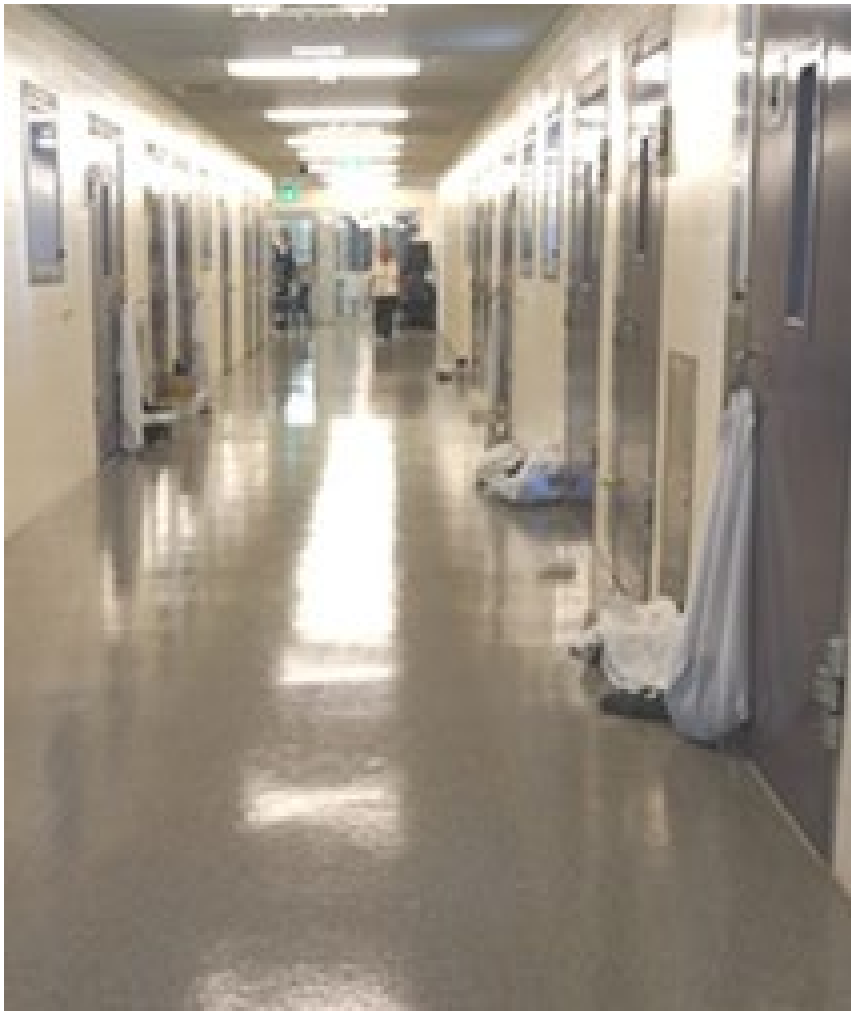
- Mental illness
- Borderline Personality Disorder
- Young woman
- Aboriginal and Torres Strait people
- LGBTQIA+ young people
- Custody



Forensicare

Female's in custody

- Higher rates of overall mental disorder
- Higher rates of PTSD (both historic and recent)
- Greater responsibilities in the community (e.g. children)
- Research has demonstrated high levels of trauma in persons with substance use disorders.
- PTSD associated with ongoing substance use, poorer health, self harm, and difficulties in emotional regulation.



Session 2

Duty of Care & Best Practice in Suicide Prevention

Forensicare

What Is Your Duty Of Care?

As an Officer, what are your roles and responsibilities in the management of an 'At Risk' prisoner?

Video activity

- Watch the Video and i**n small groups discuss:**

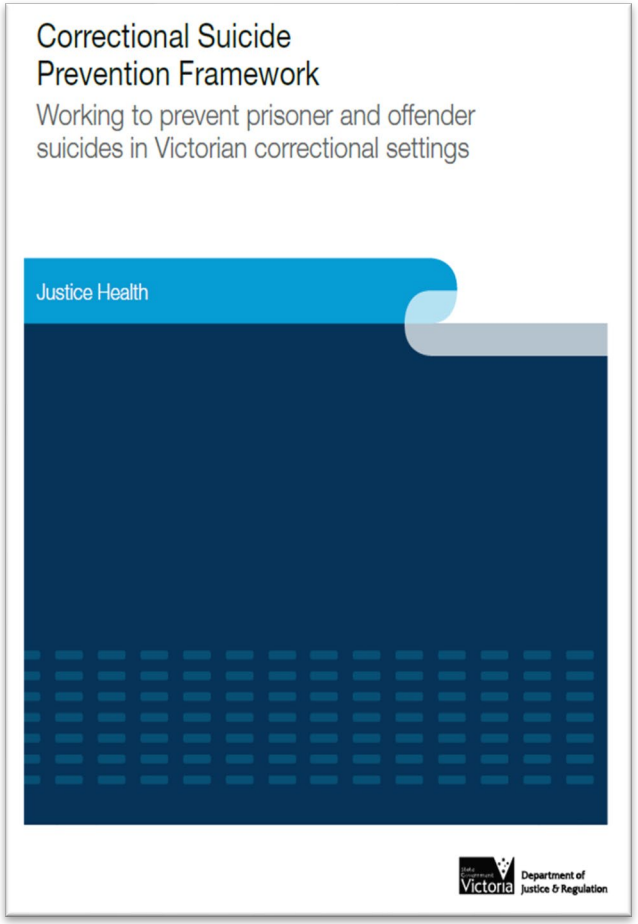
I. In your opinion did the officer display a duty of care towards the prisoner? Why or why not?

II. How do you think Smith felt being spoken to in that manner by the officer?

III. How would you have conducted the interview differently?

Forensicare

Best Practice: Suicide Prevention in prison settings



Correctional suicide prevention activities must:

- Do no harm
- Be therapeutic and not punitive
- **Staff must create *positive, responsive and supportive environments***
- Include compassion and understanding
- Use the least restrictive and intrusive responses
- Include professional treatment for crisis and recovery
- Meet management, security and therapeutic priorities

Muirhead/Observation cell

- The segregation strategy and the observation regime **do not reduce** the **longer-term risk** of suicidal behaviour.
- These strategies are in conflict with the principle, "do no harm", as they **may increase distress** for prisoners in crisis.
- Safe cells should be used for the **least amount of time required**.

Forensicare

Session 3

What Do I look for?

Identifying Prisoners 'At Risk'

Forensicare

Good Relationships and Support within Prisons are Essential to Reduce Risk of Suicide

Preventing Prison Suicide: Perspectives from the inside Howard League for Penal Reform and Centre for Mental Health 2016

Based on the evidence it is important that Officers get to know prisoners well early within their imprisonment to be able to identify behavioural changes and warning signs.

Forensicare

Risk Factors for Suicide

Beyondblue Risk factors for suicide

Prison Specific Risk Factors Increased Likelihood

- Segregation x 1.4
- High AOD abuse x 3.8
- Victimisation x 3.8
- Feelings of isolation x 5.2
- History of violence x 5.5
- Poor physical health x 5.8
- Serious Mental Illness x 7.4

Bryce E. Stoliker, February, 2018

Identifying suicide risk in prison

Risk factors can increase the ***likelihood*** of a prisoner taking their own life.

Risk factors can either be ***prison specific*** or related to the ***general population.***

Risk factors are classed as either:

- ***static, non- modifiable*** – These factors are unable to be changed
- ***'dynamic', 'modifiable' or 'situational' risk factors –*** These are stressors that can change over time.

Identifying suicide risk in prison

Tipping points include events such as relationship instability, approaching court dates

Warning signs are behavioural changes, thoughts or feelings that can provide 'clues' or 'red flags' about a persons risk of suicide.

Protective Factors

Protective factors are factors that may decrease the likelihood of suicidal behaviour and improve a prisoner's resilience to cope with stressful circumstances.

- Supportive social relationships
- Sense of social connection
- Spirituality
- Feeling safe and secure living environment
- Good physical and mental health
- Good communication skills
- Adaptive coping skills

Forensicare

Case Study Analysis

Turn to the case study in your booklets, in small groups, identify Alex Smith's:

- General and prison risk factors
- Warning signs
- Tipping points
- Protective factors

Forensicare

Case Study Analysis

Risk Factors Prison Specific

- Remand
- First Time
- Single cell placement
- Isolated
- Violent Offence

Risk Factors General

- Aboriginal
- Violent offence
- No access to child
- Family history of suicide
- History of mental illness
- Drug Use
- Self harm (scarring on knuckles)

Warning Signs

- Struggling to adjust
- Uncertain about future
- Disconnection from child

Tipping Points

- Pending court hearing/unsure of outcome

Protective Factors

- Connection with family
- Connection with Prison officer

Important

It cannot be assumed that a prisoner who is assessed as low risk or only has one risk factor is less likely to engage in suicidal behaviour than a prisoner with several risk factors. Must pay attention to warning signs.

Forensicare

Session 4

What do I Ask?

Communicating in an Effective & Understanding Manner

Forensicare

Video Activity

Watch the Video *"Working in an Effective & Understanding Manner "*

While watching the video Complete the 'At Risk' Assessment referral based on how Smith is presenting (*this referral will be discussed later in the training)*

Large Group Discussion Following the video

1. What are your thoughts about the way in which the Officer conducted the interview?

2. How do you think Smith felt being interviewed in this manner?

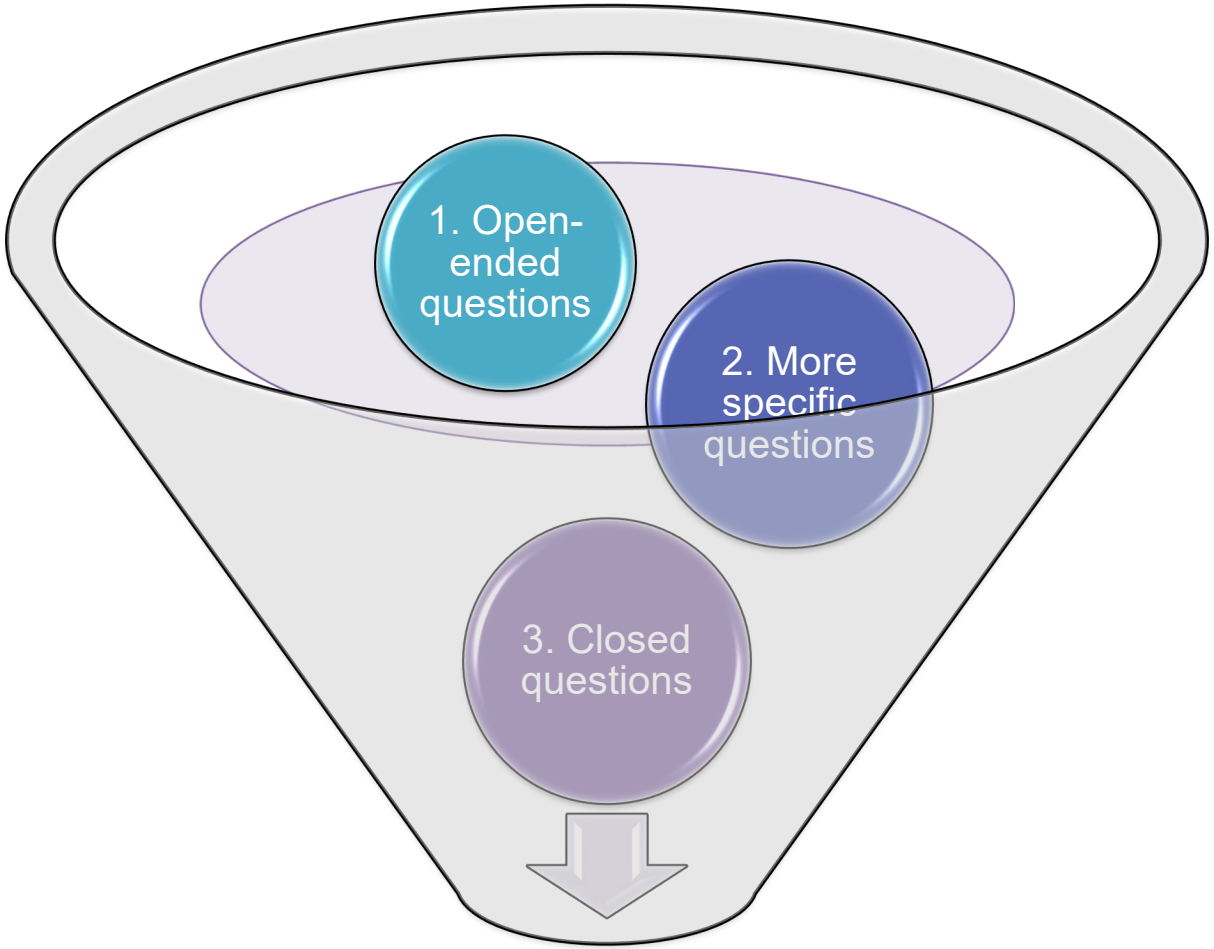
Forensicare

Engaging with a Prisoner 'At Risk'

PREFERRED
Begin with 'open ended' questions and move to more specific ones
Listen
Offer empathy
Be non-judgemental
Recognise warning signs
Help to identify supportive people
Build on a sense of hope

PROBLEMATIC
Don't be sworn to secrecy
Don't rely on 'guarantee of safety'
Don't be afraid to be direct
Don't ridicule
Don't act shocked
Don't minimise their concerns

'Funnel' Approach: Suicide & Self Harm Risk



Questions to Ask : Suicide and Self-Harm

Open-Ended Questions

"How are things going for you at the moment?"

"I have been feeling concerned about you lately..."

"I just wanted to check in with you because you haven't seemed yourself lately..."

"I know I haven't been your case manager long, but you look a bit down and I notice you keep to yourself, whats changed?"

More Specific Questions

"What was happening when you started feeling this way (e.g., sad, worried, angry)?"

"What do you mean when you say 'you're just not sure if there's any point'?"

"How long have you not been sleeping/eating/talking to anyone?"

"When did you start feeling like this?"

Closed Questions

*"Are you **thinking** about killing yourself?"*

*"Have you **planned** or rehearsed a way of hurting yourself?"*

*"Do you have specific **methods** in mind to harm yourself?*

*"Do you have the **means** to harm yourself?"*

*"Is there anyone or **anything that stops** you from carrying out plans to hurt yourself?"*

Role Play Activities – John & Youssef

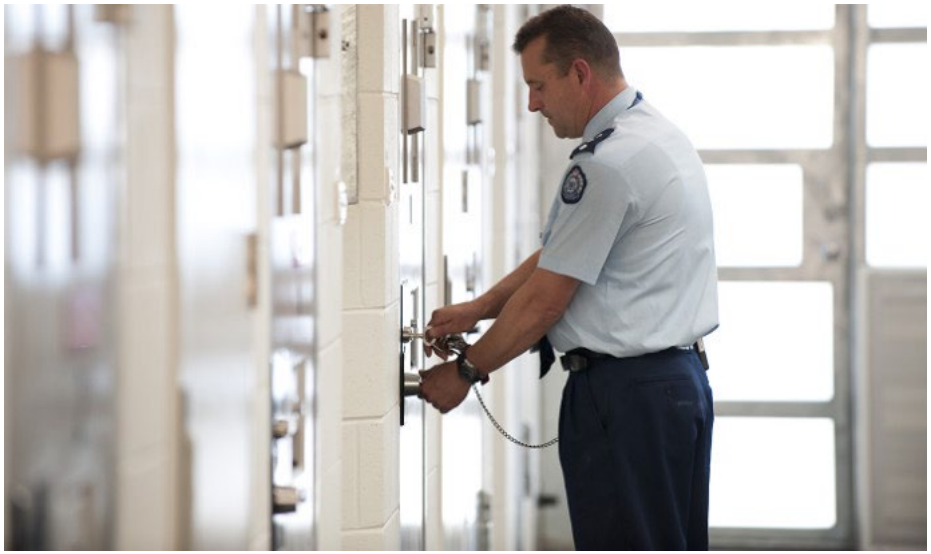
Participants please break into pairs.

The objective of this activity is about ***engaging in an effective and understanding manner.*** Listen and empathise with the prisoner, obtain as much information as possible, identify risk issues and practice asking, ***"Do you have thoughts of harming yourself or ending your life?"***

After the role play, provide constructive feedback to your partner – What worked and what didn't. Each role play to go for approx. 5 minutes.

Forensicare

John



You are conducting routine count of prisoners on the unit. You observe prisoner John crying in his cell.

Background Context

John had a visit today from his partner. His partner broke up with him. John has two children. John has also recently received an unexpected custodial sentence for aggravated assault.

Youssef

You are interviewing Yousef one of your case managed prisoners. During the interview you notice what appears to be self inflicted injuries to Yousef's wrists.
The wounds appear to be healing and superficial.

Background Context

Yousef is a first timer. He is struggling to adapt to the prison environment. Yousef says he misses his family and feels alone. Yousef is being stood over by other prisoners.

Think/Pair/Share….

Arrangements have been made to move Prisoner Finn (to another cell, unit, prison) at the time of his movement he states "If I get moved I'll kill myself" – ***does transfer go ahead?***

Background Context

Finn is not wishing to be moved because he is concerned about his safety of being assaulted by another prisoner.

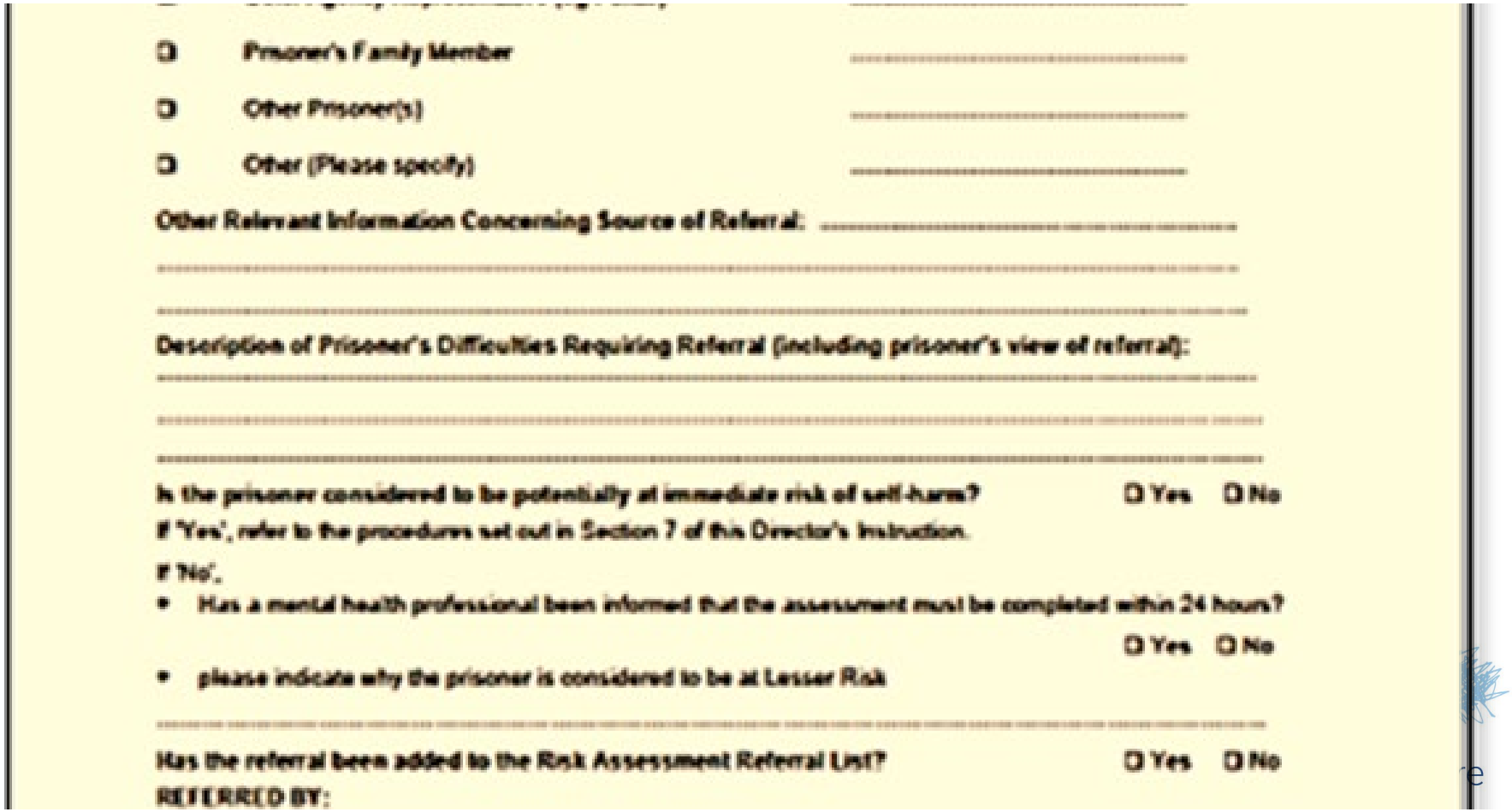
Session 5

What do I do?

Managing Prisoners 'At Risk'

Forensicare

At Risk Referral…



☐ Prisoner's Family Member .....

☐ Other Prisoner(s) .....

☐ Other (Please specify) .....

Other Relevant Information Concerning Source of Referral: .....

.....

.....

Description of Prisoner's Difficulties Requiring Referral (including prisoner's view of referral):

.....

.....

.....

Is the prisoner considered to be potentially at immediate risk of self-harm? ☐ Yes ☐ No

If 'Yes', refer to the procedures set out in Section 7 of this Director's Instruction.

If 'No',

- Has a mental health professional been informed that the assessment must be completed within 24 hours?

  ☐ Yes ☐ No

- please indicate why the prisoner is considered to be at Lesser Risk

.....

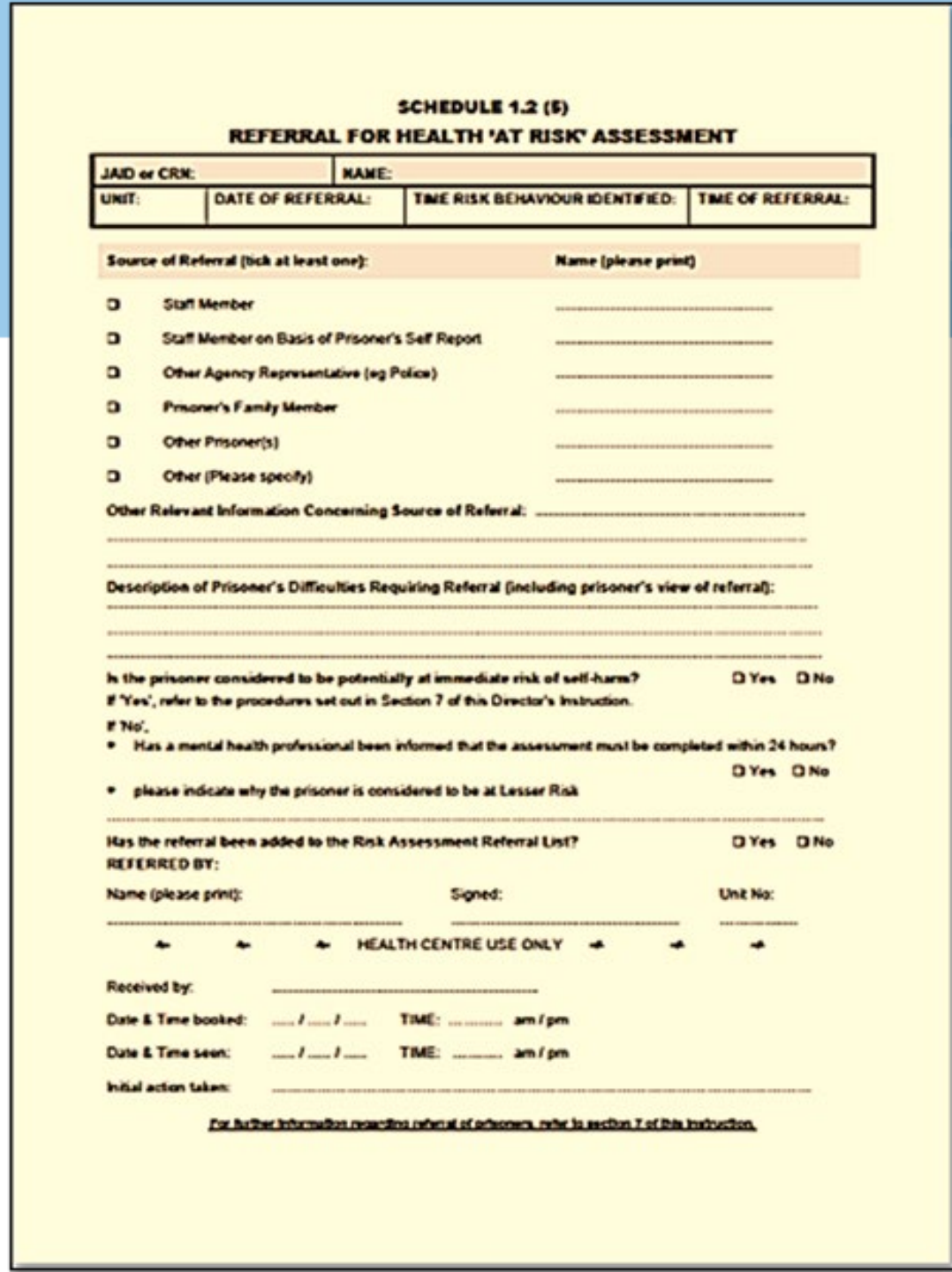
Has the referral been added to the Risk Assessment Referral List? ☐ Yes ☐ No

REFERRED BY:

At Risk Referral form.

These highlighted areas are important to:

- **Time behaviour identified.**
- **Brief reason for referral.**



SCHEDULE 1.2 (5)

REFERRAL FOR HEALTH 'AT RISK' ASSESSMENT

JAID or CRN:	NAME:		
UNIT:	DATE OF REFERRAL:	TIME RISK BEHAVIOUR IDENTIFIED:	TIME OF REFERRAL:

Source of Referral (tick at least one): **Name (please print)**

- ☐ Staff Member .....
- ☐ Staff Member on Basis of Prisoner's Self Report .....
- ☐ Other Agency Representative (eg Police) .....
- ☐ Prisoner's Family Member .....
- ☐ Other Prisoner(s) .....
- ☐ Other (Please specify) .....

Other Relevant Information Concerning Source of Referral: .....

.....

.....

Description of Prisoner's Difficulties Requiring Referral (including prisoner's view of referral):

.....

.....

.....

Is the prisoner considered to be potentially at immediate risk of self-harm? ☐ Yes ☐ No

If 'Yes', refer to the procedures set out in Section 7 of this Director's Instruction.

If 'No',

- Has a mental health professional been informed that the assessment must be completed within 24 hours? ☐ Yes ☐ No
- please indicate why the prisoner is considered to be at Lesser Risk

.....

Has the referral been added to the Risk Assessment Referral List? ☐ Yes ☐ No

REFERRED BY:

Name (please print): ..... Signed: ..... Unit No: .....

HEALTH CENTRE USE ONLY

Received by: .....

Date & Time booked: ..../..../.... TIME: ..... am / pm

Date & Time seen: ..../..../.... TIME: ..... am / pm

Initial action taken: .....

For further information regarding referral of prisoners, refer to section 7 of this Instruction.

DCI 1.02: At Risk Process

1. Identify Prisoner At Risk
2. Constant observations of prisoner (*not to be left alone*)
3. Notify Officer in Charge
4. Verbal referral to At Risk nurse
5. Written referral to At Risk "Yellow Form"
6. At-risk review by nurse
7. Interim Risk management plan (Nurse)
8. Documentation
9. Case presented at Risk Review Team (RRT)
10. Modified Risk Management Plan
11. S rating review

Forensicare

RRT/HRAT

- RRT is a multi-disciplinary team
- Meets daily, co ordinates and reviews management of “At Risk” prisoners
- Develops and reviews the Risk Management Plan
- The team will ensue ‘At Risk Register”, Risk Management Plan and PIMS/E*Justice alert are updated.

DCI 1.02: Referral For Health 'At Risk' Assessment

- The referral must be made verbally to a mental health professional ***and*** be supported by a written referral
- The assessment is to occur by the mental health professional within 2hrs of the behavior being identified
- The person making the referral is responsible for informing the officer in charge to ensure appropriate management and monitoring of the prisoner until the 'At Risk' assessment occurs.
- The mental health professional is responsible for informing officers of the nature of the risks and developing an Interim Risk Management Plan

Forensicare

Completing "At Risk Referrals"

PROBLEMATIC

Don't only write prisoner is a suicide or self harm risk .

Don't write SASH. Is the prisoner at Risk of Suicide Or Self Harm? We are moving away from using this term.

PREFERRED

Inform the prisoner you made the referral and the reason why it has been made.

Where possible get the prisoner to help you to complete the referral. Use his/her language and the reasons.

Inform the prisoner what is likely to happen next.

Forensicare

At Risk Procedures
Risk Level Framework

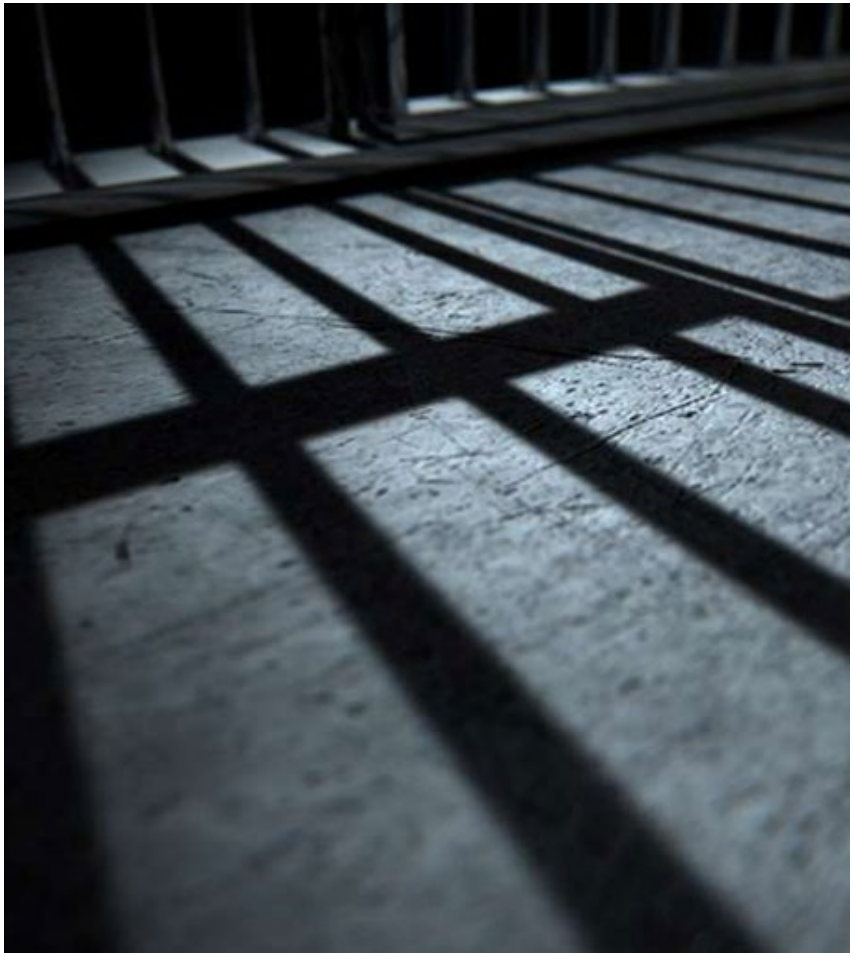
Level/ Terminology	Immediate Risk S1	Significant Risk S2	Potential Risk S3	Previous History S4
Criteria	High or chronic risk of suicide or self Harm behaviour if not supervised Requires Intensive management and support	At significant risk of suicide or self harm Requires intermediate management and support	Has identified risk factors & requires follow-up management & support Is not of high or /moderate risk of SASH	Not currently 'at risk' but has past history of suicide attempts or self-harm behaviour,
Placement	Muirhead or Observation cell, or, AAU (MAP), Marrmak or medical centre (DPFC)	Muirhead or Observation cell, or, Single cell, or Shared cell in special cases BDRP compliant cell	Single cell, or Shared cell BDRP compliant cell preferred	Single cell, or Shared cell
Observation Level	Intervals at most 15 mins	Intervals at most 30 mins	Intervals at most 60 mins	None
Risk Management Plan	yes	Yes	yes	No
Review by Risk Review Team (RRT)	Daily	Daily	Minimum of every 3 days	No
Clinical Review By Psychiatric Nurse	Daily	Twice weekly	As determined by RRT/HRAT	No

Session 6

Post Suicide Event

Forensicare

Group Activity



You are the prison officer on duty in a unit that provides single lock up cell accommodation.

You are conducting a pre let-out count and upon arriving at the cell, you observe the occupant with what appears to be a noose around their neck that is tied to an anchor point.

The prisoner appears not to be breathing.

“What do you do?”

Group Activity

- Code black, identify the location
- Enter Cell, minimum of 2 Officers, Support the Prisoner around waist the other cuts noose.
- Where prisoner is hanging, cut device well above the knot
- Check prisoner for vital signs and attempt resuscitation
- Be aware of Preservation of Evidence
- Brief Manager or Senior Manager on duty
- Lock cell until cleared by police
- Raise Officer report before leaving shift
- Obtain permission from Shift manager prior to leaving
- Attend Victorian police interviews, hot briefs, operational debriefing and counselling as required.

Forensicare

Session 7

Self-Care & Wellbeing

Looking After Yourself

Forensicare

Looking after yourself… strategies for positive mental health?

Impacts of the work…

- Your work puts you in front of trauma most days and this can have a toll on your mental health, well being, relationships and the organisation.

- It's important then to take care of yourself and look out for signs when you might need some extra you time especially following a traumatic event…..

Understanding trauma

- "Trauma can be a single event, connected series of traumatic events or chronic lasting stress."

Forensicare

Trauma can cause...

Physical

- Low energy
- Hyperarousal
- Hypoarousal
- Paleness
- Lethargy
- Somatic complaints
- Lack of coordination or balance
- Headaches
- Digestive complaints

Emotional

- Anxiety
- Emotional numbness
- Anger
- Depression
- Guilt
- Shame
- Fear
- Avoidance

Behavioral

- Substance and alcohol use
- Eating disorders
- Compulsive behaviors
- Changes in interpersonal relationships
- Anger-related issues
- Isolation and detachment from others

Cognitive

- Inability to concentrate
- Memory lapses
- Learned helplessness
- Increased distraction
- Intrusive thoughts
- Dissociation
- Cognitive errors
- Flashbacks

Forensicare

Mindfulness and Trauma…

To prevent our brains from unnecessarily going into "survival mode"

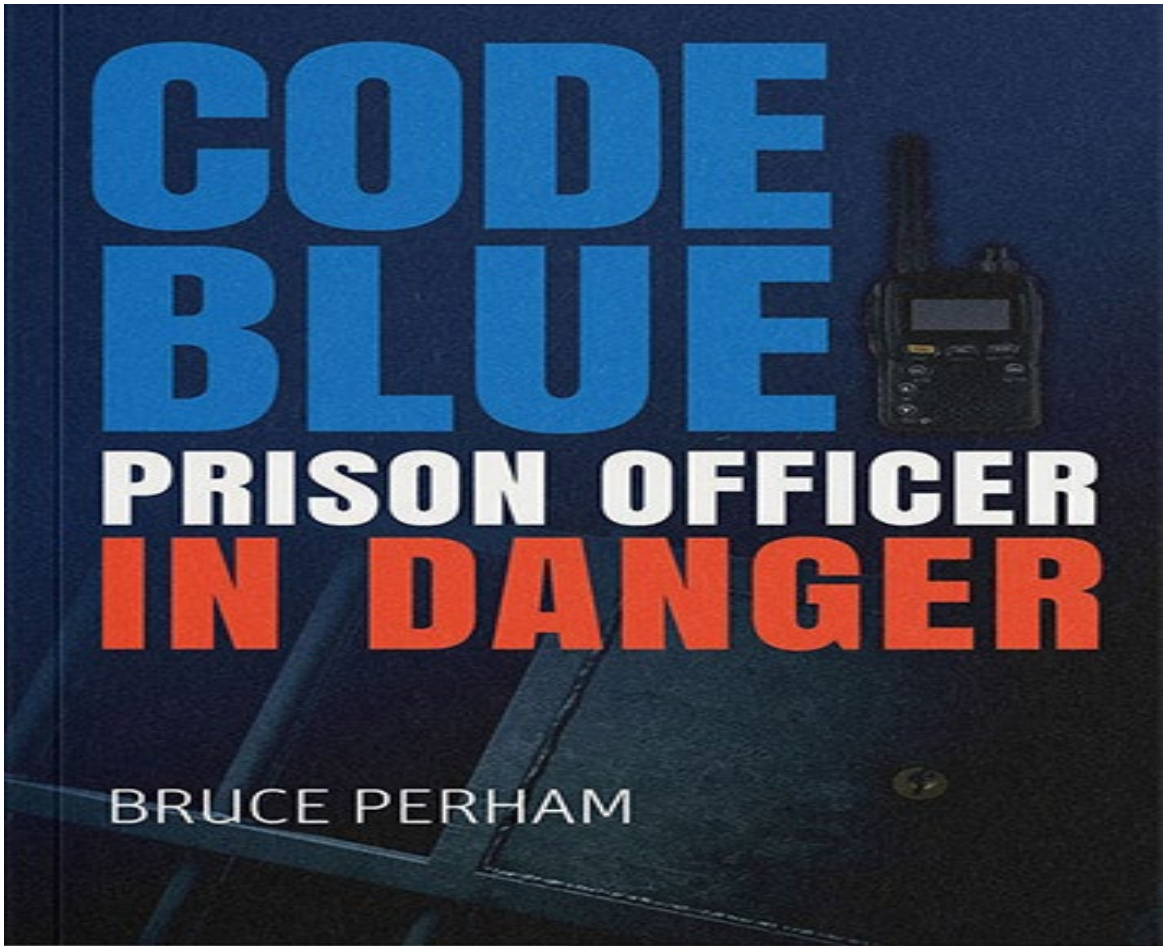
- Fight/flight/freeze can shut our "thinking brain" off.
- Breathing and mindfulness can turn our "thinking brain" back on.
- Research shows mindfulness programs can lead to structural changes in areas of brain associated with mental health and resilience.

Mindfulness and self care...

- Manage stress
- Calm the mind
- Regulate difficult emotions
- Improve relationships
- Switch off from work

Forensicare

Code Blue...by Bruce Perham



Forensicare

Meeting Bruce….

Code Blue… the voices..

‘ I had no idea what I was getting into. I had no idea how depraved prison life could be or the toll it would take on me. It took me five years to get a handle on that. And now I realise I am no good to do anything else. You slide downhill’

‘The job does burn you out and at times I think I’m done. . . These days I just come to work, dumb down, and count the days to retirement’…..

Code Blue… the voices..

'We often do not admit it, but we do feel for prisoners. I became quite connected to a young woman who was in and out of here due to a drug issue. When I would see her back I would have a feeling of sadness for her. She would say to me, "This time I am going to make it when I get out." And we would talk about what she could do. It was a couple of years ago, she hanged herself after she was released. I was shattered as it was such a waste of a young woman who had so much potential but was never able to realise it'

Code Blue… the voices..

"Johnny was in his late 20's or early 30's. He was built like the size of a jockey…He had been charged with rape….but to look at Johnny you'd go 'No way'. He would tell his story of innocence and I tended to believe him and felt his distress was genuine"

'Johnny's presentation changed one day, he was socializing with other prisoners, laughing, joking, giving his jacket away. Usually he kept to himself. Unbeknownst to staff he also gave away his canteen items. That night he took his life and we didn't pick it up.'

Self care and your well being..

- Adopt healthy eating, exercise and sleeping habits
- Set boundaries (e.g. clarify your role)
- Take a daily break from technology
- Learn how to manage stress
- Re-evaluate your goals & priorities
- Actively address problems at work
- Ask for new duties
- Get support

Forensicare

When to Get Help

- Difficulty coping with intense feelings or reactions
- Feeling numb or lacking emotional connection for longer than 3 to 4 weeks
- Physical symptoms nausea, sweats
- Continued disturbed sleep and /or nightmares
- Feeling isolated
- Strained family, friend and work relations since traumatic event
- Increased drug and alcohol use

Forensicare

Where to Get Help

- After trying strategies for a couple of weeks with no improvement contact:

- GP
- Counsellor or therapist
- Employee Wellbeing Program

Concluding Remarks

- We are all responsible for the identification and management of 'At Risk' prisoners.
- Listening and meaningful engagement with an 'At Risk' individual can make the difference.
- Take any suicidal talk or behaviour seriously.
- Suicide prediction is difficult and despite best practices not all suicides will be preventable.

Forensicare

Congratulations!

Thank you all for your participation. Good Luck and see you at future refresher sessions....

Your feedback is very Important to us.

Forensicare

SEPARATION ASSESSMENT

As per the Corrections Act 1986 and Sentence Management Manual, the purpose of Separation is to manage an unacceptable risk to prison security, the community, the prisoner or any other person. In considering the use of Separation Regimes consideration must be given to the Charter of Human Rights and Responsibilities Act 2006 and the requirement for the least restrictive option commensurate with risk.

Prisoner Profile		
First Name	**Surname**	**CRN**
Unit	**Incident Type**	**Incident Date and Time**
PIMS Incident No#	**Prisoner Risk Profile (Security Rating, P, S, T, M, E, V Rating)**	**Aboriginal / Torres Strait Islander (Y/N)**
Disability (ID / ABI)	**ICM Participant (Y/N)**	**Remand/Sentenced**

Background	
Brief Description of Incident	
Staff Involved	

Risk Assessment	
Key Stakeholders Involved in Separation Assessment (eg. Senior Clinician, Aboriginal Programs, ICM, Primary Health Provider, etc)	
Assessment of Ongoing Risks to Self or Others	
Any known triggers? (i.e. behaviours or factors that occurred before or contributed to the incident)	
Risk to (Prisoner / staff) or (security / good order) *Considerations - Type and level of Risk - Any recent incidents - Post incident presentation of prisoner - Any factors to reduce / mitigate risk	

Assessment of Potential Risks of Separation			
*Considerations - SASH history/risk factors - Mental health & wellbeing - Disconnection of programs & services			
Recommendation			
Recommended for Separation	☐ Yes ☐ No	If YES, then indicate reason why?	☐ Safety of Prisoner ☐ Safety of Others ☐ Good Order ☐ Mental Health
		If No, Behavioural Management Plan (BMP)?	☐ Yes (Complete Form 3B 3.1.10.002) ☐ No
Correctional Supervisor			
Full Name			
Signature		Date	

Outcome *To be completed by Correctional Manager			
Separation Approved?	☐ Yes ☐ No	Ops Mgr Name: Date/Time:	
If separated, recommended regime? *For further information see Forbes Regimes (**O:\FORBES\REGIMES**)	☐ Regime 1 (Most Restrictive) ☐ Regime 2 (Less Restrictive)	Recommended referrals?	☐ Moroka 1 (if at risk) ☐ ICM (if ICM participant) ☐ Clinical Support (adjustment session) ☐ Aboriginal Programs (if Aboriginal or Torres Strait Islander) ☐ Other (please specify)
Recommended for reclassification.	☐ Yes ☐ Requires further assessment (must be selected if panel was not included in separation assessment, ie. on weekends) ☐ No (recommend remain at RCC)	If further assessment is required - undertake further review with key stakeholders and record outcome in Separation Review Section (Page 3). Note: Separation Assessment Review must be provided to Sentence Management Operations prior to Forbes Management Review.	
Comments?			
Correctional Manager Sign Off			
Full Name			
Signature		Date	

Send Separation Assessment to Sentence Management Operations via sentencemanagementunit-rhccstream@justice.vic.gov.au and cc RCC-CorrectionalManagers, RCC-ProgramManagers and the relevant Senior Clinician and Supervisor(s)

Separation Review (Note: only required to be completed when further assessment is required to determine recommendation for classification).			
Key Stakeholders Involved in Separation Review: (eg. Correctional Supervisor, Senior Clinician, Aboriginal Programs, ICM, Primary Health Provider, etc)			
Assessment of ongoing requirement for separation and/or reclassification			
*Considerations - Program/Service Needs - Intelligence - Post separation presentation of prisoner			
Recommended for reclassification.	☐ Yes ☐ No (recommend remain at RCC)	If Yes, specify reason.	
		If No, specify reason.	
Senior Clinician			
Full Name			
Signature		Date	
Correctional Supervisor/Correctional Manager			
Full Name			
Signature		Date	

Send Separation Review to Sentence Management Operations via sentencemanagementunit-rhccstream@justice.vic.gov.au and cc RCC-CorrectionalManagers, RCC-ProgramManagers and the relevant Senior Clinician and Correctional Supervisor(s) by 2.30pm on the day prior to SMO Forbes Management Reviews.

GEO Group Australia and Forensicare

Moroka Program Joint Operations Manual

February 2024

Table of Contents

MOROKA PROGRAM PURPOSE 3

MOROKA PROGRAM OVERVIEW 3

ELIGIBILITY CRITERIA 4

REFERRAL AND INTAKE PROCESS 4

File Review 4

Intake Assessment 4

Admission Decisions 5

ROLE OF CLINICAL TEAM AND STRUCTURE OF CLINICAL PROGRAM 7

ROLE OF CORRECTIONAL TEAM, INCLUDING CASE MANAGEMENT 8

JOINT DE-ESCALATION AND SHARED DECISION MAKING IN RESPONSE TO BEHAVIOURS OF CONCERN 9

Joint De-escalation 9

Responding to behaviours of concern 9

Separation 11

MANAGEMENT OF SUICIDE/SELF-HARM (SASH) RISK 11

JOINT REFLECTIVE PRACTICE/TRAINING 12

SHARED EMAIL LIST AND L DRIVE FOLDER 12

DISCHARGE PROCESS 13

Discharges prior to program completion 14

MOROKA PROGRAM PURPOSE

There is a cohort of prisoners within the correctional system who present with complex and challenging behaviours associated with mental illness, predominantly personality disorder.

The prison system typically responds to these people with increasingly restrictive interventions.

These include separation from others, with sometimes extended periods of isolation, and the implementation of management regimes with highly restrictive conditions (i.e., handcuff regimes, limited access to time out of cell). For this cohort, these responses often contribute to the maintenance of the behaviours and can sometimes contribute to increasing their severity and frequency.

The mission of Moroka is to reduce frequency, severity, and/or impact of the complex and challenging behaviours through the provision of timely and comprehensive care, and system responses that do not exacerbate or reinforce the behaviours.

Care is delivered with compassion to support recovery in the least restrictive circumstances that safety considerations permit. Care is multidisciplinary (clinical and correctional) to support holistic recovery. Care is provided in line with Forensicare's Model of Care, GEO's Continuum of Care model, and the Ravenhall Charter, which aims to provide integrated services that reduce reoffending and make the community safer.

MOROKA PROGRAM OVERVIEW

The Moroka Program (Moroka) staffs a 10-bed unit in RCC for people with complex and challenging behaviours associated with mental illness, predominantly personality disorder.

A complex behaviour is one where the reasons behind the behaviour are difficult to understand. A challenging behaviour is one that people find hard to accept and/or manage. These behaviours typically violate social norms.

The behaviour prompting the referral is considered so intense, frequent, or long-standing that it:

- Diminishes quality of life, OR
- Poses a risk to self or others, AND
- Can cause serious disruption within the prison that leads to responses that are restrictive and aversive, and lead to exclusion from normal prison activities and interactions.

Examples include:

- Physical aggression
- Verbal aggression
- Inciting others
- Self-injury
- Property destruction
- Hyper-sexuality or other sexually inappropriate behaviour
- Disinhibited and impulsive behaviour
- Fire setting
- Aggressive behaviour
- Other serious violations of social, emotional, or behavioural norms (boundaries)

The core of the Moroka program is the provision of a unit-based treatment program for 12 weeks. Admission to the program consists of:

- Assessment of the prisoner, including their complex and challenging behaviour and mental health
- Identification of tailored goals, reflected in the Mental Health Recovery Plan and Local Plan Agreement
- A range of mandatory and optional group-based programs
- Individual treatment
- Coaching support
- Correctional Case Management
- Ongoing assessment of risk (clinical and correctional)

ELIGIBILITY CRITERIA

For admission to the Moroka Unit, the following eligibility criteria must be met:

- The prisoner demonstrates repetitive and entrenched complex and challenging behaviour; where:
- The behaviour(s) are related to mental illness, predominantly personality disorder; and
- The behaviour(s) are not secondary to intellectual disability or acquired brain injury; and
- There is a reasonable likelihood of participation in the Moroka Program reducing the occurrence, severity, and impact of the behaviours; where:
- The prisoner is willing to participate in the program and work on addressing their behaviours.

REFERRAL AND INTAKE PROCESS

Moroka is a state-wide service. Any individual within the Justice System may make a referral to the Moroka Program. Referrals are received via JCare or via the morokareferrals@forensicare.vic.gov.au email address. An overview of the intake process can be seen in Figure 1.

File Review

All referrals are assigned to a Forensicare clinician for a file review, which is to be completed within 5 days of allocation. If it is deemed that the referral meets program criteria, the prisoner is allocated to a Forensicare clinician and a GEO Correctional Supervisor for assessment.

Intake Assessment

Some aspects of the intake assessment are completed jointly with the Forensicare clinician and GEO Correctional Supervisor, while some are completed independently.

Forensicare Clinician and GEO Correctional Supervisor

- Overview of unit physical environment
- Overview of unit rules (e.g. out of cell hours; access to items and general prison)
- Overview of therapeutic program

- Review of recent incidents, including preliminary functional assessment of behaviour
- Treatment readiness semi-structured assessment interview

Forensicare Clinician

- Psychosocial history
- Psychometric assessment (e.g. impression management, trauma)

GEO Correctional Supervisor (with or without Forensicare clinician)

- Consultation with Correctional Staff on participant's current unit (e.g. current presentation, coping strategies, management strategies, management regimes)

> Through this intake assessment process, it is the responsibility of the *Forensicare clinician* to be assessing and providing an opinion on treatment readiness and overall program suitability. It is the responsibility of the *GEO Correctional Supervisor* to be assessing and providing an opinion on the capacity for identified risks to be managed safely on the Moroka unit.

Following the assessment, both the Forensicare clinician and GEO Correctional Supervisor write a report summarising their respective assessments. The GEO Correctional Supervisor report and an amended, redacted Forensicare clinician report are saved in the Moroka Unit folder on the L drive (see Shared Email List and L Drive Folder below).

Admission Decisions

The GEO FMH Correctional Manager and Forensicare Moroka Program Manager meet regularly to review the completed intake assessment reports and decide whether a referred person will be placed on the program waitlist for admission. Any disagreements related to this decision are escalated to GEO and Forensicare Operations Managers, with outcomes communicated to the GEO FMH Correctional Manager and Forensicare Moroka Program Manager. Where a decision is made that conflicts with the recommendation of staff completing the assessment, feedback should be provided.

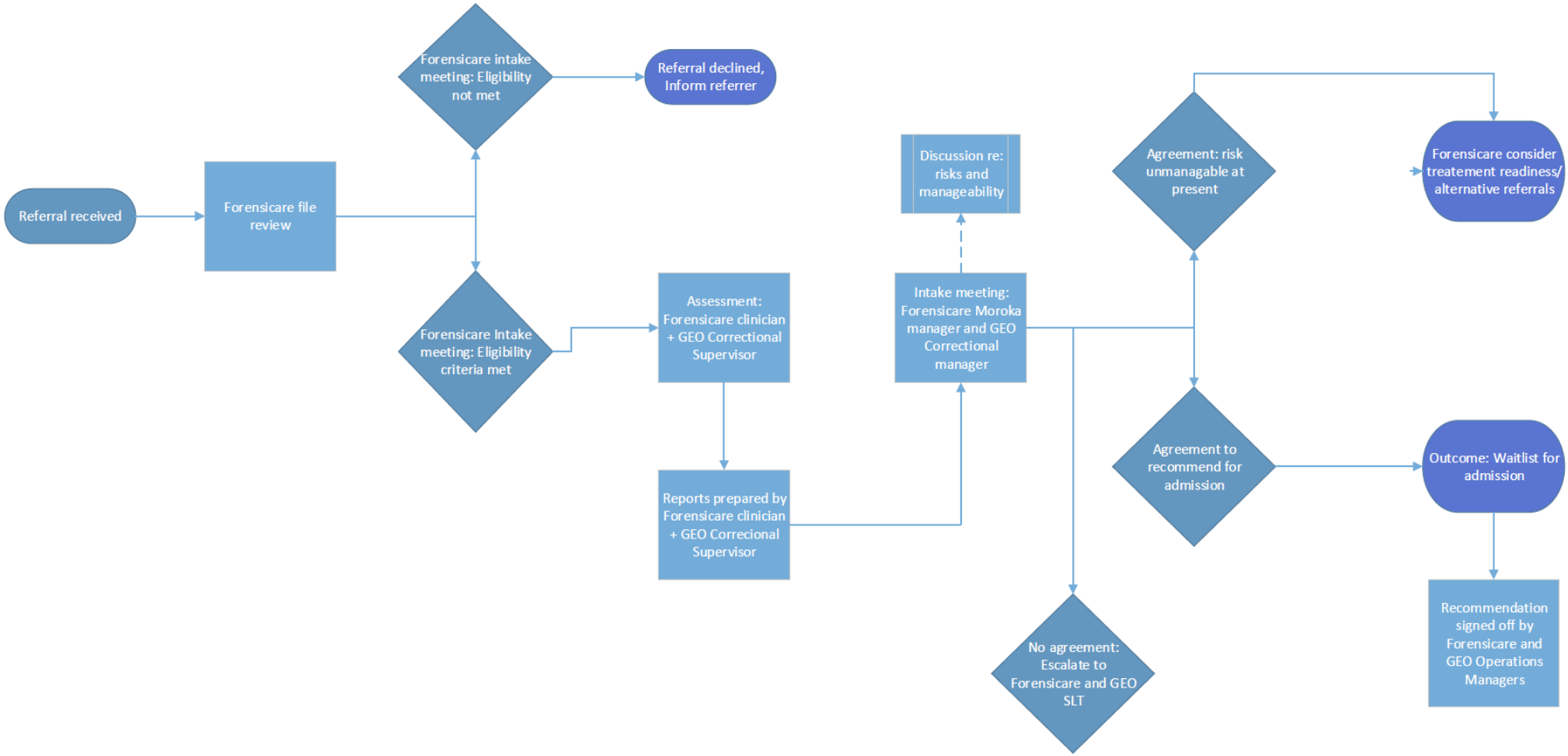


Figure 1. Overview of the Moroka intake process

ROLE OF CLINICAL TEAM AND STRUCTURE OF CLINICAL PROGRAM

The Moroka Program is focused on supporting participants with clinical recovery. Clinical recovery reflects the importance in delivering interventions focused on reducing the symptoms associated with the participant's diagnosis.

It is recognised that standard mental health treatments are not effective in supporting clinical recovery for individuals with the mental health presentations common in Moroka participants. Due to the complexity of these individuals, standard treatments do not have sufficient intensity or structure to meet their needs. Additionally, these treatments can unintentionally often reinforce the presentations, leading to behaviours remaining the same or becoming worse. As such, the Moroka Program has a unique therapeutic model providing evidence-based intervention for those who present with complex and challenging behaviours associated with mental health.

Clinical recovery on Moroka is supported through a Dialectical Behaviour Therapy (DBT)-based program that includes:

> Group-based treatment targeting skills development
> Individual therapy supporting skills development and recovery goals
> Group-based interventions supporting identification of pro-social goals for the future and pro-social leisure activities
> Coaching support to assist participants to implement learnings from the program

The Moroka Program operates on a 13-week cycle:

- Week 1: Admission to unit; assessments commence
- Week 2: Orientation group programs; assessments continue
- Week 3-12: Intensive program incorporating mandatory and optional group-based programs and 1:1 sessions
- Week 13: Discharge from unit

Prior to admission to the unit, a Forensicare clinician meets with each participant to further orient them to the program, and commences the development of a Mental Health Recovery Plan (MHRP) and Personal Safety Plan (PSP). The MHRP outlines the participant's goals for the admission, while the PSP identifies skills and strategies that can be used by the participant and their care team to support the psychological and physical safety of the participant and manage risk. The PSP is shared with clinical and correctional teams prior to their admission to the unit. A hard copy it provided to correctional staff and an electronic copy is saved to the shared unit L drive and uploaded to Gateway™.

Both the Mental Health Recovery Plan and Personal Safety Plan documents are regularly updated with the participant and their family, carers, and supporters where relevant.

Clinical team members deliver the above interventions, in addition to completing file reviews and intake assessments for new referrals, and engaging in discharge planning for current participants. The clinical team endeavour to have a Forensicare staff member on the unit during unlock hours to provide ad hoc support and coaching support to participants.

ROLE OF CORRECTIONAL TEAM, INCLUDING CASE MANAGEMENT

Correctional Officers at Ravenhall Correctional Centre play a significant role in ensuring the safety and security of the Centre as well as aiding in the rehabilitation and reintegration of people in custody by:

- Handling a Case Management portfolio where they provide first line and quality support in addressing offending behaviour;
- Actively supporting and working collaboratively with Correctional Staff, Clinicians, Health and Mental Health staff, and Alliance Partners;
- Conducting daily head counts and searching for contraband to assist with centre security;
- Escorting people in custody to various appointments, including hospital visits and court appearances;
- Managing the visitors area of the prison and overseeing visitation sessions for people in custody;
- Conducting perimeter searches of the prison and controlling access of people in and out of the facility.

Dynamic security is central to the role of a Correctional Officer in Moroka. Dynamic security is crucial to the effective maintenance of safety and security of a unit and a correctional centre, and this is especially true for prisoners with mental health concerns, including personality disorder. Dynamic security depends on staff who:

- Interact with and know their participants
- Develop positive relationships with participants
- Understand the personal situation of a participant
- Support fair treatment and the wellbeing of participant
- Support engagement in behaviour change programs

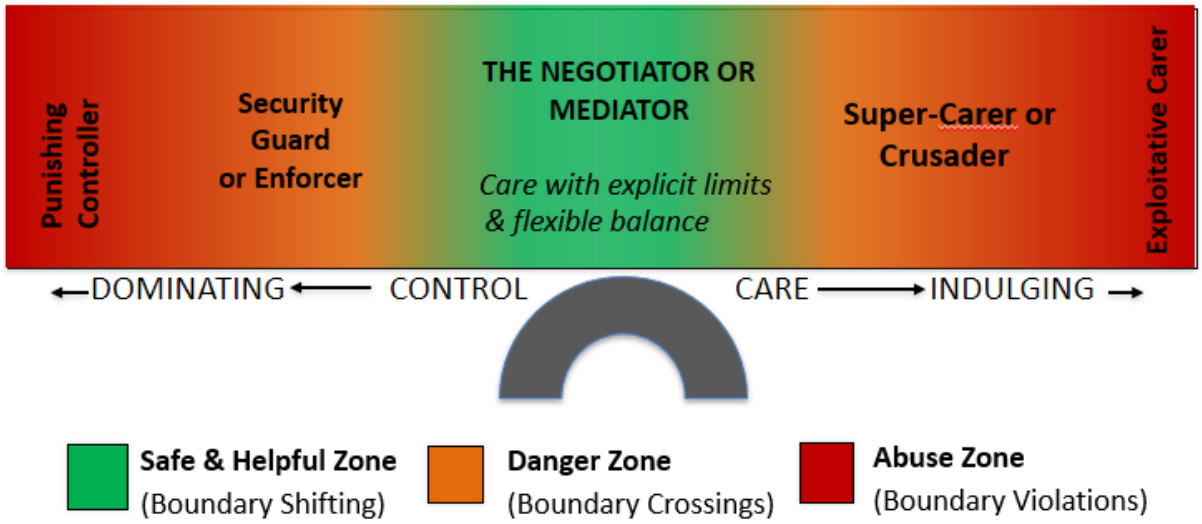
These factors are recognised and reflected in *OI 6.1.1 Prisoner Engagement and Case Management Overview*, which notes that all Ravenhall staff work together to promote motivation for change, to support engagement in behaviour change programs, to cultivate supportive relationships that assist prisoners to develop healthy lives (), to show interest in prisoner program engagement, and to support and reinforce observable behaviour change. These actions facilitate dynamic security, which, when implemented effectively, allows prisoners to feel comfortable to approaching prison staff before problems escalate (United Nations Office of Drugs and Crime Handbook on Dynamic Security and Prison Intelligence, 2015).

Correctional Case Management provides an important framework within which dynamic security is achieved and behaviour change is supported. Given the small and therapeutic nature of the Moroka program, program goals cannot be achieved without the contributions of Correctional staff to case management and dynamic security.

Boundaries

For both clinical and correctional staff on the Moroka unit, it is critical that relationships with participants remain boundaried – that is, that clear physical and emotional limits are in place. Positive, boundaried relationships reflect a balance between care and control, and this balance is central to a safe and secure environment and critical to positive therapeutic outcomes. It provides participants with assurance that relationships with staff will be respectful, consistent, and predictable, and reinforces trust in the therapeutic and correctional processes.

It can be helpful to think about boundaries on a spectrum, from dominating/controlling to indulging/providing excessive care. Relationships on either end of the spectrum are considered problematic.



For all clinical and correctional staff on Moroka, it is important to balance both care and control. In this space on the spectrum, relationships between staff and participants are balanced, contained, and respectful. They focus on both the vulnerabilities of the participants as well as the risks they may pose. This balance helps create a sense of safety on the unit, reduces risk of harm to self and others for participants, and increases the potential for change.

JOINT DE-ESCALATION AND SHARED DECISION MAKING IN RESPONSE TO BEHAVIOURS OF CONCERN

Responding to behaviours of concern

All participants admitted to the Moroka unit have acknowledged that they engage in patterns of behaviour that cause harm to themselves and/or others and want to change this. The application of appropriate and considered consequences for inappropriate behaviours is therefore an important part of the therapeutic program.

As noted in "Moroka Program Purpose," application of standard system responses are typically not effective for Moroka program participants. These typical responses can serve to reward or reinforce the behaviour, and/or result in escalations of behaviour that cause further harm to self or others. For example, a prisoner might engage in verbal aggression towards a correctional officer when they feel like the officer is not providing needed help. A code is called, the prisoner is locked down, and only the minimum required support and communication is provided to the prisoner. The beliefs driving the behaviour (e.g. they don't care about me, they won't help me) have been reinforced (withdrawal of warmth, withdrawal of additional support/advocacy, feeling "punished," withdrawal of access to unit and resources). The beliefs become more entrenched (officers don't care and don't help), leading to increased likelihood of aggressive behaviour in future (e.g. any time they feel unsupported, abuse the person who is not helping them).

It is therefore critical that any system response/consequence is based in an understanding of the participant and the reasons for their behaviour (also called the function of the behaviour).

One of the roles of the Moroka program is providing an appropriate and proportionate response that does not reward or reinforce inappropriate behaviours when they occur, but rather decreases the likelihood that the behaviour will occur in the future. Primarily, this will involve the use of therapeutic principles and responses including, but not limited to, provision of coaching, completion of behaviour chain analysis, or losing access to clinical support relating to issues outside of the core program focus for a defined period of time.

The leadership of the Moroka clinical and correctional teams have agreed to a process whereby the above therapeutic processes will form the core response to behaviours of concern where there are no imminent safety concerns. Where there is imminent risk to self or others, incident response processes should be followed in line with relevant OIs (noted below). Regardless of the response, clear feedback must be provided to the participant from relevant Moroka staff (e.g. those on receiving end of behaviours; case managers, key clinicians, contact nurse etc) regarding the behaviour and expectations for adherence to program rules and their program commitments (e.g. respectful behaviour; behaviour change).

As the program progresses and participants learn new strategies to manage the triggers and functions of their behaviours, expectations for participants to manage urges relating to their behaviours increase. If participants continue to engage in behaviours of concern with the same frequency and severity despite consistent application of therapeutic processes and the learning of new skills and strategies, it is appropriate for system/correctional responses to be applied.

On Moroka, where there are three instances of the same behaviour with no evidence of shift in the frequency or severity of the behaviour after week 5 of the program, these system responses will be considered. This may include use of the Minor Offence Register (MOR), withdrawal of privileges, snap lock-ins, or separation. Given the importance of responses that match the presentation of the participant and the function of the behaviour, Moroka clinical leadership should be consulted prior to the application of such responses. The Correctional Supervisor is responsible for the determination and implementation of these responses following consultation with the clinical team.

Joint De-escalation

Operating Instruction *7.1.17 De-escalation within FMH Units* outlines the process for responding to situations within FMH that may jeopardise the safety and security of the prisoner, the prison, or any other person. The OI highlights the expectation of a collaborative approach to responding to and managing signs of distress, anger, or agitation.

All participants admitted to Moroka have a Personal Safety Plan (PSP) that they have consented to share with Correctional staff. Prior to admission, the PSPs for all participants are provided to and reviewed with Correctional staff to inform an understanding of the participants and to inform responses to behaviours of concern and incidents. These PSPs are also saved on the shared drive (L drive) accessible to Moroka Correctional and Clinical staff. In addition to the sharing of the PSPs, Moroka clinical staff will prepare documents with recommendations for day-to-day engagement to reduce risk for each participant, and recommendations for responses during periods of escalation of risk for each participant.

As per OI 7.1.17, the PSP provides suitable short-term strategies to meet the security, safety and placement needs of the prisoner when their behaviour may otherwise escalate to warrant separation. It notes an expectation that clinical and correctional staff work collaboratively, drawing upon each other's skills and expertise, to de-escalate a situation. The OI encourages consideration of the PSP in determining de-escalation responses in place of more standard responses that might occur in other locations of the centre.

The OI notes that, if a situation escalates to the point that a Code Blue is warranted, the incident response team lead will take over control of the incident. Where there are not imminent safety concerns, advice from Moroka clinicians should be taken into consideration in the incident response, and communication between the participant and Moroka clinicians maintained.

Separation

As per OI 5.2.5 *Separation of Prisoners*, RCC has processes in place for prisoners who require to be separated from the remainder of the prison population. This OI notes that separation should only be considered when all other placement options have been ruled out.

Under Section 20 to 22A of the Corrections Act 1986 prison staff have the ability to hold a prisoner in a cell or room to the extent necessary to provide for the safe custody and welfare of prisoners and the security of the centre. Such placements should not exceed 24 hours, and may take place, for example, to provide a cooling off period following a minor altercation. Further information is available in the OI.

As noted above, on Moroka, the use of emergency short term placements (e.g. securing the participant in their cell) for individual participants or for the unit is considered an appropriate strategy. In line with principles of least restrictive practices, these snap lock-ins should be utilised for the shortest duration that is safely indicated. Correctional and clinical staff will work together to undertake risk assessments and develop a plan regarding unlock.

Where a short-term separation has been utilised and the participant is not unlocked on the same day, in line with OI 5.2.5, staff are to utilise the "23 hours lock down Behavioural Management Plan (BMP) – Separation Assessment Review" process prior to deciding to formally separate a prisoner. During this 23-hour period, the participant is to remain on the Moroka unit. This process involves the Correctional Supervisor and Forensicare Clinical Coordinator, Moroka Program Manager, or delegate (Monday – Friday) or Forensicare on-call operations manager (after hours and Saturday-Sunday; contacted by Forensicare staff) investigating the incident and conducting a risk assessment. As per the OI, the amount of time a participant is separated must not be longer than is necessary to achieve the purposes for the initial separation. Separation is not equivalent to discharge from the Moroka unit; some of those who are separated will continue to complete the program. See Discharge Process for further information.

MANAGEMENT OF SUICIDE/SELF-HARM (SASH) RISK

Participants in the Moroka program often present with chronic high risk of self-harm and/or suicidal actions or threats of same. As with all behaviours of concern seen in participants who attend Moroka, typical system responses can often reinforce or reward the behaviours or increase risk.

As such, it is critical that the approach to suicide and self-harm risk assessment and management on Moroka considers the personal circumstances of the participant, their history, their triggers, and the reinforcers of the suicide or self-harm behaviour. This is often referred to as a formulation – something that summarises and explains why the behaviour is occurring and helps make sense of it.

All participants who present with chronic SASH risk will have a formulation of their SASH behaviours. This formulation will inform the assessment and management plan of SASH risk across the program. This plan may include recommendations for responses that would not be typical within the prison system (e.g. allowing access to means under certain conditions; not being placed in safe cell despite escalated risk).

GEO and Forensicare leadership have acknowledged that such atypical responses will at times be warranted. Where this is the case, the atypical risk management plan should be discussed by clinical and correctional staff at the earliest opportunity. Where the plan is agreed upon at the local Moroka program level by the Forensicare Clinical Coordinator (or above) and GEO Correctional Supervisor (or above), the plan will be discussed with the GEO Operations Manager for approval and endorsement prior to the HRAT meeting. This should be done at the earliest possible opportunity to allow sufficient time for review and consideration and should involve the GEO Correctional Supervisor and the Moroka Clinical Coordinator or Program Manager or delegate. The agreed-upon plan should then be documented in the Interim Risk Management or Modified Risk Management form and discussed at HRAT, with outcomes documented on JCare and Gateway™.

Where an agreement cannot be reached between the Moroka clinical and correctional teams regarding a risk management plan, the situation and plan should be escalated to the Forensicare Operations Manager and GEO Operations Manager for review and discussion. Outcomes will be provided back to the Moroka team for actioning.

JOINT REFLECTIVE PRACTICE/TRAINING

It is well established that working with this cohort of individuals can have a significant impact on the wellbeing of staff. Participants on Moroka can evoke strong opinions and emotions within individuals and within teams. Inconsistent or fluctuating motivation and commitment from participants can impact on staff motivation and morale. Staff can feel frustrated, disappointed, or let down by individuals who appear calm and later engage in challenging behaviours; who express a desire for help and reject support or are hostile towards those trying to assist; who place high demands on staff; who appear to make progress though continue to engage in challenging behaviours. Without appropriate supports, these factors can contribute to the development of burnout in staff.

Several strategies can help mitigate these risks. All clinical and correctional staff on Moroka are encouraged to maintain self-care strategies (e.g., maintaining work/life balance, practising stress management strategies, maintain realistic expectations of participants and the program). In addition, supervision and reflective practice are essential to work effectively and safely with this cohort.

On Moroka, all participants are locked in for one hour weekly to provide time for all clinical and correctional staff rostered on the day to meet for training and reflective practice. Externally facilitated Joint Reflective Practice is held monthly and is facilitated by senior clinicians from Spectrum, the Personality Disorder Service for Victoria. On other weeks, time is available for training, refresher training, review of formulations and PSPs for participants on the unit, and reflective practice.

All staff on Moroka are encouraged to seek supervision and make use of available supports (e.g. EAP providers) to support their wellbeing and their practice while on the unit. The GEO FMH Correctional Manager and Forensicare Moroka Program Manager will meet weekly, and staff wellbeing will be a standing agenda item for these meetings.

SHARED EMAIL LIST AND L DRIVE FOLDER

To facilitate timely information sharing, a shared email address and L drive folder have been developed for access by Moroka clinical and correctional staff.

The email address is "RCC-MorokaUnitTeam-DST-Group" rcc-morokaunitteam@geogroup.com.au. The shared folder is located in Departments (L:) → Health Services → Moroka Unit Team.

The FMH Correctional Manager or Moroka Correctional Supervisor are responsible for notifying GEO IT when a new correctional staff member joins the Moroka team to request their addition to the email group. Similarly, the Forensicare Moroka Program Manager holds the same responsibility for new clinical staff.

The email address should be used to facilitate time-sensitive communication of information between clinical and correctional staff. This may include handover of information relating to the mental state of program participants, risk of IPV or SASH, or the good order and healthy functioning of the unit (e.g. interpersonal dynamics) where risk is not imminent.

The shared L drive folder will include information to support the functioning of the unit. This will include, but is not limited to:

- Intake assessment reports completed by the Correctional Supervisor,
- Redacted versions of the intake assessment reports completed by the Forensicare clinician,
- Relevant training slides,
- Program schedule, and
- PSPs

DISCHARGE PROCESS

Participants attending the Moroka program are discharged in "week 13" of the program, following completion of the 12-week program. Identifying discharge locations for participants is a collaborative process involving Sentence Management Division (SMD), Forensicare Prison Access Flow Coordinator, Forensicare Moroka team, GEO, and the participant. Planning around discharge considers the security level, clinical presentation, clinical needs, risk management issues, and personal preferences for each participant. Discharge planning commences at admission. Throughout the cohort, regular discussions are undertaken with SMD to identify timely discharges to least restrictive environments. All discharges from Moroka are planned.

In line with OI *7.1.14 Continuity of Care – Transfer & Discharge of Prisoners* and *OI 7.1.3 Access Flow Coordination for FMH Services*, Forensicare holds responsibility for recommendations relating to participant exit/discharge from Moroka, and SMD have responsibility for final authorisation and facilitation of placement decisions, taking into consideration Forensicare's clinical recommendations. The Forensicare Prison Access Flow Coordinator is notified of a recommendation to discharge a participant from the Moroka program, who discusses the move with SMD for authorisation and finalisation. No participants can be moved from the Moroka unit (including to management units) until they have gone through the Access Flow Coordination process.

Most participants on the Moroka unit are discharged back to a prison unit. The Forensicare Moroka team ensures continuity of care by actioning referrals where relevant and providing a handover to the health care team at the receiving location. Where participants are being considered for recommendation of a placement at RCC, the Moroka Forensicare team will consult with relevant GEO correctional and clinical stakeholders.

In addition to the handover to the health care team at the receiving location, a handover will be provided to receiving location via the completion of a Transfer Case Management Review Committee meeting (CMRC). As per OI *6.1.4 Case Management Review Committee*, the CMRC must include a handover of clinical information by Forensicare staff relating to risk of SASH and IPV, and Early Warning Signs (EWS) of mental state deterioration and increased risk. It must also contain a handover of information from GEO Correctional staff regarding prisoners' interactions with staff and

prisoners on the unit. If the participant is being discharged to a RCC placement, the CMRC will occur in person and include GEO clinical and correctional staff from the receiving unit.

Discharges prior to program completion

There are occasions on which participants are required to be discharged from the program prior to its completion. This may relate to release from custody, wherein normal discharge processes will occur in accordance with Forensicare and GEO policies.

Discharge prior to program completion may also occur in response to withdrawal of voluntary participation in the program ("dropping out"), ongoing risk to others that is assessed by clinical and correctional staff as unmanageable on the unit, or serious breach of the participation agreement that is considered to warrant a withdrawal from the program by clinical and correctional agreement. When such circumstances arise, the planned discharge process (as above) must still be followed, including notification and discussion through the Access Flow Coordination process, and completion of a transfer CMRC prior to any move. If risk requires, the participant may remain separated on the unit until these processes have been completed.

In addition to the above, as per OI 5.2.9 Forensic Mental Health units, where a prisoner is being discharged prior to program completion, a mental health assessment, including an assessment of suicide and self-harm risk, must be completed once the participant is informed that they will be transferred to a non-FMH unit, particularly in situations where the new unit will be a management unit. Staff at the receiving unit must receive a handover about the prisoner, including SASH and IPV risk prior to the move being actioned. This should be undertaken through the Transfer CMRC process.