CHAPTER 13

MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM

Introduction

13.1 In this chapter the committee considers issues that arise when people with mental illnesses come into contact with the criminal justice system. The publicity given to critical incidents involving mentally disturbed people might lead the public to believe that a high proportion of people with mental illness commit crimes, but this is not the case. Nevertheless, people with mental illness comprise a disproportionate number of the people who are arrested, who come before the courts and who are imprisoned. The reasons for this, the legislation governing the treatment of people with mental illness who commit crimes and their treatment by the criminal justice system, are dealt with in this chapter.

13.2 The Commonwealth and each state and territory have provisions in their criminal laws for the prosecution and disposition of persons with a mental illness or an intellectual disability.[1]

13.3 These laws provide that unsoundness of mind is a defence to a criminal charge. Application of the laws means that some persons charged with criminal offences are judged not fit to enter a plea, or are found not guilty because of mental disorder, and become 'forensic patients' (The treatment of forensic patients in discussed later in this chapter).

13.4 In most jurisdictions, criminal legislation and other relevant acts, such as bail and sentencing acts, interact with mental health services through the operation of mental health acts.

Law reform and human rights

13.5 The report of the National Inquiry into the Human Rights of People with Mental Illness (the Burdekin Report), which had as its focus the human rights of people with mental illness, reported that the rights of mentally ill people in the criminal justice system were covered by the International Covenant on Civil and Political Rights; the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; and the Body of Principles for the Protection of all Persons under any Form of Detention or Imprisonment. In particular:

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1 ALRC Issues Paper 29, *Sentencing of Federal Offenders*, Chapter 14, p. 8. Information regarding the various legislative provisions were submitted in evidence and may be accessed in the relevant submissions. See *Submissions 165, 343, 376, 377, 445, 470, 476, 502 and 506*.

> The Principles for the Protection of Persons with Mental Illness specifically apply to prisoners. Principle 20 stipulates that they are entitled to the best available mental health care, and to all the rights specified in the Principles, 'with only such limited modifications and exceptions as are necessary in the circumstances'.[2]

13.6 Health authorities of the Commonwealth, states and territories have developed a National Statement of Principles for Forensic Mental Health. The Principles, which are dealt with in more detail later in this Chapter, include the following statement:

> Legislation must recognise the special needs of people with a mental illness involved in the criminal justice system and comply with the International Covenant on Civil and Political Rights, the United Nations Principles on the Protection of People with a Mental Illness and the Improvement of Mental Health Care.[3]

13.7 The evidence demonstrates that state and territory governments are making progress in their endeavours to incorporate or reflect the above principle in legislation. The Queensland Government, for example, informed the committee that a comprehensive review of the state's mental health legislation found that the legislation reflected all significant rights safeguards.[4]

13.8 Other jurisdictions have recently amended relevant legislation or propose to do so. The South Australian Department of Health, for example, stated that among its achievements was a review of the *Mental Health Act* and of section 269 of the *Criminal Law Consolidation Act*,[5] and New South Wales is currently conducting a comprehensive review of the *Mental Health Act 199*0 [NSW].[6] The Australian Capital Territory has announced a review of the *ACT Mental Health (Treatment and Care) Act*.[7]

13.9 It is not clear, however, that the reforms made in all jurisdictions to date have been sufficient to adequately reflect the UN Principles. The Mental Health Legal Centre Inc. (MHLC), a Victorian community legal centre specialising in legal advice, policy and law reform, advocacy and promotion of the rights of people experiencing mental illness, informed the committee that:

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2 Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness – Report of the National Inquiry into the Human Rights of People with Mental Illness*, Canberra 1993, p p. 753.

3 National Statement of Principles for Forensic Mental Health 2002, p. 18.

4 Queensland Government, *Submission 377*, Part II, p. 49.

5 Department of Health – South Australia Government, *Submission 506*, p. 16.

6 NSW Health – NSW Government, *Submission 470*, p.7.

7 Minister for Health – ACT Government, *Submission 165AA*, p. 14.

> Whilst there has been some reduction in the gap between state and territory regimes and the UN Principles, there is a long way to go …[8]

13.10 The MHLC also commented on the 'huge disparity between Australian jurisdictions' and gave the following as an example:

> … depending on where a person lives they may have their involuntary detention reviewed anywhere between 2 and 8 weeks. They may or may not have a right to legal representation; to challenge the use of ECT; to ask a tribunal to vary their treatment, or to obtain a statement of reasons or a transcript of their review hearing.[9]

13.11 With regard to the right to legal representation before Mental Health Review Tribunals, MHLC commented favourably on the law in the Northern Territory, which mandates that the Tribunal appoints a lawyer unless satisfied that is not necessary, and empowers the Tribunal to order the government to pay costs.[10]

Mental Health Courts and Court Liaison Services

13.12 Under their mental health acts, most jurisdictions have established special courts or services designed to assess the mental health of persons arrested or brought before the courts on criminal charges and to divert for treatment those found to have a mental illness.

13.13 Within Australia, Queensland is the only jurisdiction to have established a Mental Health Court, which determines mental responsibility issues – the insanity defence or the defence of diminished responsibility.[11] The Court is constituted by a Supreme Court Judge who receives expert advice and assistance on clinical matters from two 'assisting psychiatrists'. References may be made to the Court by the accused or the accused's legal representative, the Attorney-General, the Director of Public Prosecutions or the Director of Mental Health. The Court is not bound by the rules of evidence and may inform itself in any way it considers appropriate. It may order examinations by psychiatrists and other health professionals and may make forensic orders to provide for treatment in the mental health system.[12]

13.14 All states and territories have established mental health tribunals to assess the continued detention of both civilly committed and forensic patients in the mental health systems.[13] The work of these tribunals has been described as follows:

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8 Mental Health Legal Centre Inc., *Submission 314*, p. 3.

9 *Submission 314*, p. 3.

10 *Submission 314*, p. 5.

11 Dr Janet Ransley, Senior Lecturer, School of Criminology and Criminal Justice, Griffith University, *Committee Hansard*, 2 February 2006, p. 66.

12 Queensland Government, *Submission 377*, Part 2, pp. 72–73.

13 Dr Janet Ransley, Senior Lecturer, School of Criminology and Criminal Justice, Griffith University, *Committee Hansard*, 2 February 2006, p. 61.

> … tribunals have a very difficult task because they have to balance competing paradigms: the criminal justice paradigm, with the expectation that comes from that paradigm about keeping society safe and keeping dangerous people off the streets, and the health and welfare paradigm, which is about treating people and getting them better.[14]

13.15 The tribunals are constituted differently in different jurisdictions, but typically include people with legal and medical qualifications and a member (or members) of the community. They also have different powers; some may make determinations while others make recommendations to the courts or the executive government. In jurisdictions where the tribunals have an advisory role, the decision to release a person from a custodial order will be made by a court or, in some jurisdictions, by the Governor in Council.

13.16 The states and territories have also established mental health liaison programs designed to assess the mental health of persons who come before the courts.

13.17 In New South Wales, for example, a court liaison program was established in 2002 to provide mental health assessments and referral services to magistrates throughout the state. The NSW Government has reported that in the 12 months to July 2004, 18 902 people were screened for mental health problems, and approximately 10 percent (1945) of those people were referred for a comprehensive mental health assessment. Of these, 1413 were assessed as having a severe mental illness or disorder and, as a result:

- 204 people were diverted to hospital for mental health treatment;
- 702 people were diverted to community care; and
- 507 were referred to custodial mental health services in accordance with magistrates' orders.[15]

13.18 South Australia has established a Magistrates Court Diversion Program of alternatives to incarceration for criminal offenders.[16] The program provides an opportunity for eligible individuals to voluntarily address their health or disability needs and any offending behaviours while legal proceedings are adjourned.[17]

13.19 The need for diversion programs and mental health liaison services becomes clear when the prevalence of mental illness among people who come into contact with the criminal justice system is considered.

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14 Dr Janet Ransley, Senior Lecturer, School of Criminology and Criminal Justice, Griffith University, *Committee Hansard*, 2 February 2006, p. 61.

15 NSW Health – NSW Government, *Submission 470*, p. 50.

16 Department of Health – South Australia Government, *Submission 506*, p.16.

17 Australian Institute of Criminology, *Submission 166*, p. 5.

Over-representation of people with mental illness in the criminal justice system

Studies and statistics

13.20 Most people with a mental illness, including those with major illnesses, do not commit crimes,[18] but people with mental illness nevertheless are over-represented in the criminal justice system.

13.21 Numerous studies of the health of people who come before the courts in Australia and in other countries show that the incidence of mental illness among those people is higher than in the general community. Two studies in particular were brought to the committee's notice: *Mental Illness among New South Wales Prisoners* (August 2003)[19] and *Victorian Prisoner Health Study* (February 2003).[20]

13.22 The New South Wales study found that 48 percent of reception inmates and 38 percent of sentenced inmates had suffered a mental disorder in the previous twelve months (A mental disorder was defined as a psychosis, affective disorder or anxiety disorder[21]). When a broader definition of 'any psychiatric disorder' was used, it was found that 74 percent of the NSW inmate population was affected. In Victoria, 51 percent of prisoners reported that they had been assessed, or received treatment by a psychiatrist or a doctor, for an emotional or mental health problem.[22] Together, the studies show that there is a much higher incidence of mental illness in the Australian prison population than in the general population. These findings are also consistent with those of similar studies undertaken overseas.[23]

13.23 Despite the different methodologies used in the studies, in some respects they produced remarkably similar results. The NSW study found, for example, that the prevalence of 'definite' and 'probable' schizophrenia in the prison population was between 4 percent and 7 percent,[24] while the Victorian study reported that schizophrenia was suspected to be present in about 7 percent of that population.[25] A

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18 Victorian Institute of Forensic Mental Health, *Consolidating and Strengthening Clinical Programs: Addressing Dual Diagnosis and Offending Behaviour in Forensic services*, 2004, p. 9.

19 T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003.

20 *Victorian Prisoner Health Study*, Department of Justice, Government of Victoria, 2003.

21 T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 2.

22 *Victorian Prisoner Health Study*, Department of Justice, Government of Victoria, 2003, p. 28.

23 See for example, T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 6, and accompanying footnotes.

24 T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 19.

25 *Victorian Prisoner Health Study*, Department of Justice, Government of Victoria, 2003, p. 30.

'best estimate' reported by the Victorian Institute of Forensic Mental Health (Forensicare) is that 8 percent of male and 15 percent of female prisoners suffer from a psychotic illness, with 5 percent of males and 6 percent of females suffering from schizophrenia.[26] The NSW study reported that the prevalence of psychosis in inmates was 30 times higher than in the Australian community.

13.24 Butler and Allnut found that female prisoners have a higher prevalence of psychiatric disorder than male prisoners.[27] Approximately 90 percent of female reception prisoners had experienced a mental disorder in the 12 months before their incarceration compared with 78 percent of male prisoners; among sentenced prisoners the relevant figures were 61 percent for men and 79 percent for women.[28] Butler and Allnut also found that substance use disorders[29] were more common among females than males in both the reception (75 per cent vs. 64 per cent) and sentenced groups (57 per cent vs. 34 per cent).[30]

13.25 Comparisons between the incidence of mental illness among prisoners and people in the community are based on data published by the Australian Bureau of Statistics (ABS) in *Mental Health and Wellbeing: Profile of Adults, Australia 1997*.[31] The survey was commissioned by the then Commonwealth Department of Health and Family Services within the context of the National Mental Health Strategy (NMHS). According to the ABS, the results of the survey were to assist in the monitoring of 'initiatives of the NMHS and to provide an Australian baseline against which future activity can be compared and evaluated'.[32] The survey found that 18 percent of adult Australians had a mental disorder at some time during the twelve months prior to the survey.[33] That figure contrasts with 74 percent of NSW prison inmates.[34]

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26 Victorian Institute of Forensic Mental Health, *Submission 306*, p. 14.

27 T. Butler and S. Allnut, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 2.

28 T. Butler and S. Allnut, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 14, Table 3.

29 Substance use disorders describe abuse if, and dependence on substances. They refer to the misuse of substance to the extent that the person's functioning is affected. *See* T. Butler and S. Allnut, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 30.

30 T. Butler and S. Allnut, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 30.

31 Australian Bureau of Statistics, *.Mental Health and Wellbeing: Profile of Adults, Australia* 1997.

32 Australian Bureau of Statistics, *Mental Health and Wellbeing: Profile of Adults, Australia* 1997, p. 1.

33 Australian Bureau of Statistics, *Mental Health and Wellbeing: Profile of Adults, Australia* 1997, p. 5.

34 T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 2.

Causes

13.26 There are several reasons for the comparatively high rate of mental illness among people in Australia's prisons. The contributing factors include general disadvantage, including poverty, homelessness and unemployment, deinstitutionalisation, substance abuse, a lack of early intervention and a lack of mental health services in the community.[35]

Homelessness

13.27 The Burdekin Report found that mentally ill people are especially likely to fall foul of laws concerning drunkenness, offensive behaviour, disorderly conduct, loitering or vagrancy (which commonly coincides with homelessness).[36] It was remarked that:

> … at least 75 percent of participants received fines and charges in relation to behaviour that was the direct consequence of their homelessness or mentally ill status, including: fines in relation to begging, drinking in public and other public space offences; activities caused by extreme poverty, such as travelling on public transport without a valid ticket or shoplifting food or other necessities; and activities relating to one of the underlying causes of homelessness, such as drug or alcohol dependency. This is consistent with studies in the US and Canada which have found a strong relationship between homelessness, mental illness and low-level crime.[37]

13.28 Professor Puplick also identified homelessness as being a cause of bringing people with mental illness into contact with the prison system. He suggested that when there is a campaign to make street people disappear they are eventually driven into positions where they come into contact with the police, who in frustration put them somewhere where they are regarded as being secure.[38] Forensicare submitted that it is vital for the successful community reintegration of people with a mental illness on being released from prison that they have access to stable accommodation. Bail applications generally require an address be stated to the Court in order for the application to be successful and area mental health services in Victoria are provided on the basis of address.[39]

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35 For a more comprehensive list of probable causes for the high number of mentally ill people in prison see Butler and Allnutt, *Mental Illness among New South Wales Prisoners*, p. 49.

36 Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993,p. 758.

37 Public Interest Law Clearing House Homeless Persons' Legal Clinic, *Submission 41*, p. 36. The project referred to in this quotation was a law reform project undertaken to identify the difficulties that homeless people face in the court process and to examine options to address those difficulties.

38 Professor Christopher Puplick, *Committee Hansard*, 2 August 2005, p. 43.

39 Victorian Institute of Forensic Mental Health, *Submission 306*, p. 6.

13.29 The Burdekin Report noted that, once arrested, mentally ill people may have trouble obtaining bail because they are too poor to raise bail, because they have no fixed address, or because they do not comprehend or comply with bureaucratic requirements.[40]

Deinstitutionalisation

13.30 A common theme in the evidence was that the closure of mental health hospitals following the Richmond inquiry of some twenty years ago has led to the incarceration of people who formerly would have been housed in those institutions. Sisters Inside submitted that:

> Historically, women have been overrepresented in psychiatric facilities and underrepresented in the prison system. However, with the closure of psychiatric institutions and increasingly overtaxed and under-resourced community based services, Queensland is now witnessing a marked increase in the number of women with cognitive and mental disabilities who are being criminalised.[41]

13.31 Professor Puplick claimed that following the Richmond report, governments were happy to empty out the institutions but not to put money into the community based welfare services that were needed.[42] He also stated that:

> What has become an additional problem since the days of Richmond is the number of people with acute mental health problems, psychiatric problems, which are drug related, which were not at the same level 20-plus years age when Richmond was looking at his original data.[43]

13.32 In a study of the literature on mental illness and the criminal justice system undertaken for the Mental Health Co-ordinating Council, Ms Susan Henderson reported on deinstitutionalisation as follows:

> Deinstitutionalisation is considered by some people within the mental health lobby to be responsible for the high prevalence of people with mental illness in prison … However, … this perspective overlooks an alternative explanation – that people with mental illness present other risk factors of higher risk for imprisonment, such as substance abuse, unemployment, poor education and low income. The confounding role of such evidence was recently demonstrated in an Australian study that showed increased rates of

40 Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, p. 758.

41 Sister Inside, *Submission 283*, p. 43.

42 Professor Christopher Puplick, *Committee Hansard*, 2 August 2005, p. 40.

43 Professor Christopher Puplick, *Committee Hansard*, 2 August 2005, p. 40

> inmates with schizophrenia since deinstitutionalisation parallelled by increased rated of imprisonment across the general population.[44]

Inadequate treatment

13.33 The Burdekin Report reported in 1993 that many people are taken into custody or have their detention prolonged as a consequence of their mental illness or disorder going untreated, and that:

> Untreated mental illness clearly causes some people to behave irresponsibly, irrationally or in a bizarre fashion. Sometimes this behaviour brings people to the attention of the police; in a small number of instances untreated mentally ill people commit violence against others.[45]

13.34 The evidence received by the Committee indicated that the lack of treatment for people with mental illnesses and a lack of continuity of treatment remain major factors in the over-representation of those people in prison:

> The long and short answer is … consumers are overrepresented in the criminal justice system simply because they are denied access to a range of quality mental health services which meet the consumer's individual needs and supports them effectively in the community.[46]

13.35 One tragic example that was related in the evidence concerned a young man with a history of mental illness who was found not guilty of charges of child murder and aggravated sexual assault due to mental illness. Less than a month before the crimes were committed this person had admitted himself to hospital fearful that he would become angry and violent. Despite a diagnosis of schizophrenia and despite doctors warning that he was dangerous, he was discharged after several days. These events, in the words of the Probation and Community Corrections Officers Association, offer 'a clear example of the tragic potential of illicit drug use and schizophrenia when inadequately managed'.[47]

13.36 The Mental Health Council of Australia submitted that the over-representation of people with mental illness in the criminal justice system is partly due to the failure of the mental health system to provide adequate support for those at risk of incarceration. The Council considers that the mental health system has failed to help consumers and carers to access existing services and to provide adequate crisis care.[48]

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44 S. Henderson, *Mental illness and the Criminal Justice System*, Mental Health Co-ordinating Council, 2003, p. 9.

45 Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, p. 757.

46 Northern Beaches Mental Health Consumer Network, *Submission 60*, p. 20.

47 Probation and Community Corrections Officers' Association Inc., *Submission 503*, p. 5.

48 Mental Health Council of Australia, *Submission 262*, p. 24.

Intrinsic causes

13.37 The issues discussed above are relevant for mentally ill people whether or not they come into contact with the criminal justice system. However, some of the possible causes for the high incidence of mental illness among people in the criminal justice system are intrinsic to the system.

Effects of incarceration

13.38 One possible reason for the high levels of mental disorders among prisoners is the effect that incarceration, or the threat of incarceration, may have on them.

13.39 The committee took anecdotal evidence that institutionalisation itself and the control mechanisms within prisons adversely affect inmates' mental health. Particular mention was made of segregation units and safe cells.[49] One witness, Justice Action, claimed that it had evidence of prison-induced insanity.[50] Another witness provided details of a specific case that occurred at the Brisbane Women's Correctional Centre, which indicated that prison in general and seclusion in particular may have deleterious effects on prisoners who already suffer from a mental illness.[51]

13.40 The deleterious effect of incarceration was remarked upon by Butler and Allnutt in their study of mental illness among NSW prisoners:

> Incarceration results in the loss of many person freedoms taken for granted in the community, including social supports, inter-personal relationships, employment, social status, and social role. These losses are commonly correlated with depressive disorder. At the time of reception almost one-quarter were diagnosed with mood disorder …[52]

13.41 The committee has also noted a comment made in a submission from Professor Gavin Andrews, Scientia Professor of Psychiatry, UNSW at St Vincent's Hospital, which suggested that incarceration may be a factor in the incidence of some mental illnesses among prisoners. He submitted that:

> Anxiety and depression are three times more common among inmates than in the matched general population. They are seldom the reason why the crime was committed and may give an indication of the person's background or current predicament …[53]

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49 See for example, Sisters Inside, *Submission 258*, and Justice Action*, Submission 174*.

50 Justice Action, *Submission 174,* p. 4.

51 Ms Michelle Tanin, *Committee Hansard*, 4 August 2005, pp. 77–87.

52 T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 2.

53 Professor Gavin Andrews, *Submission 176*, p. 12.

Role of sentencing

13.42 Another reason for the over-representation of mentally ill people in prison is that, in the absence of programs to which offenders may be referred, courts may have no option other than to sentence offenders to prison. This issue was brought to the committee's attention by the Northern Territory Legal Aid Commission and the Northern Territory Community Visitor Program:

> Many people who suffer from a mental illness are not suitable for community work or home detention which leaves jail as the only option.[54]

13.43 To the extent that other Australian jurisdictions have established programs designed to divert mentally ill offenders from gaol, this may not be as common a cause nationally as it was in the past. Diversion programs, however, are useful only to the extent that there are practical alternatives to which offenders can be diverted. Diversion programs are discussed in more detail later in this Chapter.

13.44 Another aspect of the role that sentencing plays in the over-representation of people with mental illness in the criminal justice system is the tendency in some jurisdictions towards the imposition of longer sentences. Professor Puplick informed the committee that:

> Mental health problems can be compounded by sentencing practices. Longer sentences inevitably mean a greater habituation to prison environments and a diminished capacity to reintegrate into the external community, especially for those already facing problems of social competence. In this sense longer sentences contribute to the problem of recidivism – thus the endless cycle starts![55]

Access to the legal system

13.45 People with mental illnesses are vulnerable in society and in prison. The Office of the Public Advocate – Queensland (OPA-Q), for example, in a paper submitted to the inquiry, referred to a Victorian Government study, *Mental illness and violence*, that had found that almost one fifth of people with a psychotic illness had been a victim of violence in the previous twelve months.[56]

13.46 The OPA-Q also quoted a study in which it is argued that if the experiences of victimisation are not resolved to the satisfaction of the victim, these experiences may later precipitate critical mental health incidents.[57]

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54 Northern Territory Legal Aid Commission and the Northern Territory Community Visitor Program, *Submission 348*, p. 13.

55 Professor Christopher Puplick, *Submission 226*, p. 10.

56 Office of the Public Advocate – Queensland, *Preserving life and dignity in distress,* Discussion Paper 4, March 2005, p. 32.

57 Office of the Public Advocate – Queensland, *Preserving life and dignity in distress,* Discussion Paper 4, March 2005, p. 32.

13.47 The chances of achieving an outcome satisfactory to a mentally ill victim are not good for a number of reasons, including the victim's perceived unreliability as a witness and the victim's limited access to legal assistance. Apart from general disadvantages such as poverty and homelessness that would limit access to legal redress, many mentally ill people, even if legal aid is available, are not able to take advantage of that aid.

13.48 Mental health problems pose a serious challenge to the provision of adequate legal advice. The problems arise at all points in the process of providing legal assistance, from the provision of initial advice to critical incidents. Some of the reasons given for these difficulties are clients' inability to inform their lawyers of their situation, their paranoia, for example, unwillingness to speak with a lawyer lest the phone be tapped, and unwillingness of many to accept that they suffer from an illness.[58] Ms Vivienne Topp, a lawyer and policy worker employed by the Mental Health Legal Centre, stated, however, that one of the Centre's major concerns is 'the lack of rigour applied in dealing with people's complaints'.[59]

13.49 Whatever the reasons, people with mental illness generally will not have legal redress for cases of victimisation. This may lead to critical mental health incidents in which mentally disturbed individuals come into contact with the criminal justice system.

Role of the Police

13.50 Mentally ill people who come into contact with the criminal justice system usually first come into contact with the police either when they are detained for their own safety or the safety of others in a critical incident, or, more often, when they are arrested for a misdemeanour or a petty crime. One witness has described police officers as 'the front line mental health practitioners'.[60]

13.51 Although critical incidents are relatively rare, they naturally attract publicity because they occasionally result in the death or injury by shooting of a mentally disturbed person, or to the death or injury of other persons, including police officers.

13.52 Police usually have to deal with these critical incidents without any support from mental health professionals. This is true especially of incidents that occur after hours, or when mental health professionals will not attend because their life or safety may be endangered.[61] In regional and especially in remote areas, the only emergency service likely to be available to respond in a crisis is the police service.

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58 Combined Legal Centres' Group (NSW) Inc., *Submission 232*, p. 16.

59 Ms Vivienne Topp, *Committee Hansard*, 6 July 2005, p. 27.

60 White Wreath Association, *Submission 91*, p. 16.

61 See for example, Ms Elizabeth Crowther, Mental Illness Fellowship, *Committee Hansard*, 5 July 2005, pp. 95-96.

13.53 More often the situations in which police deal with people with mental illness do not involve violence or danger, but even in those situations their actions can have serious consequences. One witness whose 21 year old son who had a history of mental illness and who committed suicide informed the committee that:

> My son's behaviour also attracted the attention of one rather vindictive police constable who arrested, charged and remanded him on a charge that would later be disproved in the Dandenong Magistrate's Court. The police paid all the court costs but that didn't spare my son the entire ordeal, including the seven weeks he spent in remand.[62]

13.54 Another witness, the Mill Park Family Support Group, submitted that:

> Many members of the Group have had loved ones imprisoned due to a total misunderstanding of their behaviour and actions. Police are often told that a person has a mental illness, but they still take them away and often hold them over night. This is not only extremely frightening, but also a waste of police resources and community funding.[63]

13.55 Some carers in Victoria expect that crisis assessment teams will respond in an emergency, but that is not necessarily the case – the teams are not an essential service like police and ambulance services.[64] Community mental health teams in NSW likewise may not attend critical incidents.[65]

13.56 The Police Federation of Australia stated that several jurisdictions had developed memoranda of understanding (MOUs) in relation to cooperation of health and police services, especially for dealing with crisis situations, but that these MOUs are often not complied with by mental health staff and hospitals. The Federation recommended that the MOUs be included in legislation.[66]

13.57 The Federation also raised concerns regarding the response to critical incidents involving the mentally ill. As mentioned above, these incidents sometimes result in fatalities:

> A report released in June 1998 on police shootings showed that more than half the 41 people shot dead by Australian police officers since 1990 were under the influence of drugs or alcohol and one third were depressed or had a history of psychiatric illness – a clear indication that the system is failing.[67]

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62 Name withheld, *Submission 15*, p. 1.

63 Mill Park Family Support Group, *Submission 72*, p. 3.

64 Ms Elizabeth Crowther, Mental Illness Fellowship, *Committee Hansard*, 5 July 2005, p. 96.

65 Mr Michael Strutt, *Committee Hansard*, 2 August 2005, p. 95.

66 Police Federation of Australia, *Submission 254*, pp. 4–5.

67 *Submission 254*, p. 13.

13.58 The Queensland Government is attempting to address the issue by establishing Mental Health Crisis Intervention Teams that are intended to involve both the police and mental health personnel acting together to de-escalate crisis situations so as to resolve the situations safely and humanely.[68]

13.59 Police frequently spend hours sitting in hospitals with apparently mentally disturbed individuals awaiting mental health assessments, but the individuals are often found not to be ill under the provisions of the mental health legislation. Police resources get tied up in other ways: using police resources for transporting mentally ill people; having people abscond from institutions because of poor security; and repeated use of the 000 emergency number by mentally disturbed individuals.[69]

13.60 The Police Federation advocated better training for police regarding their obligations to mentally ill people, but it was concerned that better training might be counter productive. For example, the Federation suggested that mental health professionals might not respond to incidents on the basis that the police were trained to deal with them. The Federation also was concerned that the public might take the view that the police were thoroughly trained when in fact they could not be expected to be mental health experts.[70] Nevertheless, it recommended training for police officers not only in regard to their obligations to mentally ill people but also in relation to dual diagnosis.[71]

13.61 A witness whose 29 year old son had been shot dead by a police officer stated that:

> If the police service is to continue to be left to deal with the results of an inadequate health service, they need to be given whatever training is needed to help them to deal appropriately with people with mental illness.[72]

13.62 Another witness stated that:

> … ambulance and police officers need to have competencies in handling the many and varied circumstances they confront. Managing any violence is only one of the potential scenarios. They will most likely also confront persons in various stages of distress …
>
> For the sake of the officer, the patients, the families and others they come in contact with, these officers need up to date training … They also need to care for their own mental health.[73]

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68 Queensland Government, *Submission 37,* Part II, p. 12; Mr L Irons, Senior Research Officer, Office of the Public Advocate, Queensland, *Committee Hansard*, 4 August 2005, p. 99. A possible model for a police response team, the Memphis Crisis Intervention Team, may be found at pp. 25–31 of the Public Advocate's Discussion Paper 4, Appended to *Submission 303*.

69 For more details of these issues, see Police Federation of Australia, *Submission 254*.

70 *Submission 254*, pp. 14–15.

71 *Submission 254*, p. 8.

72 Mrs Jan Kealton, *Submission 537*, p. 4.

13.63 The allocation of more resources to mental health, including more beds in hospitals, more staff and better community programs, would relieve police of the excessive burden of care for the mentally ill, returning the care of the mentally ill to where it can best be managed, by mental health professionals.[74]

Management and treatment of people with a mental disorder in the criminal justice system

The National Statement of Principles for Forensic Mental Health

13.64 The National Statement of Principles for Forensic Mental Health sets down 13 principles for dealing with offenders or alleged offenders who have a mental illness. The Statement was endorsed by the National Mental Health Working Group of the Australian Health Ministers' Advisory Council and was presented to the Correction Service Administrators Conference in May 2003.[75] The Australian Government informed the committee that it was working with the state and territory governments and with the corrections sector to develop approaches to implementation of the principles.[76]

13.65 In addition to the need for Australian laws to conform to the UN Principles, the Statement covers matters such as the proper provision of mental health care for offenders, ethical treatment, skills of the workforce and transparency and accountability.

13.66 The Statement's 'target group' includes people referred for psychiatric assessment or treatment and people found not fit to enter a plea or found not guilty by reason of mental impairment. The target group also includes people in mainstream mental health services who are a significant danger to others and who require the involvement of a specialist forensic mental health service.[77]

Diversion

13.67 As discussed earlier in this chapter, in most Australian jurisdictions mentally ill people may be diverted by the courts from the criminal justice system to the health system. Magistrates' courts may make orders for treatment of offenders following advice received from the relevant court liaison service. Diversion may result in people who would otherwise be imprisoned being released, perhaps subject to a community treatment order. In general, only those persons facing minor summary offences would be released.

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73 Health Consumers of Rural and Remote Australia, *Submission 106*, p. 3.

74 Police Federation of Australia, *Submission 254*, p. 16.

75 Australian Government, *Submission 476*, p. 65.

76 *Submission 476*, p. 65.

77 National Statement of Principles for Forensic Mental Health 2002, pp. 3-4.

13.68 In South Australia a specialist sentencing court has been established to which mentally ill offenders may be directed. The South Australian Magistrates Court Diversion Program (mental impairment) commenced in 1999 as a pilot, and subsequently was funded by the South Australian Government to continue and expand its operation. The program is designed to meet the needs of individuals appearing before the Magistrates Court who have committed certain minor and summary offences and who have impaired intellectual functioning. The program facilitates a range of health and other appropriate services to assist those individuals:

> Participants are being successfully diverted away from long term involvement with the Criminal Justice System by introducing or re-establishing links with treatment and support services while highlighting both the mental impairment and criminogenic needs of participants referred by the Court.[78]

13.69 People who have been charged with indictable offences, especially offences involving serious violence, and who have been found not fit for trial or acquitted on grounds of mental impairment, are likely to be ordered to be treated in a secure facility. Traditionally such people are categorised as 'forensic patients'.

Forensic mental health care

Forensic patients

13.70 Forensic patients constitute a small group in relation to the total prison population and to the prison population with a mental illness.[79] Other people may, however, be treated in forensic mental health facilities. Seriously ill people who were not identified as being mentally ill when they were tried and convicted, people who become seriously ill while in prison, and people in the community who pose a threat to themselves or others may well be confined within a secure facility.

13.71 There are differences between these groups of patients, in that people who were sentenced by the courts will be released when they have served their term of imprisonment, whereas people who were detained without being sentenced face indefinite detention in a secure mental health facility and may in fact never be released.

Facilities

13.72 All jurisdictions make some provision for the care of forensic patients, but that provision is inadequate, both for secure facilities and for follow-up care in the community.

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78 Magistrates Court of South Australia, *Submission 175*, p. 2.

79 See figures quoted earlier by Professor Christopher Puplick, *Submission 226*.

13.73 As at 30 June 2002, in Australia there were 424 inpatient beds for forensic patients.[80] Although NSW had the most beds (166) it seems that the best-resourced facilities for caring for forensic offenders are in Victoria, where a statutory body, the Victorian Institute of Forensic Mental Health (Forensicare), is responsible for providing forensic mental health care.

13.74 Forensicare, which has been described as a world leader in forensic mental health,[81] provides a number of services, including managing a 'state of the art' 100 bed secure inpatient facility, the Thomas Embling Hospital (TEH). Forensicare also provides the courts with opinions on the mental health of persons charged with offences, and treats prisoners and individuals for whom the courts have mandated psychiatric treatment and other individuals who are deemed to present a serious risk of serious offending.[82]

13.75 However, even in Victoria resources are inadequate. Forensicare stated that forensic mental health in Victoria has a pressing and increasing requirement for additional inpatient beds to meet the needs of the criminal justice system. Forensicare stated that although TEH opened as recently as 2000, its capacity was based on a forecast peak prison population of 2500. By June 2004 the prison population had increased to 3624, and imprisonment rates had increased from 66 per 100 00 to 94 per 100 000 of the population. [83] Nationwide, there appears to be no forensic facilities for adolescents, meaning treatment regimes for this group involve transfers back and forth between health facilities and detention, disrupting recovery.[84]

13.76 Another factor affecting the higher-than-expected demand for TEH services is that its bed capacity was determined before the reform of Victoria's mental health legislation in 1997. Forensicare informed the committee that:

> The *Mental Impairment and Unfitness to be Tried Act 1997* is a huge improvement on the earlier system of detaining people indefinitely at the 'Governor's Pleasure', but it has led to more people (appropriately) using the defence. Overseas experience suggests that the current rates of disposition will increase.[85]

13.77 The committee was informed, however, that Trieste in Italy, a region of 1.1 million, had only one forensic patient in January 2006. The level of demand for forensic beds may thus be related to more than just the size of the prison population.

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80 Department of Health and Ageing, *National Mental Health Report 2004*, Commonwealth of Australia, Canberra, Table A-21, p. 77.

81 See for example, Minister for Health – ACT Government, *Submission 165 AA*, p. 14.

82 Victorian Institute of Forensic Mental Health, *Submission 306*, pp. 2-3.

83 *Submission 306*, p. 5.

84 Dr Theresa Flower and Dr Robert Adler, *Submission 263*.

85 *Submission 306*, p. 4.

13.78 Forensicare informed the committee that step-down medium secure/intensive care beds are required, and identified additional needs including the establishment of a unit for elderly forensic patients and an exit unit to manage forensic patients within the community.[86]

13.79 Given that the best-resourced jurisdiction has a 'pressing and increasing requirement' for more facilities, the situation in the other states and territories must be far from ideal. There have, however, been initiatives taken in all Australian jurisdictions to try to address the problem.

13.80 New South Wales and Tasmania are currently constructing secure mental health units, and South Australia is planning a similar facility.[87] Queensland has recently opened a medium and high security forensic facility in Townsville in the north of the state to enable mentally ill offenders to receive treatment closer to their communities.[88]

13.81 Western Australia and the Northern Territory face particularly difficult challenges in providing for forensic patients owing to their geography and large indigenous populations. In the Northern Territory there is not a dedicated forensic mental health facility and 'persons found not guilty of a charge due to mental impairment may be subject to a custodial supervision order at a correctional facility'.[89] There are several beds for forensic patients in Western Australia and the Western Australian Government has made provision in its *Mental Health Strategy 2004-2007* to increase by twelve the number of acute secure beds at Greylands Hospital.[90]

13.82 It seems, however, that the planned facilities when built will still not meet ever-growing demand. In New South Wales for example, the number of forensic patients increased from 21 in 1982 (0.7 percent of the prison population) to 100 in 2003 (1.1 per cent).[91] Professor Mullen, the Clinical Director of Forensicare, in answer to a question about the demand for beds at the TEH, responded as follows:

> So what actually happens is what often happens in any acute medical service: the number of available beds determines the level at which you set your admission, rather than some notion that you would eventually find enough beds for the service. I do not think that is a practicality.[92]

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86 Victorian Institute of Forensic Mental Health, *Submission 306*, p. 5.

87 NSW Health – NSW Government, *Submission 470*, p. 50, Tasmanian Government, *Submission 502*, pp. 9-10; Department of Health – South Australia Government, *Submission 506*, p. 16.

88 Queensland Government, *Submission 377*, Part I, p. 10. Victorian Institute of Forensic Mental Health, *Submission 306*, p. 4.

89 Northern Territory Government, *Submission 393*, p. 22.

90 Department of Health – Government of Western Australia, *Submission 376,* p. 19.

91 Professor Christopher Puplick, *Submission 226*, p. 8.

92 Professor Paul Mullen, Clinical Director, Victroian Institute of Forensic Mental Health *Committee Hansard*, 6 July 2005, p. 40.

Female forensic patients

13.83 There is a pressing need to improve treatment of women prisoners, with the conditions in which they are currently held appearing seriously inconsistent with desirable clinical practice. In Australia there are few separate facilities for female forensic patients. In New South Wales there is no separate dedicated forensic hospital for either male or female prisoners and in Queensland:

> It is also clear that the forensic unit at John Oxley, Wolston Park, is overcrowded and not generally available for women prisoners with serious mental illness who may benefit from its services. There is a shortage of mental health beds in the Queensland health system generally for security patients. Because of the inadequate capacity or the reluctance of relevant authorities to admit and treat acutely ill patients, it appears that on more than a few occasions, women prisoners with acute mental illness may be being inappropriately detained and receiving inadequate treatment in either the CSU [Crisis Support Units], DU [Detention Units] or health units in the women's prisons.[93]

13.84 In Victoria there is a psychiatric unit in the men's prison that 'has at least some potential to provide a therapeutic and holding system for people with mental illness' if they are not able to be admitted to the TEH.[94] There is not a psychiatric unit in the women's prison (Deer Park), however, and:

> Sadly, a number of them [women prisoners with a mental illness] finish up in the block which is designated primarily as a control system and not as a mental health care system.[95]

13.85 When the committee members visited the Brisbane Women's Correctional Centre (BWCC) they were informed that women at the gaol typically wait three weeks after being assessed as needing a bed in the 'men's' John Oxley inpatient facility and that 10 percent of the female prison population of 250 are in secure units. The BWCC employs one senior psychologist and four others who conduct assessments and some group-based programs in cognitive skills, but there is no capacity to engage in long-term psychological intervention. A psychiatrist visits, mostly to review medication. There is also a full-time drug and alcohol counsellor.

Report of the Anti-Discrimination Commission Queensland

13.86 The Anti-Discrimination Commission Queensland published a report *Women in Prison* in March 2006. The Commission found that:

> Many women with mental illness are inappropriately detained in prison while their mental health needs are left unattended. Women prisoners have a much higher rate of mental health problems than men prisoners, but their

93 Anti-Discrimination Commission Queensland, *Women in Prison*, March 2006, p. 96.

94 Professor Paul Mullen, *Committee Hansard*, 6 July 2005, p. 40.

95 Professor Paul Mullen, *Committee Hansard*, 6 July 2005, p. 41.

> needs are not presently addressed. A significant increase in resources is necessary if women with mental illness are to be properly dealt with within the correctional system. Proposed changes to crisis support units, including a reduction in strip-searching, are welcomed, but address only part of this problem. Much more is needed.[96]

13.87 The Commission made seven recommendations on mental health matters. These covered: more diversionary programs for women; addressing systemic issues to reduce the over-representation of women with mental illness in state prisons; enhancement of services, including increasing the number of beds in secure psychiatric medical facilities; limiting seclusion; addressing substance abuse, mental illness and sexual assault issues; training of prison officers; and provision of step-down accommodation facilities.[97]

13.88 The report also recommended that there be an independent review:

> That the Human Rights and Equal Opportunity Commission conducts a review into how the justice and prison systems across Australia are dealing with women with mental health issues.[98]

Costs of facilities

13.89 The provision of facilities to treat forensic patients and prisoners with serious mental illnesses is resource intensive and the cost of the facilities and of caring for the health of prisoners is met by the state or territory governments. The daily cost of providing a bed in an Australian forensic facility was $542 in 2001-2002. Costs ranged from $372 in NSW to $938 in the Northern Territory.[99]

13.90 The Northern Territory Government submitted that forensic patients should be accommodated in a safe and therapeutic environment oriented toward rehabilitation and community reintegration, but that establishing such a facility in a very small jurisdiction would require a substantial capital investment and operational funding.[100]

13.91 In relation to the relative costs of caring for mentally ill people, Professor Christopher Puplick, a former chair of the Central Sydney Health Service, informed the committee that:

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96 Anti-Discrimination Commission Queensland, *Women in Prison*, March 2006, pp. 5–6.

97 Anti-Discrimination Commission Queensland, *Women in Prison*, March 2006, pp. 12–13.

98 Anti-Discrimination Commission Queensland, *Women in Prison*, March 2006, p. 15.

99 Department of Health and Ageing, *National Mental Health Report 2004*, Commonwealth of Australia, Canberra, Table A-21, p. 78.

100 Northern Territory Government, *Submission 393*, p. 23.

> It costs between $50 000 and $60 000 a year to maintain a prisoner in jail, but up to $200 000 per year to maintain a mental health bed in the NSW public health system.[101]

13.92 Professor Puplick concluded that:

> … 'treating' a mentally ill person by incarceration rather than by hospitalisation is three or four times cheaper to the State budget.[102]

Staffing

13.93 Principle three of the *National Statement of Principles for Forensic Mental Health* states, in relation to the responsibilities of the health and justice systems, that 'mental health services should be staffed by mental health personnel employed by a health service … not correctional agencies'.[103]

13.94 Although health authorities throughout the Commonwealth agree that the management of forensic mental health is a matter for the health authorities, it is not clear that all jurisdictions necessarily accept that argument. In Queensland, for example, the custodial departments are responsible for the mental health of prisoners, but services are purchased from external suppliers, 'reflecting an important separation between the provision of health services and the custodial provider'.[104] In New South Wales a statutory corporation, Justice Health, which reports to the Minister for Health, is responsible for providing medical services to prisoners 'in partnership with the Department of Corrective Services'.[105]

13.95 Butler and Allnutt reported that the majority of mental health providers within the NSW correctional environment are 'obligated to conform with the correctional ethos'. They commented that:

> This is fertile ground for conflicting priorities between clinical needs (the health priority) and security (the custodial priority). The correctional approach to the management of difficult behaviour can be the antithesis of the mental health approach.[106]

Treatment in prison

13.96 Although it is generally agreed by health authorities that prisoners requiring inpatient mental health care should be transferred from prison to an appropriate mental

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101 Professor Christopher Puplick, *Submission 226*, p. 11.

102 *Submission 226*, p. 11.

103 *National Statement of Principles for Forensic Mental Health 2002*, p. 8.

104 Queensland Government, *Submission 377*, Part II, p. 47.

105 NSW Health – NSW Government *Submission 470*, p. 50.

106 T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, 2003, New South Wales Corrections Health Service, p. 50.

health facility located beyond the geographical boundaries of the prison and run independently from correction services,[107] this will not occur in the absence of sufficient appropriate facilities. Moreover, relatively few prisoners with a mental illness are so seriously ill that they require inpatient treatment, but they still require treatment, and that treatment, if provided, will generally be in gaol. The availability and adequacy of treatment for mentally ill people within Australia's prisons are therefore important matters.

13.97 The ACT Government stated that the National Principles provide a clear framework for appropriate care within corrections facilities.[108] The first of those Principles, for example, reads as follows:

> Prisoners and detainees have the same rights to availability, access and quality of mental health care as the general population. Where health facilities are provided within a correctional facility, there should be appropriate equipment and trained staff, or arrangements made for such services to be available, at a standard comparable to regional and community standards.
>
> Services should ensure equality in service delivery regardless of an individual's age, gender, culture, sexual orientation, socio-economic status, religious beliefs, previous conditions, forensic status, and physical or other disability. This Principle of Equivalence applies to both primary and specialist mental health care.[109]

13.98 NSW Health informed the committee that it 'continued to provide high quality in-reach mental health programs across all correctional facilities',[110] but the evidence is that treatment of mental illnesses in Australian prisons is inadequate. Forensicare, for example, stated that, 'Adequate mental health services are rare in prison'.[111] That judgement is supported by evidence submitted by Sisters Inside, an organisation which advocates for the human rights of women in the criminal justice system, which stated, in relation to mental health resources allocated to Queensland prisons, that:

> In our prison system at the moment we have … 1.5 mental health workers for 3500 prisoners. Prisons have become the de facto psychiatric units but with no mental health professionals.[112]

13.99 Professor Puplick informed the committee that it appears that only 8 percent of men and 23 percent of women who had been diagnosed with some form of mental illness were on psychiatric medication while in prison.[113]

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107 *National Statement of Principles for Forensic Mental Health 2002*, p. 8.

108 Minister for Health – ACT Government, *Submission 165*, p. 14.

109 *National Statement of Principles for Forensic Mental Health 2002*, p. 6.

110 NSW Health – NSW Government, *Submission 470*, p. 50.

111 Victorian Institute of Forensic Mental Health, *Submission 306*, p. 19.

112 Ms Debbie Kilroy, OAM, Director, Sisters Inside, *Committee Hansard*, 4 August 2005, p. 92.

> In fairness I should mention that while in prison many of these same people will probably be better fed and housed and have better access to health services than at almost any other time in their lives – itself a shocking indictment of our general level of services for the mentally ill in the community.[114]

13.100 Professor Andrews also commented on the adequacy of mental health services to people in gaol:

> NSW Health is providing psychiatric care in prisons, albeit not sufficiently, but almost certainly more than was available to prisoners before they came to jail.[115]

13.101 Professor Andrews stated that priority should be given to providing treatment in gaol:

> Once we get 80 percent of people with mental disorders getting treatment [the level of treatment of most physical disorders] we could look at diversion programs for those in the criminal justice system. Until then let us be proactive in arranging good treatment in jail.[116]

13.102 Nevertheless there are difficulties involved in providing treatment in a setting that is not necessarily conducive to effective treatment of people with mental illness. Effective treatment in prison may be impossible because prison officials focus on security and placement issues rather than treatment.[117] The Mental Health Legal Centre stated that men and women with mental health issues report that they are reluctant and even frightened to reveal them because there is little support and lots of discrimination.[118] The Australian Doctors' Fund submitted that imprisonment of the mentally ill is a barrier to the delivery of good psychiatric care.[119]

13.103 In a supplementary submission Professor Andrews stated that some people believe that people who meet criteria for a mental disorder should be in hospital rather than in jail. If that were done, however, a substantial proportion of the present jail population would have to be accommodated in secure mental health units. He suggested that as there is no test for a mental disorder and the diagnosis is based on symptoms, presumably most prisoners when they recovered would continue to

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113 Professor Christopher Puplick, *Submission 226*, p. 8.

114 *Submission 226*, p. 9.

115 Professor Gavin Andrews, *Submission 176A*, p. 1.

116 Professor Gavin Andrews, *Submission 176*, p. 12.

117 Public Interest Advocacy Centre, *Submission 373*, p. 14.

118 Mental Health Legal Centre, *Submission 314*, p. 23.

119 Australian Doctors' Fund, *Submission 356*, p. 1.

complain of symptoms until their jail sentence had expired, for to do otherwise would result in their being returned to jail.[120]

13.104 Treating offenders in hospital rather than imprisoning them also raises the question of whether offenders are able to avoid the full consequences of their criminal acts.

Involuntary treatment and seclusion

13.105 Involuntary treatment of prisoners raises human rights concerns:

> TEH also provides involuntary treatment of prisoners with mental illness, as under mental health legislation Victorian prisons are not able to undertake such treatment. Victoria is of the view that involuntary treatment in prisons without clear separation of custodial and treatment requirements is contrary to the principles contained in the Mental Health Act and in breach of international human rights obligations.[121]

13.106 Professor Puplick told the committee that the incarceration of forensic patients in New South Wales is in 'clear breach of domestic legislation, the National Medical Health Forensic Policy and the United Nations Declaration of Human Rights'.[122]

13.107 Professor Mullen, Clinical Director of Forensicare, stated that in the past, when it was possible to treat mentally ill prisoners compulsorily in gaol, medications had been used, not for treatment but for control and punishment. He stated that although there are many short-term solutions which may appeal, he hoped that the compulsory treatment of patients within prison would be resisted.[123]

13.108 Seclusion of prisoners who have been assessed as being at risk of suicide, self-harm or as a danger to others raises greater concerns. The committee received evidence from Sisters Inside about the 'Crisis Support Unit S4' isolation cells at the Brisbane Women's Correctional Centre (BWCC) and the Chair and one other member of the committee subsequently visited the gaol. At the time, all but one of the nine women in these cells were affected by a serious mental illness. The cells have been designed so that there are no furniture or design features that would allow them to harm themselves. The prisoners are locked down for 19 or so hours a day, are given only a hospital gown to wear and are under constant video surveillance.[124] The Chair was advised by management that strip searches are mandatory for reception, whenever isolation cell inmates are escorted out of their cells and on return, after contact visits, whenever leaving an area in the facility such as the health centre, when placed on

120 Professor Gavin Andrews, *Supplementary Submission 176*, p. 1.

121 Victorian Minister for Health – Victorian Government, *Submission 445*, p. 9.

122 Professor Christopher Puplick, *Submission 226*, p. 8.

123 Professor Paul Mullen, *Committee Hansard*, 6 July 2005, p. 50.

124 Sisters Inside, *Submission 283*, pp. 15–22.

observation and every evening. The requirement for a further three strip searches at meal break times had recently been removed.

13.109 It is alarming to note that though these women are regarded as at very high risk of self harm, many were on relatively short sentences and would soon be released. The rate of recidivism amongst these women was said to be very high.

13.110 The process of isolating such persons and placing them in seclusion appears effectively to prevent suicide and may prevent disruption to other inmates, but is hardly therapeutic for people who are mentally ill. A former visiting general practitioner to the BWCC, Dr Schrader, made the following observations about the use of the isolation cells at the Centre:

> The treatment is the opposite of therapeutic. The use of seclusion is inappropriate for those of risk of self-harm and suicide. Observation alone does little to help the woman overcome her distress and suicidal or self-harming feelings and is alienating in itself … A key element in suicide prevention is the presence of human interaction.[125]

13.111 The committee heard similar evidence about the use of seclusion facilities for prisoners assessed to be 'at risk' in other jurisdictions. Mr Strutt, a member of Justice Action, a prisoners' activism organisation, referring to the use of isolation cells in NSW, stated that:

> If you are a prison officer and you see a prisoner who seems to be seriously depressed … your No. 1 priority is to make sure that that person does not kill themselves while you are on duty. So basically you put them in a strip cell. For all the talk about care and attention they are getting in prisons and hospitals, the way those institutions are structured means they are not getting the appropriate care and attention.[126]

Treatment of psychotic prisoners

13.112 Although anxiety and depressive conditions appear to be common among prisoners, corrections and health authorities devote most resources to the treatment (or control) of prisoners with relatively low incidence disorders, in particular, psychoses.

13.113 Butler and Allnutt found that psychosis was more common among reception prisoners than among sentenced inmates (12 percent vs. 5 percent).[127] The reason for this is not clear, but it is possible that less access to drugs in prisons may contribute to a lower incidence of drug-induced psychosis and that people in prison are more likely to receive treatment than if they remained in the community.

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125 Dr Tracy Schrader, *Submission 396*, p. 4.

126 Mr Michael Strutt, Researcher and Spokesperson on Forensic and Cirminiological Issues, Justice Action, *Committee Hansard*, 2 August 2005, p. 97.

127 T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 19.

13.114 One psychotic illness in particular is of concern to mental health and criminal justice authorities. Professor Andrews informed the committee that the association between violent crime and schizophrenia is well established in the United States of America and Denmark, and that a careful compilation of state statistics might well show a comparable situation exists in Australia.[128] Professor Andrews referred to a paper with which he is associated and which has been submitted for publication where it is reported that rates for psychotic-like experiences were 11 times higher among people being admitted to NSW prisons than in the general population.[129] Forensicare also referred to evidence that shows that those with severe mental illness, particularly schizophrenic illnesses, are more likely to commit criminal offences and more likely to end up in prison.[130] Forensicare referred to a Victorian study that found that those with schizophrenia make up between 0.5 percent and 0.7 percent of the Australian population but are responsible for 5 percent to 10 percent of homicide and seriously violent offending.[131]

13.115 Professor Andrews submitted that:

> Psychosis is associated with violence and treatment in a secure facility for some is essential, whether we call this a hospital or a jail is irrelevant as long as treatment is delivered.[132]

'Least restrictive alternative' for treatment

13.116 The Human rights and Equal Opportunity Commission (HREOC) informed the committee that Principle 9 of the UN Mental Health Principles 'emphasises the importance of "the least restrictive alternative" in relation to treatment.[133] This principle raises additional issues in relation to the treatment of forensic patients in gaol. Diversion programs are an attempt to treat forensic patients in a less restrictive environment than a prison. Diversion may result in treatment in the community. Both appear to offer a 'less restrictive environment' than does a prison.

13.117 Secure facilities may not necessarily offer a 'less restrictive alternative' than prison if the patient faces an indeterminate period of confinement in the facility. Even where Mental Health Tribunals recommend that people be released, unless the decision is made by, for example, a court, rather than treated as an exercise of executive discretion, people may be confined for long periods. One NSW case brought to the committee's attention concerned a man who shot another, was found not guilty of grievous bodily harm on the grounds of mental illness, whose release into the

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128 Professor Gavin Andrews, *Submission 176*, p. 7.

129 Professor Gavin Andrews, *Supplementary Submission 176*, p. 1.

130 Victorian Institute of Forensic Mental Health, *Submission 306*, p. 14.

131 *Submission 306*, p. 15.

132 *Submission 176*, p. 12.

133 Human Rights and Equal Opportunity Commission, *Submission 368*, p. 2.

community was recommended by the Mental Health Tribunal, but who has not been released by the responsible minister.[134]

13.118 In most Australian jurisdictions the responsibility for deciding on the release of forensic prisoners has been, or will be, removed from the political arena. The Tasmanian Government, for example, is drafting new legislation to provide that:

> Decisions regarding the discharging of patients [from the new secure mental health unit] will be based on health and risk management grounds, with the final decision body being the Supreme Court of Tasmania. This will ensure that management decisions are quarantined from the political process.[135]

13.119 These legislative changes give effect to the following recommendation of the Burdekin Report:

> Decisions concerning the release of persons unfit to be tried or not guilty on the grounds of insanity should be made by courts or independent specialist tribunals. These bodies should exercise determinative powers. The executive branch of government should not have the ultimate responsibility for release decisions.[136]

13.120 The transfer of responsibility for the release of forensic patients to the courts or the mental health tribunals may well result in the release of more people than at present. The (appropriate) release of more people than formerly released makes the provision of proper step-down programs and other treatment options in the community even more important and urgent.

Release policies and practices

13.121 The evidence shows that corrections authorities throughout Australia generally have developed and established relatively enlightened policies for the care of prisoners with mental illness. They also generally have enlightened policies for the release of prisoners. However, it seems that the practice often may be different from the theory, both as regards care and release.

13.122 A study of release policies and practice in Queensland (*In*corrections) was submitted by the Centre for Social Justice, a division of UnitingCare Queensland. The study, among many other things, listed the needs of newly released prisoners - a list that included access to money for immediate needs, accommodation, employment,

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134 Justice Action, *Submission 174*, p. 9.

135 Tasmanian Government, *Submission 502,* p. 10.

136 Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, pp. 942–943.

health needs and social and emotional support.[137] It appears from the study that the health needs of former prisoners with mental illness, especially those who have served their full sentences, often are not being met. The study reported that:

> Ex-prisoners and service providers consistently reported that prisoners are often released with 'nothing'. Drug-addicted, mentally disturbed and physically ill prisoners are often released without prescriptions for the drugs they require, or referrals to doctors or other professionals … They are released with no money, no home, no job, and without having met, or been linked with, a worker in the community who they can turn to for help.[138]

13.123 Evidence submitted by other witnesses indicates that this situation is not limited to a single jurisdiction, but may unfortunately be widespread. Forensicare stated, for example, that:

> At the point of release, coherent plans for a managed return to the community with prearranged mental health support almost never occur.[139]

13.124 The *In*corrections study sets down a number of principles for best-practice release of prisoners. These principles have general application, and are applicable to the release of prisoners with mental illness. The principles include 'throughcare', which requires the early assessment and referral of prisoners to appropriate interventions and programs, aftercare and pre-release programs.[140]

13.125 The *In*corrections study found that in a number of re-entry programs that exist throughout the world, the key feature is a solid partnership between prisons and community mental health providers.[141] As discussed elsewhere in this report, community health services in Australia appear to be inadequate. As a result, the adoption of enlightened re-entry programs would require not only the wholehearted cooperation of corrections authorities, but significant allocations of additional resources for community health.

Care on release

13.126 The St Vincent de Paul Society, although agreeing with other witnesses that persons with a mental illness should not be in prisons, stated that in the existing circumstances where there is no other reasonable method of housing some of those people, there needs to be a pre-discharge plan. That plan would include providing

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137 T. Walsh, *Incorrections: Investigating prison release practices and policy in Queensland and its impact on community safety*, Faculty of Law QUT, November 2004, Chapter 2.3, pp. 56-71.

138 T. Walsh, *Incorrections: Investigating prison release practices and policy in Queensland and its impact on community safety*, Faculty of Law QUT, November 2004, p. 100.

139 Victorian Institute of Forensic Mental Health, *Submission 306*, p. 5.

140 T. Walsh, *Incorrections: Investigating prison release practices and policy in Queensland and its impact on community safety*, Faculty of Law QUT, November 2004, pp. 73-75.

141 T. Walsh, *Incorrections: Investigating prison release practices and policy in Queensland and its impact on community safety*, Faculty of Law QUT, November 2004, p. 66.

adequate financial resources, budgeting and living skills and linkage to exit housing with appropriate supports.[142]

13.127 Forensicare suggested the post-prison care of mentally ill prisoners might be approached as follows:

> Inreach services, where local community health teams, or where available, forensic mental health teams, begin to manage prisoners prior to their release would be a major contribution. One potential reform worth considering is that mental health services in all prisons become part of the area mental health service in which the prison is situated, with special Inreach teams, augmented by input from specialist forensic mental health professionals. (As is now beginning to occur in the UK).[143]

13.128 A similar approach was suggested by Psychiatric Disability Services of Victoria (VICSERV) Inc., which made the following recommendations:

- That community-based rehabilitation and support services (CBRS) be engaged to deliver psychosocial rehabilitation within prisons and for post-prison transitions
- That housing resources (with attached CBRS resources) be allocated to assist prisoners with a mental illness to make successful transitions back into community life
- That partnerships and communication strategies be developed between prison authorities, clinical, mental health services, CBRS services and housing agencies
- That intensive transition packages such as Individual Support Packages or intensive home-based outreach funding be established to decrease the possibility of re-incarceration due to relapse.[144]

13.129 However, as reported earlier, the committee heard that the step-down and other community facilities that would enable these approaches are inadequate. Professor Andrews submitted that:

> *Units that can't discharge can't admit*. Australia presently has sufficient acute short stay beds if the beds were occupied only by acute care patients. However it has only a quarter of the rehabilitation beds required and perhaps only 40 per cent of the community beds required.

and that:

> In the absence of step down beds, public sector staff are being asked to maintain patients in the community who are too sick to live in the community and who should be in stable supervised accommodation.[145]

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142 St Vincent de Paul Society, *Submission 478*, p. 14.

143 Forensicare, *Submission 306*, p. 19.

144 VICSERVE, *Submission 347*, pp. 23–24.

Recidivism

13.130 There is a high rate of recidivism among former prisoners with a mental illness.[146] Forensicare informed the committee, in relation to patients suffering with schizophrenias, that:

> Repeat offending in schizophrenia is critically dependent on whether the individual had the ongoing structure provided by open employment, but failing that, sheltered workshop or day centre support. Services have been withdrawn from programs of active work rehabilitation in recent years, but this is a critical element in patient functioning and in reducing offending.[147]
>
> Ignored, mismanaged, released unprepared, rapidly re-offending and returning to prison. This is all too often the story of the mentally ill offender, repeated and repeated.[148]

13.131 Butler and Allnutt found that, based on a report of a British study, 'The mentally ill often revolve through prisons, with periods of incarceration interspersed with spells in the community and place high demand on services'.[149]

13.132 Forensicare referred to a study, in preparation at the time of the inquiry, examining recidivism in a mentally disordered population with and without co-morbid substance abuse.[150] The committee welcomes that study and would encourage other professionals to undertake studies of recidivism that, among other things, might cast light on the causes for recidivism and that might enable authorities to assess the effectiveness of diversion programs.

13.133 Although there is a need for more data to ensure that approaches to treatment of potential re-offenders are based on sound evidence, the relative absence of data should not prevent authorities from now offering appropriate support. There is sufficient evidence now available to suggest how this support might be provided. Forensicare made several recommendations for action that it considered would reduce the rate of offending and re-offending on those with schizophrenia. These recommendations canvas matters such as providing adequate secure continuing beds and restructuring community mental health services.[151] Forensicare commented that the implementation of those recommendations would be costly but, 'given the

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145 Professor Gavin Andrews, *Submission 176*, p. 7.

146 See for example, Public Interest Advocacy Centre, *Submission 373*, p. 15.

147 Victorian Institute of Forensic Mental Health, *Submission 306*, p. 18.

148 *Submission 306*, p. 19.

149 T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, NSW Corrections Health Service, 2003. ISBN: 0 7347 3559 6, p. 50.

150 Victorian Institute of Forensic Mental Health, *Submission 306*, p. 10.

151 *Submission 306*, pp. 19-21.

potential benefits in reduced crime, reduced prison numbers and improved care, they should be viewed as a bargain'.[152]

Dual diagnosis

13.134 'Dual diagnosis' is a term used to describe the co-existence (or co-morbidity) of mental illness and substance use disorders, although individuals rarely experience only two disorders.[153]

Incidence

13.135 Forensicare informed the committee that a recent study of rates of recidivism among people released from the TEH confirms that those patients with a co-morbid mental illness and substance use or dependence disorder were at a particular risk of re-offending. The committee was told that the data clearly shows that substance abuse and dependence and mental illness are independent risks for re-offending, and that when these disorders occur together, there is an exponential risk of re-offending.[154] The South Australian Department of Health cited a study that showed that the presence of co-morbid mental health problems and substance abuse increases the rate of offending by people with mental health disorders discharged from hospital by up to five times.[155]

Treatment

13.136 Dual disorders are extremely complicated and both diagnosis and treatment are clinically difficult.[156] Despite the difficulties, some Australian service providers are attempting to treat the condition. The Queensland Government has developed a 'strategic plan for people with a dual diagnosis' and for which nine change management positions have been established in high prevalence areas across the state.[157]

13.137 Project teams within Forensicare have suggested that the organisation undertake a systematic and comprehensive approach to the assessment and treatment

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152 Victorian Institute of Forensic Mental Health, *Submission 306*, p. 20.

153 Victorian Institute of Forensic Mental Health, *Consolidating and Strengthening Clinical Programs: Addressing Dual Diagnosis and Offending Behaviour in Forensic services*, 2004, p. 25.

154 *Submission 306*, p. 10.

155 Department of Health – South Australia Government, *Submission 506*, p. 16.

156 S. Henderson, *Mental Illness and the Criminal Justice System*, Mental Health Co-ordinating Council, May 2003, p. 8.

157 Queensland Government, *Submission 377, Part I*, p. 16.

of dual diagnosis.[158] Among other things, the Forensicare project teams suggested that consideration be given to the possible use of involuntary treatment for substance abuse in high-risk diagnosis patients, which would require that the concept of treatment under the Mental Health Acts be redefined to include treatment of substance misuse.[159]

13.138 The committee trusts that Forensicare will be able to undertake this work and that the organisation becomes, as suggested in the study, 'recognised locally and internationally as a centre of excellence in the assessment and treatment of dual diagnosis'.[160] However, it also notes that expansion of involuntary treatment could go against the spirit of mental health reform and the desires of consumers to be more involved in their treatment.

Mental illness and the criminal justice system: the role of the Commonwealth

13.139 The Australian Government has only a limited and indirect role in forensic mental health. In its submission to the inquiry, the Government stated that it has no express power to legislate in relation to criminal law, except to the extent that the criminal law may be connected to other federal powers.[161] It does, however, have the power to create offences against federal laws and in that regard the Australian Law Reform Commission (ALRC) is currently inquiring into the sentencing of federal offenders. ALRC has published a paper for comment in connection with its inquiry, which includes a chapter on mental illness and intellectual disability.[162] The Commission observes in that paper that because each jurisdiction has a different scheme, the treatment of federal offenders[163] may therefore be unequal.[164]

13.140 Because the states and territories are responsible for criminal law in their own jurisdictions, it follows that they are also responsible for the care and health of their prisoners, including their mental health.

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158 Victorian Institute of Forensic Mental Health, *Consolidating and Strengthening Clinical Programs: Addressing Dual Diagnosis and Offending Behaviour in Forensic services*, 2004, p. 42.

159 Victorian Institute of Forensic Mental Health, *Consolidating and Strengthening Clinical Programs: Addressing Dual Diagnosis and Offending Behaviour in Forensic services*, 2004, p. 38.

160 Victorian Institute of Forensic Mental Health, *Consolidating and Strengthening Clinical Programs: Addressing Dual Diagnosis and Offending Behaviour in Forensic services*, 2004, p. 42.

161 Australian Government, *Submission 476*, p. 62.

162 ALRC Issues Paper 29, *Sentencing of Federal Offenders*, Chapter 14.

163 A *federal offender* is someone who is charged with, and convicted of, an offence against a law of the Australian Government.

164 ALRC Issues Paper 29, *Sentencing of Federal Offenders*, Chapter 14, p. 8.

13.141 The Australian Government's principal contribution to the costs of treating people with mental illnesses is through Medicare and the Pharmaceutical Benefits Scheme, but prisoners are not eligible to receive benefits under either scheme.

13.142 Section 19 to the *Health Insurance Act 1973* provides that a Medicare benefit will not be paid in respect of a professional service that has been rendered by, or on behalf of, or under an arrangement with a state. A witness from the Department of Health and Ageing stated that:

> Correctional facilities and the medical services that are provided to people within those facilities would be regarded as being under an arrangement with a state.[165]

13.143 In effect, therefore, the costs of treating mentally ill prisoners are borne entirely by the states and territories. This point was made by the Victorian Government, among others.[166]

13.144 In his second reading speech to the *Health Insurance Amendment Bill 1976*, which contained the provision that was inserted into the principal act, the then Minister for Health stated that the Commonwealth was concerned about the rising costs of Medibank and the potential for cost shifting from the states to the Commonwealth. The relevant part of the speech reads as follows:

> … benefits should not be paid to relieve governments, government authorities, or employers of costs that, but for Medibank, should be borne by them.[167]

13.145 The committee notes that the cost of providing health care to prisoners is significant. In NSW alone, the Department of Correctional Services spent $68 million on medical services to prisoners in 2004-2005.[168]

13.146 The committee was informed that prisoners' ineligibility for Medicare can produce 'the most extraordinary situations'.[169] Professor Mullen stated that:

> You can have a prisoner who is physically or mentally ill in a relatively isolated prison … which may very well have a base hospital nearby, but you cannot access the doctors and the skills in that hospital or the practitioners who live nearby and might be prepared to provide care. This is because the state will have funded a health service which may be hundreds of kilometres away, and will transport the prisoners to that service rather than use the facilities right next door.[170]

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165 Ms Samantha Robertson, *Committee Hansard*, 7 October 2005, p. 65.

166 Victorian Minister for Health – Victorian Government, *Submission 445*, p. 11.

167 Minister for Health, Mr R Hunt MP, *House of Representatives Hansard*, 20 May 1976, p. 2349.

168 NSW Department of Correctional Services, *Annual Report 2004-2005*, p. 97.

169 Professor Paul Mullen, *Committee Hansard*, 6 July 2005, p. 47.

170 Professor Paul Mullen, *Committee Hansard*, 6 July 2005, p. 47.

13.147 In its indirect role in the treatment of forensic prisoners the Commonwealth has liaised with the states and territories to develop the *National Statement of Principles for Forensic Mental Health*, which has been discussed elsewhere in this Chapter, and has provided funding for the Drug Use Monitoring In Australia program. This program collects information from detainees at police stations or watch houses to provide an evidence-base for policy making in regards to drugs and crime. A section on mental illness is included in the questionnaire used for the program.[171]

171 Australian Government, *Submission 476*, p. 63.

'Peter's' story: from submission 456

The environmental component of my depression is made up of how I was raised and the seed of depression that I believe was already there. A potent mix.

I grew up with a step father who was physically, verbally and mentally abusive towards me and my family for the first fifteen years of my life. In response to this I was a complete wild child, always in trouble, aggressive and anti social. At a very early age I remember speaking with counsellors and shrinks. Never once was I asked if I was being abused or even assessed properly as to my mental well being. Just asked why I was so naughty. I think this had to do with my age (at this time I was under eight years old) and also that I lived in outback Western Australia. I'm not sure at whose insistence but I was twice sent to youth detention centres before I was ten years old, where I spent about two years in total. Even in these places I do not believe that I was assessed for my mental well being or probed on my family situation. And both times I was sent back to my abusive home and the cycle started all again.

At age thirteen I stole all the pills I could find and tried to end my life (thankfully I just made myself sick). Once, when I was fourteen I had just had severe belting by my step father and about an hour later I picked up a knife and went into his room where he was sleeping. I was going to kill him. I wanted to but I didn't. I walked out of the room. I didn't want to spend my life in jail because of him. About the age of fourteen I had my first drink and I immediately binged. I would drink until I passed out of threw up or both. I also started smoking pot around this time. I wanted to not feel anything at all so moderation didn't come into it.

At fifteen I left home and spent the next thirteen years battling the depression demon, amongst other things, I ended up in a youth hostel where drinking continued and I was introduced to 'downers', valium and the like. I also got involved in sex work, an occupation that would last for ten years. Also I progressed to harder drugs like ecstasy and speed. Until I was 28 I was a drug addict using marijuana, speed, ecstasy, crystal meth, valium (and assorted downers), alcohol and practically anything else I could find. I also dealt drugs and had run ins with the law for drug offences and assault. During this ten year period I saw many psychiatrists and counsellors and I was prescribed anti depressants, like Prozac and Xanax. I didn't like how I felt on anti depressants, I felt like a zombie. More so than when I was on my other drugs of choice.

So all of the above mentioned crossed with a family history of depression was an unfortunate mix. In my late twenties I had finally had enough of my lifestyle and I stopped taking drugs, finished with the sex industry and got a steady job. I still had to contend with my depression though and I shopped around for a counsellor that was compatible with me that could help me. I realised during these sessions that depression would be with me for life and I made the decision to fight it head on. I chose not to take anti depressants and to fight depression with lifestyle change and understanding my enemy. These days my life is much better but I have to remind myself what I am dealing with and I battle with that each day. Most days are good, some days not so good and some days are just plain terrible. But understanding my enemy has been helpful. I now want to live my life, as opposed to being suicidal for many years.