SUBMISSION

SENATE SELECT COMMITTEE ON MENTAL HEALTH

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I welcome this opportunity to make a Submission to the Senate Select Committee on Mental Health and indicate that I am doing so in a personal capacity and not formally on behalf of the Centre for the Advancement of International Health or the University of Wollongong.

I intend to address my Submission only to that part of Term of Reference (j) relating to the over-representation of people with mental illness in the criminal justice system and the extent to which this itself is a cause of mental illness.

I cannot claim any formal professional expertise in the field of mental health or its treatment, however my interest and experience in this area derives from the following:

a. Having conducted a formal enquiry for the Government of New South Wales into *Services to Developmentally Delayed Inmates by the New South Wales Department of Corrective Services.* My report entitled "The Last to be Served" was presented to the Government in September 1994 and subsequently made public;
b. From 1994 to 2003 I served as President of the *New South Wales Anti-Discrimination Board*, in which capacity I dealt with complaints from prisoners in New South Wales many of which related to aspects of their treatment which were related to their mental health status;
c. From 1992 to 1993 I was a Member of the Privacy Committee of New South Wales, from 1993 to 1999 I was its Chair and from 1999 to 2003 I was the *Privacy Commissioner of New South Wales*. In this capacity I had extensive dealings with the prisons system and prisoner population, primarily on matters dealing with the protection of their human rights;

d. In 1996/7 I was a member of the N.S.W. *Ministerial Committee on the (Goulburn) Police Academy* where one of my roles was to help provide evaluation and oversight of the educational curricula of the Academy, including its courses to train police personnel in dealing with individuals with mental health issues;
e. In 2000/2001 I was appointed by the N.S.W. Minister for Health to chair a *Ministerial Committee on Privacy and Health Information* which addressed the question of linked electronic health records, during which questions of stigmatization of people with mental illness was highlighted. The Committee Report "*Panacea or Placebo ? Linked Electronic Health Records and Improvement in Health Outcomes*" was released in February 2001.
f. In 2002 I was a member of the N.S.W. Department of Health *Expert Advisory Committee on Gender Difference* which examined aspects of the treatment (including within the corrections system) of and discrimination against transgender, transsexual and intersex people;
g. From 1993 I was a Member and from 1996 until 2003 the Chair of the *Central Sydney Area Health Service* which provided mental health services for a substantial part of the population of NSW with control of the major mental health facility at Roseville;
h. From 1996 to 2002 I chaired the Australian National Council on AIDS, Hepatitis C and Related Diseases, the Federal Government's principal advisory body on aspects of HIV/AIDS policy, including the issues arising from the incarceration of people with HIV or HCV infection and the associated problems of managing prisoners with HIV-related dementia.

As a result of these activities, I believe that, despite lacking any formal qualifications in this area I am able to offer some observations based upon a considerable degree of practical experience. This has been augmented by my frequent visits to prisons and correctional facilities throughout Australia, in Europe, the United Kingdom and the United States of America.

The Committee will doubtless be aware of the statistical material related to the level of mental and psychiatric illness and developmental delays which are evident in the prison population.

In the last decade the number of prisoners has increased by well over 52% (the female rate has increased 110%) and the rate of incarceration by about one-third (while our adult population has gown by just 15%). There are now some 24,000 people in prison across Australia, a rate which varies from 98 per 100,000 adults in Victoria to a rate of 513 per

100,000 in the Northern Territory. [refer *Australian Bureau of Statistics Prisoners in Australia 2003*]

In New South Wales, prisoner numbers have risen from less than 5,000 just a few years ago to 6,342 in 1997/8 then to 7,667 in 2001/2 and earlier this year Premier Carr actually boasted that it had now passed 9,000.

The average cost per prisoner to maintain each year is in the vicinity of $58,600 (well over the cost of keeping a child at school in most States), while some maximum security regimes cost around $76,000 p.a. but with gross variations between the States and between incarceration in public or private prisons. Our national expenditure on corrective services has risen from $ 883 million in 1994/5 to an estimated $ 1.7 billion in 2002/3. [refer *Productivity Commission 2004*}

Politicians of all persuasions are now demanding that more people spend more time in prison. Reviews of bail legislation generally end up with more people on remand, often for prolonged periods of time. Demands for heavier, longer sentences are commonplace with an increasing pressure for more crimes to be designated as ones where life sentences are to be imposed. In most jurisdictions, the discretion of the judiciary on sentencing is being eroded in favour of fixed term sentences.

We have New South Wales proposing to abolish double jeopardy provisions and it required a seismic change of government in the Northern Territory to abolish the obscenity of the three-strikes mandatory imprisonment policy.

One interesting feature of much longer or mandatory life sentences which has never really been discussed in Australia is the impact this has on health services and the need which will develop for prison based geriatric services to be provided - at enormous public cost. In 1987, prisoners aged over 50 comprised 4.1% of the prison population, this rose to 8.9% by 2003. Since 1987 the number of prisoners aged 65 and over has risen from 50 to 266 in 2003. An associated problem with the aging of the (prison) population relates

to the onset of dementia and neurological conditions such as Alzheimer's and Parkinson's diseases which have significant implications for mental health service provision.[refer John Dawes "Managing and Ageing Prison Population" in Sean O'Toole and Simon Eyland (eds) : *Corrections Criminology*, Hawkins Press, Sydney 2005.]

In the United States, where this phenomenon is already apparent, ten years ago 150 people died of natural causes in their prison systems each year; now it is 3,000 annually. [refer transcript *ABC Radio National : The Law Report* 10.12.02]

Of course that would never happen in Australia - I presume that all jurisdictions follow the New South Wales model - that is, they release prisoners just as they are about to die, or else they merely transfer them to an associated hospital and let them die there, thus becoming a hospital "separation" and not actually a prison death.

Only inadequate data is easily or publicly available about the age distribution of our prison populations and more generally, we actually know far too little about the health status of prisoners. Such statistics as there are have been collected by individual States and Territories and indeed this unsatisfactory state of affairs has been commented upon by the Australian Institute of Health and Welfare. Interestingly, statistical material about the health of prisoners, the rates of mental illness or drug-related incarcerations has gradually disappeared from publications such as the Annual Reports of the NSW Department of Corrective Services.

We do however know something of the state of the mental health of prisoners, and what we know is utterly alarming.

A 2003 study published by the New South Wales Corrections Health revealed that, among prisoners:

- the twelve month prevalence of psychosis was thirty times higher than in the Australian community

- 78 % of male and 90% of female reception prisoners were classified as having had a psychiatric disorder in the previous twelve months while 1 in 20 had attempted suicide
- 46% of reception and 38% of sentenced inmates had suffered a mental illness in the previous year and
- between 4% and 7% of reception inmates suffer a functional psychotic mental illness. [refer Tony Butler and Stephen Allnutt : *Mental Illness among New South Wales Prisoners*, Corrections Heath, August 2003]

The largest sub-group of our prison populations is made up of those suffering some form of intellectual or developmental disability. Between 15% and 25% of all prisoners fall into this category, their numbers rising by 54% over the decade to 1999.

In his Introduction to the 2003/4 Department of Corrective Services Annual Report the Commissioner noted "*the psychological profile of inmates is becoming increasingly marked by mental illness*". (page 9)

Although the precise figures given above are drawn from New South Wales, other jurisdictions exhibit similar profiles and trends.

This over representation of people with mental health issues in the NSW prison population has been a cause of alarm and comment from a variety of sources:

- a 2003 report by New South Wales Corrections Health recommended that all mentally ill offenders be transferred from jail to secure mental health hospitals because the current corrections system lacked the resources and expertise required;

- a 2001 report by a New South Wales select committee on increases in the prisoner population recommended that greater resources be invested in psychiatric consultation and assessment interventions to divert mentally ill

offenders from incarceration; [refer NSW Legislative Council : *Select Committee on the Increase in Prisoner Population, Final Report* November 2001]

- a 1996 report of the New South Wales Law Reform Commission was critical of the failure of court and prisons administrations to co-operate effectively in the management of prisoners with intellectual disabilities.

Finally another New South Wales parliamentary inquiry in 2002 analysed the consequences of deinstitutionalization which, commencing in 1982 had resulted in a radical shift in the treatment of people with mental illness : transferring people from institutions back into the community. Twenty years on the parliamentary committee stated:

> "*The weight of evidence presented to the Committee highlights that mental health services in New South Wales need revolutionary improvement. Deinstitutionalisation, without adequate community care, has resulted in a new form of institutionalization: homelessness and imprisonment.*" [refer NSW Legislative Council : *Inquiry into Mental Health services in New South Wales, Final Report*, December 2002]

All paradigms of health are socially constructed, none more so than those related to mental illness. Some researchers have asserted that illnesses such as schizophrenia or bi-polar disorder (together with depression, our most common forms of mental illness) are a product of "industrialisation", and that they were never found in pre-industrial western societies. This social construction of illness means that very often responses to illness are also socially constructed and subject to changes in fashion and community values. Again, this is particularly the case with mental health.

In New South Wales, a major government enquiry (the Richmond Report) in 1982 looked into the provision of services for the mentally ill and developmentally disabled. The

principal thrust of the Richmond Report was to advocate a decrease in the size and number of mental hospitals; an expansion of community based networks to help maintain "clients" in the community and to change various bureaucratic and funding arrangements to support such services. The Richmond recommendations were enthusiastically adopted by government which saw in them a chance to decrease real levels of public expenditure (on costly mental hospitals), to transfer expenditure from the public to the private sector (under the guise of "community" care) and to appear more "caring" in a person sense about psychiatric patients.

Of course Richmond's report really required more expenditure on community facilities and support networks – money that was never spent. Indeed, the impact of Richmond was subsequently reviewed in 1988 in the Barclay Report. It called for a more "balanced" approach between hospital and community care rather than "*the wholesale closure of mental hospitals and the decanting of large numbers of patients in a short time into the community.*" Not surprisingly, the Barclay Report indicated that deinstitutionalisation's success depended upon "*the quality, intensity, comprehensiveness and continuity of care provided* (to patients) …*as well as the amount of funds allocated*." Barclay hammered one last nail into the coffin of the government's enthusiasm for Richmond by stating:

> "*However, the deinstitutionalisation of severely disabled, difficult to manage, chronic patients who need long term accommodation with very high staff/patient ratios is very expensive and does not appear to be cost effective in community settings.*"

Here, in many respects is much of the genesis of our current prison/mental health problem. Since that date, numerous reviews of mental health services, both nationally (e.g. the Burdekin Report 1990) and at State level (NSW Legislative Council report on Mental Health Services 2002) have made the same point. People with mental illness need to be treated in an environment in which the balance between institutional (hospital) and community care is appropriate and both are funded adequately. This has simply not happened.

Frank Walker QC, a former State Labor Minister and now Judge, in his capacity as President of the Schizophrenia Fellowship of NSW prepared a paper entitled *The Quest for Justice with Dignity*. In it he stated :

> "*The truth that needs to be told is that our police lock-ups and jails are bulging with prisoners suffering mental illness, most of whom are either not being treated … or are being inadequately treated. There is no justice and definitely no dignity in this state of affairs."*

Indeed what dignity is there in the treatment of prisoners, some of whom are reported suffering so severely that they are kept in so-called "safe cells", often just stripped to their underwear and locked in for 23 hours a day for week or more.

It appears from the latest available statistics that only 8% of men and 23% of women who had been diagnosed with some form of mental illness were actually on psychiatric medication while in prison – and those tended to be the inmates actually confined in forensic wards. Again, despite the great level of need, there are only some 90 prison hospital beds actually available to cater for psychiatric patients in NSW.

A final point I make about prisons in NSW is that this is the only mainland jurisdiction and one of the very few in the world which still incarcerates forensic patients – people found not guilty by reason of mental illness – in clear breach of domestic legislation, the National Medical Health Forensic Policy and the United Nations Declaration of Human Rights. The number of Forensic Patients (previously referred to as Governor's Pleasure Inmates) in New South Wales has increased from 21 in 1982 (0.7% prison population) to 100 in 2003 (1.1%).

Michel Foucault's influential analysis of the birth of the prison, *Discipline and Punish* noted, as have all studies, that prisons fail to eliminate crime. Despite this, he says:

> "*So successful has the prison been that, after a century and a half of 'failures', the prison still exists, producing the same results, and there is the greatest reluctance to dispense with it.*"

There is nothing surprising about this. As long as people commit serious crimes which should be punished, and as long as some people need to be removed from the mainstream of society for the protection of others, there will always need to be places of imprisonment and their use will be appropriate. It is also true that people with various mental illnesses can and do commit serious and horrendous crimes, again requiring at least their separation from the rest of the community.

However unnecessarily confining people with mental illness in prisons is utterly self-defeating. In those institutions these people – especially those with developmental or intellectual problems – will be the bottom of the prison heap. They will most likely to be subject to acts of physical violence as are up to 13% of all prisoners; they will be particularly vulnerable to sexual assault – the fate of up to one-quarter of young men in prison; and they will be drawn into networks of drug smuggling and substance abuse, being least able to protect themselves or understand the consequences of their actions.

They will also suffer as a result of the cutbacks in prison education services enforced as the prison population expands well in advance of any expansion in resources provided to correctional facilities. Little wonder that prisoners with mental health problems have the highest rates of recidivism.

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. The situation in relation to health care in the United States demonstrates this at its most bizarre. As a result of the Supreme Court's decision in *Estelle v. Gamble* [(1976) 429 US 97] prisoners are the <u>only</u> people constitutionally entitled to government-provided health care and treatment in the United States.

I should also note that some States other than NSW have tried a variety of other prison health models, such as that successfully undertaken for forensic prisoners at Victoria's Thomas Embling Hospital.

Nevertheless there can be no justification for the wholesale incarceration of people with mental illness and their exposure to all the horrors of prison life when there are better alternatives.

Many jurisdictions are now experimenting with a variety of interventions.

They are seeking to improve the methods of identification of people with mental illness as they first come into contact with the criminal justice system through the courts. Attempts are being made through the introduction of specific Drug Courts to divert people with drug-related problems from the threat of immediate incarceration. Attempts are being made to achieve more effective integration of community services with correctional policies.

Abolishing imprisonment for short terms sentences and looking at alternatives such as home detention or community service orders are in practice or under consideration. It is interesting to note that in Canada about 80% of its offenders under sentence (or on remand) are being dealt with in the community rather than in prisons.

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!

Perhaps most importantly there is an increasing trend internationally, although still resisted in most Australian jurisdictions, to separate the prisoner health service from the

control of the correctional authorities. [see Emanuele Pontali : "Antiretroviral Treatment in Correctional Facilities", *HIV Clinical Trials 2005; 6(1) 25-27*.] This bureaucratic arrangement makes a difference. When prisoner health services are delivered by health professionals rather than by correctional officers, the entire focus changes. The service becomes patient-oriented, positive and proactive rather than system-oriented, reactive and punitive.

One area of encouragement is that there is an increasing body of research work being devoted to examination of the complex interactions between issues of health and corrections, spearheaded by the Centre for Health Research in Criminal Justice whose biennial research symposia showcase both relevant research and best practice examples. What is disappointing however is how utterly disinterested the regular meetings of Commonwealth and State Ministers responsible for corrections policy appear to be in considering best practice or looking at innovative solutions to problems which we all know will get no better, and indeed must inevitably get worse, if we just keep on doing all the things that have been so manifestly failed to date.

I recognise that there are major economic issues involved in proposing significant transfers from the prisons system to the health system. 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 N.S.W. public hospital system. So, "treating" a mentally ill person by incarceration rather than by hospitalization is three or four times cheaper to the State budget. Even in its current unsatisfactory state, the provision of prison health services is not inexpensive – the cost of these services in NSW correctional services in 2003/4 was in the order of $ 64 million.

It is beyond the scope of this Submission (although clearly within the Terms of Reference of the Committee under sub-clause (f)) to examine the impact which the various State and Federal laws related to drug and alcohol use/abuse contribute to the problems of mental health. This is a constantly evolving field (for example the allegedly higher psychotropic impact of new strains of hydropnically-grown marihuana; or the impact of so-called

"party drugs" such as ecstasy)) which needs to be explored in depth. However we know that most people coming into the nation's prisons have some problems in the use/abuse of alcohol and other drugs. We also know that people sentenced for drug offences range from those with what some might consider "minor" infractions (small scale possession) to those involved in major criminal activity of important, manufacture and distribution. It would clearly be in everyone's interests for those people with lesser sentences for drug related offences to have access to appropriate drug rehabilitation programmes and to be segregated from those others in the prison population who would constitute a danger to their chances of rehabilitation. The Committee should, I submit note, and support, the fact that the NSW Corrections Service runs the largest methadone maintenance programme in the world and that this has achieved great success.

My interest in this matter however focuses upon the extent to which co morbidity of drug use (especially with marihuana) with mental illness is a subject which should be studied in more depth to obtain a better understanding of the extent to which one precedes the other.

Does the use of certain drugs lead to the development of mental health problems, or is it the reverse – namely that people with mental health problems are more likely to become drug users ? Upon the answer to this question turns a major policy issue – the treatment of (some) drug users as mental health patients rather than criminals.

The Committee does not need me to draw to its attention the obvious fact that people with mental health problems are hardly assisted by being incarcerated. Although, as I have noted above, for some people, their time in prison may give them <u>better</u> access to health care (including psychiatric care) than they would otherwise have, the very nature of prison life is antithetical to anything resembling optimum health care. Conditions of overcrowding, lack of privacy, violence and exploitation are the common fare in many of our correctional facilities. People with mental illness (and especially those with problems arising from developmental delays) are exploited in the prisons and often taken advantage of in relation to such matters as the concealment or transportation of drugs or contraband.

Such people are usually least able to stand up for themselves either in relation to other prisoners or indeed to the custodial authorities.

Both these groups practice clear forms of discrimination and stigmatization of such prisoners.

The extent to which the scales of justice are tipped against people with mental illness has of course be highlighted by the Cornelia Rau case (which in some respects was the genesis of this Committee) and more latterly the case of Vivian Solon/Alvarez/Young. A similar comment could be made arising from the recent judgment of Mr Justice Finn in the Federal Court in relation to the federal government's scandalous neglect of certain Iranian asylum seekers in its care and control at the Baxter Detention Centre. When major federal Departments treat people with mental illness so badly it is hardly remarkable that prisons and other prisoners do so on such a regular basis.

Arising from the above, there are certain recommendations which might usefully be considered by the Committee:

(a) there is a need to obtain better data, and to that extent, either the States should be persuaded, or some body such as the Australian Institute of Health and Welfare should be funded, to conduct regular audits of prisoner health (including mental health) and publish that material;
(b) consideration should be given to a more detailed investigation of issues of co morbidity between mental health and drug use/abuse focused specifically upon the impact of the nation's drug laws in relation to the extent to which people with mental illness and treated when they come into contact with the criminal justice system as a result of their drug use/abuse;
(c) the federal Justice Minister should consider raising with the States the question of the extent to which health services to prisoners (for which all governments have a clear legal duty of care) should be administered by Health Departments rather

than Corrections Departments and should perhaps offer to fund a study which might explore further some of these issues;

(d) at the very least the Commonwealth should reverse all policies currently in place which deny Medicare coverage to prisoners;

(e) any proposed National Mental Health Plan should be required to contain specific reference to the special needs and circumstances of prisoners with mental health problems, starting with appropriate assessments of such people when they first come into contact with the criminal justice system and ways in which they might then be diverted into more effective treatment alternatives.

I thank the Committee for giving me the opportunity to make this Submission.

"A society may be judged on how it treats its most helpless – its prisoners."

Sir Winston Churchill

"*The degree of civilization in a society can be judged by entering its prisons."*

Fedor Dostoevsky

CHRIS PUPLICK

12 May 2005