Submission from Dr Tracy Schrader to the Senate Select Committee on Mental Health, May 2005

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Thank you for the opportunity to contribute to the Senate Select Committee on Mental Health.

I am a general practitioner working in Brisbane. I have previously worked in Aboriginal and Islander Health, private general practice in Hurlstone Park, Sydney and Acacia Ridge, Brisbane and was a visiting general practitioner to Brisbane Women's Correctional Centre (BWCC) from 1995 to 2002. I currently work at Brisbane Youth Service (BYS), a service for homeless and at risk young people, where I have worked since 1993. Through my work I am acutely aware of the lack of resources and appropriate services in mental health. I routinely see the consequences.

There are a number of issues I could comment on but in this submission, I will discuss certain issues within the prison system pertaining to mental health, in particular the use of suicide observation cells for management of "at risk" prisoners. I will refer to the literature and to my experiences working in the women's prison. Suicide observation cells are cells designed for prisoners assessed to be at risk of self harm or suicide. These have sometimes been referred to as "strip cells". There are particular concerns for female prisoners.

I believe the use of these cells contravenes accepted management for people at risk of suicide and self harm and the use in prison contravenes the United Nations charter stating that prisoners are entitled to the same standard of health care as those in the community.(28) Indeed, with the greater incidence of health problems extended health care provision should be available to prisoners. I believe Australia's international human rights obligations under such treaties as the *International Covenant on Civil and Political Rights* (ICCPR) and the *Convention Against Torture and Other Cruel Inhuman or Degrading Punishment or Treatment* that state prisoners should be treated with humanity and respect and that they shall not be subject to cruel, inhuman or degrading treatment or punishment are breached by the use of these cells.(26, 27)

Working in a prison makes one acutely aware of the failure of the system – for instance, the lack of social supports, education, health and mental health services. Female prisoners often experience "multiple social and economic disadvantages pre and post release, through a constellation of low education, limited employment skills and opportunities, inadequate housing, insufficient income and difficulties establishing social networks".(8)

The *Queensland Women's Prisoners Health Survey* 2002 found female prisoners to have a relatively young age profile, a high proportion of Indigenous Australians, low levels of education, low rates of employment prior to imprisonment and high proportion receiving social security benefits in comparison with the general population. Three issues of concern relating to the health of women in prison were identified – drug misuse, mental health and childhood sexual abuse. Fifty-seven percent reported having been diagnosed with a specific mental illness, 42% reported childhood sexual abuse, over half reported a history of injecting drug use and 63% used an illicit drug regularly in the last 12 months before imprisonment.(17)

Working at both BYS and the women's prison I saw many patients in both environments. I was beginning to see some of the young women from BYS in prison for generally minor crimes. These young women very often had an intellectual disability and mental health problems. Shortage of adequate community resources results in people, particularly those with mental disabilities, falling through the cracks of the system. Increasing numbers of young women with intellectual and mental

disabilities are being marginalised, with no chance of achieving success at school or in employment, and slip into drug use and crime.

This also emphasises the inappropriateness of prison. We should be keeping people out of prison. There should be adequate alternatives. Prisons are not designed to care for people with mental illness and should not be dumping grounds or treatment centres for people with mental health problems.

Mental illness in prisoners:

There is no available national data on the health status of Australian prisoners. There have been surveys in various states. These surveys have shown that the mental health needs of the prisoner population are high compared with those of the general community and that a large unmet need exists.(4) Rates of diagnosed mental illness among prisoners are higher than in the community, and higher in female prisoners than in male prisoners. The 2003 *Mental Illness Among New South Wales' Prisoners* report found 74% of those assessed had at least one psychiatric disorder (psychosis, affective disorder, anxiety disorder, substance use disorder, personality disorder or neurasthenia) in the twelve-months prior to interview.(4) This was higher among females than males. In the *National Survey of Mental Health and Wellbeing* (NSMHWB) the twelve-month prevalence for 'any psychiatric disorder' in the general population was 22%.(1)

The 1997 *NSW Inmate Health Survey* found women in custody twice as likely as male inmates to have been diagnosed with psychiatric problems and nearly three times as likely to be on psychiatric medication at the time of their reception into custody.(3) Female prisoners have a very high prevalence of mental illness in comparison with the general population. This can include psychological distress and disorders ranging from depression and anxiety through to schizophrenia, personality disorders and substance-induced psychosis. This is higher if drug and alcohol problems are taken into account. A study in Victoria found female prisoners experienced high levels of post-traumatic stress and their coping skills were lower than the general population.(23)

The *Queensland Women's Prisoners Health Survey* 2002 found female prisoners are characterised by lower levels of general and functional health, especially for issues related to mental health. As stated, 57% of female prisoners reported having been diagnosed with a specific mental illness, the most common are depression, anxiety and substance dependence. Sixty-nine per cent demonstrated symptoms of depression, and 32% symptoms of moderate to severe or severe depression.(17) In comparison, mental illness is said to affect 5.8% of the total Australian population and among females the prevalence of depression is 6.8%.(2)

Probable explanations for the high number of mentally ill people in prison have included homelessness, a lack of adequate diversionary options in the community, inadequate specialist community forensic psychiatric services, deinstitutionalisation of the mentally ill, inadequate rehabilitation of forensic psychiatric in-patients, the high threshold for admission to general psychiatric facilities, the reluctance of general psychiatric services to accept mentally ill patients from the courts, society's intolerance of deviant behaviour by the mentally ill, and the greater likelihood of the mentally ill being arrested. The increased use of illicit substances in the general population and among the mentally ill has likely made a significant contribution to an increase in all types of offending.(4)

Imprisoned women are much more likely to have a history of childhood sexual abuse and severe physical abuse than women in the general population. Research indicates that 89% of female prisoners have been sexually abused at some point in their lives. A survey conducted in 1989 by Women's House in Brisbane found that over 70% of women in prison had experienced incest.(18) Forty-two per cent of women in the *Queensland Women's Prisoners Health Survey* 2002 reported childhood sexual abuse and 38% reported childhood physical or emotional abuse.(17) Sixty per cent of women in the NSW 1997 *Inmate Health Survey* reported childhood sexual abuse.(3)

Suicide and self harm:

Suicide is the leading cause of death in Australian prisons.(7, 11) The rate of suicide in prison is higher compared with the general community (estimated to be at least four times higher) and has continued to rise over the last decade.(11, 19)

Self harm is linked to suicide and is far more common. The Royal Commission into Aboriginal Deaths in Custody found sixteen times as many incidents of self harm as completed suicides in custody over a six month period.(16) Prisoners with a history of self harming are more likely to commit suicide or repeat self harm in prison.(12, 15, 19) Women make up a relatively small proportion of the prison population.(21) Both suicide and self harming rates in prison are higher for women.(10, 12, 14-16)

Female prisoners tend to commit more acts of self harm than their male counterparts. Whilst in custody, women exhibit greater rates of chronic self harm and other self-destructive behaviours placing them at risk of suicide.(3, 20) On prison entry, 28% of female prisoners at BWCC in 2000 reported previous self harm.

Liebling (1992) compared women prisoners who had self harmed to a control group of women prisoners who had not self harmed and found the self harming group were more likely to have received psychiatric or other medical attention, have less outside support and more difficulties coping with prison.(20) Self harm among female prisoners has been linked to poor self-esteem, feelings of powerlessness and despair and trauma resulting from previous experiences of abuse. Self-injury is a common response by women to the stress of imprisonment. The majority of women who self-injure identified situations producing feelings of helplessness, powerlessness or isolation, as being those that make them want to self-injure. This is exactly the situation that women in prison are faced with. Prisons may have considerable rules and regulations to prevent self injury but prison policies play a significant role in fostering feelings of powerlessness.(18)

Assessment and management of “at risk” prisoners:

Suicide risk is a symptom, not a condition in itself.

There are two views to explain the high rates of suicide and self harm in prison. These are referred to as *importation theory* (prisoners bring in their problems and appear to be selected for high risk) and *deprivation theory* (stress and difficulties of prison itself are major contributors).(5) Research and management of suicide and self harm has focused around these two approaches. One examines historical and demographic risk factors in order to predict “at risk” prisoners; the other examines institutional and psychosocial factors’ relationship to self harm and suicide in prison.

Suicide prevention strategies within prisons often focus on prediction using screening and risk identification.(5) Differences in background characteristics, however, tend to be differences of degree only. Despite extensive research on risk factors, it has been noted that prediction has not greatly improved over the last fifteen years and only twenty per cent of prisoners who suicide in prison have been identified as at risk.(22) This is reflected in Australian figures.(7, 11, 19) Nearly all research has indicated that predicting suicides from risk factors is problematic.(12, 19) Alternative research has examined motives, precipitating events, prison experience, situational and psychological factors and coping skills.(9, 12, 13, 15, 22, 24) Research has suggested that a combination of vulnerability of the prisoner with situational and environmental factors of the prison environment is critical.(21)

In the UK, there has been a move away from reliance on identification of “at risk” prisoners to a more proactive approach and positive strategies for prisoners generally. In Australia, there is no national approach. Most jurisdictions in Australia, have introduced screening programs to attempt to determine “at risk” prisoners.(5)

Suicide observation cells

After a visit to New York in 1842 Charles Dickens wrote:

> 'I paid a visit to the different public institutions on Long Island. One of them is a lunatic asylum. In the dining room, a bare, dull dreary place, with nothing for the eye to rest on but the empty walls, a woman was locked up alone. She was bent, they told me, on committing suicide. If anything could have strengthened her in her resolution it would certainly have been the insupportable monotony of such an existence' (Dickens, 1842).

Suicide observation or isolation cells have been used in prisons in various states in Australia, were in operation while I was working at BWCC and still are. Researchers, however, have universally condemned the use of isolation cells for suicidal prisoners.(5) Clinicians also reject the use of any form of isolation for potentially suicidal prisoners.(25) A cell that is spartan and clinical in appearance is more likely to reinforce the prisoner's sense of isolation and depression. A safe cell does not have to be a bare and empty space.(5)

Strategies that are at odds with good practice in other settings should not be developed in prison. The Royal College of Psychiatrists has stated that there is "no justification for saying that techniques that are deleterious to people who are psychologically distressed in a hospital are acceptable for people who are psychologically distressed in a prison".(25) Prisoners are entitled to the same standard of health care as the community under the UN Charter.

Women with mental health problems are more likely to be placed in segregation. Prisoners are likely to interpret a period in such a cell as a punitive response to their distress, even if it is carefully explained that this is not the case.(5)

At BWCC a woman deemed "at risk" of suicide or self harm may be segregated from other prisoners within the Crisis Support Unit (CSU) or health centre. The CSU at the BWCC opened since my working there. This was after the closure of the CSU in the male prison where women were also accommodated. There were two suicide observation cells in the health centre at BWCC. There was the "brown cell" and another less severe room with a window and bed. This was generally used before the "brown cell" but when this was already in use (which wasn't infrequently) the "brown cell" would be used. Prisoners would be deemed "at risk" after assessment by a clinical nurse at intake or on report of behaviour or incidents thought to indicate a prisoner was at risk of suicide or self harm. "Sterile" rooms elsewhere in the prison that were searched and found to be free from items which may be used for self harm were also used.

The brown cell was a room with no furniture, no windows, rubbery baby poo yellow walls and floor, a fluorescent light permanently on, a toilet with no toilet paper, CCTV surveillance and a heavy door with observation window. There was a skylight. Women are stripped searched before being put in the cell and dressed only in a white suicide gown, allowed no underwear and are barefoot. They sleep on the floor with only a doona. They are allowed no reading material, there is no sound. The management guidelines concentrate on observation and recording. Security and risk management are prioritised over all other institutional and/or individual needs.

This treatment is the opposite of therapeutic. The use of seclusion is inappropriate for those at 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. The alienating environment of prison contributes to suicidal and self harming feelings.(6) A key element in suicide prevention is the presence of human interaction.

The number of times I would come to work and there would be a woman frantically knocking on the window to get attention. The women in the cell have to ask for toilet paper and be given a certain amount by a prison officer. There were problems when women were menstruating. As they had no underwear, this could be of particular concern for Aboriginal women who often use

sanitary pads rather than tampons. They would have to plead with prison officers to be taken outside for a cigarette.

The doctor would have to see the woman but would have no control over her being in the cell. The visit to the doctor would sometimes be a welcome break from the monotony and alienation of the cell. Comments I would frequently hear were 'Please get me out of there. I can't stand it", "How much longer do I have to be in there", "If you weren't suicidal to start with you would be after being in there" and "I am never going to tell anyone anything again". The women did not see this as beneficial. They saw it as a punishment for how they were feeling. Many said they did not feel suicidal or want to harm themselves but were feeling upset about their situation. They felt worse after being in these cells.

On one occasion on my arrival at the prison, a young woman I have seen many times at BYS was in the "brown cell". This young woman has an intellectual disability, a past history of sexual and physical abuse, drug misuse, "cutting" as a form of self harm and had recently been in and out of jail for various offences. She can be a likeable person. In prison she was often in either the "brown cell" or CSU for self harming behaviour. In the community her self harming had been confined to "cutting". In prison this escalated to more severe forms.

On this occasion, she was in the cell in a straight jacket with a helmet on her head. She was obviously distressed. I tried to talk to her through the glass window. Three prison officers arrived in what appeared to be riot gear, I think to allow her to go to the toilet. She apparently had been lashing out and this was the only way they apparently could constrain her. I was not permitted to talk to her.

All of this is not treating prisoners with humanity and respect. This is not managing female prisoners with respect and regard for dignity as set out in the Queensland Department of Corrective Services Policy Action Plan 2003-2008 *Addressing the Needs of Female Offenders*. It is degrading and alienating. It amounts to sensory deprivation and cruel treatment. It is not the recognised treatment for those in the community. This is punishment, not therapy. There are alternatives.

Although the observation cells are in the health centre, prison management determines the protocols for their use and the management of at risk prisoners. The At Risk Suicide/Self harm Committee (ARSC) comprised psychologists, correctional counsellor, health services co-ordinator (nurse manager) and correctional supervisor. There was no input from the Consultant, Health and Medical Services, visiting doctors or psychiatrists. Health care in prisons in Queensland is controlled by the Department of Corrective Services and not the health department. When contacting the visiting psychiatrists from Queensland Health about the use of these cells, I was told they had nothing to do with their use or policy and that this was not the treatment or management they would recommend for at risk patients.

Research into alternative methods of managing high risk prisoners indicates that the best way to calm the individual is to place them in a comfortable, furnished environment. (Colbourne 99) Location in a ward or dormitory accommodation, under intense supervision for severe cases, or for less serious risk, cell-sharing with selected other prisoners has been advocated.(25) Research has consistently shown that a prisoner is more likely to attempt suicide or self harm when alone. Management should involve the provision of emotional support by appropriately trained persons and interventions aimed at identifying and resolving the underlying psychological and/or social problems. A prisoner in crisis requires greater access to significant others and increased psychological support.(5)

The approach in the UK is that suicide prevention is a 'whole of prison' responsibility, which has meant a switch in emphasis away from the medical model to the residential unit becoming the centre of suicide prevention. The goal is not to take prisoners away but to provide services whilst they are experiencing the crisis.(5)

Another consequence of the risk assessment process and numbers of women placed on management plans at BWCC was that the psychologists' time was taken up mainly assessing and processing "at risk" prisoners. There was limited time left for therapeutic clinical work with prisoners. I believe this resulted in an over reliance on medication as there was not the available time for longer psychological therapy for such conditions as depression and anxiety. Corrective Services counsellors' time also became largely taken up with routine intake regulations and response to acute situations. Time for other interventions such as sleep hygiene, relaxation and stress management was very limited.

I would like to raise a final concern in relation to prisoners in general. Medicare is not universal in Australia as prisoners are not entitled to a Medicare card and are reliant on the state jurisdiction to supply health care whether this is the department of corrections or health. Thus if a prisoner wants to see an independent doctor or their usual treating doctor they are not entitled to the Medicare rebate. Prisoners in community correctional centres are restricted from visiting a general practitioner. They therefore rely on accident and emergency departments in public hospitals or free community centres such as community mental health centres (although access to these can be difficult).

I would see some women, previously from the prison but now in the community correctional centre, at the Brisbane Sexual Health Clinic (where a Medicare card is not required) for important preventative examinations like Pap smears. Continuity and coordination of care, which is vital in the care of people with conditions such as mental illness, is difficult under these circumstances.

Thank you for the opportunity to contribute to this important inquiry. The mental health needs of the Australian population are not being met. Mental health is vastly under resourced. This area has typically been marginalised and has not been a high political priority. Prisoners with mental illness are doubly stigmatised. Australia is a wealthy country. People in the community and in prison should get the best available care.

I would be happy to attend a hearing in Brisbane to provide further information.

Dr Tracy Schrader

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