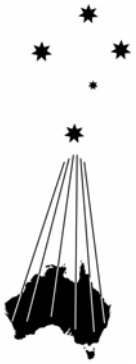

Probation and Community Corrections Officers' Association Incorporated (PACCOA)

Submission to the

Senate Select Committee on Mental Health, 2005

addressing section j. of the Terms of Reference:

j. the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people.

Fowarded on behalf of the
Probation and Community Corrections Officers' Association Incorporated.

Brian Norman, President
26th July 2005

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PACCOA, the Probation and Community Corrections Officers' Association, is a not-for-profit national group that works to promote understanding of, and discussion about, issues surrounding offender management, particularly community-based interventions. PACCOA also promotes professional development of probation/community corrections officers. PACCOA was formed in 1998 to fill a void in national communication, brought about by the existence of separate state, territory and federal justice processes.

PACCOA thanks the Senate Select Committee on Mental Health for the opportunity to lodge a submission at this very late stage. We are also keen to have an audience with the Select Committee. Due to the necessarily short timeline for completion, it has not been possible to systematically gather information from colleagues across Australia, and consequently the perspective in this submission may tend to be somewhat skewed towards the New South Wales experience. Nevertheless, NSW houses half of the prison population of Australia, and consequently is also the state where most of our members are based. It must be stated, however, that many aspects of the NSW experience are reflective of other jurisdictions.

The overrepresentation of people with a mental illness in the criminal justice system and in custody

There is overwhelming evidence that people in the criminal justice system have considerably increased mental health needs and that these needs are extensively neglected in terms of developed and unified mental health service strategies. Comparisons with the general community reveal that a disproportionately small amount of our existing mental health resources, already inadequate to meet community needs, are directed at meeting the needs of offenders and those placed on remand in the gaol system.

It is evident that two levels of mental health service fragmentation are occurring. First, the lack of an overarching health system, which should include forensic mental health services and be integrated into the broader community health and mental health systems, thereby *compelling* full cooperation at the community level, where fears about the potentially violent behavioural problems of mentally ill offenders are conducive to self-serving apathy, exclusion, or a grudging and pessimistic attitude to treatment. This is the bedrock level of discrimination. Second, the existing specialisations of service delivery are conducive to discontinuities in case management between prisons and the community, and these serve to compound existing social inequalities.

As argued by Susan Henderson in her paper, "Mental Illness and the Criminal Justice System", for the Mental Health Co-ordinating Council (2003), it would be all too easy, and misleading, to simply correlate prevalence of offending with prevalence of incarceration, having herself arrived at the conclusion

from existing studies, that "there is no inherent link between mental illness and crime, but indeed a strong causal link between mental illness and incarceration". She argues that the epidemiological approach which asks, 'what is the true denominator out of which this group is derived?' opens up a new perspective on some of the fundamental issues in forensic psychiatry (Henderson, 1988, p123).

Until the benchmark survey conducted in NSW in 2003 by Butler and Allnutt, "Mental Illness Among New South Wales Prisoners" – the first large-scale survey examining the prevalence of psychiatric disorder in Australian prison inmates – there was inadequate hard evidence of the depth of the problem. Community surveys such as the National Survey of Mental Health and Wellbeing systematically exclude institutionalised groups. The survey covered two groups of prisoners: those at reception level (including first-time offenders and many on remand) and those who had been sentenced and detained for some time. To summarise the survey's findings, compared with data taken from the National Survey of Mental Health and Wellbeing (NSMHWB) using the same diagnostic tool (the CIDI):

- 74% had at least one psychiatric disorder (psychosis, affective disorder, anxiety disorder, substance use disorder, personality disorder or neurasthenia) in the 12 months prior to interview.
  NSMHWB: 22%

- 46% of reception and 38% of sentenced inmates were diagnosed with having had at least one mental disorder (psychosis, affective disorder, or anxiety disorder) in the 12 months prior to interview.
  NSMHWB: 15%

- 66% of reception inmates and 38% of sentenced inmates met the diagnostic criteria for substance use disorder, the most common psychiatric diagnosis among NSW inmates. 40% of reception prisoners had a 12-month diagnosis of opioid use disorder.
  NSMHWB: 5%

- 4–7% of reception inmates 9% of sentenced inmates suffer from a functional psychosis. "The twelve-month prevalence of psychosis in NSW inmates was 30 times higher than in the Australian community." (pp.. 3, 21)
  NSMHWB: 0.42%

In broad terms –

- 43% of inmates suffer from anxiety disorder.
  NSMHWB: 6%

  In relation to anxiety disorder, ….. PTSD, Butler et al. have noted:

> The twelve-month prevalence of PTSD in NSW inmates (24%) was substantially higher than that found in the general Australian community (3%). **This is interesting because most people view prisoners as 'traumatisers' rather than having been traumatised themselves. It also supports the notion that inmates are more vulnerable to having experienced serious psychological trauma in the past, likely associated with their upbringing, lifestyle and temperament**.
> (p. 27 – e*mphasis added*)

- 22% of inmates suffer from affective disorder.
  NSMHWB: 6%

- 43% of inmates suffer from personality disorder
  NSMHWB: 7%

It was also noted that psychiatric disorder is more prevalent among female prisoners than male prisoners. The survey also found that the most common convictions for both males and females were: assaults, robbery and property offences. 21% of female receptions and 14% of male receptions had a one-month diagnosis of depression.

Butler and Allnutt have concluded:

> Mentally ill inmates are more disabled than those with no mental illness. However when resources are allocated there is little distinction made between the needs of the mentally ill inmate and the non-mentally ill…. Further investigation is warranted into the possible unmet mental health needs of the NSW prisoner population to identify those suffering from less severe forms of mental illness who would nonetheless benefit form psychiatric treatment.
>
> The most common offences are those associated with **substance misuse** highlighting the link between drugs and incarceration. There is also a relationship between mental illness and offending. Substance abuse can mimic, trigger or exacerbate symptoms of mental illness. Co-morbid substance abuse and mental illness substantially increases the risk of offending. Among the mentally ill, substance abuse may increase the risk of non-compliance to medication and interfere with the effectiveness of medication. (p. 49 - *emphasis added*)

It can be argued that there is no refuge from psychoactive substances in the gaols, as large-scale dependency problems, coupled with mental health problems, create an internal market for illicit substances.

Henderson points out that that, by way of risk factors of mental illness itself – little education, poverty, poor social skills and living skills, lack of family support – the mentally ill are led into situations where exposure to psychoactive substances is greatly increased. "Typically young, male, single, with a history of conduct disorder and family substance abuse, these are the people to whom are applied such pessimistic terminology as 'falling through the gaps'."(NSW Health, 2000b, p15).

Former Attorney-General and head of the Schizophrenia Fellowship of NSW, Justice Frank Walker, (2002) succinctly outlined the major barriers to effectively treating people who have been dually diagnosed:

The treatment of such patients is problematic because almost all programs dealing with addictions refuse to accept mentally ill patients and programs dealing with mental illness are seldom able to treat addictions. The problems are unfortunately complex. For example, in the case of alcohol addiction, the typical treatment under the AA plan requires insight and self discipline – qualities usually lacking in a mentally ill person. … It is hard to imagine successful treatment of the illness unless the patient is free of such drugs. In summary, my message is that the solutions I am proposing actually require interaction between the health and criminal justice systems. In other words there needs to be a cooperative effort between our courts, police, corrective services, psychiatric hospitals and community health care providers. Our State Government needs to firmly put an end to the well-entrenched bureaucratic games of blame shifting and buck passing.

A PACCOA member recently reported that there is a significant problem in Aboriginal communities concerning the issue of both mental illness and "undiagnosed" mental illness due to inadequate resources in these communities. These are often people being treated for addictions, and fall under the dual diagnosis umbrella. Often these communities do not have basic drug and alcohol services. At one Probation and Parole District Office, there are over 30 offenders with significant drug and alcohol issues, but no counsellor. Even though every effort is made to fill the gap by bringing in the services from outside the communities, wherever possible, the responsibility falls to health services. It has been recommended that, given there is a dual diagnosis treatment trial under way, such trials should be extended to poorly resourced Aboriginal communities where the treatment is so urgently needed.

The degree of unmanageability of offenders in the community with very high needs – more frequently related to mental health issues, notably dual diagnosis, than to other needs – highlights the poverty of community mental health resources allocated to this group. In such cases, community supervision has become a last resort, also a potential stepping-stone to imprisonment, as these individuals would otherwise be referred back to the courts for breach of supervision.

Such clients would need at least a level of intervention that is currently warranted, in NSW, by high-risk offenders under community supervision. Even that level of case management would not necessarily be equal to the task of maintaining compliance and community safety, given that such clients are frequently young and may not have an established track record of community disruption or conspicuous anti-social behaviour that would bring them to the attention of police and courts. Professor Paul Mullen's research has found that only measures aimed at "improved clinical services, greater social support, targeted drug and alcohol services and specialised community forensic services" are likely to have an impact on reducing offending and violence. With regard to risk assessment of potential acts of violence among the mentally ill, particularly schizophrenia and severe affective disorders, Mullen points out that:

> Currently the associations to mental health and intellectual variables can contribute little to the recognition of individuals likely to commit seriously violent and criminal acts in the future. … Short-term predictions (days to a week or so) in individuals of increased aggression can be reliably made based on clinical assessments informed by the established associations. (p. 44)

However, the recent case of Timothy Kosowicz (23 years old) found not guilty, due to mental illness, of child murder and aggravated sexual assault in March this year, offers a clear example of the tragic potential of illicit drug use and schizophrenia when inadequately managed. Itinerant, and having come adrift from community offender supervision, Kosowicz had been admitted at least 16 times to several mental health wards between 1999 and late 2003. Less than a month prior to the crime, Kosowicz had admitted himself to Liverpool Hospital, fearful that he would "become angry and violent", but "despite a diagnosis of schizophrenia and doctors warning he was dangerous" and his own protestations against leaving, he was discharged several days later.

> Records show he was suicidal, hearing voices, paranoid and threatening violence, but still he was released … His 'increasingly bizarre' thoughts included that 'Gothics' had infiltrated police and that neighbours had put microphones in his stomach. (*Sydney Morning Herald*, 25.3.05)

Where criminal justice becomes a substitute for social justice, people with mental health issues, and disabilities in general, are being dealt with in the courts or incarcerated on a large scale, primarily because of inadequate community services. The end result is further social breakdown. Where breakdown occurs and is perpetuated by inadequate services and supports, it could be said that the "unknowingness" of social breakdown takes on the added dimension that *nothing* is working, and individuals become subjected to punishment, segregation, control and containment as the answer to what would otherwise be social chaos. Those who have been marginalised by their mental health plight suffer the double injury of social exclusion and loss of liberty, generating another wave of losses. This is very acutely experienced upon release, when a person's original diminished social identity – often a reflection of their mental health issue and further damaged by their gaol experience – deteriorates with the stigma of offender and ex-prisoner. By this time, an ex-prisoner's social isolation, easily internalised by them as rejection – which of course it is, in a very real sense – deepens their extreme vulnerability.

PACCOA has recently been involved facilitating the development of protocols between Centrelink and probation and parole services (known by different names nationally) to assist their mutual client bases. This will undoubtedly lead to significant improvements for mentally ill clients with special needs and build on protocols already in place between Centrelink and custodial corrections bodies. Centrelink's Personal Support Program has been a great boon to mentally ill clients, and other clients with special needs and disabilities, under community supervision.

During 2003/04, the Department of Corrective Services, NSW, was allocated $80 million for capital works. Of that, $16 million was spent finalising a new facility at Kempsey in 2004. The cost of imprisonment has been estimated to be 18 times higher than the cost of community-based punishments. In 2003–2004, the real recurrent cost per prison per day was $173.30. The equivalent cost for a community-based supervision was $9.70. However, by contrast, growth in the probation and parole area has been placed under much tighter constraints traditionally, with run-off of funding into custodial funding imperatives.

Because community-based sentences engage the broader community in the rehabilitation of its own offenders, the community becomes engaged to some degree in a process of revaluation and, ultimately, community restoration. Community funding programs could expand ownership to include more services for people with mental illness, e.g. New Horizons Enterprises Ltd, which operates a supported accommodation program in NSW for offenders with mental illness.

A range of community-based sentencing options such as Community Service Orders, Home Detention and Periodic Detention in NSW and the ACT, and community supervision have the potential to break the cycle of the revolving door. Mentally ill people – particularly those with more serious life skill problems, typically experience life as an ongoing state of crisis – from homelessness, or often unstable housing, poverty, unemployment or under-employment and hospitalisation – from community to court, to community agency, back to court, to gaol where the social warehousing of those with mental health problems is currently being legitimated, even celebrated, at some of the highest levels of government and policymaking.

Although the Richmond Report recommended decreasing the number and size of mental hospitals, it proposed: the expansion and integration of community services and networks; the maintaining of clients in the community; a separation of developmental disability services and mental health services; and a substantial increase in funding to mental health. The challenge of counteracting the possibility of reinstitutionalisation in the criminal justice system, a development that should have been foreseen as an inevitable consequence of deinstitutionalisation – following the Richmond Report of 1983, the Barclay Report of 1988 and, finally, the Burdekin Report of 1990 – called for moral bravery, ingenuity and vision. The National Mental Health plan, now in its third phase, was proposed by the Burdekin Report, but has yet to be fully realised as an integrated national model that would vastly improve and integrate mental health services Australia-wide.

It is worth noting here, that, when giving evidence before this Senate Select Committee on 19 May 2005, Dr Sev Ozdowski, Human Rights Commissioner and Acting Disability Discrimination Commissioner, HREOC, reported on the impact of the report, *Out of hospital, out of mind,* jointly authored by HREOC and the Mental Health Council, the end result of a series of national forums

held in all capital cities on that theme.

We were so distressed by those findings that we expected the Commonwealth and the states to address these community priorities and recommend their implementation in the National Mental Health Plan 2003-08. That, clearly, did not occur. The 2003-08 plan is well worth reading simply for its lack of specificity in terms of what were the priorities of that plan, which we are now operating under, and what the measures of the outcome of that plan would be – whether it had been achieved.

Now that *re*institutionalisation within prisons has become an established reality, the pressure on our political leaders is to have the moral courage to admit that, without proper community structures and support, deinstitutionalisation without proper thought for the consequences to people who suffer from mental illness has resulted in a displacement of a high proportion of our most vulnerable and disadvantaged citizens, into the gaols where custodial severities and a punishment ethos have been allowed to effectively hide from public view a serious mental health care and human rights crisis.

Allan Fels, Dean of the Australia and New Zealand School of Government and an Associate of SANE Australia, in a recent letter to the *Sydney Morning Herald*, commented on the disastrous consequences of social planning that failed to provide an adequate alternative to institutions:

People sometimes ask if desinstitutionalisation has gone too far. The truth is that it hasn't been given the chance to go anywhere. While the old psychiatric institutions have rightly been closed, community-based services have never been given sufficient resources to provide an adequate replacement – leaving the prison system … to act as a sump.

In a similar vein, Eileen Baldry, Senior Lecturer in the School of Social Work at the University of NSW, responded to the announcement made by NSW Premier, Bob Carr, in January 2005, that prison numbers had reached a record 9000, almost half the prison population of Australia, marking a 50% increase over the past decade.

The 50 percent increase in prisoners over the past decade is a clear indication of failure on the part of government to deal effectively with serious social problems. **More than 50 per cent of prisoners have an intellectual or psychiatric disability**. … Prison, the most unhelpful place to send a person with these problems, is being used as surrogate therapeutic housing. But of course prison is not organized to provide a healing environment and many are released in a worse situation than before they entered. … The productivity Commission says NSW spends the least per person of all the state governments on mental health. NSW is also below the average in supporting people with an intellectual disability, particularly those who have been caught in the criminal justice system. (*emphasis added*)

The extent to which these environments give rise to mental illness

At the time of writing, PACCOA is reliably informed that the 40-bed Mum Shirl Unit, at the Metropolitan Remand and Reception Centre (MRRC), NSW, a recently built therapeutic assessment unit for Aboriginal women, has scarcely any inmates in it yet. It is estimated that about one-third of its prospective clients have not met the criteria for mental illness under the

Mental Health Act, yet their lives, typically, like those diagnosed with mental illness, have been described by a Probation and Parole officer as "like train wrecks".

In NSW, many aspects of Segregation Housing Units (SHUs) and the High Risk Management Units (HRMUs) or "Super Max" intended human containment dwellings, seem staggeringly inhumane. At best – and any presumption of justified utility may be overgenerous – they may assist custodial staff to closely observe inmates and prevent self-harm or suicide for short periods of time; or they may, as Premier Bob Carr has claimed, be suitable for the containment of "the psychopaths, the career criminals, the violent standover men, the paranoid inmates and gang leaders" (Wynhausen, 2005). Despite that original intention, Scott Simpson, known to be a delusional paranoid schizophrenic, hanged himself in his cell in the "Super Max" in June 2004, having spent almost two years at Goulburn Correctional Centre, locked in his cell 23 hours a day. No one in a civilised society should be exempt from civil or human rights, whether at liberty in the community or in a confined, controlled environment – whether regarded as mentally ill or not.

PACCOA members, most of whom are predominantly based in the community and spend much shorter periods of time working in parole units in the gaols, would welcome being given more information about the custodial system. Although a good deal of written information is freely available, members have expressed a desire to learn more about the prison environment and to have more personal exposure to aspects of it, especially those aspects that inform offender management in the community. The barriers between the custodial system and community offender system are detrimental to the effectiveness of throughcare systems, which have been designed to provide "holistic and coordinated services and programs to offenders." (NSW *Throughcare Strategic Framework*)

Justice Frank Walker (2002) stated, simply and eloquently:

> It is my belief that the Australian concept of justice should not include visiting cruel and unusual punishment on the sick. The rest of the community who contract serious illness are treated by health professionals in a hospital setting. Why should those whose illness throws them into a world of unreality be denied medical treatment and left to the tender loving care of prison wardens and hardened criminals? … The shock to a person suffering schizophrenia of being thrown into prison and separated from his or her support systems, denied medication and possibly also withdrawing from drugs or alcohol is catastrophic. (p. 2)

Butler et al. (2003) have expressed similar concerns for inmates experiencing incarceration in a way that is manifestly deleterious to their mental health:

> Mentally ill inmates may experience increased feelings of paranoia, anxiety, and despair, which can exacerbate a mental illness. They may have difficulty accessing regular psychiatric follow-up due to frequent transfers, and in some cases, less likely to assert themselves to obtain treatment out of fear of stigmatization. (Butler et al., p. 50)

Incarceration results in the loss of many personal freedoms taken for granted in the community, including social supports, interpersonal 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 a **mood disorder, which is more severe than simply feeling 'down' about their circumstances**. (Butler et al., p. 24) (*emphasis added*)

With regard to self-harm and suicide in NSW gaols, Butler et al. have commented:

Between 1999 and 2002, the rate of completed suicide in NSW prisons was approximately 80 per 100,000 compared with approximately 12 per 100,000 for all ages in the NSW community. … The prevalence of suicidal thoughts and behaviours among NSW inmates are approximately four times higher than in the general population (16% and 3.4%). (p.28)

Most at risk of harming *others*, as we have already noted, schizophrenics are also more likely to cause themselves harm or to be harmed than they are to harm others, as noted by Jablensky et al., 1999: "… a person with schizophrenia is 2,000 times more likely to suicide than they are to harm someone else" (BetterHealth Channel, 2002) Henderson (2002). Without being placed in a secure, forensic environment outside the gaols, such inmates would be placed at a very high risk of coming to harm.

There is concern that lockdown periods are inimical to the mental health of inmates. This beggars the question, is this preeminently in the interests of significantly limiting custodial costs, or is it in the interests of greater security? During 2003/04, the NSW Department of Corrective Services reported that,

To ensure safe and secure centre operations, out-of-cell hours were reduced in a number of maximum and medium security facilities from an average of 9.15 in 2002/03 to 7.65 in 2003/04. The 2002/03 national average for secure custody was 10.3. … The total average of all out-of-cell hours (open and secure custody) fell from 10.58 in 2002/03 to 9.68 in 2003/04, which compares with the national average in 2002/03 of 11.3. (p. 30 Annual Report 2003/04)

In the same report, the Department indicated that the underlying reason for longer lockdowns and shorter out-of-cell hours was really an *economic* one, when an undertaking was given to increase out-of-cell hours as a reflection of lower per capita operating costs achieved through workplace reforms in *The Way Forward* model.

Although the Department reported that the incidence of violent assaults had declined, it was also conceded that "the rate of inmate on inmate assaults was above the 2002/03 national averages", but that this reflected the higher concentration of higher-risk inmates in NSW.

Inmates who suffer from mental illness are more likely to be perceived to be less malleable to gaol culture, more conspicuous, more fragile and less tractable than other inmates, therefore more in need of control – often in the form of tightened punitive measures. Mentally ill people are more likely to

suffer discrimination within prison and victimisation and exploitation from other inmates. They are also less likely to be responsive to some of the more positive aspects of gaol,e.g. special therapeutic behavioural programs and education programs, because they may be cognitively impaired and traumatised, therefore have learning orientation difficulties.

Probation and Parole Officers are commonly required, especially in urban settings, to case-manage homeless, mentally ill clients, who live exceedingly bleak lives and can barely fend for themselves on the streets, much less aspire to working on creative projects, no matter how small. (This is not to say, however, that many people with mental health issues are not highly creative, original thinkers. There is abundant evidence that many are). Similarly, this is not to say that the odds against creative expression for mentally ill people in the gaols are insurmountable; not at all, just that, without encouragement and/or special programs geared to suit their individual needs, supervised to some extent by mental health professionals, the development of that expression is unlikely to happen.

Some fortunate prisoners can, by accessing special education programs, greatly enhance their mental health, wellbeing, and even future professional standing. However, these programs are relatively scarce and open only to small numbers. Zig Jaworowski, one of the artists whose works were presented in the recent *Convictions* exhibition at the Ivan Dougherty Gallery in Sydney, stated in a piece he contributed to the exhibition catalogue:

> Over the months that we remained in the Art Unit (my own experience lasted almost two years) art became a way of living and an obsession. We were consumed by it. As Terry Ayres said: "If they knew where I went every night, they'd be out after me and I'd be doing a million years for escape!" You have few personal possessions in gaol – but one thing you do have, and which cannot be taken away from you, is your imagination and your dreams.

Tragically, the social dispossession, alienation and exile from wholeness that can be experienced by mentally ill offenders can prevent their access to the rewarding world of imagination described here. Access may be effectively blocked, both in terms of an individual's level of psychological functioning and in terms of program entrance criteria, which favour a higher level of functioning than is possible for many inmates suffering a mental illness. If gaol is the source of further stigmatisation, suffering and trauma, then dispossession of a healthy and creative inner life *can and does occur*. To the mentally ill, imagination and dreams are not eternal and inviolable, and cannot be relied on as a refuge from external privations or as insulation against further psychological damage.

In his poem "Hell", the poet W.H. Auden gives a moving description of, on the one hand, painful psychological alienation and, on the other, the blunted and emotion-proofed limbo of living collectively in an unfeeling state. To quote some verses of the poem:

Hell is neither here nor there
Hell is not anywhere
Hell is hard to bear. …

In time, pretending to be blind
And universally unkind
Might really send us out of our mind.
…

To talk the dictionary through
Without a chance word coming true
Is more than Darwin's apes could do.
…
If we were really wretched and asleep
It would be easy then to weep,
It would be natural to lie,
There'd be no living left to die.

The adequacy of legislation and processes in protecting their human rights

PACCOA emphasises the value of community-based sentencing options for offenders who would otherwise be inappropriately and inhumanely incarcerated. Such community supervision should form part of wider, integrated community care. The National Human Rights Commission (1999), World Health Organisation, United Nations, has provided guidelines as to the purpose and implementation of adequate community care in the context of deinstitutionalisation (and, by implication, reinstitutionalisation):

… community care is about the empowerment of people with mental and behavioural disorders. In practice, community care implies the development of a wide range of services within local settings. This process, which has not yet begun in many regions and countries, aims to ensure that some of the protective functions of the asylum are fully provided in the community, and the negative aspects of the institutions are not perpetuated. … In 1991, the United National General Assembly adopted the principles for the protection of persons with mental illness and the improvement of mental health care, emphasizing care in the community and the rights of individuals with mental disorders. **It is now recognised that violation of human rights can be perpetrated both by neglecting the patient through discrimination, carelessness and lack of access to services, as well as by intrusive, restrictive and regressive interventions.** (p. 3) (*my emphasis added*)

It would appear that human rights are not systematically respected and protected, therefore not guaranteed in our prison systems and brought into alignment with duty-of-care issues. Greenberg et al. (2003) have cited the United Nations *Standard Minimum Rules for the Treatment of Prisoners* 1955, Rule 82 (1): "… persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible".

Mental health services in NSW are delivered under the '*Charter for Mental Health Care in NSW*'. These rights and entitlements must be translated into practice for prison inmates and offenders under community supervision. The Charter is manifestly out of kilter with mental health services available to this population. It recognises amongst these fundamental rights: respect for human rights; fostering positive attitudes to mental health; widely accessible treatment and care; comprehensive prevention programs; addressing quality of life issues; cultural sensitivity; encouraging and supporting self-help.

The Mental Health Council of Australia (MHCA) has stipulated that concern for protecting the human rights for people with mental health issues must

include: counteracting discrimination in employment, disability assessment and housing; counteracting community neglect; and action strategies to address human rights abuses or neglect.

The human rights of the mentally ill within the criminal justice system need to be protected by staff education, keeping clients informed about their human rights, and introducing human rights monitoring and reporting mechanisms that could be placed under the systematic oversight of the Human Rights and Equal Opportunity Commission (HREOC). The MHCA has called for the appointment of a permanent Deputy Commissioner for Mental Health within HREOC.

Justice Frank Walker has stated that human rights are meaningless unless backed up by mental health services that are adequately resourced (p. 5).

Community-based options that are tailor-made for people with mental health disabilities would work well in a system of greatly increased court diversion programs. Where the range of sentencing options is limited – regardless of whether sentencing takes place in a country or urban area – offenders must be effectively squeezed into sentences for which they may be ill-suited and therefore set up to fail.

In NSW, the imminent introduction of amendments to parole legislation – the *Crimes (Administration of Sentences) Amendment (Parole) Act 2004 No. 94* – will bring a more punitive approach to the breaching of parole conditions and much greater restrictions applying to parole reviews. Where offenders – particularly those with intellectual and mental health disabilities – fail to comply with their parole conditions, they will be much more likely to return to custody. Upon their eventual release, they will be entirely without support, with which they have enhanced prospects of being returned to gaol. They may reapply, but such an undertaking requires focus, resourcefulness, and the ability to tap into other sources of information – the very skills a mentally ill person would have most difficulty mobilising. These new provisions will greatly disadvantage mentally ill inmates seeking parole.

The reasons for non-compliance are multifactorial and endemic to the lives of social and economic disadvantage so commonly experienced by parolees. Despite all the possibilities of integrated throughcare and parole supervision, an individual who has been evicted from temporary or crisis accommodation may be sick or disoriented, without their usual medications, recovering from an assault, without money for public transport, phone or food, and, under those circumstances, unable to make proper sense of, let alone follow to the letter, their parole conditions. Breaches are therefore frequently not *directly* related to the intention to reoffend, but are much more likely to reflect dire life circumstances. As Eileen Baldry has stated:

Affordable housing in NSW, especially for those with disabilities, has slipped further out of reach. **Fifty per cent of prisoners are homeless with nine months of their release**. When this is combined with poor mental or intellectual functioning, most are unable to

manage and end up back in prison. **NSW has one of the highest rates of recidivism in Australia, with more than 70 per cent of people in prison having been incarcerated before**. (e*mphasis added*)

As stated in its submission to the Criminal Law Review Division, Attorney General's Department: Review of the *Crimes (Sentencing Procedure) Act 1999* and the *Crimes (Sentencing Procedure) Amendment (Standard Minimum Sentencing) Act 2002, July 2005,* PACCOA's NSW state counterpart and affiliate body, the Probation and Parole Officers' Association of NSW Incorporated (PPOANSW) has observed that, wherever possible, community-based sentencing options should replace shorter sentences. Where 63% of NSW inmates are serving sentences of six months or less, with even more disturbing statistics for sentences of up to 12 months. They conclude that, with regard to the general prison population, including mentally ill inmates who are frequently incarcerated for minor offences:

It follows that the great majority of inmates are not in gaol for serious criminality, nor will any rehabilitative work be undertaken while they are incarcerated, simply because there is insufficient time to engage them in programs which are proven to have sustainable value. What is clear is the potential to develop their criminality whilst they serve a short sentence. In short, there is no evidence of the value of imprisonment for deterrence, community protection or rehabilitation. (p. 4)

The use of diversion programs for such people

Police, courts and prison are often overstretched to the extent that the complex issues associated with mental illness, particularly dual diagnosis, mean that a mentally ill person is much more likely to be arrested or incarcerated.

Diversion from the criminal justice system towards treatment in mental health facilities is most suitable for minor charges, where prosecution has begun (Greenberg and Nielson 2003).

Deputy Chief Magistrate, NSW, Helen Symes has deplored the use of prisons as "mental hospitals for the poor". She has proposed that where people brought before the courts are not "legally competent" that they be subject to diversion to the NSW Statewide Community and Court Liaison/Diversion Service.

PACCOA fully endorses increasing existing services so that *all* courts have access to appropriate mental health staff (currently there are about 14 NSW local courts providing the service). This would prevent vulnerable people having to travel distances to those few courts, would also protect their privacy and dignity, and streamline the process of assessment under the *Mental Health Act (NSW)*, Sections 32 and 33. However a limited number of mental health diversion courts, if created, would offer an alternative for people with very challenging or violent behaviours, although travel would still be a problem. Judge Frank Walker, amongst others, has advocated the provision of secure and medium secure health care units and a specialist forensic service. This would impact very little on the prison population. Probation and Parole Officers have been alarmed to see clients referred for Section 33 assessment returned to the courts unassessed or with a finding

that they are not mentally ill or capable of being scheduled. Helen Syme has stated:

> There is a deep suspicion at court level that these referrals back to court are more to do with hospitals feeling themselves unable to handle potentially disruptive mentally ill persons and their position is that they would rather they be in custody. Often this finding will appear to defy common sense, but there is little else a court can do other than refer the matter for assessment while in custody. (p. 10)

Greenberg et al. (2002) emphasise the valuable role of advocacy and access facilitation performed by court liaison staff in a process that strongly works against criminalising the mentally ill:

> A range of factors may affect the ability of area mental health services to accept the mentally disordered offender. These may include demands on existing services, the perceived dangerousness of the mentally disordered offender, and a myth that prison mental health services are better equipped to manage mentally ill defendants with minor criminal charges. … The long-term benefit from ongoing negotiations with area mental health services is improved access to psychiatric treatment and care for mentally disordered offenders at the interface of the criminal justice system. (p. 3)

Court-based psychiatric services in NSW have been successful in assessing mentally ill offenders remanded in custody by: allowing for immediate identification of people with acute symptoms; offering an alternative to custodial treatment; where people will remain in custody, communication with Justice Health allows for immediate identification, treatment and follow-up; with the enhancement of throughcare, Justice Health and community-based services, working closely together to support people who are released; making possible immediate assessment under S.32 and S.33 of the *Mental Health (Criminal Procedure) Act*; quickly identifying and excluding persons who do not have a mental illness and where a mental illness is not relevant to the offence charged.

The use of supervised bail, both pre and post conviction could be used to reduce the numbers of offenders who are refused bail unnecessarily or for want of a home; or to ensure that offenders are linked up with detoxification/rehabilitation services and mental health teams in the community.

In NSW, the Drug Court offers a diversionary program that offers: immediate intervention; a high level of supervision; close monitoring and reporting back to the Court periodically; an emphasis on reintegration within the community rather than the imposition of punishment; imposition of a custodial sentence where offenders fail to meet the standards of the program. This program enjoys a success rate of about 60%.

Some structural and policy issues, and implications for future directions

Butler et al. (2003) have pointed out the essential conflict in the prison system between providing mental health care and functioning within a

correctional setting:

> 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. (p. 50)

NSW and Tasmania have lagged behind the other states in developing comprehensive forensic psychiatric services. There is an urgent need for this service to be broadened to include case management and advocacy to link clients to existing health and welfare services, expert practitioners for mobile treatment, and residential rehabilitation for dually diagnosed people. At the end of the program, individuals would be referred to a community support program including day treatment, intensive psychiatric rehabilitation services, and other clinical care (also akin to the model used in New York) (Henderson 2003).

Under the NSW Forensic Mental Health Strategy, forensic psychiatric services are provided purely in a prison setting. These services are being developed across the state. Plans include the building of a secure forensic psychiatric hospital.

As described by Henderson (2003), although Victoria's Forensicare compares in general with the NSW service model, it is divided into four program areas: court-based, prison-based, hospital-based and community-based. Forensicare has a research role that has attracted international attention and receives referrals from the courts – at any time – from general mental health services, police, prisons and justice agencies. The Melbourne Assessment Prison screens all prisoners upon their arrival to identify people with a mental disorder and those 'at risk'. Treatment for acute illness is given at an Acute Assessment Unit. The 100-bed Thomas Embling Hospital is a dedicated forensic psychiatric hospital that offers innovative treatment, rehabilitation and education programs. It provides acute care programs and a continuing care program, also intensive rehabilitation in the long term. The Brunswick Community Forensic Mental Health Service provides diversionary treatment in the community for offenders on bail, high-risk offenders (e.g. stalkers and sex offenders who have been released conditionally from prisons.

> Of note is the women's care program. Unique in Australia and only one of a few around the world. Using contemporary theory and evidence-based practice, women are provided with psychiatric care that specifically addresses their needs, in a secure environment. (Henderson 2003)

Western Australia also emphasises the provision of meeting the individual needs of clients. At the Frankland Centre, forensic patients are treated by a dedicated forensic team. Rehabilitation, assistance and referral are provided by a separate team. The standards of care provide an excellent model for other states, and confer particular advantages to parolees and those on community treatment orders: "Offenders with a mental illness nearing the end of their sentence are transferred from prison to hospital under a discharge program that sees their follow-up within the community planned and put in place before their release." (Henderson 2003)

The *National Mental Health Strategy's Draft National Statement of Principles for Forensic Mental Health* will cement joint ownership by health and justice portfolios by:

- Providing forensic psychiatric services outside the correctional setting, with an emphasis on research and training;
- Extending and integrating services across preventive areas, such as drug and alcohol, disability support and housing;
- Providing an evidence-based quality improvement process measuring performance and identifying strategies for development;
- Providing cultural awareness of the special needs of indigenous Australians, culturally diverse groups and women, children and people with a disability.

As outlined by Susan Henderson (2003), a whole-of-government approach would provide for the much-needed integration of mental health and forensic mental health services and networks, across the board.

A repeated call during the Select Committee Inquiry into Mental Health Services in NSW was for a statewide forensic mental health service, such as that in place in Victoria, Queensland and Western Australia.

Under this approach, a central mental health agency works strategically with other government agencies, such as housing, health, disability, education and training to create a comprehensive redress of the serious shortcomings of mental health service provision in NSW. Such a service would immediately reconcile the conflicting cultures of correctional services and psychiatric care and would facilitate the adoption of the national model by the National Mental Health Strategy, which has proven so effective elsewhere in Australia.

This model proposes a service that provides a continuum of care, through court, prison, hospital and community. Court liaison and reporting services would provide an essential safety valve for people with a mental illness encountering the criminal justice system. Reception assessment, appropriate treatment and outpatient follow-up are key inclusions of prison-based services. Hospital-based services would be provided for people too ill or at risk for management within the prison system. These would be located independently of the prison – both physically and administratively – and would be staffed by mental health and allied health professions. Hospitals would provide acute, sub-acute and rehabilitation programs and would cater for the needs of diverse groups, such as women, indigenous people and people with a dual diagnosis. In addition to providing patient care, staff will play an important role in linking with other health and community service agencies. Release plans would include provision of follow-up supervision, care and community treatment (National Mental Health Strategy, 1999).

PACCOA has affiliation agreements with the American Probation Association, the New Zealand Association of Probation Officers and the European Conference of Probation (Conférence Permanente Européene de la Probation). We strongly endorse and urge that international benchmarks of best practice and service excellence be maintained throughout Australian state jurisdictions.

PACCOA believes there are negative implications for the management of clients with mental illness, in a proposal restructure the Department of

Corrective Services in NSW. A newly configured chain of command, would see the abolition of the position responsible for the Probation and Parole Service and the creation of a single operations division for the Department. The inherent risks are that Probation and Parole would no longer have a senior executive able to argue its issues at the highest level within the Department and that prison issues, which have always dominated the Department, would utterly overwhelm probation and parole. Resourcing would be even more contingent on the views of custodial senior management than at present. The merging of Queensland and South Australian custodial and community operations in various ways, a number of years ago, proved to be disastrous as, inevitably, community corrections became badly neglected. Both states have since reverted to appointing separate heads to bolster their community corrections divisions and Queensland, we are informed, is only now recovering. Victoria, on the other hand, has achieved a reduction of 400 prison beds out of a target reduction of 600. Instrumental in working towards this change in direction, away from an overstretched prison system, have been the following strategies: the diversion of resources to community-based operatons; the wider use of front-end, community-based penalties; and the introduction of a number of throughcare options to support sentenced offenders upon release.

Given that the overrepresentation of mentally ill people in the gaols is likely to continue for some time yet until social justice and mental health policies work with greater humanity and efficiency to provide for more appropriate alternatives to reinstitutionalisation, it is important to promote and enhance the operations of vibrant, well-qualified and well-resourced probation/community corrections organizations in all states and territories. This would help to ensure that community management of mentally ill offenders, many of whom will be dual-diagnosed, wherever it occurs, is adequately supported by corrections departments, in contrast to the warehousing which is so tragically evident in parts of this country. Links between mental health and probation/community corrections need to be strengthened, with models of common case management developed, (perhaps the setting up, as in Victoria, of a Psychology Service to give appropriate professional support in the case management of more complex mental health dilemmas.) even multi-disciplinary teams introduced, and continuing education in mental health issues for probation/community corrections officers developed. This could be linked, perhaps, to the National Qualifications Framework, within which probation and community corrections training is accredited.

The following attachments, while not integral to the PACCOA submission, have been offered by both PACCOA members and non-members as brief insights, reflections, anecdotes and case histories on the experience of working with people with mental health problems within the correctional system.

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