Burdekin Report
(other important documents are on the HREOC website too)

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Chapter 25

FORENSIC PATIENTS AND PRISONERS

Untreated people are ending up in jail through either misunderstanding, non-recognition of their symptoms, or as a direct result of actions emanating from their treatable conditions going untreated. Once in jail, clearly, their opportunities to receive access to treatment and services are even more diminished.'

Definitions

This chapter addresses issues affecting mentally ill people who commit criminal offences, and those who are or have been in the custody of police or prison services. The two criteria do not necessarily describe the same group of people. For example, some offenders serve their sentences in psychiatric wards; others receive a non-custodial sentence such as a community service order. Many inmates in jail are not actually serving a sentence; they are on remand, awaiting a court hearing. And former prisoners, whether released unconditionally or on parole, face an array of daunting obstacles in living with mental illness.

Prison conditions, police practices and the criminal justice process are all important areas to examine in assessing any society's attitude to human rights. As evidence already outlined has clearly established, people affected by mental illness are especially vulnerable to abuse or denial of their rights.

'Forensic Patients'

Legally, 'forensic patients' are people whose status in the penal system is determined by a mental illness2 — eg offenders whom the court finds unfit to stand trial.

However, mental health professionals use the term 'forensic patient' to refer to any prisoner receiving psychiatric treatment, whether or not that fact has been legally acknowledged. 'Forensic psychiatrists' treat prisoners in jails and psychiatric wards, but may also provide some continuing care to ex-prisoners living in the community. They also provide psychiatric services to the courts— giving expert evidence during trials and preparing reports on particular offenders for sentencing judges to take into account.

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Relevant Human Rights Instruments
As described in Chapter 2, mentally ill people in the criminal justice system have rights prescribed in international treaties and other human rights instruments. These include the International Covenant on Civil and Political Rights (ICCPR); the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; and the Body of Principles for the Protection of all Persons under any Form of Detention or Imprisonment.

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

In addition, the UN has developed the Standard Minimum Rules for the Treatment of Prisoners ('the Standard Minimum Rules'). Australia adopted these Rules in the form of the Australian Standard Guidelines for the Treatment of Prisoners in 1978.

Prevalence of Mental Illness Among Prisoners

What is the prevalence of mental disorder within the prison system is a quite different question to the numbers of individuals being treated in the forensic psychiatric service. If the rate of mental illness in prison was measured by the number of individuals designated 'forensic patients', it would be deceptively low. According to the statistics most prison systems have only a small number. For example, NSW in October 1991 had 86 prisoners covered by the forensic review legislation. This was just over 1 percent of the State’s prisoners at the time. Similarly, South Australia's prison psychiatric ward, James Nash House, has usually 25 to 30 inmates from the criminal justice system being cared for within it. However, I suspect the prevalence of mental disorder within the prison system is very, very much higher than that.

In the general prison population, the prevalence of mental illness is difficult to quantify. Most prison services do not routinely assess inmates for psychiatric problems, either on arrival or at any time — largely due to a chronic lack of funds for health services of any kind.

Many people believe that the new approach to mental health since the 1950s has resulted in the 'criminalisation' of mental illness: instead of being detained in hospitals, large numbers of mentally ill people are said to be ending up in prison.
If you decrease the number of mental health system beds, there will be an equivalent rise in prison system beds, as those with mental health problems will be channelled into the prisons.8

Empirical research on mental illness in prisoners has been scant and at times inconsistent.9 The findings of the main Australian study on the topic indicate a high rate of mood disorders in jail, especially major depression: 12 percent of subjects had a current diagnosis. A startlingly high proportion of prisoners (82 percent) had suffered at least one 'mental disorder' at some point in their lives (including alcohol or drug abuse).10 However, the findings do not support the perception of a large scale shift from hospitals to jails as the new repositories of people with severe psychotic illness.11

The general belief among witnesses to the Inquiry was that a great deal of mental illness goes undiagnosed in jails. This is not only caused by the lack of resources: the atmosphere of deprivation and despair which is normal in prisons leads staff and inmates to become desensitised to suffering.12 The individuals affected may only come to the attention of prison authorities if their behaviour becomes severely disruptive.

Evidence to the Inquiry clearly indicated a higher rate of mental illness and disorder in prisons than among the general population.13 A Tasmanian study found that approximately one-third of female prisoners admitted over the last ten years at Risdon Prison have had a psychiatric history;14 but the absolute number with disorders has also steadily increased during that period.15 An expert witness in Sydney estimated that 30-50 percent of young people in detention facilities have a mental health problem.16 Another said 1-5 percent of prisoners have a 'classifiable psychiatric illness, meaning particularly psychotic states', while some 20 percent 'exhibit some form of psychological distress, symptoms which are troublesome or disabling and for which they require treatment or counselling'.17

NSW is estimated to have 300-400 prisoners who will require psychiatric follow-up after release, and another 500-600 currently on parole (but still under sentence) who require psychiatric management.18 (300-400 prisoners represent 5-7 percent of the State's prison population.) The Schizophrenia Fellowship in Queensland estimates there are about 150 people with schizophrenia in that State's jails19 (approximately 7 percent), while in the ACT's remand centre over half the inmates are 'believed to have a form of mental illness'.20

In Darwin the Inquiry was told that the population affected by mental illness in the Northern Territory includes a particularly high proportion of criminal offenders. This is because the NT population profile is young, with about 40 percent of Territorians under age 25, and offending is most common among young people.21
One obvious indicator of poor mental health is a high suicide rate. In 1990 and 1991 in Australia, 114 people died in prison or police custody, including at least 50 suicides.22

However, the lack of any systematic data on the mental health of prisoners is disturbing:23

We really don't know at the moment who is there because, to the best of my knowledge, there has not been an adequate census. I think one of the first things one ought to be doing is having some sort of census, because it really does matter whether we are talking about 1 percent or 5 percent.24

Despite the lack of statistical data, many witnesses told the Inquiry there are seriously ill or disordered people in our prisons who should not be there at all. Imprisonment damages them personally (by aggravating their condition); it is also an inappropriate use of the criminal justice system.25 They basically need treatment — not punishment.

The mental illnesses found in jails include schizophrenia and other psychotic disorders (including drug-induced and other 'organic' psychoses), affective disorders such as depression, and adjustment disorders.26 Two other disorders are not strictly mental illnesses, but nonetheless fall to mental health workers to treat: extreme 'personality disorders'27 and substance abuse.28 Many prisoners have more than one of these. A severe personality disorder often masks an underlying mental illness;29 drug and alcohol abuse are rife.30 The Tasmanian study of women prisoners found that, rather than chronic severe mental illness, the most common diagnoses are personality disorders and drug abuse.31

Who Are the Mentally Ill Prisoners?

Evidence to the Inquiry established that mentally ill prisoners have several common characteristics which distinguish them from other prisoners:

[They are] less likely to be in a stable relationship; they are more likely to be unemployed; they have fewer children... they have more periods of imprisonment.32

Mentally ill inmates are more likely than other prisoners to be poorly educated; many also suffer from learning disabilities or difficulties (such as attention deficit disorder) which exacerbate their condition.33

As for the offences for which they are in prison:

The nature of their offences is generally minor, although there are major crimes
committed by those suffering from mental illness. In many cases, mental illness has been an important factor in the commission of the offence or alleged offence.34

Witnesses in the Northern Territory said their forensic services deal with a large number of sexual offenders, especially those diagnosed with a personality disorder.35

Legal Recognition of Mental Illness

Our criminal justice system recognises four ways in which mental illness can affect the disposition of offenders. A person charged with a criminal offence may be:

• found unfit to plead, and thus unfit to be tried;
• tried and acquitted on the grounds of mental illness;
• convicted, but mental illness is taken into account as relevant to sentencing;
• diagnosed while in custody — either while serving a sentence or on remand.36

People who fall into the first two of these categories are often detained 'at the Governor's pleasure' — ie indefinitely — either in jail or in a psychiatric ward.

A fifth category comprises offenders who have a 'personality disorder' but not a mental illness. The most publicised prisoner in this category was the late Garry David, who was held for three years in preventive detention in Victoria after his sentence had expired, notwithstanding that he did not meet the legislative definition of 'mental illness'.

Does Mental Illness Lead to Jail?

He did hear a voice one morning — he said on the wireless — that told him if he could go to jail, he would be cured. So he went around to a used car lot, he threw a stone through a window and in sub-degree temperatures — there was ice on the ground — he went at 5 o’clock in the morning and sat and waited till 7am for the police to arrive, whilst we were driving the countryside looking for him.37

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Many people are taken into custody — or have their detention prolonged — as a direct or indirect consequence of their mental illness or disorder going untreated. Untreated mental illness clearly causes some people to behave irresponsibly, irrationally and in a bizarre fashion. Sometimes this behaviour brings people to the attention of the police; in a small number of instances untreated mentally ill people commit violence against others.

The Inquiry heard several accounts of tragedy resulting from the actions of people who were known to be mentally ill, and in fact had been under some form of psychiatric care, but without sufficient continuity. One terrible
example was a young man with long-term schizophrenia who owned firearms; he shot four young women dead. He was seeing a private psychiatrist, but was not considered critical enough for hospitalisation at the time of the offence:

The system didn’t work then, and the results were the death of four young girls with the associated tragedy for their family — but also a tragedy for the young man himself... I suspect if he were under a system whereby committal had been easier and staying in hospital had been easier, and there had been a firmer and more detailed system of control once he was discharged, he would probably have had a life which consisted of admissions to hospital and then various discharges...whereas now he’s likely to be incarcerated until the day he dies.38

The Inquiry heard many examples of untreated mental illness leading to jail:

• In [our son's] case the boredom which develops because of lack of activity (due to lack of motivation) leads to drug-taking and recently, for the first time, serious crime. [He] was arrested two months ago on a charge of armed robbery ($150 from a shop). At the time he was under the influence of drugs and alcohol. The offence was typically bizarre in that he gave us pre-advice and we were able to alert the police beforehand. But they could not prevent the happening — in which there was no bodily harm. If [he] did not suffer from a depressive illness we feel sure this would not have happened.39
• One Cambodian woman who suffered from — well, she’d suffered all the appalling experiences that anyone from the Killing Fields could have suffered...and finally found herself in Australia and suffered then a very, very major psychotic illness — depressive — and during the course of this illness believed that the giant who had raped her, a brutal man in the refugee camp from which she fell pregnant, was coming to kill her now. And the voices in her head were telling her she deserved to die and she was going to be killed by this person, and this person was now embodied in her infant. So she attempted to kill this child. Subsequently, she was arrested and taken to the women’s prison...40
• [An] example of someone with a fairly obvious psychiatric or psychological problem...but she’s quite harmless: this particular woman self-medicates with cannabis, so therefore, she has been convicted on a number of occasions, and served short sentences; or if she’s fined, it’s impossible for her to pay a fine, and she ends up cutting out the fine in the watchhouse.41

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Mentally ill people are especially likely to 'commit' certain offences such as drunkenness, offensive behaviour, disorderly conduct, loitering or vagrancy (which commonly coincides with homelessness).42 Or it may be simply that they are more likely to get caught.43 A Queensland witness described 'the case of an old man':

At the age of 76 his memory was shot. He was arrested in Cooktown for indecent
exposure: he piddled on a tree in the main street. He didn't turn up in court because, amongst other things, he can't remember what day it is. So he was sentenced to 14 days for failing to appear.

He was transported, at great taxpayers' expense, from Cooktown to Cairns; put in the Cairns Watchhouse. When he'd served his 14 days out he was released; he didn't know where he was. He went across to the Esplanade just across from the police station, stood there for a while, had a drink of water, felt the call of nature, piddled on a tree again, as was his way when he lived in the bush — and straight back into the watchhouse.44

Non-payment of fines is another common avenue to prison for mentally ill people who are poorly organised financially,45 or who do not comprehend that they owe money.46

One witness to the Inquiry described many of these minor offences as 'victimless' crimes:

A sentence to prison for essentially non-criminal behaviour adds another unshakeable label to those already ascribed to a mentally unwell person, and the process of alienation is an even greater burden.47

Mentally ill people may be at increased risk of being charged with offences they did not commit. Improbable confessions by people with psychiatric disabilities are fairly common. (One recent example concerned the death of a resident in a hostel for people with psychiatric disabilities. Six other residents reportedly confessed independently to having killed her.48)

People who do not have full control over their lives can also suffer the legal consequences of others' carelessness or misdeeds. The Inquiry was told of a mentally ill man whose financial affairs were in the hands of the NSW Protective Commissioner:

This man attempted to commit suicide by lying on the railway tracks. He was picked up by police who found that he had outstanding warrants, and he was brought to prison... He believed the warrants had been paid by the Protective Office. On checking, $250 had been paid by the Protective Office; there was $200 outstanding. But the court computer did not show any payments, [so] he served seven days in prison.49

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Once arrested, mentally ill people may have trouble getting release on bail — because they are too poor to raise bail, because they have no fixed address, or because they do not comprehend or comply with bureaucratic requirements. For example, the Inquiry heard evidence about an offender whose bail was approved, but who refused (due to delusional beliefs) to sign any forms. The
authorities felt they had no choice but to retain this individual in jail.50

Failing to obtain bail means people affected by mental illness are frequently remanded in custody — even on quite trivial charges. The same problem arises when they are tried, convicted and due to be sentenced. The policy of most court systems is to favour non-custodial sentences such as fines, bonds, home detention and community service orders. But these cannot be imposed on someone who has no money and no secure accommodation. Thus people with a mental illness, for whom prison is a particularly inappropriate and harmful penalty, often go to jail for minor offences which normally would attract a noncustodial sentence.51

Similarly, when an offender is due for parole or remission, the absence of secure accommodation can be reason for being kept in prison.52 A NSW psychiatrist recounted the case of a prisoner with mental illness and an alcohol problem, who was found not guilty of an offence on the grounds of mental illness:

He has now made serious attempts to deal with the alcohol problem by having counselling and going to AA meetings in prison, has spent about four years in prison and could be released, providing there is ongoing supervision... But because of difficulties in arranging future management, the man in fact remains in prison.53

Mentally ill prisoners' inability to cope with the distressing living conditions may also make them more likely to commit disciplinary offences in jail. One example recounted to the Inquiry concerned a man who, due to mental illness, had moved in and out of jail and psychiatric wards all his life. At the time of the Inquiry he was in Alice Springs Prison, having committed several offences after his local mental health service lost its psychiatrist and discontinued his treatment. While in jail (still receiving no treatment) he was charged with assaulting prison officers:

He had been locked in his cell without access to water on the hottest day of the summer. When he was refused water, he became angry and caused damage to the cell. Two prison officers entered the cell to prevent further damage and it was alleged that [the prisoner], a man of 61, headbutted one of the officers... A further assault was alleged [later on].54

These assaults and similar incidents were used as a reason to deny the prisoner day leave or parole, which he applied for in order to undertake a rehabilitation program arranged for him by the Disability Service of Central Australia.55 Yet
he obviously needs rehabilitation to help him 'unlearn' the institutional behaviour (including outbursts of aggression) which he has learned over years in prison.56

Evidence presented to the Inquiry also established that some people unnecessarily enter or remain in jail due to poor quality legal representation, or poor communication with their lawyers:

They have difficulty communicating with their legal representatives, particularly if they're Aboriginal; if their English isn't good; if their behaviour is bizarre; if they are aggressive, as people with some mental illnesses frequently are...57

Some lawyers may feel uncomfortable with a mentally ill client:

I first came across a solicitor, actually, in the courtroom when they were doing whatever it is they do. He refused to address me by name or to introduce himself, so I just made the statement that I refused to accept his assistance.58

Solicitors are prone to say when they have someone who has either an intellectual impairment or a psychological problem, that they find it impossible to take lucid instructions from them. But I think most people who are prepared to spend a little bit of time would be able to communicate with these people...59

Prison as an Avenue to Treatment

There certainly are times when people who are known to be 'mad' are actually treated as 'bad', because it flows from that that at least they will get some psychiatric treatment.60

Paradoxically, some evidence to the Inquiry pointed to the use by the courts of prison sentences as a means of providing access to accommodation and treatment. For example, one Victorian submission referred to a report of a judge remarking that if a particular offender were released on a bond, he would have to wait at least 18 months for suitable accommodation and treatment; but in jail he would go to the top of the waiting list for a secure psychiatric unit within the prison system, where he would receive treatment at once. The judge described this state of affairs as 'totally obnoxious and deplorable.'61 The Inquiry agrees.

Does Jail Lead to Mental Illness?

We know, and the doctors know, that he will be unable to cope with jail and the result will be an even more traumatised human being with even less chance of future wellbeing.62

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Contact with the criminal justice system is stressful for anyone. For a person with a mental illness the criminal process (being apprehended by police, arrested, bundled into a paddywagon, charged, tried and incarcerated) can be especially confusing and distressing. It can also be dangerous — because conditions in jail are likely to exacerbate mental illness. Mental health care is generally poor and at times non-existent. Living conditions in some detention facilities are disgusting. In addition, the procedures of our criminal justice and penal systems sometimes discourage people who are mentally ill from seeking treatment, by punishing them with longer sentences and even worse living conditions than usual.

Prison Living Conditions

The environment we place them in is intellectually, socially, occupationally sterile, and it doesn't help their condition at all.63

The ordinary living conditions in prison are stressful and dehumanising — precisely the opposite of the therapeutic environment required by people with mental illness. Even for people who are not already mentally ill, the conditions are very conducive to depression:

Imagine a place without a tree; a high-walled place where sunsets and sunrises cannot be experienced; a place without a dog or other pet; a place without a child, or often a person of the other sex, without elderly people; a place where one is almost totally without an opportunity to make choices, where one is cut off from family and friends to the extent that partaking in a relative's funeral, or a visit to the hospital of a seriously ill one, is a privilege; a place where very few people have meaningful (or any) work; a place where you have no choice of companions — and you have some idea of the vast majority of, if not almost all, prisons.64

Conditions in Australian prisons, detention centres and police lock-ups have been condemned by numerous Royal Commissions, inquiries, reviews and even by Amnesty International.65

Witnesses to the Inquiry cited many aspects of prison conditions which are particularly detrimental for those with mental illness. NSW came in for especially severe condemnation; based on the evidence received, our 'Premier' State could claim the dubious distinction of having Australia's worst prison conditions.66 One major problem is overcrowding.67 In mid-1991 NSW had over 7000 people in prison68 — nearly half of Australia's total, and three times as many as in the next most populous state, Victoria. Over the decade since 1981 the average prison population in NSW increased by 60 percent — compared with about 30 percent for other jurisdictions. (In Tasmania it actually declined.)69

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Witnesses considered this overcrowding has been aggravated by the changes in prison policy introduced by the Coalition Government in NSW™ — and that these changes have created a climate of increased hardship which damages the emotional wellbeing of all prisoners.71 Simultaneously with the rapid increase in prison numbers came a cut in staffing levels:

And then because of the staffing cuts, the number of hours that the individuals are locked up in their cells was increased. So that they're now in maximum security locked into their cells at 3.30 in the afternoon and released again at about 8 o'clock in the morning.72

Personal possessions policy (NSW)

Some crims have no family and are here for a long time. All they have are the things in their cells.73

Perhaps the most infamous policy change in NSW was the crackdown on personal possessions. Prisoners were told they had three days to dispose of all their possessions, including their clothes, books, letters, watches and address books; any property remaining in the cells would be confiscated and sold. Some prisoners were able to get relatives to take their possessions, but others could not organise this in three days — especially those incarcerated long distances from their families.74

The confiscation of wedding rings received wide media attention,75 but the loss of other possessions was equally disturbing and demoralising:

They're allowed one certain size photograph. So for [prisoners] who have a number of children, if they had a number of different photographs of their children, then these were taken... Some of them became very upset and behaved very badly when the photos of their children were taken away.76

Radios, cassette players and tapes were also removed, including relaxation tapes used to reduce stress.77 One prisoner with schizophrenia, who listened constantly to a radio, 'became a behavioural problem and [began] to scream all the time' when the radio was taken away.78 Another behaviourally disturbed prisoner had a talent for drawing;

[The authorities] took all drawings away, and so [this prisoner and others] were left with nothing to do, you know, so that they're just left for this long period of time being bored.79

Prisoners were no longer allowed to wear their own clothing. This was not a unique rule among Australian prison systems, but the NSW policy appeared particularly restrictive:
I think for the women it's... two sets of underwear, one t-shirt, one pair of tracksuit pants and one dress — prison dress.80

One survey reported a large number of complaints by prisoners about the clothes they were obliged to wear:

In February 1991, during extreme heat, inmates at Parramatta Gaol were still wearing winter tracksuits because no summer clothing was available... Not all sizes of underwear are available (particularly the more common sizes). Prisoners complained that often the only size available was size 24... Generally there is a shortage of prison issue clothing. One prisoner complained that he 'couldn't change clothes for a week' when first put in remand.81

The same survey revealed that the removal of tables from prison cells had created a practice as degrading as it is unhygienic:

One inmate of Maitland Gaol wrote... 'as a result of this new measure, [we] have to eat our food on the floor or toilet seat, which of course goes beyond the bounds of humanity or human rights.'82

Other aspects of the personal possessions policy also compromised prisoners' physical health:

Among items confiscated were prisoners' hats, thongs and sunglasses. As a result, many prisoners working outside in the hot summer sun had no protection from the sun's rays. Ironically, this occurred as the Department of Health launched a high-profile campaign ('Me-No-Fry')... urging 'common sense' preventive measures (such as wearing hats and using sunscreens)... In a similar vein, the prohibition on prisoners owning thongs has directly increased their chances of contracting tinea in communal showers.83

The prohibition on hats was subsequently relaxed, and prisoners could apply for thongs on medical grounds — but only after they contracted tinea.84

Another policy change was a drastic reduction in educational facilities, which particularly disadvantaged prisoners who had had difficulty in their pre-prison education.85

Conditions in the NSW jails also affect prisoners from the ACT, who are sent there to serve their sentences because the ACT has only a remand centre. This arrangement is a cause for concern in the Territory:

There is no guarantee that these prisoners will receive treatment for their illness or even be housed in safety. There is no supervision by ACT authorities of prisoners in this system.86
On the eve of this Report going to print (August 1993) the NSW Minister for Justice announced the official abandonment of the harsh personal possessions policy. The Inquiry considers this decision to be long overdue.

Other aspects of prison conditions

Although NSW jails were the most frequently criticised, evidence to the Inquiry also indicated routine abuse and neglect of human rights in other states. A Western Australian witness pointed to the very harsh punishment meted out to escapees:

They can receive up to three years' extra time, plus withdrawal of all privileges, eg no radio, TV, library, no contact visits, plus solitary or near solitary confinement for six months. The first time the harsh escape punishment was applied, one of the two men committed suicide after two weeks. He left behind a two-year-old child, a wife and two stepchildren. You can imagine the mental health stress on that family, and the family of the second man... If such harsh treatment were for deterrence, then it failed, for three men attempted to escape, two successfully, from the same prison not many months later.

Prisoners generally have little or no choice about the geographic location where they serve their sentences; and forensic psychiatry services are only available in certain jails. This can result in even more isolation from family and friends. In Queensland:

One of the difficulties with forensic services is it's all centralised... For those patients who have family members and who come from outside the general Brisbane metropolitan area, it involves long distance travel in order to maintain social networks.

One practice which causes significant distress is the abrupt forced relocation of inmates to different prisons. A forensic psychiatrist told the Inquiry:

Inmates are moved very quickly from prison to prison and sometimes are cut off...and I think that the stresses involved are unreasonably punitive... For example one of the prisons which I currently visit is the prison at Lithgow... There's quite a distance between the town and the jail; travel arrangements are not easy, and in the first three or four visits that I made to that place I had a constant series of prisoners coming and, with very good reason, explaining why having been transferred to that prison at short notice made it almost impossible for them to either organise their defence properly or to keep in contact with wives or loved ones or to see their children.

The witness pointed out that this makes a mockery of the right Australia has committed itself to under Standard Minimum Rule 37:
Prisoners shall be allowed under necessary supervision to communicate with their family and reputable friends at regular intervals, both by correspondence and by receiving visits.92

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A common complaint from transferred prisoners is that their few personal possessions are not transferred with them, but are lost, damaged or delayed en route.93 The same applies to their records — including health records. In the case of one severely mentally ill prisoner with a history of violence, who was transferred from Long Bay to Lithgow:

Three weeks after he was transferred there, the psychologist at Lithgow was unaware of his existence.94

Prison psychiatrists are sometimes not consulted about transfers of prisoners whom they are treating:

I think the communication certainly should be improved about things like the movement of prisoners that we're [treating]. If we were consulted sometimes, we might be able to prevent problems by suggesting the prisoner not be moved, or should be moved...95

Victoria's Police Surgeon gave evidence of a practice colloquially known as 'cell circuit shuffle', whereby prisoners believed to be mentally ill are moved to a different watchhouse every few days. He said this severely dislocates any continuity in assessment and medical care.96

The abusive social environment in prison is itself dangerous for inmates affected by mental illness. In a setting where any vulnerability is liable to be exploited, they may be easily victimised by other prisoners. The Inquiry received evidence of harassment, harsh punishment and violence,97 which in at least one case apparently precipitated the suicide of the mentally ill prisoner.98

Alice Springs Prison

The dormitory [we] visited occupied a whole building... The interior was entirely open plan but was subdivided by wire mesh into seven or eight discrete sections, in each of which were six or seven beds (bunks and singles), an unscreened urinal and a cold water tap. There were no facilities, nor indeed any space, for prisoners to keep personal belongings... It was hot and despite the open eaves, smelled strongly of sweat and urine... Prisoners are confined to the dormitories for 16 hours a day...[and] obliged to use toilet facilities within their caged subdivisions with little or no privacy.99

This visit led Amnesty International to single out the Alice Springs Prison as probably breaching international human right standards on 'cruel, inhuman or degrading treatment'.100 (These conditions also constitute a breach of ICCPR
Article 10, requiring that people 'be treated with humanity and respect for the inherent dignity of the human person'.

One submission to the Inquiry concerned conditions at Alice Springs Prison and an inmate who had been affected by mental illness all his life. He was initially detained in 'isolation' — at his own request, because he feared harassment from other prisoners. However, his isolation lasted four years, in conditions which clearly violated Australia's human rights treaty obligations.

He was not allowed to speak or otherwise communicate with other prisoners and they were not allowed to approach him. The cell is [2m] by [3m] and consists of a fully enclosed room with one high barred window. Outside the cell is a small yard...about twice the size of the cell, and [he] was allowed about half an hour exercise in the yard per day.

During the winter [he] was often subjected to his cell and his person being hosed down at night. In winter the overnight temperatures in Alice Springs often drop below zero.101

Conditions in Police Custody

While most complaints about conditions of incarceration related to prisons, the Inquiry also received evidence about police cells and watchhouses, where many prisoners are held while awaiting trial, bail or transport to jail. The police surgeon in Victoria observed:

[As for] psychiatrically disturbed prisoners in police custody...the majority of such prisoners are housed in appalling conditions. The state’s largest holding facility, the City Watch House, bears a striking resemblance to its neighbouring structure, the Old Melbourne Gaol, which thousands of tourists visit to view the horrific conditions prisoners experienced a century ago.102

In early 1993 the Legal Aid Commission of Victoria expressed concern that the holding cells in the State’s newly built court complexes breach the UN Standard Minimum Rules for the Treatment of Prisoners:

Unfortunately the Victorian Police Department's viewpoint in the past has been that the UN standards are guidelines only and there is no requirement to comply.103

The Commission's specific concerns were with the design of the cells, which breach the Rules requiring access to fresh air, decent toilet facilities and open air exercise. However, it also cited individual cases of abuse and neglect. For example, one offender was sentenced to a lengthy prison term and should have been taken immediately to jail. Instead:

[He] was held in the cells for ten days after his hearing. He had not had a change of clothes in that time, nor had he seen daylight.104
For a person with a mental illness, such a delay can be especially damaging:

A defendant with psychiatric problems was held in custody pending a bail application, with a direction that a forensic psychiatric report be prepared. The Office of Corrections refused to send a psychiatrist, and the defendant was not transferred to the Remand Centre or other facilities where psychiatric services could be available. The defendant was held in local cells for three weeks before being brought to court, again for a bail application — without the report. Other issues raised by the Commission include overcrowding, the total denial of visits at some police cells, and health problems including food poisoning, skin rashes and colds. In addition, the conditions in which solicitors are expected to speak to their clients are primitive.

A solicitor interviewing a prisoner must stand behind a white line some ten feet away. There is no desk, bench or seat. The interviewer stands in the open air and is exposed to all weather.

Instructions from prisoners are taken through a grill door... Instructions can be overheard by both police and other prisoners.

The Royal Commission into Aboriginal Deaths in Custody identified chronically bad cell conditions as one factor contributing to the high rate of deaths in police custody. Since the Royal Commission, governments have exerted pressure on police to improve conditions and procedures. Conditions have improved, particularly in some areas of Queensland and the Northern Territory. New police stations are now built to better designs — but many are still inadequate, considering the extended periods some prisoners spend in police cells (see below). For example, the new police stations at Innisfail (Queensland) and Katherine (NT) have spacious cells designed for multiple occupancy:

They are well lit and ventilated and protected from the hot sun. Both employ closed circuit television, are fitted with cell alarms, are manned for 24 hours, are clean and well decorated, and are fitted with laboratories, drinking fountains and showers. However, neither provides any natural light, nor has any outside exercise facilities, nor offers even a semblance of privacy... It is doubtful whether prolonged custody in such cells could be described as humane.

The Inquiry also heard disturbing accounts of the conditions in which people known to be mentally ill are transported to jail or to hospital by police:

I was taken from Townsville to Brisbane in the back of a police paddywagon, psychotic and very distressed. When the police would have a meal break or something, they’d just throw me into one of the local cells, wherever they happened to be... One of those was a padded cell with no toilet facilities, no furniture, and bloodstains all over the cladding.
The medical services...shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.111

Before an illness can be treated it must be recognised. However, a great deal of mental illness goes undiagnosed in prison. This is due, in part, to inadequate assessment on initial admission to prison.

A South Australian witness referred to 'a lack of formal process as to how people with mental illness are identified as they enter the correctional services system.' Even when psychiatric reports are presented during a trial or at sentencing, those reports are not necessarily passed on to prison or probation officers.112

In NSW the prison regulations provide that the prison medical officer should 'cause each prisoner to be examined as soon after reception as is practicable'; and then 'to cause to be carried out such medical examinations, investigations and treatment of such prisoners as may be reasonably necessary.'113 However, a review of the NSW Prison Medical Service found that in practice, nursing staff generally have total responsibility for the assessment process. Medical staff are only called on where necessary, generally through referral to Doctor's 'sick parade' when next available. The assessment process is generally short, and revolves around the completion of a reception form...which collects only limited information.114

Evidence presented to the Inquiry suggests an even less thorough process is the norm. One expert witness gave evidence that most prisoners undergo a blood test for HIV on reception; but apart from that, there is no routine medical or psychological assessment:

This is not done, because there is no funding. All agree it should be done.115

Despite this lack of systematic assessment, a psychiatrist who works as a consultant to the NSW Corrective Services Department claimed that 'the great majority of prisoners with psychiatric disorders do come to the attention of the Prison Medical Service, and do receive at least some psychiatric attention while in jail.'116

By contrast with NSW, Victoria has a systematic reception process which is the joint responsibility of the correctional and health authorities. A doctor examines and assesses all new prisoners; certain categories are typically referred on to other professionals such as a psychiatric nurse, psychiatrist or Aboriginal welfare worker. These categories include young prisoners, sex offenders, first-
timers, prisoners who are despondent, distressed, overly anxious or psychiatrically disturbed, those withdrawing from drugs or alcohol and Aboriginal and Torres Strait Islander people.117

A witness from a prisoner support group said this assessment process 'has been a great asset...a great improvement'.118 Even so, it is far from 100 percent effective:

Not all people who have either mental illness or severe behavioural disorders are in fact identified through the process...and even [among] those who are identified, those who don't appear at the time to require immediate treatment often move through into the mainstream of the prison environment, and often the...illness can [become worse] at a later stage.119

This witness particularly lamented the fact that the reception process applies only in adult jails, and not in juvenile correctional facilities.120 NSW witnesses also raised the absence of assessment for juvenile offenders in custody. This omission means mentally ill juveniles are denied the treatment they need; but also has more far-reaching implications:

It also means that those young people who have mental health problems specifically arising as a result of their custody tend to go untreated. And obviously, for...custody centres it creates all sorts of management problems, and that results in more young people being transferred to adult facilities.121

A more detailed discussion of issues affecting mentally ill juveniles in detention is contained in Chapter 20.

Assessment on Entry into Police Custody

Well before alleged offenders reach jail, they become prisoners of the police. Over 25,000 people are taken into police custody in an average month.122 The police themselves recognise that being arrested and locked up can be a traumatic experience:

Several factors combine to traumatisate a prisoner, eg the indignity and shame of arrest, guilt about the offence, concern about imagined police harassment, the physically depressing nature of many cell areas, isolation and confinement in a cell, fear of the legal process, worry about the social and employment consequences, etc.123

Over one-third of suicides in custody (and nearly 40 percent of custodial deaths) occur in police custody.124 Clearly the period immediately after arrest is a critical time for assessing the mental health of prisoners. Anyone taken into custody who appears to require mental health treatment should be taken
immediately to a hospital.

Victoria requires anyone in police custody to be assessed if they appear to be psychiatrically disturbed. Police officers themselves decide whether a particular individual requires assessment; to this end all police receive specific training in mental illness. The assessment itself is conducted by one of 45 medical practitioners who are on call for this purpose throughout the State:

Frequently the assessments are performed in less than adequate surrounds: rooftops, prison cells, the rear of divisional vans and backyards, intermingled with screaming and yelling, blue uniforms and weaponry, distraught family members and angry neighbours... The luxury of fixed appointment times, subdued lighting, soothing music, designer colour schemes and couch are never available.

In principle, NSW police have a screening procedure too. It is based on the Prisoner Admission Form, a questionnaire which officers are required to follow with every person detained. However, a recent inquiry by the State Ombudsman found that the procedure is sometimes regarded as merely a routine task preceding incarceration. Sometimes it is performed inadequately; sometimes not at all.

In North Queensland the police apparently lack even the most rudimentary screening procedure. One witness, representing a prisoner support group, said 'the Cairns watchhouse is notorious.' She cited the example of one prisoner,

who was, amongst other things, on medication for epilepsy. He wasn't getting it. We had quite some difficulty...to arrange that he did get taken to hospital to get it. [By then] he had been fitting over a number of days.

The importance of assessment

The Royal Commission into Aboriginal Deaths in Custody stressed the importance of identifying prisoners at risk of suicide. It recommended that all police and prison officers receive basic training in recognising warning signs, and 'Suspicion that all is not well must result in urgent medical referral.'

Similarly, the NSW Ombudsman has observed:

One of the major factors in suicide prevention is an effective screening process. The basic elements of the process are well recognised — the practical implementation of them does not appear to have received sufficient attention.

It appears that Victoria's screening process has been effective. When the procedure was first implemented, Victoria was averaging six or seven prison
suicides each year, with 11 in the previous 18 months. By early 1991, after

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more than two years of the screening procedure being used, there had been no further suicides.133

Treatment of Mental Illness in Custody

Our management of psychotic prisoners is made extremely difficult by lack of time, lack of proper facilities, and the fact that almost inevitably a psychotic prisoner has to go into segregation. And...segregation means an awful lot of time in a cell, very little exercise, and at times conditions close to sensory deprivation — which almost inevitably predicts a worsening of the psychotic condition.134

A recurring irony throughout evidence presented to the Inquiry was that the people who are most needy and most vulnerable in our society are precisely the ones who are denied the treatment they need. The evidence about prisons was no exception. Most prison medical services include some form of mental health care dispensed by doctors, nurses, psychologists or social workers. However, these services are seriously deficient — in terms of both resources and coordination with prison authorities. As a result, the treatment offered to prisoners affected by mental illness is usually inadequate, often inappropriate and sometimes downright brutal.

The Inquiry was told 'the care of people with schizophrenia in Queensland jails is practically non-existent.'135 In prison systems which do provide 'treatment' for severe mental illness, one of the most frequently used 'tools' is isolation:

The traditional method of [treating] someone who's showing bizarre behaviour is to strip them naked and leave them in a cell, sometimes for 24 or 48 hours — but sometimes that isolation goes on for days and even weeks.136

At Mulawa Women's Prison in Sydney, the Inquiry was told, prisoners believed to have suicidal tendencies are put in a 'dry cell', which contains nothing except a bucket toilet and a gym mat on the floor. In 1991 there were two of these cells:

One of them is in a very old building which is very dilapidated, and actually has a toilet basin which is not connected to the plumbing so it's not useable...
The other dry cell, which was built only a few years [ago]...has no ventilation at all, no windows, except for a small slot very, very high: I think the intention here was to provide something which was said to be suicide-proof. And a very heavy iron door — it faces east, and...I was called down there on a very hot day this summer, when the temperature must have been about 30' outside, and it must have been 50' inside the cell. It was just dreadful, and the smell of urine from the bucket
and the cramped, dark conditions are just horrible. I think it's terrible to consider that it was built so recently — that anybody could have designed anything like that so recently.137

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A South Australian witness said that when treatment is provided, it is overwhelmingly 'medical', with no rehabilitation. Even the limited program of activities available to ordinary prisoners may be inaccessible to those with a mental illness because, being especially vulnerable to violence, they are often housed in special protection units which restrict their movement.138

The Inquiry heard disturbing allegations of the use of psychiatric medication as a management tool in prisons. For example, in Western Australia:

Although we have no accurate statistics...one comment to come to us regarding Fremantle Prison was that 70 percent of inmates were on prescribed medication. From practical experience, we have noted an alarming number of women whom we have interviewed at Western Australia's women's prison, Bandyup, being under the influence of presumably prescribed drugs.139

We are concerned that these people [who are not really mentally ill] are given medication whilst they are in prison, and people who actually do have some mental illness which should be treated are also given medication, so it is hard to distinguish one from the other. Everybody is just seen as taking some sort of medication to keep them quiet.140

The use of medication as a management tool is an abuse of the human rights of all prisoners, mentally ill or not. It also inspires little confidence that those affected by mental illness will have their needs appropriately met.

An allegation that trading in medication occurs was also made to the Inquiry:

When a psychiatrist sees mentally ill people in jail and prescribes medication, I believe that the medication is not made up and given personally by the doctor, but the prescription is given to the prison warders. There is a strong inference that this medication then finds its way not to the patients, but is used for 'trading' in sedatives.141

Denial of Treatment in Prison

My son was denied psychiatric assistance when all the circumstances screamed out that this was essential, and according to the Mental Health Act was his right, and was requested.142

In most parts of Australia prisoners have no legal right to treatment for mental illness as prisoners; prison statutes require only that inmates be given access
to such medical treatment as is considered necessary by the prison authorities. Sometimes prisoners receive no treatment at all, even if they are known to have a mental illness before going to jail:

In recent times...it was not uncommon at times for a person with very severe psychiatric illnesses being admitted to prison, perhaps on remand, automatically having their treatment stopped, because...those were the rules.

It is particularly abhorrent that people who are in jail largely (or entirely) because of their mental illness are denied treatment for it:

You are actually preventing the inmate from seeking treatment... I saw people who had been in prison for eight years in such a way, and prevented from seeking treatment of any kind.

One report to the Inquiry concerned psychiatric medication being denied to prisoners as a form of punishment.

In most parts of Australia a prisoner who displays current, obvious and extreme psychotic symptoms will eventually attract some form of medical attention. However, 'lesser' conditions, including depression, neuroses or personality disorders, are often not seen as meriting intervention:

Where people are defined as being not psychotic, it is [assumed] that they don't necessarily require the same expertise or delivery of service, in terms of quantum or services available.

Unfortunately, these other conditions can be extremely serious and sometimes even fatal.

Denial of Treatment in Police Custody

If treatment for mental illness is difficult to obtain in prison, it is virtually impossible in police custody. Every prison system provides at least a rudimentary health service which has no counterpart in the police lock-ups.

In theory there should be little need for mental health care in police cells. They are designed for very short stays. The prisoners are people who have been denied police bail and are only being held until they can be brought before a magistrate — the next day, or at most over the weekend. Generally speaking, this is true: half the people taken into police custody are held less than five hours, and 87 percent less than 24 hours.

However, in reality, police cells are frequently used as back-up accommodation for the prisons.
Police cells were employed whenever prison accommodation was full; or pending (in remote locations) intermittent escorts to prisons; or by arrangement with the prison authorities because it was judged more economical or humane to let prisoners remain in police accommodation near their own community... In the northern outback of Western Australia, for instance, it is normal for remand or short-sentence prisoners...to remain in small police lock-ups.149

The Inquiry heard evidence of mentally ill people being held in Queensland watchhouses for two weeks,150 and of a young man held for three weeks at a suburban Melbourne police station.151 Melbourne’s ‘cell circuit shuffle’, in which prisoners are moved between watchhouses every few days, has already been mentioned. Holding prisoners for such long periods must entail a responsibility on custodial authorities to provide (or at least allow) treatment for mental illness. Yet this concept is apparently unknown at some police stations.

For example, people who know they are mentally ill and need medication may be denied it:

Because they don’t have training, [Queensland] police don’t realise the importance of people continuing to take anti-psychotic medication. And because their behaviour doesn’t immediately deteriorate, they don’t realise that it will deteriorate over a period of days or weeks, and they will...suffer more and more.152

The young man held by Melbourne police for three weeks was withdrawing from drugs, suffering acute depression and anxiety, and bore obvious marks of a suicide attempt. His mother told the Inquiry that he was not allowed to see family members or any other people significant to him — including those who were treating him for his drug problem. Both he and his mother asked that he be seen urgently by a mental health worker, but these requests were ignored or denied.

After three weeks in the police cells he was taken to Pentridge Prison, where he was placed in a cell by himself:

With a history of serious and recent suicide attempts, his pleas and cries for help were ignored. He died within 24 hours.153

For his mother the nightmare continued after his suicide:154

The handling of [the] situation was appalling and lacking in any sensitivity to [my son] or his family... For example, I was not even informed of [his] move to Pentridge, until the Community Police came to tell me that my son had died in ‘protective custody’, and to go and claim his body. The Prahran police were the first to offer any sensitivity and a kind word. For hours afterwards, I was not
able to locate my son's body; then [I was] told I didn't need to identify him, just to make arrangements to bury him.155

Such abuses of basic rights are intolerable. In a modern democracy they are also inexcusable.

Transfer to Hospital for Treatment

Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental hospitals as soon as possible.156

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All Australian prison systems have provision for individuals who are severely mentally ill to be transferred into a psychiatric hospital ward and treated as inpatients. Some jurisdictions have such a ward within the prison system: eg Long Bay Gaol in Sydney. In other systems, severely mentally ill inmates are transferred out of the prison sector and into a secure ward in an ordinary psychiatric hospital. South Australia has a special ward for prisoners, James Nash House, which is part of the public hospital system. The question of whether these inmates should be treated in the health sector or the prison sector is controversial (the arguments on both sides are addressed below).

The Inquiry heard few complaints about the treatment which mentally ill prisoners receive once admitted to hospital. However, getting to hospital can be extremely difficult — virtually impossible in some cases, eg for women prisoners in NSW (see below).

This issue was raised by a number of witnesses, including several from the ACT, which has no jail and therefore transports its offenders to serve their sentences in NSW. The Territory Government is concerned that prisoners affected by mental illness should have access to treatment. Yet prisoners from the ACT are forced to go without treatment at Goulburn Gaol, where there is no psychiatric service, while awaiting classification for the NSW prison system:

There is no care, no control... We had a horrendous case two years ago of a young man who suicided after three days in Goulburn. He should not have ever been sent there. He was just too ill and too vulnerable — and that is always going to be a problem when we send people in a vulnerable condition to places like that.157

The ACT authorities advised the Inquiry that they are trying to arrange for ACT prisoners who are mentally ill to go direct to the special facility at Long Bay in Sydney.158

A blatantly discriminatory practice was brought to the Inquiry's attention in Tasmania: prisoners who become mentally ill in jail and are transferred to hospital do not have their time in hospital credited as part of their sentence:
So a man sentenced to, say, one year's imprisonment, who falls sick within the first two months, is sent to a mental hospital, where he remains treated but incarcerated for a year before recovery — he has to return to prison to serve the rest of his sentence. So his sentence virtually becomes two years. In contrast, if he were physically ill, no such disadvantage would obtain.159

This practice is apparently not confined to Tasmania. It was raised in evidence to the Inquiry in Queensland;160 and has also been highlighted by the Committee appointed to review the operation of the NSW Mental Health Act.161

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Thus prisoners who are psychiatrically disabled are punished for their disability as though it were a further crime. Apart from being grossly unfair, this practice strongly discourages prisoners from seeking psychiatric assistance if they need it. This perpetuates the problem of mental illness going undiagnosed and untreated in prison.

Special Needs Groups in Prison

Women

Recent changes have resulted in a decreased level of care so that the situation at Mulawa [Women's Prison] is the worst for many years.162

Women comprise about 5 percent of the prison population,163 but the information available to the Inquiry suggests the prison system has largely failed to recognise their needs.

Expert witnesses gave evidence that female prisoners affected by mental illness are often more disabled than their male counterparts. Female prisoners are reported to have more physical and mental illness generally,164 and an especially high rate of alcohol and/or drug problems.165 The diagnosis of 'personality disorder' is more frequent among women.166 They generally have less education, inferior social skills and less family support than male prisoners.167 Being incarcerated also creates particular difficulty for women who have children:168

Pregnant women have no opportunities to bond with their babies, and for those children the opportunities for visits are limited ... 169

And they are not able to deal with problems that arise with their children. They may receive [bad] news about the children or other family members and can't deal with it from where they are.170

As mentioned earlier, a recent Tasmanian study established that about one-third of female prisoners admitted over the last ten years had a psychiatric history;
but the absolute number with psychiatric disorders has steadily increased in that time. Some have chronic, severe mental illness, but the most common diagnoses are ‘personality disorder’ or drug abuse.

Prison conditions for women (NSW)

In Sydney the Inquiry heard from a psychiatrist who works as a consultant to the NSW prison system that conditions generally for women prisoners are even worse than for men: for example, there are fewer activities, educational programs, employment or training opportunities and little prospect of transferring within the jail system. At Mulawa, the women's prison, overcrowding created by the Government's new policy is particularly acute. In 1989 there were 150 inmates at Mulawa; by 1991 there were over 300. At the same time, the facilities for treatment of prisoners suffering from any kind of emotional or psychiatric disturbance have decreased, so that there are less facilities available now than there were when there were only 150.

Treatment for women with mental illness

The NSW prison system provides no inpatient psychiatric facilities — and in fact no proper medical facilities — for women. Female inmates suffering from mental illness are generally 'treated' within the prison mainstream.

The Mulawa treatment regime contains several serious deficiencies. One is the use of the segregation unit to isolate women who appear to have psychiatric or emotional difficulties, especially if they are deemed by prison officers to be potentially suicidal. The segregation unit was purpose built, at low cost, as a punishment and deterrence unit:

The general atmosphere evokes a feeling of punishment and indignation which is not conducive to any form of psychiatric treatment. There are no facilities for examination/interview and assessment, or for observation of prisoners. There is no 24-hour nursing cover. Medication and files are not stored in the unit. Inmates are locked in cells from 3.30pm to 8.30am.

This building also contains the new 'dry cell' described earlier in this chapter. As if the setting were not punishment enough, segregated prisoners may be subject to the humiliation of being stripped naked. This is 'said to be for their own protection', to prevent them hanging or strangling themselves with items of clothing:

And on some occasions...they are stripped by male officers and left stripped, sometimes for long periods of time... under observation by male (or maybe male
and female) officers. There's only this gym mat and no blankets or covers.179

This kind of treatment is distressing for anyone, but especially for a person with a mental illness. Moreover, a large proportion of female prisoners have previously been victims of sexual harassment or abuse;180 this practice creates the potential for such abuse to be repeated by prison staff.181 Even on grounds of simple physical health it is objectionable: the cell which gets so hot on summer days can also be very cold at night, but a woman who has been stripped is obliged to sleep naked and uncovered on the gym mat.182

Incredibly, the decision to put a prisoner into a dry cell and strip her is made entirely by prison officers, without any assessment or advice by any health worker. The psychiatrist who described this practice to the Inquiry made a plea for some health expertise to be involved:

I would recommend first of all that there should be assessment by someone from the health team, preferably by a psychiatrist, but certainly at least by a nurse who's got some psychiatric training... I'm not saying prison officers are wrong to be concerned, but they should get professional help quite early.183

In any event, the witness said she does not believe it is ever necessary 'to strip anybody completely and then leave them naked'. As a practicality, she suggested the use of heavy calico gowns and special blankets which are hard to tear into strips.184 However, there is obviously great scope to reduce the danger of suicide merely by involving staff who have some expertise in mental health — and by eliminating 'treatment' practices which actually exacerbate mental illness.

Transfer to hospital

In extreme cases, women who become acutely ill can be transferred to hospital. However, this is no simple matter. Unlike male inmates, for whom a hospital exists within the prison system, women must be transferred out into the general mental health system.

In principle, Cumberland Hospital makes five beds available for female prisoners. But these five beds may be already full; even if they are not, the bureaucratic delay in transferring an inmate out of jail can be up to 14 weeks!185 For a person who is suicidal or suffering from an acute psychotic disturbance, this delay is tantamount to official medical negligence. (It is certainly a violation of a sick woman's basic right to appropriate treatment.) The process of transfer essentially consists of a form being completed by two doctors, one of whom is a psychiatrist. It is a procedure which should take, according to the witness, 'a few days at the longest'.186
In practice, for the many prisoners who are on remand awaiting trial, a quicker way to get into hospital is simply to wait for the day of their court hearing to arrive. A forensic psychiatrist makes the application under the Mental Health Act; the magistrate has the power to act on the application and send the person directly from the court to a hospital, 'if he considers that mental illness may have been a factor in the commission of the offence, or that the person needs urgent treatment.' Even so, severely disturbed women can spend several weeks in prison — a totally unsuitable environment — waiting for their court cases to come up. For example:

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A 54-year-old woman suffering from early dementia was admitted to Mulawa. She had been charged with 'trespass'... She had harassed the owners of a house where she had previously lived, telling them it was her house. Police took her [first] to a mental hospital, who refused admission. She spent three weeks in prison before she was transferred to a mental hospital from the court.

While waiting for a transfer, these acutely ill women are kept in conditions likely to aggravate mental illness. The expert witness gave other examples — including that of a young woman who had a history of psychotic episodes. She was sentenced to three months in prison. At the time of her admission to Mulawa she was stable and not on medication. However, she soon became distressed and then developed psychotic symptoms:

When she expressed her delusional beliefs to prison officers, she was told not to tell lies and was transferred to a 'dry' cell because of her disruptive behaviour. At first she settled, but when she went to the toilet and realised the toilet could not be flushed, there was no toilet paper and she could not wash her hands, she became increasingly psychotic and her agitation increased. She began screaming and was told that the longer her noise continued, the longer she would remain in this cell.

The psychiatrist was gravely concerned:

A Schedule 3 certificate was written by myself and also the other attending psychiatrist, for her transfer to a mental hospital as a matter of urgency. Medication was administered and she was seen as often as possible by one of us — but this young woman remained in the 'dry' cell for most of her three months imprisonment, as the Health Department stated that no beds were available in a mental hospital facility.

Such treatment of sick people is not only a violation of human rights — it is a disgrace to a nation that considers itself civilised.

Women in male prisons
Up until 1990 female prisoners who were mentally ill could be transferred to the hospital at Long Bay, an otherwise all-male prison. The Inquiry was told the women received 'very inadequate' treatment, and encountered strong prejudice from staff: 'a feeling that there was something really quite aberrant about being a female prisoner.'

Women were strip-searched by male staff and many were refused admission:

There was a tendency...for them not to be accepted but just sent back on the grounds that they were being 'manipulative'... They were simply [deemed] 'personality disordered' and 'manipulative' and should be sent back to Mulawa — and a very high number of them were sent back within half a day or a day or so, some of whom I consider were actually quite psychotic and who later ended up in mental hospitals.


Women prisoners are no longer transferred to Long Bay psychiatric unit; however, the current arrangement with Cumberland Hospital is also patently inadequate. The psychiatrist who gave this evidence noted recent suggestions that disturbed women should again be moved to Long Bay:

I am open to any of these ideas as they certainly would offer better opportunities than the present lack of facilities at Mulawa. However, these women are placed in a position where they are the minority in a group of psychiatrically disturbed inmates and they are thus in a very different to a normal situation... Their experience of males is mostly adverse, and their transfer to a male institution is generally regarded as negative and sometimes perceived as a punishment.

She maintains the women prisoners 'would be better off being treated within the female prison system, with programs devised for females.'

Aboriginal and Torres Strait Islander People

We're the most imprisoned race of people in the world.

Aboriginal and Torres Strait Islander people are over-represented in prisons: they constitute 1.5 percent of Australia's population (and less than 1 percent of the adult population), but 14 percent of prisoners. They are especially overrepresented in Western Australia, South Australia and the Northern Territory. Furthermore, these statistics on prison populations do not cover police cells. In police lock-ups the proportion of Aboriginal people is even higher: nearly 29 percent of those taken into custody nationally — an over-representation by 26 times.

In Sydney the Inquiry heard evidence from LINK-UP, the support agency for
Aboriginal people removed from their families as children, that the overwhelming majority of Aboriginal people in jail have suffered the mental effects, either directly or indirectly, of this separation. Witnesses also referred to the dispossession of Aboriginal people as a cause of profound spiritual, emotional and mental harm.

One of the functions of forensic psychiatrists and psychologists is to provide assessments for the use of courts, legal services, probation and parole officers. These reports allow mental disturbance to be taken into account in preparing a case, and for making decisions about sentencing and parole. A psychologist who regularly performs this role in the Northern Territory told the Inquiry that Aboriginal offenders do not get the benefit of this service, because the 'experts' understand so little about Aboriginal mental health:

We can do it for non-Aboriginal people, [but] we really, at this stage, cannot do it with any sound theoretical base for Aboriginal people. I guess it raises a social justice issue: they are not getting a thorough enough job done.

One specific characteristic which still appears not to be understood by our traditional penal and mental health systems is that incarceration itself creates severe mental disturbance for Aboriginal people. The consequences are sometimes fatal, as the Royal Commission into Aboriginal Deaths in Custody has revealed. Witnesses to the Inquiry repeatedly stressed the seriousness of this issue, which is a deeply ingrained cultural difference between Aboriginal and non-Aboriginal people. As the parents of one prisoner said:

While he's in jail over there...you know, he's not — just not like an Aboriginal over there. It's not [right] for an Aboriginal to be in that sort of situation all the time — locked up — because, you know, it's against our culture.

Whether the incarceration is in a prison or a psychiatric ward, the problem is the same. A solicitor in Darwin told the Inquiry the story of one of his clients, an Aboriginal man from a remote community who has schizophrenia. Arrested in 1986 for a series of offences, he was sentenced in 1987 to detention under the Mental Health Act for up to six months. Taken to Alice Springs Hospital, he became violent, insisting he wanted to leave. He was then medicated and transferred to the security ward at Royal Darwin Hospital. He remained there, '1500km away from his family, his community, his language, his culture, his land', for over five years. When the Inquiry sat in the Northern Territory (and visited him) he was about to be transferred back to Alice Springs Hospital, closer to his community — but was still no closer to release.

Why was this man's six-month sentence extended for so long? His solicitor explained what the hospital records reveal:
All that [he] has ever wanted throughout the last seven years of custody up here is to be allowed to return to the Centre... Again and again, all the entries made...as to [his] conduct and his utterance throughout the day repeat this: 'When am I going home? When can I get back to Alice Springs?'

The other thing that is quite clear...is the man's frustration... On several occasions during this seven years he was told by staff, 'Another six weeks in Darwin with a view to moving you down.' The next day's notes: '[Patient] very happy'; and the concepts they used disturb me, but these are the concepts they used: 'No management difficulties. Behaviour excellent. Not upset. Very happy. Excited about, looking forward to going down.' This would happen continuously over that period of seven years and then something would happen — an incident would occur... It did not happen. The Health Department would say, 'We didn't have the resources down at [Alice Springs]... He is dangerous. He fulfils the criteria.'

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[He] would misbehave. Entries in the notes describing his misbehaviour follow thus: '[He] refuses to do the dishes.' [He] would always refuse to do the dishes! It is against his culture — he is an Aboriginal man from a settlement in Central Australia. There is no accommodation for that, it would appear, in the treatment of the man by the staff.205

One Aboriginal witness warned against the assumption that disturbed Aboriginal people in prisons should be transferred to the mental health system, saying this 'doesn't actually treat the cause, it just transfers one problem to another.'206

People of Non English-Speaking Background

A particular difficulty for prisoners from non English-speaking background who are affected by mental illness is the lack of interpreter services.207 The problem is not only insufficient services:

We've had one instance of a prison warder refusing to allow an interpreter to go into the prison, because the warden felt all conversations should be in English — because they weren't sure what was actually being discussed.208

Resistance may also come from the interpreters themselves:

There have been a lot of interpreters who have not particularly wanted to go [out] to the prison, but...have been willing to meet elsewhere, at the courthouse in town, down in the cells there.209

Other Groups
Children and young people in custody who have a mental illness are another special needs group. They are discussed in Chapter 20 of this report. Two other groups of prisoners also at particular risk are older men with dementia or severe depression, and prisoners with developmental disability and behavioural problems.210 (See Chapter 21 — People with Dual and Multiple Disabilities.)

Shortage of Staff and Resources

It may be that one of the roles of a Commission such as this is to point out to governments that they really shouldn't go on doing things like this — establishing prisons, which of course we must have in our communities, but not staffing them properly.211

The main reason why mental health care in jails is so poor is the shortage of staff.212 The Standard Minimum Rules require 'a sufficient number of specialists such as psychiatrists, psychologists [and] social workers'.213 Yet every forensic psychiatrist who addressed the Inquiry referred to the severe understaffing of mental health services for prisoners — a group with a very high rate of mental illness and other disabilities, living in an inherently stressful environment, and prevented from seeking assistance privately.

The Prison Medical Service is the worst staffed area in the health (hospital or community) system in NSW.214

The NSW Prison Medical Service (PMS), responsible for the health of nearly half of Australia's prisoners, relies mainly on part-time consultant psychiatrists. In October 1990 the amount of psychiatric time available was 100 hours a week — equivalent to less than three full-time psychiatrists! PMS psychiatrists are also required to provide court and tribunal reports and to attend some court hearings. When these activities are taken into account there is even less time available for providing psychiatric care to patients.215 Given the number of prisoners requiring care, the number of psychiatrists available is hopelessly inadequate.216 Other mental health workers are similarly scarce. For example, at Mulawa Women's Prison in Sydney:

There are no social workers or other kinds of ancillary staff that we'd like. There are two good psychologists at Mulawa and they work [well], but they have a very full load.217

At Lithgow Corrections Centre, which is a much better appointed prison and the segregation facilities there are much more sensibly designed — the jail has been opened for six months, [and] there is still no psychologist. They have appointed a drug and alcohol worker.218

The problem is by no means confined to NSW. In Queensland the Inquiry heard:
The psychiatrists from the community psychiatry team go up to Lotus Glen [Prison] once a month, I think. There is a psychologist employed at Lotus Glen, but there are no programs.

In Western Australia:

The prison medical service is small and deals with minor health problems. As more mentally ill offenders are imprisoned, the system will increasingly fail to address the real issues associated with this group.

In Victoria the shortage is especially acute in the detention centres for young offenders:

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We have about 250 young people in our youth training centres in this state, with one medical person who's specifically involved with their mental health.

The staff shortage in prisons is due to a lack of funding for positions; but even the positions which are funded are difficult to fill. Forensic psychiatry is not perceived as an attractive field of work, and the work environment is hardly alluring:

Conditions are difficult for staff as well as prisoners, and qualified staff accept a much lower standard of conditions than their counterparts in the community.

Lack of Training for Police and Prison Staff

Too many police are sent to stations without this knowledge — and even if they gain it, they are transferred [away] and the rapport is lost; and the people with mental illness and their families are left without any support once again.

The distress suffered by mentally ill people in the criminal justice system is made worse by the fact that most police and prison officers have no training in recognising or dealing with mental illness. Yet they are routinely the only people present when someone is taken into custody. Many police and prison officers are humane individuals who 'make a valiant effort to do what they can' — but they are not trained to deal with mentally ill or disturbed people. Given the potential seriousness of the consequences, the absence of training for these officers is a dangerous oversight which must be corrected.

Additionally, in a society where mental health crisis teams are a rarity, police are frequently called specifically to deal with episodes of mental illness, even if no offence has been committed. These officers must assess whether an individual is likely to be dangerous, and if so how much force to employ in subduing or arresting the person. Sometimes they use too much force, causing
further distress and humiliation for the mentally ill person and their family.

Obviously they need training for these emergencies. The Inquiry was told that all Victoria's police now receive such training; clearly our other police forces should follow the Victorian example.

Consequences of the Staff Shortage

I think the longest list of prisoners I've been asked to see in any one visit is 27, which really doesn't allow for any more than band-aid psychiatric management.

For highly trained and committed professionals, the job satisfaction available in our prisons appears to be absolutely minimal. They have little contact with individual prisoners, very few resources and no say in the administrative fate of their patients. Notions like 'continuity of care', 'best available treatment' or 'the doctor-patient relationship' appear to be unknown to prison authorities.

The concept of health workers being primarily concerned with the health of their patients is comprehensively overridden by the demands of penal administration:

The institutional mental health professional at any one time is wearing two hats. He's wearing the hat of the person contracted to the institution...is containing [disruptive behaviour] and providing administrative answers — not necessarily acting entirely for the therapeutic benefit or value of the prisoner or patient.

And the second hat we wear in delivering services is, in fact, to consider what illness the prisoner or patient exhibits and the most appropriate form of treatment.

Now, I think a lot of the time we see ourselves operating in the second mode, whereas in actual fact we are operating in the first mode. And where there is a shortage of time to offer what I consider an adequacy of services, almost exclusively we're operating in the first mode and therefore treatments are actually not delivered.

Even prisoners identified as being 'in treatment' for mental illness have very little contact with their treating professionals. As one former inmate told the Inquiry:

The treatment was absolutely minimal, perhaps ten minutes a fortnight for people such as myself who were needy, and almost nothing at all for [other] patients.

A further effect of the staff shortage is the potential denial to forensic patients of their legal rights. For example, in South Australia the law requires that involuntary hospital detention orders be issued and reviewed by different psychiatrists. But because of the shortage of forensic psychiatrists:
it would be fair to say...that the same people are reviewing those orders and maintaining them on occasions... And the same person may be providing the assessment and also providing the treatment.233

Another legal consequence of the shortage was noted by the PMS Review Committee:

The Committee has been informed of instances where prisoners appear before parole review hearings, and are refused parole on the basis that they have not undertaken appropriate psychiatric or psychological counselling.234

Despite their extremely difficult conditions, the mental health staff who choose to work in our prison systems are capable and dedicated. When prisoners actually get to see a mental health worker, they are often satisfied with their treatment:

• My psychiatrist has given me the most help in my life, excellent.
• I have had occasion to have assessment by Department psychologists and found these people very helpful.
• I have seen three different psychiatrists/psychologists and they have all been most understanding and helpful.
• We would like to see more of the psychiatrist please.235 A psychiatrist working in the NSW prison system told the Inquiry:

The nursing staff in all of the ten years that I've been there have been of the very highest standard and calibre. My job has been made enormously more easy by their common sense and caring approaches and principles.256

Country jails

The shortage of staff — and thus the inadequacy of service — is especially acute in country jails. According to one psychiatrist:

In the early 80s, I was visiting [Bathurst Gaol] once a week...probably offering four hours a week — I think up to 20 hours a month was my contract. Now, partly through the way the system has contracted, partly because of my own practice requirements, I travel to the country once a month and probably only go to Bathurst Gaol maybe ten times a year. And four hours, of course — even if it were ten hours a month, that is not enough time.237

This witness told the Inquiry that he was the only consultant psychiatrist available to the Bathurst and Lithgow jails. At the time (mid 1991) there were over 650 prisoners in those two facilities,238 for whom he was available three
In NSW, where prisoners are all too easily transferred between jails at short notice, arranging a transfer from a country jail to the prison hospital in Sydney is difficult:

Unless somebody is very crazy indeed, and of course I'm using that term in the lay sense, it is not easy to transfer them as an emergency... [There is] a resistance that crops up in maintaining what some of us in the country would see as a proper flow, proper clinical care 240.

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Release from Jail

Often they leave prison without medication, though they may have been taking medication whilst in prison. And they are released often without any accommodation being arranged for them at all.241

Prison systems are frequently criticised for failing to prevent crime because some inmates commit further offences after release into the community. The standard response from governments is to call for longer sentences and crack down on conditions, day leave, remissions and parole. This recent and increasingly strident emphasis on punishment clearly contravenes the Standard Minimum Rules' requirement for rehabilitation to receive appropriate emphasis.

Rule 58. The purpose and justification of a sentence of imprisonment...is ultimately to protect society against crime. This end can only be achieved if the period of imprisonment is used to ensure, as far as possible, that upon his return to society the offender is not only willing but able to lead a law-abiding and self-supporting life.

Rule 59. To this end, the institution should utilise all the remedial, educational, moral, spiritual and other forces and forms of assistance which are appropriate and available, and should seek to apply them according to the individual treatment needs of the prisoners.242

These Rules recognise that punishment alone will not prevent re-offending; and that offenders should not be incarcerated in prisons which do not attempt to equip them for a self-supporting life. This is especially true for mentally ill offenders, for whom imprisonment actually reduces the chances of a self-supporting life.243

It seems a very obvious point — but one the evidence demonstrates is widely ignored; almost all prisoners are released eventually. If mental illness contributed to their breaking the law in the first place, and the illness is not treated, then it is very likely they will break the law again.

Prison mental health staff are in a position to observe first-hand the failings of a
system that makes no attempt to rehabilitate offenders, nor to establish even the most minimal safeguards which might prevent them coming back to jail. For example, NSW prison psychiatrists are not even informed when an inmate whom they are treating is about to be released or transferred to another jail:

I have often just gone to find a patient to write up medication or something, and found that they have been released.244

There are no case management plans, nor any system of notification. Whether a psychiatrist hears of an impending release 'depends on individual personalities working together,' i.e. on the goodwill of prison staff. The prisoners themselves are not always notified of their release date in advance. Even if they know they are due for release, planning for aftercare is difficult because [Prisoners] don't always have the right information either, because there are complications about giving particular dates and sometimes they don't know what area they are going to live in.245

The absence of a notification system implies a lack of respect in the penal system for the doctor-patient relationship. On a practical level, it also prevents psychiatrists making any follow-up arrangements for individuals who are often extremely vulnerable: as well as being mentally ill, they may have lost many of their social ties and coping skills while in prison. Discharge procedures at prisons (like psychiatric wards) are at times quite inappropriate. For example, a psychiatrist told the Inquiry of a prisoner suffering from 'schizophrenia and quite a lot of social disadvantage', who was released in the middle of the night:

From this prison which is situated right in the middle of — well, a very long way from public transport anyway — with no money at 2.30 am, because [the prisoner] had a 48hour sentence and the 48 hours finished at 2.30 in the morning.246

Obviously it would be unfair to keep inmates in prison for longer than their maximum sentence requires. But the alternative should not be release into a vacuum. If mental health workers in the prison system are notified, they can try to arrange some support for these prisoners to ease them back into the community.

In Western Australia prison officers sometimes contact Outcare, a housing and support agency for ex-prisoners, before an inmate is released on parole. Having secure accommodation can be a prerequisite for parole being granted — but if none is found, prisoners will often be released anyway. Prisoners who have served their full sentences are generally released without such a referral being made.247

Follow-Up after Jail
I would say that in most of Sydney the follow-up of former prisoners either is inadequate or doesn’t take place at all.248

The lack of support for mentally ill people released from jail was one of the most common concerns raised in the Inquiry. Mental health service providers often discriminate against ex-prisoners (see below). But prison systems also make no provision for psychiatrists to arrange follow-up care for their patients on release. Concern about inmates' health, while minimal at the best of times, evaporates completely when they walk out the prison gates.

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Forensic psychiatrists who do try to maintain contact with their ex-patients are often obstructed by the corrective services culture itself. A psychiatrist who visits the NSW country jails said that if he makes a 15-20 minute STD phone call to check on a former patient, 'people start to ask questions' about the cost.249

In October 1990, members of the forensic psychiatry section of the RANZCP wrote to the NSW Minister for Health expressing concern about the grave difficulties in securing psychiatric care for ex-prisoners, and especially for discharged forensic patients. One of those psychiatrists told the Inquiry there were about 500-600 prisoners on parole in NSW in need of psychiatric care, but most of them are probably not receiving it.250 Such a situation is shortsighted in the extreme; not only are the rights of sick individuals not observed — the rights of the wider community may well be imperilled. Apart from meeting the needs of prisoners, appropriate follow-up care can provide a means of reducing overcrowding:

Any method of reducing the prison population is well worth looking into. And this is one method: that a number of psychiatrically ill prisoners could in fact be released, providing that appropriate psychiatric follow-up were available.251

What Happens to Mentally Ill People Released from Jail?

Mentally ill people released from jail often follow a path like that of people released from psychiatric hospital wards. However, they bear the additional stigma that goes with a criminal record. This makes it even harder to obtain the health care and other services they need:

Either criminal behaviour or mental disorders, when viewed separately, create prejudices and rehabilitation difficulties. However, when clients have a history of both criminal and mental health issues, [they] tend to be shuffled from one agency or hostel to another... Whatever their pressing problem is at the time [determines] where they go.252

Discrimination against offenders on the grounds of mental illness
People coming out of jail frequently have no job, nowhere to live, and little social support. If they are also affected by mental illness, these problems are compounded by the inadequacy of the support available. For example, they have extreme difficulty in securing accommodation (see Chapter 10).

In Perth a witness from Outcare told the Inquiry that ex-prisoners generally face discrimination in trying to rebuild their lives; but prejudice against mental illness is greater still. As another witness who works with ex-prisoners in Melbourne said:

"It's easier to be forgiven if you're just bad. If you're mad and bad, you've got real problems."

The Outcare worker described a common reaction from support agencies approached to assist Outcare clients who are mentally ill:

"Initially, they are probably a bit put off about helping, because...they know we only deal with newly released prisoners. But once anything about mental illness is mentioned, they withdraw totally from providing any assistance."

Discrimination by mental health services against ex-prisoners

If they endeavour to get services from agencies or institutions that provide assistance to people with psychiatric disabilities, the fact that they are ex-prisoners goes against them. Mental health services themselves are not immune from prejudice. One of the reasons prison psychiatrists have considerable difficulty arranging follow-up care is that many community health services are reluctant to take on patients who bear a forensic label. (As mentioned previously, this reluctance can be the reason why a prisoner went to jail in the first place, instead of receiving a non-custodial sentence involving mandatory treatment.)

It is ironic to find such prejudice among mental health professionals, many of whom work hard to dispel the myth that mental illness equals violence. The idea that all ex-prisoners are dangerous is equally an overgeneralisation.

Some mental health services refuse assistance outright. Outcare cited this experience of trying to help a mentally ill prisoner about to be released:

"We approached the psychiatric hospital where he had most recently attended before he went to prison, and we were told that they were not prepared in any way to re-accept him, to provide outpatient follow-up support, nor to refer him to the community psychiatric division for accommodation... It was suggested that we organise accommodation for him in a single-sex hostel. However, when we checked the prisoner's [records],"
the same hospital had prepared a report indicating that this prisoner should not be released to unsupported accommodation.260

This prisoner was released from jail with no supervision or medication program. He very soon re-offended and found himself back in prison.261

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In some parts of Australia prisoners can be released directly from jail to a psychiatric hospital, ostensibly to ease the transition to the community. However, hospitals may not understand how disabling the effects of incarceration itself are. The Outcare witness told the tragic story of a prisoner who, after 17 years in jail, was released to a hospital for 'resocialisation' — a one-week program. As well as being mentally ill, he was physically disabled and on medication for epilepsy. Within a very short time he was released into the community with no support structures in place. Outcare several times raised concerns with the hospital about the lack of support. Eventually he reoffended, served another short prison term and another stint in hospital, then drifted into a boarding house where he contracted pneumonia and died.262

One solution for following up mentally ill inmates, described to the Inquiry by a forensic psychiatrist in Sydney, is for a few community mental health clinics to receive extra resources to develop a specialist expertise in caring for patients with a prison record. These centres would employ staff with experience of dealing with offenders. The Prison Medical Service would refer selected prisoners to the centres on release, thus ensuring continuity of care. The centres could also provide a consultative service to Probation and Parole Services.263 This proposal was put to the NSW Government in 1990, but no response was ever received.

A version of this proposal operates in Melbourne, but it has its own shortcomings. The Parliament Place clinic is a psychiatric outpatient facility for people on probation or parole. But this focus on formal status in the penal system excludes ordinary prisoners who have been released after serving their full sentences:

If you're not on a corrections order then you're really not eligible to use that particular service.264

Probation and Parole

The mental health system's refusal to treat ex-prisoners has adverse consequences for the prisoners' health and liberty. But it also creates deep discontent among workers in the criminal justice system, including probation and parole officers. These officers are charged with supervising offenders who are released conditionally into the community: either on parole (after serving part of a jail term) or on probation (instead of a jail term, eg a community service order or a bond).
If the offenders have a mental illness, probation officers are often expected to seek treatment for them. According to the Probation and Parole Officers' Human Rights and Equal Opportunity Commission Page 791 Association of NSW, this task is made 'difficult, if not almost impossible' by the health services' reluctance to take on these clients. The officers are thus left by default with a responsibility for which they have no training, and which they insist should be shouldered by the health sector rather than the penal system.

The Association rejects the suggestion that the officers should merely be trained in how to supervise a mentally ill offender on parole:

What is needed is better coordination with the Health Department, an increase in resources available for these people [mentally ill offenders] and for the health system to accept responsibility.265

The officers' main concern is with prisoners who are floridly psychotic, aggressive or dangerous. In some cases the criminal justice system, recognising that jail is an inappropriate solution, will recommend hospitalisation of such offenders. However, such recommendations are hardly enforceable if the hospital takes a different view of the matter:

A leading Sydney psychiatric hospital proposed discharging a long-term psychotic patient on the grounds of lack of facilities for aggressive/dangerous patients. On a prior discharge, against family wishes, the patient had killed his mother. It took the coordination and intervention of both responsible Ministers to block the proposal.266

On the other hand, court-ordered treatment can fail for more mundane reasons. Witnesses from the Epistle Post Release agency in Melbourne told the Inquiry of a young man with schizophrenia who, being 'quite a resourceful person', was able to get a job when released on parole. However, his parole conditions required him to attend the Parliament Place clinic, in the centre of Melbourne, to receive his medication. The clinic did not make out-of-hours appointments. His job was in the outer suburbs, so he constantly had to leave work early to honour his appointments. If he did not attend, he was breaching his parole order; if he did, he was breaching his employment obligations. Epistle Post Release tried to get the parole conditions altered so that he might receive treatment closer to work; but before this could be resolved he gave up his job.267

The Northern Territory Mental Health Service Forensic Team

The Inquiry heard of one forensic psychiatry service which appears to have surmounted some of the bureaucratic obstacles to aftercare. The forensic team in the Northern Territory Mental Health Service 'operates at the interface
between the health system, the criminal justice and corrections system. '268 It is a multidisciplinary team with a part-time consultant psychiatrist. It provides all forensic psychiatry services, including running security Ward 9 at Royal

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Darwin Hospital; assessing inmates at Darwin Prison and the juvenile detention centre, then making recommendations to the prison medical service about treatment; monitoring and counselling individual prisoners where necessary; training prison officers in mental health issues; and consulting to the courts during trials and at sentencing. In addition, the team provides a regular outpatient service for offenders. The existence of this service allows the Parole Board to grant parole, and the courts to order non-custodial sentences, on the condition that the offender attend for treatment — and to be confident that the condition will be fulfilled.269

Are Mentally Ill People Violent?

It's important to recognise that nearly all the people who are discharged from psychiatric hospitals are just like everyone else. But there is a tiny number who are extremely dangerous and have a high recidivist rate in violent crime.270

Discrimination against mentally ill people, especially if they have been to jail, is based largely on the public perception that these individuals must be violent. The evidence to the Inquiry overwhelmingly stressed that this view is greatly exaggerated. Not all ex-prisoners have a history of violence;271 nor does mental illness equate with violence.272

The presumed link between violence and mental illness was described by one expert witness as 'a furphy and a red herring'.273 According to another:

The facts of the matter are that most mentally ill people are not violent... There is a slightly higher proportion of violence amongst the mentally ill than amongst the non mentally ill. However... the strongest indicators of violence are age and sex... All [the] research indicates that we are at much greater risk of violence from males between the ages of 18 and 25 than we are from the mentally ill.274

Do Mentally Ill Offenders Re-offend?

All people released from prison without adequate support face the very real risk of reoffending. For those with any degree of mental illness this risk is compounded, not only by their health difficulties, but also by the lack of suitable community care.275

Expert witnesses to the Inquiry agreed that mentally ill ex-prisoners are most likely to re-offend if they do not receive treatment and support after their release from jail.276 In the absence of appropriate aftercare, the 'revolving door syndrome' becomes established:
They are released without any follow-up arrangements being made, and they turn up again a week or so later.277

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Prisoners with a dual disability are doubly disadvantaged. The following account of an inmate with a mental illness and an intellectual disability was typical of several presented to the Inquiry:

This was a young man serving a short prison sentence following a fairly trivial offence...and towards the end of the sentence we became aware that he had nowhere to live on leaving prison — that he’d essentially been living on the streets prior to the offence, and unless something was done quickly he would return to living on the streets. We wrote to the community mental health clinic which tries to provide a service including accommodation for the developmentally retarded; [but] they were not able to offer any help with accommodation. The man left prison, went back to the streets, and...re-offended within a matter of weeks, and simply came back to prison again.278

The witness pointed out that each person in prison costs taxpayers at least $50,000 a year. As a form of housing for people affected by mental illness, this is a ludicrously expensive and unsatisfactory solution.279 From a human rights perspective it is repugnant.

Prison vs. Hospital

I’ve seen psychiatric facilities which are as dehumanising as any jail. On the other side of the coin, you see some prison facilities which are very modern in certain parts of the world...which emphasise aspects of human dignity.280

Should offenders who are mentally ill be detained in the prison or the health system? Mental illness per se does not justify hospitalising a prisoner as an inpatient, any more than it does a person outside jail. One witness drew an analogy between prisoners living in the main jail and other mentally ill people living in the community:

The majority of individuals with emotional or mental difficulties are cared for by the prison medical service, who are the equivalent of general practitioners. That mirrors the situation in the community at large where the majority of mental disorder is dealt with by non-specialist practitioners and only a small proportion enters into specialist psychiatric care.281

Wherever people live they are entitled to the 'best available mental health care' (Mental Illness Principle 1.1). The prison medical services in most parts of Australia are clearly failing in this respect.

All prison systems acknowledge there are some severely ill offenders who need
hospital treatment. The question then becomes whether this should be provided in a prison hospital (‘a hospital within a prison’) or in a secure psychiatric ward of an ordinary civil hospital (‘a prison within a hospital’). Both models are in use in Australia.

Apart from standards of care, both models raise the issue of competing rights. In an ordinary psychiatric hospital, the competition is between the rights of forensic and civil patients:

It is a very difficult balance between the rights of individuals with mental illness to receive optimal treatment in the least restrictive environment...and the rights of those who have a mental illness and a co-existing criminal justice problem to receive optimal treatment.282

In the prison system, the rights of mentally ill inmates compete with those of other prisoners, and of staff untrained to handle mental illness:

Some [non mentally ill] inmates believe they are imprisoned in an institution for mentally disturbed people rather than a prison... We have observed increasing tensions in both staff and inmates.283

The existence of a psychiatric ward within the prison system does not make it easy to obtain treatment for mental illness: as described above, transferring an inmate out of the cells and into the prison hospital can be extremely difficult. Standards of care in these wards are not immune to the effects of gross understaffing in prison medical services. The punitive atmosphere pervading corrective services is also unconducive to mental health. For these reasons the Inquiry takes the view that prisoners who become seriously mentally ill should be treated in the health care system, not a prison hospital. It is, after all, their right to receive the same standard of health care as other mentally ill people.

Hospital Within a Prison

Psychiatric wards inside prisons are found in Victoria (G-Division at Pentridge), Queensland (Security Patients Hospital, Wacol Prison), and NSW (Malabar Psychiatric Unit at Long Bay). The Malabar unit was established to replace an old ‘prison within a hospital’, the forensic Ward 21 at Morisset Hospital near Newcastle.284 This was in response to recommendations by the Royal Commission into NSW Prisons, which was highly critical of conditions at Morisset.285

Prison Within a Hospital

In most Australian jurisdictions forensic psychiatry is treated as part of the health care system. South Australia switched to this approach when it closed its
old 'hospital within a prison', Northfield Security Hospital at Yatala Labour Prison. It now has a specialist forensic psychiatry hospital, James Nash House, built in the grounds of Hillcrest Hospital and run by hospital staff. 286 Hillcrest itself is now being closed, but the forensic unit will remain. 287

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Individuals from the criminal justice system are admitted [to James Nash] as either voluntary or detained patients, depending on their mental state, as any other citizen would be to a hospital. But because they're within the criminal justice system the legal convention is used that they are placed on special leave from the prison system... We have found [this] to be a successful strategy for ensuring that the custodial system retains an interest in these individuals, but that they are managed within the health care system. 288

Victoria also has three forensic wards in psychiatric hospitals, two at Mont Park and one at Aradale Hospital.

Elsewhere, inmates affected by severe mental illness are transferred out to an ordinary secure ward in a public psychiatric hospital. This is the case, for example, in Western Australia (at Graylands Hospital), the Northern Territory (Royal Darwin Hospital's Ward 9), Tasmania (Royal Derwent Hospital) and for women prisoners in Sydney (Cumberland Hospital).

One problem with relying on transfers to the health system is that only a few beds are generally allocated for forensic patients. If those beds are full, the prisoner must remain in jail, 289 or else:

Sometimes we'd have to negotiate with a hospital to get a bed [for] someone with a mental illness who was a prisoner, and then we would have to get prison officers to come and stand outside the room. 290

Some witnesses to the Inquiry also objected to this transfer system, believing mentally ill offenders could pose a danger to ordinary patients in the hospital. 291 On the other hand, the manager of forensic services in the Northern Territory told the Inquiry the two classes of patients are not so different from each other:

In the majority of cases, civilian patients admitted to [Ward 9] have an extensive history of involvement in the criminal justice system, even if they are not currently involved. 292

Darwin's 'multi-purpose mental health facility'

One option for hospitals which cannot afford to build an entirely separate forensic unit is Royal Darwin Hospital's proposal for a 'multi-purpose mental health facility'. This will be a high-security ward accommodating three groups of inpatients: civil acute patients, mentally ill prisoners and sexual offenders diagnosed as having personality disorders. The first purpose-built psychiatric
facility in the Territory, it will replace Ward 9, the secure ward which currently takes all acute patients from throughout the jurisdiction.

This proposal was the subject of a great deal of the evidence heard by the Inquiry in Darwin. A witness from the NT Association for Mental Health said:

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Relatives and friends of acute admission patients who have seen the plans are both appalled and distressed that their loved ones will be housed in such an integrated structure.291

One objection is to the proposal's 'very dominant forensic ethos...[its] oppressive security-oriented design and surveillance systems'. Another is that non-forensic patients may be harmed by sharing facilities with prisoners, and their rehabilitation hindered by having to live in a highly restrictive, maximum security environment. The cost is very high — $7 million, which is equivalent to most of the mental health service's annual expenditure. In addition, the Association told the Inquiry that the community had not been adequately consulted in the planning process.294

In response to these grievances, NT Government witnesses insisted that separation will be maintained between civil and forensic patients in the new unit. The three groups of patients will be accommodated in different wings, with common facilities like the gymnasium allocated for the use of each group at different times.295 The capital funding will be additional to the current mental health budget.296

The government also maintains there is a need for an inpatient treatment program for sexual offenders:

The sole aim of this program is to reduce the rate of re-offending in this group, and thereby reduce the number of children and women who would otherwise be abused and traumatised in the future.297

As a result of the concerns raised during the Inquiry's visit to Darwin, the Government agreed to modify the proposal's design to provide, for example, separate entrances to each of the three wings.

Governor's Pleasure Prisoners

One of the worst things that could happen to anybody in this State is to be found not guilty of an offence on the grounds of mental illness.298

The classic 'forensic patient' is an offender who goes to trial and pleads not guilty by reason of insanity.299 If the plea succeeds the accused is acquitted, but still kept in custody for mental health treatment 'at the Governor's pleasure'. The same occurs if the accused did not stand trial because mental illness rendered him or her unfit to plead.
The purpose of the insanity defence is to recognise that mental illness can rob people of the capacity to understand what they are doing. Conviction for a crime requires that both the act itself and the requisite intent be proved. An acquittal on the grounds of mental illness means the accused person committed the criminal act, but cannot be held responsible for it.

This solution appears to emphasise treatment rather than punishment of the offender. However, the purpose of Governor's pleasure detention is not treatment, but only protection of the public. In reality, such detention can be a particularly severe punishment because it is not subject to the normal legal protections which apply to those convicted of crimes.

The most obvious disadvantage of Governor's pleasure detention is that it is indeterminate. An ordinary prison term is proportional to the offence committed and its maximum duration is clearly stated by the sentencing judge. By contrast, Governor's pleasure detainees have no idea when they can expect to be released. In fact, their detention can turn out to be much longer than they would have served if they had actually been convicted.

I give as an example a 23-year-old mentally retarded invalid pensioner charged with aggravated burglary...[who] was permanently unfit to plead... He was committed to the prison in April 1985, having already been in custody two months. It was not until a year later that he applied through the efforts of the prison psychiatrist for transfer or release. It [then] took some months before the tribunal secured his release.

Governor's pleasure cases are reviewed regularly by an advisory body, but it is the executive government which makes any decisions about a detainee's release or continued detention, and about treatment, transfer in or out of hospital, and fitness to be tried. Several expert witnesses told the Inquiry that this use of executive discretion sometimes produces serious injustices.

The Review

Forensic patients' 'rights' in the review process vary widely from State to State. In NSW, the Mental Health Review Tribunal reviews cases every six months; the patient may give evidence to the Tribunal and normally has legal representation. However, neither the patient's evidence nor the lawyer's submissions are transcribed or passed on to the ultimate decision-maker.

In Tasmania the Tribunal is specifically exempted, where the patient being reviewed is a prisoner, from its normal requirement to give reasons for an adverse recommendation.
In Victoria the review is conducted by the Adult Parole Board once a year, and patients have no right of appearance before the Board, no right to make any submissions, no right to be informed of the matters which the Board takes into account. Often the material which is placed before that Board is coordinated by parole officers and not by qualified medical practitioners.307

In Western Australia the review is also conducted by the Parole Board, which under statute is specifically exempted from requirements of natural justice.308 An expert witness in that State called this 'the very antithesis of a judicial procedure'.309

The Decision

A review body can recommend to its executive government that a detainee is no longer dangerous and should be released. However, the executive can accept or reject the recommendation. In Victoria the recommendation goes to the Attorney-General:

Again the patient has no right of appearance, no right to be informed of materials which are placed before the Attorney-General, and no right of questioning anyone who might be saying anything adverse to their interests.310

The matter then goes to Cabinet, where (still without the patient having had any involvement) the decision is made. The president of the Victorian Mental Health Review Board told the Inquiry:

That system is simply terribly wrong and terribly unfair.311

In NSW the decision-maker is the Minister for Health:

No reasons have to be given by the Minister if he chooses not to accept the [Tribunal's] recommendations, and therefore the patient has no opportunity to address any fresh concerns or correct apprehensions of fact with which he or she disagrees.312

As well as being unfair, it seems likely that this process would result in poor quality decisions — since very little information is provided to the decision maker. In NSW, for example, the Tribunal supplies the Health Minister with brief written reasons for any release recommendation. Based entirely on this information, the Minister alone must decide whether transferring or releasing the patient would pose too great a danger to the community. Clearly this assessment would be more competently made by an expert body which has had
Perhaps mindful of how poorly equipped they are for the task, decision-makers tend to make very conservative assessments. The impression of witnesses who gave evidence on this topic was that regardless of what the advisory body recommends, the decision-makers generally decide against release. A Tasmanian witness said that even where the recommendation is merely to transfer a patient from prison to hospital, about half the time it is refused. It seems improbable that such decisions are always based on a rational assessment of the prisoner's potential threat to the rights of the wider community. The prime criterion is sometimes the potential for political damage to a government perceived by the public as being soft on criminals.

The Minister, if he's got any sense, is going to think about votes — and it's easier to play it safe than to let someone go.

Apart from the consequences for individual patients, this outcome undermines confidence in the legal process and insults the expert members of the advisory bodies. The Committee reviewing the NSW Mental Health Act observed that if the Tribunal judges patients to be no longer dangerous, as persons found not guilty [by reason of mental illness] they are entitled to their liberty. To effectively impose a sentence of an unspecified additional period...makes a mockery of both the verdict and the review system.

One witness to the Inquiry was an eminent Tasmanian psychiatrist who publicly resigned from that State's Tribunal in protest over this issue.

International Human Rights

Article 9(4) of the ICCPR requires that anyone in detention be able to seek review of that detention by a court. This should mean that a prisoner who is recommended for release by an expert tribunal, but kept in custody by the executive rejecting that recommendation, can apply for judicial review. However, the High Court of Australia has held there is no obligation on the executive to follow the tribunal's advice:

The executive council can ignore that recommendation, and can do so on the grounds of what has been termed 'high level political responsibility'.

Effectively this means there is no judicial review of the decision to keep in custody a person who a) was legally acquitted in the first place; b) is deemed by the advisory body to be no longer dangerous or even mentally ill; and c) has already spent more time in custody than he or she would have if convicted.
One witness pointed out the irony of blatantly political decisions being accepted in this area, at a time when the general trend is to de-politicise the administration of criminal justice. In his opinion this practice also breaches Article 9(1) of the ICCPR, which requires freedom from arbitrary detention:

'Arbitrary', in this sense, must necessarily mean where the detention is ordered by an entity...that is not an entity that gathers and sifts the facts, [ie] a non-judicial determination. In fact, the notion of Governor's pleasure detention has been referred to, quite rightly in my submission, as political detention of those who are mentally ill at the time of commission of their offences.

The United Kingdom, which gave Australia its Governor's pleasure system, was taken to the European Court of Human Rights in 1983 for these same breaches of international law. As a result the UK changed its law, giving the Mental Health Review Tribunal the power to order the release of an offender whom it considers no longer mentally disordered or dangerous. The wishes of the executive (i.e. of the Home Secretary) must still be considered, but the detainee also has the chance to refute them.

The human rights principle is clear: an individual's liberty should only be denied by a judicial determination, not an unfettered and sometimes secretive political decision. As for danger to the public, evaluation of the Tribunal's decisions since 1983 has found:

The Tribunal is no better, and in fact no worse, than the Home Secretary in terms of the right number of decisions as to release. In other words...the chances of making an incorrect decision are the same whether it is the Home Secretary or the Tribunal itself.

Apart from Article 9, two other human rights are endangered by the executive discretion to extend detention of a person judged to be no longer mentally ill. Article 10(1) of the ICCPR requires that people deprived of their liberty be treated with humanity; Article 7 prohibits cruel, inhuman or degrading treatment. The Inquiry was told it is cruel, inhuman and degrading treatment to detain in a mental hospital a person who is no longer mentally ill. This view has also received recent support from the European Court of Human Rights, and from the English Court of Appeal.

Avoidance of the Defence

The practical consequence of all these drawbacks, according to evidence presented to the Inquiry, is that the insanity defence 'is almost universally rejected' by people accused of major crimes. Even if they are mentally ill, their lawyers advise that 'it is worse for their clients to [chance] the Mental Health Review Tribunal than to face a custodial sentence.' This means some people are convicted who otherwise may well have been found not guilty; it
also means people whose greatest need is for psychiatric treatment prejudice their chance of receiving it; and it obscures the role that mental illness plays as a contributing factor in offences being committed. In addition, it leads to second guessing in the courts. Sometimes the sentencing judge will see mental illness as a mitigating factor to take into account in sentencing.331 On the other hand, the defendant may be disadvantaged:

The judges will see that a person has avoided a mental illness defence because that is likely to lead to longer confinement... But at the same time, the judges realise how potentially dangerous that person is. They have the reports of the psychiatrist who interviewed him, and so they tend to move towards something that is perhaps harsher in the long run than if [he] were treated under a well-balanced mental health review system.332

Abandoning the Executive Discretion

Several reviews and inquiries in Australia have urged that procedures for dealing with mentally ill offenders be overhauled. One important reform is the abolition of Governor's pleasure detention, or at least executive discretion in the disposition of these patients. Instead, an expert body such as a Mental Health Review Tribunal should have the power to order their release — as is the case in the UK.333 No Australian jurisdiction has yet taken this step.

Other reforms need to be implemented to give the police and the courts more flexibility in the apprehension, remand or sentencing of people who are mentally ill or disordered — to allow and encourage non-custodial treatment rather than detention.334 Effective action must be taken to bring this area of our mental health and legal systems into line with the accepted international and domestic legal principles of natural justice and human rights.

Personality Disorders

Expert witnesses from forensic mental health services referred frequently to 'behavioural' or 'personality disorders'. These conditions do not qualify as mental illnesses under mental health legislation335 — even though they are listed as psychiatric disorders in the standard diagnostic tool, DSM-III-R. Thus an individual diagnosed with a personality disorder cannot be hospitalised as an involuntary patient; cannot rely on the defence of insanity in a criminal trial;336 and will often be turned away by psychiatric hospitals and crisis services.

Yet personality disorder is the single most common diagnosis among patients seen by prison psychiatrists.338 It is also among the most serious conditions, in terms of the risk of physical harm. People with personality disorders often engage in self-mutilation; in fact the symptoms can be as horrifying and dangerous as any psychosis:
If you've got a personality disorder to the extent that...you're cutting bits off yourself, mutilating yourself, chopping fingers off, defecating, throwing urine...growling, and

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basically very uncontrollable — then if you're not deemed to have a mental illness and somebody who may have a well-controlled chronic delusion is deemed to be mentally ill, then there is some sort of perversity in that.335

It is not only the patient who is at risk: personality disorder is often associated with actual or threatened crimes against others.340 This may be one reason why so many people with personality disorders are found in jail.

The mental health system's refusal to treat personality disorders causes frustration, bewilderment and anger among people whose work brings them in contact with the individuals affected. Police, prison officers, probation and parole officers, prison psychiatrists, refuge and shelter workers see the consequences as the same individuals move through their services, often creating extensive disruption, then move on without receiving any treatment at all — only to reappear later:

We have a number of long-term clients on our records who constantly repeat the same pattern of behaviour and the same pattern of referral: they are referred to public hospitals for observation and assessment; then they go to Graylands [Hospital] where the diagnosis is generally that they are of mixed anti-social personality disorders. They move between the hostels, lodging houses, Graylands and back to the prison system.341

The Inquiry was told the refusal to treat personality disorders is based on a belief that these disorders cannot be treated.342 The Inquiry was also told this is not true:343

This group is notoriously difficult to treat, and frequently require management rather than just treatment... [The] reluctance by psychiatric professionals to treat such people [is] because of the length of time and amount of resources required.344

Treating personality disorders is costly and time-consuming, because it requires behavioural programs rather than medication. However, as well as the time and cost involved, one expert witness suggested another reason why hospitals reject these patients — prejudice against prisoners:

In many psychiatric hospitals, 'personality disorder' is the label assigned to virtually any patient
who comes from the criminal justice system. They write that on the file to justify sending them back to prison.345

Often patients rejected on this basis are also being denied treatment (or early intervention) for a ‘recognised’ mental illness, which may accompany or follow a personality disorder.346 Because they are frequent reoffenders, they often develop a third problem which overlays and aggravates the first two: destructive behavioural patterns as a result of long-term institutionalisation in prisons:347

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I haven't got a personality disorder...I call it a social disorder. I haven't learnt skills like paying taxes or catching trams.348

It's obvious that a lot of the outbursts...are affected by environmental factors. The fact [is] that he is in the prison service and he has learnt behaviours. We feel these behaviours will have to be untaught and he will have to be re-educated...back into society.349

Given the size of the problem, and the severe impact that people with personality disorders often have on their families, the wider community, welfare agencies and the prisons, it is essential that this unjustifiable stand-off between the health and prison sectors is resolved:

Management of people suffering from personality or behavioural disorders requires cooperation from a number of agencies including Health, Police, Corrections, Alcohol and Drug authorities and Community Services. There is a need for joint initiatives to ensure that the rights of these individuals and the community are upheld.350

Conclusion

The Inquiry recognises that several of the issues raised in this chapter are complex and present difficult questions of both policy and practice. However, the human rights abuses currently being committed against people affected by mental illness in remand and correctional facilities cannot be allowed to continue. Australia has undertaken to honour certain standards clearly set out in a range of international instruments — and these obligations must be honoured.

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2. In some jurisdictions, including NSW, the definition also includes some prisoners who have a developmental disability. Robert Hayes et al, A Profile of Forensic Patients in New South Wales and an Assessment of the Role of the Mental Health Review Tribunal in Effecting Their Release, Mental Health Review Tribunal, 1991, pi.
3. Dr David Ben-Tovin, Director of Mental Health Services, South Australia. Oral evidence, Adelaide 22.10.91, p219.
4. Hayes et al, op cit, pi. These 86 comprised: 65 found not guilty on the grounds of mental illness, 9 unfit to be tried, and 12 who had been transferred out to a psychiatric hospital ward, having been diagnosed as mentally ill while in prison.
5. NSW Department of Corrective Services, 'Weekly states for the week ending 27 October 1991'.
7. The exception is Victoria: see the section of this chapter on assessment.
8. Marion Leach, Outcare Civil Rehabilitation Council of Western Australia. Submission, p3. The same view was expressed by Sister Bernadine Daly, Sister of Mercy and prison visitor. Submission.
9. A US survey of the research found an extraordinary range of prevalence: from 5 percent with 'psychosis' to 75 percent with schizophrenia. Linda Teplin, 'The prevalence of severe mental disorder among male urban jail detainees: Comparison with the Epidemiologic Catchment Area Program,' American Journal of Public Health, June 1990, v80, n6, p669. The disparities are partly due to methodological variations: some studies (and some jails) take random samples of prisoners, while others focus on inmates on remand or those referred for psychiatric assessment. Another inconsistency is in the criteria used to define a mental illness or disorder: many studies count substance dependency as a mental disorder, while others do not.
10. id.
15. ibid, p427. A Sydney psychiatrist also confirmed that the rate of mental illness is especially high among women prisoners: Skinner, op cit (oral evidence), p668.
16. Prof Brent Waters, Department of Children and Adolescent Psychiatry, Prince of Wales Hospital.
Oral evidence, Sydney 17.6.91, p29.
17. Dr Hugh Jolly, consultant psychiatrist to the NSW Prison Medical Service. Oral evidence, Sydney 8.7.91, p647.

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25. ibid, pp649, 655.
26. Skinner, op cit (submission), pi.
27. id. Also Peter Mels, manager, forensic team, Northern Territory Mental Health Services. Oral evidence, Darwin 21.7.92, pl23.
29. Skinner, op cit (submission), pi.
32. id.
33. Dr John Ellard, NSW Branch President, RANZCP. Oral evidence, Sydney 17.6.91, p69.
34. Skinner, op cit (submission), pi.
35. Ridley, op cit, pl30; Mels, op cit, pl23.
36. Peter Chivers, ACT Housing and Community Services Bureau. Submission, pi.
39. Name withheld. Submission No391, pi.
40. Dr Marie Bashir, Director, Central Sydney Area Health Service. Oral evidence, Sydney 20.6.91, p505.
42. Leach, op cit, p3. Also Dr Geoff Smith, Director of Policy and Planning, Mental Health Services, WA Health Department. Oral evidence, Perth 12.2.92, p412. Also Orme Hodgson, Schizophrenia Fellowship of South Queensland. Submission, pl7.
44. Andrews, op cit, pl 126.
45. Hodgson, op cit, pl8.
46. Dr Yvonne Skinner pointed out that illiteracy is fairly common among the mentally ill; some people receive fine notices or bills in the mail and simply put them aside because they cannot read them. (Information provided to the Inquiry after the close of formal hearings.) In 1988 NSW introduced a scheme to keep fine-defaulters out of prison, following the near-fatal bashing of a young defaulter, Jamie Partlic. However, the scheme has been declining steadily since 1989, and people now regularly go to jail in NSW for non-payment. Ivan Potas, 'The Sentencing Act 1989: Impact and review', in (1992) 3(3) Current Issues in Criminal Justice 318-328, p321.

47. Leach, op cit, p3.

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49. Dr Jenny Thompson, Forensic Study Group, RANZCP. Submission, pi.
50. Skinner, op cit (oral evidence), p663.
53. Barr, op cit, p423.
55. ibid, p6.
57. Andrews, op cit, pi 129.
60. Jolly, op cit, p25.
62. Name withheld. Submission No391, pi.
63. Nordan, op cit, p299.
64. Daly, op cit, p2.

66. Another contender is Alice Springs Prison, which was singled out in Amnesty's report for 'conditions which could well be judged unacceptable according to international standards'. Amnesty International, op cit, pl. Amnesty concluded that conditions in some Australian prisons could amount to 'cruel, inhuman or degrading treatment' — the terminology used in the UN Convention Against Torture (Article 3), the Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment (Principle 6), and the Universal Declaration of Human Rights (Article 5). Its delegation 'observed extremely varied conditions...ranging from the excellent to the quite bad'. One of the worst conditions was gross overcrowding in cells — eg in one wing of Long Bay Gaol in Sydney, prisoners were living three to a cell measuring about 3m by 2.2m. (However, prisoners in that wing were only confined to their cells for eight hours at night.) Of course, Amnesty was considering prison conditions from the point of view of ordinary prisoners who are not mentally ill. Those affected by mental illness are even more needy and less able to cope with hardship.
67. Barr, op cit, p421. Also Skinner, op cit (oral evidence), p670. This concern about NSW prisons is borne out in the academic literature. For example at Parklea Prison, which was designed to house 210 inmates, the population in mid 1991 was 350. Angela Gorter, 'Impact of the Sentencing Act 1989 on the NSW prison population', (1992) 3(3) Current Issues in Criminal Justice, 308-317, p312.
69. id, pl09.
70. Barr, op cit, p421; Skinner, op cit (oral evidence), p670. The Sentencing Act 1989 abolished remissions and aimed to ensure 'truth in sentencing'. As a consequence, fewer offenders now receive non-custodial sentences (eg community service) and those who go to jail are imprisoned for longer. Gorter, op cit, p317.
72. ibid, p665.
76. Skinner, op cit (oral evidence), p665. The official policy was to allow each prisoner six photographs, but its interpretation was left to individual prison governors, some of whom took an especially harsh approach.
77. NSW Prisons Coalition. Submission, p44.
79. ibid, p666.
80. id.
81. NSW Prisons Coalition, op cit, p45.
82. id.
84. id.
86. Steeper, op cit, p3.
88. Daly, op cit, p3.
93. Independents' Report, op cit, pp20,32,55.
94. NSW Prisons Coalition. Information provided to the Inquiry after the close of formal hearings.
95. Skinner, op cit, p666.
96. Dr David Wells, Police Surgeon and Director of Forensic Medicine, Victoria Police. Submission, p3.
97. Skinner, op cit (submission), p2; Daly, op cit, pi; Hodgson, op cit, pl8.
98. Steeper, op cit, p3.
100. ibid, p5.
101. Banks, op cit, pi.
102. Wells, op cit, p3.
104. ibid, p2.
105. id.
106. id.
107. ibid, p3.
109. id. Similar criticism could apply to the lock-up at Sydney Central Police Station, built in 1987 to accommodate up to 150 inmates. All the cells are underground, ibid, p9.
110. Name withheld, op cit endnote 58, p305.
113. NSW Prisons (Administration) Regulation, clause 11. Quoted in PMS Review, op cit, pl08.
114. PMS Review, op cit, pl08.
115. Thompson, op cit, p2.
117. PMS Review, op cit, pl09.
118. Nordan, op cit, p293.
119. id.
120. id.
121. Gurr, op cit, p78.

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123. NSW Police Service Custody Manual, paragraph 1.104, quoted in David Landa, Inquiry into the circumstances surrounding the injuries suffered by Angus Rigg in police custody and into the subsequent police investigations, Ombudsman's report to the NSW Parliament, Jan 1993, pill.
124. McDonald and Howlett, op cit, p8.
125. Dr David Wells, Police Surgeon and Director of Forensic Medicine, Victoria Police. Oral evidence, Ballarat 11.4.91, p595.
126. ibid, p594.
127. Wells, op cit (submission), p2.
128. Landa, op cit, pl30.
129. Andrews, op cit, pl125.
130. id.
133. PMS Review, pl08.
134. Jolly, op cit, p650.
137. Skinner, op cit (oral evidence), p659-60. Since this evidence was given, a toilet has been installed. In Victorian jails the special isolation cells are called 'wet cells' — because they can be hosed down for cleaning. Geary, op cit, p299.
139. Leach, op cit, p2.
140. Marion Leach, Outcare Civil Rehabilitation Council of Western Australia. Oral evidence, Perth 10.2.92, p50. A similar report came from a former inmate in Queensland. Name withheld, op cit endnote 58, pl299. See also Skinner, op cit (submission), pl6.
141. Name withheld. Submission No440, p30.
142. Name withheld. Submission No45, pl.
143. Ian Campbell, Mental Disorder and Criminal Law in Australia and New Zealand, Butterworths 1988, pl89.
144. Dr Joan Lawrence, senior psychiatrist, Royal Brisbane Hospital. Oral evidence, Brisbane 16.8.91, pl745.
145. Name withheld, op cit endnote 58, pl300.
146. Hodgson, op cit, pl8.
147. Jolly, op cit, p652. Also Nordan, op cit, p290.
148. McDonald, op cit, p2.
150. Andrews, op cit, pl126.
151. Name withheld. Submission No45.
152. Andrews, op cit, pl127.
154. She believes there is doubt about whether her son's death was a suicide.
155. id.
156. Standard Minimum Rule 82(1).
158. Chivers, op cit, pi.
159. Dr Russell Pargiter, consultant psychiatrist. Oral evidence, Hobart 12.11.91, pl49.
162. Skinner, op cit (submission), pi.
163. Walker, op cit, pl7. In 1991 there were about 730 women in Australian jails, out of a total of 15,000 prisoners. About 400 of those female inmates were in NSW.
164. Skinner, op cit (oral evidence), p668.
166. ibid, pl6.
167. ibid, pl5.
168. 'Most have children and few are married or have a stable relationship (less than 10 percent).’ ibid, p5.
169. id.
172. ibid, p428.
173. ibid, p427.
175. See endnotes 68 and 71.
177. id; also Skinner, op cit (submission), pi.
178. Skinner, op cit (submission), pl5.
180. Skinner, op cit (submission), pl5.
181. ibid, pl6.
183. id.
184. id. The NSW Ombudsman has pointed out that tear-resistant blankets exist and are officially standard issue for NSW police lock-ups — but in practice many old blankets are still in circulation. One was used by Angus Rigg, a juvenile offender who hanged himself in police custody in July 1991. Landa, op cit, plpl07-III.
186. id.
187. id.
188. Skinner, op cit (submission), plO.
195. id. The issue of women inmates being moved to male prisons has arisen this year in Victoria, where the Government proposes to close down the main women’s prison, Fairlea. At Fairlea the women have been living in shared cottages where they can cook and spend substantial amounts of time with their children. Local women’s services operate programs at the prison. The planned closure would see the women moved to Pentridge, a male prison where conditions are much more restrictive. Shelley Burchfield, ‘Fairlea closure’, Framed No22, Aug 1993, p7.

196. Watson, op cit, pl528.
197. Walker, op cit, p22.
198. The jurisdiction with the highest proportion of black prisoners is the Northern Territory, where they make up 70 percent of inmates. But based on their share of the general population, the disproportion is worst in Western Australia, where Aboriginal people are in prison at 29 times the average. In South Australia the ratio is 23.6. In the Northern Territory the over-representation is by a factor of 11; but the Territory also imprisons non-Aboriginal Australians far more than elsewhere. Walker, op cit, p23.

199. McDonald, op cit, p2. Over-representation rates in police lock-ups also vary widely. The worst are in Western Australia (where Aboriginal people are over-represented by a factor of 52), South Australia (a factor of 21) and NSW (a factor of 16). In the Northern Territory, 80 percent of people taken into police cells are Aboriginal or Torres Strait Islander — an over-representation by a factor of 14.

201. See Chapter 23 for a more general discussion of Aboriginal people and mental illness.
205. ibid, pp95-6.
206. Watson, op cit, pl515.
209. id.
210. Thompson, op cit, p2.
211. Jolly, op cit, p650.
212. Lawrence, op cit, pl745; Geary, op cit, p292; Leach, op cit (oral evidence), p55.

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214. Thompson, op cit, p3.
216. The PMS Review Committee described the prisoners as 'grossly inadequate', ibid, p56.
218. Jolly, op cit, p650.
220. Leach, op cit (submission), p2.
221. Geary, op cit, p292.
222. Middleton, op cit, pl355.
223. id. Also Skinner, op cit (submission), p4. number of psychiatric hours available to
225. Andrews, op cit, p 127; Dahl, op cit, p405: 'There is still considerable confusion as to what is
mental illness and what is intellectual disability and what is difficult behaviour.'
226. Skinner, op cit (oral evidence) p668. See also Hodgson, op cit, pl9.
227. Wells, op cit (submission), ppl-3. Also Hodgson, op cit, pl7, observing that Queensland police —
especially the younger ones — are 'on the whole...most co-operative and sympathetic in
handling involuntary admission'.
228. Wells, op cit (oral evidence), p595.
229. Jolly, op cit, p650.
230. ibid, p654.
231. ibid, p648.
232. Name withheld, op cit endnote 58, pl299.
234. PMS Review, op cit, p57.
235. Prisoners quoted in ibid, pl36-139.
236. Jolly, op cit, p650.
237. id.
238. Walker, op cit, pl3.
239. Jolly, op cit, p651.
240. ibid, p650.
241. Leach, op cit (oral evidence), p55.
244. Skinner, op cit (oral evidence), p671.
245. ibid, p672.
246. ibid, p671.
247. Leach, op cit (oral evidence), p56.
248. Barr, op cit, p422.
249. Jolly, op cit, p653.

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251. ibid, p421.
252. Leach, op cit (oral evidence), p50.
253. id.
255. Leach, op cit (oral evidence), p50.
256. Calabro, op cit pl46.
257. Barr, op cit, p422; Jolly, op cit, p24; Leach, op cit (oral evidence), p51.
258. id.
259. Lancefield, op cit, pl54.
260. Leach, op cit (oral evidence), p52.
261. id.
262. ibid, p51.
263. Barr, op cit, p422.
264. Lancefield, op cit, pl48.
265. Sue Marlin, Probation and Parole Officers' Association of NSW. Submission, pi. Similar evidence was given by Barr, op cit, p422.
266. Marlin, op cit, p2.
268. Mels, op cit, pl22.
269. ibid, ppl22-124.
270. Ellard, opcit, p61.
271. Calabro, op cit, pl47.
272. Milton, op cit, p684. The Victorian Parliament's Social Development Committee has also challenged the assumption that psychiatry has expertise in predicting dangerous behaviour. See Parliament of Victoria, Social Development Committee, Third Report upon the Inquiry into Mental Disturbance and Community Safety: Response to the Draft Community Protection (Violent Offenders) Bill, April 1992, p83.
274. ibid, p26.
275. Leach, op cit (submission), pi.
276. eg Leach, op cit; Jolly, op cit; Skinner, op cit; Marlin, op cit.
278. Barr, op cit, p425.
279. id.
280. Middleton, op cit, pl372.
283. Clodagh Jones and Marie Sykes, prison visitors, Risdon Prison, Tasmania. Submission.
284. 'The notorious ward 21 — thank goodness it has finally closed.' Prof Rodney Morice, Director, Division of Mental Health Services, Hunter Area Health Service. Oral evidence Newcastle 9.7.91, p27.

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285. Campbell, op cit, pl94.
287. ibid, p228.
288. ibid, p219.
289. Skinner, op cit (oral evidence), p36; Ridley, op cit, pl40.
290. Ridley, op cit, pl40.
Also Shirley Maher, carer, Queensland. Submission, p2.
292. Mels, op cit, pl22.
293. Dr Bill Tyler, NT Association for Mental Health. Oral evidence, Darwin 21.7.92, p22. A community group in Townsville also expressed concern about an apparently similar facility proposed for Townsville General Hospital. However, their main objection was to the 'institutional' character of the plan, rather than the inclusion of forensic patients. Name withheld. Oral evidence, Townsville 12.8.91, pl218.
294. Tyler, op cit, p21.
295. Ridley, op cit, pl40.
297. Mels, op cit, pl23. Also Beaver, op cit, pi 18; Ridley, op cit, pl40.
298. Barr, op cit, p424.
299. The definition of insanity or mental illness for the purposes of the criminal law defence is quite different from that used for involuntary detention in hospital under civil legislation.
300. Campbell, op cit, pl86 (citing various judicial decisions).
304. except in the Northern Territory, where no such body exists.
305. Mental Health Act Implementation Monitoring Committee, op cit, p31.
306. Pargiter, op cit, pi48, citing ss76(4) and 68 of the Mental Health Act.
308. Dr Ian Campbell, Senior Lecturer in Law, University of Western Australia. Oral evidence, Perth 11.2.91, pll9.
309. id.
311. id.
312. Mental Health Act Implementation Monitoring Committee, op cit, p31.
313. id.
314. Rees, op cit, p26; Milton, op cit, p690.

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318. Mental Health Act Implementation Monitoring Committee, op cit, p33.
319. The psychiatrist, Dr Russell Pargiter, resigned after the Attorney General rejected the Tribunal's unanimous recommendation for the release of Rory Jack Thompson, who had been acquitted of murder by reason of insanity. The Tribunal found that the prisoner no longer posed a danger to the public. The Attorney General claimed his decision was not political, but based on certain information in his possession. However, he refused to reveal what this information was. Michael Lester, 'Rory Jack freedom bid halted', Mercury 31 Jan 1991;
Dr Russell Pargiter, Submission.
321. ibid, pi 19.
322. ibid, pl20.
The court found the UK legislation breached Article 5(4) of the European Convention for the Protection of Human Rights and Fundamental Freedoms, which mirrors Article 9(4) of ICCPR. See also the similar case of Thynne, Wilson and Gunnell v United Kingdom, (1991) 13 EHRR 101, ppl35-143.
324. Mental Health Act (UK) 1983, s73.
325. Campbell, op cit (oral evidence), pl24.
326. ibid, pl20.
327. ibid, pl22.
329. R v Home Secretary; Ex parte Herbage [1987] 1 All ER 324.
330. Milton, op cit, p688. The witness said the lawyers' reluctance to use the defence 'is not because they're
ignorant — it's because they're informed.' id.

331. ibid, p691.
332. ibid, p685.
335. e.g. the Victorian Mental Health Act states categorically: Is8(2) A person is not to be considered to be mentally ill by reason only...(l) that the person has an antisocial personality.' Cited by Wells, op cit (submission), p5.
337. See Chapter 18 for evidence on homeless agency workers, faced with residents behaving in a bizarre and threatening manner, being denied assistance from psychiatric hospitals and crisis teams on this basis.

338. Skinner, op cit (submission), pi; Jones, op cit, p427; Mels, op cit, p123.
341. Leach, op cit (oral evidence), p53.
342. Skinner, op cit (information provided to the Inquiry).
343. id.
345. Skinner, op cit (information provided to the Inquiry). Dr Skinner said these patients are often also aggressive, manipulative or irritating, which makes hospitals even more reluctant to take them.
346. Skinner, op cit (submission), pi; Wells, op cit (submission), p5.
347. Skinner, op cit (information provided to the Inquiry).
349. Hopkins, Disability Services of Central Australia. Quoted in Banks, op cit, attachment 1, p6.