

Crime, Punishment and Mental Illness

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I would like to acknowledge the Ngunnawal people of this area as well as the traditional owners of this whole country in which we meet, and their descendents, and pay my respects to the elders.

I would also like to thank the National Judicial College of Australia for inviting me to speak to you today. The matters I am talking about have been of great concern to me since I became aware of them working for Sisters Inside, a community-based organisation providing support and advocacy for women in prison in south-east Queensland both before and after their release. At Sisters Inside, it became clear to me that a great many of the women I worked with were very unwell. Some had at least sporadic mental health treatment prior to their incarceration. Few had any treatment while they were in prison. Almost none had arrangements made for mental health treatment after their release. Those who had, perhaps because their parole or bail conditions stipulated that their release was conditional on mental health assessment and treatment, were frequently turned away by the mental health services we visited. It seemed to me that my society must have taken a seriously wrong turn for these circumstances to prevail.

Prevalence of people with mental illness among prison populations. Dr Paul White and Professor Harvey Whiteford, in the Medical Journal of Australia in 2006 cited research by Butler et al with the following statistics¹:

¹ Prisons: mental health institutions of the 21st century?
Paul White and Harvey Whiteford

Comparative prevalence of psychiatric disorders in prisoners and in people living in the community

Disorder	Prevalence	
	In prisoners	In community
Any psychiatric disorder	80%	31%
Psychosis	7%	0.7%
Affective disorder	23%	9%
Anxiety disorder	38%	11%
Substance abuse disorder	66%	18%
Personality disorder	43%	9%

So a great many people who appear before you will suffer from one or more psychiatric disorders.

Who are these people. Of the ones who end up in prison, on the whole, four out of five will have some psychiatric disorder. Two thirds will have a substance abuse disorder; two in every five will have an anxiety disorder; a quarter will have an affective disorder, a category of mental health problems that includes, but is not limited to, depressive disorders; fewer than one in ten will have a psychosis of some kind; but not much short of half will have a personality disorder. These people are particularly unfortunate since there are few recognized effective medico-pharmaceutical treatments for such disorders, and those that are promising are not the quick fix solutions that our mental health system has grown to depend on, like drug therapies. Talking therapies have shown a degree of

efficacy, but such treatments are complex and resource intensive, and require a great deal of staff training, and therefore reach few of the people who need them.²

If they have been living with mental illness in the community, the chances are that they are poor. There has been a lot of argument about whether mental illness causes poverty or poverty causes mental illness. However those questions might be resolved, there is no doubt that poverty and mental illness coincide frequently. This is something that we have known for fifteen years, since Brian Burdekin released his report in 1993³. Indeed, we should have known it for more than thirty years, since the Commonwealth Commission of Inquiry into Poverty undertaken by Ronald Henderson in 1972–75⁴.

If they are lucky, they might have achieved a reasonable standard of education before their illness adversely impacted on their lives. But because half of all lifetime cases of mental illness begin by age 14, and three quarters have begun by age 24⁵, people's opportunity to successfully undertake vocational education, thus putting a buffer between themselves and life-long poverty, may well be compromised.

What brings them to court. We could be forgiven for thinking that they are the “crazy psycho killers” we read or hear about so frequently through the media. But the truth is a lot less dramatic. They'll appear before you for drug offences, break and enters, mail theft, shoplifting, credit card fraud, social security fraud. They will sometimes be charged with violent offences, but the range of offences so classified is very great. It can include resisting arrest or spitting as well as more intentional assault. They are the “revolving door” respondents. For the most part, the sentences you will impose, when you impose a custodial sentence, will be relatively short, perhaps less than six months.

² Release Date: February 8, 2006

Few Effective Treatments Exist for Borderline Personality Disorder

By Milly Dawson, Contributing Writer

Health Behavior News Service

³ Human Rights and Equal Opportunity Commission 1993, *The Report of the National Inquiry into the Human Rights of People with Mental Illness*, (Brian Burdekin, chairman), AGPS, Canberra.

⁴ Australia. Commission of Inquiry into Poverty, *Poverty in Australia : First Main Report* (Prof R.F. Henderson, Chairperson) (Canberra : AGPS, 1975)

⁵ National Institute of Mental Health
Science News, June 6, 2005

What happens in prison. When you impose this sentence, you might think that the person you have sentenced will receive comprehensive health assessment and treatment to address mental and physical health problems, as well as developmental programs to redress educational and other disadvantage. Not so, unfortunately.

In many jurisdictions, educational or developmental programs are only available for prisoners serving terms of greater than six, or perhaps even twelve, months. And their application tends to be indiscriminating. Literate, numerate prisoners can be required to do literacy and numeracy courses. Prisoners with no history of addiction can be required to do relapse prevention courses. Options for vocational or academic study are frequently rationed. One prison I know, while having a 50% unemployment rate in a population of about 300 prisoners, limits the number of full-time study places to ten. And should a prisoner be fortunate enough to be granted one of those places, they will have to pay all applicable fees themselves, purchase all necessary resources from within the thirteen dollar weekly allowance they receive, and complete their study with very limited computer access, and absolutely no access to the internet nor to the kind of library facilities tertiary, and even secondary, students need and take for granted.

Prison health services are notoriously under funded. People are commonly incarcerated with significant unmet physical and dental health needs, to say nothing of mental health needs. Access to physical health treatment is impacted on by the availability of medical practitioners within the prison, the availability of escorts when prisoners are referred to external health services for diagnostic procedures or treatments, and the capacity of the prison health budget to cover additional costs. Prisoners can wait for nine months and longer to have GP referrals to tertiary health services effected.

In many prisons, dental services are only available for prisoners serving sentences of greater than one or two years. Poor dental health, common amongst people with addiction problems in particular, adversely affects nutrition and is linked with increased rates of

major chronic conditions, including cardiovascular disease, stroke and diabetes. It is not merely, as is often thought, a cosmetic matter.

Even more than in the general community, mental health services in prisons are limited to those with very severe illnesses. While some provident prisoners might go into prison with medical reports, prescriptions and medications from their treating doctors on the outside, the most likely fate for those provisions is that they will be placed with the prisoners' clothes and other impedimenta in their property, to be collected on their release. They may or may not be referred to the prison mental health service. If they are, they may or may not receive a diagnosis that is congruent with the one that they received on the outside. The medications prescribed may or, most likely will not, be the same as those they are already taking. Some significant period of time will definitely elapse before any of these things begin to happen, so at least for that period they will be untreated and unmedicated. If they advise prison medical staff that they have adverse reactions to the medications prescribed in prison, they will almost definitely be told that those medications are what they will take while they are in prison, and if they do not comply with medication they will be disciplined. Mental health policy developers are aware of these deficiencies, but adequate changes to the system are a long time coming.

“Forensic and prison mental health services are target areas for the COAG National Action Plan. However, drafting and funding an action plan is one thing; turning good intentions and money into better services is another, much harder task. To know whether services are improving, we will need public reporting of specific performance indicators, which are currently being developed. In time, the data may be able to tell us whether the historical deficiencies in care for people disadvantaged by both mental illness and involvement in the criminal justice system are at last being addressed.”⁶

⁶ Prisons: mental health institutions of the 21st century?
Paul White and Harvey Whiteford
MJA 2006; 185 (6): 302-303

Such public reporting would depend, of course, on public scrutiny, which is generally not forthcoming, since it is regarded as “not in the best interests of the security and safety of the prison”.

What happens if you don't send them to prison? The short answer is “Exactly what has been happening up to now”. Courts might impose a probationary sentence that includes conditions about receiving treatment for mental health disorders, but mental health services will not necessarily feel bound by the court to provide those services—particularly in the case of personality disorders, which are widely regarded as untreatable, at least by the cheap, quick responses that characterize our resource-starved public mental health services at present. The convicted person will still be poor, tenuously housed, unconnected with the community, with uncertain custody of their children, uneducated, marginally employable, without prospects for improvement, without hope. Without, in short, all the things that keep the rest of us satisfied with our lives and making decisions that keep us out of the criminal justice system.

The role of the criminal justice system. Australia's criminal justice system reflects the broader societal dynamics within which it operates. It tries to find a balance between principles of retribution, rehabilitation and community safety. There is a certain tension between these various principles, and actions which might be dictated by one are often inconsistent with those dictated by the others. Community demands, directed by or reflected in sensationalist press and shock jock radio seem to emphasise punishment, but justify this by saying that this is what will ensure community safety—that people punished sufficiently will not reoffend.

While this might be a popularly held view, it is not supported by research. In fact, studies have shown that increasing the severity of punishments, particularly incarceration, has an

adverse effect on rates of recidivism.⁷ Thus, community safety is not only not enhanced by sentencing people to imprisonment, it is compromised.

Community safety is enhanced by a reduction in crime. People feel safe, and are safe, if they can walk down the street without fear of violence; they can go to their car in the morning confident that it hasn't been stolen overnight; they can come home to a house that hasn't been broken into. A reduction in crime committed by people with mental illness can be facilitated by the availability of and referral to community based services which support people on their journey of recovery.

Recovery: A diagnosis of mental illness has connotations of the ending of a life. It is a widely held view, not only in the community in general, but even within the mental health sector, that mental illness is incurable. People with a psychiatric diagnosis will live with the concomitants of that diagnosis—medication and its side-effects; ongoing treatment, sometimes very harsh treatment; infringement of their civil and political rights; stigmatization. Such expectations inhibit people from acknowledging their mental distress and seeking treatment. So their suffering becomes more profound; their symptoms spiral out of control; their decision making becomes more and more impaired. If, however, the consequence of a diagnosis of mental illness were the prospect of interventions that would enable the person to lead the same kind of life as everyone else, the reason for that reluctance would disappear. Recovery is possible and it happens, and those two facts hold out the prospect of life.

What is it: The notion of recovery from physical illness can mean different things for different people with different diagnoses. Recovering from some acute illnesses can be simply the removal of the causes and consequences of illness, and return to life as it was before. In some cases, recovery can mean removal of the causes of illness, but with some ongoing consequences that need to be adapted to, but nevertheless a fundamental continuance of living without the need for further interventions. Sometimes recovery, for

⁷ Bonta, J. 2002 'The effects of punishment on recidivism', *Research Summary*, Vol. 7 no. 3, Solicitor General Canada, Ottawa, ON, http://www.sgc.gc.ca/publications/corrections/pdf/200205_e.pdf (accessed January, 2008).

instance with chronic illnesses like diabetes, means adapting your life to the realities of your condition, but with the possibility of regaining a satisfying and productive life.

Similarly, recovery from mental illness will inevitably mean different things for different people. For some, it might be ongoing treatment and/or medication that “normalizes” the way they feel. For others, it might be learning to recognize and adapt to the onset of distress. For others yet again, it might be building into their lives strategies that keep them on an even keel. The only person who can recognize and construct the right approach for any individual is that person themselves. They need appropriate support, support that they identify, to do so. But they must be at the centre of the recovery process, not a passive recipient of services determined by others to be what they need.

While every recovery journey is necessarily different, there are nevertheless some underlying requirements for the journey to be possible. At a bare minimum, there needs to be hope, connectedness and self-determination.

Our institutional responses, within both the medico-pharmaceutical and criminal justice systems deny hope, enforce isolation and impose helplessness. Community safety, as well as the best possible outcomes for people with mental illness require that we change the way we deal with mental illness in the community, within the health sector and within the criminal justice system.