

**OUT OF MIND, OUT OF SIGHT: THE SCANDAL OF  
PUBLIC POLICY**

address to the

**QUEENSLAND ALLIANCE FORUM**

by

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

So wrote Fyodor Dostoyevsky in 1861 and it is little wonder that his book was entitled *The House of the Dead*.

I welcome this opportunity to talk to this meeting organized by Queensland Alliance and to share a platform with Deb Kilroy whose work on behalf of *Sisters Inside* I admire greatly. Thank you all for being here and indicating by that your interest and concern about one of the great scandals of our current social policy environment – the unacceptable levels of people with mental health problems being thrown into prison as a primary tool of the management of their condition.

None of you, especially in this State, need me to remind you of the sage of Cornelia Rau. In his report on the matter (*Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau*, July 2005) Commissioner Palmer made many damning observations

about the inadequacy of mental health services at both the State and Commonwealth levels, in both the health and the immigration systems.

However at least in Ms Rau's case there is a possibility of redress for her and reform of the systems. Others are not so fortunate :

- in July 2005, Scott Ashley Simpson hanged himself in Long Bay jail in Sydney. He was suffering from acute schizophrenia but had been denied hospital treatment for three years despite psychiatrist's recommendations. He had been arrested in March 2001 after assaulting a friend during a psychotic episode. Despite his long history of violent behaviour he was placed in a cell with a juvenile prisoner who had requested protective custody. Within fifteen minutes Simpson had kicked to death this poor unfortunate and was charged with murder. After that he was held in circumstances making his condition worse and almost inevitably his suicide followed. Two people died for want of proper treatment of his psychiatric condition.
- also in July 2005 Jeffrey John Hillsley was jailed for thirty years for murder and sexual assault. He was a serial pedophile who, while in jail for other offences, had begged for treatment and care, but received none and was thrown back out into the community without supervision or care – only to commit the crimes which he had warned he would, again with the loss of innocent life.

These are not isolated cases, only the most recent.

In the last decade the number of prisoners has increased by well over 52% (the female rate has increased 110%) and the rate of incarceration by about one-third (while our adult population has grown by just 15%). There are now some 24,000 people in prison across Australia, a rate which varies from 98 per 100,000 adults in Victoria to a rate of 513 per 100,000 in the Northern Territory. [refer *Australian Bureau of Statistics Prisoners in Australia 2003*]

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

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

Building prisons is a growth industry. Prior to the last Victorian elections the Labor Government committed over \$400 million to overhaul the prison system with two new jails to be built. In New South Wales the Labor Government has committed \$115 million for a new prison in the Central West with upgrades at Kempsey and Parklea. Queensland announced plans to spend \$97 million on a prison at Maryborough to add to the new or revamped facilities at Capricornia Corrections Centre (\$89 million) and Woodford (\$68 million). The first prison is to be built in the ACT whose prisoners are currently accommodated in the NSW system. Regional and rural communities compete actively with each other to be the site of new prison developments.

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

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

One interesting feature of much longer or mandatory life sentences which has never really been discussed in Australia is the impact this has on health services and the need which will develop for prison based geriatric services to be provided - at enormous public cost. In 1987, prisoners aged over 50 comprised 4.1% of the prison population, this rose to 8.9% by 2003. Since 1987 the number of prisoners aged 65 and over has risen from 50 to 266 in 2003. An associated problem with the aging of the (prison) population relates to the onset of dementia and neurological conditions such as Alzheimer's and Parkinson's diseases which have significant implications for mental health service provision.[refer John Dawes "Managing and Ageing Prison Population" in Sean O'Toole and Simon Eyland (eds) : *Corrections Criminology*, Hawkins Press, Sydney 2005.]

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

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

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

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

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

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

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

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

Although the precise figures given above are drawn from New South Wales, other jurisdictions exhibit similar profiles and trends. For example, the current issue of the *Australian and New Zealand Journal of Public Health* notes that more than half (51.4%) of the women prisoners surveyed in Queensland's prisons self-reported a previous diagnosis of a mental illness. [Young, M. et al : "Opportunities for Health Promotion in the Queensland women's prison system", *ANZ J Pub Health* v.29(4) Aug. 2005]

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

- a 2003 report by New South Wales Corrections Health recommended that all mentally ill offenders be transferred from jail to secure mental health hospitals because the current corrections system lacked the resources and expertise required;
- a 2001 report by a New South Wales select committee on increases in the prisoner population recommended that greater resources be invested in psychiatric consultation and assessment interventions to divert mentally ill offenders from incarceration; [refer NSW Legislative Council : *Select Committee on the Increase in Prisoner Population, Final Report* November 2001]
- a 1996 report of the New South Wales Law Reform Commission was critical of the failure of court and prisons administrations to co-operate effectively in the management of prisoners with intellectual disabilities.

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

*“The weight of evidence presented to the Committee highlights that mental health services in New South Wales need revolutionary improvement. Deinstitutionalisation, without adequate community care, has resulted in a new form of institutionalization: homelessness and imprisonment.”*

[refer NSW Legislative Council : *Inquiry into Mental Health services in New South Wales, Final Report*, December 2002]

All paradigms of health are socially constructed, none more so than those related to mental illness.

Some researchers have asserted that illnesses such as schizophrenia or bi-polar disorder (together with depression, our most common forms of mental illness) are a product of “industrialisation”, and that they were never found in pre-industrial western societies. This social construction of illness means that very often responses to illness are also socially constructed and subject to changes in fashion and community values. Again, this is particularly the case with mental health.

In New South Wales, a major government enquiry (the Richmond Report) in 1982 looked into the provision of services for the mentally ill and developmentally disabled. The principal thrust of the Richmond Report was to advocate a decrease in the size and number of mental hospitals; an expansion of community based networks to help maintain “clients” in the community and to change various bureaucratic and funding arrangements to support such services. The Richmond recommendations were enthusiastically adopted by government which saw in them a chance to decrease real levels of public expenditure (on costly mental hospitals), to transfer expenditure from the public to the private sector (under the guise of “community” care) and to appear more “caring” in a person sense about psychiatric patients.

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

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

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

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

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

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

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

A final point I make about prisons in NSW is that this is the only mainland jurisdiction and one of the very few in the world which still incarcerates forensic patients – people found not guilty by reason of mental illness – in clear breach of its own legislation (the NSW *Mental Health Act* which requires the mentally ill to be treated with “*the best possible care and treatment in the least restrictive environment*”), the National Medical Health Forensic Policy, the United Nations Declaration of Human Rights and the United Nations Principles for the Protection of Persons with Mental Illness (1991). The number of Forensic Patients (previously referred to as Governor’s Pleasure Inmates) in New South Wales has increased from 21 in 1982 (0.7% prison population) to 100 in 2003 (1.1%).

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

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

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

However unnecessarily confining people with mental illness in prisons is utterly self-defeating. In those institutions these people – especially those with developmental or intellectual problems – will be the bottom of the prison heap.

They will most likely to be subject to acts of physical violence as are up to 13% of all prisoners; they will be particularly vulnerable to sexual assault – the fate of up to one-

quarter of young men in prison; and they will be drawn into networks of drug smuggling and substance abuse, being least able to protect themselves or understand the consequences of their actions.

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

In fairness I should mention that while in prison, many of these same people will probably be better fed and housed and have better access to health services than at almost any other time in their lives – itself a shocking indictment of our general level of services for the mentally ill in the community.

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

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

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

Many jurisdictions are now experimenting with a variety of interventions.

They are seeking to improve the methods of identification of people with mental illness as they first come into contact with the criminal justice system through the courts.

Attempts are being made through the introduction of specific Drug Courts to divert people with drug-related problems from the threat of immediate incarceration. Attempts are being made to achieve more effective integration of community services with correctional policies.

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

Mental health problems can be compounded by sentencing practices. Longer sentences inevitably mean a greater habituation to prison environments and a diminished capacity to reintegrate into the external community, especially for those already facing problems of social competence. In this sense longer sentences contribute to the problem of recidivism - thus the endless cycle starts!

Perhaps most importantly there is an increasing trend internationally, although still resisted in most Australian jurisdictions, to separate the prisoner health service from the control of the correctional authorities. [see Emanuele Pontali : “Antiretroviral Treatment in Correctional Facilities”, *HIV Clinical Trials* 2005; 6(1) 25-27.] This bureaucratic arrangement makes a difference. When prisoner health services are delivered by health professionals rather than by correctional officers, the entire focus changes. The service becomes patient-oriented, positive and proactive rather than system-oriented, reactive and punitive.

One area of encouragement is that there is an increasing body of research work being devoted to examination of the complex interactions between issues of health and corrections, spearheaded by the Centre for Health Research in Criminal Justice whose biennial research symposia showcase both relevant research and best practice examples. What is disappointing however is how utterly disinterested the regular meetings of Commonwealth and State Ministers responsible for corrections policy appear to be in

considering best practice or looking at innovative solutions to problems which we all know will get no better, and indeed must inevitably get worse, if we just keep on doing all the things that have been so manifestly failed to date.

I recognise that there are major economic issues involved in proposing significant transfers from the prisons system to the health system. It costs between \$50,000 and \$60,000 a year to maintain a prisoner in jail, but up to \$200,000 per year to maintain a mental health bed in the N.S.W. public hospital system. So, “treating” a mentally ill person by incarceration rather than by hospitalization is three or four times cheaper to the State budget. Even in its current unsatisfactory state, the provision of prison health services is not inexpensive – the cost of these services in NSW correctional services in 2003/4 was in the order of \$ 64 million.

Now is neither the time nor the place to go into the question of to what extent our archaic, punitive and generally failed drug laws have contributed to this problem. The increase in drug use, or changes in drug use patterns (eg the advent of hydroponically grown marihuana; the rise in “party drug” use) have not only sent more people into prison as a result of their related (caused ?) criminal behaviour but is equally manifest in the shocking levels of violence against medical staff in hospital emergency departments which we are seeing.

The Emergency Department at St Vincent’s hospital in Sydney in January 2003 made 115 psychiatric referrals per month. It is now 414, most following violent episodes or assaults on staff. Security officers have to be called to 3 in every 100 emergency admissions at the Royal Melbourne Hospital where in the last year, half of the 151 patients who were vital had major mental illnesses.

There is an urgent need to focus upon the extent to which co-morbidity of drug use (especially with marihuana) with mental illness is a subject which should be studied in more depth to obtain a better understanding of the extent to which one precedes the other.

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

Incarceration itself, despite potentially giving some people better access to health care, (including psychiatric care) can only do longer and lasting harm to people with mental illness as the very nature of prison life is antithetical to anything resembling optimum health care.

Conditions of overcrowding, lack of privacy, violence and exploitation are the common fare in many of our correctional facilities. People with mental illness (and especially those with problems arising from developmental delays) are exploited in the prisons and often taken advantage of in relation to such matters as the concealment or transportation of drugs or contraband. Such people are usually least able to stand up for themselves either in relation to other prisoners or indeed to the custodial authorities.

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

The extent to which the scales of justice are tipped against people with mental illness has of course be highlighted by the Cornelia Rau case and more latterly the case of Vivian Solon/Alvarez/Young.

A similar comment could be made arising from the recent judgment of Mr Justice Finn in the Federal Court in relation to the federal government's scandalous neglect of certain Iranian asylum seekers in its care and control at the Baxter Detention Centre. When major federal Departments treat people with mental illness so badly it is hardly remarkable that prisons and other prisoners do so on such a regular basis.

[I very much regret that time today does not permit me to say anything about the additional and exceptional problems faced by Indigenous Australians and those of culturally and linguistically different (CALD) backgrounds – especially those who have been through the trauma of removal, refugee status and displacement – in relation to their special mental health problems and needs. They are, as distinct populations, not only grossly over-represented in the prison population, but in the general community. When these two aspects of over-representation are combined, problems expand exponentially. To the best of my knowledge there are but limited programmes which cater for these populations, while even specific academic Chairs in matters such as trans-cultural mental health hardly appear to exist at all. Unfortunately this must be a subject for another day – indeed I hope, for many other days.]

From my analysis, there are a series of policy recommendations which I think need to be considered:

- (a) there is a need to obtain better data, and to that extent, either the States should be persuaded, or some body such as the Australian Institute of Health and Welfare should be funded, to conduct regular audits of prisoner health (including mental health) and publish that material;
- (b) consideration should be given to a more detailed investigation of issues of co-morbidity between mental health and drug use/abuse focused specifically upon the impact of the nation's drug laws in relation to the extent to which people with mental illness and treated when they come into contact with the criminal justice system as a result of their drug use/abuse;
- (c) States where this is not the case should consider the question of the extent to which health services to prisoners (for which all governments have a clear legal duty of care) should be administered by Health Departments rather than Corrections Departments and should perhaps offer to fund a study which might explore further some of these issues;

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

I started with Dostoyevsky in 1861, so let me conclude with Winston Churchill, who, as a reforming Home Secretary spoke to the House of Commons in 1922 :

*"The mood and temper of the public with regard to the treatment of crime and criminals is one of the most unfailing tests of the civilisation of any country. A calm, dispassionate recognition of the rights of the accused, and even of the convicted, criminal against the State - a constant heart searching by all charged with the duty of punishment - a desire and eagerness to rehabilitate in the world of industry those who have paid their due in the hard coinage of punishment; tireless efforts towards the discovery of curative and regenerative processes; unfailing faith that there is a treasure, if you can only find it, in the heart of every man. These are the symbols, which, in the treatment of crime and the criminal, mark and measure the stored-up strength of a nation."*

Thank you.