

JusTas submission April 2019



Promoting justice, best practice and
valuable outcomes for returning citizens
and the community

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Mental Health Inquiry
Productivity Commission
GPO Box 1428,
Canberra City,
ACT 2601

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REF: Inquiry into the economic impacts of mental ill-health

JusTas is an organisation which is concerned with less than favourable outcomes for people re-entering the community following periods of incarceration, as well as issues faced by people who are caught up in the criminal justice system more generally.

The following submission is limited to the identified issues pertaining to justice and mental illness. It is warranted due to the high prevalence of mental illness within the prison population and more broadly among those people in contact with the justice system in the community. Our submission is informed by discussions held at our monthly forums, the experience of people with lived experience and local, national and international literature.

JusTas has been communicating with the Mental Health Council of Tasmania (MHCT) and both have agreed to submit within areas of their respective expertise. It is a fine example of collaboration by organisations sharing similar visions for a system which could do much better to cater to the needs and aspirations of people with mental illness. In their words; *to ensure that Commissioners receive a broad, cross-sectoral response from Tasmania.*

All societies who experienced deinstitutionalisation toward the end of the last century have grappled with the challenges of supporting people who would formerly have been excluded from society by being housed in mental asylums. Some of those challenges will be highlighted, probably the most salient being; how do we propose to deal with the increasing prison population which is being driven to a large extent by the comorbidities of mental

health and addictions? This is a significant problem, not only among prisoners, but extends beyond the prison gate on release.

The daily cost of incarceration in Tasmania is among the highest in the country and this state is not immune to the rapidly rising national prison population. From an economic perspective, given recidivism rates and rising costs across the entire justice system, perhaps it is time to look at the drivers rather than wait for the inevitable deterioration of the condition of some people where their behaviour brings them into contact with the justice system.

The 'Rethink Mental Health - Better Mental Health and Wellbeing – A Long-Term Plan for Mental Health in Tasmania 2015-25' pays scant attention to the issue making passing reference to Forensic Mental Health Services and the forensic mental health facility.

A government initiative, the intent of which, is to break the cycle of offending, is; 'Breaking the Cycle - A Safer Community; Strategies for Improving Throughcare for Offenders. This is visionary long-term strategy, initiated by a Labor Government, continued by the following Labor Green Government and has been adopted by the Liberal Government.

Unfortunately, there is little to be found within this document which places a strong emphasis on mental health interventions, considering the high prevalence of mental illness within the prison population.

This apparent lack of attention to the needs people with mental illness in the prison system is highlighted in the Custodial Inspector's, which will be commented on later.

Our experience, having facilitated monthly discussions, holding a symposium in 2016, a public forum in 2017, co-hosting the Reintegration Puzzle Conference in 2018, stakeholder meetings and most importantly, consultation with people with lived experience; indicates to us that there are many passionate and committed individuals and organisations working to improve the circumstances of those we refer to as 'returning citizens' and especially those people who have the added pressure of mental illness as they complete their custodial sentence and return to community life.

It is timely therefore, that the momentum to destigmatise mental health in the community, improve access to service users and promote person centered responses, be extended to our prison population and those caught up in the criminal justice system.

For prisoners, incarceration is their punishment but ultimately their successful rehabilitation is which counts in the context of community safety. So, at the end of the day, nearly all prisoners will return as our neighbours. Our society should afford them every prospect of a successful reintegration and ensure appropriate measures are in place to manage the risks around reoffending– not only for their sake but for the sake of the community.

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Australian Government Productivity Commission - Enquiry into the economic impacts of mental health - 2019

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Introduction

JusTas was founded in 2014 by a number of people concerned with a rising Tasmanian prison population, driven in part by people not being able to secure parole to serve the remainder of their sentence under supervision in the community - as they had nowhere to live.

Since then, we have broadened our remit to include all barriers to successful reintegration for people following periods of incarceration as well as promoting a range of responses to crime in line with our vision which is to see:

A safe Tasmanian community, preventing and repairing harm, and delivering justice

We hold monthly forums where stakeholders are able to present, discuss, debate or simply listen. We have a strong belief that the solutions to reintegration (and many justice issues) will be learned through listening to those with lived experience.

We see our role within the Tasmanian Criminal Justice System as:

- Highlighting deficits within the current structural, cultural and legal framework that limit the achievement of our vision
- Providing alternatives by activating research, education, advocacy & constructive narratives, and
- Influencing policy, governance & management reform

In pursuing these roles, JusTas adopts a collaborative approach using a Collective Impact philosophy, recognising the good will and intent of all stakeholders. We take a preventative, rather than reactive stance, adopting a systemic approach to achieving safety and justice, which relies on evidence-based responses to crime, punishment, and prisoner reintegration.

The mental health issues

JusTas recognizes that one of the principal ways of reducing demand on our corrections system (in particular our prisons) is to advocate for and support appropriate community mental health interventions which ensure that those individuals who might come to the attention of police and end up in the criminal justice system are diverted and supported.

There is no argument that prisons have become the de facto mental health institutions following deinstitutionalisation in the 1970's and 80s.

According to the Australian Institute of Health and Welfare 'Almost half of prison entrants (49%) reported being affected by a mental health issue'¹. This places enormous pressure on the prison correctional primary health services and according to many commentators, including the current director of clinical services, there is a significant lack of psychiatric inpatient services within Tasmania Prison Services, with the shortfall being picked up by practitioners, often not suitably qualified to deliver services.

In short, this scenario not only risks - and in practical terms leads to - a dilution of the effectiveness of prison rehabilitative programs and places undue pressure on prison management to 'provide a safe, secure and constructive environment to address their offending behaviour, leading to rehabilitation, personal development and safer communities'²

Given the exponential rise in the prison population since 2014, there is every reason to expect that prisons will continue to house an increasing number of people with mental illness. It is vital that health services are increased to accommodate the needs of prisoners. The recent Custodial Inspector's Report states:

Over the course of this inspection, it became obvious that, while prisoner numbers have increased and extra beds have been installed, corresponding health infrastructure and services have not been increased proportionally. The increase in prisoner numbers places increased pressure on the health system, leading to longer waiting times and, in some cases, results in the health needs of prisoners not being met. This situation was strongly reflected in feedback from prisoners, who identified a lack of health care as a significant issue at all custodial centres.³

Community responses and the move to person centred practice.

Primary Health Networks, in this case Primary Health Tasmania has indicated in its commissioning process:

¹ Australian Government: Australian Institute of Health and Welfare (2015). *The health of Australia's prisoners 2015*. Cat. no. PHE 207. Retrieved from Australian Institute of Health and Welfare website <https://www.aihw.gov.au/getmedia/ffe940d2-36b1-4df7-a7a2-4ea3409ac05c/18878-report-profile.pdf.aspx>

² Tasmanian Government (2019). *Tasmania Prison Service*. Retrieved from <https://www.justice.tas.gov.au/prisonservice>

³ Tasmanian Custodial Inspector (2017). *Inspection of adult custodial services in Tasmania: Care and wellbeing inspection report*. Retrieved from www.custodialinspector.tas.gov.au

The overarching objectives, evidence from the literature review, service mapping and stakeholder engagement have informed the outcomes that services for adults with severe and complex mental illness must deliver.

These outcomes are:

- improved coordination of care and services between health and other sectors
- an appropriate range of services to meet patients' needs (including comorbidities) within a stepped care model
- reduced hospital bed-days for adults with complex and severe mental health conditions
- improved equity of access to appropriate intensity services for adults with complex and severe mental illness
- reduced symptoms and improved quality of life for adults with complex and severe mental illness. Interventions will be evidence-based and provided by a suitably skilled and qualified mental health nurse workforce⁴.

All of the above, if fully implemented, would be most welcome as they well define responses, albeit reactive, to the structural deficits in the system. The inclusion of the words 'quality of life' in the last, encourages us to examine practice models which infer something in addition to a clinical or systematic response. Perhaps what it alludes to, is a 'patient or person-centred' approach.

Luxford et al, 2010⁵ describe this as follows:

Patient-centred care is: 'is an innovative approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. Patient- and family-centred care applies to patients of all ages, and it may be practiced in any health care setting.

One such example is in Trieste, Italy which 'hosts a program of community mental health services called the "Trieste model," which has been recognized by the World Health Organization (WHO) as one of the most progressive in the world (World Health Organization 2001). It is one which has not escaped the interest of Australians.

⁴ Primary Health Tasmania (2017). *Mental health services for adults with complex and severe mental illness: Commissioning Intentions Document*. Retrieved <https://www.primaryhealthtas.com.au/wp-content/uploads/2018/07/Adult-Severe-and-Complex-Mental-Illness-Commissioning-Intentions.pdf> accessed 26th March 2019.

⁵ Luxford, K., Piper, D., Dunbar, N., Poole, N. (2010). *Patient-Centred Care: Improving quality and safety by focusing care on patients and consumers*. Discussion paper Draft for public consultation. Retrieved from <https://www.safetyandquality.gov.au/wp-content/uploads/2012/01/PCCC-DiscussPaper.pdf>

Twelve years ago, the then leader of the Australian Democrats Lyn Alison, presented a report to the Australian Parliament.⁶ The report described in detail how Trieste, a province in Italy, anticipated the challenges of deinstitutionalisation and developed strategies to manage the transition. The report highlighted the work of Dr. Franco Basaglia and those who followed him in their efforts to create a new paradigm described by the World Health Organisation (WHO) as follows:

.. the “Trieste model” of public psychiatry is one of the most progressive in the world. It was in Trieste, Italy, in the 1970s that the radical psychiatrist, Franco Basaglia, implemented his vision of anti-institutional, democratic psychiatry. The Trieste model put the suffering person—not his or her disorders—at the centre of the health care system.⁷

Remarkably, the gains *have not* come at a cost, in fact Trieste spends far less these days. The savings were accomplished in a relatively short space of time as indicated below:

The results prove that the new psychiatric assistance methods have also reduced spending in the sector. Furthermore, at the end of 1971 the budget for the management of the Psychiatric Hospital amounted to approximately 55 million euros; in 2010 instead, the management of all local services cost about 18 million euros. Staff decreased from 524 in 1971 to 225 in 2010. The 1,182 hospital beds in 1971 became 140 beds distributed throughout the entire area. The proportion of persons involved in these services each year is close to 20 per thousand people(P:3).⁸

The Trieste model is one, if not the leading, example of how the costs of criminal justice processing and sanctions, far outweigh the costs of community intervention under their model. The obvious cost benefits of such an approach demand that policymakers consider it and other innovative approaches when they weigh up the establishment and long-term costs involved in building more prisons.

8.1. What mental health supports earlier in life are most effective in reducing contact with the justice system?

Individuals suffering from mental health disorders and cognitive impairment are significantly overrepresented in the criminal justice system, in court and juvenile and adult custody. New South Wales statistics show that individuals with mental health disorders are 3 to 9 times

⁶ Allison 2006, Senate Select Committee on Mental Health, Mental Health Services Report.
http://www.triestesalutementale.it/english/doc/report-trieste_2006_allison.pdf

⁷ Portacolone, F., Segal, S., Mezzina, R., Scheper-Hughes, N., Okin, R. 2015, A Tale of Two Cities: The Exploration of the Trieste Public Psychiatry Model in San Francisco
https://www.researchgate.net/publication/277078425_A_Tale_of_Two_Cities_The_Exploration_of_the_Trieste_Public_Psychiatry_Model_in_San_Francisco

⁸ dell’Acqua, P. Presentation in Innovation for Development and South-South Cooperation, Italy
<http://www.triestesalutementale.it/english/doc/BrochureTriesteENG.pdf>

more likely to be imprisoned than the general NSW population.⁹ These numbers are alarming. For example, 22% of the general population, 45% of court defendants and 77% of the prison population suffering from mental health conditions.⁹

Similarly, youth suffering from mental health disorders and cognitive impairment are at least 6 times more likely to be imprisoned than the general youth population, not suffering from mental health difficulties, in NSW.⁹ Currently, the proportion of youth (aged 18-24) receiving primary mental health care is 12.7%.¹⁰ This proportion increases with the increase of a young person's age.¹⁰ However, these supports should be more significantly in place from early life, even earlier than 18 years of age

For youth, the introduction of mental health discussion to educational and social spheres can contribute to positive relationships with mental health, constant dialogue about mental health and illness and thus, possible reduction of contact with the criminal justice system in youth and later in life. It is known that the majority of individuals that have contact with the justice system suffer from some sort of mental illness. This idea works both ways: mental illness may cause individuals to commit crime, and contact with the criminal justice system may worsen pre-existing, or even non-existing mental health conditions.

If a conversation exists from very early in life, the idea of mental health and illness and youth's access of these services continuing throughout life, will increase dramatically. If individuals grow up surrounded by a multitude of mental health supports as well as the knowledge about where and how to access them, individuals will be more likely to access such resources when they perceive that they are in a particularly difficult situation. This will result in fewer youth entering the justice system as they have tackled head-on one of the major problems associated with their offending behaviour. In regard to the social, mental health services will be more effective and will be accessed more readily by youth if they are created in a dialogue between adults and youth. It is unhelpful to simply have the mental health services available, yet not educate youth about them and have them be easily accessible to youth, on their own terms.

With regard to the educational context, it has been demonstrated that a positive schooling climate, featuring student engagement is associated with lower reports of mental health stigma.¹⁰ Supporting these findings is research in Canada on the effectiveness of models of

⁹ McCausland, R., Baldry, E., Johnson, S. & Cohen, A. (2013). *People with mental health disorders and cognitive impairment in the criminal justice system: Cost-benefit analysis of early support and diversion*. University of New South Wales & Price Water House Coopers. Retrieved from <https://www.humanrights.gov.au/sites/default/files/document/publication/Cost%20benefit%20analysis.pdf>

¹⁰ Townsend, L., Musci, R., Stuart, E., Ruble, A., Beaudry, M. B., Schweizer, B., Owen, M., Goode, C., Johnson, S. L., Bradshaw, C., Wilcox, H. & Swartz, K. (2017). The association of school climate, depression literacy and mental health stigma among high school students. *Journal of School Health*, 87(8). doi: 10.1111/josh.12527

anti-stigma mental health education within high-schools.¹¹ Such programs will work to break down the negative-associations that are attributed to poor mental health or mental illness. This is the first step toward reducing youth contact with the justice system. It was found that there exist key program elements for the reduction of stigma around mental illness in youth: Connection, engagement and empowerment.

Connection involves the interaction of high school students with individuals who have lived experience of mental illness in the past and are willing to share their personal recovery and success story. Here, the speaker promotes empathy; causing students to see these individuals as human, not as their prior mental illness. Engagement involves the speaker actively disproving mental health misconceptions, myths and stereotypes about mentally ill people being unkempt, dangerous, disruptive and intellectually limited. They discuss facts, providing students with accurate information and discuss and educate them about the mental health resources available.

Empowerment involves the speaker providing students with the education and resources for them to take on a leadership role to actively change the view of mental illness in the school setting, which may ripple out to the community. Students are empowered to design and implement anti-stigma activities in their schools.¹¹ Such empowerment of students has positive implications for the reduction of mental health stigma in the community. The benefits are twofold: Students involved in this type of anti-stigma model may grow up possessing more acceptance of mental illness and anti-stigma programs and activism by students may be recognized by the community, that then benefits from the mental illness education these students can provide.

The study found that breaking down the misconceptions, including myths and stereotypes about people with mental illness enhanced student disclosure, encouraged help-seeking and ultimately increased social acceptance.¹¹ Interestingly, as highlighted in the authors previous study, programs delivering purely mental health education (information about the signs, symptoms and diagnoses of mental illnesses) that lacked a continuing vein of recovery and empowerment, had little effect on the reduction of stigma.¹¹

These key factors have been supported. Psychoeducational programs for families, care givers and even the general population are key to preventing social drift for those with mental illness and enhancing the social capital of individuals and communities.¹² (i.e. a reduction in

¹¹ Chen, S., Koller, M., Krupa, T. & Stuart, H. (2016). Contact in the classroom: Developing a program model for youth mental health contact-based anti-stigma education. *Community Mental Health Journal*, 52, pp. 281-293. doi: 10.1007/s10597-015-9944-7

¹² Mezzina, R. (2014). Community mental health care in Trieste and beyond: An "open door-no restraint system of care for recovery and citizenship". *The Journal of Nervous and Mental Disease*, 202(6), pp. 440-445. doi: 10.1097/NMD.0000000000000142

mental health stigma and better outcomes for those with mental illness).

JusTas recognizes that the determinants of risk for both adults, and especially youth (considering their developing mental state, hormonal development, vulnerability and possibility to be influenced) regarding contact with the justice system, encompass the following: negative family relationships, lacking employment, poverty and productivity, homelessness, substance abuse and addiction, limited health and wellness, poor education, limited or anti-social social networks, immoral and harmful values and norms and criminal behaviours

The HOPE mental health model encompasses all aspects of the barriers that youth face in accessing mental health resources.¹³ The break-down of such barriers will result in more effective delivery of and increased access by youth of mental health services, ultimately working to reduce youth contact with the justice system. The success of HOPE has been experienced for over 15 years in the U.S. and may be beneficial to an Australian context. The model recognizes both structural and social factors that prevent youth from seeking mental health services within the community. Structural factors involve system barriers, such as lack of culturally competent, linguistically-appropriate services and social factors consist of personal reasons, such as lack of trust in mental health service providers, fear of stigmatization, preference to rely on self, family or friends to solve problems and low mental health literacy.¹³

The HOPE model collaborates youth and adults in youth-adult partnerships and creates programs and initiatives drawing from combined knowledge and experience.¹³ By allowing youth to have a say and contribute to the mental health programs and promotion that they access, they will feel more involved, empowered and heard, as well as the programs being more appropriate and effective. This is as opposed to accessing services that are designed only by adults, who may not understand entirely the challenges that youth face. The end goal of HOPE is to improve general mental health programming for youth and increase youth service utilization.¹³

HOPE acknowledges that being a younger person makes access and engagement with services more difficult and service seeking less likely. This is even more true for youth who are male, of an ethnic minority, of low socio-economic status, homeless, LGBTIQ or involved within the justice system. The HOPE coalition's goal is to reduce youth violence and substance abuse and to promote positive mental health and youth voice through youth-adult partnership. Its intention is also to strengthen the organisations that youth access and

¹³ Ross, L. & Connors, L. C. (2018). Improving youth access to mental health support through a youth-adult partnership. *Journal of Youth Development*, 13(3), pp. 24-42.

address community issues.

HOPE currently operates in four youth development organisations in the U.S. serving youth of all demographics, including low-income, ethnic minorities, children in foster care, suffering housing instability, homeless or gang involved.¹³

The model consists of trained mental health counsellors, youth workers and peer leaders being placed within community-based youth organisations such as recreation centres, club houses or groups run at a town hall, something similar to Youth ARC in Hobart. Youth workers are of post-high school age and reflect the general demographics of the youth. HOPE staff build relationships with youth and the host organisation's staff. They do this by engaging in activities run by the group to be 'on the ground' and seem more approachable and involved, rather than distanced in an office.¹³

The model was based in-part on the young peer leader's beliefs that youth would be more likely to use mental health services if these services were more accessible. For example, if located where youth wanted to go or already did frequent, rather than where they were mandated to go. Peer leaders also felt that mental health staff should not only possess educational qualifications and professional experience, but also have 'street knowledge' to ensure that youth were able to relate to them. Another element was the belief that mental health services should be delivered by professional staff less formally than they would usually be. For example, during activities such as going for a walk or playing pool.¹³

Peer leaders believed that youth would engage best if the mental health staff were regularly in contact with them and became somebody that youth began to know and trust, rather than a foreign service provider. This person should also become somebody that youth could speak to and engage with, regardless of whether they were experiencing problems at that time; somebody whom they would want to keep in contact with. In peer leader's eyes, an important element of this relationship was also be the ability for youth to drop-in to see the mental health counsellor whenever required, rather than wait for scheduled appointments or be placed on waiting lists.

Essentially, these community youth-hubs now have HOPE mental health clinics that run from within them, being both geographically close to and comfortable for the youth accessing them. Youth workers and peer leaders, as well as mental health counsellors maintain a positive and engaging presence along with openly speaking about mental health issues, engage youth that it is okay to speak about these issues and seek help (stigma-reduction) and empower youth to advocate for mental health in the same way. HOPE mental health clinics would provide children with a positive, safe and entertaining space of refuge, where they would learn with time spent, that everybody experiences mental health issues from time to time, learn to breakdown personal mental health stigma and become more likely to access

these services if required.

8.2. To what extent does inadequate identification of mental health and individual needs in different parts of the justice system increase the likelihood, and extent, of peoples' future interactions with that system?

Mental health supports may exist and be put in place. However, if the mental health problems or illnesses of offenders are not adequately identified at beginning of their entry to custody or to prison, such mental health problems will go unaddressed and untreated and individuals will fall through the gaps in regard to receiving effective and appropriate mental health care. Lack of treatment of mental illnesses upon initial contact with the criminal justice system will result in re-offending with possible worsening of such mental illness and thus, increased severity of the crimes being committed.

Psychological examinations do occur within remand and upon entry to prison. However, thought needs to be given to the continued re-evaluation and checks that are performed after these people have been initially checked. If there exists no validation of an offender's particular mental health problems at particular times, how is appropriate and continuous treatment and support endeavoured to be provided?

Within community corrections, remand, prison and whilst on parole, regular and continuous psychological evaluations need to be conducted. This is to ensure that evaluations are always up-to-date, treatments are appropriate at particular times in an offender's life and that treatment and support is effective in reducing a particular individual's propensity for recidivism long-term.

These factors show how important constant, regular and mandatory mental health support and treatment would be for every single individual entering the criminal justice system, no matter how they present in terms of illness and no matter the severity of their crime. Again, NSW statistics show that young people with mental illness are 6 times more likely and adults are 3 to 9 times more likely to be in prison as compared with those without mental illness.¹ Supporting the idea of mandatory mental health support is research out of the University of New South Wales that states that the reason for such alarming statistics is the 'difficulty of assessing remand and short-term prisoners for these conditions, as well as a lack of routine identification of people for specialist assessments.'¹ This difficulty needs to be broken-down and analysed in order to attend to these offender's particular personal needs regarding mental health intervention.

8.3. Where are the gaps in mental health services for people in the justice system including while incarcerated?

Doubly-deviant are those who are or have been imprisoned and also suffer with mental illness. This means that a prisoner's offending behaviour may be targeted in order to achieve

rehabilitation and subsequently re-integration into society. However, this does not mean that the mental illness contributing to one's offending - which is often the case with crimes being interwoven with stress, drugs and mental illness – is always appropriately treated and managed.

There exist gaps within the criminal justice system in regard to mental health services within prison. These gaps, as well as the inherently anxiety-laden environment of a prison, lead to the mental health of prisoners being well below that of non-incarcerated citizens.¹ The identifiable gaps include slow, reduced and non-consistent availability of mental health services within prison, the lack of long-term, personalized mental health programs for prisoners and the lack of NDIS intervention within the prison.

Slow, reduced and non-consistent availability of services in prison

On the ground, within Tasmania's major Southern prison, it is known that there are long waiting times to see doctors, psychologists and psychiatrists and such staff are not always assigned to inmates that require such services.¹⁴ This is due inherently to both a lack of funding for these therapeutic staff, as well as correctional officers, resulting in reduced staff numbers. Lacking staffing levels means an inability to attend to a multitude of requests for services, in a timely manner or maintain intervention where required. The achievement of ample therapeutic staff in relation to inmate numbers is first essential to bridge the gap between mental health services and inmates within prison.

On the ground, inmates would benefit from not having to fill out request forms to see such practitioners for hour-long sessions weekly, but from immediate access to these therapeutic staff both in crisis and non-crisis situations. This would work to bolster their mental health as they would have constant intervention and support upon which they could rely, promoting prevention of their mental illness worsening. This is opposed to intervention only when their mental ill health reaches a crisis level. It is known that mental health will contribute to successful reintegration and long-term reductions in recidivism.

On the same vein, it was found that even though prisons have increased the number of beds according to higher numbers of inmates, health services and staff have not been proportionally increased. This has resulted in increased pressure on the health system, longer wait times for inmates and in some cases, inmate health needs not being resolved.³ This was supported by inmate feedback, identifying health care as an issue at all custodial centres. Custodial requirements and Tasmanian Prison Service processes were identified as causes of

the problem to access healthcare.³

If adequate staffing levels are achieved, all inmates, whether they are currently mentally ill, simply stressed or managing well, may each be able to access therapeutic, mental health services within the prison, at any time. This is regardless of whether their sentence spans one month or 10 years. The improvement of mental health both with short and long-serving inmates is important. For short-serving inmates, prison may become a place where simply protective mental health skills are obtained. For long-serving inmates, constant rehabilitation will be achieved and strategies will be learned to continue using upon release. As well as this, it will contribute to general wellbeing and peace in the prison population.

This could be achieved by stationing therapeutic staff such as psychologists and counsellors within each of the prison's residential units, just as correctional officers already are. This would achieve instant access of these services for inmates, when otherwise both declining mental health and behavioural issues may ensue. Having therapeutic staff stationed in the living quarters of the prison would also allow for observation of the everyday behaviour of their clients. In this way, it could highlight the factors within the prison that are maintaining inmate illness and would work to create a mutual respect and appreciation between inmate and therapeutic staff.

Lack of NDIS intervention in prison

With regard to NDIS, JusTas is not a body that delivers services. JusTas is a body of people working toward best practice, innovation and reform in corrections. Therefore, JusTas has not worked directly with inmates previously benefiting from or in need of support from the NDIS. However, a concern was raised at the most recent JusTas forum. This concern regarded the lack of continuation of NDIS care for people with both physical and mental illness when they enter the prison system. The NDIS seems not to take effect from within the prison system and therefore, its beneficial and essential services end when one experiences incarceration.

Lack of long-term, personalized mental health programs for prisoners

Not all inmates are appropriately assigned case workers and relevant therapeutic staff, due to inadequate staffing numbers and a high inmate population, disproportionate to staff. Thus, personalized, longer-term, whole-person therapeutic interventions are not always provided. When mental health programs are personalized to an offender's psychological, social and intellectual background, increased benefits are seen. The benefits of theoretical

personalized mental health plans are shown in a UNSW study on the outcomes and costs of mental health interventions with offenders.⁹

Presented is a real case of an adult male, Peter, 40 years old with a mental health disorder and a mild intellectual disability; suffering from schizophrenic and psychotic episodes, posttraumatic stress disorder, obsessive-compulsive disorder and social personality disorder. Peter did not have contact with the criminal justice system until 26 year of age, with the point of contact being influenced significantly by his severe mental illnesses. He was supported by a complex needs parole officer on a community order and had no prior recorded criminal offences or hospital admissions. However, without this support Peter returned to his previous cycle of offending, including regular re-admission to hospital.⁹

The study introduces the idea of long-term, personalized mental health intervention for Peter's specific case. This care entails intensive case management support services such as the Integrated Services Project. This service helps clients with mental health disorders or cognitive impairment that result in challenging behaviour. The program provides its users with 'a comprehensive assessment and individualized care plan, supported accommodation, clinical support and therapeutic investments.' It is aimed at through-care, helping individuals establish relationships with agencies regarding housing and other needs, in order to continue support after the program.⁹

Peter, within his lifetime, is not going to 'recover' from any of his mental health illnesses, given their complexity, the co-morbidity of his multiple disorders, and his intellectual disability. This means that Peter requires constant, personalized, long-term support and mental health intervention that will work to stabilize his mental health problems, leading not to a cure but to the highest level of normal functioning that Peter can possibly manage. In turn, this will result in reduced his interaction with the criminal justice system.

Inadequate through-care

Through-care is incredibly important for the sustained mental health of inmates once they are on parole or have served their sentence and are released into the community. Handover from the therapeutic staff within the prison to community supports of the same quality is essential. Mental health problems don't cease to exist once inmates are released, and may even worsen if supports aren't put in place. Effective through-care will maintain mental health and ensure that re-offending does not occur.

An ex-inmate at an Australian prison, suffering from mental health illness voiced his concerns

about the correction system and mental health, based on his personal experience. He identified the lacking re-integration in a particular Australian jurisdiction. Similar problems may exist in other jurisdictions, including possibly Tasmania.

He stated that he was entirely responsible for the bettering of his mental health, without substantial support in the community. He claims the process of re-integration would have been made easier if a support worker, well-versed in the areas of psychology, corrections and re-integration was assigned to him, this would have been invaluable.

He identifies that the parole officer assigned to him took on some of this role. However, that they were often too busy and had too high a case load to spend more time with him. He states that a dedicated community support worker should be available to support ex-prisoners in the home. He highlighted that inmates suffering from mental health illnesses should have to, as part of their parole and to ensure mental stability, see mental health professionals regularly. If not for these social work and mental health professionals, spiralling of the mental illness may occur for the person, as it did for him.

He put forward the idea of a dedicated professional who, a month or so before prison release, helps the inmate with a pathway plan. He states that he did not experience any such support. In Tasmania, 'planning officers' fill this role to organize social supports, housing, employment and to create a general plan for inmates' post-release. However, it can be clearly identified that the amount of planning officers at Tasmania's major Southern prison is too few. This results in high case-loads and ultimately the assigning of these staff to some inmates, based on need.

A mental health model out of Trieste, Italy may serve as an example to improve the current recidivism situation within Tasmania's justice system and ensure through-care into the community. An international benchmark of community care, recognized as a World Health Organisation collaborating centre, the community mental health care model is based on through-care and problem solving, rather than just clinical treatment.¹² The model includes 24-hour, 7-day a week community mental health centres, staffed with a team of nurses, social workers, psychologists, psychiatrists and rehabilitation specialists. There is a general hospital psychiatric unit (used for emergencies at night), supported housing facilities (45 beds in group homes and housing at different supervision levels, 24 hours a day), social co-operatives for vocation, profession and education in various domains within the local community and links to NGO-led programs such as clubs, self-help centres, workshops for culture and education and professional training.¹²

It is regarded as a 'whole system', 'whole community' approach, in that does not just treat a

mental illness clinically, but looks at the social background relevant to the illness – nurturing citizens into ordinary life with housing, work and extra-curricular activities.¹² It is innovative in its ability to empower recipients of care, in contrast to strategies that clinically treat illness, hand out resources and don't ensure through-care, running on hospitality rather than hospitalization. The models facilities are run within the community by the same rotating team, to ensure continuity of care for patients, and to avoid both 'turfing' problems and care being provided in silos. There exists a short waiting list and no wait for crisis situations.¹² The community mental health centres are not intended to house individuals long term, as many in other countries become, but act as a refuge to avoid deterioration and social drift.

8.4. What interventions in the justice system most effectively reduce the likelihood of re-offending, improve mental health and increase prospects for re-establishing contributing lives? What evidence is there about the long-term benefits and costs of these interventions?

To combat any mentally-ill individual 'falling through the cracks' and to effectively provide mental health treatment, the previously mentioned community mental health care model out of Trieste, Italy may serve as an example.¹²

As per the above answer to question 8.3., the model has shown statistical evidence of its effective treatment. By targeting disadvantaged mentally ill individuals, at risk of possible offending behaviour or recidivism within the community, the model effectively keeps these individuals within the community, where intervention and support can be more easily, thoroughly and regularly administered. It acts as both an intervention when criminal behaviour has occurred and a preventative strategy to this behaviour. It applies to individuals not experiencing mental health illness, mentally ill individuals without prior criminal behaviour, ex-inmates and paroled offenders.

Community through-care

Twenty-four seven community support is required improve mental health outcomes for individuals, reduce re-offending and increase prospects for healthy and fulfilled lives that contribute to society. This applies equally to therapeutic services such as psychologists, psychiatrists and counsellors. As well as social workers, mentors and volunteers that will provide general social supports and normalcy, acting as positive role models for individual's ordinary life struggles. Within the Trieste community mental health care model, the concept of empowerment and self-efficacy is emphasized, as is clear in the walk-in, walk-out nature of the model. However, this does not mean leaving one to better themselves, without support. It simply means providing support and assistance to the mentally ill person own their own personal time line and terms and collaborating with them, hearing their input into their own

care.¹²

The Trieste community mental health care model would improve the current recidivism situation within Tasmania's justice system and ensure through-care into the community. Statistics from the evaluation of the model show its enormous benefits for mental health. The model features low rates of hospitalization, low compulsory treatment rates, effective job placement, low forensic patient numbers and continually decreasing suicide rate.¹² A 50% reduction in emergencies and decreases in acute presentation and crises. The re-admission rate of the community mental health centre is at 30% and has shown better outcomes for those suffering with schizophrenia. Less than 10 people per 100,000 have received compulsory psychiatric treatment orders within the model. There exist no homeless clients within the model, as housing is always found and no people from the area are currently in forensic hospitals.¹² Their model was also found to harbor an improvement of 50% in social functioning. In relation to re-integration, statistics show that the model has approximately 600 people working in cooperatives within the area. Nine of these individuals obtained competitive jobs and 12 have managed to live independently.

Community mentors

An intervention as small as a volunteer within the community assigned to particular mentally ill individuals within the community would make all the difference. These volunteers could be students of social work, criminology or psychology or simply people willing to volunteer for a social activity, that form a mutually beneficial relationship with the individual. The student would gain first-hand experience with somebody experiencing problems that they learn about in their academic field and will interact with in their future profession. The individual would have somebody to check in on them, rely upon and enjoy regular contact with. The student may also, if appropriate to do so, accompany the individual to appointments with service providers within the community, for moral support. This would be similar to a mentoring system such as that discussed below for ex-prisoners, even if individuals have had no contact with the justice system.^{14 15}

The Women's Justice Network, Women in Prison Advocacy Network (WIPAN) runs these programs, matching prisoners with mentors to reduce re-offending. Within the program, a low recidivism rate of 7% exists.^{14 15} In one case, a mentor was a social work student who

¹⁴ Stewart, J. & Sherde, A. (2016, February 24). Personal mentoring for jailed women 'the key' to reducing reoffending rates. *ABC News*. Retrieved from <https://www.abc.net.au/news/2015-08-28/prison-mentoring-program-for-women/6732198>

¹⁵ McDonald, P. (2017, March 3). Women prisoners avoid reoffending with help of mentoring program. *ABC News*. Retrieved from <https://www.abc.net.au/news/2017-03-03/women-prisoners-avoid-reoffending-mentoring-program/8320156>

wrote to a female inmate whilst she was incarcerated, visited her in prison, supported her in court and continued contact on the outside, once she was released.

WIPAN director, Kat Armstrong states that most women are going to prison for drug- and alcohol-related crimes and that they could be better treated outside of the jail system. She states that mentoring will empower ex-inmates by giving them the tools to get a job, become better educated and be better parents for their children.^{14 15} Here, there exists the opportunity for mentoring with people serving sentences, i.e. connecting them with a mentor whilst imprisoned and continuing this mentorship outside, or simply equipping those in community corrections with a mentor. A similar mentoring intervention may work with offenders of any gender and may act as a more minor and cost-effective intervention that eases the pressure on professional mental health workers within the community.

8.5. What are the main barriers to lowering the over-representation of people living with a mental illness in the justice system and what strategies would best overcome them?

The lack of effective mental health intervention within the community is a barrier to decreasing the current overrepresentation of mentally-ill individuals within the criminal justice system. Another barrier encompasses the lack of knowledge and education that key players within the criminal justice system possess regarding interacting with mentally ill individuals who have committed crime. Resolve of the second barrier: criminal justice workers in-education about the mentally ill and crime, feeds into the achievement of the first idea: the lack of effective community mental health intervention.

Firstly, reference is again made to the Italian model of community mental health care in Trieste.¹² This community mental health care is consistent, easily accessible at any time and equipped to cater to and treat the most challenging of mentally-ill individuals in all spheres. This is essential to lowering the over-representation of the mentally-ill within the criminal justice system.

Secondly, key players within the justice system, mainly police officers should have a basic understanding of mental health conditions and illnesses. Such players will execute the appropriate mental health safety strategies against mentally-ill offenders. This knowledge will also provide these workers with the ability to manage a mentally-ill individual that has been reprimanded until the time that care is reached. This is opposed to simply ignoring or understating the mental health problems that have contributed to the individual's offending behaviour and starting the process of incarceration of the mentally-ill individual.

Simple interventions such as the completion of a Mental Health First Aid training course

through agencies such as Mental Health First Aid Australia¹⁶, may help to equip police and other criminal justice workers in the treatment, management and intervention of those suffering from severe mental health conditions. These two to three day courses are available to all, regardless of professional field or educational level. Standard adult-to-adult courses as well as teen courses for adolescents are available.¹⁶ Such courses provide extensive, easy-to-understand information on a multitude of mental illness and include case study exercises and real-life stories from those affected. They also touch more informally on the criminalization of those with mental illness. The course equips individuals with the skills to approach and support those suspected to be suffering with mental illness or a mental health crisis, such as suicide.¹⁶

Achieving regular, personalized mental health care within prisons and the community. As well as, training key players within the criminal justice system to identify individuals with mental health illnesses and acknowledge their sometimes uncontrolled propensity to commit crime, will work toward keeping mentally ill individual within the community. Subsequently, individuals suffering from mental health problems will be appropriately shielded from entering the criminal justice system, where their mental ill-health as a cause of their offending behaviour, will only worsen. Their diversion to community corrections will allow them to receive the mental health support that they require and this will result in their reduced contact with the criminal justice system.

¹⁶ Mental Health First Aid Australia (2019). *Take a Course*. Retrieved from <https://mhfa.com.au/take-course>