The ACT prison: a de facto mental institution?

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Introduction

I am privileged to be here tonight and I think both Gary and Richard have laid down the issues, perhaps not the total solutions, and all we can do is look and see where we can move. I'm confident of one thing and that is there will never be a total solution. We will always be working towards a better deal. I thought I would talk more about the practical implications where, in my experience of work, these issues come to the fore and then wonder how they might work in a prison. Remember, we have never had our own prison. I remember when I first became a magistrate in 1977, I started an organization I think that still exists, I think Bill Redpath took it up later - and that was the End Transport Coalition. We were doing a lot of kids' court work and we were seeing a lot of 13, 14 and 15-year old kids being sent to New South Wales because there was a lack of the facilities here. I'm glad to report that happens less often now but, in relation to our adult prisoners, up to now there is no power to retain them in the ACT except in the Remand Centre and that is prior to their conviction or if they come back on appeal.

Mental health issues can commence right from the very start of the criminal justice system. In the Magistrates Court – Richard in the Supreme Court, of course, has this to a lesser extent – the question of bail will often give rise to the very first issue of mental illness or mental affliction. Usually, you are struck with a problem where someone has committed sometimes an inexplicable offence, it does not seem to make a lot of sense. Police, prosecutors, defence, court workers are all saying that the person's acting strangely, the person's dangerous, the person is likely to go out and do exactly the same thing again. The first question that arises there is, "Are they a safe bet?" Is it appropriate that they be given bail and, if you are going to refuse bail, is it justified sometimes for the most insignificant of offences on the scale of offending? At that stage, to take up Gary's point, assessment even at that early stage becomes very important. I am glad to report that there are some positives.

Over the last five or six years, the mental health services have instituted a forensic liaison officer who is attached to the court and provides on-the-spot advice, checks on the person's previous history and gives some guidance and risk assessment on bail. That service continues at the moment into the Remand Centre. Remember that we do not have any prisoners actually convicted and serving sentences in the ACT, which we will do in the near future. At the Remand Centre, we now have Dr Daniel Bonner, an excellent, young forensic psychiatrist, who does a mountain of work and I think was recognized last year for his efforts in this area. He is permanently available for assessment at the Remand Centre along with a mental health team there. So those things are in place. When we apply this to the scale of the prison, Gary's idea of having an assessment and, perhaps if necessary, a treatment plan, already has its seeds of development. Sure, we can do better.

Mental health and sentencing

The criminal justice system deals with the question of sentence. On the question of sentence, the court, hopefully, will be able to get some assistance as to the mental status of the person involved and can take that into account in the sentencing. When you go to the prison stage, there is the issue, then, of how any treatment regime that has already been set up continues. Assessment is a key, because assessment and diagnosis is not the simple process that many people think it is. It is often very difficult to even get a final assessment of what a person's mental status is. That's important because Richard was talking about the issues of mental affliction and talked about the terrible situation in respect of his person, Kurt.

At a certain level of lack of criminal responsibility because of mental illness, namely mental impairment and that is an offence along the lines of the old McNaughton Rules, in an updated fashion, the person is held not to be criminally responsible, so sentencing does not come into it. The question is - we haven't answered that yet and I'm not sure of that and I don't think it has been really thought out locally - as to where those persons would be put. Someone found not guilty on the grounds of mental impairment, they are not a convicted prisoner, they are not serving a sentence. Almost always, it will be at the Supreme Court level and the process that takes place is that person will be given what I would call a 'putative' sentence on the basis that had they had the ability to form the requisite intent and had sufficient responsibility, this is what they would get.

At this stage, it is then turned over to the mental health tribunal to review them. The most difficult thing is to place them. The options are not very great - and that is not a criticism of the government of either persuasion, it is a question of the scale of the ACT. Do we set up a special prison for those found not guilty on the grounds of mental impairment and you can add to that the people who are found unfit to plead – they are in a similar situation. If you are found unfit to plead and not likely to be fit to plead for twelve months, again, that is a situation where you will be held in limbo. You may be held in custody and you may be released but, again, that is another category and there are quite a few people in that category. I am posing questions not answers.

An holistic approach is needed

We do have some options in the community and I think we need to look at this issue holistically. I see Phil Lee here, I see David Biles here, people who are both very expert in what happens in prisons but also what happens once people are paroled and go on probation orders. In many cases, the sentence will only be relatively short but the problem of mental illness will continue and, also, it will continue and have to be enforced on a post-release probation or parole order or maybe on a community-based order.

We do have some options. We have community organisations here that do a sterling job and offer supported-accommodation but people that are actually quite ill, usually, do not comply with the rules of the houses and they bounce back because they cannot be accommodated there. They are usually placed there on condition of bail or a condition of release or a condition of parole but they decide they cannot stay there because they cannot comply with the rules due to their mental illness.

Community organisations do a magnificent job and they need to be supported. They are an essential part of the problem. If we have appropriately-supported community organisations that can provide what we need, there'll be less people in gaols. There will be the people in

gaol who are at the sharp end and they are not numerous. They will be the people that are dangerous and I will come back to that in a minute.

The next thing I wanted to address is that we need to look at mental health, whether it be in prison or elsewhere, holistically. Very seldom do we have someone that we can say, "Oh, that person is paranoid, that person has got depression, there is no other problem." You usually find also - when sitting at least twice a week on mental health cases in the civilian area as well as dealing with them in court - there are very few young people under forty, who do not have a mental illness that is hard to distinguish from a drug habit. Either the drug habit comes first and causes the drug-induced psychosis or, alternatively, the mental illness leads them to a self-medicating condition. I see Michael here from the Men's Centre. I think all of his clients would be in that category. It is not just a case of dealing with a pure mental illness.

There is a necessity of having a holistic approach – and I would go further than Gary's suggestion – and that is that there be an assessment, not concentrating purely on mental illness but looking at behavioural problems, looking at alcohol and drug problems and looking at mental health problems. So that each prisoner, in an ideal prison situation, would have a case plan and a proper assessment as to what that person's needs are. There are very few people you could just simply say it is mental illness and nothing else, and in many cases it's difficult to distinguish the two.

Then you put into the mix another disability issue and that is a degree of intellectual impairment/intellectual disability, because those people are less able to resist temptation and are more vulnerable - they get into all sorts of trouble as well. I think an assessment is a great idea on entry. We would not make it a psychiatric institution but at least we would then be able to look at a case plan, not only to rehabilitate the prisoner but also to see what is required to meet that prisoner's needs. Also, for the purposes of those responsible for looking after the prisoners in a prison, to enable them to better understand what is needed.

The issue of a secure facility is a political issue about where it is located. It is a perfect example of the tension between the criminal justice system that deals with punishment, crime, retribution, deterrence and rehabilitation, and the therapeutic approach taken by the medical profession. The clash between the approaches will never be solved – it is two ways of dealing with the matter.

Can informed consent occur with mental illness?

One example that is not totally related here is: I often ask myself the question – I read the *Rogers and Whittaker* definition in the High Court of what is meant by informed consent. That is, you can only give informed consent if you have explained to you all the risks of what is going to happen to you - the treatments, the side-effects - and make a conscious choice about whether you consent to that treatment or not.

I defy anyone who really has a psychosis, is affected by drugs, whether any person can give informed consent at that high legalistic definition. I tell you what - we would need five mental health tribunals because there are certainly a lot of people in the community having aspects of psychosis who are not able to give informed consent. That is an issue I think we have to deal with legally, medically and community-wise. We need to come to grips with the fact that the legal definition, if you take it in extreme theory, is way up here to justify

someone consenting to mental health treatment. The medical definition is something different – and practical. Those are only some of the issues.

The difficulty of diagnosis

Mental illness, personality disorder and other matters we are talking about in this context are a matter of definition. I can also tell you that I could put someone up for assessment and I could get two or three different opinions about what that diagnosis is. That is not being flippant, it is true. It is a very hard thing to diagnose; as I say to people and clients in the mental health tribunal every day, if you have a mental illness, it is very difficult to diagnose, it is very difficult to progress and it is very difficult to judge how long you will need the treatment. If you have a broken arm, you can be fairly sure of what the process of that illness will be. If you have depression, a drug-induced psychosis or a combined drug-induced psychosis and paranoia, it is very difficult to predict.

I want to emphasise the lasting nature of mental illness in whatever manifestation it is. The sentence will only be for a finite period. It may be that some of our clients in the mental health field are going to be – the word is not cured - controlled and managed but only with the assistance of treatment. On the issue of treatment, we are talking about pure mental illness in the sense of schizophrenia, bi-polarism – that is much more accessible and able to be dealt with by way of medication but a long-standing personality disorder with all the complexities there are often just as dangerous, just as pervasive, and just as difficult, is a much more long-term difficulty and requires counselling. Treatment sometimes cannot be imposed.

Michael and I have been seeking through the Men's Centre to deal with a young man. He is not really mentally ill but he certainly has a personality disorder. You can take the horse to the trough – and that is not being disrespectful – but you cannot make the horse drink, so a lot of the treatment for mental illness, in the wider sense, requires the co-operation of the patient.

The other aspect of the prison and the human rights issue is that, in the community, before you can be treated against your will, without going into the issue of informed consent again, you have to exhibit the mental illness as defined and the definition we could talk about for a week as well, you then have to be significantly affected to the point you are a significant risk to yourself and others to a significant degree and you have to meet those qualifications before an order putting your treatment in the hands of a treatment team under the supervision of the Chief Psychiatrist can take place.

You are in prison, you will be treated

I raise the question, in a human rights community, should we be treating prisoners on the basis that, "You are in prison, we are going to treat you whether you like it or not because you are easier to handle and you need to do it?" That's a question I pose. I do not profess to know the moral, psychological or philosophical answer to it. If a prisoner does not want treatment, is not a prisoner just as entitled as any other citizen to refuse it? Yet, we seem to be thinking that if you go into prison you shall be treated. That is underlined by the fact that most treatment requires co-operation.

Then of course the sentence finishes, we go to see Phil Lee at the sentencing administration board. The illness still exists, the sentence has been served and finite, the situation is going to continue, the mental illness will still require treatment. Of course we know, as Richard

and Gary have both said, that recidivism is even more likely if there is a mental illness because the mental illness is the cause of the problem.

We have to look at what is the purpose of our sentencing, because I think we need to look at that and, of course, we look at it in the framework of sentencing being really the last resort. I think all of the textbooks say that; the legislation says it. We can talk about deterrence and I think we all have grave doubts about just how effective it is. Dave Biles can give us a lecture on that, general and specific. We talked about retribution, to use Richard's alluding to the shockjocks - that seems to be their cup of tea.

I think rehabilitation is very important on the basis that if you can rehabilitate you will stop the recidivism, that is the theory and I think that is probably true. The tension is there, the criminal justice system is something different from the mental health system – quite different - and that comes about when we look at the difference between someone who is dangerously mentally ill and needs to be restricted in secure premises and someone who has committed a crime, albeit being found mentally-impaired or albeit having been found guilty but still suffering a very significant mental illness. We have to come to grips with that tension.

When you are dealing with psychiatrists, as I do frequently every week, they are totally focussed, usually, on the therapeutic aspects of it. I have taken the hypocratic oath and I am bound to treat my client. Once he does not require to be treated, maybe my role should finish. Of course, that cannot be said in the prison system because, once you get into the prison system, the prison situation will continue but still those issues are still there about consent to treatment. I do not profess to know the answer but I am certain that a full holistic assessment of all the difficulties, both for the benefit and rehabilitation of the prisoner, as well as the staff and those looking after the prisoners being better equipped to look after them is a great idea.

I suppose the other challenge for us is to educate public opinion on the role of mental illness and the need to treat it sensitively within the prison system. I think, at this stage, it is a scary prospect for those responsible for setting up the prison - it is a difficult problem.

Conclusion

How do you solve those conundrums that Gary has raised, that Richard has raised, that I have hopefully raised, within a reasonable budgetary confine. I have been pushing for a long time and I have to say I did not make a lot of friends in high places when I was pushing for a long time about the need for secure mental health facilities so that, when someone is clearly mentally ill and needing treatment, they do not reside in the Remand Centre, they reside in a secure facility. Now. at last, I think we are getting that, it is a far way off yet but we are getting it. It is going to be located in the hospital and I can see the arguments for and against that. It is a constant battle and I do not think the issues are going to be easily solved.

The question of public safety, I think, in my simplistic way, is the real reason we put people behind bars because we are worried they are going to commit the crime again. We have finite sentences, I know there is truth in sentencing and all that sort of stuff but we do have finite sentences. If the illness is fairly chronic, which it often is, and needs treatment, you have to ensure that, upon release, that treatment continues and public safety is ensured. We all abhor the idea of preventative detention but they are some of the issues that I wish to raise. I do not profess to have all the answers. I look forward with interest and hope that we can achieve a lot of the goals that both Gary and Richard have advanced.