Submission to Senate Inquiry into Mental Health 2005
By Justice Action 18 May 2005

Justice Action makes this submission largely adressing one term of reference only (see below). We appreciate that the urgent issues of Human Rights and other abuses including institutionalisation and the use of force, and the lack of progress on Burdekin are being examined by the Committee. Justice Action is a volunteer organisation without formal funding focussing on prison issues. We are always stressed for resources, and our priority must also be assisting our members in and out of prison, we submit additional relevent materials trusting that the Commitee will take up suggestions we have made in our work on these exact same topics prior to this Inquiry, such as in our Submissions regarding NSW Mental Health, which discuss issues within all the terms of reference of this Committee's Inquiry.

Justice Action Position Statement on Mental Health Policy:

Justice Action believes that there are several serious failings in the way public policy addresses mental illness in our society, the most serious being as follows:

- The endemic institutionalisation of those designated as mentally ill, whether that institutionalisation is carried out within the framework of a criminal justice or public health response to those so designated.

- The lack of a public voice in Australia for those who have been designated as mentally ill and the delegitimisation (and pathologisation) of their viewpoints by professional and political authorities.

- The abuse of psychiatric medication for the behavioural management of those designated as mentally ill, both in institutions and the community, and the lack of access by sufferers to well informed, noncoercive choice of therapeutic and support options.

- Neglect and lack of support for those living in the community with mental illness and making the transition from institutional to community living.

- False media portrayals of the mentally ill as being particularly prone to commit violent acts which justify intrusive and coercive measures to avert. Misleading media portrayals which promote the view that people can be appropriately categorised by their mental illness and that mental illness can be easily diagnosed and successfully treated by mental health professionals.

- The acceptance of the dubious diagnoses and untested opinions of mental health experts as 'scientific evidence' by elements of our criminal justice system.

- The increasing influence of large multinational pharmaceutical companies over mental health professionals, policymakers and the statutory bodies and NGOs involved in the resourcing, planning and delivery of mental health services.

- The ongoing stereotyping, vilification, discrimination and abuse suffered by those designated as mentally ill in our society.

Justice Action does not deny the existence of mental illness nor the real suffering it causes the many thousands of Australians afflicted with it and the millions of Australians affected by it. However, we believe the single greatest cause of distress and difficulty to the greatest proportion of those living with mental illness is the way our society responds to them.

Justice Action:

- Recognises that those designated as mentally ill are particularly vulnerable to vilification, neglect, abuse and denial of rights during their interaction with public and private institutions. Seeks to address such discrimination wherever it exists, but with particular emphasis on its presence in the criminal justice system.

- Prioritises the voices of those who have been diagnosed as mentally ill and promotes their participation in mental health education, policy development, planning and service delivery.

- Supports the establishment in Australia of independent grass roots mental health advocacy and activism groups along the lines of 'Support Coalition International' (US) http://www.mindfreedom.org/, 'Mad Nation' (Canada) http://tinyurl.com/6o7su and 'Mad Pride' (UK) http://www.madpride.org.uk/

- Demands an end to the use of psychiatric drugs for patient/prisoner management purposes.

- Promotes programs, policies and campaigns that seek to end the institutionalisation and forced treatment of those designated as mentally ill. Opposes programs which are likely to lead to greater use of institutionalisation and forced treatment. Forced treatment is not therapy, it is abuse.

- Rejects the methods used by drug companies to exert disproportionate influence on mental health policy, including financial backing for practitioners, political parties and mental health NGOs.

- Supports the right of the mentally ill to access a wide range of support and treatment services or to reject treatment and services. Respects the right of the mentally ill to choose their own therapies and treatments.

- Calls for the rejection of psychiatric or psychological expert opinion in criminal proceedings unless supported with considerable experimental or actuarial data. Actuarial data should be treated with extreme caution and skepticism, especially in attempting to apply generalised findings to specific cases.

- Calls for streamlining of the procedures governing the release of forensic prisoners and significant investment in services to facilitate the reintegration of forensic prisoners into the community. All responsibility for the release of forensic prisoners should be taken from the hands of the executive (i.e. crown ministers).

- Rejects the all systems which seek to socially classify people by their alleged mental illness (e.g. 'registers' of the mentally ill, transfer or sharing of their medical records without their consent, New York style 'Kendra's Laws').

- Rejects the popular stereotyping of those designated as mentally ill as a threat from which the community must be protected. They are part of the community who have unmet medical or social needs and are particularly vulnerable to individual and institutional abuse.

Term of reference:
1) the overrepresentation of people with a mental illness in the criminal justice system and in custody,
2) the extent to which these environments give rise to mental illness,
3) the adequacy of legislation and processes in protecting their human rights and
4) the use of diversion programs for such people.

1) The overrepresentation of people with a mental illness in the Criminal Justice System and in custody

Poverty is disabling and disability leads to poverty. A criminal justice system weighted against those suffering either results in what we have now - jails full of people from very poor areas, who have high levels of disability, and most particularly those who fulfill both criteria. One-third of the people in NSW prisons have a mental illness - they are locked up in their cells for 11-23 hours a day, dressed in prison clothes and fed prison food. An offender diagnosed with mental illness is more likely than other offenders to be arrested, to be remanded to custody rather than be granted bail, to be viewed as dangerous, to spend longer in remand before court process completion, and to spend more time in prison. Lack of legal aid and general disempowerment leads to innocent people with mental illnesses being wrongly convicted. When the charges are minor, it is easier for the accused to just do the time than try to fight the charge.

The 2003 NSW Corrections Health Service (now Justice Health) Report on Mental Illness Among NSW Prisoners states that the 12 month prevalence of any psychiatric disorder in prison is 74%, compared to 22% in the general community, and while this includes substance disorder the high rate cannot be attributed to that alone.

We have included their key findings for your convenience in appendix A.

The "deinstitutionalisation" of mental health patients that began in the 1970s and accelerated after the Richmond Report 20 years ago, was not carried out as envisioned. The community resources, respect for disabled persons and support for what disabled people say is needed, have not appeared, whilst we continue to experience abusive institutional care in hospitals, jails and unofficial institutions like locked boarding houses.

Since the deinstitutionalisation of mental health services, community care is focused on home care. However, a reliance on this is clearly deficient, considering that a high percentage of the homeless also have a mental illness. Many community services, including housing, exclude people on so many grounds (including other disabilities, prison record and so on) that it is a wonder that anyone is eligible.

For adequate 'treatment and care' for people with a mental illness in the community these must all be substantially increased: funding, staff skills mixes, free access to diverse, cultually and personally appropriate services and facilities .

NSW has the poorest funded mental health system in Australia, but a lot of money going into building prison beds. We need to stop building and filling prisons and instead put our efforts into empowering and supporting our most vulnerable, excluded and dispossessed, to enable our communities to heal ourselves.

2) The extent to which these environments give rise to mental illness

Safe Cells

So-called Safe Cells, suicide cells, observation cells, strip cells supposedly designed to prevent suicide are part of the problem. A prisoner tells about the Mum Shirl Unit in Mulawa:

"Imagine yourself locked in a cube of thick Perspex with a series of small air holes in it. The electric light is always on. The camera is always watching you. You are allowed to use the toilet. Sometimes you are allocated a pill. You are not allowed a pillow to cry into, or hug. You are alone. This is 24 hours a day."

These torture chambers rely on such things as no hanging points to die on. But it is merely a short-term solution to a problem of utter devastation. These cells are commonly used as punishment. Cellmates tell of prisoners taken away in the night to the cells, hearing the screaming and breaking down at their inability to do anything.

Segregation Housing Units (SHU's)

These types of cells include the control units and all other such environments of extreme isolation and austerity with near permanent lockdown.

SHUs are the problem, not just the holding of prisoners with psychiatric disabilities in SHUs.

We have evidence of prison-induced insanity and this is strongest in SHU type places. Human Rights arguments under the "cruel and unusual treatment" can and should be launched to remove SHU system for *everyone* in prison.

Modern prisons were developed by Stalin in the 1920¹s-30¹s following the work on the Russian psychologist Pavlov who is famous for his experiments on dogs developing the concept of classical conditioning. These experiments consisted of stressing dogs and observing their behaviour. Stalinist prisons soon adopted these methods applying them to people to obtain confessions and as punishment regimes that did not require elaborate or time-consuming methods of torture. By isolating and depriving prisoners of stimulation and comforts, the same effects as electro-torture and beatings could be effected, but on a large number simultaneously and without the staffing required before. These methods spread to the west in the 1950¹s, notably the United States, which experimented and documented its brain washing exercises. The effect of bland institutions on staff and inmates is well documented, see Goffman, Asylums.

All prisons in Australia today employ Pavlovian principles in their design and operation. This is the science of custody. In order to subjugate and punish individuals, the State had developed these hands-off approaches as a modern alternative to physical torture.

Anyone working and being held in confinement will show the symptoms of institutionalisation, a mental illness affecting everyone in a closed institution. This illness is progressive and is described as blunting a person's sensitivity and awareness of their environment. They become depersonalised, and such a person will regress to an infantile stage. Loss of living skills, despair, loss of control of urinating and defecating, playing with faeces, pacing, wailing, self mutilation, nudity and other inappropriate behaviour are some of the signs of institutionalisation.

3) The adequacy of legislation and processes in protecting their human rights

Please see Appedix B, "At the Minister's Pleasure?" regarding the case study of Michael Kelly.

There is concern at the imprisonment of people who were found not guilty of an offence because of mental illness. Many people found not guilty or unfit to plead by reason of mental illness are sent to jail anyway.

There is no official oversight of Australia's Human Rights obligations - even the limited number of rights accorded by the small number of UN treaties that Federal governments have signed up to, cannot be ensured, as the UN is not even allowed to do snap inspections of the treatment of Australia's State and Federal prisoners.

Australia has been negligent in signing up to Human Rights treaties and in passing them into domestic law. There are also loopholes in Human Rights that allow abuse to occur. Plus we argue that there is a blind spot in human rights regarding the 'English-speaking Western Democracies' that are put up as models for the world. In places like the UK, US and Australia, it is very easy to hide abuse due to disbelief that it could ever possibly occur here ('they only do that sort of thing over there'), and due to the fact that those in power are well versed in the language of International Laws, and the propaganda needs related to this percolate through the system. So for instance as the UNHCR has ruled that solitary confinement of one month in a cell with 24 hour a day artificial light is torture, it is quite easy for a prisons Commisioner to claim that there is no solitary at all, by saying every prisoner has access to exercise for an hour a week even if that is not the experience. Or, a person can be transferred around a system, never really getting out of solitary, or they can flick the lights. A disempowered person has little chance of winning a 'he said-she said' type argument. The art of legal abuse is well practiced in Australia, in all institutions. It makes a mockery of the ICCPR requirement that, "...all persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person."

As another example of the problems of human rights protection and advocacy in this field, the difficulties of making a complaint if you are a person labelled mentally ill, especially if you are also a prisoner, cannot be underestimated. Problems include legal credibility, a person's knowledge of rights, and belief that they themselves are a person whose rights are worth defending, education and ability to express and communicate in the style required for complaints, enforced silence and censorship, dismissive attitudes amongst professionals, society and officials, destruction of or slackness in creating records, and the fact that psychiatric treatments interfere with narrative memory and ability to think and communicate clearly (ie, making the type of story that evidence requires, rather than perhaps flashes of events told orally and collated by another).

4) The use of diversion programs for such people.

Justice Action promotes Mentoring in the community.

The best mentors have been there and they're usually people who have experienced the treatment programs, such as ex-prisoners, ex hospital patients or people who have some knowledge of the pitfalls and have experience of the systems that have

treated them. Mentors can go into the prisons, hospitals and mental health institutions to expand our community support and goodwill to these community members.

At the moment the Mentoring groups have been blocked and locked out of the prison by the authorities because they often have criminal records.

Another diversion that is too often ignored is basic law reform. Many prisoners with mental illness have first contact with the criminal justice system as a result of extremely minor events, often as children. The criminal justice system is very "sticky" and once noticed by it, a person has a problem for life. The inherant prejudices of the criminal justice system need to be removed so as to allow real change. A lot of minor offences could be removed from the formal legal system, and people's drug use needs to be dealt with as a health, rather that legal matter. In this way much needed resources, manpower and funds can be freed up for vital services that people need to allow them to avoid problems and learn to change their lives.

Additionally, Justice Action wishes to draw the attention of the Senate Select Committee on Mental Health to the following:

Submission of the Indigenous Social Justice Association (ISJA) and Justice Action (JA) to the NSW Health Department's

1) Discussion Paper on the Review of the Mental Health Act.

Location: http://home.iprimus.com.au/dna_info/mh/

2) Where the Norm is Not the Norm: Goulburn Correctional Centre and the Harm-U

In the absence of public policy, this paper is an attempt to shine a light through the rhetoric and test for coherency in the policy and function of NSW's only supermax prison, the High Risk Management Unit. Its present use will be compared with the 'vision' flogged by the Premier and the Department of Corrective Services (the Department) at its inception in 2001.

Location: http://www.geocities.com/nswac14/archive1/WNNGCCHU.pdf

3) 'Killing Rational' and Prisoner Control in NSW

The following is a case study of a complaint made to justice action about the treatment of prisoners.

More: http://www.melbourne.indymedia.org/news/2005/02/87303.php

4) Mental Health Tribunal recommendations on forensic inmates

Below is the answer we have received from the Minister for Health regarding prisoners recommended for parole or release by the Mental Health Tribunal

More: http://www.adelaide.indymedia.org.au/newswire/display/7995/index.php

5) Lunatics Running The Asylum

This is a media release about the Gold Coast Institute of Mental Health 6th International Mental Health Conference at Conrad Jupiters Casino on the Gold Coast. To hold a mental health conference at Jupiters Casino is akin to arranging a seminar on drug and alcohol addiction at an inner city pub. Consumers, survivors and victims of mental health services will feel themselves thoroughly excluded from this conference, particularly if they are living with a gambling problem.

More: http://www.melbourne.indymedia.org/news/2005/03/89198_comment.php

6) Mental Illness and the Criminal Justice System

Relationship Between Mental Disorder And Violence Similar scrutiny must also be applied to the theory that people with a mental illness are more violent than the general population.

Violence and violent crime are commonly regarded by the public as the domain of the mentally ill (Australian Institute of Criminology, 1990). Public misconception about the true nature of mental illness, as distinct from personality disorder or behavioural disorder, frequently links extreme violence with mental illness. This misconception is enhanced by media depictions of the involvement of the 'schizophrenic' or 'psycho' in violent crime.

More: http://www.mhcc.org.au/projects/Criminal_Justice/aetiology.html

7) Death in custody: In memory of Scott Simpson

Scott Simpson 34 died in custody on 7 June 2004 leaving behind two children aged 9 and 14. It is alleged that he hanged himself in a segregation yard at Long Bay Prison Complex. Justice Action has reasons to believe that Scott had been mistreated from the time he was taken into custody, and that his mental illness was not properly addressed.

More: http://www.geocities.com/nswcn13/archive04/2004c21.html

Appendix A:

From: 2003 NSW Corrections Health Service Report on Mental Illness Among NSW Prisoners. Tony Butler & Stephen Allnut, August 2003.

Key Findings

o The prevalence of mental illness in the NSW correctional system is substantial and consistent with international findings.
o The twelve-month prevalence of Œany psychiatric disorder¹ (psychosis, anxiety disorder, affective disorder, substance use disorder, personality disorder, or neurasthenia) identified in the NSW inmate population is substantially higher than in the general community (74% vs. 22%).

o Almost half of reception (46%) and over one-third (38%) of sentenced inmates had suffered a mental disorder (psychosis, affective disorder, or anxiety disorder) in the previous twelve months.
o Female prisoners have a higher prevalence of psychiatric disorder than male prisoners.
o Psychiatric morbidity was higher among reception prisoners compared with sentenced prisoners.
o There was comparatively little difference between the one-month and twelvemonth prevalence estimates of mental disorder.
o Two-thirds of reception prisoners had a twelve-month diagnosis of substance use disorder.
o The high rate of mental disorder among inmates cannot be attributed to substance use disorder alone.
o 40% of reception prisoners had a twelve-month diagnosis of opioid use disorder.
o Almost one in ten inmates reported experiencing symptoms of psychosis in the twelve months prior to interview.
o An estimated 4% to 7% of reception inmates suffer from a functional psychotic mental illness.
o The twelve-month prevalence of psychosis in NSW inmates was thirty times higher than in the Australian community.
o 14% of male receptions and 21% of female receptions had a one-month diagnosis of depression.
o The most common group of mental disorders were anxiety disorders with over one-third of those screened experiencing an anxiety disorder in the previous twelve months.
o Post-traumatic stress disorder (PTSD) was the most common anxiety disorder (24%).
o One in twenty prisoners had attempted suicide in the twelve months prior to interview.
o Females were more likely than males to utilise health services for mental health problems.
o Prisoners with a psychiatric diagnosis had higher levels of disability.

Appendix B: From Framed: The Magazine of Justice Action, December 2002, Issue No. 43

At the Minister's Pleasure? The case of Michael Kelly:

In 1996, Michael Kelly, husband and father of two, shot a stranger on the stairwell in his block of units. Michael was terrified the stranger would harm his wife and children.

He was in the grip of a serious mental psychosis when he pulled the trigger. A court found him not guilty of grievous bodily harm on the grounds of mental illness and Michael is still in gaol.

If he had been found guilty, he would probably have served his sentence and been released by now.

Michael is caught up in a particularly cruel version of the game of Cat and Mouse. Because he is classified as a forensic patient under the Mental Heath Act of NSW, the Minister for Health is his master, not the Minister for Corrective Services. And the Minister for health will not let him go.

The Act requires a Mental Health Tribunal to review Michael's case every six months. The legal requirements of the Tribunal under the Mental Health Act is to determine if a forensic patient poses a risk to the community if they don't they should not be held in prison

The Tribunal has found Michael ready to be placed in the community for treatment and rehabilitation. The expert forensic psychiatric team managing him say he poses no risk to the community. The community psychiatric team has repeatedly reported they are ready to take him into care, but the Minister for Health refuses to let him go.

Deliberately undermining of professional psychiatric teams by the Minister's refusal to release mentally ill people under his control must end.

In addition forensic matters should not be subject to Ministerial Discretion because it is inappropriate use of Parliamentary powers and people with positive reports from the (MHRT) Mental Health Review Tribunal for release, conditional release and transfer (for example to allow people with intellectual disability to transfer to jail Disability Units from jail forensic wards) are kept for years unnecessarily in inappropriate accommodation and in jail.

In NSW one man has total power and choice over all people in this situation. Ministerial Discretion must end.