



Rural and Remote Mental Health Conference 2013

*At the crossroads of criminal justice and mental illness:
where to from here?*

address by

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Northam

Introduction

I am greatly honoured to have been invited to give this address to the Rural and Remote Mental Health Conference 2013, not least because it has provided me with an excuse to travel to one of my favourite places, the Avon Valley, but also because, for reasons which I will endeavour to develop, this is a significant point in time in the development of public policy pertaining to the intersection of the mental health system and the criminal justice system. It is generally accepted that the challenges which arise at the crossroads of those two systems have not been well met in the past. However, increasing public awareness of the importance of these issues has attracted the attention of policy makers and resource providers, giving grounds for cautious optimism as to the path ahead.

Before I go any further, can I express my thanks to Deborah Moody and to Frank and Trevor Davis for their inspiring welcome to country. I acknowledge the traditional owners of the land on which we meet, the Ballardong Noongars, part of the great Noongar clan of south western Australia, and pay my respects to their Elders past and present. It is great to be on Ballardong country during the season the Ballardong know as Djilba, when the greenery which follows the rain is quite stunning.

One of the grounds for the optimism to which I have referred is reflected in the significant involvement of Aboriginal people in the presentations which are to be given in the course of this important conference. A topic I will address later in my paper is the need to actively engage with Aboriginal people in relation to the delivery of mental health services to Aboriginal people in regional and remote Western Australia (and

elsewhere), and to recognise the importance of Aboriginal culture in the development and delivery of effective services. The programme for this conference provides a tangible example of the progress which we are making on these important issues.

I would also like to acknowledge the Minister for Mental Health, Disability Services and Child Protection, the Honourable Helen Morton MLC, and Mr Eddie Bartnik, Mental Health Commissioner. Both have been instrumental in raising public awareness of the important issues in this area, and in the development of public policy which is making a difference. Might I also acknowledge and congratulate all of those involved in the organisation of this important conference.

The Importance of Mental Health Services

It is impossible to overstate the importance of delivering adequate and effective mental health services. I am sure that all of you are more acutely aware than I of the significance of mental illness and cognitive disability, and the consequences of those conditions, for the health and wellbeing of our community. For me, the importance of these issues was brought home by the very eloquent words spoken by the member for the Kimberley, Josie Farrer MLA, in her inaugural address to the Parliament earlier this year.

I would like to touch on something that is very dear to me. This is an issue that has been in my heart for a long time. It is about Kimberley youth suicide. Why do so many Kimberley children feel that the only option they have in life is to take their own life? Why is little money or government resources dedicated to helping these young people live long and happy lives? Why do we in this place think a debate on the location of a football stadium or the development of Elizabeth Quay is more important than keeping an

Aboriginal person alive or in proper housing? I think we need to question ourselves on that. This is an issue of utmost urgency and I think the government has to place a high priority on stopping the flood of young lost lives...

Unfortunately, too many young people have died and too many young people continue to take their own lives. This means that more and more Kimberley families are searching for answers and trying to deal with grief. Just in the lead-up to my swearing in and becoming the member for Kimberley, we had about six to seven deaths through suicide in the Kimberley; so it has been a hard time for people up in the Kimberley...

The Kimberley is a small place by number of people, and like all regional communities loss is felt across the country; and the loss is multiplied in families and friends, in cafes, in shops, in homes and also around camp fires. I plead with this government and to anyone who can help that the Kimberley needs people who can help with the issues that those left behind after suicide face—more often by themselves. We need mental health professionals located in the Kimberley dedicated to assisting these families and individuals who can break through the barriers of pain and grief. In our work here in this place it is important that we all remember that no-one should be forgotten—no one!

Ms Farrer ended her speech in her own language, Gidja, followed by the English translation:

Please listen, listen to the words I am saying. We need to stop what's happening to our young people because they are our future.¹

Of course, mental illness and suicide do not respect cultural and ethnic boundaries. They affect all races, cultures, genders and ages.

¹ To read the whole text of her inaugural speech see Ms Josie Farrer MLA (Member for Kimberley), *Inaugural Speech*, Legislative Assembly, 17 April 2013, pp 3-5, at: [http://www.parliament.wa.gov.au/Parliament/Memblast.nsf/\(MemberPics\)/95B781E034EF1CA448257B33001FC79A/\\$file/InaugJFarrer.pdf](http://www.parliament.wa.gov.au/Parliament/Memblast.nsf/(MemberPics)/95B781E034EF1CA448257B33001FC79A/$file/InaugJFarrer.pdf) (accessed 16 September 2013).

However, as I am sure many of you will be only too well aware, research indicates that participants in occupations that are prominent in regional and remote communities may be at a significantly higher risk of suicide - for example, men in the agricultural sector in particular, but also women in the agricultural sector have been found to be at a higher risk of suicide.²

Deinstitutionalisation and Reinstitutionalisation

John Mendoza, a researcher at Sydney University's Brain and Mind Research Institute, and the inaugural chair of the Federal Government's National Advisory Council on Mental Health has joined with others in publishing a report analysing the last 30 years of mental health policy in Australia. The report has been published under the slightly discouraging title *Obsessive Hope Disorder*.³ The report chronicles the history of mental health policy over the last 30 years in Australia, since the Richmond Report in 1983.⁴ That report essentially recommended the deinstitutionalisation of treatment. Adjunct Professor Mendoza's report also covers the implementation of the National Mental Health Strategy in 1993 following a report by the then Federal Human Rights Commissioner Brian Burdekin.⁵

The report is less than complimentary. It has been summarised by Adjunct Professor Mendoza in the following terms:

² Abstract of Andersen K, Hawgood J, Klieve H, Kølves K, De Leo D, 'Suicide in selected occupations in Queensland: evidence from the State suicide register' *Aust N Z J Psychiatry* 2010 March 44(3):243-9.

³ John Mendoza, Amanda Bresnan, Sebastian Rosenberg, Amy Elson, Yvonne Gilbert, Peter Long, Keith Wilson & Janet Hopkins *Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia and visions for the future* 2013.

⁴ Department of Health NSW, *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled*, 1993.

⁵ Human Rights & Equal Opportunity Commission, *Human Rights & Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, 1993.

Australian mental health reform over the past 30 years is one of world-class policies and strategies let down by inadequate planning, poor implementation and our complex system of government. The results are disappointing, wasteful of scarce resources and too often devastating for millions of Australians affected by mental illness.

Despite significant new investment in mental health care since 2006—some \$8 billion in new funding—there is still no coherent national service framework, no service model, few care guidelines and continuing poor accountability.

The quality of and access to care continues to vary depending on your postcode, your income and your determination to find care. There are still daily accounts of "people falling through the cracks". People needing care enter a bizarre lottery.

People with mental illness experience a 15- to 25-year lower life expectancy than other Australians. Australia's failure to lift the life expectancy of people with a mental illness since Richmond's report in 1983 is arguably the starkest indictment of our public policy failure in this area.

The incremental, incomplete and inconsistent approach to mental health reform to date is clearly inadequate and unaffordable for the challenges now confronting our nation.⁶

The reference to the quality of care depending on postcode has a particular poignancy for this conference. The geography and demography of Western Australia make this challenge acute. The provision of adequate mental health services across a vast but sparsely populated State is the vital task in which you are all engaged. The enormity and difficulty of that task are other things which cannot be overstated.

⁶ Synopsis - *Obsessive Hope Disorder* available at: <http://www.sfnsw.org.au/Awareness---Education/Mental-Health-Reports/Mental-Health-Reports> (accessed 16 September 2013).

The data to which I will shortly refer suggests, and a number of commentators have also suggested, that the policies of deinstitutionalisation which have dominated Australia since the closure of the large mental hospitals in almost all jurisdictions about 30 years ago, have resulted in a form of reinstitutionalisation of many of those who would have been treated in those hospitals. However, the institutions to which those persons have been committed are not hospitals, but prisons.

This point was put succinctly by Professor Bryant Stokes AM in a report published in 2012:

The Deputy State Coroner expressed concern to this Review that prisons could be described as a catchment for patients with mental illness. Similarly, the Director of the State Forensic Mental Health Service claimed that prison services have been likened to an acute mental health intensive care unit, with an average length of stay of three to five years, and that they provide care to more persons with psychiatric illness than any other mental health service.⁷

The Mentally Ill and the Cognitively Disabled in the Criminal Justice System

There are some wide variations in the data relating to the reported incidence of mental illness and cognitive disability amongst those who enter the criminal justice system. In the report to which I have just referred, Professor Stokes suggests that 85% of court attendees had some earlier contact with mental health services.⁸ However, this is not consistent with data gathered last year prior to the commencement of the mental health court in this State, which suggested that about 20% of those who presented to the Perth Magistrates Court during the course of

⁷ Professor Bryant Stokes AM, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, July 2012, p 116.

⁸ Professor Bryant Stokes AM, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, July 2012, p 111.

one week were either in receipt of, or had previously received mental health services. Similarly, at times WA's Commissioner for Children and Young People, Michelle Scott, has referred to estimates that up to 50% of children and young people in custody could be experiencing mental health issues that are impacting on their safety and wellbeing,⁹ but on other occasions she has been reported as putting the estimate as high as between 50% and 75% having a serious mental health problem.¹⁰

It is unnecessary to quibble about these numerical differences and distinctions. What is consistent throughout all the data is the significance of the incidence of mental health and cognitive disability amongst those who engage with the criminal justice system.

Some index of the magnitude of the issue can be gained from a report published by the Australian Institute of Health and Welfare (AIHW) on the health of Australia's prisoners in 2012. Unfortunately, the report does not include data from Western Australia.

According to AIHW, in 2012, almost half (46%) of prison dischargees in Australia reported having ever been told they have a mental health issue (including alcohol and drug use issues), and one in five (21%) of those entering prison were taking mental health related medication. About one-quarter (26%) of prison entrants were referred to mental health services for observation and further assessment following the reception assessment.¹¹ Female, non-Indigenous and older prison entrants had a higher incidence of mental health history.¹²

⁹ Commissioner for Children and Young People, *Youth Justice* (Issues Paper 13) May 2013, p 4.

¹⁰ Paige Taylor, 'Mental health issues pushing up juvenile detention rates' *The Australian* 10 May 2013.

¹¹ AIHW, *The health of Australia's prisoners 2012*, p ix.

¹² AIHW, *The health of Australia's prisoners 2012*, p 35.

AIHW suggests caution should be used in comparing dischargees and those entering prison, as the groups comprise different people and are therefore not directly comparable. However it also goes on to note that overall, dischargees (46%) were more likely than entrants (38%) to report having been told they have a mental health disorder, including alcohol or drug use problems.¹³ AIHW suggests that this could reflect exposure to health care professionals in the prison setting who can make diagnoses that may otherwise go unnoticed. It is of note that one-quarter (27%) of prison dischargees reported that their mental health changed to become "a lot better" while in prison; and only 9% reported that their mental health and wellbeing were a little (6%) or a lot (3%) worse since being in prison.

WA data

In his 2012 Mental Health Review, Professor Bryant Stokes noted:

There has been no specific survey of the WA prison population of 5000 prisoners. However, at any given time about 615 patients are receiving mental health care—an estimated 50 per cent of the total number of prisoners who need mental health services. While these figures reflect disadvantage and poor resourcing of mental health services, custody also offers a unique opportunity to address the needs of mentally ill people who would otherwise go untreated.¹⁴

Professor Stokes also reported advice from Acacia Prison that 40% of the 1,000 prisoners it held at that time had a mental illness and that at any one time 10 per cent were experiencing active psychosis.¹⁵

¹³ AIHW, *The health of Australia's prisoners 2012*, p 35.

¹⁴ Professor Bryant Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* July 2012, p. 116.

¹⁵ Professor Bryant Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* July 2012, p 118.

There has been a limited WA study on the mental health of maximum security (male) prisoners that was published in 2011, 'Creating HoPE: Mental Health in Western Australian Maximum Security Prisons'. Although the WA survey was not strictly comparable to the questions in the AIWH national study of prisoners referred to earlier, it is of note that in the WA study 54% of the maximum security prisoners surveyed responded that they had previously received treatment for an emotional or mental health problem.¹⁶ This compares to the 38% of prison entrants in the national survey who reported they "had been told" by a medical professional they had a mental health disorder, including drugs and alcohol.

The authors of the limited WA study, Jennifer Fleming, Natalie Gately and Sharan Kraemer, cite common reasons for the over-representation of mental disorders in prisoners as including:

*the deinstitutionalisation of mentally ill people resulting in them ending up on the streets without necessary services and a target for arrest, an increase in the use and misuse of drugs and alcohol, and changes in laws which preclude offenders with a serious mental illness from avoiding a prison sentence.*¹⁷

They go on to emphasise that:

*Given these findings, screening for undiagnosed mental disorders for all prisoners presents an opportunity to identify those with mental health problems and provide evidence-based treatment. This will assist affected prisoners to cope more effectively both in prison, and with the transition from prison to the community.*¹⁸

¹⁶ Fleming, J, Gately, N & Kraemer, S, 'Creating HoPE: Mental Health in Western Australian Maximum Security Prisons' 2011 *Psychiatry, Psychology and Law*, doi:10.1080/13218719.2010.543405, p 11.

¹⁷ Fleming, J, Gately N. & Kraemer, S, 'Creating HoPE: Mental Health in Western Australian Maximum Security Prisons' 2011 *Psychiatry, Psychology and Law*, doi:10.1080/13218719.2010.543405, p 5.

¹⁸ Fleming, J, Gately, N & Kraemer, S, 'Creating HoPE: Mental Health in Western Australian Maximum Security Prisons' 2011 *Psychiatry, Psychology and Law*, doi:10.1080/13218719.2010.543405, p 5.

In particular the authors highlight the importance of screening and treatment of female prisoners given the higher prevalence of mental health problems including "mood disorders, anxiety/phobias, post traumatic stress disorder and obsessive compulsive disorder, and males are more likely to present with conduct disorders, attention-deficit/hyperactivity disorder, substance abuse, and learning disorders". However they also cite males' reticence to disclose their needs and to seek treatment as making screening for mental health problems in prisons an imperative.¹⁹

In relation to the overrepresentation of Indigenous people in prison, the authors note the likelihood of these prisoners having previously served time in prison, and for shorter sentences:

*... indicates that despite spending more frequent but shorter periods in prison, incarceration alone is not a deterrent and the reasons for their offending are not effectively being addressed.*²⁰

The authors point out the risks of untreated mental health problems not only for prisoners but for the community more broadly (when the prisoners are released), as well as the increasing stressors on prisoners and prison health services associated with overcrowded prisons.

The authors conclude:

As these prisoners [with untreated mental health problems] complete their sentences and are released, potentially without parole, the impact is felt on the public health system as they start accessing public health resources. Imprisonment is an opportune time to screen for mental health problems and provide appropriate treatment, which may then reduce repeat offending, brought about by undetected mental illness and/or substance abuse. Thus, prisoner mental health must be screened for and treated, with data provided to health organisations and government agencies to

¹⁹ Fleming, J, Gately, N & Kraemer, S, 'Creating HoPE: Mental Health in Western Australian Maximum Security Prisons' 2001 *Psychiatry, Psychology and Law*, doi:10.1080/13218719.2010.543405, pp 5-6.

²⁰ Fleming, J, Gately, N & Kraemer, S, 'Creating HoPE: Mental Health in Western Australian Maximum Security Prisons' 2011 *Psychiatry, Psychology and Law*, doi:10.1080/13218719.2010.543405, p 6.

*ensure programs are effective, and the health of prisoners meets standards expected in the general community.*²¹

Juveniles

The data to which I have referred in the previous sections of this paper is essentially concerned with adult prisoners. Turning to juvenile detainees, a New South Wales study in 2009 highlighted:

*the disadvantaged backgrounds of young people in custody. Nearly half (45%) had parents with a history of incarceration, with Aboriginal young people twice as likely to have a parent who had been imprisoned. Six in ten young people had a history of some form of child abuse or trauma, with young women being nearly twice as likely to have a history of abuse as young men. The majority (87%) of young people were found to have at least one mental health diagnosis and most had significant problems with alcohol or other drugs (78% were risky drinkers; 89% had ever used illicit drugs, of which 65% had used drugs at least weekly in the year prior to custody).*²²

As far as I am aware, no equivalent study has been undertaken in WA. The 2008 Auditor General's report on juvenile justice in WA sampled 15 young people who had more than 20 contacts with police over the past five years. It found:

- five had physical and/or mental health problems
- six had substance abuse problems
- three had been neglected or maltreated
- one had an intellectual disability.²³

²¹ Fleming, J, Gately, N & Kraemer, S, 'Creating HoPE: Mental Health in Western Australian Maximum Security Prisons' 2011 *Psychiatry, Psychology and Law*, doi:10.1080/13218719.2010.543405, pp 7-8.

²² Indig D, Vecchiato C, Haysom L, Beilby R, Carter J, Champion U, Gaskin C, Heller E, Kumar S, Mamone N, Muir P, van den Dolder P & Whitton G, 2009 *NSW Young People in Custody Health Survey: Full Report* 2011, p 11.

²³ Office of the Auditor General, *The Juvenile Justice System: Dealing with Young People under the Young Offenders Act 1994: Performance Examination* 2008, p 24.

That report also refers to an earlier *Department of Justice Review of the incidence of various mental health issues in the WA Justice System* (2006) which found only 26% of juveniles in detention had mental health issues. If correct, that report indicates that the rates of mental illness amongst detainees in WA may have been, at least some time ago, lower than in NSW.

It is likely that the rates of mental illness amongst juvenile detainees in WA are nevertheless high. Professor Bryant Stokes referred to 10% of juveniles in detention having major psychiatric illness (not including mental impairment) and stated that 8-10 per cent of these were affected by head trauma, substance abuse or foetal alcohol syndrome.²⁴

Recently I had the benefit of attending a stimulating address given by Dr Marshall Watson, who is a forensic psychiatrist and a senior registrar in Child and Adolescent Forensic Services. He is also a Noongar man from Albany. He reports that the majority of the young people that he sees at Banksia Hill/Hakea Detention Centres have severe post-traumatic stress disorder.

Sometimes, probably too often, mentally disturbed juveniles are placed in detention because there is simply nowhere else their safety can be guaranteed. A stark example is provided by the case of a 10-year-old boy who had been detention in Banksia Hill on the night of the riot in January 2012. When the President of the Children's Court reviewed his case, he noted that this 10-year-old, from a town in the north west, was in detention on remand after breaching bail on charges of stealing some glue, a trespass and stealing some deodorant cans. The President was

²⁴ Professor Bryant Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* July 2012, p. 116.

clear that the child was being detained in Perth for offences which would not warrant detention; he was in Banksia Hill because he had a serious solvent sniffing problem. When the boy had presented to the court in the regional town, he was under the influence and not in a position to plead; he was also in need of some urgent medical assistance.

The President understood that this child had been remanded in custody because there were no other arrangements for him in his community, either with his family or any welfare agency. There were concerns that there could "be serious consequences so far as his wellbeing is concerned". In fact the remanding magistrate had been fearful that this young boy would die in the absence of any local arrangements for his accommodation and care. The relevant police officer had also expressed alarm to the magistrate in the following terms: "With [this child] being only 10 years old and his substance abuse being out of control, I hold grave fears for [this child] and his future". The officer also noted that she was trying to contact mental health authorities to find out the level of contact that they had with the child, "if any".

The response of the police and the judicial officers to the dilemma which this boy presented was understandable. They felt they had no option other than to place him in detention in order to keep him safe, even though his offending behaviour did not justify that course.²⁵ I am very pleased to be able to advise that the child appears to have ceased substance misuse after the counselling he subsequently received from a regional service provider and the more recent relocation of the child and

²⁵ There are significant problems making a hospital order under s 5 of the *Criminal Law (Mentally Impaired Accused) Act 1996* for accused people with suspected mental health issues in regional areas: see Department of the Attorney General, *Equality before the Law Benchbook 2009*, p 9.3.14 even if such an order was available. Although disorders such as substance abuse disorders are commonly diagnosed by mental health professionals, they would not necessarily be considered "mental illnesses" under the statutory definition (Karen Freeman, 'Mental Health and the Criminal Justice System' *Crime and Justice Bulletin* (No 38) October 1998, p 2).

his family to Perth which changed his peer associations and the environmental factors which had contributed to his substance misuse. However, as a community I think we should be very concerned when the only apparent means at our disposal to keep an obviously unwell child as young as 10 safe from harm is to place that child in detention.

Criminal Law (Mentally Impaired Accused) Act

The data to which I have been referring up until this point concerns those who have been placed in prison or detention as a consequence of their conviction for an offence. However, there is another category of detainee suffering mental illness or intellectual disability which is numerically smaller but by no means insignificant. I am referring to those who are detained pursuant to the provisions of the *Criminal Law (Mentally Impaired Accused) Act 1996* as a result of being not mentally fit to stand trial, or having been found not guilty on account of unsoundness of mind.

On previous occasions I have pointed out what I consider to be the deficiencies in this legislation. First, when a court makes a custody order in respect of a mentally impaired accused, that person has to be detained in an authorised hospital, a declared place, a detention centre or a prison. Placement in an authorised hospital will only be appropriate if the person has a treatable mental illness. In the case of intellectual disability or cognitive impairment which is not susceptible to treatment, placement in a hospital would not be appropriate and no places have yet been declared under the Act, with the result that the only alternative is prison. To its credit, the government has announced the allocation of funding to construct places which can be declared under the Act, and in which persons can be housed other than in a prison, although, as might

perhaps have been expected, the identification of an appropriate location for those facilities has been contentious.

Second, if a court decides that an accused person is not mentally fit to stand trial and is not likely to become mentally fit to stand trial within 6 months after making that finding, only two options are available under the Act. The first is to make a custody order which will, in almost all cases, mean that the accused person will be imprisoned indefinitely. The only other option is to make an order dismissing the charge with the result that the accused person is released unconditionally. As I have previously observed, it would, I think, be most desirable if the court was given the option to impose conditions upon the discharge of the accused person - for example, requiring the accused person to undertake treatment, or to reside at a particular place where support might be provided, or perhaps to refrain from attending places at which the accused person might be at greater risk of offending behaviour. The stark choice between indefinite imprisonment on the one hand and unconditional release on the other is an unusually blunt instrument in dealing with the wide variety of circumstances which arise under the Act.

Third, because the effect of a custody order is to place the accused person in indefinite detention, there is a very real prospect that such a person might remain in custody for longer than if they had been convicted of the offence or offences with which they have been charged. This is not a theoretical prospect - it has happened in the case of Mr Marlon Noble, with which many of you will be familiar. The same issues can arise with respect to those sentenced to indefinite detention under sentencing regimes which no longer apply, as in the case of Mr Gregory

Yates whose sentence to indefinite detention in 1987 was recently quashed by the High Court in an extremely belated appeal.

Dangerous Sexual Offenders

There is another increasingly significant category of prisoners who are, in effect, being detained indefinitely, very often as a consequence of mental illness or disability increasing the risk that they will lack capacity to change their offending behaviour. I refer to those who are the subject of continuing detention orders made under the provisions of the *Dangerous Sexual Offenders Act 2006*. Experience of the operation of the Act has shown that those suffering from some form of mental illness or cognitive disability are over-represented in those against whom orders are sought and made, as are Aboriginal men from remote and regional communities.

This brief analysis of data drawn from prisoner cohorts reinforces the point I made earlier to the effect that for many, one form of institutionalisation has been replaced by another. People are imprisoned or detained, sometimes indefinitely, because their mental illness or cognitive disability renders them incapable of meeting the behavioural standards required by a structured and disciplined society.

Of course some mentally ill offenders will commit such serious crimes, or pose such a risk to the community, that detention, perhaps in a prison, is the only appropriate disposition. But there may be mentally ill offenders who are more of a nuisance to public order than a threat to public safety. Diversion of these offenders into a therapeutic regime instead of institutionalisation in a penal regime, offers a greater prospect that their

behaviour can be brought within acceptable community standards, not least because the prospects of rehabilitation will likely be enhanced if the stigma and trauma and social dislocation which accompany imprisonment are avoided.

The prevalence of people with mental illness and intellectual disability in the criminal justice system poses the important question of how well we deal with such people in that system. That is the question to which I will now turn, starting firstly with those in custody, and then turning to those who intersect with the police.

Prisons

It is evident from the data referred to previously that prisons now deal with significant populations affected by mental illness and cognitive impairment. As I have noted, the Director of the State Forensic Mental Health Service has observed that prison services are providing care to more persons with psychiatric illness than any other mental health service. Prison can provide for positive intervention into the mental health conditions of prisoners. There is some evidence that incarceration can increase the prospect of appropriate treatment, and the incidence of persons taking appropriate medication. But how much capacity do prisons have to fulfil this role?

A study conducted by Curtin University in 2006 and 2007 at eight West Australian prisons including metropolitan and regional sites, surveyed 184 health professionals, correctional staff and prisoner patients. It found that more than 65% of the staff who participated in the study had not received any training in managing mental illness; more than 65% said they did not feel they had adequate training to have people with a

mental illness under their care. Health professionals and correctional staff looking after male prisoners with a mental illness felt they were merely "crisis managing" because they lacked enough skills, knowledge and resources.

The study was summarised in these terms:

Dr [Kate] Hancock's research supports other findings that people with a mental illness were over-represented in prison populations and are struggling to function in correctional environments...

"Over a third of the staff sampled say they are coping day to day, and the majority of staff report they are doing the best they can with the facilities and knowledge they have."

Insufficient resources, struggling to find a balance between therapy and security, and prison officer role conflict were some of the reasons cited by staff.

"On the positive side of the prison work experience ... prisoner patients in the sample reported that prison can be a helping hand providing them with access to some mental health services."

But Dr Hancock said the findings also demonstrated the complexity and frightening situation experienced by prisoner patients living in prisons, not only coping with a mental illness, but with people who generally did not understand them and with limited services to adequately address their needs.

More than half of the prisoners also reported they were treated differently by other inmates because of their mental illness with many taunted and discouraged from taking their medication.

"There was a general sentiment that individuals with mental health issues are vulnerable and isolated in the prison system," Dr Hancock said...

"Prisons provide a captive audience and an opportunity to work with the mentally ill who unfortunately come into contact with the justice system," she said.

There is a need to develop a correctional approach to health and mental healthcare delivery because the present model is ineffective.

Dr Hancock said there was also a need to improve community mental health services in order to reduce the number of mentally ill people coming into contact with the justice system.²⁶

According to a 2008 briefing paper on Key Human Rights Issues in Australia, the Human Rights Law Research Centre argued:

The number of forensic patients and mentally ill inmates in Australian prisons is increasing, without a proportionate increase in health resources... There is substantial evidence from across Australia that access to adequate mental health care in prisons is manifestly inadequate, that the mentally ill in prison are often 'managed' by segregation, and that such confinement – often for very long periods – can seriously exacerbate mental illness and cause significant psychological harm.²⁷

Another significant factor in the effectiveness of any mental health intervention for prisoners is how this translates into support for people upon release. A 2007 NSW study of released prisoners found that:

suicide and drug overdoses are frequent causes of death in the period immediately following release from prison. The shift in responsibility for prisoners from prison health authorities to the community is rarely formalised, and these people often return to the community with few supports in place. Without adequate measures to ensure that responsibility for care flows seamlessly from the prison to the community, despair and death among these people will likely continue unabated.²⁸

²⁶ Curtin University Media Release, 'Curtin research reveals lack of mental illness support in prisons' 9 November 2010.

²⁷ Human Rights Law Research Centre, *Briefing on Key Human Rights Issues in Australia* February 2008, p 24.

²⁸ Azar Kariminia, Matthew G Law, Tony G Butler, Michael H Levy, Simon P Corben, John M Kaldor and Luke Grant, 'Suicide risk among recently released prisoners in New South Wales, Australia' *Medical Journal of Australia* 2007, 187(7) 387-390.

A supported transition from prison back into the community is often critical to realising any of the benefits that are intended to accrue from a term of incarceration. For example, in another study of ex-prisoners:

It emerged ... that prisoners released unconditionally without parole or other supervision may have less prospect of successfully returning to the community than those released under supervision conditions. Prisoners released from remand or at the end of a sentence without a parole period were more likely to have to try and get by without support or guidance. Many prisoners found this too difficult and a lack of supervision and support was seen by both staff and clients to directly relate to levels of re-offending.²⁹

In relation to ex-prisoners with mental health issues, the study further noted:

A number of staff [working in the agencies studied] identified mental health issues as a major challenge in providing accommodation and other services. Many ex-prisoner clients present with problems such as depression and anxiety while one staff member estimated that 85 per cent of women being supported by her agency have Post Traumatic Stress Disorder (PTSD) as a result of domestic violence and abuse. Agencies are not equipped to provide the services needed to deal with these sorts of problems and find specialist mental health services lacking in some areas.

Many ex-prisoners also present with intellectual disability issues which can interfere with their ability to deal with daily living problems and integration with the community.

The problem is compounded by the shift of mental health treatment and care responsibilities from institutions to the community. Staff indicate this has placed a great deal more people with mental health problems into situations of homelessness and contact with the criminal justice system and accordingly increased the complexity of servicing the area of homelessness.³⁰

²⁹ Australian Institute of Criminology (AIC), *Ex-Prisoners, SAAP, Housing and Homelessness in Australia* May 2004, p vii.

³⁰ AIC, *Ex-Prisoners, SAAP, Housing and Homelessness in Australia* May 2004, p 109.

The significant reduction in the number of prisoners released on parole in Western Australia since 2009 might be having the adverse effect upon prisoners suffering from mental health issues to which these reports refer. However, as far as I am aware, no studies have been conducted in Western Australia to ascertain whether there is any evidence of the effects which the significant change in parole policy has had upon this significant category of prisoner.

Police

Of course it is also important to recall that prisoners represent only a proportion of the people who commit criminal offences, as most convicted offenders do not receive a custodial sentence. In a study conducted by the Australian Institute of Criminology (AIC) in 2012, it was observed that:

*For example, in New South Wales, from 2004 to 2008, around seven percent of those convicted in local courts and 70 percent of those convicted in higher courts were given a prison sentence. This highlights the importance of adopting a multi-pronged and comprehensive approach to the identification and treatment of mental disorder among people throughout the criminal justice system—not only those in prison.*³¹

The AIC study found that:

Results suggest that almost half of detainees [in the custody of police in NSW] may have a diagnosable mental disorder at the time of arrest, including 42 percent of women and 28 percent of men with no previous diagnosis. In the routine screening of police detainees as they enter the criminal justice system, the CMHS [Corrections Mental Health Screen] could be used to identify for

³¹ Lubica Forsythe and Antonette Gaffney, 'Mental disorder prevalence at the gateway to the criminal justice system' *Trends & issues in crime and criminal justice* July 2012, p 1.

the first time those who would benefit from psychological assessment and appropriate intervention [underlining added].³²

A recent report by the Independent Police Complaints Commission (IPPC) in the UK found that of the 15 deaths in police custody in 2012-13 almost half (7) were known to have mental health issues; nine of the deaths had a link to alcohol and drugs and in an additional 21 deaths that followed police contact, in 17 cases the police were contacted as a result of concerns being raised about the individual's safety or well-being. Dame Anne Owers, chair of the IPCC, said:

The police are often called in to deal with acutely mentally ill people, who may be a danger to themselves or others or who may be behaving in a disturbing or strange way. It is clearly important that they are better trained in mental health awareness. But these figures also point to gaps and failings in the services that ought to support those with mental illness - before, instead of and after contact with the criminal justice system.³³

Ian Cummins, Senior Lecturer in Social Work at University of Salford, noted:

It is not just these figures that need to be examined. The report also found a rise in the number of apparent suicides in the two days following release from police custody; 64 individuals took their own lives in 2012-13 under such circumstances. Over two thirds of this group had some history of mental illness, including seven who been detained under the Mental Health Act.³⁴

His research "found that police officers are frustrated that they receive relatively little specific mental health training, but are called upon to deal with individuals experiencing acute distress."³⁵

³² Lubica Forsythe and Antonette Gaffney, 'Mental disorder prevalence at the gateway to the criminal justice system' *Trends & issues in crime and criminal justice* July 2012, p 1.

³³ IPCC, 'IPPC publishes annual deaths during or following police contact for 202/13 – mental health a key factor' 22 July 2013.

³⁴ Ian Cummins, 'Police are unprepared to care for people with mental illness' *The Conversation*, 29 July 2013.

³⁵ Ian Cummins, 'Police are unprepared to care for people with mental illness' *The Conversation*, 29 July 2013.

Another study, using WA data and published in 2008 (although the data was from 1985-1996) had a specific focus on schizophrenia:

The place in society and the care of people with severe mental illness such as schizophrenia constitutes one of the thorniest issues in public health and social policy worldwide. In recent years, changes in the management of this disorder have made it possible for an increasing number of individuals with schizophrenia to lead semi-dependent or independent lives in the community. However, irrespective of the deinstitutionalisation of mental health care and the concomitant focus on the human rights of the mentally ill, the capacity of communities and of society at large to deal with emerging problems of marginalisation, homelessness, poverty, victimisation and criminal behaviour has been put to a severe test. This has been compounded by widespread stereotyping and stigmatisation of individuals with mental illness. The 1996 General Social Survey (US) revealed 'an underlying negative attitude toward persons with mental health problems, an exaggeration of the impairments or "threat" associated with these disorders, and a startling negativity toward individuals with substance dependence problems'. Information on the prevalence of police contact for individuals diagnosed with schizophrenia and other psychiatric disorders is of vital importance for public policy. Resources are available in courts and corrective services to identify and provide support for individuals with mental health problems. However, the adequacy of service levels and their geographic coverage is unknown. There is a corresponding need to identify trends in the demand for services over time. These issues are increasingly important in the context of deinstitutionalisation, with some arguing that inadequate specialist and community support has led to the criminalisation of mental illness. However, little is known in Australia about the social ecology of offending by persons with schizophrenia.³⁶

³⁶ Frank Morgan, Vera Morgan, Joe Clare, Giulietta Valuri, Richard Woodman, Anna Ferrante, David Castle and Assen Jablensky 'Schizophrenia and offending: area of residence and the impact of social disorganisation and urbanicity' *Trends & Issues in crime and criminal justice* August 2008, pp 1-2.

The study concluded that "Crime prevention considerations point to a greater need for services for people with serious mental illness living in areas characterised by social disorganisation or inequality":³⁷

*... the same area or community processes that generate high arrest rates for individuals with schizophrenia produce high crime rates for the general population. For example, homelessness, drug and alcohol abuse, unemployment, and lack of family support are associated with criminality and victimisation for all citizens, not only those with mental disorders. However ... these 'burdens of everyday life' are far more prevalent in individuals with psychoses than in the general population. Only 19 percent of persons with psychosis were currently employed, 85 percent were on a government pension or other social benefit, 59 percent had impaired social functioning and 49 percent had impaired capacity to undertake basic household activities. The self-reported rate of victimisation in the past year was 18 percent.*³⁸

In WA there are provisions in the *Mental Health Act 1966* which empower police to apprehend people if they have a reasonable suspicion that the person has a mental illness and needs to be apprehended to prevent harm to that person, other people or serious property damage, and to refer them to a medical practitioner as soon as practicable (s 195). There is also a power for police to refer persons arrested for an offence for an examination by a medical practitioner where the officer suspects on reasonable grounds that person has a mental illness (s 196). In 2011, the Minister for Police advised that the police do not collate figures on the use of s 196.

In other jurisdictions (such as the Netherlands), arrangements have been made for police to be accompanied by psychiatric nurses or others with appropriate mental health training when called out to disturbances

³⁷ Frank Morgan et al 'Schizophrenia and offending: area of residence and the impact of social disorganisation and urbanicity' *Trends & Issues in crime and criminal justice* August 2008, p 6.

³⁸ Frank Morgan et al 'Schizophrenia and offending: area of residence and the impact of social disorganisation and urbanicity' *Trends & Issues in crime and criminal justice* August 2008, p 6.

likely to involve those with mental illness. In those jurisdictions, the arrangements seem to have worked very well. Assuming that it is unlikely that the resources for arrangements of this kind could be found within Western Australia, another way of addressing these issues might be by improving the levels of training given to police with respect to psychiatric illness and as to the most appropriate and effective means of dealing with persons with psychiatric illness.

The Crossroads - where to from here?

The topics which I have addressed are capable of leading to a sense of gloom, despair and despondency. However, it is not all bad news. I have already referred to the provision of funding to provide places in which mentally impaired accused may be kept other than prison. There have been some other very positive developments in relation to mental health issues in the criminal justice system, to which I will now turn, in the hope that they might cheer us all up. Those developments include:

- (a) increasing recognition of the need for community-led projects, including projects of the kind to be discussed at this conference, and in relation to Aboriginal healing;
- (b) improvement in local health services, such as by the expansion of the Wheatbelt Mental Health Clinic;
- (c) the establishment of a mental health court;
- (d) the establishment of a mental health team at the Children's Court.

Aboriginal Healing and Other Community Led Responses

Recently Professor Fiona Stanley wrote: "It seems obvious, but it is a lesson we have been slow to learn." She was referring to what she had

learned working at the Fiona Stanley Institute with Aboriginal people, and specifically to the comments of Associate Professor Ted Wilkes, a Wadjuk Noongar man. His advice to her about Aboriginal people's apparently intractable health problems was that: "Who knows and cares most about Aboriginal health? We do. So give us the knowledge and partner with us to enable us to be responsible for our own health and well-being".³⁹

In 'On the ground: Key to successful policy outcomes', Professor Stanley advocates for two key changes that must be achieved if we are to secure positive outcomes: the first is truly engaging with the people who are the intended recipients of services. Professor Stanley notes:

*Understanding this is crucial. It explains why we spend so much money on Aboriginal services that have failed. They have not failed because Aboriginal people are hopeless, drunk and useless, but because the services were not appropriate.*⁴⁰

Whether talking about Aboriginal people or more generally, we have been slow to learn that those who care most can be the most effective architects of effective service delivery - provided they are given knowledge and partnership. An example of this can be seen in the work of the Regional Men's Health Initiative in the WA Wheatbelt, and the national recognition of its Executive Officer and Community Educator in 2011, Julian Kreig, for his suicide prevention work.⁴¹ Much of the program for this conference reflects the same reality.

³⁹ Fiona Stanley, 'On the ground: Key to successful policy outcomes' [online] *Griffith Review*, No. 41, 2013: [200]-[210].

⁴⁰ Professor Stanley cites the fate of the Indigenous Family Program developed by two "outstanding Noongars, Dean Collard and Barbara Henry" which worked with the most disadvantaged and needy Aboriginal families, describing it as "one of the most cost-effective programs yet delivered in the state for Aboriginal people." The funding ran out, it was "mainstreamed" by government and it stopped being effective.

⁴¹ Colin Bettles, 'Mental health initiative recognised in Wheatbelt', *Farm Weekly*, 15 September 2011.

The second part of the new paradigm advocated by Professor Stanley, specifically for working with Aboriginal people, is the "importance of culture in developing and delivering effective services". A recent publication by the Aboriginal and Torres Strait Islander Healing Foundation provides guidance about what might assist in tackling the causes of offending by young Indigenous people. It advocated:

- respect for Aboriginal and Torres Strait Islander culture, empowering families and communities to take control and responsibility;
- instilling a strong sense of identity and cultural pride and providing opportunities to participate in cultural life for Aboriginal and Torres Strait children and young people;
- supporting Aboriginal and Torres Strait Islander service systems by providing the necessary training, resources and support; and
- incorporating the latest research in trauma recovery and healing with Indigenous cultural wisdom.

The Aboriginal and Torres Strait Islander Healing Foundation observed:

Aboriginal and Torres Strait Islander children and young people may experience trauma through direct experience or secondary exposure. Direct experience occurs through abuse, neglect and exposure to violence. Secondary exposure for Aboriginal and Torres Strait Islander children and young people occurs through bearing witness to the past traumatic experiences of their family and community members as a result of colonisation, forced removals and other government policies. A key consequence of secondary exposure to traumatic experiences is intergenerational trauma.

Intergenerational trauma is a form of historical trauma that is transmitted across generations. It is the trauma that is transferred from the first generation of survivors that directly experienced or

witnessed traumatic events to the second and further generations... researchers have suggested that historical trauma can become normalised within a culture because it becomes embedded in the collective, cultural memory of a people and is passed through the generations using the same mechanisms by which culture is generally transmitted...

Childhood trauma has the potential to interrupt the normal physical, physiological, emotional, mental and intellectual development of children and can have wide-ranging, and often life-long implications for their health and wellbeing. Prolonged exposure to chronic stress and trauma alters a child's brain development, continually activates a stress response and leads to hyper-arousal. The capacity to learn and concentrate, develop trusting, reciprocal relationships, regulate behaviour and make use of self-soothing or calming strategies is all severely impaired in children who have experienced trauma, including intergenerational trauma. Without the necessary skills, many children grow into young people and adults who struggle with self-destructive, pain-based behaviours including aggression and violence, substance misuse, criminal acts, suicide, sexual promiscuity and inactive lifestyles.

Aboriginal and Torres Strait Islander children, families and communities experience significant social and economic disadvantage and fare worse on almost all measures of health and wellbeing compared to their non-Indigenous contemporaries. This disadvantage is even more pronounced among those affected by the policies of forced separation and removal from family and country. The Western Australian Aboriginal Health Survey reported that carers of children and young people who had experienced the legacy of the Stolen Generations, either directly or through family, were more likely to have contact with the criminal justice system, struggle with excessive alcohol use and gambling and have poorer mental health. In addition, those parents and carers who had been forcibly separated from their own families were deprived of the experiences necessary to become 'successful' parents themselves, a significant but not necessarily well understood factor in why Aboriginal and Torres Strait Islander children and young

*people come to the attention of statutory child protection authorities at such alarming levels.*⁴²

Recently Jim Morrison, of the Stolen Generations Alliance, called for an audit of the prisons to identify those affected by the stolen generations, directly and through inter-generational trauma, so that psychological support could be given to them. He said:

*I could take a bet that most of the kids in juvenile detention are descendants of stolen generations who haven't been able to move on from what happened to them.*⁴³

I referred earlier to Dr Marshall Watson. Significantly Dr Watson also emphasises that for Aboriginal people, cultural safety is as important as clinical safety. He identifies this as a problem if not recognised when treating Aboriginal people. He also draws attention to the problems arising from the fact that instruments used to assess risk are derived from non-indigenous populations and are consequently unreliable. Dr Watson cited a statement by the President of the Indigenous Doctors Association to the effect that, "We need to stop medicalising indigenous people and start indigenising medicine".

The collaborative and respectful approach advocated by Fiona Stanley, the Healing Foundation and Dr Marshall Watson can be seen at this conference with the presentation by Gina Williams, the 'Ngaamrul Sessions' with Linda Sharman and Alison Woods, 'Yarns of the Heart' with Geri Hayden and Sonia Kickett and the 'Culturally Competent Community Development In Aboriginal Mental Health' workshop with Nathan Coleman, Doreen Davis, Leanne Moody And Des Williams, and much more.

⁴² Aboriginal and Torres Strait Islander Healing Foundation, *Growing our children up strong and deadly: healing for children and young people* (2013).

⁴³ Colleen Egan, 'Indigenous group backs prisons audit' 29 August 2013, *The West Australian*, p 4.

Wheatbelt Mental Health Clinic

As I indicated, the improvement in local health services, such as by the expansion of the Wheatbelt Mental Health Clinic is another significant advance that deserves recognition. The Wheatbelt Mental Health service, with its main office in Northam and offices in Merredin and Gingin, has consultant psychiatrists, clinical psychologists, social workers, child and adolescent professionals and community health nurses. Its services include child and adolescent mental health, adult and seniors mental health programs.

When the clinic re-opened, after being refurbished in 2010, the Member for the Agricultural Region Hon Jim Chown MLC welcomed the investment and highlighted the crucial need for support networks for people with a mental illness, noting that the suicide rate for young men throughout the WA Wheatbelt was the highest in the country.⁴⁴ When Dr Graham Jacobs MLA, the then Mental Health Minister, opened the clinic, he commented on the breadth of services that were to be available, with services for children, adolescents, adults, Aboriginal people and the elderly, as well as support for carers and families. As a first for rural Western Australia, Dr Jacobs also noted the establishment of a small specialist youth mental health team focusing on specific programs for Avon Valley Aboriginal youth, who have high-risk mental health problems.⁴⁵

Of course there is always more to be done. Recent service plans by WACHS for the Western and Eastern Wheatbelt Health Districts noted a number of gaps in mental health/drug and alcohol services in those

⁴⁴ ABC News on-line, 'Wheatbelt mental health service to re-open', 2 September 2010.

⁴⁵ Minister for Mental Health, 'Wheatbelt mental health service - Northam clinic officially opened', 1 September 2010.

regions. These included the need for more preventative programs and the expansion of programs targeting:

- youth and adolescents, particulate given the high suicide rate;
- those with both substance abuse issues and mental illness;
- the gaps in men's health – especially targeting family violence;
- the mental health needs of Aboriginal people; and
- supported accommodation for people with a mental illness in the Eastern Wheatbelt.⁴⁶

I was very pleased to note that another local service, Wheatbelt Men's Health, has been nominated as a finalist in the 2013 Mental Health Good Outcomes Awards.

The Mental Health Court

The mental health court, also known as the START (Specialist Treatment and Referral Team) court, is another very significant initiative.

It is a \$4.5 million pilot project which commenced operations on 18 March 2013, so it is now only six months old. At present it is available to people appearing in the Perth Magistrates' Courts. Referrals can be made by general courts, police or prosecutors. It involves a court-based mental health team which conducts assessments, reports to the court, and develops intervention plans to divert people into treatment to address their mental illness and their offending behaviour. Some people may need to be referred to hospital, some may benefit from simply being reconnected with their GP or mental health service, and some may not need any assistance from the mental health team.

Others are referred to a voluntary intervention program and have an individualised intervention plan prepared, often linked to their bail

⁴⁶ WACHS, *Service Plan: Western Wheatbelt Health District 2011/12 2021/22*, June 2012 p 25; WACHS, *Service Plan: Eastern Wheatbelt Health District 2011/12 2021/22*, June 2012, pp 23-24.

conditions. The intervention plan could include treatment by the court team, referral to community mental health and liaison with relevant non-government providers and government departments. The team also has access to a small amount of funds to ensure that urgent needs, such as crisis accommodation, can be secured quickly. It was intended that the liaison and support work be led by an NGO with experience in providing these services. Significantly the Mental Health Commission notes that the "capacity to stabilise a person's condition can make the granting of bail more likely, and assist in people away from custody where possible".⁴⁷

As at 31 July 2013, 169 individuals had appeared in the court. Approximately one-third of these were women, and one in five was between the ages of 19-25. The largest age cohort was 23% between 31-55 years old; almost one in four were over the age of 40; three in four were under 40. Only 10% of those appearing before the court were Aboriginal, lower than anticipated given the disproportionate involvement of Aboriginal people with the criminal justice system.

Some preliminary statistics which have not previously been released publicly indicate that these individuals had been charged with over 450 offences, the most significant category (almost 30%) being "offences against justice procedures and ... government operations". These include breaches of community based orders, violence restraining orders and resisting public officers. Magistrate Vicki Stewart advises that the most significant offence type relates to breaches of restraining and other orders. However there are also a significant number of personal violence charges – almost 15% (including acts intended to cause injury;

⁴⁷ Mental Health Commission, 'Mental Health Court Diversion and Support Plan' accessed on 3 September 2013.

and a small number of sexual assaults and dangerous or negligent acts endangering a person). Theft and fraud make up almost 25% of the charges and surprisingly perhaps illicit drugs charges only less than 3%. As might be expected public order offences (including public disorder and offensive conduct charges) and property damage, account for some 20% of charges.

Legal representation was available for all appearing in the court. So far more than four in five of those who have appeared in the court were represented – most being represented by Legal Aid (over half) but also by other agencies including the Mental Health Law Centre (nearly 20%), ALS (7%) and CASE for Refugees.

The court has moved to a broad entry requirement, of the person having "mental health issues". Provided other criteria are met, the person is not in custody and does not have a serious violence charge, is willing to voluntarily participate and generally—but not necessarily—is not charged with an indictable offence, no one is turned away.

The court will sentence offenders but does not conduct trials. 117 individuals were supported by the clinical team and approximately 30% participated in the PATHS program.⁴⁸ The difference in numbers includes individuals who are still on assessment, were not suitable, did not want to participate or were dealt with immediately.

The Mental Health Commissioner recently reported that the "take up" of the services of the clinical team by people appearing in the START Court was "very, very high". Importantly, he noted that the court

⁴⁸ After assessment and if recommended for START court the participant is placed on the PATHS program. The program involves an individualised care plan, monitoring by the START court team and regular case reviews by the court. The length of the program is usually between 4 and 6 months.

provided a link to assessment and treatment and "not just going down the criminal justice route". The Commissioner highlighted that an independent evaluation of the program would evaluate both the implementation and the outcomes of the program. Ideally, he said, the program would not only continue beyond the pilot stage, but also, most importantly, extend to country areas as well.⁴⁹

The key advantages of the START Court identified to date have been its capacity to:

- look after people while links to community support agencies are being established;
- develop individualised care plans addressing a person's holistic needs;
- set up community support for people so they do not need to be in custody;
- make a hospital order due to the person's risk to themselves or others when required which, from a medical perspective, is a very valuable tool if used appropriately; and
- liaise between treating teams and other agencies to help optimise treatment and reduce the risk of re-offending.

One example of how important this court can be for the individuals appearing before it involved an older man who was charged by a local shire for sleeping rough. Bail was set but the man refused to sign the bail papers. He was ordered to have his mental fitness to plead assessed but this would take 2 months. In the meantime he was being kept in custody and went on a hunger strike. The START court was able to make arrangements for the man to be supported in the community and the duty lawyer commenced negotiations on his behalf with the

⁴⁹ Extract from Hansard [ASSEMBLY—Wednesday, 21 August 2013] p395b-407a.

prosecuting shire; he was released from custody pending the hearing in October to finalise the matter.

The START court replaced the list known informally as the "Noon List" at Perth Magistrates Court which had operated for many years. This informal arrangement operated for only one day a week, while the START court runs five days a week. START court also has specifically dedicated resources to support people while the list only provided for a mental health assessment to be undertaken and a report provided to the court.⁵⁰ I note that the Court Liaison Service continues to assist mentally unwell persons in other metropolitan, regional and higher courts on request. This service works in close collaboration with the START team clinicians, to ensure clients get the best possible care.⁵¹

However the START court is limited in a number of respects:

- at present it has only one community corrections officer (compared to the 6 in the Drug Court);
- the partnership arrangement with a community support organisation is yet to be finalised;
- there is relatively low participation by Aboriginal people. It is believed if the court is expanded into regional areas the proportion of Aboriginal people appearing before it would increase;
- the severity of the disorders is problematic from a medical perspective – these are often chronic, persistent and the patients are treatment-resistant; and
- the clinical team are restricted to being court based and have to rely on community services for home visits and support.

⁵⁰ Department of the Attorney General & Mental Health Commission, 'New start for people with mental illness', 26 March 2013.

⁵¹ START Court, CLS and START Clinical Service - Information sheet.

The expectations associated with the establishment of this court are very high. This is understandable given the importance of such an initiative. While it certainly needs to be, and is being, objectively evaluated, it must be recognised that the START court will not be able to address the multifaceted needs of the criminal justice system in its dealings with mentally ill people. The intersection of the criminal justice system and mental illness, as everyone at this conference knows, is an uneasy junction and it takes a toll on all involved; it is also difficult and high risk.

Any initiative in this area will be most meaningful if it is effective in assisting mentally ill people negotiate the criminal justice terrain. The START court has the potential to be just that – a new START not just for the individuals who appear before it but also for ways in which the courts interact with the mentally unwell. It is something to watch closely, with interest, and also to support and hopefully expand.

An assessment of the Court Liaison Service in 2010 by Psychiatrist Adam Brett, 'Western Australia's Mental Health Court Liaison Service', provides some important guidance on how an initiative such as the START court can be evaluated.⁵² He noted that a mature service will develop close links with community mental health services, police and community corrections. He writes that when these services are working in close harmony there will be a much higher chance to improve community safety and reduce reoffending rates. Dr Brett also noted that it was important that a court liaison service was assessed on factors on which the court has a direct effect. So, for example, it might be useful to assess the service on the proportion of people it assessed; also on the

⁵² Adam Brett, 'Western Australia's Mental Health Court Liaison Service' *Australas Psychiatry* 2010 18: 158
DOI: 10.3109/10398560903294298

referral process to identify any flaws so this can be addressed by the service.

At that time, Dr Brett commented that the most compelling deficit in the operations of the Court Liaison Service was its inability to refer offenders to mainstream inpatient facilities, reflecting the ease of admission to the forensic unit (at Graylands). He reports the view that there needed to be earlier diversion at the point of arrest, a view which I share. In other respects however, it would seem that the START court's resourcing and broader linkages with the health and community sector have the potential to address some of the other deficits identified.

The Children's Court Mental Health Team

Another very significant initiative has been the establishment of a mental health team at the Children's Court. The \$2.2 million pilot program commenced on 8 April 2013 and initially is focussed on the metropolitan area. It is different to the START court because it involves the placement of a small mental health and NGO team in the Court. Unlike the adult program, a separate court will not be established, because in the Children's Court it was identified that the priority was to integrate the services into the existing case management and multi-agency services working within the Children's Court. The Mental Health Commission states that the team offers assessments, some clinical intervention, and referrals and assistance in accessing community and NGO services. Similar to the adult court, the team has access to some funds to meet urgent psycho social needs, particularly those not able to be provided by existing resources.⁵³

⁵³ Mental Health Commission, 'Mental Health Court Diversion and Support Plan' accessed on 3 September 2013.

The Mental Health Commissioner recently reported that in the first two months of its operation the team assessed 30 children. Like the adult mental health court, this program is also being evaluated with a view to its continuation and expansion into country areas.⁵⁴

Where to from here?

Each of the initiatives to which I have referred is an extremely positive development and can be expected to go some way towards addressing the problems associated with the prevalence of people with mental illness and cognitive disability in the criminal justice system.

However, it is obvious, particularly to those in rural and remote areas that none of the initiatives to which I have referred are a complete response to the significant needs in this area. The establishment of a mental health court and a mental health team at the Children's Court go some way to addressing the recommendations of Professor Stokes (and others before him). However a number of Professor Stokes' other recommendations in relation to the criminal justice system remain outstanding:

- the expansion of the currently inadequate number and location of secure forensic mental health inpatient beds;
- the diversion of early and minor offenders, and further offending behaviour if appropriate, from the formal justice system through a police diversion service in WA;
- the provision of a full range of mental health services in WA prisons and detention centres, involving dedicated units and services for mentally ill women, youth, Aboriginal and people with acquired brain injury/intellectual disability; and

⁵⁴ Extract from Hansard [ASSEMBLY—Wednesday, 21 August 2013] p395b-407a.

- the expansion of community services to facilitate the transition from prison, to assertively follow up people who are seriously mentally ill; to closely follow up and monitor mentally impaired accused patients on custody orders in the community; and to assess and care for particular groups of individuals with particular care needs such as sex offenders, stalkers and arsonists.⁵⁵

In a speech he gave in 1988, the 11th Chief Justice of Western Australia, Sir Francis Burt noted that calls for harsher sentences distract "from the true causes of crime ... you cannot eradicate the causes by dealing with the consequences."⁵⁶ The initiatives which have been taken, and which Professor Stokes has recommended, address the causes of crime and as such should not only reduce crime, but also improve the lives of those affected by mental illness – people with mental health conditions, those who work with them and those who care for them.

However, it is important to steadfastly bear in mind that there are real limits on what the criminal justice system can and should seek to do in relation to people who are mentally unwell or intellectually disabled. It could be argued that the vacuum left by withdrawal of institutional and other supports for mentally ill people 30 years ago has been filled to some extent by the criminal justice system; not always appropriately and certainly not always with adequate or properly skilled resources.

While it is undoubtedly true that there is a proper and critically important role for the criminal justice system in responding to mental health issues, it is a limited one. In that sense the many initiatives that are to be discussed at the conference, taking place outside of the justice system,

⁵⁵ Professor Bryant Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* July 2012, p 21.

⁵⁶ Speech '1988 Rotary District 1945 Conference', p 3, referred to in Francis Burt, *Interview with Sir Francis Burt, lawyer, judge, Chief Justice and Governor of Western Australia* [interviewed by Ronda Jamieson] (1994-95) p 232.

are crucial to the success of any initiatives taken by the police, the courts and the prisons. The broadly based initiatives which are to be discussed at this conference will hopefully reduce the intersection between the mentally ill and the cognitively disabled and the justice system. Where intersection occurs despite these initiatives, diversion of appropriate cases away from the criminal justice system into a therapeutic rather than punitive environment must be a key priority. For those whose offending behaviour necessitates that they remain within the criminal justice system, we must realise and seize the opportunities provided for therapeutic intervention, which will hopefully not only improve the health and welfare of the people concerned, but also improve community safety by reducing the risk of re-offending. These are perhaps the lessons to be learned at the cross-roads of criminal justice and mental health.