

Forensic Mental Health in Australia: Charting the Gaps

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Abstract

The process of national mental health reform is constrained by the failure to take account of forensic mental health services adequately. While there is some recognition that achieving national consistency in forensic mental health is important, the achievement of this goal is hampered by substantial inter-jurisdictional differences in justice-sector funding, sentencing, and program infrastructure, leading to service gaps in forensic health services and inadequate connections between health and corrections services within jurisdictions. Achieving national consistency in forensic mental health within the broader mental health reform agenda requires national leadership directly to target people accessing health through a corrections gateway. The interconnectedness of public services such as education, housing, health and criminal justice must be acknowledged to provide a starting point from which equity of access and services can be addressed.

Introduction

The present federal government has made a commitment to a program of national mental health reform. This program recognises the high incidence and cost of mental illness in Australia and the structural arrangements that currently inhibit effective and efficient mental health service delivery (Department of Health and Ageing 2012). Despite general agreement across the international and Australian literature about the high numbers of prisoners experiencing mental illness, the mental health reform agenda in Australia does not acknowledge or address forensic mental health services, delivery or responsibility. This paper is a response to that paradox.

The national reform agenda excludes forensic mental health arrangements as a result of a number of service gaps. These gaps may be conceptualised as a gap in *a* service (forensic health at national level) or *between* services (health and corrections). Moreover, the different structural arrangements of responsibility for health and criminal justice in Australia inhibit the possibility of forensic mental health reform, despite international and national attention given to the broad principle of ‘equivalence’ in health care. The absence of ‘forensic’ mental health care from the national reform agenda is facilitated by a broad acceptance of the differential treatment of criminal justice populations generally — in different jurisdictions — and in comparison to the broader community.

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The government launched a strategic document in the 2011–12 Budget to improve mental health and health services in Australia (Australian Government 2011). The document outlines the start of a ‘ten year roadmap for reform’ (2011:5), which focuses upon the early identification of mental illness, improving access to mental health services and integrating mental health service provision. While this program of reform can be located within a health framework, there is some recognition that mental illness requires a holistic response, which includes, for example, reducing barriers to employment. However, the link between mental health treatment and the criminal justice sector is not explored or discussed in this document, nor in the various outputs from the reform agenda. It is estimated that one-third of the institutional population of patients with diagnosed mental illnesses receive their treatment in a prison setting (Ogloff et al 2007). This paper aims to explore some of the reasons that the national strategy on mental health has not covered forensic mental health arrangements.

There are several ‘gateways’ into health treatment, depending upon the needs and location of consumers. We are primarily interested in the criminal justice gateway and, in particular, the pathway to services for people in prison. While it is clear that an effective national response to mental illness must take into account the needs of people in the criminal justice system, there are a number of policy and resource issues that constrain such a response. A key issue is the high level of differentiation and inequality in sentencing and program provision in criminal justice and correctional services across Australia and the substantial impact this has on access to appropriate and timely mental health services. This situation contrasts with the apparently low tolerance of inequality in the health domain, and raises important issues about human rights and the structural organisation of health and criminal justice at state, territory and federal levels.

Background

The national reform agenda for mental health was instigated following the 1989 Australian Health Ministers’ Advisory Council decision to review mental health service delivery and policy. This led to the Mental Health Statement of Rights and Responsibilities and a series of national mental health plans, each spanning a five-year period from 1992. The post-1992 period represented a sea change in the provision of services in the community that were integrated and part of mainstream health responses (including, for example, the co-location of psychiatric units in general hospitals: Judd and Humphreys 2001; Richmond and Savy 2005). The first national mental health plan was considered to have made progress towards a positive process of reform; however, gaps in provision around access to services, evenness of progress and stigmatising staff attitudes were reported. The community arrangements that replaced institutional mental health services were fragmented from the outset (Richmond and Savy 2005). A second plan was agreed for the period 1998–2003 and included three priority areas: promotion of mental health and prevention/early intervention, the development of service partnerships to achieve reform, and improvements in the area of service quality and effectiveness (Judd and Humphreys 2001).

However, the first national plan did not include any consideration of forensic populations at all and the second national plan only briefly acknowledged the importance of partnership working across health and criminal justice. The early reform agenda clearly demarked a boundary between community and criminal justice populations experiencing mental illness. The third national mental health plan, covering 2003–08 and based on a model of population health, concentrated on the quality of mental health services, and

research and innovation, and advocated a prevention-led approach. This was framed within a multi-sectoral response, which included housing, employment and justice.

The most recent and fourth national mental health plan was endorsed in 2008 and covers the period 2009–14. The plan continues the principle of collaboration through the development of ‘integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage’ (Department of Health and Ageing 2009:iv). There is some consideration of the potential development of nationally consistent mental health legislation, but this is presented in the context of facilitating the transfer of people under civil and forensic orders across jurisdictional boundaries, or improving communication across sectors, rather than on consistent service provision across jurisdictions. There is also some recognition in the most recent national mental health plan that responding to mental illness in correctional settings is complicated by differences in the nature and extent of mental health services and the structural arrangements that underpin them in each state and territory. While the challenges of working towards national consistency are recognised, solutions are not presented in the document.

The generalised nature of targets and outcomes detailed in successive national mental health plans has been criticised (Hickie et al 2005). Richmond and Savy (2005) also point to the dearth of information on community mental health services in Australia — a situation which successive national mental health reports have failed to rectify.

In 2006, the Council of Australian Governments (‘COAG’) launched a National Action Plan on Mental Health, to operate alongside the third and fourth national mental health plans. The COAG reforms called for ‘coordination and collaboration between government, private and non-government providers in order to deliver a more seamless and connected care system’ (COAG 2006:i), with a COAG Mental Health Working Group convened to ‘ensure that all relevant Commonwealth, State or Territory government agencies work with each other at a State and Territory level’ (2006:6). However, it has long been recognised that integrated governmental responses to complex social issues are inherently problematic and require recognition of the policy and structural complexities involved and the development of collaborative response strategies (Australian Public Service Commission 2007). The COAG reforms applied to all government agencies and represented a commitment to think across education, health, housing and corrections in relation to the provision and quality of mental health services (White and Whiteford 2006). Prison mental health services are listed as an area of priority in the COAG national action plan; however, there is still an emphasis on jurisdiction-level reform, as opposed to national reform or achieving consistency in service provision at national level. Notably, forensic services are not included in areas of ‘common action’ (2006:2).

In the most recent Budget (2011–12), the government has prioritised proactive mental health services, particularly in the area of prevention of suicide. Mental health is considered a national priority, consolidated by the appointment of a Federal Minister for Mental Health (Australian Government 2011). The Budget plan and ‘ten year road map for reform’ aim to rectify the ‘fragmented and complex system of clinical and social support services’ (2011:6). However, forensic mental health services are not included in the Budget plan, suggesting a continued separation of mental health service provision and policy reform in community and corrections environments. In January 2011 the National Mental Health Commission was launched with a commitment to examine the ‘whole picture of mental health in Australia’ (Australian Government National Mental Health Commission 2012). Here too the importance of a cross-sectoral approach was emphasised, but it is too early to

tell what this will mean in practice. Indeed, criminal justice and forensic populations have not been explicitly identified as part of the reform agenda.

Mental disorder in the Australian criminal justice system

There is broad consensus that rates of mental disorder¹ are higher in criminal justice populations than in the community (Adams et al 2009; AIHW 2011; Department of Health and Ageing 2009; Richardson and McSherry 2010). Reported rates of mental distress are three to six times higher in Australian police arrestees than in the general population (Mouzos et al 2007), and studies of Australian court defendants also show high rates of mental disorder (Ross and Graham 2012). The Australian Institute of Health and Welfare ('AIHW') reported that, during a two-week census period in 2010, 31 per cent of prison entrants across most Australian jurisdictions (excluding New South Wales and Victoria) reported some history of mental disorder, with 16 per cent currently taking medication for a mental illness (AIHW 2011:vii). In addition to experiencing mental illness, the majority of people detained on remand in prison are alcohol or drug dependent (White and Whiteford 2006).

The criminal justice and mental health systems can interact in a variety of ways. Persons arrested or charged with crimes may be diverted into the mental health system, either as an alternative to criminal justice processes or as a preliminary to court decisions about bail or sentence. If they are found guilty of an offence, offenders may be required to undergo assessment and (if appropriate) treatment for a mental disorder either as part of a community corrections order or, in some jurisdictions, under specialised treatment orders. If imprisoned, mentally disordered offenders may receive psychiatric or psychological treatment while in custody in either general prison facilities or specialised secure psychiatric institutions, or while under conditional release (parole). Where a person is found to have a serious mental illness and as a result is unable to stand trial, or is found not guilty because of his or her mental condition at the time of the offence, specialised sentencing provisions, including detention in a secure institution, are available. While provision exists in all Australian jurisdictions for each of these diversionary and sentencing options, there is great variability in the specific orders and processes that are available, and in the institutional arrangements under which they are provided.

There are a number of reasons for diverting people with mental health difficulties away from the criminal justice system altogether. Perry (2008:371) summarises these in four themes: reducing recidivism, cost (economic reasons), human rights and health. Each of these 'offender led' concerns must be balanced against the protection of the community and the public interest in punishment and deterrence and considered within a framework of actuarial risk assessment (McSherry 2004). The World Health Organization also recognises the negative impact of imprisonment on mental health, which involves the physical environment, the psychological environment and, importantly, 'inadequate health services, especially mental health services, in prisons' (Perry 2008:371–2).

¹ Many of the estimates for levels of mental disorder in criminal justice populations are derived from screening studies, rather than clinical diagnostic studies. Screening studies do not generally allow cases involving mental illness to be accurately identified. The term 'mental disorder' includes both mental illness and other forms of mood disorders, mental distress and personality disorders.

Put together, the over-representation of mentally ill persons within prisons, the negative effects of prison on mental health and the difficulties of properly treating severely mentally ill persons in a prison setting, make a compelling case for diverting mentally ill offenders out of the criminal justice system and into appropriate mental health facilities (Perry 2008:372).

Structures are in place in all Australian jurisdictions for diverting mentally ill offenders away from the criminal justice system. However, the scope, coverage and resourcing of these arrangements vary greatly (see Richardson and McSherry 2010 for an overview of diversion). In addition, the take-up rate for diversionary mechanisms could be improved. Walsh argues that ‘a whole of government approach will be necessary to ensure that these mechanisms are utilised by the courts’ (2003:237). This is one example of where a national policy which addresses the overlap between health and criminal justice services may be usefully applied.

The process of deinstitutionalisation and subsequent policy changes has been significant in pace and nature, including a substantial reduction in psychiatric hospital beds from 30 000 in the early 1960s to 8000 in 2005 and the wholesale reform of community-based services since the late 1980s. At the same time, the demand for mental health services has increased alongside population growth, and has outpaced the establishment of community-based services (Richmond and Savy 2005). As a result, critics have argued that mental health services have been unable to keep up with demand, particularly by those with serious mental illness. Criminal justice settings have, to some extent, become the primary gateway for people who have been unable to receive care and treatment in the community; for example, it is estimated by one police service that half of all high-risk incidents that result in a police response involve mental illness (Ogloff et al 2007; White and Whiteford 2006).

More recently, the AIHW report on the health of Australia’s prisoners (AIHW 2010) examined the level of take-up of health services — including psychological and psychiatric consultations — in the community in the 12 months prior to imprisonment and prison and found that prisoners use community services more often than prison services. A direct comparison of the take-up of psychiatric and psychological services pre- and post-imprisonment is of limited value as it may speak to the ‘acuteness’ of a mental illness episode, or the time period at which the episode was experienced. However, there was a lower proportion of prisoners who needed to see a health professional but did not in prison than in the general community. This suggests that while the take-up rate of community-based services is higher overall, there may be fewer access barriers to psychological and psychiatric services in prison (in relation to time, cost, travel requirements and appropriateness of service, for example).

Structural factors

The health system

As detailed above, Australian mental health policy and services have undergone significant change since the beginning of deinstitutionalisation in the 1960s (Richmond and Savy 2005). These changes have been underscored by a complex web of responsibility for health and criminal justice policy and service delivery, which includes the federal government, state and territory governments, private sector organisations and non-governmental community organisations.

Broadly speaking, the federal government has primary responsibility for health policy and strategic direction and provides two-thirds of the health expenditure by governments (Australian Institute of Health and Welfare 2006). Each state and territory has distinct mental health legislation and responsibility for future legislative direction (Whiteford and Buckingham 2005).

The federal and state and territory governments also have different roles in regard to mental health reform. The Commonwealth has taken a co-ordination role at national level in mental health matters, which includes the publication of reports on the progress of mental health reform. States and territories have, arguably, a bigger role in the reform agenda as they are responsible for service delivery (Groom et al 2003). Each state and territory has a separate system of criminal justice and health; therefore different approaches to policy and practice in the area of mental health within the criminal justice sphere have developed across Australia (Groom et al 2003; Richardson and McSherry 2010).

In general, people with mental health problems are less likely to receive treatment or care than people with common physical health problems (Hickie et al 2005). The complex arrangements between state and territory governments and a variety of non-government and private providers have increased the likelihood of mental health service gaps (Hickie et al 2005). This has been acknowledged by the Australian government in the Budget plan that is the focus of this paper (Australian Government 2011:11): '[T]here remains substantial variation in the range and type of services that are available across the country. This causes service gaps and results in people with the same illness and needs receiving services based on local availability rather than their actual service needs'. However, the nature of service gaps and the populations most affected are not delineated further in relation to forensic mental health in this Budget or in the broader reform agenda.

The criminal justice system

Criminal justice legislation, policy and service delivery occurs at state and territory level in Australia. Perhaps more than any other area of government service delivery, criminal justice exhibits substantial variations across jurisdictions in policy goals and the nature, quality and extent of services provided. On a basic level, this is because justice services and corrections institutions are owned and operated by states and territories, not the federal government.

The most striking variations are in the extent of involvement in the criminal justice system. There is a three-fold difference in the rate of arrest between Victoria (1580 persons per 100 000) and the Northern Territory (5090 per 100 000), and a seven-fold difference in the rate of imprisonment between Victoria (105 adults per 100 000) and the Northern Territory (719 adults per 100 000) (Australian Bureau of Statistics 2012). While some of this variation is related to social and economic characteristics (most notably, the high rate of involvement of Indigenous people) much of it arises from differences in criminal justice policy, especially in regard to sentencing and parole. Given that mentally disordered persons are over-represented in all criminal justice populations, the likelihood that *any* mentally disordered person will be subject to a court order or imprisoned is inevitably a function of these jurisdictional variations in punitiveness.

During the 1990s the federal government, through the Standing Committee of Attorneys-General and the Australian Law Reform Commission, attempted to create greater national consistency in sentencing through the promotion of a *Model Criminal Code* (Standing Committee of Attorneys-General 2009). However, despite endorsement by the Standing Committee more than 10 years ago, the key elements of this model legislation that bear on the problem of sentencing mentally disordered offenders (2009:ch 2) have not been enacted

by the majority of state jurisdictions. More generally, the Law Council of Australia has argued that 'there is no evidence that uniformity of criminal law across jurisdictions is amongst the primary goals of state law reform (Law Council of Australia 2007:2).

A further source of inequity arises from the variability in orders and programs intended to divert mentally disordered offenders or provide treatment under sentence. All jurisdictions provide some form of screening for mental disorders at the arrest or court appearance stage, but there is little consistency in methods and much variation in coverage (Ogloff et al 2007). Some jurisdictions offer specialised lower court processes, such as the Magistrates Early Referral into Treatment program in New South Wales (NSW Health 2007), the Mental Health Diversion list in Tasmania (Newitt and Stojcevski 2009) and the Assessment and Referral Court and Court Integrated Services programs in Victoria (Ross and Graham 2012). (Plans to establish a mental health court in Western Australia were announced in May 2012.) However, even in these jurisdictions, access to these diversionary options is limited to some courts, usually in metropolitan centres. While all Australian jurisdictions provide for some form of insanity or mental impairment defence, there are substantial variations in the scope and application of these provisions (Bartlett and McGauley 2010).

There is also considerable jurisdictional variation in service infrastructure. In general, the larger jurisdictions offer more differentiated program regimes and more sophisticated institutional facilities (Heseltine et al 2011). Only Victoria and New South Wales operate specialised 'program' prisons, and there is considerable variation in the provision of forensic mental health services (Mullen et al 2000). The national prisoner health survey (AIHW 2011) noted that service arrangements included provision by health agencies, corrective service agencies, outsourcing to third parties, and combinations of all approaches.

The *Standard Guidelines for Corrections in Australia (Revised 2004)* are a 'statement of national intent' for corrections policy, legislation and practice, and include the caveat:

[E]ach Australian State and Territory jurisdiction must continue to develop its own range of relevant legislative, policy and performance standards that can be expected to be amended from time to time to reflect 'best practice' and community demands at the state and territory level (Australian Institute of Criminology 2004:2).

Forensic mental health services are only broadly acknowledged in the guidelines, which recommend that prisoners experiencing mental illness should receive 'appropriate management and support services' (2004:21) and should be screened for mental health problems upon admission to prison. Such vague statements in the toothless context of a jurisdictional caveat and 'intent' framework will do little to increase confidence in timely and equitable access to mental health services across jurisdictions.

Only recently has there been significant movement towards establishing benchmarks and key performance indicators in the area of prisoner health, including mental health. The AIHW published the first national data on prisoner health in 2010. The report (AIHW 2010) confirms findings across international and national research literature that there is a higher rate of mental illness in the prison population (compared to the community, broadly defined: see Richardson and McSherry 2010), that imprisonment is a further source of psychological distress for a significant proportion of prisoners, that many people in prison have 'complex needs' (such as co-occurring substance misuse, intellectual disability or chronic physical illness and mental illness: see Mouzos 1999), and that being in prison presents access barriers to appropriate health services.

Prisoners are not a homogeneous group; for example, additional barriers to wellness may be experienced by women in prison (evidence suggests that women are more likely to experience mental illness: see Walsh 2003). The increased likelihood of mental illness in remand and reception populations has also been noted by Butler et al (2005 cited in Adams 2009). While groups of prisoners experience mental illness in different ways, at different rates and with variable opportunities to access support and treatment, it is clear that *all* prisoners who need or attempt to access forensic mental health services are likely to experience some difficulties in accessing services. Furthermore, prisoners are likely to experience a different standard of mental health care across jurisdictions and across corrections and community points of access. These difficulties may be a result of one or all of the following factors: variable service demands (in areas that have a high proportion of prisoners, for example), the local structure and/or funding arrangements for forensic services, inadequate communication between prison-based and community-based care providers, and the potentially conflicting priorities of correctional and health service cultures.

Budgetary and expenditure inequities

The national inequities in the delivery of services in the health, mental health and justice sectors are highlighted by the expenditure data reported in the annual Productivity Commission Report on Government Services (SCRGSP 2012). While the report notes in relation to health expenditure that 'expenditure per person in each jurisdiction is affected by different policy initiatives and socioeconomic and demographic characteristics' (2012:E5), in fact jurisdictional recurrent expenditure varies in a relative narrow band, with the highest per capita expenditure (in South Australia) only eight per cent greater than the lowest (in Western Australia).² There is a greater degree of jurisdictional variation in mental health services funding, with a 20–25 per cent difference in per capita expenditure between the highest (Tasmania and Western Australia) and lowest (Victoria and New South Wales). Variations in per capita expenditure on corrective services vary by a much greater extent, with per capita operating expenditure in Western Australia 230 per cent higher than in Victoria. Even jurisdictions with apparently similar social and economic characteristics, like New South Wales and Victoria, show a 40 per cent variation in per capita expenditure. Much of this variation is attributable to policy-driven factors, such as sentencing and the over-representation of Indigenous people. However, even if expenditure comparisons are made on a per prisoner or per community corrections offender basis, large jurisdictional variations remain. Expenditure per prisoner in Tasmania is 70 per cent higher than in Queensland, and in Victoria it is 30 per cent higher than in New South Wales.

The relative consistency in health expenditure reflects several factors, including the 'levelling' role played by federal hospitals and health services funding and the mix of government and non-government expenditure in this sector. In the justice sector, expenditure levels are almost entirely determined by the jurisdictions and reflect the large differences in policy priority accorded to this sector. However, the level of sector variation may reflect a degree of acceptance by the community of variation in service provision and quality. In the case of health services, the community expects a similar level of service provision wherever they are, while in the case of corrective services, the 'client population'

² Data on the ACT and the NT is excluded from these comparisons. Service expenditures in the ACT are difficult to distinguish from those in NSW, while expenditures in the NT are distorted by high levels of federal support to Indigenous communities.

has little or no power to demand equity of service and the general population has little interest in requiring this on their behalf.

Human rights

There are a number of human rights mechanisms for addressing access to mental health services in Australia, including the *International Covenant on Economic, Social and Cultural Rights* (United Nations 1966a), the *International Covenant on Civil and Political Rights* (United Nations 1966b), the *Convention on the Rights of the Child* (United Nations 1989) and, more recently, the *Convention on the Rights of Persons with Disabilities* (United Nations 2007). Taken together, these international legal instruments place a responsibility on the federal government to ensure that citizens have access to the ‘highest attainable standard of physical and mental health’ (United Nations 1966a:art 12; Mental Health Council of Australia 2005). In addition to these international legal human rights mechanisms, the United Nations adopted the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (United Nations 1991). These principles, including the right to the same standard of health care regardless of the mental or physical nature of illness and the right to be treated in the least restrictive environment, were used to guide the development of the Australian national mental health strategy in 1992 (Mental Health Council of Australia 2005). While most Australian policy and service level changes in mental health have focused on consolidating and improving community provision of services, Lammers and Happell (2004) argue that these reforms have also illuminated the need to recognise, and provide for, human rights for people experiencing mental illness.

More recently, the United Nations *Convention on the Rights of Persons with Disabilities* (United Nations 2007) came into force. The Convention was ratified by Australia in 2008. Article 4a obliges states ‘[t]o adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention’. This includes rights to the same ‘range, quality and standard of free or affordable healthcare’ generally and specifically mentions that people deprived of liberty are entitled to the protections afforded in the Convention (United Nations 2007). As the National Disability Strategy continues to be rolled out, it remains unclear whether the Commonwealth commitment to the Convention will result in any legislative change.

The United Nations *Standard Minimum Rules for the Treatment of Prisoners* (United Nations 1957) includes provision for the treatment of people experiencing mental illness. Specifically, it recommends that treatment should occur under medical supervision and management in specialised institutions. Moreover, it is stipulated that everyone has the right to receive the best possible health care. In Victoria, this final point is recognised in legislation — that people with a mental illness should receive the highest possible standard of care, in the least restrictive environment. Further, the *Mental Health Act 1986* (Vic) recognises that this standard of care should be comparable to the standard of care provided within the general health system. This legislative change in part reflects an acknowledgement that general health care has been of a higher standard than mental health care in Victoria (Lammers and Happell 2004).

In 2002, the National Mental Health Working Group of the Australian Health Ministers’ Advisory Council proposed a *National Statement of Principles for Forensic Mental Health*, which has since been endorsed (AHMC 2006). The *National Statement of Principles* recognised that forensic mental health reform has not kept pace with mainstream mental

health service reform in Australia. It aimed to provide a set of nationally agreed principles to guide states and territories in forensic mental health reform. Three forensic health service boundaries were identified: forensic mental health services and correctional services (including competing service cultures); forensic mental health services and general mental health services; and forensic mental health services and other human services (2006:4–5). The statement recommended legislative reform to improve national consistency in criminal codes and the treatment of forensic mental health clients.

The *National Statement of Principles* contained 13 principles. While all are broadly relevant, the most pertinent to this paper are principles 1, 3, 7 and 13. Principle 1 addresses the notion of equivalence — that forensic clients should have the same access to and quality of mental health care as non-forensic clients. Principle 3 encourages the setting out of clear boundaries of responsibility for forensic health care across and between health, justice and corrections services. Principle 7 refers to ethical standards and highlights the importance of compliance with various international rights instruments. Principle 13 describes the need for legal reform to facilitate legislative change that will move forensic mental health care forward towards greater national consistency and quality and effectiveness of service.

Three years after the draft *National Statement of Principles* was released, the Mental Health Institute of Australia (2005:16) recommended:

[T]hat as a matter of urgency all jurisdictions develop nationally consistent guidelines on the assessment, sentencing and provision of specialised mental health care (according to the NMHS) for mentally ill people in contact with the justice and/or detention systems; and c) that all Australian jurisdictions provide specialised legal services, diversionary and reintegration programs for people with a mental illness in contact with in the justice and/or detention systems.

More recently, the Victorian Institute of Forensic Mental Health (Forensicare) stated in its 2009 submission to the National Human Rights Consultation Committee that ‘the prison system overall does not provide the range of services necessary to ensure that those with a mental illness are afforded the best possible outcomes’ (Forensicare 2009:4). Forensicare has argued that while broad principles relating to equity of access to mental health services exist, there are relatively few mechanisms by which people experiencing mental illness can seek redress when these principles are breached. One of the central arguments in this submission was that ‘the current system for managing mentally ill offenders in the criminal justice system and the community does not afford adequate protection of the human rights of this group’ (2009:8). This suggests that the *National Statement of Principles for Forensic Mental Health* has had limited impact in promoting jurisdictional consistency and protecting the human rights of prisoners with mental health problems.

Thinking holistically about forensic mental health service provision

While there is a general consensus that an effective national response to mental health issues must address the needs of those in the criminal justice system, there has been little consideration of the legislative, policy, operations and resource issues involved. It is clear that the current organisational structure (which distinguishes policy from service delivery, Commonwealth from state and territory, health from criminal justice and so on) is inadequate. In their review of correctional offender programs, Heseltine et al noted that the ‘awkward constitutional structure’ that divides responsibility for health, education, welfare and criminal justice between Commonwealth, state and territory agencies ‘has operated to hinder any attempt at a national approach’ to offender rehabilitation (2011:4), and this concern holds equally true for mental health care. Although a significant number of people

in prison have mental health problems, access to services is largely dependent upon state or territory arrangements with health service providers, and this is further complicated by demand for services, legislation and the prioritisation of security, control and protection, rather than clinical care (Hickie et al 2005; Forensicare 2009).

While the record of providing mental health services in the community is far from satisfactory (Groom et al 2003; Mental Health Council of Australia 2005), commentators have argued that the provision of mental health services to those who have been convicted of crime (and who come into contact with police but may never come to court, much less receive a criminal conviction) is particularly poor (Hickie et al 2005; Richmond and Savy 2005). Access (or lack thereof) to mental health services may be low in the community in comparison to physical health services, but there is some evidence that the percentage of the population receiving mental health services is nationally consistent (SCRGSP 2012), with the exception of the Northern Territory. However, there is significant variation across jurisdictions in criminal justice policy and program infrastructure, suggesting that there is a broad acceptance of differential policy and practice at state and territory level (SCRGSP 2012). There is a 'general disconnect' between forensic mental health services within and between Australian jurisdictions (Ogloff et al 2007:2).

Conclusion

The demand for forensic mental health services is likely to continue to increase, if only as a result of rising arrest, conviction and imprisonment rates. Some jurisdictions, such as Victoria, have recognised the complexity of responding to mental illness in the criminal justice system (Forensicare 2009), but there have been few attempts to address this at the national level. The Senate Select Committee on Mental Health (2006) recommended that states/territories should review anomalies in the quality of care between community services and prison services. Ogloff et al (2007) refer to the concerns about the potential of community-based services to adequately respond to the needs of offenders with mental health problems. Mental health services that operate through, or in conjunction with, corrections may present a more useful opportunity to identify people experiencing mental illness and direct resources at improving health outcomes for this group. However, this is contingent on the adequate provision of services through a corrections gateway. The evidence reviewed here strongly suggests that there are significant issues with access to and consistency of forensic mental health services across Australian states and territories.

In recent years there has been significant national attention paid to the need to reform health services across Australia, including mental health services. However, a key question remains: Why has forensic mental health been omitted from the national health reform agenda? This question is particularly significant in light of substantial evidence that forensic mental health care is unevenly distributed across jurisdictions and populations (for example, forensic and non-forensic clients) and that, for a significant number of people, a criminal justice or corrections gateway is the primary access point for mental health treatment. This omission can also be located in the context of a number of international human right protections that have so far failed to remedy the inequity of access to and availability of forensic mental health services.

There have been some documented acknowledgements that national consistency in criminal justice and correctional services is desirable — and would facilitate better delivery of related services. However, structural and budgetary constraints have inhibited attempts to make the necessary legislative reforms. While it is beyond the scope of this article to make a

case for *how* national reform might achieve uniformity in criminal justice across the states and territories, it is noted that national consistency appears to be the federal government's favoured approach to health reform — with the exception of forensic mental health.

We are concerned with investigating why forensic mental health has been ignored in the national health reform agenda and argue that there are at least three reasons for this omission. First, the structural arrangements that govern responsibilities for health and justice at national and state and territory levels inhibit the possibility for legislative reform that would allow greater consistency across Australian jurisdictions. Moreover, the complex structure of health and criminal justice policy and service provision at national and state and territory levels precludes the effective delivery of mental health services to people in criminal justice environments.

Second, while it is inevitable that variations in the nature and demand for criminal justice services will have a differential impact on the capacity to deliver linked services across jurisdictions, most public policy areas (health, education and social support payments, for example) are premised on the notion of nationally consistent policy and service provision. Such equity may not yet be in place, but there is certainly growing attention to the consistency principle. However, in criminal justice, there are relatively few calls to address diversity across jurisdictions in the nature and provision of services or treatment of people who come into contact with the criminal justice system (with the notable exception of debates on the over-representation of Indigenous Australians in the criminal justice system). Where those calls have been made, the current separation of responsibilities for health and criminal justice at federal and state and territory levels noted above has inhibited attempts to achieve consistency. In short, we have come to accept a high level of differentiation in criminal justice services across Australia, and this has a bearing on the likelihood of accessing appropriate and timely mental health services.

Third, the increased attention to rights talk has resulted in the ratification of a number of human rights protections that have the potential to act as catalysts for comprehensive national reform that include forensic mental health. To date, however, these international instruments have had limited impact on Australian criminal justice arrangements. Given that there are very few avenues open to pursue potential breaches of human rights instruments, this is unlikely to offer a remedy to the complex problem of establishing consistent, equal and quality forensic services in a reform climate that does not adequately acknowledge forensic populations experiencing mental illness.

United Nations documents

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