"Why people with a mental illness are Over-represented in the Criminal Justice System."

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It has long been acknowledged that there is an over-representation of people with mental illness in the criminal justice system. Despite numerous government inquiries into mental health in NSW over the past 15 years, evidence exists indicating that the situation has further deteriorated.

In order to understand the link between mental illness and the criminal justice system, it is important to be aware of the extent to which mental illness is present in the general population, together with the socio-economic and environmental factors that frequently lead to interactions with the criminal justice system.

A figure of 1 in 5 indicates the proportion of Australians who will be affected by mental illness at some time in their life. Recent estimates internationally suggest that this could be a gross underestimation. Based on figures in the National Survey of Health and Wellbeing (ABS, 1999), approximately 2.4 million of Australians are thought to experience a mental health problem over any 12 month period. Over 1 million are estimated to suffer from a mental disorder, with almost half of these affected long-term.

Mental disorders account for almost 30% of the non-fatal burden of disease. Depression is the most common mental disorder reported, both recent and long-term, and has been identified as one of the most pressing priorities. In 2001-02, total spending on mental health services was $3.1 billion, a 65% increase in real terms since 1993.

Nevertheless, specialised mental health services accounted for only 6.4% of Australia's recurrent health expenditure (Mathers et al., 1999). Australian Institute of Health and Welfare (AIHW) analysis shows that the proportion of mental health expenditure rises to 9.6% if substance abuse and dementia are included. Substance abuse accounts for 11.5% of the costs of mental health in Australia. (AIHW, 2005).

According to ABS (Australian Bureau of Statistics) the cost of mental health disorders is dominated by years lost due to disability, responsible in 1996 for 13.3% of total Disability Adjusted for Life Year (DALY), (Mathers et al., 1999). These figures emphasise mental illness not as a major direct cause of death, but as a major cause of chronic disability (ABS, 1998d).

Identifying the breakdown of burden in terms of mental illness and gender, the ABS stated the major cause of mental disorder for females to be affective disorder, accounting for 39% of women's mental health DALY. This was represented almost entirely by depression (87%) and anxiety disorder (22%). Men are more than twice as likely as women to have substance use disorder (11%). Young adults of both sexes (18 -24 years) have the highest prevalence of mental disorder (27%), (ABS, 1999, Mathers et al., 1999).

Despite the high incidence of mental illness, there remains widespread fear, misunderstanding and stigma. Community attitudes concerning mentally ill offenders and their treatment by the criminal justice system are no exception. Much of this misunderstanding comes from dramatic depictions of mentally ill persons in films, on television, and sensationalised reports in the media.

Current preoccupation with risk assessment: “privileges policies of control and containment as against support and management; diverts resources towards those believed to embody further risk and away from the majority of the mentally disordered; encourages constructions of the mentally disordered which gives primacy to their supposed level of dangerousness; can create a spurious technology of risk management which can dominate wide areas of clinical practice and obfuscate the actual causes of crime in the community, ” (Mullen, 2001).

However, it has long been established that mentally ill persons are much more likely to be a danger to themselves than to others, as highlighted in ‘Tracking Tragedy,’ a report on suicide deaths of recent mental health inpatients (NSW Mental Health Sentinel Events Review Committee, 2003).

A defence of mental illness is commonly viewed as a loophole used to escape punishment. Debate surrounds the offender’s state of mind - whether they must be ‘mad’ to commit a crime or simply ‘bad’. The perception that a perpetrator feigning madness can avoid a sentence is not supported by evidence. Only 1% of charges are dismissed under the Mental Health Criminal Procedure Act, which represent a total of 555 charges dismissed (data from the Bureau of Crime Statistics & Research (1996), accounting for only 0.3 % of the total criminal charges finalised in NSW local courts in 1996.

Individuals whose charges are dismissed may be transferred through the court diversion program, and those who become forensic patients may spend a longer period incarcerated than had they received a guilty verdict. In view of the high incidence of people with a mental illness who do not have their charges dismissed, it is unsurprising that NSW goals and juvenile detention centres have become ‘de facto’ mental institutions.

In a study of 500 psychiatric patients, a lifetime prevalence of crime was rated at 4%, which is comparable to the population in general (Gunn ,1987, in Henderson, 1988). Whilst there is no inherent link between mental illness and crime, there is a strong causal link between mental illness and incarceration. Furthermore, there is extensive evidence that people with severe mental illness are more likely to be convicted of misdemeanours than their mentally healthy counterparts, and tend to be incarcerated for longer periods (Lamberti et al., 2001).

A study in 1983 observed no relationship between mental illness and general crime, when controlled for age, race, socio-economic status and previous hospitalisation or imprisonment. (Monahan, 1992). Such demonstrative statistics imply the existence of another variable or variables that may have an association with both mental illness and imprisonment.

Similar scrutiny must also be applied to the notion that people with a mental illness are more violent than the general population. The Australian Institute of Criminology (1990) stated that, "violence and violent crime are commonly regarded by the public as the domain of the mentally ill." Public misconception about the true nature of mental illness as distinct from personality disorder or behavioural disorder, frequently associate extreme violence with mental illness. The evidence base has long displayed greater scepticism.

Whilst a weak association between mental disorder and violent behaviour has been demonstrated, it is limited to people with mental illness not receiving treatment or who have a history of violence and/or abuse alcohol or drugs (Steadman et al., 1998, Swartz et al., 1998, Better Health Channel, 2005, Munetz et al., 2001). Research has noted this relationship may be mediated by a range of factors including: gender, socio-economic status, age, and substance abuse (identified by many researchers as a powerful co-morbid factor). Monahan (1992) also noted that increased risk was evident only in the immediate presence of psychotic symptoms, thus eliminating the vast majority of people with mental disorder.

For people with mental disorders, co-morbidity is common and individuals may have more than one disorder. The problems exacerbated by a high prevalence of co-existing substance disorder which exists, depending on the population sample, in 30% to 80% of people with a mental illness in the community (NSW Health, 2000).

Socio-economic status can be clearly seen as impacting on the prevalence of mental illness. People who live in the most socio-economically disadvantaged circumstances (depending on age) are between 1½ and 3½ times more likely to have mental or behavioural problems as compared with people who live in the least socio-economically disadvantaged circumstances (ABS, 2001).

The 2001 National Health Survey did not include information on Indigenous mental health, due to concerns about the cultural appropriateness of the mental health-related questions in that survey. However, hospitalisation and mortality rates from intentional injury or self-harm (over twice as prevalent in the Indigenous community) may be indicative of mental illness and distress (ABS, AIHW, National Hospital Morbidity Database, 2003c).

According to the 2004 Census, NSW correctional and forensic facilities contained 8510 adults and 300 juveniles. This figure represented a snapshot of the annual throughput of approximately 18000 adults and 6000 juveniles. Justice Health reported in the same year that 78% of the male prison population and 90% of the female population presented at reception with a broad spectrum of mental disorders (Halpin et al., 2004). Whilst acknowledging that the figures are not directly comparable, it is noteworthy to mention that in Victoria (2003) the Department of Justice reported that 28% of inmates had been told that they had a mental illness.

This one could suggest, could be seen as a reflection of the more favourable access to appropriate community services in Victoria, and the establishment of the Thomas Embling Hospital in 2001. It is instructive to consider the diversity of outcomes across Australia in association with state spending per capita and allocation of resources to the NGO sector, which average at 5.5% of the total national mental health expenditure. Over the last year, the NSW government have made a commitment to increase NGO resources which in 2005 were 2.4%, as compared to 9.6% in VIC (AIHW, 2005).

If there is no fundamental causality between mental illness and crime, and only a mediated link between mental illness and violence, what other factors may explain the over-representation of people with a mental illness in the criminal justice system?

In 1993, Hodgins' study was one of the first able to examine clinical associations between mental illness and crime. The research identified that people with a mental illness are at a higher-than-average risk of offending, not because of mental illness per se, but because of the higher-than-average prevalence of substance abuse in this population. In a 2001 study of people with a mental illness in prison, two thirds of their crimes were related to substance use, usually non-violent (Munetz et al., 2001).

Fragmentation of mental health services and the accompanying risk factors of mental illness – poverty, poor education, unemployment, poor social skills and family support lead the mentally ill to situations of high exposure to psychoactive substances (Drake & Mueser, 2000). These are the people who are described as 'falling through the gaps,'- "the gaps are wide and the fall is hard," (NSW Health, 2000b). Such high exposure factors are reflected in the 2004 Census figures highlighting the level of socioeconomic disadvantage prior to incarceration (Justice Health, 2004).

On Census Night 2001, approximately 100,000 people were homeless of whom 14% were "sleeping rough." Almost 50% were less than 25 years of age, 26% were 12-18 years. Statistics on juvenile offenders in the Young People in Correction Health Survey (YCPiCHS, 2003) clearly identified some of problems that lead to incarceration in addition to the prevalence of co-existing mental illness and substance abuse, which included a close relationship between child sexual abuse and physical violence, and the continuation of young people remaining homeless. Speaking at a National Congress on Homelessness (2003), David Tully of Adelaide Central Mission referred to abuse as the primary factor causing young people to seek safety by leaving home.

In 2002, Justice Health NSW noted that within the prison population, "50% of males and 30% of females warrant mental health referral for major depression." Approximately 80% have been incarcerated for offences relating to drug and alcohol use. In an environment in which substance abuse so closely accompanies mental illness, a policy of zero tolerance with regards to drug crimes automatically leads to an increase in interactions with criminal justice system.

The combination of inadequate community mental health services, heightened legal imperatives and shrinking facilities for people with mental illness requiring acute care have resulted in an increased reliance on the police for crisis management and referral, regardless of the mental state of the individual. Police have become 'de facto' ambulances transferring people from one hospital to another. Frequently failing to secure a hospital admission the police must "do something", and "arrest by default," (Davis, 1992).

Unfortunately, the most appropriate treatment is usually unavailable within the criminal justice system. Effective treatment is one that emphasises recovery and appropriate support to facilitate integration back into the community. This is no less applicable to mentally ill inmates as forensic patients for whom goal is an unsuitable environment in which 'management' and 'medication' rather than 'recovery' and 'rehabilitation' are the main focus (NSW Mental Health Sentinel Events Review Committee, 2003).

Professor Mullen writes that, “the correctional culture and physical realities of prisons are rarely conducive to therapy. Rigid routines, the pedantic enforcement of a plethora of minor rules, the denial of most of that which affirms our identity, add to the difficulties of managing vulnerable and disordered people,” (p.36).The hope is that some of these issues will be addressed when the new forensic hospital at Long Bay is opened in 2008.

Another probable cause of increased criminalisation of mentally ill persons may be as a result of closure of many ‘living skill’ and ‘drop in centres,’ limited access to appropriate coordinated community based services, absence of planning of discharge arrangements and the support crucial in avoiding lapse and relapse into crisis, and recidivism. Many who would have benefited from treatment for their mental illness, receive none prior to being imprisoned (Halpin et al., 2004).

Apart from high risk of interactions with the criminal justice system as a consequence of the relationship between mental illness and substance abuse, the additional likelihood of homelessness together with treatment non-adherence bring about the greatest challenges for intervention - due to the segmented nature of services, barriers to access, assessment and treatment and the implications of complex need on receptiveness to treatment.

The over-representation of people with a mental illness in the criminal justice system is demonstration of the extent to which the environment gives rise to mental illness, highlighting the urgent need for legislative reform and implementation of collaborative practices that break the cycle of mental illness, substance abuse, poverty, unemployment, domestic violence and interactions with the criminal justice system. The importance of the NGO sector in providing services for early intervention, pre and post release programs cannot be too strongly emphasised.

Finally, in supporting collaborative approaches to mental health service provision, the protection of the human rights of people with mental illness needs to be stressed as a priority. As identified in UN Resolution 46/119 to which Australia is a signatory, those rights are primarily embodied in Principle 1: Fundamental freedoms and basic rights. These principles are central to all our endeavours when addressing the needs of the mentally ill - a population group often the most vulnerable and marginalised in our society:

- All persons have the right to the best available mental health care, which shall be part of the health and social care system.
- All persons with a mental illness shall be treated with humanity and respect for the inherent dignity of the human person.
- All persons with a mental illness have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.
- There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights.

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