Executive Leadership Program: Course 04/002

BOARD OF MANAGEMENT PRESENTATION

Inmates With Mental Health Issues

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<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Background</td>
<td>5</td>
</tr>
<tr>
<td>Richmond Report: Inquiry Into Health Services For The Psychiatrically III and Developmentally Delayed</td>
<td>5</td>
</tr>
<tr>
<td>Profile of Mental Health Inmates at MRRC</td>
<td>6</td>
</tr>
<tr>
<td>Induction and Screening of Inmates</td>
<td>8</td>
</tr>
<tr>
<td>Current Services</td>
<td>8</td>
</tr>
<tr>
<td>Recommendation 1: Court Liaison/Diversion</td>
<td>8</td>
</tr>
<tr>
<td>Recommendation 2: Induction &amp; Screening Process</td>
<td>8</td>
</tr>
<tr>
<td>Recommendation 3: Accreditation</td>
<td>8</td>
</tr>
<tr>
<td>Therapeutic Units</td>
<td>9</td>
</tr>
<tr>
<td>Current and Scheduled Capacity</td>
<td>9</td>
</tr>
<tr>
<td>Recommendation 1: Therapeutic Units</td>
<td>9</td>
</tr>
<tr>
<td>Functionality</td>
<td>9</td>
</tr>
<tr>
<td>Structure</td>
<td>10</td>
</tr>
<tr>
<td>Evaluation and Monitoring</td>
<td>11</td>
</tr>
<tr>
<td>Organizational Benefits</td>
<td>11</td>
</tr>
<tr>
<td>Training</td>
<td>13</td>
</tr>
<tr>
<td>Current Situation</td>
<td>13</td>
</tr>
<tr>
<td>Recommendation 1: Basic Course</td>
<td>13</td>
</tr>
<tr>
<td>Recommendation 2: Advanced Course</td>
<td>14</td>
</tr>
<tr>
<td>Benefits of Training</td>
<td>14</td>
</tr>
<tr>
<td>Transitional Planning</td>
<td>15</td>
</tr>
<tr>
<td>Recommendation 1: Referral Database</td>
<td>15</td>
</tr>
<tr>
<td>Implementation</td>
<td>15</td>
</tr>
<tr>
<td>Review and Update</td>
<td>15</td>
</tr>
<tr>
<td>Recommendation 2: Support &amp; Advisory Unit</td>
<td>16</td>
</tr>
<tr>
<td>Implementation</td>
<td>16</td>
</tr>
<tr>
<td>Review and Update</td>
<td>16</td>
</tr>
<tr>
<td>Recommendation 3: Post Release Transition Centre</td>
<td>16</td>
</tr>
<tr>
<td>The Program</td>
<td>17</td>
</tr>
<tr>
<td>The Location</td>
<td>17</td>
</tr>
<tr>
<td>Budget Considerations</td>
<td>17</td>
</tr>
<tr>
<td>Conclusion</td>
<td>17</td>
</tr>
<tr>
<td>Bibliography</td>
<td>18</td>
</tr>
<tr>
<td>Appendices</td>
<td>23</td>
</tr>
<tr>
<td>Appendix I: Survey of Inmates</td>
<td>23</td>
</tr>
<tr>
<td>Appendix II: Training</td>
<td>24</td>
</tr>
<tr>
<td>Costing for Development of Proposed Advanced Mental Health Education Program</td>
<td>24</td>
</tr>
<tr>
<td>Costing for Development of Proposed Basic Mental Health Education Program</td>
<td>24</td>
</tr>
</tbody>
</table>

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Executive Summary

A mental health survey of inmates conducted by Justice Health (Corrections Health Service, 2003) stated that 33% of male sentenced inmates and 59.2% of female sentenced inmates had some form of mental health disorder. This compares to 10.8% of males and 18.4% of females in the community. The information in this survey also indicates that this high level of mental disorder in NSW inmates linked to a high level of substance abuse.

A recent survey of inmates at MRRC indicates that the profile of male inmates with a mental illness currently being taken into the system indicate that they are generally in their mid-30s, 48% overseas born (with a high proportion coming from countries where civil war has raged for years, ie. Yugoslavia, Iran, Iraq, Bosnia and Ghana). They are generally repeat offenders (with an average of 4 previous episodes of incarceration, many with very short periods between incarcerations), with a previous history of psychiatric hospitalisation. They are often homeless, with no close personal relationships and the majority are accused of having committed violent crimes (70%). Those committing violent crimes are most likely to have drug-induced mental illness.

This paper proposes to offer cost effective strategies to assist the NSW Department of Corrective Services to better manage the mentally ill offenders currently housed in the system, and to offer some options for meaningful post release resettlement through a suite of community level interventions, of which the NSW Department of Corrective Services would be a partner. The following recommendations aim to address this.

Induction Screening

- That the Department encourages and promotes the Court Liaison / Diversion Program and actively seeks to enhance this program by providing training to staff at Court Cells in mental health issues.
- That the Department adopts the induction and screening process currently utilised at the MRRC as a standard operating procedure for all reception centres.
- That the Department seeks accreditation of its induction process under ISO 9001 and conducts regular compliance audits.

Therapeutic Units

- That the department establish Mental Health Therapeutic Units in three selected Correctional Centres, one per Region, to assist in the intermediate management of mentally ill inmates. That is, as an alternative to placement in an acute care facility and to assist such inmates to phase into standard accommodation areas and the community on release.

Training

- That the current CSA course “Managing inmates with mental health issues” be redesigned to include features of other courses being taught in correctional centres around the state. The course is to be standardised across the department, replacing current in-house courses, and conducted either in the workplace or at the Corrective Services Academy, as appropriate. The course should be aimed at base level correctional officers, OS&P and COS staff and be adapted to the needs of all staff categories.
- That the Corrective Services Academy develop an advanced course, for senior staff in the department who work with inmates with mental health issues – that is, correctional, CSI, COS & OS&P staff.

Transitional planning

- That a data base be set up on the intranet to provide a referral network of all available community support agencies to assist exit strategy planning for inmates with Mental health issues.
- That a support and advisory unit be established in Head Office, similar to the current Disability Unit. This unit would be able to offer a telephone, email or written contact point where Correctional Centre staff, responsible for the day to day management of offenders with mental health issues, could access information, placement options, management strategies and through care advice.
- That an institution be made available as a Post Release Transition Centre to provide multi agency community support for inmates immediately upon their release.

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Introduction

A mental health survey of inmates conducted by Justice Health (Corrections Health Service, n.d.) stated that 33% of male sentenced inmates and 59.2% of female sentenced inmates had some form of mental health disorder. This compared to 10.8% of males in the community and 18.4% of females in the community.

The survey also found that 36.7% of male sentenced inmates and 38.1% of female sentenced inmates had some form of personality disorder. This compared to 6.8% of males and 6.1% of females in the community. It also showed that 33.6% of male sentenced inmates and 57.4% of female sentenced inmates had a substance abuse disorder compared to 7.1% of males and 2.8% of females in the community.

The information in this survey indicates there is a high level of mental disorder in NSW inmates linked to a high level of substance abuse. This would support overseas findings of high rates of dual diagnosis of mental disorders and substance abuse in inmates. In the United States it has been estimated up to 11% of the inmate population have co-occurring disorders. (Edens, Peters & Hills, 1997).

The inmate population as at 9th May 2004 was 8,442 inmates, 7,862 males and 580 females, (NSW Department of Corrective Services, 2004) and current research indicates 10 to 15% of inmate populations suffer from severe mental disorders (Edens, Peters & Hills, 1997). Based on the Justice Health survey the NSW Department of Corrective Services would be required to accommodate, treat and manage over 2,500 male inmates and over 340 female inmates with mental health disorders. Based on a conservative estimate of 10% of the inmate population in NSW the Department of Corrective Services currently would be required to manage over 800 inmates with serious mental health issues.

Although the available information indicates female inmates suffer higher levels of mental illness than male inmates, this proposal focuses on male inmate needs.

The management of mentally ill inmates in the NSW correctional system, particularly those with severe mental health problems, is a contentious issue with an ongoing cost to the organization and the community in material and human terms.

The ELP project team has reviewed available information on this issue from Departmental, national and international sources. This paper is a result of that review and proposes to offer cost effective strategies to assist the NSW Department of Corrective Services to better manage the mentally ill offenders currently housed in the system, and to offer some options for meaningful post release resettlement through a suite of community level interventions, of which the NSW Department of Corrective Services would be a partner. While the members of the project team do not profess to have specific expertise in the field of mental illness, all members are associated with correctional management and have experience in dealing with this matter and significant related issues.

Background

Richmond Report: Inquiry Into Health Services For The Psychiatrically Ill and Developmentally Delayed

On the 27th August 1982 the Minister for Health, announced the establishment of an Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled, (Richmond, 1983). The terms of reference essentially highlighted the need to review the existing range of care and services provided for the psychiatrically ill, psycho-geriatrics and the developmentally disabled in New South Wales and recommend future arrangements for co-operative planning, funding and co-ordination between government and non-government agencies. (Richmond, 1983).

The report espoused a range of values that society should embrace in respect of people suffering from psychiatric illness. In brief, it was suggested that psychiatric patients should have the opportunity for social and physical contact in the normal community environment, irrespective of their level of physical, intellectual or social functioning and that society should tolerate a wide range of behaviour within the community.

The report further argued that psychiatric patients are ‘best treated as troubled individuals, not necessarily as ‘mentally ill’, chronically dependent patients, demon-possessed or criminals … and should not be segregated from other aspects of health services’. The report added that the responsibility for health care should be shared between professions and the community. In reality the main impetus for the closure of psychiatric hospitals was to eliminate the excessive operating costs - estimated at approximately $200 million per annum for full time residential care and medication.
One has to appreciate the historical perspective of the closure of psychiatric hospitals, which has had the effect of creating a sole deviancy reservoir, where both the criminal and psychiatric are combined. Sadly, a high proportion of inmates being received into custody have some form of mental illness (at least 30%), as shown by recent research conducted by the MRRC Mental Health Team. Most offenders with mental illness are poor and homeless; they live either on the streets or in shelters. In response, the Department has adapted policies, practices and provided mission statements to deal with this changing situation.

Profile of Mental Health Inmates at MRRC

In June 2004, MRRC staff working with mental health inmates conducted a survey by accessing information on each individual to create a profile of mental health inmates (see: Appendix I).

The average age of the 33 mental health inmates accommodated in Pod 18 is 33 years old. This will have a serious impact on Departmental resources in years to come, given their propensity to re-offend. Of this number 48% are overseas born, with a high proportion coming from countries where civil war has raged for years, i.e. Yugoslavia, Iran, Iraq, Bosnia, Assyria and Ghana.

Various literature almost unanimously support the fact that a significant number of mental health inmates are homeless when they are received into custody. This theory is consistent with the above statistics that provide evidence that there is definitely a correlation with repeat offending (76%) among the mentally ill and being homeless (76%). These figures are also consistent with inmates having had a previous hospital admission due to the mental illness (79%). So in fact, one could argue that at any given time, the mentally ill are either homeless, incarcerated or hospitalised.

It should be noted that most inmates returned to custody within a month of being released from custody and three (3) inmates returned within hours of being released. Of the 76% who are repeat offenders, the average number of previous episodes of incarceration is 4 separate occasions. These results substantially prove that there is no post release support for the mentally ill and their return to Corrections due to their homelessness can only be described as a social disgrace.

All 33 inmates are diagnosed with schizophrenia. However, a high proportion have developed schizophrenia as a result of drug and alcohol dependency over several years. Typically, drugs that induce schizophrenia include: ‘Speed’, marijuana and ‘ice’. The MRRC research indicated that inmates born with a mental illness have a propensity to commit non-violent crimes. In contrast, inmates who have drug/alcohol-induced schizophrenia have a propensity to commit violent crimes. In fact 70% have committed violent crimes and will continue to commit violent crimes upon release, unless adequate post release support is provided.

Without exception, all Pod 18 inmates were placed into safe cells upon reception due to their history of mental illness and/or detoxing. Without exception, all inmates were not taking medication at the time of their arrest. In the previous 12 months there has been one (1) suicide by hanging. The deceased had a history of violent crimes committed while homeless and not taking medication.

Pod 18 inmates, or mental health inmates generally, are vulnerable within the Correctional environment and must be kept separately from the mainstream inmates. Although the MRRC has a comprehensive screening and induction process, there will be inmates who ‘slip through the net’ and end up in normal placement. Often they will be violent to staff and other inmates, or alternatively, violence will be inflicted upon them by inmate predators, usually for sexual favours.

In secure environments they feel safe but become dependent on staff and view Prison as their home. They view other inmates and staff as their family support. They have no money and rely on the Department’s weekly financial payments of $13.00 to buy their tobacco - often their only luxury and enjoyment.

Despite the Richmond Report’s eloquent and convincing arguments to return psychiatric patients back into the community, where their health care should be shared between professions and the community, in reality, this has never evolved. They have become a permanent fixture in Correctional Centres, where it could be argued that it costs considerably less to accommodate them in our environment ($60,000 per person per annum) as opposed to psychiatric residential care estimated to be in the region of $200,000 per person per annum. The consequence of the Richmond Report was tragically, not the return of hospital inmates to society, but effectively their being discarded by society. The result has been that Correctional Centres have inherited homeless patients.

Acknowledgements:

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Induction and Screening of Inmates

In 2001/2002 over 18,000 inmates were received into NSW Correctional Centres. In 2001, approximately 35% of receptions into Correctional Centres and 70% of sentenced inmates were suffering from psychotic, mood, anxiety, substance abuse and personality disorders or a combination of these complaints (Corrections Health Service, 2001).

Upon reception into Custody, inmates are inducted into the Correctional System and are screened for a number of indicators to assess the individuals' needs and risks that will need to be managed by staff and the level of service required to facilitate their rehabilitation. With a high proportion of inmates suffering from mental illness and substance abuse issues, the need for early and accurate identification of mental illness is heightened.

Current Services

Justice Health provides two levels of service to newly received inmates with mental illnesses. There is the Court-based Court Liaison/Diversion Program and Correctional Centre-based health service including reception interviews, assessments, and referrals.

The Court Liaison/Diversion program has been on trial in several regional and metropolitan courts. It has proven to be successful and will be expanded into other court complexes over the next few years. The program involves Clinical Nurse Consultants working alongside other professions in the Court System to identify and assess mental illness in offenders and to provide referral for diversionary treatment within community-based health systems or alternatively within Justice Health. This program is currently funded on a recurrent basis for $1.6 million per year and has recently been included as part of a $241 million increase in spending for Mental Health by the NSW Health Minister Morris Iemma.

In the case of the MRRC, each inmate is separated from the general population upon reception until they are interviewed and screened by both Medical and Welfare staff. Where the inmate is identified through the Court Liaison program or by Correctional Officers or Police as suffering from a mental illness or presenting with abnormal behaviour, the inmate is further separated from other inmates.

Justice Health are involved in the initial reception and assessment of inmates into the Correctional Centre and provide detailed documentation for each inmate in relation to health and mental illness issues that are included in the inmates' case notes. These forms taken from actual documents utilised at MRRC include:

- Health Problem Notification Form
- Health Risk and Harm Minimisation Checklist Form

Welfare Staff then interview inmates and complete the Intake Screening Form, which also identifies mental health and psychological issues and problems. All of this information is compiled on the inmates' Case Management File and forwarded to his or her Case Manager.

Identified at risk inmates are placed on RAIT notification and assessed in the pod over a minimum 48-hour period prior to either being placed into the general population with referrals to Clinical Nursing Staff or being placed into a management wing for inmates with mental health issues (Hamden Pod at MRRC).

Due to the shortage of beds in the Hamden Pod and associated programs, a high proportion of inmates with Mental Illness are placed directly into the Centre's general population. This has resulted in many incidents of violence either by or against the inmates. This leads to more inmates being placed into protection or segregation, which incurs an increase in both cost and the level of supervision required.

Recommendation 1: Court Liaison/Diversion

That the Department encourages and promotes the Court Liaison/Diversion Program and actively seeks to enhance this program by providing training to staff at Court Cells in Mental Health issues.

Recommendation 2: Induction & Screening Process

That the Department adopts the induction and screening process currently utilised at the MRRC as a standard operating procedure for all reception centres.

Recommendation 3: Accreditation

That the Department seeks accreditation of its induction process under ISO 9001 and conducts regular compliance audits.

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Therapeutic Units

There are many ongoing management problems in a normal routine environment with inmates with mental health issues. These relate to self-harm incidents, segregation requirements, assaults, fights, injuries to staff and inmates and an increased level of breaches of regulations.

It has been shown in some studies (Lovell, Allan, Johnson and Jemelka, 2001) that there can be a reduction in the costs of managing such inmates after completion of an appropriate residential treatment program.

Current and Scheduled Capacity

The organization currently has 100 beds available in Long Bay Hospital Area 1, to offer acute treatment to mentally ill inmates. There is accommodation available there for 90 male inmates and 10 female inmates. Additional accommodation is scheduled for completion which will create accommodation for a further 235 inmates. This will leave a deficit of possibly over 500 significantly mentally ill inmates to manage in a normal routine correctional environment.

There are further treatment areas scheduled to be opened in the Metropolitan Remand and Reception Centre, (NSW Department of Corrective Services, 2004a) and Mulawa Correctional Centre. The Metropolitan Remand and Reception Centre facility will supply a further 40 beds accommodation and the Mulawa Correctional Centre facility will supply another 10 beds.

A Forensic Hospital is scheduled for construction at the Long Bay Correctional Complex with a forecast capacity of 135 beds. Additional works will result in a further 40 beds for mental health assessment and “step down beds.” (Corrections Health Service, 2004)

With the proposed new facilities there will be approximately 325 beds available, all within the Sydney Metropolitan area, to meet the needs of inmates with mental health disorders. Assuming at least 10% of the current inmate population has serious mental health issues, this would satisfy less than 50% of the need. There are currently no treatment facilities to service the needs of mentally ill inmates in rural areas.

Many inmates with mental health issues will spend part or most of their time in custody in a normal routine environment. That is, a generic custody area external to specific treatment areas. This may be in an area designated for protection, special management or normal discipline in terms of security and/or safety. The more of these inmates who can function in a normal routine environment the safer, more secure and cost effective the management of these inmates will be.

Recommendation 1: Therapeutic Units

That the department establish Mental Health Therapeutic Units in three selected Correctional Centres, one per Region, to assist in the intermediate management of mentally ill inmates. That is, as an alternative to placement in an acute care facility and to assist such inmates to phase into standard accommodation areas and the community on release.

The organization is currently successfully utilizing Therapeutic units to deliver a range of Therapeutic Programs to address specific criminogenic needs and assist inmates to amends their offending behaviour. Examples of these are the Custody Based Intensive Treatment Program (C.U.B.I.T) for sex offenders and the Ngara Nura Program for inmates with Alcohol and Other Drug issues.

Inmates with mental health issues can be admitted to these programs on the basis that their condition is stabilized in terms of medication regimes, a good standard of behaviour and a capacity to participate in all aspects of the programs. The Therapeutic Programs offer a range of development training and treatment to meet the inmate’s needs. These include, stress management, anger management, communication, assertion and relaxation. (NSW Department of Corrective Services, n.d.a)

Functionality

The Therapeutic units would be multifunctional to ensure maximum return for the resources invested.

“Step Down” Function

This would incorporate the “step down” function reflected in Justice Health plans. The concept of a “step down” unit is to reduce the trauma of direct placement into the correctional environment on an inmate who has been discharged from an acute treatment area for the mentally ill. The objective would be to improve the capacity of mentally ill inmates to function in a normal routine area in a correctional centre.
Studies indicate that the use of group psychotherapy services (Morgan, Winterowd and Ferrell, 1999) with an aim to modify negative behaviour to enable inmates to resolve conflict constructively, not in an antisocial way, can assist inmates to develop socializing techniques which will assist them to cope with issues associated with living in a normal routine correctional environment.

The units could address a range of needs and offer training in specific issues such as management of depressive symptoms, life skills, substance abuse education, medication maintenance etc. These issues are addressed in modified Therapeutic community programs in the United States, particularly with inmates with co-occurring disorders. (Edens et al, 1997)

Overseas experience indicates that up to 70% of inmates returned to normal routine environments after discharge from an intermediate treatment unit function more effectively following treatment. (Krelstein M. 2002, Lovell D., Johnson C., Jemelka R., Harris V. and Allen D., 2001)

**Pre-Release Function**

The units would incorporate a pre release segment to address throughcare issues in the post release period, such as accommodation, medical treatment, social security issues, employment, etc. This could offer inmates support to assist them to manage themselves in the community on release and reduce the risk of relapse and reoffending.

Studies have shown release planning for inmates with mental health issues is often given a lower priority than inmates with other health issues such as HIV infection or heart disease. (Wolff, Plemmons, Veysey & Brandi, 2002). For example, in New Jersey jails communication with an outside provider occurs in 82% of inmates with heart disease, 53% of inmates with HIV or AIDS but only 29% of inmates with mental illness.

Some conception of recidivism rates for inmates with mental illness may be gained from the recidivism rates for Intellectually Disabled inmates, who confront similar difficulties (NSW Department of Corrective Services, n.d). Figures available state the recidivism rate for the total population is about 35% and the rate for inmates with intellectual disability is about 65%.

**Intermediate Treatment Function**

The units could also perform a third function in acting as an intermediate treatment area for inmates from the normal routine environment who have suffered a mild relapse and/or are experiencing difficulty in coping.

Studies in the United States (Lovell, Allen, Johnson & Jemelka, 2001) indicate that intermediate care facilities can be utilized to provide post discharge support and to readmit participants who are experiencing difficulties in a normal routine environment. There would be benefits in stabilizing inmates, where possible, in the intermediate care units in terms of reduced transport and treatment costs and to lessen any disruption to the inmate.

**Structure**

**Staffing**

The program staffing would include Psychologists, Offender Services and Program staff and operational staff, with input and oversight from attending Psychiatrists and a Mental Health nurse from Justice Health.

It would be recommended to have baseline staffing of a Unit coordinator, a Senior Psychologist, two Psychologists and three Offender Services and Program staff per unit. Operational staff would be based on the Way Forward model, that is one Principal Correctional Officer, or equivalent, one Senior Correctional Officer and two Correctional Officers per unit.

Community corrections issues would be addressed by local Probation and Parole Officers attached to the parent correctional centre. The management team for the unit would be the unit coordinator in terms of program issues and the Principal Correctional Officer in terms of security matters. These boundaries should overlap with coverage of all areas shared by the management team and the work team.

This staffing structure would be mirrored in all three units. In terms of cost offsets it would be envisaged to establish the units in tandem with the introduction of the Way Forward model into all correctional centres with a view to utilizing staff positions which are redundant in the Way Forward model to offset against the costs of establishing the units.

Adopting the Way Forward model would not be restricted to staffing designations but would embrace the concept of operational staff moving with the inmates during the programs structured day activities and participating in program delivery.

The inmate structured-day would be based on an eight-hour time frame, for example, 8.00am to 4.00pm. This would reduce costs, maximize the use of available staffing resources and offer the inmates a controlled, structured environment.

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Duty in the units would be of especial benefit to operational staff in terms of program involvement and the opportunity to develop skills to manage inmates with serious mental health issues. These skills could be transported to normal routine areas as a consequence of standard staff rotation practices. Research suggests there are benefits in correctional officers taking on selected duties, which have been traditionally carried out by mental health staff. (Dvoskin & Spiers, 2004)

**Location**

It is proposed to initially establish one forty bed intermediate care unit within the Long Bay Correctional Complex. Ideally this would be situated within Area 2 of the Long Bay Hospital, to establish continuity of treatment within the same correctional centre as the acute care facility. Alternatively areas currently under-utilised could be adapted to accommodate an intermediate treatment unit. For example the 52 bed Additional Support Unit located in the Metropolitan Special Programs Centre.

Following the establishment and evaluation of the unit at Long Bay Correctional Complex it would be proposed to establish two thirty bed units: 1 unit at Grafton Correctional Centre and 1 at Goulburn Correctional Centre.

The objective would be to establish intermediate treatment units in each of the three management regions of the Department of Corrective Services. This would allow for placement of affected inmates within each region and obviate, to some degree, the need to transport inmates to the Metropolitan area.

**Implementation**

Implementation of the units could be integrated into the implementation of the Way Forward model in all NSW correctional centres. The aim would be to incorporate the establishment of the units into identified correctional centres in tandem with the implementation of the Way Forward Model.

The initial unit would be established in an identified centre at the Long Bay Correctional Complex. Initially a working party composed of representatives from all stakeholders could be established to reach consensus on staffing levels, operational policies and procedures and source funding, internally and externally. It is essential the working party is composed of persons/parties who have the capacity to achieve the establishment of the units in terms of industrial relations, authorising/sourcing funding and staffing and overcoming whatever barriers may arise.

Staff position descriptions would be required to be developed, job evaluations conducted, positions established and pertinent policies and procedures developed.

When the Long Bay unit has been established a monitoring and evaluation period of some six months should follow to allow any required adjustment of programs and processes to be conducted.

When it is considered the Long Bay Unit is operating effectively a thirty-bed unit would be established in Goulburn Correctional Centre. It would be preferable to sequence the establishment of the units to Goulburn Correctional Centre given the high number of program areas already in operation in that centre and local experience at introducing fresh concepts. The same sequence of planning and implementation would be followed in Goulburn and then repeated at Grafton Correctional Centre.

**Evaluation and Monitoring**

The operation of the units must be subject to a stringent monitoring and evaluation process to ascertain if the costs of operating the unit are justified by the results. An oversight committee composed of senior corrective services staff, Justice Health and other independent agencies would be established to conduct quarterly evaluations of the units and their operations, over a 3 year period. This will be part of the quality management system.

Key performance indicators would need to be identified to gauge the success of the units. It would be expected such issues as the level of regulation breaches, self harm incidents, fights, assaults, readmittance to the units and/or acute care facilities, staff retention and reoffending would be included.

**Organizational Benefits**

The costs of operating intermediate units would be higher than the average cost of managing inmates in normal routine areas but the overall benefits would outweigh the operating costs in terms of:

- Reduced assaults, fights and periods in segregated custody
- Reduced level of injury to staff and inmates
- Reduction of self-harm incidents.
- Lessen the risk of litigation

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- Reduce the level of reoffending
- Reduction in the costs of managing inmates within the client group
Training

There is wide recognition in the literature that inmates with mental health disorders make greater demands on the staff that works with them (Kropp, Cox, Rorsch & Eaves, 1989; Dvoskin & Spiers, 2004; Landsberg & Smiley, 2001). There is also a question of liability for the organization, as personnel are often at risk if something goes wrong with an offender while he/she is under supervision (Landsberg & Smiley, 2001: 43-2). Training can assist this situation by promoting the acquisition of skills, enhancing existing skills and fostering positive attitudes by replacing misconceptions about individuals with a mental illness. This training can be especially effective when it is conducted in an environment of “cross-training”. That is, involving the personnel of many different occupational groupings within the department in a single class (Landsberg & Smiley, 2001: 43-3). In addition, research has indicated that many correctional officers are highly motivated to obtain extra training in working with mentally ill offenders (Dvoskin & Spiers, 2004).

Current Situation

Custodial officers currently spend 2 days of their basic training on mental health issues and probation and parole officers have 1 day’s training (personal communication). In addition there is a further 2-day course held at the Corrective Services Academy called “Managing inmates with mental health issues” which teaches participants how to recognise the symptoms of various types of mental illness and gives practical advice and strategies for managing this group of offenders within the correctional environment (Corrective Services Academy, 2004: 12). This course is also taught to probation and parole staff, but is considered by these participants to have too much of a focus on the correctional environment, which is not necessarily useful to their workplace (personal communication).

There are also a number of courses either being taught, or in planning, at various sites across the department. For example, Justice Health is currently planning a mental health education program at MSPC. It is in draft form and comprises 6 topic areas: overview of mental health disorders, psychotic symptoms, mood disorders, anxiety disorders, other mental health disorders, working with inmates who have self injurious and/or suicidal behaviour. There is also a course being developed at MRRC in conjunction with the new mental health unit.

Many staff in correctional centres have expressed a desire to have further training in how to deal with mentally ill inmates. Even in areas such as Hampden at MRRC, where the inmates often have quite serious disorders, the staff have been given little formal training, and would appreciate very much being more informed about the problems of the inmates they deal with day to day (personal communication).

Recommendation 1: Basic Course

That the current CSA course “Managing inmates with mental health issues” be redesigned to include features of other courses being taught in correctional centres around the state. The course is to be standardised across the department and conducted either in the workplace or at the Corrective Services Academy, as appropriate. The course should be aimed at base level correctional officers, CSI, OS&P and COS staff and be adapted to the needs of all staff categories.

The standardisation of the course is necessary to prevent the current situation where a proliferation of courses is being developed by separate units across the department (eg. MSPC, MRRC). In order to redesign the course, an extensive survey of planned or current courses being run across the department should be conducted and the resulting curriculum should address all pertinent issues currently being taught. Combining the courses would enable the best features of each to be included in the final course.

There are also a number of very successful training courses used in other jurisdictions, which could assist in the development of this course (eg. Prins, 1986; Pima Community College, 2000; Landsberg & Smiley, 2001; Sovronsky & Shapiro, 1989).

The course should be designed with cross training in mind, although it would also need to be specific to the needs of the different occupational groups. This could be done by combining all categories of staff for certain sections of the course, with teams being formed of similar occupational groupings to carry out other sections of the course.

The course should be flexible in delivery method to adapt to the differing needs of staff. For example it may need to be taught at the workplace as well as at the Academy. It may be split into separate modules, taught over a period of weeks or taught in a block for a number of days. The modules could cover areas such as specific mental illnesses & strategies for dealing with the behavioural manifestations, treatments and symptom control, violence, suicide, case management and advocacy.

c. Dinsdale, Kennedy, Ruecroft, Smith & Smith, 2004
Recommendation 2: Advanced Course

That the Corrective Services Academy develop an advanced course, for senior staff in the department who work with inmates with mental health issues – that is, correctional, CSI, COS & OS&P staff.

This course will aim to enable the participants to better understand the nature of mental illness, the needs of mentally ill offenders (including medication and therapeutic issues) and recommended strategies to deal with their behaviours. It should also provide an understanding of the nature of the mental health sector, including its statutory, social, political and historical context and the available programs and services for people with mental illnesses in the justice system. This would both broaden their knowledge of the subject area and the relationship between the justice system and the community and also assist them in their dealings with inmates with a mental illness (case management). It will also equip them to act as mentors for other junior staff in their areas, encouraging attitude and behavioural changes in their staff towards these inmates.

The advanced training could be designed using selected competencies taken from the Mental Health Work (Non-Clinical) Certificate 4 course, and adapted to the needs of the Corrective Services departmental staff (TAFE NSW, 2004). This is part of the NSW TAFE Community Services training package, which the Corrective Services Academy is approved to teach. It is proposed that the course could be conducted in two segments of 4 days each, with a break in between in order to enable the participants to develop an individual or group project which will encourage them to extend their knowledge in the subject area.

Benefits of Training

The basic course is designed to prepare staff to deal with mentally inmates on a day-to-day basis. That is, to give an understanding of what mental disorders are, and how individuals with these disorders may behave, and how best to react to these behaviours. The advanced course will build on this knowledge to provide a broader understanding of the disorders, behaviours, and medication needs of these individuals, as well as an understanding of the general nature of the mental health sector as a whole, and the ability to assist junior staff in their dealings with these inmates.

The benefits of the two-tiered training will be to increase acquisition of skills and knowledge and to reduce fear of the unknown among the staff. It will foster positive attitudes towards individuals with mental disorders and replace misconceptions about them and their behaviour. It will also help to promote a better understanding of mental health issues among all levels of staff in the department.

c. Dinsdale, Kennedy, Ruecroft, Smith & Smith, 2004
**Transitional Planning**

All jurisdictions across the Western World have identified that with the deinstitutionalisation of the mentally ill within our societies there has been a concomitant rise in the number of these people finding themselves in the criminal justice system. NSW Corrections has found itself housing an increasing number of these people.

However Corrections can only be one part of the equation in working towards solutions for incarcerated persons with a Mental illness. A whole of Government response is required to assist the community in accommodating the needs of this group. Diversionary processes must commence with police and the judiciary and involve stakeholders from Health, Welfare, Housing, Employment, Local Governments, and Community providers.

The Select Committee Inquiry into Mental Health Services in NSW found concerning the lack of integration of Mental Health Services in NSW. This included a splintered approach to treatment, lack of follow up and supervision, and a dearth of care or community treatment. (Henderson, 2003).

A number of initiatives have been trailed in the US such as Mental Health Courts, diversionary programs, Drug courts, mental health case management, screening and evaluation, pre-booking diversions and utilising specially trained police officers (Roy, 2004). However, studies of these diversionary programs show that the most effective would seem to be screening and evaluation, Mental Health Case Management and Medical evaluations.

As discussed previously, within NSW a number of diversionary programs have been commenced including the Community and Court Liaison Project, which has expanded to 14 sites. However it is sadly still the case that most often mentally disordered offenders who commit misdemeanour crimes end up in the prison system.

These inmates represent considerable challenges because they are not only vulnerable (violence, self harm and victimisation), but they also have high rates of recidivism. Many of these inmates cannot locate or access the minimal support systems available in the community and thus end up gravitating towards the Justice system on a rotational basis. It is considered that appropriate diversions and post release care would assist the Department of Corrective Services to better achieve its Mission Statement of reducing recidivism.

Through being the default mechanism, the agency that can’t say no, The Department of Corrective Services is placed in the untenable position of having to provide ongoing and repeat care for this sector of the population who will also invariably boost recidivism numbers. In the current fiscal environment of agency’s competing for limited funding, and budgets linked to performance this is not a desirable outcome.

**Recommendation 1: Referral Database**

That a database be set up on the intranet to provide a referral network of all available community support agencies to assist exit strategy planning for inmates with Mental health issues.

This is of particular importance as the majority of these inmates will be held in normal routine Correctional Centres, and the managing staff will require information and networks to resettle these inmates with the appropriate level of available services and post release care. With most inmates in this category serving sentences for minor and even nuisance crimes, COS may have minimal interaction and thus the Correctional Centre staff will carry the burden of locating and referring the inmate appropriately.

All of the literature researched, has noted that in every country, the fragmentation of information and the splintering of resources, prevents cohesive treatment being available to these inmates. There is also a propensity for duplication of services and administrative functions.

Through the course of this research it has been impossible to break through the barriers to gain meaningful information from Justice Health, Mental Health Division. Countless phone calls have been ignored and there is no communication between Corrections and Justice Health on the intranet. This would indicate a system-wide communication gap that the proposed database may help to span.

**Implementation**

It is envisaged that a collaboration of current discipline heads would provide a framework for clerical staff currently at Head Office to flesh out with specific details. Technical expertise in terms of placing the information on the intranet could be supplied by the IT branch. As such this resource database available statewide would be cost neutral to implement.

**Review and Update**

The database utilisation could be tracked electronically through hits on the system, and a brief Q & A could be sent to staff at Correctional Centre level for any suggestions for improvements to the service. This information would be collated and included for review as part of the quality management system.

c. Dinsdale, Kennedy, Ruecroft, Smith & Smith, 2004
The database currency would need to be updated to ensure contact details were accurate. Again, clerical support staff could undertake this. Most agencies will notify of the changes to staffing structures or contact details as they occur, particularly if we were on their mailing list. It would be a matter of updating single changes as necessary.

**Recommendation 2: Support & Advisory Unit**

That a support and advisory unit be established in Head Office, similar to the current Disability Unit.

This unit would be able to offer a telephone, email or written contact point where Centre staff, responsible for the day to day management of offenders with Mental Health issues, could access information, placement options, management strategies and Throughcare advice.

It is envisaged that this group would include a psychiatric nurse, a clinical psychologist, a placement and pre-release co-ordinator, a diversional therapist, a special education advisor and a manager. This service would also have access to a psychiatrist. It would also be considered valuable to have access to personnel with expertise in alcohol and other drug issues, as a large number of mentally ill offenders have co-occurring substance abuse disorders.

**Implementation**

There are two perceived methods of implementation. With the Way Forward restructure there may be sufficient positions available from within the current discipline structure to be re-assigned to this unit (excluding the psych nurse). This would make the costing minimal. Office space and furniture, appropriate technology, ie fax, phone and computers would need to be supplied. Alternatively, should positions not be available from other savings the following estimates of the staff costs are shown in Appendix IV.

**Review and Update**

The utilisation of the unit would be measured, and a brief Q & A could be sent to staff at Correctional Centre level for any suggestions for improvements to the service. This information would be collated and included for review as part of the quality management system.

**Recommendation 3: Post Release Transition Centre**

That an institution be made available as a post release transition Centre to provide multi agency community support for inmates immediately upon their release.

‘Nowhere is transition planning more valuable and essential than in jails. Jails have, in many parts of the country, become psychiatric crisis centres of last resort. Many homeless people and uninsured people with mental illness receive mental health services only in jail because they have been unable to successfully access mental health services in the community, and lack of connection to mental health services in the community leads some individuals to cycle through jails dozens or even hundreds of times. Inadequate transition planning puts jail inmates who entered the jail in a state of crisis back on the streets in the middle of the same crisis. The outcomes of inadequate transition planning include the compromise of public safety, an increased incidence of psychiatric symptoms, hospitalisation, relapse to substance abuse, suicide, homelessness and re-arrest’ (Draine & Solomon, 1994).

‘Good transition planning for jail inmates with mental illness and co-occurring substance-abuse disorders requires a division of responsibility between jails, jail-based mental health and substance-abuse treatment providers, and community-based treatment providers.’ (Osher, Steadman and Barr, 2003)

‘Special consideration must be given to the critical period immediately following release to the community—the first hour, day, and week after leaving jail. High-intensity, time limited interventions that provide intensive support as the detainee leaves the jail should be developed. The intensive nature of these interventions can be rapidly tapered as the individual establishes connections to appropriate community providers.’ (Osher, Steadman and Barr, 2003).

As can be seen from the above literature best practice transition planning needs to be managed from a multi-jurisdictional approach with strategic partners from NSW Health, DET, Employment Providers, Housing, Corrections, Community Services, Aging Disability and Home Care, Attorney Generals Department and Police.

This proposal would situate Corrections NSW as an Outreach service, assisting other Government and non-Government agencies to provide transition support, community interaction, and resettlement issues in vivo. This strategy would be in line with the National Mental Health Strategy Recommendations of 1999, and would address some of the issues raised by the Select Committee Inquiry into Mental Health Services NSW. Specifically mentioned were ‘a lack of follow up services on release from custody, a chronic shortage of supported accommodation, a lack of support services the community, including the administration of medication.’ (Henderson, 2003)

c. Dinsdale, Kennedy, Ruecroft, Smith & Smith, 2004
Not only would this strategy move in positive and internationally recognised pathways but this would spread the resourcing burden across a number of agencies, rather that Corrections carrying consistently high numbers of repeat offenders in this category.

The Program

The program would offer to appropriate clients the ability to have supported accommodation provided to them, outside of the constraints of a Correctional Centre, while staff from numerous agencies assisted them with their resettlement needs. While staff within Correctional Centres work on these issues with the inmates, very often many things cannot be accomplished.

For example, an inmate leaving prison needs to have a bank account to receive Centrelink payments. Correctional Centre staff cannot open bank accounts for inmates. In order to open a bank account 100 points of identification are required. This generally requires a primary document such as a birth certificate, which costs $29.00 non urgent, and $44.00 urgent. In order to get a birth certificate you need 1 primary identification and two secondary (yes, that is, to get a primary you need a primary) such as Medicare cards, old drivers license etc. The crisis payment from Centrelink could be utilised to pay for the birth certificate, but the system is so entwined that people with a mental disorder would not be able to fathom the intricacies.

If Community services were working to sort through these requirements while community health professionals were hooking the ex offender up with support services (A & OD, medications, etc) and housing were locating accommodation then there is a real possibility of post release success. Further, this process is reassuring the ex-offender at the time he or she, is feeling at their most vulnerable.

Many inmates are released from custody with requirements for psychotropic medications. Justice Health currently spends $217,469 per month on these medications. Proposed changes to the PBS will likely result in increases in the cost of these medications. Ex-offenders who are not on social security will be faced with these large costs when they return to the community. They will need advice and support on release to help them budget for these and other day-to-day expenses.

The amount of intervention offered and the length of stay would be entirely individual. Some clients may need to stay 1 day or 1 night and others may need more intensive interventions over longer periods.

The Location

An institution such as Emu Plains would suit the needs of such a program. It is within the Metropolitan region, with access to an array of services. A regional centre would not be able to meet the needs of the program. With the anticipated opening of Dillwynia Correctional Centre, Emu Plains may not require the same level of space that it currently occupies.

Budget Considerations

It is not proposed to define costings at this stage. The proposal would see a small contingent of Corrections staff dedicated to the project to perform linkages for information sharing. However until the appropriate players are brought to the table it would be meaningless to guess at what agency would supply what service and how much of it.

Conclusion

The NSW Department of Corrective Services mission is to reduce re-offending through secure, safe and humane management of offenders (NSW Department of Corrective Services, 2003). This mission is often not being accomplished in relation to mentally ill offenders. They often have a high recidivism rate and may not be kept safe, either from themselves or others. They are sometimes not treated in a humane manner by staff or other inmates, often as a result of inadequate training and education of the staff. Various actions are necessary before, during and after their incarceration to assist mentally ill offenders to reduce their recidivism. That is, diversionary programs may help to keep them out of gaol and therapeutic programs within the correctional centres would help them to cope better with their incarceration. Improved staff training would help the staff to cope better with these inmates and ensure that they are treated more appropriately within the correctional centres and transitional programs would assist them to adjust to life outside the correctional centres. The department needs to take a holistic approach to this problem, in cooperation with other agencies, to ensure the accomplishment of its mission in relation to the mentally ill people who become involved in the justice system.

c. DIasdale, Kennedy, Ruecroft, Smith & Smith, 2004
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c. Dinsdale, Kennedy, Ruecroft, Smith & Smith, 2004


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c. Dinsdale, Kennedy, Ruecroft, Smith & Smith, 2004


Appendices

Appendix I: Survey of Inmates

Snapshot of 33 MRRC Mental Health Inmates (Pod 18) June 30 2004

<table>
<thead>
<tr>
<th>Average Age</th>
<th>33 year old</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationality</td>
<td>48% (n=16) Overseas Born</td>
</tr>
<tr>
<td>Homeless</td>
<td>76% (n=25)</td>
</tr>
<tr>
<td>Type of Mental Illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Schizophrenia</td>
</tr>
<tr>
<td></td>
<td>• Bipolar Affective Disorder</td>
</tr>
<tr>
<td></td>
<td>• Manic Depression</td>
</tr>
<tr>
<td>Previous Hospital (Psychiatric) Admission</td>
<td>79% (n=26)</td>
</tr>
<tr>
<td>Violent Crime (Murder, Sexual Assault, Indecent Assault, Armed Robbery)</td>
<td>70% (n=23)</td>
</tr>
<tr>
<td>Non-violent Crime (breach of parole, loiter in public place etc)</td>
<td>30% (n=10)</td>
</tr>
<tr>
<td>Regular Visits (Family, Friends, Religious)</td>
<td>64% (n=21) Do not receive any visits</td>
</tr>
<tr>
<td>Phones Calls</td>
<td>As above</td>
</tr>
<tr>
<td>Previous Custodial Sentence</td>
<td>76% (n=25)</td>
</tr>
<tr>
<td>Average episodes of incarceration</td>
<td>Average 4 per inmate (shortest period out of gaol = 1 day, longest 5 years)</td>
</tr>
<tr>
<td>Number of MRRC Inmates on Psycho-tropic medication</td>
<td>21% (n=188, gaol state: 900)</td>
</tr>
<tr>
<td>Safe Cell Admission</td>
<td>100% upon reception</td>
</tr>
<tr>
<td>Martial Status</td>
<td>100% Single</td>
</tr>
<tr>
<td>Suicide Actual – Previous 12 months</td>
<td>1 (September 2003)</td>
</tr>
</tbody>
</table>

c. Dinsdale, Kennedy, Ruecroft, Smith & Smith, 2004
Appendix II: Training

Occupational Groupings for Proposed Advanced Mental Health Education Program

Extended training should be done for all occupational groupings who have dealings with inmates. This would be done in order of seniority to ensure that managers can act as mentors for more junior staff.

**Correctional:** Governor, Deputy Governor, Area Manager, Case Manager, Senior Correctional Officer

**Industries:** Manager of Industries, Manager Corrective Services Employment, Senior Overseer, Overseer

**Offender Services & Programs:** Manager of Offender Services and Programs, Senior Correctional Education Officer

**Community Offender Services:** Manager of COS offices.

Costing for Development of Proposed Basic Mental Health Education Program

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Officer – 20 days</td>
<td>$5000.00</td>
</tr>
<tr>
<td>Goods &amp; Services (photocopying, desktop publishing etc)</td>
<td>$750.00</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$5750.00</strong></td>
</tr>
</tbody>
</table>

Costing for Development of Proposed Advanced Mental Health Education Program

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Officer – 20 days</td>
<td>$5000.00</td>
</tr>
<tr>
<td>Goods &amp; Services (photocopying, desktop publishing etc)</td>
<td>$750.00</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$5750.00</strong></td>
</tr>
</tbody>
</table>

c. Dinsdale, Kennedy, Ruecroft, Smith & Smith, 2004
Appendix III: Therapeutic Units

Intermediate Care Unit Recommended Staffing Requirements

**Justice Health Staffing**

<table>
<thead>
<tr>
<th>Position</th>
<th>Number per Unit</th>
<th>Total Number</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Mental Health Nurse</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**Corrective Services Staffing**

<table>
<thead>
<tr>
<th>Position</th>
<th>Number per Unit</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit Leader Senior Psychologist</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Psychologist</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>O.S. &amp; P.</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Principal Correctional Officer</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Senior Correctional Officer</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Correctional Officer</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Positions</th>
<th>289 Formula</th>
<th>Actual Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Correctional Officer</td>
<td>1.746</td>
<td>1</td>
</tr>
<tr>
<td>Senior Correctional Officer</td>
<td>1.746</td>
<td>2</td>
</tr>
<tr>
<td>Correctional Officer</td>
<td>3.492</td>
<td>4</td>
</tr>
</tbody>
</table>

c. Dinsdale, Kennedy, Ruecroft, Smith & Smith, 2004
### Intermediate Care Unit Cost Estimates

(Costs Based on one unit with a capacity to accommodate 30 inmates)

<table>
<thead>
<tr>
<th>Salary and Allowances</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Psychologist</td>
<td>$72,000</td>
<td>$72,000</td>
</tr>
<tr>
<td>Psychologist</td>
<td>$67,000 x 2</td>
<td>$134,000</td>
</tr>
<tr>
<td>OS&amp;P</td>
<td>$55,000 x 3</td>
<td>$165,000</td>
</tr>
<tr>
<td>Principal Correctional Officer (SAS)</td>
<td>$71,000</td>
<td>$71,000</td>
</tr>
<tr>
<td>Senior Correctional Officer</td>
<td>$60,500 x 2</td>
<td>$121,000</td>
</tr>
<tr>
<td>Correctional Officer</td>
<td>$48,000 x 4</td>
<td>$192,000</td>
</tr>
</tbody>
</table>

**Subtotal** $755,000

Estimated “On costs” $239,000

**Total Estimated Employee Related Costs** $994,900

Estimated administration costs (uniforms, telephone etc) $12,000

### Inmate Related Costs

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provisions</td>
<td>30 x $8.50 x 365 days</td>
<td>$93,000</td>
</tr>
<tr>
<td>Clothing</td>
<td>30 x $200</td>
<td>$6,000</td>
</tr>
<tr>
<td>Linen,stores</td>
<td>30 x $200</td>
<td>$6,000</td>
</tr>
<tr>
<td>Inmate Wages</td>
<td>30 x $13 x 52 weeks</td>
<td>$20,100</td>
</tr>
</tbody>
</table>

**Subtotal** $32,100

**Overall Total** $1,131,000

**Total Costs for 3 x units** $3,393,000

c. Dinsdale, Kennedy, Ruecroft, Smith & Smith, 2004
Appendix IV: Transitional Planning

Staff Costs for Proposal 2

<table>
<thead>
<tr>
<th>Position</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psych Nurse</td>
<td>$55,000</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>$70,689</td>
</tr>
<tr>
<td>Diversional Therapist</td>
<td>$50,000</td>
</tr>
<tr>
<td>Special Education</td>
<td>$66,033</td>
</tr>
<tr>
<td>Placement and Pre-Release Co-ordinator</td>
<td>$57,656</td>
</tr>
<tr>
<td>Clerk Grade 5/6</td>
<td></td>
</tr>
<tr>
<td>Unit Manager Clerk Grade 9/10</td>
<td>$75,598</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>$374,976</strong></td>
</tr>
<tr>
<td>Oncosts @ 30%</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$487,468</strong></td>
</tr>
</tbody>
</table>

Salaries are quoted at the maximum level for each grade.

Legislative Framework

Research shows that the collaborative practices and multi agency frameworks have been introduced in the UK and in some states of the US. Almost all researchers in the field recognise that this care continuum is required to provide adequate support and meet public safety concerns for mentally disordered people in the community.

In the UK, policy revisions of the Mental Health Act of 1983 include:

- Dept of Health: 1990 Caring for People
- Dept of Health: 1994 Report of the working group on high security and related psychiatric provision
- National Health Service Management Executive: 1994 Introduction of supervision registers for mentally ill people from 1 April 1994
- Dept of Health: 1995 Mental Health (Patients in the Community) Act.
- Dept of Health: 1999a Managing dangerous people with severe personality disorder: Proposals for policy development
- Dept of Health: 1999b National Service Framework for Mental Health: Modern standards and service models.
- Dept of Health: 1999c Reform of the Mental Health Act 1983: Proposals for consultation
- Dept of Health: 2000 Effective care co-ordination in mental health services: Modernising the care programme approach: A policy booklet.

These policy revisions underpin the ability for agencies to develop structures and work practices that promote collaboration and information sharing.

Within the US, there are a number of inter-agency programs with slightly different parameters and emphases. However, due to the nature of state law there are different underpinning legislations and policies. The National GAINS Center for People with Co-Occurring Disorders in the Justice System 1999a has spawned a number of programs and interventions across the US. Further, the National Coalition for Mental and Substance Abuse Health Care in the Justice System has developed a number of innovative interventions. The National Association of State Mental Health Program Directors through the Forensic Division also contributes to policy development.

Within US Federal law the Children’s Health Act was passed by Congress on October 17, 2000, and America’s law Enforcement and Mental Health Project Act (S. 1865) was passed on November 13, 2000. The enactment of these two laws had allocated to them more than $500 million dollars for new programs. Key to accessing these funding grants are

c. Dinsdale, Kennedy, Ruecroft, Smith & Smith, 2004
the coordination of mental health services with health care, social services, substance abuse programs and the criminal justice system.

The legislature quoted above encouraged numerous diverse agencies to work collaboratively together to meet Federal and State needs. For NSW Corrections there are already two Memoranda of Understanding with both Centrelink and Justice Health. Similar such service agreements could be forged with other agencies and providers to allow for the sharing of information and other collaborative practices.