Offenders with Mental Health issues: Community Re-entry and Reintegration

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'Re-entry planning, as a social investment protects the outcomes produced by correctional health care during incarceration and protects the public from future crime associated with untreated mental illness' (Wolff, Bjerklie & Maschi, 2005)

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INTRODUCTION

Correctional systems worldwide deal with high volumes of people with addiction issues, low self-esteem, poor resilience and little possibility of recovery or harmonious integration into communities, without significant help from skilled professionals and an adjustment in community attitudes. ‘There is an increasing recognition that prisoners carry a considerable load in lesser forms of mental illness; conditions such as depression, anxiety and stress related conditions affect the majority of prisoners.’ (Fraser, Gatherer & Hayton, 2009).

The purpose of this paper is to:

- describe and compare worldwide and Australian trends and the prevalence of mental illness;
- outline the key issues of whole of government responses and community engagement in the development of coherent mental health services, and
- to make strategic recommendations that have the potential to improve the management of re-entry processes for released offenders with mental health issues Australia wide.

The paper will argue that coherent mental health services assist in the development and promotion of a healthy and vibrant society. Corrective Services have a meaningful role to play in this development and the challenge will be to develop a suite of skills that will ensure successful engagement across boundaries. Importantly, Corrective Services need to provide strong and effective leadership to develop a culture that promotes cooperation and collaboration across agencies and the community.

DEFINITION

Mental illness is ‘a clinically diagnosable disorder that significantly interferes with an individual’s cognitive emotional or social abilities, the diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD)’. A mental health problem ‘diminishes cognitive emotional or social abilities but not to the extent that the criteria for a mental illness are met’ (National Mental Health Policy 2008).

TRENDS

Primarily attributable to progressive worldwide post-war deinstitutionalisation without the delivery of promised community health strategies, people with mental health issues have been increasingly criminalised. The resulting over-representation puts pressure on Corrective Services' systems, better designed to protect the community through safe and secure containment, monitoring and surveillance, than it is to address the issues underlying the offending behaviour. Consequently, those with mental health issues often get caught in a well documented revolving door phenomenon, characterised by multiple incarcerations interspersed by short periods of unemployment, homelessness and other manifestations of social disadvantage. ‘The ever increasing correctional population includes a large number of individuals with multiple, complex and interrelated treatment needs, which are often exacerbated upon release into the community’ (Vogel, Noather, Chan & Steadman, 2008, p. 168). The resultant exclusion and alienation further increases the likelihood of re-offending.

‘Exact prevalence is hard to establish on an international basis because of differences in sample selections, institutional types, and the definition of mental illness’ (Birgden, 2010, p. 11.5). Australian and New Zealand studies have shown that many people involved in the criminal justice system have had psychiatric contact before entering the system and
prevalence rates for all psychiatric morbidities in the prison population are markedly higher than rates in community samples. The 2007 National Survey of Mental Health and Well-being found that 20% of the population aged between 16 and 85 had a mental disorder in the twelve months prior to the Survey. Work in the New South Wales prisoner population using the same tool found the prevalence of psychiatric disorders in prisoners was more than double those among people living in the community (Butler, T., Allnut, S., Cain, D., Owens, D., & Muller, C. 2005). Other Australian and New Zealand studies of prisoners have found prevalence rates of between 25% and 50% for non-psychotic disorders such as major depression, anxiety disorders and post-traumatic stress disorder. When considering severe mental illness, evidence indicates that the prevalence rates in corrections in many different countries is even more disproportionate with rates in the general community, occurring ‘five to ten times more frequently among persons in prison than in the general population. These data hold true in countries as diverse as Australia, Iran, New Zealand, the UK and the USA’ (Gostin, 2008 p.911).

ISSUES

Challenges

There appears to exist today a significant gap between international and national rhetoric on this issue and the reality that a consumer of mental health services is faced with. In order to promote inclusion, create public value and better protect the community, re-entry planning must safeguard the health outcomes produced by investment during incarceration. ‘Here the challenge facing public official is not mental illness but rather how to use the scarce public dollars to produce and protect mental health and prosocial behaviour.’ (Wolff et al, 2005, p.22). Mental health service delivery is often uncoordinated and limited in its scope, failing to appropriately cater for the particular and complex needs of an offender re-entering society, it places a significant strain on the public purse, in 2006/2007 it is estimated that $4,707 million was spent on mental health services. (Australian Institute of Health and Welfare, 2009). In July 2006, the Council of Australian Governments (COAG) announced a National Action Plan representing COAG’s commitment to ‘deliver mental health services in a more integrated way – between governments, and between the government and non-government sectors’. Agreement was reached to develop a model of community-based and coordinated care for people with serious mental illness, particularly those who are ‘at risk of falling through the gaps in the system’ (COAG 2006).

Neither corrections, human services agencies nor the community can justifiably maintain the re-entry of offenders with mental health issues to be a responsibility in which they do not share. We will therefore focus on brief discussion of key critical issues: multi agency collaboration and the engagement of the community.

Multi agency collaboration

There is shared national and international recognition of the need for multi agency collaboration if the complex task of meeting the needs of offenders with mental health issues is to be properly addressed. Lord Bradley’s recent review of people with mental health issues in the UK’s criminal justice system devotes a chapter to delivering change through partnership. Consideration is given to the piecemeal approach to policy and practice development with agencies working independently of one another and addressing one problem or one part of the system at a time. Lord Bradley acknowledges the mistakes of the past few years and the resulting ‘uncoordinated approach to the implementation of liaison and diversion services.’ (Bradley, 2009 p.122 – 149).

In Thailand there is no research available on multi agency collaboration. However, prisoners who suffer from mental health issues are hospitalised for treatment. There has never been any provision, within the custodial setting, for the management of prisoners with mental health issues. In 1997

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the Department of Corrections initiated policies and services for mental health offenders. The Medical Services Division has recommended: the provision of advice to offenders; the establishment of mental health clinics; recreational activities; and rehabilitation and pre-release programs for mentally ill offenders. (Warunee, 2001)

The Council of Australian Government’s (COAG) National Action Plan on mental health has informed State government strategy in the development of policy and delivery of mental health services. The plan recognises the scale and complexity of mental health issues in the community and adopts a whole-of-government approach to the coordination of mental health services (COAG 2006).

In Victoria, the Department of Human Services has developed a mental health reform strategy to 2019 focussing on a whole-of-government and whole-of-community approach. This is a different approach from previous mental health strategies as it is not only designed to address mental health issues but also to build capacity (Department of Human Services Victoria, 2009).

In Western Australia (WA), there is recognition by both the Departments of Corrective Services (DCS) and Health, of the need to work collaboratively. A paper titled WA Mental Health toward 2020 identified the requirement to enhance the range of quality mental health services in the criminal justice system. The paper proposes a whole-of-government approach at both the national and state/territory level, recognising that there are factors outside of the mental health system that need to be considered (Mental Health Commission 2010). DCS is a key stakeholder in this project.

The New South Wales Offenders with Co-Existing Disorders project is an example of successful multiagency collaboration in action. The project aims to reduce re-offending by effectively meeting the criminogenic needs of supervised offenders who have defined co-existing disorders. The project has been operated by designated Project Officers in selected locations since 2006. The NSW Housing and Human Services Accord is a framework that is used to formalise and strengthen this interagency partnership in NSW. The process of accepting a client is by joint assessment and decision making.

The creation of public value calls for collective action; to achieve this, existing organisational barriers must be overcome.

Community engagement

Currently, public confidence in corrections is low. Media reporting reflects and drives this sentiment; ‘More than eight out ten people surveyed have no or very little confidence in the ability of the prison system to rehabilitate prisoners or deter recidivism.’ (SMH November 24 2009). Inherent in this finding is the perception that sole responsibility for this issue is that of corrective services agencies; in reality successful reintegration is an interdependent process with complex synergies between numerous stakeholders. This will require strong and adaptive leadership, unity of purpose and the organisational maturity to adopt innovative solutions.

The Correctional Service of Canada produce a fact sheet on Community Involvement, on any given day some 80,000 volunteers donate their valuable skills and time to agencies within the Department of Public Safety Canada, including 9000 in the Correctional Service of Canada (www.csc-scc.gc.ca). ‘In the Netherlands, there is great interest in the issue of mental health care during detention. Politicians, the government and professionals all contribute to this increasing interest.’ (Bulten, B., Vissers A. & Oei, T. 2008, p. 40) Treating prisoners during their detention to reduce recidivism has become one of the main points of debate in Dutch policy, with significant recognition of the need for heavy emphasis on theoretical maintenance and promotion of mental health.

In Australian corrections the notion of community engagement held by and presented to the public is not framed within
these Canadian and Dutch contexts of shared responsibility and public value creation. Under the banner of community engagement, the New South Wales website reveals a range of positive initiatives through the establishment of Community Consultative Committees in all correctional centres, reparation to the community through unpaid community projects, partnerships with remote communities and a community funding program (www.correctiveservices.nsw.gov.au). A search for ‘community engagement’ on the websites of other corrections agencies includes random discoveries, the existence for example of a Community Engagement and Advisory group at Boronia Pre-release Centre for Women in Western Australia. Tasmanian Corrective Services website is the exception (www.justice.tas.gov.au). The Primary link on this website is Breaking the Cycle, in 2009 the Minister announced the development of a strategic vision for corrections in Tasmania over the next ten years, the Breaking the Cycle: Tasmanian Corrections Plan (2010-2020). A discussion paper and resource documents are made available and responses invited. The documents include a discussion paper on Best Practice in Offender Rehabilitation with robust discussion of the Risk Needs Model and the Good Lives Model and the greater recognition of the need to address both psychological/psychiatric needs and criminogenic needs in order to create behavioural change.

To successfully engage the community, Corrective Services must establish relationships based on trust and reciprocity, we must develop skills in communication, negotiation, participation and diplomacy (Tiernan & Althaus 2005).

CONCLUSION AND STRATEGIC RECOMMENDATIONS

The prevalence of mental illness within the criminal justice system in Australia ranges between 25 and 50%; this is significantly higher than that of the general community and one that has a significant economic impact on the community. The need for a more coordinated approach to the delivery of mental healthcare to offenders as they transition back into the community, to stop them ‘falling through the gaps’ is readily acknowledged, but a lack of accountability and ownerships allows them to slip through. A comparative analysis of international trends indicates that there are similar difficulties in the delivery of mental health care to offenders in overseas jurisdictions. The provision of mental health services is a complex process that requires input from a number of government, non-government and community stakeholders; effective and efficient solutions will only be achieved by a coordinated and collaborative approach by all. This presents an array of opportunities and the challenge will be to respond effectively. We need to embrace the shift to a whole of government approach to solve the problem of people with mental health issues entering the criminal justice system; this will require strong leadership, goodwill and imagination.

In support of an integrated and coordinated approach, the following recommendations are made:

1. State boards be created, (in keeping with Lord Bradley’s recommended National UK Programme Board) which will bring together all the relevant government departments, covering health, social care and criminal justice. With the support of a National Advisory Group, (providing independent evidence-based advice to Ministers and the boards, acting as an independent challenge to the development and progress of the work programs, highlighting examples of good practice and commissioning in-depth studies) the boards will develop clear state plan approaches to mental health for offenders.

2. A review of relevant legislation and systems for sharing client information between corrective services and human service agencies is undertaken to support the best interests of individual offenders with mental health issues re-entering the community.

3. Research is undertaken to establish best practice guidelines for mentoring
programs for offenders with mental health issues re-entering the community and that jurisdictions work collaboratively in actioning this strategy and developing and implementing an overall communication strategy as a means to commence engaging the Australian community.

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