Management of Inmate Mental Health

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Introduction
This report outlines the findings of a group research project in relation to the 'Management of Inmate Mental Health' undertaken as part of the 2008 Australian Correctional Leadership Program (ACLP). The research team comprised:

- Ms Kim Blinkhorn - New South Wales;
- Ms Claire Heffernan - Western Australia;
- Ms Cheryl Mikaere - New Zealand;
- Mr Ian Goulden - Victoria; and
- Mr Gary Hancl - Tasmania.

The project, which incorporated both national and international research, had the following aims:

- To outline the key issues;
- To identify current international trends/research and best practice;
- To contrast international trends with current practice in Australia; and
- To make strategic recommendations to the Corrective Services Minister's Conference (CSAC).

While the focus of the research project was primarily from the perspective of correctional organizations, it is important not to forget the human cost associated with incarcerating people suffering with ~at is essentially a medical issue in prison environments that are not adequately designed or resourced to cater for them. In fact, during the course of the research, group members found the following quote made by the famed author Charles Dickens in 1842 that provides some insight to the plight of people with mental illness who find themselves in prison:

"I paid a visit to the different public institutions on Long Island. One of them is a lunatic asylum. In the dining room, a bare, dull dreary place, with nothing for the eye to rest on but the empty walls, a woman was locked up alone. She was bent, they told me, on committing suicide. If anything could have strengthened her in her resolution it would certainly have been the insupportable monotony of such an existence"

Key Issues
Three major issues identified by the research team were:

1. The increasing prevalence of mental illness within prison populations;
2. The inherit conflict between the security mission of prisons and the medical needs of people suffering from mental health issues; and
3. Post-release aftercare.

Prevalence of mental illness within prisons

There is significant evidence worldwide of an increasing prevalence of inmates with mental health problems ending up in prisons, particularly at rates much higher than the general population.
A 2003 survey undertaken by Mullen, Holmquist and Ogloff in New South Wales found that 13.5% of male prisoners and 20% of female prisoners had reported prior psychiatric admissions, and that 8% of male and 14% of females had major mental health disorders with psychotic features. Major mental illnesses (e.g. schizophrenia and depression) were found to be 3-5 times higher than in the general community.

A 2003 Human Rights Watch publication observed that there were three times more people with mental illness in United States' prisons than in mental hospitals, and four times more people with such illnesses in prisons than in the community. Information provided by the Canadian Correctional Service (CCS) in 2007 notes that, in 1997, 7% of male offenders entering prison in Canada were identified as having mental illness but, by 2007, the proportion had jumped to 1 in 8 - 71% increase. By 2007, at least 25% of female inmates in Canada were identified as having mental health problems (Correctional Service of Canada, 2007(a)).

The situation across the Atlantic is similar. For example, a 2007 thematic review by Her Majesty's Inspectorate of Prisons in the United Kingdom found a significant over representation of mental disorders in prison populations when compared to the general community. It reported approximately 74,000 people serving prison sentences in the UK, with as many as 90% having some kind of mental disorder. It also observed that up to 80% of women prisoners have diagnosable mental health problems, with 66% having symptoms of neurotic disorders. The comparable figure in the community is less than 20%. A number of contributing factors were identified, namely:

- The de-institutionalisation of mentally ill people;
- An increase in the use of drugs and alcohol by people with mental illness; and
- The limited capacity of community-based mental health services to address the needs of mentally ill people.

These reasons, which were overwhelmingly supported by research from Australia, the United States and Canada, clearly indicate that prisons are fast becoming de-facto mental health institutions.

**Prison - v - medical model**

Prisons traditionally do not have the facilities, expertise or the qualified mental health staff to treat inmates with mental health issues. They typically treat them identically to all other inmates regardless of their individual needs.

The problem, however, is that people with mental illness do not have the same capacity to comply with prison rules as other prisoners. They may exhibit the illness through disruptive behaviour, belligerence, aggression and violence which, in a prison environment, often sees them being segregated from the general population. In fact, a US study (Fellner, 2006) showed that, not only are the mentally ill disproportionately represented among prisoners in segregation, they typically account for one quarter or more of the segregated population and in some states account for half. A major implication of this is that prisoners with pre existing psychiatric disorders are at even greater risk of suffering psychological deterioration while in segregation (Fellner, 2006).

This issue is exacerbated by the fact that most prison systems throughout the world provide their staff with little more than minimal mental health
training; nor do many have integrated systems with medical personnel to manage inmates with mental health issues, meaning that the overrepresentation of this cohort in segregation will continue to grow. There is also a global shortage of mental health professionals working within the health sector, and this makes it harder to fill less attractive custodial-based mental health positions.

Post-Release Aftercare

The experience of the CCS (2007a) is that inmates with mental health problems are the least likely to be released on parole, meaning that the opportunity to actively formally supervise them on return to the community is invariably non-existent. Unfortunately, it was also found that these inmates are also often released without any form of community mental health support or pre-release planning specific to their needs.

The UK Inspectorate of prisons (2007) also noted that:

1. Offenders with primary mental health needs rarely had communication with resettlement teams prior to release. They were not routinely involved and kept informed about resettlement planning;
2. Referral to GPs in the community was variable; and
3. Only half recorded contact with community mental health teams within three months of the date of release.

The major implication of these findings is that inmates with mental health problems are not only staying in prison longer, but are then returning to prison because of inadequate reintegration and community support.

International Trends/Research

Two broad findings came from the 2007 thematic review undertaken by the UK Inspectorate of HM Prisons, namely

1. The need for a system-wide, evidence-based blueprint for the provision of mental health care within prisons that has the following elements:
   - Based on the individual (complex) needs of the individual;
   - Appropriate support and governance for mental health staff;
   - Identifies services required;
   - Appropriate external support and internal integration with other prison staff and services; and
   - Holistic care.

2. The need to manage such inmates 'holistically', taking all their needs into account.

A 'holistic' approach was seen as crucial because inmates with mental illness often experience a range of additional needs, such as learning and coping disabilities, and their mental health problems are only part of a more complex picture of multiple disadvantage and social exclusion, which may fall through the net of community health, social care, housing and drug agencies. As such, care for those with mental and emotional needs should not be seen as the exclusive province of mental health professionals.

The Correctional Service of Canada (2007) is in the process of trialing and implementing a 5-prong mental health strategy that aims to provide a continuum of mental health services from the time an inmate arrives at an institution until they are released back.
into the community, as well as manage them holistically. The elements of the model are:

1. **Intake assessment and screening**

Under the previous system, correctional centres did not have the resources to administer the necessary battery of psychological tests to all new inmates; however the new strategy includes a voluntary standardised computerised screening system screening for all new inmates, comprising a 30 to 40 minute test at a private computer. Further human contact comes in the form of a face-to-face interview with a psychologist, if necessary, after the test is completed. The benefits of this approach are:

- It flags inmates for further screening if necessary;
- Data is electronic and can be analysed to provide regional profiles of mental health needs; and
- It obviates the need for data entry and minimises human error.

2. **Primary Care**

This involves providing primary mental healthcare in each prison facility, in order to have services as close as possible to the inmate.

Each centre will have fully fledged and dedicated mental health teams comprising of psychologists, psychiatric nurses, social workers and other professionals. Each team will undergo training, to orient them to best practices in correctional mental health. Correctional officers will also be trained to better understand signs and symptoms of mental illness to help them interact with inmates and mental health teams.

3. **Intermediate Care**

Some mentally disordered inmates, while not requiring hospitalisation in a specialized treatment centre, need more structure than that offered by a regular prison. They need accommodation where they can still work on their correctional sentence plan, but have the treatment and support they need to manage their illness.

4. **Intensive Care - Regional Treatment Centres**

These are designed to provide intensive care for offenders with acute mental disorders (e.g. schizophrenia). They are to be accredited as psychiatric hospitals, with standards equal to those found in the community and with standardised admission criteria.

5. **Transitional Care - Back into the Community**

Discharge planning is to start 9 months before release, along with specialised mental health staff in selected parole offices being actively involved in this. Another key element will be CSC partnering with community service providers, to ensure mentally ill offenders continue to get the help they need when no longer on parole.

**Jurisdictional Comparisons**

As part of the research project, Group 3 undertook a comparison of what happens in New Zealand and two Australian jurisdictions, Western Australia and New South Wales. The features of these systems are:

1. **New Zealand**

- General Intake process/assessment conducted by correctional staff for reception inmates;
- Medical screening process may identify mental health issues in reception inmates;
- If diagnosed as acute, male inmates are transferred to the
forensic unit at Mason Clinic - Auckland;
- Regional Forensic Mental Health Services provides treatment services to regional prisons;
- Court Liaison system operates in all courts;
- Primary mental health services are provided by the Ministry of Health; and
- Prison Services provides training to correctional officers in suicide assessment and awareness.

2. Western Australia

- Correctional officers conduct a general intake assessment for all new reception inmates;
- A medical screening process may identify mental health issues in reception inmates;
- If diagnosed as acute, male inmates transferred to the State Forensic Unit at Graylands Hospital;
- Corrective Services provides primary mental health services through the Health Services Directorate;
- State Forensic Mental Health Services provides treatment services to metropolitan and some regional prisons;
- Mental Health Services are provided in crisis care unit at Casuarina, Hakea and Bandyup (women) and the infirmary at Casuarina;
- Court Liaison Service provided to most metropolitan courts and the provision of video conferencing assessments to regional courts;
- Prison Counseling Service provides back up service in suicide assessment and general mental health management; and
- Prison Officers have access to mental health first aid training.

3. New South Wales

- Comprehensive screening assessment by program staff on all new receptions
- Comprehensive medical screening assessment by Justice Health staff on all new receptions;
- There is a statewide Forensic Mental Health Directorate;
- A new 13S-bed maximum security forensic hospital is currently under construction - to be managed by NSW Health;
- There are two mental health screening units - one for men and one recently built for women which utilise:
  * A collaborative model of care;
  * Close working relationship with staff from Parole,
  * Comprehensive Discharge Management Plans prepared for all offenders
  * Joint case management;
  * Regular staff debriefs by Justice Health personnel;
  * Strong focus on programs - education, living skills, mental health education; and
  * Strong links with Department of Health to provide continuity of care on release

Summary

The increasing prevalence of inmates with mental health disorders in prisons appears to stem from the deinstitutionalisation of mentally ill people; increases in the use of alcohol and drugs by people with mental illness; and a diminishing capacity of community based mental health services. This, together with poor post-release care and the inherent conflict between the traditional, security-focused model of prison management and the specialist medical needs of people with mental illness, are three significant and
pressing issues for correctional administrators.

A 2007 thematic review in the United Kingdom found a need for a system-wide, evidence-based blueprint for the provision of mental health care within prisons; and the need to manage such inmates 'holistically'. The Canadian Correctional Service is in the process of implementing such a model and, while holistic care is a feature of this approach, the research group feels that the model would benefit from a greater role for correctional officers as outlined in the UK study.

New Zealand and each of the Australian jurisdictions are in the process of addressing this issue to varying degrees, however there is no consistent approach between jurisdictions. Nor, does there appear to be a coordinated focus on the holistic management of inmates from a multidisciplinary perspective.

On this basis, Group 3 makes the following recommendations:

**Recommendations**

- That the CSAC be approached to sponsor a representative from each jurisdiction (or a joint working party) to conduct further research on the Canadian, United Kingdom and other international best practice models for managing inmates with mental illness;
- That Australian jurisdictions and New Zealand work toward developing high level sustainable partnerships with mental health service providers; and
- Develop a joint Australian and New Zealand framework for managing inmates with mental illness that can be implemented in each jurisdiction.

**References**


Ogloff, JRP, Davis MR, Rivers, G & Ross, S, (2007), 'Mental Disorders in the
Criminal Justice System', *Trends and Issues in Crime and Criminal Justice*, Australian Institute of Criminology, Canberra.


This project was undertaken as part of the Australian Correctional Leadership Program (ACLP) at the Brush Farm Corrective Services Academy, NSW Department of Corrective Services in 2008. For more information on ACLP go to: [http://www.bfcsa.nsw.gov.au/bfcsa/pdhome.html](http://www.bfcsa.nsw.gov.au/bfcsa/pdhome.html)

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Prior to joining corrections Gary was a police officer with the Tasmania Police Service, achieving the rank of Inspector.

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