Mental Health in the Criminal Justice System: Offender Health and Disabilities

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Mental Health in the Criminal Justice System: Offender Health and Disabilities
Introduction

The criminal justice system throughout the world has a proportionally higher population of people with a mental health illness — approximately 3 – 5 times higher than that found in the general community (Mahoney, 2005; Commonwealth Government, 2006; Ogloff, Davis, Rivers & Ross, 2007; Sacks, Melinick, Coen, Banks, Friedmann, Grella & Knight, 2007; WHO, 2007; Gebbie, Larkin, Klein, Wright, Satriano, Culkin & Devore, 2008; Bogart & Bruce, 2009).

The reasons for this over representation are many and varied but are often attributed to factors such as deinstitutionalisation, dysfunctional family life, risky behaviour homelessness, poor education, poor nutrition, substance abuse, economic disadvantage through unemployment, lack of community based mental health services, fear by the community of the behaviour demonstrated by the mentally ill, and lack of sentencing options for the judiciary (Commonwealth Government, 2006; Belcher & Al Yaman, 2007; Kraemer, Gately & Kessell, 2009). Although options such as court diversion for the mentally ill are available, they are often not used because services to support the defendant are not available in the community. Hence prison becomes a sentencing option of choice to ensure that appropriate health care and housing is available (Butler & Allnutt, 2003; Ogloff et al, 2007; Bogart & Bruce, 2009; Commission on English Prisons Today, 2009).

Each jurisdiction has an obligation to ensure that upon reception the offender is examined by a qualified health care professional. This screening varies in time and circumstance, from jurisdiction to jurisdiction and from prison to prison, but each of them tends to collect the same types of information (Belcher & Al Yaman, 2007; Kraemer, Gately & Kessell, 2009). Once the mentally ill offender is screened and identified as having a defined mental illness it is the responsibility of the jurisdiction under which they fall to provide appropriate mental health care (Mahoney, 2005; Ogloff, et al, 2007; Lines, 2008; Bogart & Bruce, 2009).

This responsibility is enshrined in a number of international treaties, conventions and principles which Australia has signed (Mental Health Council of Australia, 2005; Edgar & Rickford, 2009). One such principle states that detained persons ‘are entitled to the best available mental health care…with only such limited modifications and exceptions as are necessary in the circumstances’ (cited in Commonwealth Government, 2006). In other words ‘the State….. is under an obligation to provide . . . appropriate . . . psychiatric care’ (cited in Lines, 2008).

Whilst there is evidence of prevalence rates, diversion, screening and continuity of care models from international and Australian practitioners and criminal justice systems the collection of data has been haphazard and inconsistent (Appendix 1 – Statistical Tables) (Ogloff et al, 2007; Butler & Allnutt, 2003; Belcher & Al Yaman, 2007). To plan for and provide mental health services for a criminal justice system requires valid and reliable data be collected. This makes analysis for use in reporting and planning extremely difficult. With the collection of reliable data such information could be put to use in developing policy and in planning services for offenders in both the custodial and community offender environments.

Given the difficulty of obtaining mental health services in the community, prison does afford the opportunity to help offenders address their illness (Ogloff et al, 2007; Belcher & Al Yaman, 2007). However, without this care following them into the community, the reality is that they are likely to reoffend and return to custody, usually within a short period of time (Butler & Allnutt, 2003; Mahoney, 2005; Kraemer, Gately & Kessell, 2009).
Key Issues and International Trends

Diversion

A significant international trend is diversion for people with mental health problems. Diversion is an outcome or a process to divert someone away from criminal activity or the criminal justice system, or within the criminal justice system, in order to improve mental health.

Whilst many Governments have supported diversion, there is evidence to suggest that implementation has been patchy for several reasons:

- In the United Kingdom (UK), the lack of a nationally guided approach has meant that implementation has been inconsistent (Bradley, 2009).
- Diversion is a fairly new phenomenon (Parsonage, 2009). Evidence for long-term outcomes is hard to find.

A model that represents a noteworthy example for diversion is attached (Appendix 2 - Model for Diversion) (Parsonage, 2009).

Outcomes after 3 and 12 months for 635 individuals in the United States of America (USA) diverted as part of 6 programs and for 625 people with mental illness who were not diverted at the same point in the criminal justice process showed that:

- Diversion "works" in terms of reducing time spent in jail,
- Diversion does not increase public safety risk,
- Jail diversion programs link divertees to community based services, and
- Jail diversion results in lower criminal justice costs and greater treatment costs, as diverted participants receive more treatment than those not diverted (Steadman & Naples, 2005).

Lord Bradley's (2009) review of people with mental health problems and learning disabilities in the criminal justice system concluded that many of the functions of the [diversion] teams have been proven to be very effective in ensuring that court processes can be made more efficient and timely.

In New South Wales (NSW), the Statewide Community and Court Liaison Service (SCCLS) was initiated for those charged with minor offences before magistrate Courts and provides mental health assessment and psychiatric triage in the courts and holding cells. Court diversion does not equate with discontinuation of criminal prosecution but it does allow the courts to be informed of relevant mental health issues as they relate to the defendant and the community. A formal diversionary measure is included in the NSW Mental Health (Criminal Procedures) Act 1990.

According to published research (Greenberg and Nielsen, a & b) the SCCLS represents a viable alternative to incarceration for minor offences.

In the South Australian Magistrates Court Diversion Program (mental impairment) participants are being successfully diverted away from long-term involvement with the Criminal Justice System by introducing or reestablishing links with treatment and support services while highlighting both the mental impairment and criminogenic needs of participants referred by the Court (Commonwealth Government, 2006).

In Tasmania, the Magistrates Court commenced a new Mental Health Diversion List (MHDL) in May 2007 as a pilot program.

Special procedures apply in the MHDL Court involving:

- An acknowledgement of guilt/admission of responsibility for the offence by the offender;
- Referral for initial assessment by forensic mental health psychiatric nurses at the Court;
- Development of a more detailed Treatment Plan for the offender.
involving therapy in the community; and
- Regular supervision of the offender by the Court whilst undertaking further assessment and treatment in the mental health sector (Connolly, 2009).

In conclusion, most countries and jurisdictions share common objectives in using diversion programs for mentally ill offenders. Some of these are:
- Increasing awareness of mental health issues among criminal justice staff,
- Reducing the risk of dangerous or disruptive behaviour,
- Reducing the use of remand,
- Reducing delays in the provision of psychiatric assessments;
- Reducing the need for unnecessary formal psychiatric court reports,
- Facilitating non-custodial sentences for offenders with mental health needs in appropriate cases.

However, the use of diversion programs is generally patchy and often lacks a national impetus, standard framework, policy or goals. In Australia, the National Action Plan on Mental Health 2006-2011 values implementation plans at $4 billion over 5 years yet funding for diversion programs is at most $24 million or 0.6%. As the international research shows, spending on diversion programs is likely to result in savings across a range of services in the medium to long terms and provide improved public value.

Screening
The aims of screening are to identify mentally disordered offenders and provide necessary treatment, prevent violent and disruptive incidents in institutions, allocate resources to those with the greatest or most immediate need, and reduce the cycle of admissions to the criminal justice system (Ogloff et al, 2007).

International research shows that early identification is not adequate and that many offenders with psychotic illnesses are not being treated prior to incarceration:
- In a survey carried out by the Prison Reform Trust of independent monitoring boards in England and Wales, over half of the respondents expressed concerns about assessment processes in prison reception areas, which were by no means adequate to identify mental health problems (Edgar & Rickford, 2009).
- Lines (2008) gives the example of two mentally ill persons who were arrested separately and placed in the same prison cell. One of the men was later beaten to death by the other. In finding that the applicant’s Article 2 rights [European Convention] had been violated, the Court cited “the failure of the agencies involved in this case (medical profession, police, prosecution and court) to pass on information . . . to the prison authorities and the inadequate nature of the screening process” in the police station and the prison.

By contrast in NSW, a survey of prisoners in 2001 found that 44% of women and 37% of men had received support, counselling or treatment for a mental health problem at sometime in the past (Butler & Allnut, 2003).

The Victorian Intervention Screening Assessment Tool (VISAT) is a part of an integrated assessment process that includes a module for mental health. The VISAT is a decision aid, not a decision maker. However, it is clear from both national and international literature that a great many screening tools are deployed within jurisdictions and across countries.

The literature also stresses the importance of screening and or assessment prior to an individual’s contact with prison:
Bradley (2009) states that screening services in police stations need to be more consistent, and include better availability of information about a detainee’s previous contact with services.

Cutting Crime: A new Partnership 2008-2011 refers directly to ‘responding to offenders with mental health needs’. The report notes the importance of ‘early intervention…to prevent later offending or further victimisation’. It says that ‘approaches should involve multi-agency collaboration and information-sharing between the police, education and health care professionals, social services, housing, and NHS mental health services’ (Home Office, 2007).

It is not surprising, therefore, that International trends in the early identification of mental illness are based around the consistency in use of screening tools and their widespread application.

Working in New York State Corrections, Gebbie et al (2008) reviewed 47 screening tools against standard criteria such as reliability, ease of administration and scoring and suitability for a health professional who is not a mental health specialist. They found that although mandatory screening is required, a standard screening tool had not been used although a tool was available that met the criteria.

Cost is a significant concern in the literature. Discussing suicide risk, Frottier states that the psychiatric screening of all inmates admitted to correctional institutions, as suggested, for example, by Arboleda-Florez and Holley (1988), cannot be implemented for administrative and financial reasons.

However, assessment is considered quite feasible by Ogloff et al (2007). Their report estimated national costs in Australia for mental health assessment demand to be $267,000 per annum although this cost is based on nursing hours, assuming these are available. In New Zealand (NZ), the implementation of a Mental Health Screening Tool (MHST) for all prisoners on reception is costed at NZ$3.4 million in year 1 rising to $3.8 million in future years including associated primary health interventions. As noted in the discussion on diversion, the importance of funding these primary interventions seems obvious yet often missing in government’s forward planning. Continuity of Care – Integrated or Multi Disciplinary Models

McDonald and Teitelbaum (retrieved 08-09-09) provides descriptions and evaluations of a number of integrated approaches. They concluded that:

- Service integration is critical to meet the many needs of mental health parolees and or probationers with mental illness.
- Intensive case management programs that link mental health, substance abuse treatment, and other social support services with housing and citizen entitlements will assist in endeavouring to reduce re-offending and making communities safer.
- Memorandum of Understanding support and encourage system integration in order to identify and overcome barriers to the provision of services, particularly turf and fiscal issues. It is noted that Probation programs that contract for or provide mental health services in conjunction with special revocation or supervision practice show great promise.
- Cross-training between probation and mental health staff is crucial to develop an understanding of the complex needs of individual probationers and of the systems involved in providing services.

It is acknowledged in Mason’s, Williams’ and Vivian-Byrne’s paper (2002) that working in a multi-disciplinary team
environment involves working with people who have differing sets of skills, competencies and ideologies and that they must also have an understanding of other members’ roles in order to maximize the functioning of the overall team. It was found in this study that multidisciplinary staff appeared to adopt a three level ethical code of reference in relation to decision-making or problem solving. These levels were identified as (1) within their individual ideological framework, (2) reference to the collectivity of the local unit and 3) a reference to the professional code to which they belong. Groups involved being psychiatry, clinical psychology, nursing community forensic mental health nursing, social work, occupation therapy, probation staff, academics and administration.

Providing Training for Staff
The World Health Organization (2003) says that training on mental health issues should be provided to all people involved in prisons including prison administrators, prison guards and health workers. Training should enhance staff understanding of mental disorders, raise awareness on human rights, challenge stigmatising attitudes and encourage mental health promotion for both staff and prisoners. An important element of training for all levels of prison staff should be the recognition and prevention of suicides. In addition, prison health workers need to have more specialized skills in identifying and managing mental disorders.

At the Advancing Solutions to Offender Mental Health Symposium (2008) speakers representing jurisdictions from Australia, UK, USA and Canada spoke of best practice requirements relating to staff training:

- Training should be supported by better communication between operational and clinical staff and focus on staff-offender interaction
- Training should be based on a pro-social modelling approach.

Noteworthy Example that Impacts on the Mentally Ill
A noteworthy example of mental health practice in the criminal justice system can be found at the 43 bed mental health screening (MHSU) at Silverwater Metropolitan Remand and Reception Centre (MRRC). At the MRRC all prisoners are screened on reception on a number of factors, one of which is for mental illness. When a prisoner is identified through this process as having a mental illness they are referred to the Risk Assessment Team. Ms Kerry Trafford - Manager Offender Services and Programs confirmed that ~37% were found to have a mental illness, not all of which were acute (active). Those with an acute illness, either low or high acuity were placed in the mental health unit. In the high acuity section the staff ratio is ~1:4 and in the others 1:10.

Mr Dave Farrell – Training Officer, stated that staff are not compelled to work in the unit, only those that wish to do so. These officers receive special training in mental health to enable them to work effectively as part of the MHSU. This staffing option is taken to enable staff to deepen their understanding of mental health and to become familiar with the behaviour of the prisoners, so enabling them to identify when a prisoner’s symptoms are deteriorating and to notify the Justice Health team for assistance for the prisoner (personal communication, September, 2009).

As prisoners in the units illnesses are stabilised they gradually step down until they are able to join the general prison population. There is no time limit on how long this may take. It is determined by the prisoner’s welfare. The prisoner is monitored and his treatment continued, however at any stage he may
be readmitted to the unit if his condition destabilises (K. Trafford personal communication, September, 2009).

The downside of addressing the needs of the mentally ill in prison in such an effective manner is that the courts, in abeyance of any equitable support in the community, increasingly rely on them to provide the mental health care necessary, particularly where the alternative is likely to be homelessness (K. Trafford personal communication, September, 2009).

Where it is known that a prisoner is to be released and has an address the team will liaise with community offender services, other community agencies and healthcare providers to ensure continuity of care through the booking of appointments and where appropriate the sharing of information (K. Trafford personal communication, September, 2009).

Recommendations

1) That a national working group of suitably qualified corrections personnel from a range of jurisdictions be established to design and develop a comprehensive electronic screening tool for the use of all Justice partners eg Police, Courts, and Corrections employees which includes a section on mental health and is administered by suitably trained personnel.

2) That the data collected from the above tool should be collated and analysed on an annual basis to identify trends and issues. The information should then be disseminated to jurisdictions to inform planning for health care needs that have been based on reliable and valid data.

3) That a system of data sharing between criminal justice agencies and health agencies that support offenders with a mental illness should be developed to facilitate continuity of care between prisons and the community. This may require changes to legislation.

4) That area mental health services to be tasked with setting up Inreach service teams at each prison site that includes prisoner involvement and collaboration with support persons.

Conclusion

At present sentencing options such as court diversion are rarely used. This may be attributed to a lack of services available in the community for people at risk. As such the judiciary will often impose a custodial sentence on people perceived to be at risk. They are aware that offenders sentenced to custody will be screened, assessed and provided with housing and appropriate mental health care.

In a best practice continuity of care scenario the offender would be screened upon their arrest and diverted to appropriate placements and programs. The reality is that screening in the most part only occurs once the offender enters the prison.

A problem arises with what happens with the data that has been collected. Within the prison it is utilised to inform treatment decisions. However, it is a rich source of information that could be mined for data to inform jurisdictions on planning for service requirements, not only in the prison and for health partners but also in the community for when prisoners are released. In reality it sits at the collection point and informs very little.

It is not until data on the mental health of prisoners is collected and analysed in a uniform, valid and reliable way throughout the jurisdictions that effective policy can be developed and implemented to effect a change in practice. This data would provide evidence for the effective deployment of resources to ensure continuity of care throughout the criminal justice and...
health systems as well as in the community.

References


Conway against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment [http://www2.ohchr.org/english/law/cat.htm](http://www2.ohchr.org/english/law/cat.htm)


Greenberg, D., Nielsen, B. (b) Date not available. Moving towards a statewide approach to court diversion services in NSW. *NSW Public Health Bulletin*.14 (11-12).


Principles for the protection of persons with mental illness and the improvement of mental health care [http://www2.ohchr.org/english/law/principles.htm](http://www2.ohchr.org/english/law/principles.htm)


**Appendices**

**Appendix 1 – Statistical Tables**

**Table 1 - Prevalence of Mental Health within Australian and New Zealand and International Community**

In 2003 an estimated 3 million individuals in the United States either received treatment for mental health problems or did not receive services but perceived an unmet need for mental health treatment.

<table>
<thead>
<tr>
<th></th>
<th>Australia</th>
<th>New Zealand</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime prevalence percentage in the community</strong></td>
<td>45.5%²</td>
<td>39.5%²</td>
<td>26.2%²</td>
</tr>
<tr>
<td><strong>Cost to the Government per annum</strong></td>
<td>$20 Billion³</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Percentage of population of people per annum with any affective mental health disorder</strong></td>
<td>6.9%²</td>
<td>8.6%</td>
<td>10.3%</td>
</tr>
<tr>
<td><strong>Percentage of population of people per annum made use of any services for mental health problem</strong></td>
<td>11.9%⁴</td>
<td>13.8%⁵(4)</td>
<td>17.9%⁶(4)</td>
</tr>
<tr>
<td><strong>% Males with mental health issues reported</strong></td>
<td>19.5%²</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>% Females with mental health issues reported</strong></td>
<td>23.6%²</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Population of Residents</strong></td>
<td>21,007,310⁶</td>
<td>4,173,460⁵</td>
<td>303,824,640⁷</td>
</tr>
</tbody>
</table>

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1. Journal of Correctional Health Care; improving access to mental health services of New York State Prison Inmates 2008
<table>
<thead>
<tr>
<th>Table 2 - Correctional Prevalence and Prisoner Information in Australian States and Territories and New Zealand</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Table 2</strong></td>
</tr>
<tr>
<td>No of Prisoners</td>
</tr>
<tr>
<td>No of Prisons</td>
</tr>
<tr>
<td>Spend per annum on Mental Health in Prisons</td>
</tr>
<tr>
<td>No of assessments carried out per day</td>
</tr>
<tr>
<td>% Prevalence within Prisons</td>
</tr>
<tr>
<td>Cost to prisons per annum on mental health screening</td>
</tr>
<tr>
<td>% of Male prisoners previously identified with mental issues prior to incarcassation</td>
</tr>
<tr>
<td>Total % Male Prisoners with Mental Health Issues</td>
</tr>
<tr>
<td>% of Female prisoners previously identified with mental issues prior to incarcassation</td>
</tr>
<tr>
<td>Total % Female Prisoners with Mental Health Issues</td>
</tr>
</tbody>
</table>

¹ Corrective Services Administrators Council, Jurisdictional Reports Agenda Item 6.1
⁵ The National study of Psychiatric Morbidity in New Zealand Prisons; an investigation of the prevalence of psychiatric disorders among New Zealand Inmates. An epidemiology study commissioned by the Department of Corrections and co-sponsored by he Ministries of Health and Justice 1999.
⁶ Justice Health, Corrections Health Service survey 2003

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| Responsible for Management Mental Health for Prisoners | DCS Health, Services Directorate referred to Graylands Hospital or State Forensic Health Services 4 | DHS, Justice Health and Foresicare¹ | Justice Health, NSW Health and DCS Services⁴ | Dept of Health and Families¹ | Offender Health Services External Agencies¹ | Ministry of Health via the Mason Clinic and Regional Forensic Psychiatry Services ⁴ |

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⁷ Queensland Corrective Services. An overview Dec 2007

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Table 3 - Prevalence and Prisoner Information in Australian, New Zealand and International

An estimated 450 million people worldwide suffer from mental health or behavioural disorders\(^1\). These disorders are especially prevalent in prison populations\(^2\) of the two million prisoners in Europe at least 400,000 suffer from a significant mental disorder and a larger number suffers from common mental health problems such as depression and anxiety\(^3\).

A 2003 Human Rights Watch publication\(^4\) observed that there were three times more people with mental health illness in United States prisons than in mental hospitals and four times more people with such illness in prisons than in the community. In Information provided by Canadian Correctional Services in 2007 notes that, in 1997 7% of male offenders entering prison in Canada were identified as having a mental illness but, by 2007, the proportion had jumped to 1 in 8 and a 71% increase\(^5\).

<table>
<thead>
<tr>
<th></th>
<th>AUSTRALIA</th>
<th>NEW ZEALAND</th>
<th>UNITED STATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of Prisoners</td>
<td>29737(^6)</td>
<td>8200</td>
<td></td>
</tr>
<tr>
<td>No of Prisons</td>
<td>86(^6)</td>
<td>20(^6)</td>
<td></td>
</tr>
<tr>
<td>Spend per annum on Prisons</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of assessments carried out per day</td>
<td>106(^7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Prevalence within Prisons</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per annum on mental health screening</td>
<td>$267,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Male Prisoners with Mental Health Issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Female Prisoners with Mental Health</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

\(^3\) World Health Organization, Health in Prison, Fact Sheet on Prisons and Mental Health 2007
\(^5\) Correctional Services of Canada, (2007b) Lets talk Publication, CSC to launch computerized mental health screening [online]
\(^6\) Corrective Services Administrators Council, Jurisdictional Reports Agenda Item 6.1
\(^7\) Australian Government, Australian Institute of Criminology – Trends and Issues in Crime and Criminal Justice No 334 March 2007
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Table 4 - Screening in the Correctional Environment

Even though it has been described that the Australian Police are front line mental health practitioners\(^1\). Police members are generally first on site of an incident and with out the support of health professionals are having to deal with the critical incidents as a priority\(^1\). A majority of Australian Police jurisdictions do not carry out formal screening of people committing offences in the community. In Victoria the Justice Health business unit is responsible for the planning and coordination of health services across Police, Courts and Corrections Victoria.

Internationally the United states: More than 30\% of state correctional facilities do not screen inmates for psychiatric disorders at intake\(^2\) and of the 47 tools that were reviewed, 22 were reviewed in greater detail because they met one or more of the selection criteria\(^2\).

In New Zealand; although the waiting list numbers have decreased since July 2008 this issue remains a concern to Corrections\(^3\). During a pilot a total of 1292 screens were completed. The pilot found that 30\% of new male receptions required a referral to forensic psychiatric services for further assessment\(^3\).

<table>
<thead>
<tr>
<th></th>
<th>WA</th>
<th>SA</th>
<th>VIC</th>
<th>NSW</th>
<th>NT</th>
<th>ACT</th>
<th>QLD</th>
<th>TAS</th>
<th>NZ</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of daily admissions to police lock ups requiring assessment</td>
<td>7(^4)</td>
<td>3(^4)</td>
<td>8(^4)</td>
<td>21(^4)</td>
<td>2(^4)</td>
<td>1(^4)</td>
<td>11(^4)</td>
<td>4</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Tool used</td>
<td>No of screenings carried out by Courts</td>
<td>Foresicare Assessment</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Tool used</td>
<td>No of screenings carried out by Prisons</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Tools used</td>
<td>No of screenings</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>VISAT (^4)</td>
<td>District Health</td>
<td></td>
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</table>

\(^1\) Corrective Services Administrators Council, Jurisdictional Reports Agenda Item 6.1 Victoria
\(^2\) Chapter 13 Mental Health and the Criminal Justice System
\(^3\) Journal of Correctional Health Care; improving access to mental health services of New York State Prison Inmates 2008
\(^4\) Minister of Corrections; Mental Health Screening Tool December 2008

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<table>
<thead>
<tr>
<th>carried out by Community Corrections</th>
<th>(Victorian Intervention Screening Assessment Tool)</th>
<th></th>
<th></th>
<th>Board and referred to Regional Forensic Psychiatry Services³</th>
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<tbody>
<tr>
<td>Tool used</td>
<td></td>
<td></td>
<td></td>
<td>Mental Health Screening Tool (4)</td>
</tr>
<tr>
<td>Diversion Program</td>
<td>Magistrates Court Mental Impairment Diversion</td>
<td>Magistrates Court Community Treatment Order</td>
<td>Magistrates Court Community Treatment Order</td>
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<tr>
<td>Program Started</td>
<td>1999</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
### Appendix 2 - Diversion – A Model of Best Practice

#### Early Intervention

**Prevention**
- Early identification of risk factors for vulnerability, mental health problems and offending and of supporting protective factors

**Pre-Arrest**
- Identification of vulnerable people before they experience a crisis
- Links to local mental health and other support services
- Prevention of vulnerable people coming into contact with the criminal justice system
- Support for families and carers

**Point of Arrest**
- ‘Common sense policing’
- Options for police officers other than arrest
- Increased partnership working between the police, mental health and other support services
- Appropriate referral to local mental health and other support services

#### Criminal Justice Decision Making

**Arrest / Pre-Court**
- Identification and assessment of mental health problems at police stations
- Appropriate use of cautions
- Early liaison with bail support services
- Liaison with Police/Crown Prosecution on charging decisions
- Appropriate referral to local mental health and other support services

**Bail, Remand and Sentence**
- Identification and assessment of mental health problems at the courts
- Improved understanding and use of diversion options
- Avoidance of remand and imprisonment where appropriate
- Co-ordinated packages of care
- Assertive interventions to ensure engagement with services

#### Through-care and Recovery

**Custody / Detention**
- Identification and assessment of mental health problems in prisons
- Appropriate referral to prison mental health inreach teams
- Appropriate transfer to hospital
- Plan for resettlement

**Community**
- Resettlement and continuity of care
- Assertive interventions to ensure continuing engagement with services
- Support to promote stabilisation, aspirations and lifestyle change
- Support for families and carers

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Note: This research paper was submitted for the Advanced Diploma of Correctional Management (CSC60107) in the Australian Correctional Leadership Program 09/001 September 2009

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