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*Mental Health in Prisons - monitoring and oversight*

John Taylor, Deputy Ombudsman

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Abstract

The mental health of prisoners in Victoria has long been a concern of the Victorian Ombudsman. He has addressed mental health issues in several of his reports to the Victorian Parliament. In his most recent report of an investigation into prisoner access to health care (August 2011) the Ombudsman identified that about 28 per cent of Victoria’s male prisoners have diagnosed mental health conditions, with the prevalence of schizophrenia and bipolar disorder almost 10 times greater than in the community. Yet less than two per cent of the male prison population has access to acute mental health care beds.

This paper addresses the challenges currently being faced in the Victorian prison system, drawing on case studies and recent research undertaken by the Ombudsman’s office.
Introduction

In his House of Common speech given as the UK Home Secretary in July 1910 Winston Churchill said:

We must not forget that when every material improvement has been effected in prisons, when the temperature has been rightly adjusted, when the proper food to maintain health and strength has been given, when the doctors, chaplains and prison visitors have come and gone, the convict stands deprived of everything that a free man calls life. We must not forget that all these improvements, which are sometimes salves to our consciences, do not change that position.

The mood and temper of the public in regard to the treatment of crime and criminals is one of the most unfailing tests of the civilisation of any country. A calm and dispassionate recognition of the rights of the accused against the state, and even of convicted criminals against the state, a constant heart-searching by all charged with the duty of punishment, a desire and eagerness to rehabilitate in the world of industry all those who have paid their dues in the hard coinage of punishment, tireless efforts towards the discovery of curative and regenerating processes, and an unaltering faith that there is a treasure, if you can only find it, in the heart of every man - these are the symbols which in the treatment of crime and criminals mark and measure the stored-up strength of a nation, and are the sign and proof of the living virtue in it.

Conditions for persons in custody - 2006 Ombudsman/OPI report

In July 2006 the Victorian Ombudsman echoed Churchill’s words in the introduction to his report, *Conditions for persons in custody*, stating that ‘a society’s level of civilisation can be judged by how it treats people detained in custody’.¹

In addressing the conditions and treatment of persons in custody in 2005, we looked at conditions both in prisons and police cells; this included the two private prisons, Port Phillip Prison and Fulham Prison, and the Melbourne Custody Centre.

At that time, the Ombudsman identified that prisoner complaints to his office had increased by 86 per cent over the previous 10 years. This was in the context of a 50 per cent increase in the number of prisoners over the same period.

The Ombudsman identified that access to mental health care was a major issue in the custodial facilities managed by Corrections Victoria, the private prison operators and Victoria Police. In 2005, increasing numbers of detainees were reported to have mental health issues, often complicated by illicit substance and alcohol abuse. Violent behaviour was frequently reported in relation to detainees with mental illness.

There were insufficient beds at the Melbourne Assessment Prison (MAP) for male detainees with mental health issues; as a result they were often left waiting

in police cells for longer than necessary or desirable. The Ombudsman recommended that Victoria Police ensure that detainees who are assessed as suffering from a serious medical condition not be held in police cells overnight. Victoria Police agreed with this recommendation. The Ombudsman also recommended that the police liaise with Corrections Victoria to enable the number of vulnerable persons waiting in police cells for beds in MAP and elsewhere in the prison system, to be reduced.

The investigation identified that across all male and female prisons and police watch houses visited, mental health problems were of concern. This issue had already been acknowledged in many forums, including parliamentary inquiries.²

The investigation found that there was insufficient capacity within prisons to adequately deal with the many mental health problems, including personality disorders, psychiatric and suicidal conditions, and that visiting mental health staff did not have enough hours on duty to meet the need. They were too few in number and there was little or no access to after-hours services. When a prisoner’s mental health condition was so acute that they had to be moved to psychiatric care, there were often long waiting periods before a bed became available to provide appropriate treatment. Even then, the options were restricted to a transfer to the Acute Assessment Unit (AAU) at MAP or a bed in the Thomas Embling Psychiatric Hospital.

At that time there was a lack of vacancies in the Thomas Embling Hospital for mentally ill prisoners, particularly female prisoners. Only 70 out of 100 beds were available for prisoners. This number subsequently reduced to around 40 out of 100 beds of which 10 were for female prisoners, as the Hospital's beds were filled increasingly with long term non-prisoner patients.

Prisoners who were assessed as having ‘personality disorders’ rather than classified as ‘mentally ill’ were often neglected or ignored. These prisoners did not meet the criteria for access to specialised mental health services and were generally considered untreatable. It was also found that, in general, custodial staff within the prison system were not sufficiently trained to recognise the signs of mental illness, nor sufficiently prepared to deal with and handle these prisoners.

The Ombudsman recommended that Corrections Victoria review mental health services for prisoners within all the prisons.

Have improvements occurred?

Has much changed in the five and half years since the Ombudsman’s 2006 report?

For the period of June 2006 – June 2011, complaints from prisoners to the Ombudsman increased nearly 400 per cent from 410 to 2,000. One would have hoped that the recommendations arising from the 2006 report to Parliament

would have led to many of the concerns identified in the report being addressed. The increase in numbers of complaints indicates that they were not.

The Victorian Department of Justice responded to the 2006 report by agreeing ‘with the general outcomes sought by the majority of the recommendations,’ and indicating that ‘where practicable, the department will take appropriate steps to implement them’. However, while some of the recommendations were implemented, others were not. Indeed, many of the issues identified in the 2006 report had not been remedied by early 2011. As a consequence, and in light of numerous complaints to his office, in 2011 the Ombudsman decided to commence an own motion investigation into prisoner access to health care, including mental health care.

Investigation into prisoner access to health care – 2011 Ombudsman report

In August 2011 the Ombudsman tabled in Parliament his report Investigation into prisoner access to health care. The Ombudsman found that there is a ‘revolving door’ between Victorian prisons and the community. According to the Australian Bureau of Statistics, as at 30 June 2011, 49 per cent of male Victorian prisoners (and 36 per cent of female prisoners) had previously been imprisoned in the adult system; and 43 per cent of all prisoners had a sentence of between one and five years. Furthermore, a Department of Justice study reported that Victorian prisoners were ‘an extraordinarily needy, unhealthy and life damaged cohort ... at the very high risk end of the Victorian health spectrum’. It identified that Victorian prisoners suffered significantly higher than average levels of hepatitis (A, B and C); depression; sexually transmitted diseases; self-harm and injury; suicide attempts and hospitalisation.

Given high rates of recidivism and the return into the community by almost half the prison population within five years, the health of Victoria’s prisoners can have significant impact on the broader community. It is imperative that this impact is minimised by providing prisoners with a reasonable standard of health care.

When the provision of mental health services in the prison system was examined, the 2011 investigation found that in 2009 – 10, 30 per cent of female prisoners and 37 per cent of male prisoners (excluding those transferred to the psychiatric Hospital Thomas Embling) required some form of mental health treatment, assessment or care. More than 200 male prisoners had either a serious psychotic or significant ongoing psychiatric condition requiring intensive or immediate psychiatric care or treatment; while more than 1,300 had a stable psychiatric condition requiring a psychiatric appointment or ongoing treatment. However, to provide services for these mental health needs, in particular of male prisoners, the prison system had only 66 dedicated mental health beds.

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1 Victorian Ombudsman, Investigation into prisoner access to health care, August 2011
2 Australian Bureau of Statistics, Prisoners in Australia 2011, (Cat. 4517.0).
The then director of Justice Health (within the Department of Justice), in response to the Ombudsman’s draft report, noted the high occupancy rates (93 per cent) of these mental health beds, and that there were lengthy waiting times for admission, and sometimes delays in securing appointments with psychiatrists.

Data on the number of contracted hours of consulting psychiatrists, showed that (assuming an average consulting time of 30 minutes), an estimated 132 male prisoners per month would be able to have access to a psychiatrist. Given that there were more than 1,500 male prisoners requiring some form of mental health care or treatment, that would mean that such prisoners would have only a one 30 minute session with a mental health consultant over a 12 month period.

The investigation also identified that prisons frequently use segregation or isolation as a behaviour management response to prisoners with mental health conditions. Furthermore, misdiagnosis of personality disorders can lead to confrontations with other prisoners and staff, which then lead to disciplinary hearings, isolation or restricted regimes and loss of privileges, which in turn may worsen mental health conditions.

The investigation concluded that untreated mental health conditions in prison can adversely impact on the general community when prisoners are released; increase the likelihood of re-offending; and impact on the internal good order and management of prisons. The report also identified that the level of mental health services, in particular for male prisoners, was grossly inadequate, and recommended that the Department of Justice review male prisoner access to psychiatric services with a view to increasing mental health beds and consultant psychiatric hours within prisons.

Case studies

Case studies are presented below to illustrate the complex nature of dealing with mental health in prisons, both in being able to respond appropriately to prisoner mental health needs, and in preventing or reducing violent or aggressive behaviours which may stem from or be associated with such needs. While research indicates that the majority of people with a mental illness are not violent (and are more likely to be victims of violence), there is a risk that someone with a psychotic condition may be violent or aggressive if they do not receive treatment; have a previous history of violence; and are abusing drugs or alcohol. In the prison setting, management approaches to violent behaviour usually emphasise control through restraint or seclusion, or symptom reduction through medication. Whether these approaches are effective in the longer term is unclear.

**Case study 1**

In November 2011 a prisoner was assaulted by another prisoner in an exercise yard at the MAP. He suffered minor injuries as a result; he did not know his assailant. The aggressor had a history of mental illness and offered no explanation for the assault.
**Case study 2**

A complaint was received from the mother of a male prisoner who had a number of psychiatric problems in 2010. At the time of the complaint he was held in a management/high security unit in a maximum security prison. He was held in solitary confinement and was refusing to take his medication. His mother said that his mental health condition was deteriorating rapidly, the longer he was without psychiatric care. The mother called Justice Health as she was very concerned about his welfare. She was told that she needed to put her concerns in writing. A sibling also raised concerns with Justice Health as nothing appeared to be happening. The family expressed their frustration with the responses they had received from Justice Health as well as from the Health Services Commissioner (to whom medical complaints would normally be referred). The matter had also been referred to the Office of the Chief Psychiatrist.

Outcome: The prisoner is currently in a management unit in a maximum security prison; it is reported that he receives regular counselling from Therapeutic Services.

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**Case study 3**

A prisoner had been convicted in 2005 on armed robbery, assault and kidnapping offences, and sentenced to a prison term of six years and nine months, with a non parole period of four years (see R v Jones, Victorian Court of Appeal, October 2006⁶). The sentencing judge acknowledged the nexus between his mental condition – chronic paranoid schizophrenia – and the commission of the offences. The judge stated that the prisoner would be best suited to detention in a mental health facility such as Thomas Embling Hospital, but that he could 'say that til the cows come home'. The lack of 'money, facility and appropriate places to detain people who are sick' meant that the prisoner would still 'do his time in mainstream prison'.

In light of these limitations, the judge said that the prisoner would be best accommodated at the MAP, which contains a prison psychiatric facility, the AAU.

The prisoner’s legal representatives appealed his sentence in October 2006 on the ground that the sentencing judge had, in the exercise of the sentencing discretion, placed insufficient weight on his mental illness and the burden of imprisonment on someone suffering from a mental illness, the effect being the imposition of a manifestly excessive term of imprisonment.

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⁶ The decision of the Court of Appeal is at: http://www.austlii.edu.au/au/cases/vic/VSCA/2006/266.html.
It was submitted that the prisoner did not remain at the AAU and was frequently moved between prisons. This negatively affected the continuity of his psychiatric treatment. There was also evidence that he experienced ongoing difficulty obtaining adequate medication, and that the symptoms of his schizophrenia were regularly ‘managed’ by placing him in 23-hour solitary confinement for up to eight days at a time.

The diagnosis consistently applied to the prisoner over many years was paranoid schizophrenia. It was stated that there was strong likelihood of recurrence of his psychotic illness, although by the time of his discharge from the hospital there was no evidence of ongoing psychotic symptoms, and he adhered to his anti-psychotic medication regime and expressed a keenness to return to prison.

At the appeal, counsel for the prisoner submitted that international law supports the position at common law that a person imprisoned for committing a criminal offence should not suffer punishment over and above the deprivation of liberty which imprisonment entails.

The Human Rights Law Centre, which appealed the sentence with Victoria Legal Aid, considered that mentally ill persons are typically not adequately supported or provided for in correctional facilities. In particular, limited resources mean that prisons are often unable to provide adequate professional services, including mental health professionals. This results in inadequate screening, assessment, treatment, crisis intervention, institutional and post-release community management.

The appeal was dismissed. The Jones case could be said to illustrate the deficiencies in our prison system in relation to the provision of adequate mental health care for prisoners.

Case study 4

A County Court judge on 13 December 2010 described detaining a violent, mentally ill man for the past ten months in virtual solitary confinement in Victoria’s maximum security remand centre, as one of the ‘saddest and most depressing cases I’ve had to deal with and it’s deeply troubling’.

Since February 2010 the prisoner, aged 27, had been isolated, regularly handcuffed and without the stimulation of an exercise or education regime. The judge said the prisoner was confined to his concrete cell for 18 hours each day, had access to a small exercise yard, received no natural sunlight, had become overweight and pale and had lost motivation.

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7 Reported in The Age, ‘Schizophrenic man’s remand a “sad and depressing case”’, 14 December 2010, Steve Butcher.
The judge accepted that the prisoner, diagnosed with paranoid schizophrenia, was an aggressive and violent offender who had twice seriously injured prison officers and presented a difficult management problem for prison authorities. The judge deemed his environment in the prison’s management unit as of ‘great austerity and considerable deprivation’ and quoted a psychiatrist who warned that the onerous conditions could contribute to deterioration in his mental health.

The prisoner had been held in St Paul’s, a psycho-social unit at Port Phillip Prison, where he repeatedly attacked and seriously injured an officer with a cricket bat on December 12, 2010. The director of Justice Health, revealed that for three days after the prisoner’s move to St Paul’s, he received far less than the correct dose of his anti-psychotic medication due to an ‘oversight’ by staff. The director, when questioned by the judge, agreed that Justice Health knew the prisoner had been in solitary confinement for 10 months and conceded that ‘we have to do better’.

Stating the obvious – the link between mental health and prisons

It has been estimated that one in five persons aged 16 – 85 years will experience some form of mental illness during their life. Mental illness produces high levels of psychological distress and reduces people’s functioning and quality of life. It imposes a significant burden in terms of human suffering; it also imposes a major economic cost.\(^8\)

The number of psychiatric beds across Australia decreased from about 30,000 in the 1960s to 8000 in the 2000s, as a result of de-institutionalisation. Some argue that since then prisons have become de-facto mental institutions and that ‘there has been a transmigration of people from psychiatric beds to remand centres... and prisons. Although it is unclear whether the apparent rise in prevalence in mental illness among prisoners reflects a genuine increase or an improvement in detection rates’.\(^9\)

Within the prison system, the prevalence of mental health problems among prisoners is much greater than in the general population, and is often compounded by illicit drug use, alcohol addiction or withdrawal. The rates of prisoners with mental health conditions are estimated to be between three and five times higher than in the general community.\(^10\) Consistent findings in Australia and elsewhere show that people with serious mental health problems are over-represented in prison. They are also more likely to be arrested by

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\(^8\) An estimated $3 billion is lost in employee productivity as well as the significant cost of providing mental health services.


police; to be held in police custody and to have court appearances. Research\(^{11}\) has shown that, for people who have been imprisoned in the past, around 40 per cent reported a mental illness in the last 12 months, compared to half that rate for those without prior prison experience.

Many people involved in the criminal justice system have also had prior contact with mental health services. While mental health services for ex-prisoners are reported to be ‘very limited and often ineffectual… the experience of release may present an additional challenge to prisoners’ mental health and well being, particularly in the absence of ongoing support’ (White and Whiteford 2006\(^{12}\)). Former prisoners are also at greater relative risk of mortality, including from accidents and suicide, and can be associated with drug and alcohol use in particular in the months following release.

In a major study on the health of Australia’s prisoners (2010)\(^{13}\) it was reported that 37 per cent of prison entrants said they had been told they have a mental illness and 18 per cent were currently on mental health medication. More than half of prison entrants experienced moderate to very high levels of psychological distress during the four weeks preceding entry to prison. Research has shown that the frequency of ‘any psychiatric disorder’ among NSW prisoners is substantially higher (74 per cent), than that in the general community (22 per cent), and it was further reported\(^{14}\) that 42 per cent of male prisoners and 62 per cent of female prisoners assessed at reception had at least one current mental health condition.

According to the 2003 Victorian prisoner health study\(^{15}\), approximately 25 per cent of prisoners had a history of a major mental illness, with rates of schizophrenia and bipolar disorders reportedly almost 10 times higher than in the community. Disorders like affective and anxiety disorders were also grossly over-represented in the prison population, with approximately 40 percent of prisoners stating they had received professional intervention for emotional or mental health problems. The study found that this high prevalence of mental health conditions in prison was ‘serious enough to require careful attention to be paid to the provision of broad-based mental health services to prisoners’.

Research into prisoner patients at Thomas Embling Hospital who were returned to prison in 2000-2003, found that 55 per cent had reoffended within 2 years of release from custody and for 27 per cent, the reoffending involved a violent offence.\(^{16}\) Figure 1 shows the number of prisoners with a serious mental illness from June 2000 to June 2010 as estimated by Forensicare (the operational name of the Victorian Institute of Forensic Mental Health), and shows a 43 per cent increase over the ten year period.

\(^{11}\) Butler, T. and Allnot, S. Mental illness among NSW prisoners: Corrective Health Service, NSW Government 2003.
\(^{14}\) NSW Corrections Health Service Mental illness among NSW prisoners, August 2003.
\(^{15}\) http://www.justice.vic.gov.au/home/prisons/research+and+statistics/justice+-+victorian+prisoner+health+study+%28pdf%29
\(^{16}\) Ferguson, M. Major Mental Illness, Substance abuse and Antisocial Personality Implications for a Mentally Ill Offender Population, Doctoral thesis, Forensicare, 2011.
Figure 1 – Estimated number of Victorian prisoners with a serious mental illness, 2000 - 2010

Source: Forensicare, February 2011

Further research by Forensicare has estimated that in an average month, more than 400 prisoners are admitted to the MAP. Of those, one out of three prisoners admitted has had contact with public mental health services and one in four has been registered with at least one psychiatric diagnosis – five per cent with psychosis and an additional three per cent with drug induced psychosis. Almost half (48 per cent) of people detained by police had contact with a public mental health service, and one in six (17 per cent) of those were current patients of a public mental health service.17

Impact of prison on mental health

Although prisons carry most of the responsibility for providing secure mental health facilities for prisoners, these facilities themselves can exacerbate existing mental health conditions or create new ones.

Conditions in prison that are found to contribute to mental health problems and deterioration include:

- lack of privacy, overcrowding
- bullying, harassment, victimisation, violence, fear, distrust
- isolation from family and community support networks
- poor access to services and programs, and to health and mental health services.

Much depends on the physical and social environment of the prison and on the nature and quality of the interactions with staff for prisoners’ mental health.

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17 Project PRIMEeD – Police Responses to the Interface with Mental Disorder, 2010.
Research has shown\(^\text{18}\) the effects of imprisonment and different prison environments on mental health vulnerability and on suicides, as well as on post release survival and re-integration into the community.

Mental health issues do not only apply to prisoners. The impact on mental health of detainees held in immigration detention centres has also been recognised recently\(^\text{19}\), with the Department of Immigration and Citizenship significantly boosting the number of psychiatrists available to treat them. In 2001, the Commonwealth Ombudsman identified ‘that mental health is often a significant issue in cases involving immigration detainees, particular those who have spent a lengthy period in prison’\(^\text{20}\).

It clear that there is a need to understand better the impact of being held in places of detention on the mental health of persons held there, and to find ways of addressing it.

**What happens in Victorian prisons regarding mental health?**

All prisoners in Victoria are given a medical assessment at reception to identify health needs, which includes mental health, self harm or suicide risks. Those assessed with mental health risks are classified as:

- P1 - serious psychotic condition requiring intensive and/or immediate care
- P2 - significant on going psychiatric condition requiring treatment
- P3 - stable psychiatric condition requiring appointment or continuing treatment
- PA - suspected psychiatric condition requiring assessment.

In 2009-10, based on the daily average prison population, there were 1,585 male prisoners (37.5 per cent of all male prisoners) with a P classification indicating mental health concerns. For female prisoners, the corresponding number was 95 (31 per cent of all female prisoners).

In terms of mental health services in Victorian prisons, Corrections Victoria provides a number of dedicated mental health beds:

- 16 bed short stay inpatient facility (AAU) for male prisoners at the MAP, opened in 1996
- 30 bed psycho-social ward (St Paul’s) for male prisoners at Port Phillip Prison, opened in 1997
- 20 bed mental health unit (Marrmak) for female prisoners at Dame Phyllis Frost Centre, opened in mid-2007.

\(^{19}\) *The Age* 14 December 2011.  
Using prisoner numbers on 14 February 2012, for male prisoners (4,481) it is estimated that there is one dedicated mental health prison bed for every 97 prisoners, while for females (320) there is one for every 16 prisoners. In the context of the total 66 dedicated mental health bed capacity in the Victorian prison system, Corrections Victoria advised that ‘that is not to say that prisoners in other beds/units do not receive any mental health services’.

Thomas Embling Hospital

When a prisoner experiences acute mental illness, and the prison’s mental health facilities are unable to cope with his or her needs, the prisoner can be transferred to the secure psychiatric facility of Thomas Embling Hospital, if there is a vacant bed. The hospital was opened in April 2000 and has a capacity of 118 beds, plus up to 18 non-custodial patients in transitional accommodation in the Jardine Unit. The hospital also provides a dedicated 10-bed unit for women prisoners in the acute phase of their illness. It is operated by Forensicare. Under the Mental Health Act 1986, Forensicare has a statutory requirement to provide inpatient and community-based forensic mental health services in Victoria for male and female prisoners requiring mental health treatment, as well as for others (10-15 patients) from the community requiring admission as a security patient under the Mental Health Act.

There is a shortage of mental health beds for male prisoners who are acutely mentally unwell as there are only 16 beds at the MAP Acute Assessment Unit and 30 beds at Port Phillip Prison. The relative number of dedicated mental health beds for male prisoners, both in the prison system and at the Thomas Embling Hospital, clearly has not kept pace with the large increase in the prison population, nor with the increased prevalence of mental illness both within prison and the community requiring psychiatric hospital care.

Our recent investigation identified that increasing pressure for beds at the hospital from prisons can lead to short stays by prisoners with frequent returns, leading to a ‘revolving door’ between the hospital and the prison system, particularly as there are generally only 20 – 25 beds available to male prisoners.

It has been shown that untreated mental health conditions can adversely impact on the broader community when prisoners are released; there is also an increased likelihood of re-offending. Mental health conditions when not addressed also impact on the internal security and good order within prisons.

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21 Women prisoners account for approximately 6 per cent of all prisoners.
22 Justice Health advised (Feb 2012) that ‘all prisoners have access to primary health services, including primary mental health services. Primary mental health services in prison are delivered by General Practitioners and mental health nurses based out of the prisons’ Health Centres. Secondary consultation is available where required and delivered by Forensicare employed psychiatrists. Upon reception all prisoners receive a mental health assessment by a mental health nurse, persons requiring ongoing assessment and treatment are referred to Forensicare’.
Challenges for mental health in prisons

1. Increases in numbers in Victorian prisons and police cells

While the number of prisoners in Australian prisons has decreased for the first time in 10 years, according to recent ABS figures, Victoria has shown an increase of 4.4 per cent (30 June 2011), compared to the previous year. Between 2006 and 2011, the Victorian prisoner population grew by 21 per cent, ahead of population growth of about 2 per cent. On 14 February 2012, there were 4,801 prisoners in Victoria prisons, 323 more than at the same time last year. In addition, on 14 February 2012, there were 191 detainees held in Victorian police cells (some waiting for a prison bed), where conditions are basic and amenities limited. While police cell numbers have been varied from around 50-100 during 2011, there has been a significant recent increase, in part due to numbers of ‘protection’ prisoners, including those with mental health concerns who may be at risk.

Figure 2 - Male and female prisoners in Victoria: 2005 – 2011
and total number of dedicated mental health beds in Victorian prisons

![Graph showing number of prisoners and mental health beds in Victorian prisons]

Source: Australian Bureau of Statistics. Prisoners in Australia, Cat. 4517.0 2011.

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Figure 3 – Number of mental health assessments conducted at Melbourne Assessment Prison 2005 – 2006 to 2010 – 2011.

Source: Forensicare, 2012

Figure 3 shows the significant rise in the number of mental health assessments conducted by Forensicare at reception at the MAP when prisoners enter the prison system between 2005-06 and 2010-11. The increase over that period was 26 per cent. When this trend is compared to the number of prisoners in the Victorian prison system (daily average) from 2005 to 2011, as shown in Figure 2, a similar increase is found (28 per cent). This indicates that as prisoner numbers are increasing, the number of mental health assessments is showing a similar trend.

However, the availability of dedicated inpatient beds for mentally ill prisoners (see inserts in Figures 2 and 3), show no increase in recent years. Since the opening of Marrmak for mentally ill women prisoners in 2007 there have been no new mental health beds added to the Victorian prison system. The shortage is particularly acute for male prisoners where there are only 46 beds in total for male prisoners with serious mental health needs. This further adds to the pressure on transferring mentally ill male prisoners to Thomas Embling, which has a limited capacity to accept admissions from the prison system.

2. System blockages

After a number of years of implementing mental health strategies in Victoria, little appears to have changed. In 1991 it was pointed out\(^\text{24}\) that the services for people with mental illness in Australian prisons were inadequate and in need of urgent reform. Forensicare (which operates the Thomas Embling Hospital and prisoner mental health services at the MAP and Dame Phyllis Frost Centre) has a unique perspective on mental health and prisons as its work spans both the mental health and criminal justice sectors.

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Forensicare has identified that the current demand for forensic mental health services continues to rise well beyond the levels that were used to determine the size and capacity of what was needed in the past. Despite efforts to accommodate as many patients as possible, it is considered that the longer waiting times to assess and treat people who pose a risk to society may impact on levels of public safety. Bed numbers for the hospital were planned in 1993 and were based on the best information then available. At that time the Department of Justice predicted that the prison population would peak at 2,500 in the mid 1990’s before starting to decline. In the last year the Victorian prison population has been around 4,500. On 14 February 2012 it was 4,801.

Operating with a capacity of 116 beds, Thomas Embling Hospital is struggling to meet demand for inpatient admissions from the prison system, courts and public mental health services. The result is that people with a serious mental illness in the prison system cannot access the level of psychiatric care and treatment they need.

It is clear that the limited number of beds available to mentally ill prisoners in the male prison system means high demand for beds at Thomas Embling Hospital. Strategies to manage this situation include not meeting the targets for admission to Thomas Embling Hospital during the year, and reducing the average length of stay in its acute units.

The number of forensic patients from the community requiring beds at Thomas Embling Hospital also continues to grow, which further reduces bed availability for mentally ill prisoners.

Most of the Thomas Embling Hospital beds are now utilised by forensic patients. This has led to a grim situation where very few beds are available for male prisoners in Victoria, many of whom require psychiatric hospitalisation. The situation is now such that mentally ill prisoners are returned to prison following limited treatment, to allow more acutely mentally ill prisoners to be transferred from prison to hospital. International bench-marking of forensic mental health beds shows that Victoria is behind compared to other ‘like services’. For example, Scotland, with a population close to Victoria’s, has 534 beds; the Toronto Metropolitan area, also with a population similar to Victoria, has more than 350 beds (not including beds for mentally ill unwell prisoners).
3. Oversight arrangements for mental health in prison

Prisons require robust oversight arrangements and effective means of dealing with prisoner concerns. However, for Victorian prisoners, access to complaint mechanisms regarding health concerns is in practice very limited. While the Ombudsman has a free call telephone line available for all prisoners about general complaints (84 per cent of prisoner approaches to this office in 2010 came this way), any complaints from prisoners involving health and medical treatment matters, including mental health concerns, generally fall within the jurisdiction of the Health Service Commissioner or are the responsibility of Justice Health, a unit within the Department of Justice. However, no free call telephone line exists for prisoners to contact either of those bodies, making it hard for a prisoner to make a complaint.

The Ombudsman made a number of recommendations in his 2011 prison health report including facilitating prisoner telephone access to these two bodies.

As indicated in the Ombudsman report\textsuperscript{25}, there are considerable obstacles for prisoners to make a complaint about health issues, including mental health. It would have to be a very determined prisoner to be able to make contact with either of these oversight and complaint bodies. Thus the Health Services Commissioner, had only received two complaints involving prison psychiatric services in 2010-11, according to her Annual Report 2011, out of a total of 104 complaints made regarding psychiatric services. For Justice Health, which requires that complaints be made in writing, no published figures are available on the number of complaints it received.

Monitoring arrangements

Monitoring of conditions in prison relies on two mechanisms within the Victorian Department of Justice and which are interconnected: the Independent Prison Visitor Program and the Office of the Correctional Services Review. The latter manages the former.

- **Independent Prison Visitors**

The Independent Prison Visitors program was set up in 1986 to provide independent advice to the Minister for Corrections on the operation of the Victorian prisons; they have been called ‘the eyes and ears’ of the Minister. They are volunteers and visit prisons regularly to observe and report on any issues or concerns and are available to prisoners and staff to ‘listen to their concerns’. During 2010-11, according to the Department of Justice’s Annual Report (Appendix K, page 186), the 38 Visitors made over 250 prison visits. While their reports are analysed by the Office of Correctional Services Review (OCSR), it is unclear what concerns were raised and whether any prison mental health issues were identified. There are no published reports, unlike the Community Visitors who, under the auspices of the Public Advocate, visit mental health and disability facilities in the community, and

whose annual report is tabled in Parliament.26 Prison visitors in Western Australia come under the independent Office of the Custodial Inspector; in Tasmania, the prison visitors are managed by the Ombudsman.

The lack of transparency of the work of the Independent Visitors is of concern for what is supposed to be an independent source of advice, contributing to the scrutiny of conditions and treatment of prisoners. While they may contribute to the monitoring processes for prisons that are overseen by the Department of Justice, it remains unknown whether any mental health concerns are ever noted by these volunteers.

• **Office of Correctional Services Review**

The OCSR was established in 2007; prior to that it was called the Corrections Inspectorate. The OCSR oversees the corrections system to ensure ‘it is fair and accountable by meeting the needs of offenders and staff and minimising risk to the safety and security of the community’.27 Its activities include conducting reviews, investigating critical incidents, handling serious complaints and allegations and monitoring and reporting on the performance of all prisons. It also conducts a number of unannounced inspections, including prisoner transport services and the management of prisoner property. The Department of Justice Secretary chairs a Steering Committee which oversees the OCSR. While the Department of Justice Annual Report (Appendix K) provided a 2 page summary of OCSR activities in 2010-11, there are no publicly available reports. It is unknown whether there have been any matters referred to OCSR which may provide insight into how the prison system is addressing the mental health needs of prisoners.

There have been previous criticisms by the Ombudsman about the OCSR. Following the Ombudsman’s investigation into conditions in custody in 2006, there were ongoing concerns about the then Corrections Inspectorate’s ability to perform its functions which included monitoring of prisons in an independent and impartial manner.

In 2007 the Ombudsman conducted a review of the Corrections Inspectorate and identified that the Corrections Inspectorate:

• did not operate independently: it took direction from a range of internal Department of Justice stakeholders, including the Corrections Victoria Commissioner
• operated in a ‘shroud of secrecy’ and had no accountability mechanisms in place outside the Department of Justice
• failed to investigate matters adequately
• could not provide proactive and timely advice
• demonstrated poor record keeping.

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The Ombudsman’s office has continued to monitor the performance of the OCSR.

4. Emerging issues for mental health in prison

Life expectancy: the increase in older prisoners

It was recently reported by the Australian Institute of Health and Welfare\(^{28}\) that Australians are living longer: women have a life expectancy of 84 years, while for men it is 79. While fewer Australians are being hospitalised for preventable conditions, two other conditions are emerging as having a significant and widespread impact on people’s well-being: mental health (estimated to affect 20 per cent of the population) and obesity. The increasing prevalence of mental health conditions and the ageing population means that the prison system faces significant challenges in addressing mental health in prisoners, including those associated with ageing, such as dementia.

Cost of maintaining prisoners

The Productivity Commission’s recently released report on government services\(^{29}\) shows that Victoria spent the equivalent of $257 per prisoner per day on running costs across its 13 prisons. This is the highest of all states except Tasmania, and 19 per cent more than the national average rate of $216. Calculated annually this represents $93,805 per Victorian prisoner. It was noted that the generally low imprisonment rate in Victoria, compared to other jurisdictions, and a high proportion of prisoners on more intensive management regimes, contributes to the higher costs. However, it was also noted that placing 19 per cent of Victorian prisoners in two private prisons did not appear to have had an impact on containing prison costs. The total prison budget is likely to increase, as Victoria’s population expands and as sentencing policies increase numbers entering prison and the length of time they stay there.

While the Department of Justice is anticipating further increases in prisoner numbers, with a stated program to expand capacity (adding a further 641 male prison beds and 102 female prisoner beds according to its 2010-11 Annual Report), the growing demand for mental health services within the prison system does not appear to have been catered for.

Conclusions

It is a simple story – there are insufficient beds available for the treatment of prisoners with mental health conditions, but there are no simple solutions. It has

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29 Released on 31 January 2012.
been said that ‘the failure to tackle widespread mental illness among prisoners is storing up huge social and public health problems for the future’.\textsuperscript{30}

To quote the World Health Organisation ‘without urgent and comprehensive action, prisons will move closer to becoming twenty-first century asylums for the mentally ill, full of those who most require treatment and care but who are held in unsuitable places with limited help and treatment available.’\textsuperscript{31}

John R Taylor  
Deputy Ombudsman

\textsuperscript{31} WHO Health in Prisons Project 2009, www.euro.who.int/prisons.