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*Sisters Inside Inc. is an independent community organisation which exists to advocate for the human rights of women in the criminal justice system*

# Sisters Inside Submission to the Productivity Commission Mental Health Draft Report

(February 2020)

## About Sisters Inside

Sisters Inside exists to advocate for the human rights of women and girls in the criminal legal system, and their children, throughout Australia (and internationally). We also provide services in response to the unmet human rights and needs of criminalised women in Queensland.

Criminalised women and their children are highly marginalised, and are one of the most disadvantaged cohorts in the Australian population. The human rights of this group are currently being routinely breached in Australia. Aboriginal and Torres Strait Islander women and girls are disproportionately, and increasingly, being criminalised. They are particularly vulnerable to breaches of their human rights at all levels in the criminal legal system and more widely. Compared with both other women and criminalised men, Aboriginal and Torres Strait Islander women are more likely to be living in over-policed communities, more likely to be charged with an offence, less likely to be granted police bail, more likely to be imprisoned on remand, more likely to receive a prison sentence, and less likely to be released on parole. Aboriginal and Torres Strait Islander women are the fastest growing prison population in Australia.

The vast majority of women and girl prisoners are charged with minor, non-violent offences. Most criminalised women live with racism and discrimination and come from backgrounds of poverty, homelessness and family and domestic violence. As a result, most criminalised women face mental health (including substance abuse) and/or physical health issues. All these factors contribute to women's criminalisation and imprisonment – in particular, the appalling rate of imprisonment of women on remand (currently almost 40% of all women prisoners) and for, often minor, breaches of parole typically associated with their disadvantage (currently approximately 25% of women prisoners). The human rights of their children are also regularly breached – both directly and indirectly.

The Queensland Productivity Commission estimates that 'around 30% of the burden of imprisonment is borne by chronic, but low harm offenders.'<sup>1</sup> Relevantly, approximately 50% of prisoners had a prior hospitalisation for a mental health issue.<sup>2</sup> In our experience working with women, often an un-treated mental health condition is the underlying reason why a woman finds herself homeless, unemployed and repeatedly in court and prison. Court diversion programs, such as the Special Circumstances Court (de-funded in 2012), provide a more appropriate mechanism for responding to simple offences committed as a by-product of mental ill health.

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<sup>1</sup> Queensland Productivity Commission, *Inquiry into Imprisonment and Recidivism* (Final Report, August 2019) xviii.

<sup>2</sup> *Ibid* x.

## About this Submission

Following some brief comments on the overall Draft Report, this response focuses on the Draft Findings, Draft Recommendations and an Information Request in Section 16. Our response (and intext referencing) are based on the *Draft Report: Overview and Recommendations*.

## Overall Comments on the Draft Report

### Mental Health Service Provision

The Draft Report recognises that 'a focus on clinical services which often overlooks other determinants of, and contributors to, mental health' is a key factor that has driven poor outcomes in our mental health system.<sup>3</sup> Yet the Draft Report appears to make the unquestioned assumption that the current dominant model of mental health support – that is, the conventional western medical model – is most effective in addressing mental illness. This is reflected, for example, in Draft Recommendations advocating increased numbers of Psychiatrists,<sup>4</sup> and Mental Health Nurses.<sup>5</sup> However, similar increases are not recommended for Aboriginal health practitioners and workers,<sup>6</sup> who do not rate a mention in the Draft Recommendations. Nor, for the Peer and Traditional Healing workforces,<sup>7</sup> which engage with a wider range of approaches of demonstrable value.<sup>8</sup> Further, in both cases, closer alignment to the medical model is proposed. Nor does the Draft Report recommend an increase in access to psychosocial support,<sup>9</sup> another approach which has proven effective in reducing mental illness.

Sisters Inside proposes that alternate approaches, which have evidently contributed to improving the mental health of criminalised women, should play a much more significant role in the pathway forward. Mental health services should be trauma-informed, culturally-driven and gender-specific.

#### Trauma-informed

The report seriously overlooks the role of trauma in mental illness, and hence, mental health service provision. 'Trauma' is only mentioned three times in the Draft Report and then only in relation to Aboriginal and Torres Strait Islander people. We strongly support the proposed finding that the 'accumulated effects of traumatic experiences over many generations, and racism and discrimination' must be addressed,<sup>10</sup> alongside improvements in the conditions of daily life and actions to promote healing and address past (and, we would argue, continuing) trauma and discrimination. We strongly support requiring a trauma-informed approach to work with Aboriginal and Torres Strait Islander peoples.<sup>11</sup>

We suggest that a trauma-informed approach is warranted for working with most women in prison. Past (and present) trauma also plays a key role in most women and girls' criminalisation and in the incidents of mental illness experienced by women more widely. Repeated studies have found that between 80% and 90% of women and girl prisoners have survived violence – sexual assault, family violence and/or other forms of violence. Trauma-informed practice is equally critical for all criminalised women (and, some would argue, all women).

#### Culturally-driven

As detailed in Draft Report Aboriginal and Torres Strait Islander people experience *high/very high levels of distress* at approximately three times the rate of non-Indigenous Australians.<sup>12</sup> Yet, little

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<sup>3</sup> Australian Government Productivity Commission, *Mental Health: Overview & Recommendations* (Draft Report, October 2019) 6 ('*Mental Health Draft Report*').

<sup>4</sup> Ibid 62.

<sup>5</sup> Ibid 63.

<sup>6</sup> Ibid 28-29.

<sup>7</sup> Ibid 64, 96.

<sup>8</sup> See, for example, submissions in response to this draft report from Blue Knot and Lived Experience Leadership Roundtable (Queensland).

<sup>9</sup> *Mental Health Draft Report* (n 3) 69.

<sup>10</sup> Ibid 95.

<sup>11</sup> Ibid 80.

<sup>12</sup> Ibid 5.

attention is paid in the Draft Report to the particular failure of the conventional western model of mental health in responding to the distress of Aboriginal and Torres Strait Islander people. Further, the only recommendation related to culturally-driven practice diminishes the value of traditional healing (as having the *potential* to help with *social and emotional wellbeing*) and proposes alignment of cultural healing to mainstream mental health services.<sup>13</sup> This implies the superiority of the dominant western model over culturally-driven models, when addressing (western-defined) mental illness.

Sisters Inside strongly agrees that 'improvements in mental health of Aboriginal and Torres Strait Islander people require improvements in the conditions of daily life as well as actions to promote healing of past traumas and address discrimination' (Draft Finding 20.2). For this reason, we advocate culturally-driven services provided, wherever possible, by community-controlled services. Culturally capable practice includes the ability and willingness to be led by Aboriginal and Torres Strait Islander Elders and wisdom. This includes enabling Aboriginal and Torres Strait Islander controlled organisations to design local suicide prevention activities, rather than positioning them as preferred providers of pre-defined services;<sup>14</sup> only then can programs be truly 'responsive to the experiences, culture and specific social issues faced' within particular communities.<sup>15</sup>

### **Gender-Specific**

A history of sexual assault, domestic and family violence and racism are key drivers of women's criminalisation. These are exacerbated by poverty, homelessness and discrimination. The profile of women with mental illness is profoundly different to that of men. The Draft Report fails to address the specific needs of women throughout.

### **Social and Economic Contributors to Mental Illness**

Sisters Inside strongly supports the stages outlined in the *Stepped-Up Model of Care*.<sup>16</sup> In particular, we welcome the recognition of the underpinning role of income support, housing support, disability support and cultural services in people's mental health. We are surprised that the Draft Report estimates that only 190,000 – 250,000 Australians experience severe mental illness, driven by physical health issues, psychosocial needs and social/economic needs. We strongly agree that failure to meet practical needs such as stable accommodation and income support can significantly impact mental health, and that this situation is exacerbated through lack of culturally appropriate services for Aboriginal and Torres Strait Islander people, particularly in remote communities.<sup>17</sup>

We support the Draft Report's call for governments to immediately commit to no discharges from care (including prisons) into homelessness,<sup>18</sup> and additional supported (and, we argue, independent) housing places.<sup>19</sup> Sisters Inside also supports changes to expectations of employment service providers which go beyond compliance with so-called 'mutual obligations', for people experiencing mental ill-health.<sup>20</sup> Too often, women are criminalised or imprisoned (particularly on remand) due to either homelessness or lack of income support.

### **Substance Abuse**

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<sup>13</sup> Ibid 96.

<sup>14</sup> Ibid 11.

<sup>15</sup> Ibid 16.

<sup>16</sup> Ibid 18.

<sup>17</sup> Ibid 25.

<sup>18</sup> Ibid 30.

<sup>19</sup> Ibid 75.

<sup>20</sup> Ibid 41.

Substance abuse often co-exists with other mental health issues amongst criminalised women. It is disappointing that the Draft Report has failed to address this issue. Drug-related charges are particularly common amongst criminalised women and, in most cases, are a result of personal use. Very few drying-out and rehabilitation services are available. Those which do exist, generally operate out of a narrow range of models and are not gender-specific, family-friendly or culturally competent. Too often, women are imprisoned on remand due to this systemic failure.

Sisters Inside proposes that the Final Report should address this deficiency as a matter of urgency.

## Draft Findings

### **Draft Finding 16.1:** Prevention and early intervention to reduce contact with the criminal *justice* system

We support this finding and refer the Commissioners to Sisters Inside's report, *Early Intervention in Specialist Reconnect Services* (2017)<sup>21</sup>. Sisters Inside operates a program called Crucial Connections, which is a Specialist Reconnect service that supports 12-18 year old young people whose mother is in prison or who are themselves criminalised, are outside the school system and at risk of homelessness. This report details how the program is delivered, how it reduces multi-generational criminalisation and how it benefits the community.

### **Draft Finding 16.2:** Police responses rely on community mental health services.

Sisters Inside recognises that women often 'bounce' between police and mental health services. Too often, police criminalise these women (e.g. charge them with minor, public nuisance-related charges) rather than explore alternate pathways.

### **Secure Accommodation**

We submit that in addition to increasing funding to mental health services, it is equally important to increase affordable, safe accommodation options for women once they are released from mental health observation or orders. Our staff observe that, typically, the women who are 'bounced' between mental health services and police do not have access to safe and secure housing, which affects their mental health and, consequently, contributes to their criminalisation. Often women are released from observation or involuntary orders in hospital directly into homelessness, short-term accommodation or unaffordable long-term accommodation. We submit that access to safe, long-term housing is the essential first step in mental health recovery. Without the stability created by secure accommodation it is extremely difficult for a person to stabilise and engage consistently with support services and mental health care. We further note that the cost of public housing, or even private rental and residential mental health care is significantly lower than the cost of imprisonment, which is little less than the cost of long-term supported accommodation at a net operating cost of approximately \$223.38 per day in 2017-18.<sup>22</sup> The latter figure does not, however, take account of the individual, generational and social harm arising from imprisonment, and associated, often long term, costs to the police, health, child safety, youth justice and education systems, and our national productivity.

The nexus between homelessness and criminalisation is well established. The Australian Institute of Health and Welfare (AIHW) reports that 33% of prison entrants reported being homeless in the month prior to entering prison.<sup>23</sup> This is primarily because homelessness or insecure accommodation exacerbates a person's mental health conditions and makes recovery or management of those conditions more difficult.<sup>24</sup> This, in turn, increases the likelihood of behaviour which attracts the attention of the police. A person is likely to continue to 'bounce'

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<sup>21</sup> Sisters Inside, 'Early Intervention in Specialist Reconnect Services: Crucial Connections – A genuine early intervention and prevention service' *Sisters Inside – Service & Program Evaluation* (Submission to the review of the Reconnect Program) <<https://sistersinside.com.au/research-hub/research-library/sisters-inside-publications/services-programs/>>.

<sup>22</sup> Table 8A:18 in Productivity Commission, *Report on Government Services 2019*, Part C, Chapter 8 at <https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/justice/corrective-services>

<sup>23</sup> Australian Institute of Health and Welfare, *The Health of Australia's Prisoners 2018* (Report, 30 May 2019) 22 ('*Health of Australia's Prisoners*') at <https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/contents/summary>

<sup>24</sup> *Health of Australia's Prisoners* (n 1) 22.

between mental health services and police, or prison, until their health and wellbeing stabilises, and secure accommodation is required for a person to stabilise.

### **Access to Treatment**

Under the emergency examination authority provisions, ambulance and police officers can transport a person they believe is experiencing a mental health issue and at risk of immediate harm or requiring urgent examination, to a health service.<sup>25</sup> Here, the person can be held for examination for six to 12 hours.<sup>26</sup> During this time a doctor will determine the person's care needs and either discharge them back into the community or make a recommendation for assessment,<sup>27</sup> under the *Mental Health Act 2016* (Qld), Section 39.

To make a recommendation for assessment, the health practitioner must be satisfied that the treatment criteria apply to the person and there is no less restrictive way for the person to receive treatment.<sup>28</sup> The treatment criteria are that the person has a mental illness, does not have capacity to consent to be treated and because of this illness, and the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in: imminent serious harm to the person or others, or the person suffering serious mental or physical deterioration.<sup>29</sup> We note that, generally, the people who are discharged back into the community still have mental health conditions that require treatment, but often lack the supports needed to access treatment in the community.

If a person is deemed to be well enough to be discharged into the community then the onus is placed on them to pursue mental health care. This can be problematic because the person struggling with mental health conditions may not be in a position to identify their needs and access consistent medical treatment, particularly if they are homeless. Currently there is not adequate infrastructure in place to support people who would benefit from mental health intervention and support, but are not suffering so acutely so as to satisfy the requirements for involuntary treatment.

The nexus between untreated mental health issues and criminalisation is also well established. Multiple studies have found that the majority of women prisoners have a history of mental health issues,<sup>30</sup> with PTSD being a particularly common diagnosis due to the large proportion of women who have experienced trauma. Too often, women with mental health needs end up in prison, due to the state's failure to provide adequate accessible community-based mental health services.

### **Draft Finding 16.3: Court diversion programs**

We agree with this finding and direct the Commissioners to the report *How We Do It: Diverting Women from Prison (Evaluation of the Sisters Inside Special Circumstances Court Diversion Program) 2011*<sup>31</sup>. This report explains how Sisters Inside supported women while they engaged with the Special Circumstances Court (SCC) and evaluates the success of the Sisters Inside SCC Diversion Program.

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<sup>25</sup> *Public Health Act 2005* (Qld) ss 157B(1),(3), 157E(4) ('PHA Act')

<sup>26</sup> *Ibid.*

<sup>27</sup> *Ibid* s 157E(1).

<sup>28</sup> *Mental Health Act 2016* (Qld) s 39.

<sup>29</sup> *Ibid* s 12.

<sup>30</sup> For example, the AIHW 2019 *op cit* found that 2/3 of women prisoners have a mental health history at <https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/contents/summary>

<sup>31</sup> Suzi Quixley, 'How We Do It: Diverting Women from Prison (Evaluation of the Sisters Inside Special Circumstances Court Diversion Program) 2011', *Sisters Inside – Service & Program Evaluations* (Report,2011)<<https://sistersinside.com.au/research-hub/research-library/sisters-inside-publications/services-programs/>> ('*Evaluation of the Special Circumstances Court Diversion Program*').

The Special Circumstances Court (SCC) was a specialist Magistrates Court which operated in Queensland from 2007 to 2010 and provided a voluntary alternative to imprisonment for people who were homeless and/or facing mental health issues. Our SCC Diversion Program assisted by facilitating women's access to housing and mental health services. This program was incredibly valuable because it provided women with an entrenched history in the criminal legal system the support to address the long standing issues underlying their criminalisation.

An empirical analysis of the success of the Queensland SCC clearly demonstrates that the specialist court model is highly effective at diverting people with cognitive and psychiatric disabilities from the criminal legal system. The Sisters Inside SCC Program ran for 3 years in partnership with the Court. Of the 240 women who chose to have their cases heard before the SCC and engage with the Sisters Inside program, only 4% returned to prison (as at July 2011) – in marked contrast with the usual return rate of approximately 65% over a 2 year period.<sup>32</sup> Sadly, despite overwhelming evidence of the success of both the SCC and the Sisters Inside program in diverting women from prison, and generating significant financial savings to the state, both were defunded following a change of state government in 2011. It is highly problematic that even demonstrably successful diversionary courts are at constant risk of closure, and community organisations with a successful history of diverting people from the system operate on a small budget. We recommend that court diversion programs, and the associated support services, be funded adequately and long-term (in the case of non-government services, on at least a 5 year contract).

## Draft Recommendations

### Draft Recommendation 16.1: Support for police

Sisters Inside submits that police are not trained social workers or mental health professionals, thus they are not appropriate first responders in situations involving mental health issues. Women with mental health issues often have an adverse history with police, and police intervention commonly escalates an already tense situation, leading to women being arrested and charged – essentially, punishment for being mentally ill. Further, it is not realistic to expect that police can be trained to the level of sophistication required to respond appropriately to the range of mental health issues. Culturally appropriate and competent women first responders would be better placed to connect vulnerable women in crisis with the support services they need to stabilise.

### Draft Recommendation 16.2: Mental healthcare standards in correctional facilities

Mental healthcare services in Australian women's prisons are far below the level provided in the community – and, even community-based systems have routinely failed criminalised women (and often led to their imprisonment). Sisters Inside strongly supports this recommendation and offers insight to aid in the effective implementation of this recommendation.

## Prison Overcrowding

Prison overcrowding in conjunction with under-staffing and under-resourcing is severely reducing prison medical care providers' capacity to facilitate comprehensive, consistent mental health care. The ADCQ reports that 'Over the past decade, the total number of women in prison in Australia has increased by 66% and the increase in Aboriginal and Torres Strait Islander prisoner numbers accounts for most of that growth.'<sup>33</sup> The Queensland Ombudsman's 2016 investigation into

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<sup>32</sup> Ibid 21

<sup>33</sup> Anti Discrimination Commission Queensland, *Women In Prison 2019: A Human Rights Consultation Report* (Report, 2019) 51 ('*Women in Prison 2019*').



overcrowding at Brisbane Women's Correctional Centre (BWCC) found that the prison was 47.7% above its single cell capacity on the average day in 2015.<sup>34</sup> Similar findings have occurred in other states and territories. Today, Queensland prisons are still overcrowded; across all prisons, capacity is currently at 130 per cent.<sup>35</sup> On its own, increasing medical staff is only effective as a 'Band-Aid' solution and overcrowding itself must be rectified.

Overcrowding in prisons should be addressed through systematic decarceration and diversion programs. If prisons are running at the capacity for which they were designed, and they are staffed and resourced correspondingly, then they have the best chance of providing a level of mental healthcare approaching a community standard. As it stands, overcrowding prevents women in prison from receiving timely, high-quality medical care and this negatively impacts their capacity to remain outside prison post-release.

The mental health consequences of overcrowding are myriad. The ratio of health staff to prisoners is unbalanced and this pressure on staff reduces their capacity to work to a high standard. The Ombudsman's report identified that 'despite an increase in prisoner numbers at BWCC between August 2013 and August 2015, the number of full-time equivalent ... psychologists employed at BWCC actually decreased.'<sup>36</sup> Long wait times for appointments, test results and medications are typical, and the quality of care received is often diminished by the clinician's time-constraints and dearth of job satisfaction,<sup>37</sup> and constraints imposed by prison authorities, such as not dispensing medications during lock-down. Further, prison authorities often impose strategies which are contrary to all medical advice, such as placing women at risk of self harm or suicide in solitary confinement, and strip searching women with a history of sexual abuse. Such practices are re-traumatising and, as a result, too many women leave prison in poorer mental health than they entered.

Furthermore, being in prison is disempowering and is not conducive to women managing their own health, which is detrimental to their capacity to support themselves once they are released. Mental health care in prisons should facilitate women being able to make appointments when they need them and see a clinician of the gender of their choice, or one who is culturally appropriate.

Finally, in many situations the effectiveness of mental health care is problematised by the prison environment itself. In addition to isolation from friends and family, women in prison have limited access to healthy whole foods, exercise, fresh air and sunshine all of which negatively influence mental health outcomes.

### **Specialised services for women**

In general, women in prison have a very different profile and history from men in prison<sup>38</sup>. The Anti-Discrimination Commission Queensland (ADCQ) notes that, 'Female prisoners are among the most disadvantaged and vulnerable groups in our society'<sup>39</sup> and, 'an extremely high prevalence of trauma exists among women prisoners.'<sup>40</sup> A gender neutral approach should not be taken to mental healthcare reforms in prisons. It is essential that women in prison have their specific needs catered for by the prison's mental health services. Similarly, Aboriginal and Torres Strait Islander

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<sup>34</sup> Queensland Ombudsman, *Overcrowding at Brisbane Women's Correctional Centre* (Report, September 2016) 3 ('*Overcrowding at BWCC*').

<sup>35</sup> Queensland Productivity Commission, *Inquiry into Imprisonment and Recidivism* (Final Report, August 2019) xxi ('*Imprisonment and Recidivism*').

<sup>36</sup> *Overcrowding at BWCC* (n 15) 38.

<sup>37</sup> *Ibid* 30-36.

<sup>38</sup> *Women in Prison 2019* (n 10) 61.

<sup>39</sup> *Ibid*.

<sup>40</sup> *Ibid* 62.

women prisoners have distinctive needs that should be met by culturally-competent and trauma-informed services.<sup>41</sup>

As the Standard Guidelines for Corrections in Australia state, 'The management and classification of female prisoners should reflect their generally lower security needs, but their higher needs for health and welfare services, and for contact with their children.'<sup>42</sup> The AIHW reports that 65% of women in prison have pre-existing mental health issues, and this often co-exists with, or is affected by, a history of sexual or physical abuse, substance abuse, poverty and homelessness.<sup>43</sup> In particular, the Queensland Productivity Commission reports that 75% of Aboriginal and Torres Strait Islander women in prison had a prior hospitalisation for a mental health issue and/or were subject to a child protection order.<sup>44</sup> Relevantly, the ADCQ reports that, 'When prison staff adopt trauma-informed practices, this can lead to a notable decrease in behaviours such as prisoner-on-staff and prisoner-on-prisoner assaults, the use of segregation, suicide attempts, and the need for mental health watches.'<sup>45</sup>

### **Use of Solitary confinement**

It is highly problematic that solitary confinement is used by prison staff to 'manage' women with acute mental health challenges. Solitary or 'separate' confinement is used as explicit punishment (i.e. for actual or alleged disciplinary breaches) in prisons and is also routinely used to 'manage' women prisoners who are unwell or otherwise deemed 'uncontrollable' or 'difficult' by prison officers through the use of 'safety orders'.<sup>46</sup> It is common for prison staff to respond to actual or threatened self-harm, by placing women in isolation, whether this is in a Detention Unit, or her cell.<sup>47</sup> This occurs because of a lack of appropriate mental health services and facilities within the prison and/or due to the authority of prison staff over health staff, even in matters related to women prisoners' health. As the ADCQ writes, 'It is clear that QCS has no capacity or expertise to satisfactorily deal with [acutely mentally unwell] individuals in the prison environment, and other solutions need to be found.'<sup>48</sup>

Solitary confinement is known to have severe and harmful effects on people, especially in cases where isolation is prolonged and/or the person has a mental illness, disability or other personal vulnerabilities<sup>49</sup>. For these reasons, the Australian Medical Association argues that, 'Solitary confinement is medically harmful as it may lead to a number of physical and/or mental disorders.'<sup>50</sup> and the Standard Guidelines for Corrections in Australia state that 'prolonged solitary confinement... and all cruel, inhumane or degrading punishments should not be used.'<sup>51</sup> Per the Corrective Services Act 2006 (Qld) (CSA), an order for separate confinement must take any special needs of the prisoner into account, the period of the order must not be for longer than seven days, and a doctor or nurse must examine the prisoner for any health concerns as soon as practical before the order takes effect and after it ceases<sup>52</sup>. Unfortunately, in practice, Sisters Inside staff frequently support women who spend extended periods of solitary confinement and consequently suffer a deterioration of their mental health.

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<sup>41</sup> Ibid 63.

<sup>42</sup> *Standard Guidelines for Corrections in Australia* (Revised 2012) 1.80-1.85.

<sup>43</sup> *Health of Australia's Prisoners* (n 1) 27.

<sup>44</sup> *Imprisonment and Recidivism* (n 16) x.

<sup>45</sup> *Women in Prison 2019* (n 10) 63.

<sup>46</sup> *Corrective Services Act 2006* (Qld) s 53.

<sup>47</sup> Ibid.

<sup>48</sup> Ibid 143.

<sup>49</sup> Ibid 142.

<sup>50</sup> Section 7.1, Australian Medical Association (2013) *AMA Position Statement: Medical Ethics in Custodial Settings at [https://ama.com.au/sites/default/files/documents/position\\_statmenet\\_on\\_medical\\_ethics\\_in\\_custodial\\_settings\\_2013.pdf](https://ama.com.au/sites/default/files/documents/position_statmenet_on_medical_ethics_in_custodial_settings_2013.pdf)*

<sup>51</sup> *Standard Guidelines for Corrections in Australia* (Revised 2012) 1.80-1.85.

<sup>52</sup> *Corrective Services Act 2006* (Qld) ss 121(1)-(3).

### **Draft Recommendation 16.3: Mental healthcare screenings in correctional facilities and on release**

Sisters Inside supports this recommendation and offers further insight to aid in its effective implementation. Competent mental health screening is essential to informing the resourcing of mental health services in prisons, and care and release planning with women prisoners.

We have learned from the women we support that sometimes intake health screenings are conducted by prison staff. Police and prison staff are not medical professionals and all health screenings should be performed by qualified doctors and nurses. This totally unacceptable practice must be prevented. Every woman should have access to a confidential, thorough health screening by health professionals upon arrival at a prison. Clear and detailed guidelines should set out what health and history information must be collected and appropriate staff, time and privacy should be allocated to the assessment. It is essential that while a person is in prison, consistent and reliable health records are maintained. Mental health and disability assessments should use the most up to date screening methods. These records are necessary to establish a benchmark against which to measure future health outcomes.

Additionally, we note that entry to prison or a watch house is often a highly stressful experience and may reduce a woman's ability to be forthcoming about her mental, physical and family health history. This inhibits a clinician's ability to conduct an adequate medical assessment; therefore, if a woman is highly stressed on intake, another mental and physical health screening should be conducted in the coming weeks to ensure comprehensive medical screening.

Comprehensive medical assessments and record keeping not only benefits the woman prisoner, but allows for macro data to be created and analysed. The AIHW reports on the health of people in prison, yet their data is largely informed by respondents' self-assessments. Self-assessments from people about their mental and physical health can be useful, but it should be possible to complement this information data compiled from accurate medical records. Systematic record keeping is necessary to create reliable data that can be used to identify trends and influence policy and resourcing.

Providing women with medical records that detail their physical and mental health history and medications is particularly important post-release when they are trying to take responsibility for their health and connect with health services. The AIHW reports that about 4 in 5 (81%) sentenced prisoners had a health-related discharge summary on file when they were released from prison<sup>53</sup>. However, one Sisters Inside Health Support Workers reports that, in the past three years, of the 310 women she has supported post-release from prison, only two had comprehensive medical records and referrals provided to them on release.

### **Draft Recommendation 16.4: Culturally appropriate support for incarcerated Aboriginal and Torres Strait Islander people**

Sisters Inside strongly supports this recommendation. It is crucial that mental health supports and services for First Nations women prisoners are designed, developed and delivered by Aboriginal and Torres Strait Islander controlled organisations wherever possible. In particular, we recognise the importance of implementing a trauma-informed approach to work with Aboriginal and Torres Strait Islander women and ensuring they are connected to culturally-appropriate (ideally, culturally-driven) mental healthcare in the community upon release.

## **Information Request**

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<sup>53</sup> *Health of Australia's Prisoners* (n 1) 149.

## **Information Request 16.1: Transition support for those with mental illness released from correctional facilities**

With return to prison rates amongst women typically found to be approximately 65%, comprehensive transition support services are essential. Most women transitioning between prison and the community have complex, interrelated needs, which are often the result of long term and multi-generational trauma and socio-economic marginalisation. Unsurprisingly, these vulnerabilities are exacerbated by the prison environment. Reintegrating into the community and resuming responsibility for all one's exigencies is challenging and made more so by mental ill-health. It is unrealistic to expect that, immediately following release from prison, a person will be equipped to assume full responsibility for their health care. Most women will need substantial support in the first few months post-release from prison. We believe that an investment of resources upfront is the most effective way to help former prisoners stabilise, reintegrate into the community and reduce the likelihood of returning to prison.

### **Sisters Inside's Health Support Program**

For information about a successful Queensland program that provides health support services to women transitioning out of prison, we direct the Commissioners to Sisters Inside's 2018 report *Evaluation of the Health Support Program Pilot, for Queensland Health*.<sup>54</sup>

The Sisters Inside Health Support Program (HSP) provides physical and mental health support to women following their release from prison. The report demonstrates why these supports are necessary: 54% of the women had complex needs and 66% of the women experienced homelessness during their involvement in the HSP.<sup>55</sup>

Of the 109 participants over a 2 year period, only 6 were known to have returned to prison at the time of the reporting.<sup>56</sup> Furthermore, the rates of self-harm, suicidal ideation and attempts were significantly lower than is typical for women released from prison.<sup>57</sup>

### **Transitioning from prison into homelessness**

Support workers at Sisters Inside observe that having long term, safe accommodation is the most influential element in a woman's mental health prognosis as she transitions back into the community. Secure accommodation creates an opportunity for a former prisoner to stabilise, re-engage with the community and, ultimately, reduces the likelihood of their being re-imprisoned. Unfortunately, the AIHW reported in 2018 that 54% of people discharged from prison expected to be homeless on release.<sup>58</sup> A short term or emergency accommodation address is often sufficient to secure release from prison on parole; however, these types of accommodation are by nature insecure and do not provide the stable environment necessary to access health services consistently. We submit that (consistent with the Draft Report) more subsidised, safe, long-term, independent and supported accommodation options are essential across Australia, in order to appropriately support former prisoners with mental illnesses as they transition back into the community and reduce their risk of returning to prison.

Furthermore, it would be beneficial if community mental health services were resourced adequately to enable their staff to travel to the women whom they are treating, rather than requiring the women to travel to them. This is particularly important for women depending on

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<sup>54</sup> Suzi Quixley, 'Evaluation of the Health Support Program Pilot, for Queensland Health', *Sisters Inside – Service & Program Evaluations* (Report, 2018) <<https://sistersinside.com.au/research-hub/research-library/sisters-inside-publications/services-programs/>> ('*Health Support Program Pilot*').

<sup>55</sup> Ibid 23, 11.

<sup>56</sup> Ibid 10.

<sup>57</sup> Ibid 33.

<sup>58</sup> *Health of Australia's Prisoners* (n 1) 13.

Centrelink payments – too often, the cost of public transport is prohibitive, and women cannot afford to access services (and, often, prescribed medication). It also recognises the massive workload most women face post-release – meeting the requirements of statutory bodies including Centrelink/employment agencies, Probation/Parole and, often, Child Safety.

### **Support provided by the prison on release**

Sisters Inside' staff stress that communication between service providers prior to a woman's release should be facilitated and prioritised because it enables development of a coordinated support plan. For this to be possible, the lead agency needs accurate information about the woman's release date and her needs and preferences post-release.

Our staff report that often women in prison do not have access to key personal identification documents, such as their birth certificate, which poses an impediment to accessing social security and health supports once they are released from prison. According to the AIHW, 46% of prison dischargees reported they would not have a valid Medicare card from their first day of release from prison.<sup>59</sup> Prison discharge papers can be used as proof of identity for the purpose of accessing Medicare or Centrelink; however, if a person is in survival mode or in a crisis, they may not retain this documentation or may not attend Centrelink at all.

As mentioned above, a Sisters Inside Health Support Worker reports that, in the past three years, of the 310 women she has supported post-release from prison, only two have had comprehensive medical records, medications lists and referrals provided to them on release. Additionally, our staff report that it is common for women to be released without a supply of their necessary medications, without a script for those medications or even without a list of the medications that they were prescribed in prison. It is essential that women released from prison be provided with their medical records, referrals and medications. Without these basic provisions, it is difficult for them to receive timely and appropriate medical care and to access a mental health plan.

As a first step, organising a mental health plan is very positive, because it allows a person to access the Medicare rebate for ten appointments with an approved mental health care provider. However, remembering appointments and arranging travel can be very difficult for people with mental health conditions, especially if they are also experiencing homelessness or poverty. In our experience, often women require support to make these appointments and access the benefits of the subsidised mental health support, which is why community-based transition support programs are essential.

### **Information Request 16.2: Appropriate treatment for forensic patients**

We observe that there are far too many women in prison who require high levels of mental healthcare, but do not meet the threshold for forensic orders or treatment orders under the *Mental Health Act 2016* (Qld). It is also common for people to be taken off of forensic orders and returned to the community without adequate support. As a result, prisons are populated with high needs people that QCS and Queensland Health are not capable of treating effectively. As discussed above, it is particularly problematic that QCS routinely places women in long-term separate confinement to manage their mental health conditions. Separate confinement may reduce a woman's ability to harm herself or others, but does not treat her underlying condition/s.

For example, Sisters Inside supports a Jess\*,<sup>i</sup> a woman in prison who has severe mental health conditions but is does not meet the threshold for forensic orders. To manage her mental health conditions, prison staff make Jess spend the majority of her time in separate confinement. She is routinely tackled to the ground and wrestled by multiple prison staff who then cut her clothes off of her body, restrain her and place a spit hood over her head. This degrading and violent

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<sup>59</sup> Ibid 149.

treatment illustrates that prison staff are not trained to work with people who suffer from serious mental illness.

For another example, Sisters Inside supports Libby\*, a woman with serious mental health conditions who is frequently placed on forensic orders and then, at review, she is taken off of the orders and returned to the community. Libby's finances are managed by the Public Trustee and she finds this difficult to navigate, which often results in her committing minor offences like shoplifting and public nuisance. For years Libby has been trapped in a cycle where she transitions back and forth between forensic orders, homelessness and prison.

## Conclusion

Sisters Inside would be very happy to provide further evidence of any claims made in this submission, and to discuss the issues raised further with the Commission.

Yours faithfully,

Debbie Kilroy  
CEO  
**Sisters Inside Inc.**

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<sup>i</sup> Names of clients have been changed to protect privacy