10

Mental Disorder and Cognitive Disability in the Criminal Justice System

Ed Heffernan, Kimina Andersen, Elizabeth McEntyre and Stuart Kinner

OVERVIEW

This chapter examines what is known about the prevalence of mental disorder and cognitive disability amongst Aboriginal and Torres Strait Islander peoples in contact with the criminal justice system and how these issues impact on individuals, families and communities. The literature in this area is reviewed; there is now a considerable body of evidence supporting the premise that mental disorders are a significant health challenge for Aboriginal and Torres Strait Islander peoples in contact with all aspects of the criminal justice system. There is emerging evidence to suggest that this is also the case for cognitive disability, however further research is required to fully articulate the extent of this challenge. With this understanding, we consider the important and complex implications for mental health and disability services in meeting the needs of Aboriginal and Torres Strait Islander peoples in the criminal justice system.[1]

BACKGROUND

> *Commissioners could trace the familiar pattern of State intervention into, and control of, Aboriginal lives. The files start from birth; perhaps recording a child adopted out, perhaps its birth merely noted as a costly additional burden; through childhood, perhaps forcibly removed from parents after having been categorised as having mixed racial origins and therefore being denied a loving upbringing by parents and family; through encounters at school, probably to be described as truant, intractable and unteachable; to juvenile courts, magistrates courts, possibly Supreme Court; through the dismissive entries in medical records ('drunk again'), and in the standard entries in the note books of police investigating death in a cell ('no suspicious circumstances').*[1(1.2.12)]

The landmark report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) published in 1991 highlighted for the general Australian community the significant problems associated with the over representation of Aboriginal and Torres Strait Islander peoples in custody.[1] It also clearly described the associated social and emotional wellbeing (SEWB). The RCIADIC[1] examined all 99 deaths of Aboriginal and Torres Strait Islander peoples in custody between 1 January 1980 and 31 May 1989, and in 1991 published a report containing 339 recommendations, of which 338 were accepted by the Australian Government. Among the many important issues highlighted in the extensive report were the extraordinary rates of incarceration of Aboriginal and Torres Strait Islanders compared with other Australians and the poor general and mental health of this group; 'The 99 cases have highlighted the issue of mental health as a significant underlying issue and a factor of concern for those who died in custody.'[1] Now, 22 years since the report was released, these issues are just as prominent for Aboriginal and Torres Strait Islander peoples incarcerated today, as is the ongoing trauma of deaths in custody.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES IN CUSTODY

Aboriginal people are 15 times more likely to be incarcerated than other Australians and represent 27 per cent of the adult custodial population[2] despite being around 3 per cent of the Australian population.[3] In the most recent National Aboriginal and Torres Strait Islander Social Survey (NATSISS), 15 per cent of people aged 15 years and over reported that they had been arrested at least once in the preceding five years[4] and it has been estimated that more than one-in-five Aboriginal and Torres Strait Islander children experience incarceration of a parent by the age of 16 years.[5]

The annual National Prisoner Census[6] indicates that, over the past decade, there has continued to be a dramatic rise in the proportion of Aboriginal people incarcerated.[6] In 2002, there were 4,494 Aboriginal people incarcerated in adult prisons, increasing to 7,982 in 2012.[2] Over the same time period, the proportion of prisoners identifying as Aboriginal increased from 20.0 per cent to 27.2 per cent and the age-adjusted ratio of Aboriginal to non-Aboriginal incarceration increased from 10.1 to 14.8. In 2012, the national age-standardised incarceration rate for Aboriginal people was 1,914 per 100,000 population compared with 129 per 100,000 population among other people. Aboriginal and Torres Strait Islander peoples are over-represented among prisoners in every state and territory of Australia, although the extent of this over-representation varies from a factor of 4 in Tasmania up to twenty fold in Western Australia (WA). New South Wales (NSW), Queensland and WA account for 73 per cent of the total Aboriginal and/or Torres Strait Islander prisoner population.[2] The number of Aboriginal women in prison is increasing at a much faster rate than that for Aboriginal men, with a 20 per cent increase in women compared with 3 per cent in men over the past 12 months.[7]

Across Australia, Aboriginal prisoners are mostly male (92 per cent) and relatively young, with 26 per cent less than 25 years old and 48 per cent less than 30 years old. Aboriginal and Torres Strait Islander peoples in prison are also more likely than other people to have been sentenced or charged with acts intended to cause injury and less likely to have been sentenced or charged with illicit drug offences. The average sentence length (two years) for Aboriginal prisoners is considerably shorter than for other prisoners (3.9 years). Three quarters (74 per cent) of Aboriginal prisoners have a history of prior adult imprisonment, compared with around half (48 per cent) of other prisoners. Many of these individuals have spent time in juvenile detention across Australia. Over half (53 per cent) of all juveniles in detention are Aboriginal or Torres Strait Islander or both Aboriginal and Torres Strait Islander.[8]

These statistics paint a stark picture, but in isolation do not capture the suffering and distress experienced by incarcerated Aboriginal and Torres Strait Islander peoples, their families and their communities. The experience of the criminal justice system is likely to be different for Aboriginal and non-Aboriginal people. The majority of the Australian prison population are non-Aboriginal males[2] and the majority of correctional officers, correctional health staff and non-custodial staff employed in the correctional system are non-Aboriginal. Programs and supports that relate to the SEWB of Aboriginal and Torres Strait Islander peoples in custody must be culturally informed,[9] however it is debatable whether this is the case.[10] Similarly, whereas the focus of rehabilitation for Aboriginal and Torres Strait Islander prisoners must be culturally informed, to the authors knowledge, there is no published evidence of the outcomes of preventive or post-release programs for Aboriginal Australians that were developed, implemented and evaluated in collaboration with Aboriginal families and their communities. It has been suggested, though, that using an approach based on desistance theory may not be useful for Aboriginal women caught in the criminal justice system; this approach is based on work with non-Indigenous males, focuses on offending behaviours, not necessarily individual and cultural needs, and does not take account of broader social and cultural drivers of criminalisation.[11]

In addition, for Aboriginal and Torres Strait Islander women, many of the challenges of incarceration are compounded by the fact that they usually have young children in their care prior to coming into custody.[12] Many also report experiences of trauma and social disadvantage related to family violence, sexual assault, alcohol and other drug use, racism, unemployment and poverty.[13, 14] However, it is apparent that there is a lack of appropriate services to meet these complex social, cultural and health needs.[15]

THE SOCIAL, HEALTH AND INCARCERATION NEXUS

When compared with the general community, prisoners experience higher levels of adversity with respect to the social determinants of health. They have:

- higher levels of unemployment;
- unstable accommodation;
- lower levels of education; and
- poorer access to health services.[16, 17]

This appears to be particularly the case for Aboriginal prisoners who, when compared with their non-Aboriginal counterparts, report earlier and more frequent contact with the criminal justice system,[18] a higher prevalence of unemployment and poorer education, defined as completing 10 years of schooling.[13] Aboriginal and Torres Strait Islander prisoners are more likely to have been placed in care as a child and to have experienced parental incarceration, with one-in-three reporting that they had a parent imprisoned when they were children.[13]

For Aboriginal and Torres Strait Islander peoples, being charged by police or imprisoned in the preceding five years is strongly correlated with misuse of alcohol or other drugs, failure to complete high school, unemployment, financial stress, crowded accommodation and being a member of the 'stolen generation.'[19] Experiences of trauma, discrimination, domestic violence, substance misuse, mental health problems and mental illness, are also strongly associated with incarceration.[18, 20, 21]

This nexus between social adversity, poor health and incarceration for Aboriginal people can at least in part be understood in terms of the impact of historical factors such as the colonisation of lands and the forced removal of children, discrimination, and associated experiences of unemployment, poverty, poor education and a lack of social capital.[13, 19, 22-25] Aboriginal and Torres Strait Islander peoples have been the target of various forms of social control including mass killings, dispossession of land, being forced onto missions, children being stolen and imprisoned in girls' and boys' homes and restrictions affecting mobility and personal liberty policed by mission and reserve authorities.[1] Knowledge of this history is critical to understanding the impact that interaction in the criminal justice system can have on Aboriginal and Torres Strait Islander individuals, family and communities. In Chapter 1, Dudgeon and colleagues discuss the social and historical context; in Chapter 6, Zubrick and colleagues examine the social determinants of SEWB; and in Chapter 30, Hovane and colleagues outline elements for culturally appropriate rehabilitation programs.

MENTAL DISORDER AND COGNITIVE DISABILITY AMONG PRISONERS

This section reviews the current evidence related to the prevalence of mental disorder, (mental illness and substance use problems) and cognitive disability among Aboriginal and Torres Strait Islander men and women involved in the criminal justice system. In doing so, it is acknowledged that these elements are only part of the more holistic concept of health for Aboriginal and Torres Strait Islander peoples' SEWB.[9] The evidence base for mental illness and substance use disorders in this population is relatively well characterised, the extent of cognitive

disability among Aboriginal and Torres Strait Islander peoples in contact with the criminal justice system is not as well understood, despite its importance as a component of broader SEWB.

In the largest and most recent survey of the mental health and wellbeing of the Australian community, mental disorders—defined in accordance with the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10)[26]—were considered to include affective (or mood) disorders, anxiety disorders, substance use disorders[27] and psychotic disorders.[28] It was estimated that almost half of the Australian population aged 16 to 65 years (45 per cent) had experienced a mental disorder at some stage in their lifetime, with 20 per cent experiencing a mental disorder in the preceding 12 months. This survey, like most population surveys in Australia, did not include people in custody.

At a population level, a comprehensive understanding of the distribution of mental illness requires a focus on incarcerated populations, given that when compared with the general community, the prevalence of mental disorders among prisoners is elevated by orders of magnitude.[29] However until recently, relatively little has been known about the mental health of Aboriginal people in custody.[30, 31] Recent studies have shed some light on the prevalence of mental illness among Australian prisoners, although few have focussed on Aboriginal and Torres Strait Islander peoples in prison. Research related to the rates of cognitive impairment in Aboriginal and Torres Strait Islander prisoners is even more limited; however the research that does exist suggests that Aboriginal and Torres Strait Islander prisoners who experience cognitive impairment are likely to also experience mental illness and alcohol or other drug use.[32, 33]

A study of individuals with intellectual and other cognitive impairment in the criminal justice system in NSW found that, compared with other Australians, Aboriginal and Torres Strait Islander peoples with an intellectual disability had earlier police contact and higher levels of police contact, and were less likely to receive a disability service.[32, 33] Given uncertainty about the prevalence and presentation of cognitive disability among Aboriginal and Torres Strait Islander peoples in the criminal justice system, there is a need for further research to better understand the nature and extent of this problem. Equally, there is a pressing need to improve our understanding of how Aboriginal and Torres Strait Islander peoples with co-occurring mental disorder and cognitive impairment interact with, and are dealt with by, the criminal justice system and by human service providers after release from custody.[2]

More is known about mental disorders among Indigenous people in custody, but much of the evidence has come from only two Australian jurisdictions. The 2009 NSW Inmate Health Survey: Aboriginal Health Report[13] was the first significant Australian report to focus on the general health of Aboriginal inmates. It was based on a cross-sectional survey that included screening items related to mental health, administered to 312 Aboriginal prisoners in NSW. The mostly self-report items covered psychiatric history (ever assessed or treated by a doctor or psychiatrist for an emotional or mental health problem), psychiatric admissions (ever admitted to a psychiatric unit or hospital), medication use (current use of psychiatric medications), history of suicide thoughts/attempts or self harm, and screened for depression using the Beck Depression Inventory. Consistent with previous studies in NSW, the findings indicated a high prevalence of mental health distress among Aboriginal prisoners and while not diagnostic, the findings suggested a high prevalence of mental disorder. On all measures related to mental health women had poorer outcomes than men. (Table 10.1)

Table 10.1: Mental Health Items, by Gender

	Male %	*Female %*
Psychiatric History	44.5	51.9
Psychiatric Admission	14.5	21.6
Current Psychiatric Medication	16.8	31.4
Moderate/ Severe Depression	34.1	51.0
Suicide Thoughts	33.6	39.2
Suicide Attempts	22.7	37.3

Source: 2009 NSW Inmate Health Survey[13]

The survey also identified that substance use was a significant problem for Aboriginal inmates. The vast majority of both men and women were current tobacco smokers and based on responses to the Alcohol Use Disorders Identification Test (AUDIT),[34] three-quarters of men and one-half of women were classified as having engaged in hazardous or harmful alcohol consumption before incarceration. The vast majority reported a history of illicit drug use and around one-in-two reported a history of injecting drug use (Table 10.2). Consistent with suggestions of a link between substance use and offending among Aboriginal and Torres Strait Islander peoples,[35] the majority also reported that they were intoxicated at the time of their offence .

Table 10.2: Substance Use Characteristics, by Gender

	Male %	*Female %*
Current Smoker	83.2	88.0
Hazardous Harmful Alcohol Use	74.2	51.0
Illicit Drug Use Ever	88.3	88.0
Injecting Drugs Ever	46.1	50.0
Intoxicated During Offence	73.0	67.3

Source: 2009 NSW Inmate Health Survey[13]

Two major diagnostic surveys of mental illness have been conducted with Aboriginal prison populations. The first was embedded within the 2001 NSW Inmate Health Survey[36] that included a sample of 277 Aboriginal prisoners (226 men, 51 women), the second was undertaken in Queensland. The NSW survey included a modified version of the Composite International Diagnostic Interview (CIDI) to diagnose mood, anxiety and substance use disorder and screen for the presence of possible psychotic disorder.[37] Among this sample, the prevalence of affective and anxiety disorder was extremely high, as was the estimate of psychotic disorder inferred by the psychosis screen and this was particularly evident among the female sample (Table 10.3).

Table 10.3: Mental Disorders (12-Month Prevalence), by Gender

	Male (n = 226) %	*Female (n = 51)* %
Affective Disorder	83.2	88.0
Anxiety Disorder	74.2	51.0
Psychosis Screen	73.0	67.3

Source: 2001 NSW Inmate Health Survey[36]

This study highlighted not only that mental disorder was extremely common among Aboriginal people in NSW prisons, but also that the prevalence of mental disorder was much higher than would be expected in a community sample of Aboriginal people. The research indicated that there was a significant demand for mental health services for Aboriginal people in custody, and also that women in custody were a particularly vulnerable group with respect to mental disorder.

The most recent and most comprehensive study of mental illness among Aboriginal people in custody was conducted in Queensland in 2008, with the findings reported in 2012.[14] This study, known as the *Inside Out* study, focused exclusively on the mental health of Aboriginal and Torres Strait Islander prisoners (331 men, 65 women). Depressive, anxiety and substance use disorders were assessed using the CIDI, while a novel and comprehensive method was developed to diagnose psychotic disorders. This involved psychiatrist assessments and the use of a diagnostic panel including a cultural advisor to ratify diagnosis. A particular strength of the study was the culturally competent method that included community consultation to inform the research design and implementation, Aboriginal leadership throughout the project, and data collection conducted by trained Aboriginal mental health practitioners.[38]

Consistent with the earlier NSW studies, the *Inside Out* study identified that mental disorder was extremely common among Aboriginal and Torres Strait Islander prisoners (Tables 10.4 and 10.5). Depressive disorders, which included major depression and the less severe but chronic dysthymic disorder, were common among both men and women. Major depression, the more severe form of depression, was the most common depressive disorder diagnosis in both groups.

Table 10.4: Twelve Month Prevalence of Mental Disorder, by Gender

	Male (n = 347) %	*Female (n = 72)* %
Depressive Disorder	11.4	29.2
Anxiety Disorder	20.2	50.7
Psychotic Disorder	8.1	25.0

Source: Inside Out[38]

Anxiety disorders were present in one-fifth of all men and in one-half of all women surveyed. For both groups, the main anxiety disorder was Post Traumatic Stress Disorder (PTSD).[26] This is a disorder characterised by exposure to a significantly traumatic event or events that result in mental health symptoms including re-experiencing the event (nightmares or flashbacks), hyper-arousal (difficulty sleeping, anger, poor concentration, hyper-vigilance) and avoidance phenomena. While the rates of PTSD were very high (12 per cent of men, 32 per cent of women), this finding was congruent with other studies of trauma experiences among Aboriginal and Torres Strait Islander inmates.[28-30] It is likely that these very high rates of trauma reflect the high prevalence of trauma experiences among Aboriginal and Torres Strait Islander peoples in the community.[5,31,32] Several chapters in this book address the issue of trauma, particularly Chapter 17 (Atkinson and colleagues). Other chapters outline healing programs to address the levels of trauma experienced.

A major strength of the *Inside Out* study was the ability to diagnose psychotic disorders in a way that was both rigorous and culturally competent. Using this approach, the prevalence of psychotic disorder among Aboriginal prisoners, when compared with prevalence estimates from the community, was found to be high for men and dramatically higher in women.[14] Psychotic disorders are brain disorders characterised by hallucinations, delusions, disorganised thoughts and behaviours and sometimes associated with changes in cognition, mood and motivation.[26] In the Australian community the 12 month prevalence of psychotic disorder is relatively low (0.47 per cent), however the impact of these disorders on an individual's social, occupational and general level of functioning is significant.[28] The *Inside Out* study found that psychotic disorder is much more common among Aboriginal and Torres Strait Islander peoples in prison than in the general community.[36, 39] Among Aboriginal and Torres Strait Islander people in custody, psychotic disorder is associated with significant morbidity,[40] higher rates of reoffending[41] and significant rates of hospital re-admission post-release.[42]

The *Inside Out* study into the mental health of Aboriginal people in custody also found that substance use disorders were extremely common (Table 10.5), with alcohol and cannabis being the most common substances misused. In the general Aboriginal community, substance dependence is relatively rare,[43, 44] however among Aboriginal prisoners substance dependence was normative.[14] Alcohol dependence was the most common dependence problem and is more common among Aboriginal and Torres Strait Islander prisoners than other prisoners.[45] There is a recognised association between offending, particularly violent offending, and alcohol dependence for Aboriginal and Torres Strait Islander peoples.[46] This underpins the critical importance of having culturally appropriate drug and alcohol services available to Aboriginal and Torres Strait Islander peoples in custody.[47]

Table 10.5: Twelve Month Prevalence of Substance Use Disorders, by Gender

	Male (n = 347) %	*Female (n = 72)* %
Alcohol	51.3	60.0
Amphetamine	10.8	6.1
Cannabis	21.1	26.1
Opioids	9.6	10.7
Sedatives	1.8	6.1
Others (a)	8.4	16.9
Any Substance	65.5	69.2

(a) Includes Hallucinogens, Volatile Solvents and Psychoactive Substances and other stimulants

Source: Inside Out[38]

Cognitive impairment among Aboriginal and Torres Strait Islander peoples in custody is associated with factors including brain injury from trauma and substance misuse.[48, 49] There are no reliable estimates of the prevalence of cognitive disability among Aboriginal and Torres Strait Islander peoples in the criminal justice system, partly due to significant uncertainty about the cultural appropriateness of assessment tools. Furthermore, stakeholders in the criminal justice system such as police, lawyers, correctional officers and other justice system personnel rarely have the skills and training necessary to recognise cognitive disability in an Aboriginal and Torres Strait Islander person.[50]

The evidence suggests that Aboriginal and Torres Strait Islander peoples in custody suffer from complex health problems, with a high prevalence of co-occurring disorders that may include chronic health conditions, mental health disorders, substance use disorders and intellectual disability.[10, 30, 33, 36] An understanding of these inter-related health issues, and their impact on the broader SEWB of Aboriginal and Torres Strait Islander peoples in custody, sheds light on some of the drivers of incarceration of Aboriginal and Torres Strait Islander men and women and some potential targets for intervention. However, these complex health problems must also be placed in the context of the social disadvantage that characterises the majority of Aboriginal and Torres Strait Islander peoples who come into contact with the criminal justice system and the challenges faced in returning to their communities.

MENTAL DISORDER AND COGNITIVE DISABILITY AND TRANSITION BACK TO THE COMMUNITY

There is limited Australian data available on the health outcomes of Aboriginal and Torres Strait Islander peoples with a mental disorder following release from custody, and even less is known about the outcomes for those with a cognitive disability. Most prisoners return to the community after a relatively short incarceration period and, due to the rapid turnover of those on remand or serving short sentences, the number cycling through prison each year is considerably greater than the number in prison on any one day; probably in excess of 55,000 per annum.[51]

Release from prison is associated with a range of poor health outcomes including homelessness, risky patterns of substance use, drug overdose and death.[39,44-46] Among the leading causes of death among recently released prisoners is suicide,[52,53] highlighting the pivotal role of mental health in shaping post-release outcomes for vulnerable ex-prisoners. Drug-related deaths are also common, particularly in the weeks immediately following release from custody.[54] For example, the rate of unnatural death among people released from Victorian prisons between 1990 and 1999 was found to be 10 times the rate of unnatural deaths in the general population,[55] with most deaths due to drug overdose and suicide.

Similarly, in a retrospective cohort study of over 85,000 people leaving NSW custody from 1988 to 2002, it was found that the risk of death due to mental and behavioural disorders was elevated by a factor of 13.2 for men and 62.8 for women.[53] Among the 9,353 Aboriginal and Torres Strait Islander ex-prisoners in the cohort, the risk of death from suicide was 2.9 times higher among men and 6.5 times higher among women, than among age and sex-matched members of the NSW community.[56] The mortality excess in the cohort was greater for Aboriginal and Torres Strait Islander peoples.

Similar findings emerged from a study by Hobbs (2006) of 13,667 ex-prisoners in WA, released from custody between 1995 and 2001 and followed for an average of 4.5 years.[57] The majority of the cohort was male (88.3 per cent) and 36.1 per cent identified as being Aboriginal. The rate of death was highest in Aboriginal men and higher among Aboriginal women than other women. The main causes of death were suicide (20 per cent of deaths) and drug related (29 per cent of deaths). Among Aboriginal men, the overall rate of death was 9.4 times higher than among age and sex-matched members of the community, while the rate of suicide death was 4.3 times higher; among Aboriginal women the rate of suicide death elevated by a factor of 15.

Given the unstable environments to which many ex-prisoners return, few studies have been able to examine mental health outcomes after release from prison. One study in WA linked correctional records with hospital records for prisoners released between 2000 and 2002 (N=7,414) and found that one-in-five (20.4 per cent) were admitted to hospital at least once in the first year after their release. Hospitalisation was 60 per cent more common among females and 20 per cent more common among Aboriginal people. Mental and behavioural disorders accounted for 37 per cent of the 12,074 bed days and this was mostly accounted for by schizophrenia and depression.[42]

RESPONDING TO THE MENTAL HEALTH NEEDS OF ABORIGINAL PEOPLES IN CUSTODY

The mental health of Aboriginal and Torres Strait Islander peoples in contact with the criminal justice system is a public health priority and a key social justice concern. Finding appropriate ways to assess and treat poor mental health and provide the necessary custodial and community services for those with mental disorders and cognitive disabilities will not only assist in closing the health gap, but may also reduce Aboriginal and Torres Strait Islander incarceration, ultimately improving SEWB for individuals, families, carers and communities.

One of the key challenges to achieving these public health and social justice outcomes is to ensure access to adequate and culturally appropriate health and disability services pre-custody, in custody, at the time of release and post-release.[58, 59] Aboriginal prisoners report difficulty accessing mental health services and alcohol and other drug services appropriate to their needs, and this is compounded by isolation from SEWB supports that are inherently part of community and cultural activities and Elder support.[10, 38, 47, 60-62] In order for these issues to be addressed decisively, health and social services in custody and in the community must be informed by the growing evidence base regarding the delivery of culturally capable health services, and the benefits of culturally appropriate programs for Aboriginal and Torres Strait Islander peoples in contact with the criminal justice system, as outlined in Chapter 30 (Hovane and colleagues).

Similarly, given the emerging evidence that cognitive disability among Aboriginal and Torres Strait Islander peoples in contact with the criminal justice system is a significant challenge, it is critical that reliable and valid methods for identifying cognitive disability among Aboriginal people in contact with the criminal justice system be developed. There is also a clear need to ensure the availability of specialised disability services that are culturally capable, both in the criminal justice system and in the community, to enable a smooth transition between service systems. These services should be responsive to challenges that can be faced by communities, carers and extended family networks when individuals with cognitive disabilities return to the community. A mechanism that enables diversion from the criminal justice system for individuals with cognitive disability, to appropriate health and community services, could help address the recruitment of adversity that may otherwise follow.[63]

Despite the recommendations of the RCIADIC, Aboriginal and Torres Strait Islander peoples continue to be overrepresented at all levels of the criminal justice system and there continues to be a struggle for mainstream services to provide culturally competent health care and ongoing support. This in part has necessitated that the National Aboriginal Community Controlled Health Organisation (NACCHO) absorb responsibility for the provision of health and disability support services to Aboriginal and Torres Strait Islander peoples coming into contact with the criminal justice system. Accessing these services is often the only opportunity for Aboriginal and Torres Strait Islander community members to receive appropriate and culturally-informed services that are responsive to their individual cultural needs and differences. See Chapter 12 (Walker and colleagues) regarding the principles and strategies for ensuring organisational and individual cultural competence.

The networks of Aboriginal community-based services for those coming into contact with the criminal justice system includes diversion programs, in-reach programs to custodial settings, and programs to assist individuals to transition back to life in the community.[55-57] These activities are provided in acknowledgement of the need for services that are meaningful for Aboriginal and Torres Strait Islander peoples and are strengths-based, building upon cultural knowledge and practices. However, in the busy custodial environment where resources are scarce, culturally-informed services are often required to compete with mainstream service models that are universal and directed at the needs of an individual, but not necessarily in a social or cultural context.[64]

The challenge is, therefore, for mental health and disability services to deliver care for Aboriginal and Torres Strait Islander peoples involved in the justice system in a manner that is culturally respectful and competent. Appropriate mental health and disability services would actively seek Aboriginal and Torres Strait Islander mental health practitioners to provide mental health and SEWB services to a large and culturally diverse population. They would need to be culturally aware and responsive to local individual, family, carer and community practices. Such services would also include meaningful transitional support systems that would commence at the system entry point and continue on post-release, to improve the prospects for successful integration into the community.[65] In parallel, training for police, justice, custodial and correctional health staff, with a goal of increasing their cultural competence—that is, their understanding of Aboriginal and Torres Strait Islander history, cultural distinctiveness and diversity—would empower professionals and paraprofessionals within the criminal justice system to contribute to the improvement of health and social outcomes for Aboriginal and Torres Strait Islander peoples.

There is some evidence that some existing initiatives have been of benefit to prisoners and their communities. These initiatives range from locally-based, community-driven initiatives to more structured programs, such as described in Chapter 30 (Hovane and colleagues) and in a range of healing programs in Part 6. There are existing formal partnerships between justice departments and Elder groups in most states and territories, which could be utilised as a mechanism for building formal partnerships that can positively impact at the service delivery level. Numerous informal, cross-sectoral collaborations exist, which are generally inspired by a common motivation to strengthen cultural identity and practices within Aboriginal and Torres Strait Islander families and communities. There is also the recognition that, within prison, isolation from their family, community, land and cultural activities can further contribute to adverse life experiences.[38, 62, 66]

Health practitioners, particularly mental health practitioners, working in custodial environments need to have a good understanding of the linkages between social inequalities, poor health and incarceration for Aboriginal and Torres Strait Islander peoples. They must have the ability to recognise the historical, cultural and sociopolitical context of SEWB, including the impact of colonisation; trauma, loss, separation of families and children, and dispossession of lands.[9, 67] If practitioners operate from an understanding of Aboriginal and Torres Strait Islander views of health, mental health and disability, and are aware of the interconnections between spiritual, social, emotional, cultural and physical domains,[9] the delivery of services would be more holistic by design and outcomes for Aboriginal and Torres Strait Islander peoples in contact with the criminal justice system would be more optimistic, positive and meaningful.

REFLECTIVE EXERCISES

1. What impact might the high rate of incarceration of Aboriginal and Torres Strait Islander peoples have on their communities?
2. How might having a mental illness increase the risk of having contact with the criminal justice system, and under what circumstances?
3. What barriers may exist for Aboriginal and Torres Strait Islander peoples accessing appropriate mental health services in custody and post-release?
4. Why might the rates of mortality and morbidity associated with mental health problems be so high for Aboriginal and Torres Strait Islander peoples when they leave custody?
5. What steps should be taken to prevent the cycle of adversity faced by many Aboriginal and Torres Strait Islander men and women with mental health and other disabilities when they come into contact with the criminal justice system?

REFERENCES

1. Australia. Royal Commission into Aboriginal Deaths in Custody. (Commissioner Johnston E). Royal Commission into Aboriginal Deaths in Custody: Canberra: AGPS; 1991.
2. Australian Bureau of Statistics. Corrective Services, Australia. Canberra; 2013.
3. Australian Bureau of Statistics. Australian demographic statistics. Canberra; 2012.
4. Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Social Survey. Canberra; 2010.
5. Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Social Survey. Canberra; 2002.
6. Australian Bureau of Statistics. Prisoners in Australia. Canberra; 2011.
7. Australian Bureau of Statistics. Prisoners in Australia. Canberra; 2012.
8. Australian Institute of Health and Welfare. In: Juvenile detention population in Australia. 2011. Canberra: AIHW.
9. Swan P, Raphael, B. The Ways Forward : National Aboriginal and Torres Strait Islander Mental health Policy National Consultancy Report. Canberra; 1995.
10. Grace J, Krom I, Maling C, Butler T, Midford R. Review of Indigenous offender health. Australian Indigenous Health Bulletin. 2011; 11(2):1-17.
11. Baldry E. Women in transition: prison to ..... Current Issues in Criminal Justice. 2010; 22(2):253-268.
12. Baldry E, Ruddock J, Taylor J. Aboriginal women with dependant children leaving prison project: Needs analysis report. Sydney; 2008.
13. Indig D, McEntyre E, Page J, Ross B. *2009 NSW Inmate Health Survey: Aboriginal Health Report.*, In: Health Journal. editor. 2011. Sydney.
14. Heffernan E, Andersen A, Dev A, Kinner S. Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland prisons. Medical Journal of Australia. 2012; 197(1):37- 41.
15. Herring S, Spangaro J, Lauw M, McNamara L. The Intersection of Trauma, Racism and Cultural Competence in effective work with Aboriginal People: Waiting for Trust. Australian Social Work. 2013; 66(1):104-117.
16. Australian Bureau of Statistics. Prisoners in Australia. Melbourne; 2009
17. Australian Bureau of Statistics. Prisoners in Australia. Issue 4517.0; Canberra; 2010
18. Putt J, Payne J, Milner L. Indigenous Male Offending and Substance Abuse. Trends and Issues in crime and criminal justice. 2005; (293):1-6.
19. Weatherburn D, Snowball L, Hunter B. The economic and social factors underpinning Indigenous contact with the justice system: Results from the 2002 NATSISS Sydney; 2006.
20. National Aboriginal and Torres Strait Islander Health Council. Social and Emotional Well Being Framework 2004-2009. Canberra; 2004.
21. Wundersitz J. Indigenous perpetrators of violence: Prevalence and risk factors for offending. Canberra; 2010.
22. Saggers S, Gray D. Defining what we mean. In: Carson B, Dunbar T, Chenhall R D, Bailie R, editor. Social determinants of Indigenous Health. Crows Nest: Allen and Unwin; 2007. p. 1-20.

23. Anderson I. Understanding the Process. In: Carson P, Dunbar T, Chenhall RD, Bailie R, editors. Social Determinants of Indigenous Health. Crows Nest: Allen and Unwin; 2007. p. 21-37.

24. King M, Smith A, Gracey M. Indigenous health part 2: the underlying causes of the health gap. Lancet. 2009; 374(9683):76-85.

25. Krieg AS. Aboriginal incarceration: health and social impacts. Medical Journal of Australia. 2006; 184(10):534-6.

26. World Health Organisation. The ICD-10 Classification of Mental and Behavioural Disorders. Geneva: World Health Organisation; 1993.

27. Slade T, Johnston A, Teeson M, Whiteford H, Burgess P, Pirkis J, et al. In: The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Well Being., 2009. Canberra.

28. Morgan VA, Waterreus A, Jablensky A, McGrath J, Carr V, Bush R, et al. People living with psychotic illness. 2010. Canberra; 2011.

29. Butler T, Andrews G, Allnutt S, Sakashita C, Smith NE, Basson J. Mental disorders in Australian prisoners: a comparison with a community sample. Australian and New Zealand Journal of Psychiatry. 2006; 40(3):272-276.

30. Heffernan E, Andersen K, Kinner S. The insidious problem inside: mental health problems of Aboriginal and Torres Strait Islander People in custody. Australasian Psychiatry. 2009; 17(1):41-46.

31. Australian Medical Association. Undue Punishment ? Aboriginal and Torres Strait Islanders in Prison: An unacceptable reality. Melbourne; 2006.

32. Baldry E, Dowse L, Clarence M. People with intellectual and other cognitive disability in 32 criminal justice system. Sydney; 2012.

33. Dias S, Ware RS, Lennox NG, Kinner SA. Co-occurring mental disorder and intellectual disability in a large sample of Australian prisoners. Australian and New Zealand Journal of Psychiatry. 2013; (in press).

34. Babor T, Higgins-Biddle J, Saunders J, Monteiro M. The Alcohol Use Identification Test, Guidelines for Use in Primary Care, World Health Organisation. 2001.

35. Weatherburn D J. The role of drug and alcohol policy in reducing Indigenous over-representation in prison. Drug and Alcohol Review. 2008; 27(1):91-94.

36. Butler T, Allnut S, Cain D, Owens D, Muller C. Mental Disorder in the New South Wales prisoner population. Australian and New Zealand Journal of Psychiatry. 2005; 39(5):407-413.

37. Butler T, Allnutt S, Kariminia A, Cain D. Mental health status of Aboriginal and non-Aboriginal Australian prisoners. Australian and New Zealand Journal of Psychiatry. 2007; 41(5):429-435.

38. Queensland Government. Inside Out - The Mental Health of Aboriginal and Torres Strait Islander People in Custody Report. Brisbane; 2009.

39. Tye CS, Mullen PE. Mental Disorders in Female Prisoners. Australian and New Zealand Journal of Psychiatry. 2006; 40(3):266-271.

40. White P, Chant D, Whiteford H. A comparison of Australian men with psychotic disorders remanded for criminal offences and a community group of psychotic men who have not offended. Australian and New Zealand Journal of Psychiatry. 2006; 40(3):260-265.

41. Fazel S, Rongqin Y. Psychotic Disorders and Repeat Offending: Systematic Review and Meta Analysis. Schizophrenia Bulletin. 2009; 37(4):800-10.

42. Alan J, Burmas M, Preen D, Pfaff J. Inpatient hospital use in the first year after release from prison: a Western Australian population-based record linkage study. Australian and New Zealand Journal of Public Health. 2011; 35(3):264-9.

43. Australian Institute of Health and Welfare. In: 2010 National Drug Strategy Household Survey report. Issue Cat no. PHE 145, 2011. Canberra.

44. Australian Institute of Health and Welfare. Substance use among Aboriginal and Torres Strait Islander people. Canberra; 2011.

45. Kinner S, Dietze PM, Gouilloi M, Alati R. Prevalence and correlates of alcohol dependence in adult prisoners vary according to Indigenous status. Australian and New Zealand Journal of Public Health. 2012; 36(4):329-334.

46. Weatherburn D, Snowball L, Hunter B. The economic and social factors underpinning Indigenous contact with the justice system: Results from the 2002 NATSISS in Contemporary Issues in Crime and Justice. Sydney; 2006.

47. National Indigenous Drug and Alcohol Committee. Bridges and Barriers: Addressing Indigenous Incarceration and Health. Canberra; 2009.

48. Schofield PW, Butler TG, Hollis SJ, Smith NE, Lee SJ, Kelso WM. Traumatic brain injury among Australian prisoners: rates, recurrence and sequelae. Brain Injury. 2006; 20(5):499-506.

49. Jackson M, Hardy G. In: Acquired brain injury in the Victorian prison system. Victoria Department of Justice. Melbourne; 2011.

50. Simpson J, Sotiri M. Criminal justice and indigenous people with cognitive disabilities. Beyond Bars Alliance; 2006.

51. Martire K, Larney S. Increasing numbers of inmate separations from Australian prisons. The Medical Journal of Australia. 2012; 196(2):110.

52. Kinner SA, Forsyth S, Williams GM. Systematic review of record linkage studies of mortality in ex-prisoners: Why (good) methods matter. Addiction. 2013; 108(1):38-49.

53. Kariminia A, Law G, Butler T, Levy M, Corben S, Kaldor J, et al. Suicide risk amongst recently released prisoners in New South Wales, Australia. Medical Journal of Australia. 2007; 187(7):387-390.

54. Merrall ELC, Kariminia A, Binswanger IA, Hobbs MS, Farrell M, Marsden J, et al. 54-analysis of drug-related deaths soon after release from prison. Addiction. 2010; 105(9):1545-1554.

55. Graham A. Post-prison Mortality: Unnatural Death Among People Released form Victorian Prisons Between January 1990 and December 1999. The Australian and New Zealand Journal of Criminology. 2003; 36(1):94-108.

56. Kariminia A, Butler T, Jones J, Law M. Increased mortality among Indigenous persons during and after release from prison in New South Wales. Australian and New Zealand Journal of Public Health. 2012;36(30:274-280.

57. Hobbs M, Krazlan K, Ridout S, Mai Q, Knuiman M, Chapman R. Mortality and morbidity in prisoners after release from prison in Western Australia 1995-2003. Canberra; 2006.

58. Hockings BA, Young M, Falconer A, O'Rourke PA. Queensland Women Prisoners' Health Survey. Brisbane; 2002.

59. Australian Institute of Health and Welfare. The health of Australia's prisoners 2010. Canberra; 2011.

60. Lawrie R. Speak out, speak strong: Researching the needs of Aboriginal women in custody. Sydney; 2003.

61. Goulding D. Severed Connections: An exploration of the impact of imprisonment an women's familial and social connectedness. Perth; 2004.

62. Poroch N. The Winnunga Prison Health Report: You do the crime, You do the time: Best Practice model of holistic health service delivery for Aboriginal and Torres Strait Islander inmates in the ACT Prison. ACT; 2007.

63. Aboriginal Disability Network NSW. Telling it like it is: A report on community consultations with Aboriginal people with disability and their associates throughout NSW, 2004-2005. Sydney; 2007.

64. Aboriginal and Torres Strait Islander Social Justice Commissioner. Social Justice Report 2009. Sydney; 2009.

65. Senate Select Committee on Regional and Remote Indigenous Communities. Indigenous Australians Incarceration and the Criminal Justice System Discussion Paper. Canberra; 2010.

66. Baldry E. Home Safely: Aboriginal Women Post-release and their Children. Indigenous Law Bulletin. 2009; 7(5):14.

67. Gracey M, King M. Indigenous health part 1: determinants and disease patterns. Lancet. 2009; 374(9683):65-75.