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Goals or de facto mental institutions?

Why individuals with a mental illness are over- represented in the Criminal Justice System in New South Wales, Australia

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ABSTRACT The over-representation of people with mental illness in the criminal justice system highlights the need for legislative reform and the implementation of programs breaking the cycle of mental illness, poverty, unemployment and substance abuse across Australia. Whilst there is no inherent association between mental illness and crime, there is a strong causal link between mental illness and incarceration. The fragmentation of mental health services and the closure of many community-based services have led to the criminalisation of the mentally ill. As a consequence, unsurprisingly, goals and juvenile detention centres have become 'de facto' mental institutions.

KEYWORDS Mental illness, criminal justice system, violence

Introduction.

It has long been acknowledged that there is an over-representation of people with mental illness in the criminal justice system.¹ Despite numerous government inquiries over the past 15 years into mental health in Australia (both state and federally),² evidence exists indicating that the situation has further deteriorated.³

The problem is compounded by the fact that the (New South Wales) *NSW Mental Health Act 1990 and Mental Health (Criminal Procedures) Act 1990* make no specific provision for people with intellectual disability who may frequently be classified as 'forensic' patients. As a consequence, there is a 10% over-representation of people with intellectual disability in the criminal justice

¹ Human Rights and Equal Opportunity Commission. (1993). Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness, AGPS, Canberra, p. 757. Northern Beaches Mental Health Consumer Network. (2002), Submission 60, p. 20. Probation and Community Corrections Officers' Association Inc. (2002). Submission 503, p. 5. Mental Health Council of Australia. (2002). Submission 262, p. 24. Cited in: Commonwealth of Australia. (2006). The Senate Select Committee on Mental Health. (2006). A national approach to mental health - from crisis to community: First Report. Henderson, S. (2003). Mental illness and the Criminal Justice System, Mental Health Co-ordinating Council, p. 9.

² Commonwealth of Australia. (2006). The Senate Select Committee on Mental Health. (2006). A national approach to mental health - from crisis to community: First Report.

³ Mental Health Council of Australia (2005). Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia (2005).

system as against representation in the general population. Whether intellectual disability is present as a result of developmental disability, brain damage, illness or genetic disorder, intellectual disability is not a mental illness which can be managed by medication or therapeutic practices from which there is 'recovery.'⁴

The absence of a consistent definition of intellectual disability in the relevant Mental Health Acts has led to considerable confusion, particularly where co-morbidity of intellectual disability and mental illness occur.⁵ A revised *NSW Mental Health Act* was been tabled in the NSW Parliament in December, 2006, and the forensic provisions of the Act are under review. Nevertheless, reform as a result of further consultation and inquiry will no doubt take considerable time. In the interim, unless increased diversionary programs are provided, people with intellectual disability will continue to be over-represented in the criminal justice system whether they present with co-morbidity or not..

Prevalence of mental illness and burden of cost to the Australian community

In order to understand the link between mental illness and the criminal justice system, it is important to be aware of the extent to which mental illness is present in the general population, together with the socio-economic and environmental factors that frequently lead to interactions with the criminal justice system.

A number of studies have indicated that 1 in 5 Australians will be affected by mental illness at some time in their life.⁶ Recent estimates internationally suggest that this could be a gross underestimation of the prevalence of, and disability caused by mental illness. Based on figures in the National Survey of Health and Wellbeing (ABS, 2002),⁷ approximately 2.4 million Australians are thought to experience a mental health problem during any 12 month period. Over 1 million are estimated to suffer from a mental disorder, with almost half of these affected long-term.

Mental disorders account for almost 30% of the non-fatal burden of disease in Australia (Mathers, C., Yos, T. & Stevenson, C. (1999)).⁸ Depression is the most common mental disorder reported, both recent and long-term, and has been identified as one of the most pressing priorities for mental health care. In 2001-02, total spending on mental health services was \$3.1 billion, a 65% increase in real terms since 1993.⁹

⁴ Henderson, C. D. (2007). Submission to the Consultation Paper: Forensic Provisions of the *NSW Mental Health Act 1990 and Mental Health (Criminal Procedures) Act 1990*, p.9.

⁵ Ibid.

⁶ Mathers, C., Yos, T. & Stevenson, C. (1999). The burden of disease and injury in Australia. Australian Institute of Health and Welfare: Canberra. Available: <http://www.aihw.gov.au/publications/health/bdia/>

⁷ (AIHW) Australian Institute of Health and Welfare (2002). Australia's Health 2002. Canberra.

⁸ Mathers, C., Yos, T. & Stevenson, C. (1999). The burden of disease and injury in Australia. Australian Institute of Health and Welfare: Canberra. Available: <http://www.aihw.gov.au/publications/health/bdia/>

⁹ Ibid.

Nevertheless, Australia lags behind other western nations in the proportion of national wealth spent on mental health care and specialised mental health services accounted for only 6.4% of Australia's recurrent health expenditure.¹⁰ An analysis by the Australian Institute of Health and Welfare (AIHW, 2005) shows that the proportion of mental health expenditure will rise to 9.6% if substance abuse and dementia are included. Substance abuse accounts for 11.5% of mental health costs in Australia. (AIHW, 2005).¹¹

According to estimates from the Australian Bureau of Statistics (ABS), the cost of mental health disorders is dominated by years lost due to disability, responsible in 1996 for 13.3% of total Disability Adjusted for Life Year (DALY), (Mathers et al., 1999). These figures emphasise mental illness not as a major direct cause of death, but as a major cause of chronic disability (ABS, 1998d).

Identifying the breakdown of burden in terms of mental illness and gender, the ABS stated the major cause of mental disorder for females to be affective disorder, accounting for 39% of women's mental health disability. This was represented almost entirely by depression (87%) and anxiety disorder (22%). Men are more than twice as likely as women to have substance use disorder (11%). Young adults of both sexes (18 -24 years) have the highest prevalence (27%) of mental disorder (Mathers et al., 1999).

Stigma and a preoccupation with excessive risk management

Despite the high incidence of mental illness in the general community, there remains widespread fear, misunderstanding and stigma. Community attitudes concerning mentally ill offenders and their treatment by the criminal justice system are no exception. Much of this misunderstanding comes from dramatic depictions of mentally ill persons in films, on television, and sensationalised reports in the media.¹²

Mullen (2001) writes that current preoccupation with risk assessment, "privileges policies of control and containment as against support and management." As a consequence, resources are diverted from the mentally disordered towards those believed to be of potential risk. This encourages stigmatising constructions of the mentally disordered, giving primacy to their supposed level of dangerousness and has resulted in the development of a "spurious technology of risk

¹⁰ Mathers, C., Yos, T. & Stevenson, C. (1999). The burden of disease and injury in Australia. Australian Institute of Health and Welfare: Canberra. Available: <http://www.aihw.gov.au/publications/health/bdia/>

¹¹ Australian Institute of Health and Welfare (2002). Australia's Health 2002. Canberra: AIHW.
AIHW. Australian Institute of Health and Welfare (2005). Mental Health Expenditure and Priorities. Section: 6. Available: <http://www.aihw.gov.au/publications/health/bdia/bdia-c06.pdf>
Australian Institute of Health and Welfare (2003). Australia's Welfare 2003. (The Sixth Biennial Welfare Report of the Australian Institute of Health and Welfare). Canberra: AIHW.

¹² Blood, R. W., Putnis, P., Payne, T., Purkis, J., Francis, C., McCallum, K., & Andrew, D. (2001). The Media Monitoring Project: A Baseline Description of How the Australian Media Report and Portray Suicide and Mental Health and Illness: Case Studies. School of Professional Communication, University of Canberra, & the Centre for Health Program Evaluation, University of Melbourne.

management,”¹³ which has come to dominate a broad spectrum of clinical practice, obfuscating actual causes of crime in the community.

However, it has long been established that mentally ill persons are much more likely to be a danger to themselves than to others. The ‘Tracking Tragedy,’ report on suicide deaths of recent mental health inpatients (2003) highlighted the vulnerability of people with mental illness to suicide and self-harm, following acute episodes of mental ill health.¹⁴

In NSW, a defence of mental illness is commonly viewed as a loophole used to escape punishment. Debate surrounds the offender’s state of mind - whether they must be ‘mad’ to commit a crime or simply ‘bad’. The perception that a perpetrator feigning madness can avoid a sentence is not supported by evidence.

The real facts

The NSW Bureau of Crime Statistics and Research (1996) has estimated that only 1% of charges are dismissed under the *NSW Mental Health (Criminal Procedure) Act (1990)*. This accounted for only 0.3 % (555) of the total criminal charges finalised in NSW local courts in 1996.¹⁵ In view of the high incidence of people with a mental illness who do not have their charges dismissed, it is unsurprising that NSW goals and juvenile detention centres have become ‘de facto’ mental institutions.

Individuals whose charges are dismissed may be transferred through court diversionary programs, whilst those who become forensic patients may spend a longer period incarcerated than had they received a guilty verdict. Although NSW has undergone reform relating to persons found unfit to be tried, a person found not guilty of an offence due to mental illness still may face the prospect of indefinite detention. There is no limit placed on length of time which a person may be detained after a special verdict is handed down, and since the individual ceases to be a forensic patient only if the Executive Council orders his or her unconditional release, or on the expiry of any conditions of release, it is therefore possible, in practice, that a person may be detained for a period longer than the maximum penalty for the offence for which he or she has been acquitted.¹⁶

Despite acquitees having been classed as NGMI (not guilty by virtue of mental illness), the very nature of the criminal justice system and interpretation of the Act supports an underlying concept of culpability - the need for a NGMI to serve some period of incarceration that represents a sentence at least similar to what they would have received under ‘normal’ circumstances.¹⁷

¹³ Mullen, P. (2001). A review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services. Criminology Research Council, p. 23.

¹⁴ NSW Mental Health Sentinel Events Review Committee (2003). Tracking Tragedy. First Report of the Committee (December 2003). NSW Health, Australia. Available: http://www.health.nsw.gov.au/pubs/t/serc_contents.html

¹⁵ Weatherburn, D., Matka, E. & Lind, B. (1996) Crime perception and reality: Public perception of the risk of criminal victimisation in Australia. Bureau of Crime Statistics & Research. (1996).

¹⁶ James, G. QC. (2007). Consultation Paper: Review of the forensic provisions of the *Mental Health Act 1990* and the *Mental Health (Criminal Procedure) Act 1990*. NSW Health, p. 38.

¹⁷ Personal opinion of the author.

In a study of 500 psychiatric patients in the United Kingdom, a lifetime prevalence of crime was rated at 4%, which is comparable to the population in general and applicable to Australia (Gunn, 1987).¹⁸ Whilst there is no inherent link between mental illness and crime, there is a strong causal link between mental illness and incarceration. Furthermore, there is extensive evidence that people with severe mental illness are more likely to be convicted of misdemeanours than their mentally healthy counterparts, and tend to be incarcerated for longer periods (Lamberti et al., 2001).¹⁹

A study in 1983 observed no relationship between mental illness and general crime, when controlled for age, race, socio-economic status and previous hospitalisation or imprisonment (Monahan, 1992).²⁰ Such demonstrative statistics imply the existence of another variable or variables that may have an association with both mental illness and imprisonment.

Similar scrutiny must also be applied to the notion that people with a mental illness are more violent than the general population. The Australian Institute of Criminology (1990) stated that, “violence and violent crime are commonly regarded by the public as the domain of the mentally ill.”²¹ Public misconception about the true nature of mental illness as distinct from personality disorder or behavioural disorder, frequently associate extreme violence with mental illness. The evidence base has long displayed greater scepticism.

Whilst a weak association between mental disorder and violent behaviour has been demonstrated, it is limited to people with mental illness not receiving treatment or who have a history of violence and/or abuse alcohol or drugs (Steadman et al., 1998, Swartz et al., 1998, Better Health Channel, 2005, Munetz et al., 2001). Research has noted this relationship may be mediated by a range of factors including: gender; socio-economic status; age and substance abuse.

Substance abuse in particular has been identified by many researchers as a powerful co-morbid factor. Monahan (1992) also noted that increased risk was evident only in the immediate presence of psychotic symptoms, thus eliminating the vast majority of people with mental disorder. For people with mental disorders, co-morbidity is common and individuals may have more than one disorder, exacerbated by a high prevalence of co-existing substance disorder which exists, depending on the population sample, in 30% to 80% of people with a mental illness in the community (NSW Health, 2000).

¹⁸ Cited in Henderson, A. S. (1988). An Introduction to Social Psychiatry. New York: Oxford Press, p.123.

¹⁹ Lamberti, J.S., Weisman, R.L., Schwarzkopf, S.B., Price, N., Ashton, R.M., Trompeter, J. (2001). The mentally ill in jails and prisons: towards an integrated model of prevention. *Psychiatric Quarterly*, 72 (1): pp. 63-77.

²⁰ Monahan, J. (1983). The prediction of violent behavior: Developments in psychology and law. Chapter in Scheirer, J.C., Hammonds, B. L. (Eds). Psychology and the law. Master lecture series, Vol. 2. (pp.151-176). Monahan, J. (1992) ‘Mental Disorder and violent behaviour: perceptions and evidence’, *American Psychologist*. 47 (4), pp. 511-521.

²¹ Australian Institute of Criminology (1990). Violence: Directions for Australia. In *Crime and Violence Prevention*. Canberra: Institute of Criminology, pp.74-76.

Socio-economic status can be clearly seen as impacting on the prevalence of mental illness. People who live in the most socio-economically disadvantaged circumstances (depending on age) are between 1½ and 3½ times more likely to have mental or behavioural problems as compared with people who live in the least socio-economically disadvantaged circumstances (ABS, 2001). Hence the high percentage of Indigenous people with a mental illness in the criminal justice system.

The 2001 National Health Survey did not include information on Indigenous mental health, due to concerns about the cultural appropriateness of the mental health-related questions in that survey. However, hospitalisation and mortality rates from intentional injury or self-harm (over twice as prevalent in the Indigenous community) may be indicative of mental illness and distress (ABS, AIHW, National Hospital Morbidity Database, 2003c).

According to the Australian Census (2004), NSW correctional and forensic facilities contained 8510 adults and 300 juveniles. This figure represented a snapshot of the annual throughput of approximately 18000 adults and 6000 juveniles.

Justice Health (NSW) reported in the same year that 78% of the male prison population and 90% of the female population presented at reception with a broad spectrum of mental disorders (Halpin et al., 2004). Whilst acknowledging that the figures are not directly comparable, it is noteworthy to mention that in state of Victoria (2003) the Department of Justice reported that 28% of inmates had a mental illness when they presented at reception.

This disparity one might suggest could be seen as a reflection of the more favourable access to appropriate community services in Victoria, and the establishment of a secure facility, the Thomas Embling Hospital in 2001. It is instructive also to consider the diversity of outcomes across Australia in association with state spending per capita and allocation of resources to the NGO sector, which average at 5.5% of the total national mental health expenditure. Over the last year, the NSW government has made a commitment to increase resources for non-government organisations which in 2005 were 2.4%, as compared to 9.6% in Victoria (AIHW, 2005).

Other influential factors

If there is no fundamental causality between mental illness and crime, and only a tenuous link between mental illness and violence, what other factors may explain the over-representation of people with a mental illness in the criminal justice system?

A study in the UK (Hodgins, 1993), was one of the first able to examine clinical associations between mental illness and crime. The research identified that people with a mental illness are at a higher-than-average risk of offending, not because of mental illness per se, but because of the higher-than-average prevalence of substance abuse in this population.²² In a 2001 study of people with a mental illness in prison, two thirds of their crimes were related to substance use, usually non-violent (Munetz et al., 2001).

Fragmentation of mental health services and the accompanying risk factors of mental illness – poverty, poor education, unemployment, poor social skills and family support lead the mentally ill to situations of high exposure to psychoactive substances (Drake & Mueser, 2000). These are the

²² Hodgins, S. (ed.) (1993). *Mental disorder and crime*. London, Sage.

people who are described as 'falling through the gaps,' - "the gaps are wide and the fall is hard," (NSW Health, 2000b). Such high exposure factors are reflected in the 2004 Census figures highlighting the level of socioeconomic disadvantage prior to incarceration (Justice Health, 2004).

On Census Night 2001, approximately 100,000 people were homeless, 14% were 'sleeping rough.' More than half (54%) of the homeless population were adults over 24 years of age, of the 46% under 24 years of age, 26% were between 12-18 years old. Less than half (42%) of homeless people were female. Single homeless people represented 58% of the numbers, while 19% were couples and 23% were homeless families.²³

Statistics on juvenile offenders in the Young People in Correction Health Survey (YCPiCHS, 2003) clearly identified some of problems leading to incarceration in addition to the prevalence of co-existing mental illness and substance abuse. This included a close relationship between child sexual abuse and physical violence, and the continuation of young people remaining homeless. Speaking at a National Congress on Homelessness (2003), David Tully of Adelaide Central Mission in South Australia referred to abuse as the primary factor causing young people to seek safety by leaving home.

Criminalisation of the mentally ill

In 2002, Justice Health NSW noted that within the prison population, "50% of males and 30% of females warrant mental health referral for major depression." Approximately 80% have been incarcerated for offences relating to drug and alcohol use. In an environment in which substance abuse so closely accompanies mental illness, a policy of zero tolerance with regards to drug crimes automatically leads to an increase in interactions with criminal justice system.

The combination of inadequate community mental health services, heightened legal imperatives and shrinking facilities for people with mental illness requiring acute care have resulted in an increased reliance on the police for crisis management and referral, regardless of the mental state of the individual. Police have become 'de facto' ambulances transferring people from one hospital to another. Frequently failing to secure a hospital admission the police must "do something", and "arrest by default," (Davis, 1992).

Unfortunately, the most appropriate treatment is usually unavailable within the criminal justice system. Effective treatment is one that emphasises recovery and appropriate support to facilitate integration back into the community. This is no less applicable to mentally ill inmates as forensic patients for whom goal is an unsuitable environment in which 'management' and 'medication' rather than 'recovery' and 'rehabilitation' are the main focus (NSW Mental Health Sentinel Events Review Committee, 2003).

In a review of the relationship between mental disorders and offending behaviours, and the management of mentally abnormal offenders in the health and criminal justice services, Mullen (2001) writes that "the correctional culture and physical realities of prisons are rarely conducive to therapy. Rigid routines, the pedantic enforcement of a plethora of minor rules, the denial of most

²³ Australian Census (2001). Analytic Program: Counting the Homeless, 2050.0.

of that which affirms our identity, add to the difficulties of managing vulnerable and disordered people,” (p.36).²⁴

Another probable cause of increased criminalisation of mentally ill persons may be as a result of closure of many ‘living skill’ and ‘drop in centres,’ limited access to appropriate coordinated community based services, absence of planning of discharge arrangements and the support crucial in avoiding lapse and relapse into crisis, and recidivism. Many, who would have benefited from treatment for their mental illness, received none prior to being imprisoned (Halpin et al., 2004).

Apart from high risk of interactions with the criminal justice system as a consequence of the relationship between mental illness and substance abuse, the additional likelihood of homelessness together with treatment non-adherence bring about the greatest challenges for intervention - due to the segmented nature of services, barriers to access, assessment and treatment and the implications of complex need on receptiveness to treatment.

The over-representation of people with a mental illness in the criminal justice system is demonstration of the extent to which the social environment gives rise to mental illness, highlighting the urgent need for legislative reform and implementation of collaborative practices that break the cycle of mental illness, substance abuse, poverty, unemployment, domestic violence and interactions with the criminal justice system. The importance of the non-government sector in providing services for early intervention, pre and post release programs cannot be too strongly emphasised. Non-government organisations are often less constrained by institutional and political influences, are more flexible and able to react swiftly to changing social conditions.

In order to fulfil our responsibilities as a humane society, it is critical to protect and preserve the human rights of people with mental illness as stated in the principles of the Australian National Mental Health Strategy: National Mental Health Plan 2003 – 2008, and the NSW guidelines and standards. These principles support a collaborative approach emphasising a recovery model of mental health service provision within the criminal justice system that removes itself from notions of culpability, and a need for detention and punishment in order to manage a perceived risk.

As identified in UN Resolution 46/119 to which Australia is a signatory, those rights are primarily embodied in Principle 1: Fundamental freedoms and basic rights .These principles are central to all our endeavours when addressing the needs of the mentally ill - a population group often the most vulnerable and marginalised in our society:

- *All persons have the right to the best available mental health care, which shall be part of the health and social care system.*
- *All persons with a mental illness shall be treated with humanity and respect for the inherent dignity of the human person.*

²⁴ Mullen, P. (2001). A review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services. Criminology Research Council, p. 23.

- *All persons with a mental illness have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.*
- *There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights.*

Authors' Notes

The Mental Health Coordinating Council (MHCC) is the state peak body for mental health non-government organisations in New South Wales, Australia. Providing leadership and representation to its membership, MHCC improves, promotes and develops quality mental health services to the community and facilitates effective linkages between government, non-government and private sectors. Participating extensively in public policy development, research and development, the organisation also provides educational opportunities through its registered training division, conferences, seminars, publications and other initiatives to the community.

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References.

- ABS. (1999). Australian Bureau of Statistics. *National Survey of Health and Wellbeing: Mental Health of Australian Adults*. (1998b).
- ABS. (2001). Australian Bureau of Statistics. *National Health Survey: Mental Health*.
- AIHW) Australian Institute of Health and Welfare (2002). *Australia's Health 2002*. Canberra: AIHW.
- Australian Institute of Health and Welfare (2003). *Australia's Welfare 2003*. (The Sixth Biennial Welfare Report of the Australian Institute of Health and Welfare). Canberra: AIHW.
- AIHW & ABS (2003). Australian Institute of Health & Welfare, Australian Bureau of Statistics. *National Hospital Morbidity Database*, 2002a, 2003c.
- AIHW. Australian Institute of Health and Welfare (2005). *Mental Health Expenditure and Priorities. Section: 6*. Available: <http://www.aihw.gov.au/publications/health/bdia/bdia-c06.pdf>

Australian Census Analytic Program: *Counting the Homeless, 2050.0.*

Australian Institute of Health & Welfare (AIHW). (2005). *Mental Health Expenditure & Priorities, Section 6.* Available: <http://www.aihw.gov.au/publications/health/bdia/bdia-c06.pdf>

Australian Institute of Criminology (1990). *Violence: Directions for Australia. in Crime and Violence Prevention.* Canberra: Institute of Criminology.

Better Health Channel. (2005). Available:

http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Mental_illness_and_violence_explained

Blood, R. W., Putnis, P., Payne, T., Purkis, J., Francis, C., McCallum, K., & Andrew, D. (2001). *The Media Monitoring Project: A Baseline Description of How the Australian Media Report and Portray Suicide and Mental Health and Illness: Case Studies.* School of Professional Communication, University of Canberra, & the Centre for Health Program Evaluation, University of Melbourne.

Bureau of Crime Statistics & Research. (1996).

Commonwealth of Australia. (2006). *The Senate Select Committee on Mental Health. (2006). A national approach to mental health - from crisis to community: First Report.*

Davis, S. (1992). *Assessing the 'criminalization' of the mentally ill in Canada.* Canadian Journal of Psychiatry, 37, October, 532-538.

Draine, J., Salzer, M., Culhane, D.P. & Hadley, T. R. (2002). *Role of social disadvantage in crime, joblessness, and homelessness among persons with a serious mental illness.* Psychiatric Services, 53, 5, 565-573.

Drake, R. E. & Mueser, K. T. (2000). *Psychosocial approaches to dual diagnosis.* Schizophrenia Bulletin, 26, 1, 105-118.

Gunn cited in Henderson, A. S. (1988). *An Introduction to Social Psychiatry.* New York: Oxford Press.

Halpin, R., Barling, J. & Levy, M. (2004). *Capturing Perceptions: 2004 NSW Inmate Access Survey.* Justice Health, NSW: Australia.

Henderson, A. S. (1988). *An Introduction to Social Psychiatry.* New York: Oxford Press.

Henderson, C. D. (2007). *Submission to the Consultation Paper: Forensic Provisions of the NSW Mental Health Act 1990 and Mental Health (Criminal Procedures) Act 1990.*

Henderson, S. (2003). *Mental illness and the Criminal Justice System.* Mental Health Coordinating Council.

Hodgins, S. (ed.) (1993). *Mental disorder and crime.* London, Sage.

Hodgins, S. (2002). *Research Priorities in Forensic Mental Health*. International Journal of Forensic Mental Health, 1, 1, 7 – 23.

Human Rights and Equal Opportunity Commission. (1993). *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*. AGPS, Canberra.

James, G. QC. (2007). *Consultation Paper: Review of the forensic provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990*. NSW Health.

Lamberti, J.S., Weisman, R.L., Schwarzkopf, S. B., Price, N., Ashton, R. M. & Trompeter, J. (2001). *The mentally ill in jails and prisons: towards an integrated model of prevention*. Psychiatric Quarterly, 72, 1, 63-77.

Mathers, C., Yos, T. & Stevenson, C. (1999). *The burden of disease and injury in Australia*. Australian Institute of Health and Welfare (AIHW): Canberra.

Mental Health Council of Australia. (2002). *Submission 262*.

Mental Health Council of Australia (2005). *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia*.

Monahan, J. (1983). *The prediction of violent behavior: Developments in psychology and law*. Chapter in James C. Scheirer, Barbara L. Hammonds (Eds). Psychology and the law. Master lecture series, 2, 151-176.

Mullen, P. (2001). *A review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services*. Criminology Research Council.

Munetz, M. R., Grande, T. P. & Chambers, M. R. (2001). *The incarceration of individuals with severe mental disorders*. Community Mental Health Journal, 37, 4, 361-371.

Northern Beaches Mental Health Consumer Network. (2002). *Submission 60*.

NSW Health. (2000). *The Management of People with co-existing Mental Health and Substance Use Disorder – Service Delivery Guidelines*. NSW Health Department: Australia.

NSW Mental Health Sentinel Events Review Committee (2003). *Tracking Tragedy*. First Report of the Committee (December 2003). NSW Health, Australia. Available: http://www.health.nsw.gov.au/pubs/t/serc_contents.html

Probation and Community Corrections Officers' Association Inc. (2002). *Submission 503*.

Steadman, H. J., Mulvey, E.P., Monahan, J., Robbins, P. C., Appelbaum, P. S., Grisso, T., Roth, L. H. & Silver, E.. (1998). *Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighbourhoods*. Archives of General Psychiatry, 55, 393-401.

Swartz, M. S., Swanson, J. A. W., Hiday, V. A., Borum, R., Wagner, H. R. & Burns, B. J. (1998). *Violence and severe mental illness: the effects of substance abuse and nonadherence to medication*. American Journal of Psychiatry, 155, 226-231.

Tully, D. (2003). *Childhood Sexual Assault and Homelessness*. Paper presented at the 3rd National Conference 'Beyond the Divide' convened by the Australian Federation of Homelessness Organisations. April, 2003.

Weatherburn, D., Matka, E. & Lind, B. (1996). *Crime perception and reality: Public perception of the risk of criminal victimisation in Australia*. Bureau of Crime Statistics & Research. (1996).

Whiteford, H. A., & Buckingham, W. J. (2005). *Ten years of mental health service reform in Australia: are we getting it right?* MJA 2005,182, 8, 396- 400.