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# Prisons: the psychiatric institution of last resort?

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**Accessible summary**

- Throughout recorded history, the mentally ill have been living at the fringes of society, frequently alienated, treated inhumanely, and made as scapegoats for the prevailing societal ills.
- Australia has seen the number of public psychiatric hospital beds fall from 30 000 in the early 1960's to 8000 as of 2006. The Australian population has more than doubled since this time, such phenomena is mirrored in the UK and the USA.
- As of June 2011, there were 28 964 individuals detained in Australian prisons, this represents a figure close to 70% higher than in comparison to the figure reported in 1996. However, Australia's population has only increased by just over 27% in this time period.
- Authors and researchers are claiming that a debilitated public psychiatric health-care system has resulted in large 'trans-migrations' of patients from psychiatric hospital beds to prisons and jails, via an intermediary period in their communities.

**Abstract**

The World Health Organization declared in 1948 that the enjoyment of the highest individual attainment of health for any person is a fundamental human right. Australia, the UK and the United States all legally ratified this declaration as becoming signatories to their founding treatise with the United Nations. Despite this, there are many conspicuous examples of inequities of public health as found within these nations. One of the more disparate and outrageous examples of inequities in public health has been an insidious trend towards criminalizing mental illness, and the largely unjust treatment of many mentally ill persons. This change has resulted in untold numbers of mentally ill persons being over-represented within the criminal justice system, experiencing higher morbidity, co-morbidity and mortality rates, and having difficulty in surviving in a society frequently dealing with their illness in a persecutory manner. Questions must be raised: that although over the passage of time medical science and technology has changed, but has western societies' attitudes to health equity kept pace?

## Introduction

This paper is a discourse of a cyclical phenomenon that has occurred in Australia, and many Western nations, over a period in excess of two centuries. Argument exists that our jails and prisons have returned to being the 'mental health warehouses', as they were in the 18th century (MacDonald *et al*. 2010). Therefore, we will now examine, explore and discuss the societal and demographic movements of many of our mentally ill, as they travel through governmental and non-governmental social systems, and what they may experience within their

communities, and the subsequent impact upon our society as a whole.

Throughout recorded history, the mentally ill have been living at the fringes of society, frequently alienated, treated inhumanely and made as scapegoats for the prevailing societal ills (Foucault 1964). The late 19th and early 20th centuries oversaw a growth in public enlightenment towards the mentally ill, which leads to the rise of the what we now recognize as the public psychiatric hospital, or as it was then colloquially known, the 'lunatic asylum' (Gilligan 2001). Arguably, these institutions only resulted in limited improvements for the treatment and management of mental illness in comparison to the jails and prisons that incarcerated and sheltered the mentally ill in the preceding centuries (Gilligan 2001, Arnold 2008).

Large psychiatric hospitals fell out of favour with the wider public conscience from the mid 20th century due to numerous reports and evidence of rampant squalor, scandals and frequent inhumane treatment (Gilligan 2001, Markowitz 2006). Successive governments in Western nations introduced new mental health legislation and policies, over many decades, which ultimately lead to the phenomenon known as 'deinstitutionalization' (Smark & Deo 2006). Deinstitutionalization of psychiatric care within Australia has seen the number of public psychiatric hospital beds fall from 30 000 in the early 1960s to 8000 as of 2006 (White & Whiteford 2006). The Australian population has more than doubled during this same period (White & Whiteford 2006). Due to an ever growing population and the decreasing bed numbers available for psychiatric care, argument is building that Australia's psychiatric healthcare system is critically overstressed, and has been for a long period (Watson *et al*. 2001, Smark & Deo 2006, White & Whiteford 2006). Resultantly, authors and researchers are now claiming that the outcome of a debilitated psychiatric healthcare system has seen, and is seeing large 'trans-migrations' of patients from psychiatric hospital beds to prisons and jails, via an intermediary period in their communities (Watson *et al*. 2001, Smark & Deo 2006).

Exceptional gravity was added to this matter by a United Nations (2008) report. This report cited Australia for not complying with its signatory obligations under the '*Convention Against Torture*' on many accounts. Alarmingly, this report from the Office of the High Commissioner for Human Rights (OHCHR) on our corrections system cited the lack of access to adequate primary health care, overcrowding, lack of community supports, poor cultural integration, over-representation of the mentally ill and their subsequent inhumane treatment as inmates within Australian jails and prisons (United Nations 2008). As of January 2011 the OHCHR reviewed the progress made by Australia, in the way it treats its prisoners (Human Rights Law Centre 2012). Importantly, the Government of Australia has agreed with 90% of the recommendations made by the OHCHR (Human Rights Law Centre 2012). However, due to the federal diversity of Australia's states and territories, and the diverse range of state and private 'for-profit' run prisons, uniform improvements have not, or have yet, been reported (Human Rights Law Centre 2012). Questions must be raised: although over the passage of time medical science and technology have changed, have Western societies' attitudes to health equity kept pace?

## The mentally ill populous in Australian prisons and jails

Gilligan (2001) highlights the important work of the US social reformer and activist Dorothea Dix. Dix was appalled in her work as a pioneering nurse, at the state of, care for and living conditions of the mentally ill in her nation's jails and prisons (Gilligan 2001). Dix's observations took place in the mid 19th century, and parallels are still being made of her observations today (Gilligan 2001). Such observations include the over-representation of the mentally ill within prisons, and their lack of adequate care (Smark & Deo 2006, White & Whiteford 2006). Such observations are not limited to the USA, but are also reported in the UK and Australia (Panzer *et al*. 2001, Fazel & Danesh 2002, White & Whiteford 2006). Although the estimated imprisoned population worldwide is 9 million, due to lack of accurate recording and global studies, particularly in non-Western nations, a precise number of imprisoned mentally ill individuals is not available (Fazel & Danesh 2002). However, as of June 2011, there were 28 964 individuals detained in Australian prisons; this represents a figure which is close to 70% higher in comparison to the figure reported in 1996 (16 800) (Federal Government of Australia 2011). However, the Australian population has only increased by just over 27% in this time period (Australian Bureau of Statistics 2011). Allowing for a correlated (27%) increase of prisoners, as a percentage paralleled with the rising population, it becomes difficult to explain the additional 43% increase in prisoner numbers. From this, questions must be asked as to what has changed in our society, so that we are now seeing many thousands more people being detained in prisons, in percentages that are beyond what can be explained by population growth.

White & Whiteford (2006) state that Australian prisoners suffer from various psychiatric illnesses, at a rate two to seven times higher than the wider community. Therefore, prisoners with mental illness are grossly over-represented in Australian prisons (White & Whiteford 2006). This phenomenon is not unique and has been observed in the USA

and the UK (Panzer *et al*. 2001, Watson *et al*. 2001, Fazel & Danesh 2002). Adding further validity to these claims, Queensland's Department of Corrective Services is predicting an estimated 90% increase in prisoner numbers over the next 10 years, and of those prisoners entering detention, some 80% will have a psychiatric illness (Butler *et al*. 2006). Such statistics are expected to be closely replicated in other states and territories (White & Whiteford 2006, Federal Government of Australia 2011). With statistics displaying mentally ill persons entering Australian prisons in significant numbers, this fact has been noticed by the United Nations OHCHR (United Nations 2008, Human Rights Law Centre 2012). This situation is an international embarrassment for a nation who is signatory to the United Nations conventions on human rights (Smark & Deo 2006, Human Rights Law Centre 2012).

In 1993 Australia's Federal Human Rights Commissioner reported on his national inquiry into the human rights of people with a mental illness (Burdekin 1993). This report ominously highlighted the 'startlingly high' number of Australian prisoners who had suffered mental illness during their lives (>80%) (Burdekin 1993, Smark & Deo 2006). Burdekin (1993) cited that one-eighth and one-fourth of male and female prisoners, respectively, were acutely suffering from severe forms of mental illness that would meet the criterion for hospital admission. Burdekin (1993) stated that prison conditions were detrimental for, and exacerbated mental illness. Such statistics have been available for successive state and federal governments, within Australia for many years (Burdekin 1993, Smark & Deo 2006, Federal Government of Australia 2011). However, there appears to be a continual state of inaction by successive governments, for at least the last 20 years to make effective steps towards improving this situation nationally (Human Rights Law Centre 2012).

Burdekin (1993) also highlighted that persons within our communities that suffered mental illness were more likely to go to jail, prisoners were frequently denied psychiatric treatment in jail and if they were given treatment it was drug therapy only. Counselling services and supportive therapies are rarely made available to Australian prisoners (Burdekin 1993, Smark & Deo 2006). Burdekin (1993) continued that when prisoners are prescribed medication, the medications often does not reach them, due to a thriving prescription drug trade in their environment. Burdekin (1993) also remarked on many individual cases of the neglect of mentally ill prisoners by corrections staff and government agencies in his report; unfortunately, this situation is still being reported by many authors, close to two decades later (Burdekin 1993, Smark & Deo 2006, White & Whiteford 2006, United Nations 2008, Federal Government of Australia 2011).

White & Whiteford (2006) argue that little has changed since the Burdekin (1993) report, or indeed the situation has become graver. This is illuminated by the mortality rate of ex-prisoners being 17 times higher than the wider community, in the first 2 weeks of their release from prison (Bink 2005, White & Whiteford 2006). Causative factors for such high mortality rates are correlated with drug and alcohol misuse (Bink 2005, White & Whiteford 2006). The misuse of drugs and alcohol is inseparable from mental health, and mortality rates may be interrelated with the pathological mental states of many Australian prisoners (Bink 2005, White & Whiteford 2006). Watson *et al*. (2001) stated that over 90% of prisoners with severe forms of mental illness such as schizophrenia, bipolar disorder and/or a major depressive disorder have had a lifetime history of drug and/or alcohol abuse. Over half of these prisoners also state being under the influence of a substance while committing the offence that lead to their incarceration (Watson *et al*. 2001). Despite the recognition of these statistics, very little has been done in tackling this ongoing human tragedy within our society (Bink 2005, White & Whiteford 2006). The absurdity of not addressing the issues of the poor state of mental health and substance abuse as found in Australian prisoners is that it costs the society an added burden in the recidivism of mentally ill offenders which stands in Australia at over 60% (Bink 2005, White & Whiteford 2006, Payne 2007).

## Rhetoric or reality: the process of deinstitutionalization

A primary question of modern public health is: whose job is it to ensure that we lead a healthy life (Anonymous 2007, Baum 2011, Keleher & MacDougall 2011, Nuffield Council on BioEthics 2012)? Libertarians inspired by Mill's 18th century essay on liberty would assert that it is wholly the individual's choice, and that the state must not interfere with an individual's free choice, liberty and freedom unless the individual was to bring harm onto others (Mills 1859, Anonymous 2007). However, this governmental style of non-intervention also includes when an individual or community may be at risk of poor health outcomes due to many factors, such as behaviours, environment, education, laws, rules, social structures, pre-existing illness and macro/microeconomics (Olson 2006, Nuffield Council on BioEthics 2012). At the other end of the spectrum from this individualist philosophy is the collectivist approach founded in social contract theory (Nuffield Council on BioEthics 2012). Here, the state may interject in any action, behaviour or choice of the individual based on the mandate of the will of the collective community (Nuffield Council on BioEthics

2012). Therefore, the rights of the individual are subject to the shared will of their fellow citizens in forming and benefiting the community, and not antecedent to it (Nuffield Council on BioEthics 2012).

However, in between these two poles falls the 'stewardship model of public health', a theory where a liberal state has both the responsibility to look after the needs, rights, freedoms and welfare of the individual, and the responsibility for the collective good (Olson 2006, Anonymous 2007, Nuffield Council on BioEthics 2012). The stewardship model is described as the most important function in public mental health care, as it provides the theoretical foundation on which the other applied aspects of input production, financing and service provision can operate (Olson 2006). Olson (2006) states that the responsibility of stewardship lies within the governments of nations, and that it requires vision, intelligence and influence in tackling health inequity among its citizens. Indeed, the World Travis *et al*. (2002) viewed stewardship as the effective trusteeship of national health. Stewardship is dynamic, and is always subject to competing social, political and economic agendas (Olson 2006, Nuffield Council on BioEthics 2012). However, if an effective balance is not struck between the competing societal elements, health inequities begin to become conspicuous, at the cost of the individual and nation as a whole (Saltman & Ferroussier 2000).

The process of reducing public psychiatric inpatient services, without increasing community services and supports, despite a doubling of population numbers over the same period, represents a definitive shift in governmental policy against the stewardship model of public health (Weber 1947, Scull 1984, Johnson 1990, Lamb & Weinberger 2005). Curiously however, this governmental reduction of mental health provisions for its society has largely been recognized as a positive outcome within the larger public psyche (Elder *et al*. 2010), as deinstitutionalization was theoretically modelled and presented upon sound ethical and moral libertarian arguments for providing the least restrictive care for mentally ill patients (Elder *et al*. 2010). So they may enjoy their civic and individual freedoms as any other member of their community; it was stated that care would be provided in non-custodial settings whenever possible (Elder *et al*. 2010). Theoretically, this was to have had a secondary effect of lessening dependency, hopelessness, learned helplessness and other maladaptive traits as frequently found in long-term custodial psychiatric inpatients (Stroman 2003). The deinstitutilization process began to occur from the early 1960s, and is the current trend in Western psychiatric policy (White & Whiteford 2006).

In Australia, deinstitulization did not take place uniformly due to the differing states and territories, which all have independent mental health legislation and policy (Smark & Deo 2006). However, as documented in the Richmond report of the New South Wales Government in 1983, it was evident that deinstitutilization had largely occurred before it became official policy (Richmond 1983, Smark & Deo 2006). Gilligan (2001) describes a more uniform legislative change within the USA from successive Eisenhower, and Kennedy administrations, which invoked and reshaped the US Community Mental Health Act. Subsequently, tens of thousands of people in the USA moved from psychiatric inpatient hospitals to community settings, at similar times as their Australian and UK counterparts (Gilligan 2001, Prince *et al*. 2007). Although the libertarian principles and moral arguments behind the deinstitutilization process were fundamentally sound, many voices are questioning the real motives behind governmental policy, and legislative change as not being consistent with a stewardship model (Parsons 1977, Scull 1984, Smark & Deo 2006, Prince *et al*. 2007, Nuffield Council on BioEthics 2012).

Further to this, there seems to be a schism as to what was promised to the public and patients, and as to what has actually occurred (Scull 1984, Gilligan 2001, Panzer *et al*. 2001, Watson *et al*. 2001, Smark & Deo 2006, White & Whiteford 2006, MacDonald *et al*. 2010). Smark & Deo (2006) argue that government policy revolves around programmes of performance (cost–benefit basis), and not for the overall assistance of the mentally ill in our society. Scull (1984) contends that governmental policy readily supported deinstitulization, not wholly from humanitarian motives, but from a cost-saving perspective, with an impetus towards economic rationalization and classical neoliberal economic theory.

Numerous authors are stating that if the governmental rhetoric of deinstitulization was motivated from the primacy of humanitarian philosophy, we would have seen extensive aftercare facilities within our communities, consistent with the stewardship principles of balancing individual and collective welfare alongside personal freedoms (Scull 1984, Gilligan 2001, Panzer *et al*. 2001, Watson *et al*. 2001, Olson 2006, Smark & Deo 2006, White & Whiteford 2006, MacDonald *et al*. 2010, Nuffield Council on BioEthics 2012). Rather, community care is often scant, or in some cases absent all together, a phenomenon noted in the USA, the UK and Australia (Scull 1984, Gilligan 2001, Panzer *et al*. 2001, Watson *et al*. 2001, Smark & Deo 2006, White & Whiteford 2006, MacDonald *et al*. 2010). The promises made of improving the lives for the majority of people with mental illness, through re-integration within their communities, on a basis of social supports have not been met by successive governments (Scull 1984, Gilligan 2001, Panzer *et al*. 2001, Watson

*et al*. 2001, Smark & Deo 2006, White & Whiteford 2006, MacDonald *et al*. 2010), leading many to argue a reality of governments having largely classical neoliberal economic motivations behind their humanitarian rhetoric (Scull 1984, Gilligan 2001, Panzer *et al*. 2001, Watson *et al*. 2001, Smark & Deo 2006, White & Whiteford 2006, MacDonald *et al*. 2010). Due to the social conditions now experienced by individuals with mental illness in our communities, Gilligan (2001) states that for a significant number of individuals deinstitutilization never actually occurred. Rather, a '*trans*-institutilization' has taken place; this process involves the eventual movement of patients from large, neglected and isolated state psychiatric hospitals to equally large, neglected, isolated and much more violent prisons (Steadman *et al*. 1989, Fuller 1990, Isaac & Armat 1990, Kupers 1999, Gilligan 2001, Butler *et al*. 2006, Smark & Deo 2006).

## Paths to prison: causative factors among the mentally ill within our communities

As early as the year 1939, Penrose displayed studies which observed an inverse relationship between prison and psychiatric hospital numbers in the nations of Europe (Penrose 1939, Markowitz 2006). A further study by Palermo *et al*. (1991) in the USA, some 52 years after Penrose's study, displayed markedly similar results (Palermo *et al*. 1991, Markowitz 2006). However, Markowitz (2006) describes public psychiatric hospital capacity as a historically important element of social control. Markowitz (2006) reports that the early 20th century view of reduced psychiatric hospital capacity would lead to those who were custodial inpatients entering their societies, behaving and presenting in a manner that threatened social order. Although such belief systems may seem archaic today, the principles of safety, tolerance, community services and adequate housing are as valid today, as they were before the deinstitutilization process took place (Markowitz 2006). Unfortunately, very little work has taken place during the proceeding decades to examine links between psychiatric hospital numbers, crime rates, arrest rates and prison numbers (Markowitz 2006). Importantly, the void of adequate numbers of studies, understanding and knowledge also includes the experiences of the mentally ill themselves within our communities, who are often the victims of crime due to increased vulnerability and adverse social conditions (Smark & Deo 2006, White & Whiteford 2006, MacDonald *et al*. 2010).

Smark & Deo (2006) describe anything but an integrated community care network for the mentally ill, within and between Australian communities.

The Richmond report (Richmond 1983) clearly identified the integration of community care as pivotal to allow people with mental illness to successfully live within their own communities. Yet, despite the passage of almost 30 years since the release of this report, this important goal has never been achieved (Smark & Deo 2006, White & Whiteford 2006). An integrated community care model should afford consistency: follow-up, maintenance and monitoring of patients' health status, which are all vital factors for successfully managing any complex medical issue (Elder *et al*. 2010).

Additionally, the bureaucratic nature of organizing public housing within Australia is especially difficult; Burdekin (1993) emphasized the multifarious process of the shuffling between commonwealth, state, housing and health departments. Frequently, the outcome of many departments being involved in the provision of shelter to the mentally ill is often that no one department wants to take responsibility for the provision of housing on a case-by-case basis, rather often arguing that it is the responsibility of others (Smark & Deo 2006). The bureaucratic process of organizing public housing may be navigable for someone who is mentally well, but may be extremely difficult for someone who has poor organizational and cognitive skills, as frequently seen as the symptoms of acute and chronic mental illness (Smark & Deo 2006, White & Whiteford 2006, Elder *et al*. 2010). Smark & Deo (2006) explain outcomes where many people with mental illness fall through the bureaucratic cracks, and into homelessness or marginal housing such as boarding houses. The issues of mental illness then become compounded by homelessness, particularly as the homeless population within Australia are often overlooked or ignored, all difficulties further multiplied by being a problematic cohort to pinpoint due to their transitory nature (Saint Vincent de Paul 1998, Smark & Deo 2006, Johnson & Chamberlain 2011).

Non-government organizations (NGOs) such as St Vincent de Paul, Sydney City Mission, Salvation Army, Wesley Mission and the Haymarket Foundation report that between 50% and 75% of people presenting to utilize hostel and shelter services had at least one form of mental illness (Saint Vincent de Paul 1998, Smark & Deo 2006, Johnson & Chamberlain 2011). Disturbingly, studies by these NGOs show that prior to people utilizing their homeless services, 58% had been physically assaulted, 55% had witnessed someone being seriously injured or killed, 68% of women report as being indecently assaulted and 50% raped (Saint Vincent de Paul 1998, Smark & Deo 2006, Johnson & Chamberlain 2011). Furthermore, Gilligan (2001) states that most imprisoned offenders of violent crime in our society have at an earlier point in their lives been a victim themselves of behavioural violence (physical

assault, sexual abuse, life-threatening neglect) and/or structural violence (poverty, racial discrimination). Such experience has been connected to the development of personality disorders, post-traumatic stress disorder and other forms of mental illness (Gilligan 2001, Markowitz 2006). Therefore, it is possible to see a sadly uninterrupted life cycle of violence, mental disorder and criminal offending (Gilligan 2001, Markowitz 2006).

Shelters for the homeless are not designed for, and/or capable of being treatment centres for people with a mental illness (Markowitz 2006, Smark & Deo 2006). Compounding this issue is that mentally ill homeless persons also have the extremely stressful continual burden of finding safe abode for each day, such acute stress exacerbates the symptoms of all forms of mental illness (Markowitz 2006, Smark & Deo 2006). Homeless mentally ill persons often find hostels inappropriate for their needs, or worse, are not welcome due to untrained staff not being able to cope with or understand the symptoms and behaviours as relatable to their illness (Gilligan 2001, Markowitz 2006, Smark & Deo 2006, Johnson & Chamberlain 2011). Although not ideal, homeless shelters are far better alternatives than sleeping on the streets (Smark & Deo 2006, Johnson & Chamberlain 2011). Therefore, the current situation of Australia's mentally ill and homeless shuffling from shelter to shelter, and street to street often results in a lack of any form of medical treatment, which dramatically increases rates of morbidity and mortality (Smark & Deo 2006, Johnson & Chamberlain 2011).

With a lack of adequate community resources and readily accessible housing, the police are all too frequently being seen as the referral source for persons with mental illness (Markowitz 2006, Prince *et al*. 2007). Intrinsically, the police are often placed in a situation of responding to disturbing, odd and/or socially inappropriate behaviour from individuals with mental illness (Markowitz 2006, Prince *et al*. 2007). As the police are not medically trained professionals, they will often view such behaviours through the lens of their role as law enforcers (Markowitz 2006, Prince *et al*. 2007). Consequently, the mentally ill individuals' actions and behaviours will often be criminalized, or even if they are recognized as symptoms of mental illness, the police may have limited options but to use 'mercy bookings' to enact a custodial setting to ensure mental health treatment (Teplin 1984, Markowitz 2006, Wallace *et al*. 2006, Prince *et al*. 2007). This has resulted in using police officers as one of the primary means of referral to mental health, leading to many authors on this topic now arguing that mental illness in our society has now been criminalized (Teplin 1984, Markowitz 2006, Prince *et al*. 2007). In support of this criticism, Teplin's (1984) study examined police–citizen encounters, and then demonstrated that mentally ill individuals were 20% more likely to be arrested than their civic counterparts. Teplin's (1984) study results have been closely replicated in successive following contemporary studies (Silver 2000, Markowitz 2006, Prince *et al*. 2007). Again, it should be noted that untreated individuals with acute and/or severe forms of mental illness might be highly vulnerable to crime, or committing a criminal offence (Watson *et al*. 2001, Markowitz 2006). One example of this may include someone experiencing an acute psychotic episode that may misperceive the actions or behaviours of others, which may make them a recipient or offender of aggression and violence (Watson *et al*. 2001, Markowitz 2006). Such issues combined with socio-economic status, substance abuse and homelessness can generate community disorder, increase fear and reduce social cohesion which all leads to more aggressive policing of the most vulnerable in our communities (Watson *et al*. 2001, Markowitz 2006).

Studies conducted in Scandinavia, New Zealand, Australia, the UK and the USA estimate that an individual with psychosis is two to eight times more likely to commit a violent offence than the general population (Fazel & Grann 2006). Paradoxically, mentally ill individuals who were receiving treatment were found to pose no additional risk to their communities, compared with their 'mentally well' civic counterparts (Fazel & Grann 2006). Inclusive of this, Wallace *et al*. (2006) found that Australian prisoners with schizophrenia had two to seven times more criminal convictions than prisoners without schizophrenia.

## An environmental context: social systems and characteristics

Gilligan (2001) argues that in modern Western culture relatively few people care about the needs of the mentally ill; otherwise, the public psychiatric systems would not have deteriorated the way it has, despite the ever increasing pressure from a growing populous. Gilligan (2001) continues that analogous to this is the prison system, as very few people in society truly care about the rehabilitation of criminals; however, this neglect is multiplied when an individual is labelled both as a criminal and as mentally ill.

MacDonald *et al*. (2010) argue that the first steps to addressing this issue within Australian society is for health professionals to become aware, and then commence lobbying for change and public awareness. Federal and state governments in Australia need to drastically improve their practices of capturing accurate and comprehensive data from healthcare providers, hospitals, police, corrections and lastly from the mentally ill themselves (Smark & Deo

2006, Wallace *et al*. 2006, White & Whiteford 2006). Without this, it is impossible to correctly ascertain the prevalence and social consequence of mental illness within Australian communities (Smark & Deo 2006, Wallace *et al*. 2006, White & Whiteford 2006).

It may be suggested that Australian health and law policy makers take note of the Swedish government, who has kept an accurate combined national database of their citizens' health records and criminal convictions for over 25 years (Fazel & Danesh 2002). Such databases afford accurate statistical analysis of the relationship between mental illness, crime and other epidemiological data (Fazel & Danesh 2002). However, it must be mentioned that such data collection is not utilized for further stigmatizing, labelling, disenfranchising, marginalizing and/or discriminating against persons and/or populations (Fazel & Grann 2006). Rather, such data are utilized for breaking life cycles of disadvantage, reducing the individual and social impact of mental illness, increasing social cohesion and safety for all. Critically, Smark & Deo (2006) highlight that the dynamics of psychosocial health can be very difficult to quantify; however, we are largely aware that societal health decisions should not be made solely as accounting decisions, yet this seems to be the way in which Western cultures are predominantly governed. Smark & Deo (2006) continue that the financial bottom line within Australian health programmes has achieved such dominancy that other concerns within health policy equations seem to become lost. Although accountancy is a critically useful tool, it also can be used for political ends by further enforcing one version of reality while obfuscating another. Extending the argument of Smark & Deo (2006), Johnson (1990) states that historically it has been extremely fortunate that the true societal cost for caring for the mentally ill is hidden, because that fact obscures many of the problematic issues within our society.

Unfortunately, responsibility for the mentally ill seems to be diffuse, as is accountability for policy decisions made (Richmond 1983, Scull 1984, Johnson 1990, Burdekin 1993, Smark & Deo 2006, White & Whiteford 2006). And nowhere is this fact more evident than when trying to delve beneath the vagaries as to the whereabouts of the mentally ill in their communities, inclusive of the costs in maintaining the abstruse social systems that support this phenomenon (Smark & Deo 2006). However, the fog of obscurity as to the whereabouts and living conditions of significant numbers of our mentally ill may be lifting, as we are now seeing our prison numbers swelling (Lamb & Weinberger 2005, Federal Government of Australia 2011). This highlights Scull (1984) and Weber's (1947) theories of the paradoxical dichotomy of governmental decisions made between humanist and rationalist motivations. This paradoxical dichotomy has led some authors to suggest governmental agenda of merely being satisfied with the mentally ill living 'somewhere' within the community, or better yet in someone else's community, and on someone else's entitlement rolls (Johnson 1990, Smark & Deo 2006).

Gran & Henry (2007) expressed concern for the welfare for the large numbers of mentally ill Australian prisoners, in relation to the growing phenomenon of the privatization of many prisons in which they are detained. Numerous Australian prisons are now being run by private companies, on a 'for-profit' basis, which reflects a wider societal belief that private entities can operate community services as effectively as the state (Gran & Henry 2007). Therefore, detention, punishment, rehabilitation and public safety are now being viewed through a purely economic prism, explained both as a money-making exercise for private companies and as a cost saving for several state governments (Gran & Henry 2007).

Of grave concern for many is that the very nature of private companies is to survive to generate maximum possible profits for their stake holders, a paradigm that does not equate easily into the provision of human services for the disadvantaged, marginalized and disenfranchised (Gran & Henry 2007).

The business model of making a profit upon the numbers of those detained in prisons may raise scepticism in some (Gran & Henry 2007). Many humanitarian authors and interest groups have been alarmed at the awarding of government corrections contracts to multinational private corporations, some of whom have had (at best) questionable human rights records in their national and/or global operations (Gran & Henry 2007, Coroner WA 2009, English *et al*. 2010). These corporations are now at the helm of many of Australia's prisons (Gran & Henry 2007, Coroner WA 2009, English *et al*. 2010). Unfortunately, it is beyond the scope of this paper to explore this further.

## Recommendations and conclusion

This paper has been more than just a discussion on the competing motivations of economic rationalism and humanitarian policies. This paper has also explored the insidious and corrosive effects to our society which occur when an adequate balance is not struck between responsible fiscal management and governmental spending on community health (Smark & Deo 2006). When viewing the mentally ill solely through statistics or monetary value, we fail to grasp the true nature of the issues which face our communities and ultimately us all (Smark & Deo 2006). However, this paper has not been a criticism about the

Australian courts and the wider legal system, as it does what it can for mentally ill offenders within the current confines of its own definitions and boundaries (MacDonald *et al*. 2010). It is not within the expertise of legal professionals to determine the clinical needs and best community placements for the mentally ill (MacDonald *et al*. 2010). MacDonald *et al*. (2010) argue that if we accept the premise that mental illness should be treated, the only question left is where it should be treated: in the community, in prisons or both. Yet, society can no longer view the mentally ill enmeshed within the criminal justice system as separate from the mentally ill in our communities, as they are one in the same, and not an unconnected populous (Watson *et al*. 2001).

Legislators, policy makers and health directors must start taking greater roles of responsibility for the welfare of those whom wider society has effectively alienated, with the double stigma of being mentally ill and criminal (Gilligan 2001). This destructive trend is unfortunately seeing the diversion of many persons with mental illness into prisons and jails where their psychopathology will most likely often be undertreated and/or poorly managed, a situation not entirely dissimilar to what was observed by Dorothea Dix two centuries earlier (Gilligan 2001, Markowitz 2006).

Foucault (1964) argued that the broader European society of the 17th and 18th centuries viewed the mentally ill as having made a conscious choice of grave moral error to become 'mad'. However, the mitigating circumstances for the societal injustice, punishment and cruelty experienced by the mentally ill during these centuries may be partially explained by the times inferior medical knowledge and scientific understanding (Foucault 1964). In an age of medical and scientific enlightenment, what excuse does our society have in observing the mentally ill entering institutions of punishment, experiencing injustice and cruelty as resultant from neglect within their communities (Foucault 1977, Teplin 1984, Panzer *et al*. 2001, Lamb & Weinberger 2005)? However, society continues with the attachment of the same millennia old label of deviance to the mentally ill, a label that endures to be as effectively fatal on a social level as it was in antiquity (Foucault 1964, Foucault 1977, Scull 1984).

Upon recognizing the increased demands for community care resultant from the process of deinstitutilization, Watson *et al*. (2001) reason that mentally ill individuals within our communities have multiple service needs. Community care needs must be addressed towards taking steps to building a more cohesive, safe, just and inclusive society for all (Watson *et al*. 2001). The current circumstance for many mentally ill individuals is that adequate community care is not being provided (Watson *et al*. 2001, Butler *et al*. 2006, MacDonald *et al*. 2010). This may occur for many reasons, inclusive of the aspects of their illness, lack of community resources, poorly integrated services and poor coordination of care (Richmond 1983, Burdekin 1993, Watson *et al*. 2001, White & Whiteford 2006).

Whatever the reason, we can see that the community care model in its current form has ultimately failed the mentally ill who are detained in our nations prisons (Smark & Deo 2006, White & Whiteford 2006, Federal Government of Australia 2011). As in centuries past, many now argue that prisons have reluctantly returned to being the mental health institutions of last resort (Foucault 1964, Foucault 1977, Isaac & Armat 1990, Kupers 1999, Gilligan 2001, Bink 2005, Lamb & Weinberger 2005, Butler *et al*. 2006). However, prisons now have, at minimum, an obligation to meet the basic medical needs of the mentally ill whom they detain (Watson *et al*. 2001). Such basic needs are inclusive of psychiatric and social services. Failure to provide services at an acceptable standard to the imprisoned mentally ill equates to state-mandated torture (Foucault 1977, Watson *et al*. 2001, United Nations 2008).

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