Rapid review report for the Australian National Mental Health Commission

STIGMA AND DISCRIMINATION EXPERIENCES AMONGST THOSE WITH MENTAL ILLNESS IN CONTACT WITH THE CRIMINAL JUSTICE SYSTEM

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Executive Summary

Those with a lived experience of mental illness are known to suffer from the effects of stigma and discrimination, as are those who come into contact with the Criminal Justice System (CJS). Rates of mental illness are high amongst those in contact with the CJS and thus the potential exists for a compounding of stigma and discrimination for those with both mental illness and contact with the CJS. The following rapid review considers the extent to which the current literature has explored this issue, including in relation to social/self-stigma and structural stigma/discrimination. The review also considers the issues for a number of especially vulnerable and disadvantaged subgroups amongst those with mental illness and CJS contact experience. Finally, the review considers CJS contact not only in the context of alleged perpetration of offences but in the context of victimisation, the rate of which is elevated amongst those with mental illness.

On the basis of the review, a number of recommendations for possible further investigation and action are noted, in order that the problem be better understood and so that opportunities to reduce stigma and discrimination amongst those with mental illness and CJS contact experience are taken. Overall, the research evidence in this area has many gaps, including with regard to whether there might be potential differences across settings and jurisdictions, and whether different approaches yield different impacts on stigma/discrimination.

Section 1: Mental illness and the criminal justice system: an overview

It has long been recognised that individuals involved in the Criminal Justice System (CJS) suffer a disproportionate burden of mental ill health in comparison with those in the general population. Systematic reviews of the prevalence of mental illness in prisons worldwide (Fazel & Seewald, 2012; Prins, 2014; Sirdifield et al; 2009) demonstrate that rates are significantly higher than in the community, and this is also the case in Australia (Butler et al., 2006). In the most recent report into the health of Australia's prisoners (Australian Institute of Health and Welfare, 2019), 40% of prison entrants reported ever being told by a health professional that they had a mental health condition, including alcohol and other drug use; nearly double the self-reported rate of lifetime mental and behavioural conditions in the general population (20.1%; ABS, 2018). Nearly one quarter (23%) of prison entrants in the AIHW study reported currently taking medication for a mental health condition.

Amongst offending populations, those with a diagnosed mental illness also have higher rates of conviction and incarceration than those without (Fazel, Wolff, et al., 2014; Stewart et al, 2020; Wallace et al, 2004), as well as higher rates of subsequent overall recidivism and reincarceration (Cloyes et al. 2010; Stewart & Wilton, 2014). While the research is clear that those with mental illness are more likely to come into contact with the CJS than those without, the reasons for this are more complex.

While the majority of those with mental illness do not offend, there is evidence that, as a group, people with mental illness have a greater risk of CJS contact than those without mental illness. Having any psychiatric diagnosis is associated with contact in relation to violent and non-violent offences, even when controlling for key sociodemographic and criminological factors (Chang et al., 2015; Stevens et al, 2015), although the strength of associations varies to some extent by diagnostic group and the presence of co-morbid substance use problems are consistently found to be an important explanatory factor. Psychosis specifically has been found to be associated with risk of CJS contact in relation to any type of criminal offence (Yee et al., 2020), as well as violent offending specifically (Fazel et al., 2009), with a further increase in risk of violence for those with untreated illness (Fazel, Zetterqvist, et al., 2014; Witt et al., 2013). Those released from prison with a diagnosis of mental illness are also significantly more like to have repeated CJS contact, particularly if their illness is severe (Bales et al., 2017).

As well as having a direct association with offending, mental illness is also well known to be associated with several indicators of disadvantage that may increase the risk of coming into contact with the CJS, such as homelessness, unemployment, low levels of education, financial instability and substance use problems (Draine et al., 2002). Some have argued that those with mental illness are becoming increasingly 'criminalised' (Baldry & Russell, 2017; Dvoskin et al., 2020); the lack of adequate mental health services in the community can mean that frontline services such as the police and other emergency services are increasingly required to respond to incidents involving mental health crises. This brings individuals who would otherwise have been assessed and treated within the health system into contact with the CJS. Those unable to get a bed in a mental health facility may face a revolving door of police cells and incarceration.

The trend towards deinstitutionalisation of those with mental illness worldwide, and the inadequate funding of alternative community-based mental health services, is often cited as the catalyst for possible increases in the rates of mental illness in custody - as mental health beds decrease, it is posited, the number of people with mental illness being imprisoned increases (Etter et al., 2008; Penrose, 1939). Despite the popularity of this hypothesis, analyses of the association between the number of psychiatric beds and rates of incarceration in several countries have not provided support for the notion that a decrease in psychiatric beds consistently leads to an increase in incarceration rates (Bluml et al., 2015; Large & Nielssen, 2009). A meta-analysis of rates of mental illness in prisons internationally found no statistically significant increase in rates of psychosis or major depression in prisons between a 2002 review (Fazel & Danesh, 2002) and 2012 review (Fazel & Seewald, 2012). However, a recent study of the prevalence of self-reported mental illness in NSW prisons over time (Browne et al., in preparation) has demonstrated significant increases in the prevalence of self-reported diagnoses of any mental health problem, of serious mental illness (schizophrenia, psychotic illness or bipolar disorder), and of the rate of those reporting more than one mental health diagnosis, between 2001 and 2015. Those in prison reporting any lifetime psychiatric diagnosis increased from 39.1% in 2001 to 63.1% in 2015; the national rate of self-reported lifetime mental or behavioural diagnosis reported by the Australian Bureau of Statistics also increased during this period, however less steeply (9.6% in 2001 to 17.5% in 2014-2015).

Individuals with mental illness who are in contact with the CJS are a highly disadvantaged and often neglected group in terms of research, service provision and policy (Dean et al., 2013). The next section will examine the stigma and discrimination experienced by these individuals and the impact on health and criminal justice outcomes.

Section 2: Stigma and discrimination experienced by individuals with mental illness in contact with the criminal justice system

The experience of stigma and discrimination is common amongst those with mental illness. An Australian national survey of psychotic illness conducted in 2010 (Morgan et al., 2011) found that 37.9% of participants reported experiencing stigma or discrimination in the past year as a result of their mental illness. 20.3% reported that actual stigma or discrimination had prevented them from doing some of the things that they had wanted to do, and 22.7% reported that the fear of facing stigma or discrimination had stopped them from doing some of the things that they had wanted to do. Research shows that perceived stigma amongst those with mental ill health results in poorer health outcomes, delaying help-seeking and leading to poor health service utilisation and treatment adherence (Carrara et al., 2018, Clement et al., 2015, Corrigan et al., 2014).

Stigma and discrimination is also experienced by those involved in the criminal justice system. Apart from the obvious stigma associated with criminal justice contact, and incarceration in particular, those within this group are typically also members of several other social groups which suffer discrimination, including those with drug and alcohol problems, those of lower socio-economic status, ethnically diverse communities and those with mental ill health; hence they often present with 'multiple stigmatised identities' (LeBel et al., 2012; West et al., 2014). In criminal justice samples, perceived and anticipated stigma is high (Moore et al., 2013), and this leads to poorer community adjustment, social withdrawal and poor mental health post-release from prison (Moore et al, 2016; Moore & Tangney, 2017). Individuals in this group are also likely to perceive unfair treatment and discrimination as a result of having a criminal record, which is in turn associated with psychological distress (Turney et al., 2013).

There is clear overlap between stereotypes about those in contact with the justice system and those with mental illness. An Australian national survey of mental health literacy and stigma (Reavley & Jorm, 2011) found that schizophrenia was associated with perceptions of dangerousness and unpredictability, in line with extensive research around perceptions of serious mental illness (Jorm et al., 2012). Evidence suggests that stigma and discrimination experienced by those with a mental illness is further compounded by involvement with the

criminal justice system – 'criminality self-stigma' has been found to magnify the effects of mental illness self-stigma on self-esteem and depression (West et al., 2015).

In a survey of forensic mental health patients undertaken in NSW (Justice Health and Forensic Mental Health Network, 2017), more than a third (35.8%) of those surveyed reported that they had experienced stigma in the twelve months prior to entering custody or hospital. An even higher proportion (44%) reported fear of future stigma due to their mental illness or unlawful act. Those with both a history of criminal justice contact and mental illness are a particularly disadvantaged group who suffer the "double stigma" of being both "mad" and "bad" (Mezey et al., 2010). This leads to poorer outcomes not only in comparison to the general population, but also in comparison to those with mental illness or criminal justice contact alone. This section covers the various forms of stigma and discrimination experienced by this group; all of which intersect and influence each other.

2.1 Social and self-stigma

People with a criminal justice history and mental health problems experience a high level of social stigma and qualitative studies have elicited rich accounts of the experience of people within this group (Livingston et al., 2011; Mezey et al., 2016; Williams et al., 2011). Commonly experienced is the negative impact of stigma on interpersonal relationships; both in terms of the difficulties of forming and maintaining these relationships (participants described feelings of being avoided, shunned or excluded, or feeling the need to hide their mental health problems from others), as well as the impact on their existing relationships (for example, stigma being, by extension, experienced by their families and partners). More broadly, individuals described feeling like 'outcasts', and dehumanised by virtue of being seen as a 'diagnosis' rather than a person. Stigma and discrimination is perceived by many in this group as a major barrier to their recovery.

Public perceptions, opinions and attitudes are largely shaped by the media and popular culture. Research shows that representations of mental illness in television programs and film are often negative and perpetuate the idea that people with mental illness are dangerous or aggressive (Pirkis et al., 2006; Riles et al., 2021). Covey (2009) argues that the notion of 'criminal madness' so often propagated in the popular media can influence the way that people with mental illness are treated, including within a justice system that responds to public concern over the perceived dangerousness of this group.

The news media also contributes to popular perceptions of mental illness. Kesic et al.'s (2012) examination of media items in major newspapers across Australia found that people with mental illness were stigmatised in a third of the items reviewed, with common themes emerging around the dangerousness of this group and the threat that they pose to the public. Frequent references were also made regarding a 'failing' mental health system or system in crisis, ill-equipped to manage the risk potentially posed by patients but with little focus on the broader social context, on the under-resourcing of the mental health sector or current approaches to policing. The sensationalised media coverage of incidents involving those with mental health difficulties further reinforces the public perception of the dangerousness and unpredictability of this group and may lead to the impression that such incidents are a frequent occurrence, when in fact they are rare.

Self-stigma, or internalised stigma, occurs when a person internalises negative stereotypes about themselves or a group to which they belong; believing the stereotypes to be true and resulting in self-prejudice and self-discrimination (Corrigan & Rao, 2012). Self-stigma is common among those with mental illness, with high levels of internalised stigma being associated with lower levels of hope, empowerment, self-esteem, self-efficacy, and quality of life (Livingston & Boyd, 2010). While little research has focussed on the impact of multiple stigmatised identities, self-stigma around criminality has been found to magnify the effects of mental illness self-stigma in terms of self-esteem and depression in a forensic sample, indicating that overlapping self-stigmas can lead to worse outcomes than individual stigmatised identities (West et al., 2015).

2.2 Structural stigma and discrimination

Structural stigma has been defined as the 'societal-level conditions, cultural norms, and institutional practices that constrain the opportunities and wellbeing for stigmatised populations' (Hatzenbuehler & Link, 2014, p.2). Inequity and injustice for those with mental illness is so widespread and normalised within society that '…stigma is no longer dependent on individual action; instead, disadvantage and exclusion are routinely perpetrated by institutional systems.' (Livingston, 2013, p.9).

Structural stigma in regard to people with mental illness who are involved in the criminal justice system exists on various levels: within the criminal justice system itself, differences and inequalities exist in terms of how people with mental illness are policed, dealt with by the courts, and managed within custodial and community correctional settings. Beyond the criminal justice system, these individuals continue to be impacted by stigma and other barriers to accessing housing, employment, and health care. It must be noted that there are difficulties in unpicking the contribution of structural stigma versus other confounding factors related to criminality in terms of health and criminal justice outcomes and more research is needed in this area (Pugh et al., 2015), however there is ample evidence that those with mental illness and criminal justice histories are regularly subject to systematic disadvantage, as outlined in the following sections.

2.1.2 Policing

The process of deinstitutionalisation and lack of adequate supports for those with mental illness in the community has been argued to have increased the burden on police to act as 'first responders' to people in mental health crises (Morgan, 2021). Contact between police and those with mental illness in Australia is common, often unplanned and time consuming (Short et al., 2014). Police are heavily relied on for mental health transfers between services and frequently report difficulties in securing adequate mental health services and support for those with mental illness that they come into contact with (Godfredson et al., 2011; Short et al., 2014). Ogloff, Thomas et al. (2013) argue that 'mentally ill detainees present with a number of needs that often exceed the resources afforded to deal with them. Very often the

police are forced to employ creative ad-hoc options to resolve encounters with mentally ill people that they would not use if mental health resources were more forthcoming' (p. 65). In one Australian study, police officers described their understanding of mental illness, and their responses to those with mental illness, as being largely derived from their personal experiences and 'on the job' training by more experienced officers, rather than by any formal training provided by their employer (Godfredson et al., 2011).

The often problematic nature of this contact is reflected in the research around police use of force. In a study of police incidents of non-fatal uses of force in Victoria between 1995 and 2008 (Kesic et al., 2013), people with mental illness were more likely to use, or threaten or use, weapons on the police than those without mental illness; they were also more likely to have weapons used or be threatened with the use of weapons by the police. An examination of fatal use of force by police officers in the same state (Kesic et al., 2010) found that between 1982 and 2007 there were 48 incidents involving fatal shootings by police. Of those who died, more than half of the sample (54.2%) had an Axis 1 psychiatric disorder; the rate of those diagnosed with psychotic disorders/schizophrenia was highly disproportionate to the rate of the disorders in the community.

People with mental illness are also overrepresented among those detained by police in Australia. In one study of 150 police cell detainees in Victoria (Baksheev et al., 2010), approximately three-quarters (76%) of the sample met the criteria for at least one psychiatric disorder. Another study of 614 Victorian detainees (Ogloff et al., 2011) found that over half had a history of contact with the public mental health system and a third exhibited psychiatric symptoms whilst in police custody.

The availability and nature of mental health training for police officers varies greatly between Australian jurisdictions and a description of same is beyond the scope of this report. There is some evidence for the effectiveness of mental health training (as part of a Mental Health Intervention Team model) in increasing the confidence of police officers when dealing with those with mental illness (Herrington & Pope, 2014) and preliminary evidence to support the effectiveness of the PACER (Police Ambulance Crisis Emergency Response) model in Australia which sees a joint police and mental health response to crises (Evangelista et al, 2015; Huppert & Griffiths, 2015; Lee et al., 2015). The implementation of such programs is a step in

the right direction, however it is clear that more is needed to improve the processes by which those with mental illness are managed in their initial contacts with the justice system.

2.1.3 Legal Processes

In certain cases, mental or cognitive impairment may be considered relevant to court proceedings. In such circumstances, much of the law that guides Australian courts (and elsewhere) actually derives from the English law that applied in the 1843 acquittal of M'Naghten (Goldstein & Rotter, 1988; McSherry, 1999). Nowadays, a range of special considerations, provisions, and sentences can be made for those with mental or cognitive impairment who are processed through Australian courts, although such developments have not succeeded in substantially addressing the problem of individuals with mental illness or cognitive impairment being over-represented in the CJS, including in prisons (NSW Law Reform Commission, 2010).

While the specific legislative provisions and case law implications may differ, many legal principals are held in common across Australian jurisdictions and beyond. Mental illness and cognitive impairment may be considered relevant to legal proceedings throughout the pathway an accused individual traverses within the criminal justice and legal systems. In NSW courts, for example, consideration of mental and cognitive impairment is provided for by the Mental Health and Cognitive Impairment Forensic Provisions Act 2020 (the New Act), effective as of March 27th, 2021, and replacing the Mental Health (Forensic Provisions) Act 1990 (the Old Act). The New Act, like the Old, provides for the application for diversion, a defence of mental or cognitive impairment, as well as special procedures, such as special hearings for unfitness and verdicts. The structure of legislation regarding mental and cognitive impairment vis-à-vis court proceedings is similar across other Australian jurisdictions. In Victoria, for example, issues of cognitive and mental impairment in an accused are codified in the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997.

It is also important to note that questions surrounding mental or cognitive impairment may be relevant to some parts of a case but not others. Furthermore, questions of mental or cognitive impairment in an accused may not, of themselves, necessitate any particular

variations in court proceedings. For example, common law principles, such as the notion of the open court, will tend not to vary simply because of questions of mental or cognitive impairment in an accused.

Treatment of mental illness in legal proceedings - unfitness

Where a judicial officer accepts that there are questions surrounding mental or cognitive impairment for an accused, an often-complex set of procedures ensues. One of the key considerations is often whether or not an individual is mentally *fit to be tried*, an issue which is variously dealt with across jurisdictions. In some international settings, a finding of likely ongoing unfitness, in the context of it being determined that the accused committed the relevant act, can result simply in a healthcare disposal. In many Australian jurisdictions, including in NSW, the situation is quite different and thought by many to be wholly unsatisfactory and discriminatory, with longer periods of custodial detention resulting than if the individual had been fit (i.e. involving the imposition of 'limiting terms'). Given the disadvantages inherent in being found unfit to be tried due to mental illness and/or cognitive impairment, there is a need to ensure that those identified as unfit are given every opportunity to have their fitness restored/supported so that they may not only benefit from improved health and wellbeing but also that they are able to effectively participate in their own defence. In many circumstances, the opposite situation arises in which individuals found unfit are left for potentially indefinite periods in custodial settings with very limited access to mental health support.

Treatment of mental illness in legal proceedings - defences

Beyond consideration of the impact of mental/cognitive impairment on fitness to stand trial, such circumstances may also be of relevance to the mounting of a legal defence against the charges. As noted earlier, the origins of the special verdict of being *Not Guilty by reason of Mental Illness* (now in NSW termed 'act proven but not criminally responsible due to mental illness or cognitive impairment) date back in England in the mid 19th century and the case of

M'Naghten. This case rests on notions of mental illness, particularly psychotic illness, impairing an individual's ability to know what they were doing and/or that it was wrong. The terminology associated with this verdict has aroused considerable concern of relevance to the discussion of stigma experienced by those with mental illness in contact with the CJS. Those advocating for consideration of the rights of victims argue that a 'not guilty' verdict fails to acknowledge that the act was committed (and in NSW this has led in the New Act to a change in terminology to include the wording 'act proven but not criminally responsible….'. The latter phrase (i.e. 'not criminally responsible') has been adopted in a number of jurisdictions internationally in an attempt to reduce the negative public perception and resulting stigma that might result from other terminology but the evidence to support this is not clear. There is certainly a public perception that those accused who successfully apply a mental health defence or are diverted from the CJS into health services have avoided the 'punishment due to them'. This is also fuelled by a lack of understanding of forensic mental health services and pathways. Beyond the NGMI or similar special verdict, it should also be noted that issues of mental illness and cognitive impairment may arise in the context of other defences (e.g. substantial impairment defences, provocation, self-defence, automatism), as well as a factor potentially considered in mitigation arguments in the context of sentencing.

The focus on the extent to which mental illness and/or cognitive impairment is relevant to a potential defence against a charge can itself lead to discrimination in relation to accessing mental health services and support. An individual who has a mental illness, the symptoms or impact of which are able to be demonstrably linked to the offence, is more likely to have the opportunity of being transferred to the forensic mental health system (e.g. in the case of those given a special verdict in NSW), than is another individual with the same level of mental health need but without a clear 'nexis' between their symptoms and the offence. If sentenced to custody, the latter individual will be left to rely largely on the mental health services provided in that setting which are far below those available in a forensic mental health or other mental health facility. In some jurisdictions internationally (e.g. the UK), this focus on a successful mental health defence being the key to accessing forensic mental healthcare has been removed to a large extent by enabling diversion in the higher courts. In this context, the focus is on the mental health needs and risks posed by the individual at the time of disposal.

Treatment of mental illness in legal proceedings – complexity and variability

Clearly, the details of the processes invoked when an accused is considered to have a mental or cognitive impairment are complicated and the way in which they are dealt with can appear to vary substantially between cases. There are many reasons for this, including that courts and judicial officers are expected to take many factors into account in the course of a trial, including common law precedent. Judicial commissions in Australian states and territories exist, amongst other reasons, to assist judicial officers and courts to achieve consistency in the complexities of interpreting and applying the law, including for cases involving an accused with mental or cognitive impairment (Potas, 2001; Bathurst, 2020). They achieve this through various means, such as through the Judicial Commission of NSW's Criminal Trial Courts Bench Book (the Book) which lays out the principles and practice for dealing with those accused of committing crimes, including those with mental or cognitive impairment (Donnelly, 2013). Thus, while there is both legislation and common law in Australian states and territories that defines the boundaries, as well as guides, how the issues of mental or cognitive impairment ought to be approached by judicial officers, ultimately judicial discretion is still very influential in determining whether an accused will be tried according to the law or diverted from it. The complexity and variability described can potentially result in a 'postcode lottery' problem for people where the extent to which an individual's mental illness and/or cognitive impairment is recognised and appropriately considered during the legal process depends on where their matter is dealt with, by whom and when. When mental illness and/or cognitive impairment reduces an individual's ability to appreciate their legal options, this impact is exacerbated (e.g., an individual with mental illness who may be able to rely on a mental health defence to a charge may be unaware of this option and not be in a position to raise it).

Legal and judicial training/expertise in mental health

Legal practitioners and judicial officers in NSW and elsewhere may deal with cases where an accused might have a mental or cognitive impairment. However, it is unclear whether legal practitioners, including judicial officers, in Australian states and territories must receive any specific training, or must explicitly demonstrate any specific competency, in dealing with

those accused with mental or cognitive impairment, including in terms of assessing the fitness, as it were, of an accused. It is clear that legal practitioners and judicial officers with an interest in mental health cases may well develop specialist experience in the field by seeking to take on cases within their area of interest and by pursuing formal study in the field, there is no requirement, formal guidance or set of standards to support such professional development. There are a number of formal postgraduate coursework programs offered in Australia and internationally that focus on forensic mental health, and these are typically offered to professionals from a range of relevant backgrounds, including the law, but there is no requirement for such study to be undertaken.

Mental Health Court diversion

Mental health court diversion has been found to be associated with a reduction in risk of reoffending among those with serious mental illness. Albalawi et al. (2019) examined a group of individuals in NSW diagnosed with a psychotic disorder prior to the court finalisation date for their first offence. They found that the reoffending rate was lower, and time to first reoffence was longer, for those who received a treatment order and were diverted from the criminal justice system under s32 or s33 as opposed to being given a punitive sanction (e.g. bond, fine, community order, suspended sentence or probation). Those in the treatment order group were also more likely to access mental health treatment after diversion than those in the punitive sanction group, and across both groups, those with higher rates of treatment were less likely to reoffend. These findings are consistent with international studies that demonstrate a reduced rate of reoffending amongst those who have been diverted from the CJS into mental healthcare (Honegger, 2015; Loong et al., 2019). This research supports the notion that not only is mental health diversion at court likely to lead to improved health outcomes, but it might also lead to reductions in risk of future contact with the CJS.

However, in many jurisdictions, including in Australia, mental health court diversion is legislatively restricted (e.g. blocked for indictable offences and/or only applicable in a local court setting) and even where it is enabled by legislation, judicial officers have considerable discretion in granting diversion and adequate mental health services to meet the needs of

diverted individuals are often lacking. The Albalawi study found that almost three quarters of those coming before the courts with a diagnosis of psychosis were given punitive sanctions rather than a treatment order, and in another recent study examining court diversion in NSW (Soon et al., 2018) only 57.3% of individuals assessed by trained mental health clinicians as eligible for diversion were actually diverted by magistrates. These studies, along with others, also demonstrate that some individuals are less likely to access diversion, including those of Aboriginal and/or Torres Strait Islander background and those with more complex mental health and co-morbid substance use problems, for example.

Beyond the research evidence, case law also demonstrates the way in which access to mental health diversion at court can be restricted, particularly in relation to the nature and seriousness of the offence with which an individual has been charged. Consider that, in the case of Confos v Director of Public Prosecutions (NSW) [2004] NSWSC 1159, the magistrate deemed that, despite the accused's "obviously suffering from a mental illness", and their "great sympathy" for those circumstances, that they considered "the offences too serious to deal with them pursuant to section 32" (i.e. they considered the charges too serious to allow diversion, despite having accepted that the accused was in fact somebody who had mental or cognitive impairment and was otherwise eligible for diversion). In another case, that of the Director of Public Prosecutions v El Mawas [2006] 66 NSWLR 93, the plaintiff did not succeed in their appeal to have their case diverted as opposed to being dealt with in accordance with the law, again highlighting, in the words of Justice Spigelman, a general view that that "the seriousness of the alleged offence is always a matter entitled to weight in formulating a judgment for which s(32)(1)b calls".

Violence/reoffending Risk Assessment

Formal risk assessment tools and processes are increasingly used as a tool in legal decision-making, employed to inform sentencing, release, parole conditions and levels of supervision and treatment required (Monahan & Skeem, 2016). Risk assessment tools utilised for these purposes are generally actuarial in nature, based on empirically-derived risk factors demonstrated in a specific sample to be statistically associated with reoffence or other

adverse outcome. While this approach to risk assessment is generally preferable to unstructured, professional judgements (which demonstrate low reliability and perform poorly in terms of risk prediction) alone, the use of actuarial risk assessment tools in sentencing, release and other determinations can be problematic for a number of reasons. Firstly, research suggests that risk assessment tools perform better at screening out individuals at low risk of offending than identifying those who will actually go on to offend, and are more suited to classifying individuals at a group level than they are at estimating a person's individual risk of offending (Fazel et al., 2012).

Secondly, there are ethical concerns raised about basing sentencing and release decisions on actuarial assessments that rely on historical, mostly static risk factors that, while statistically associated with risk of reoffence, are generally out of an individual's control and may themselves be sources or indicators of disadvantage. Such factors often include a history of mental illness, for example, as well as other factors that might be related to such illness (e.g., unemployment, drug and alcohol use and homelessness). Such approaches to legal decision-making have been criticised as criminalising disadvantage and need and are potentially a source of discrimination faced by individuals with mental illness in contact with the CJS. Interestingly, within the sentencing process, while mental illness may be considered as a mitigating factor that reduces the individual's culpability for the offence, leading to a more lenient sentencing outcome, in the context of risk assessment it can be seen as an aggravating factor that indicates an increased risk of reoffending, leading to a harsher or more restrictive outcome (Walvisch, 2018)

In a recent study examining the impact of risk assessment on sentencing across sociodemographic groups (Skeem et al., 2020), experienced judges were asked to review a vignette and based on the information presented, sentence the defendant to probation or incarceration. They found that in the absence of risk assessment information, judges were more likely to be lenient in their sentencing of the relatively disadvantaged group in comparison with the relatively affluent group when all other details were held constant. However, when judges were presented with risk assessment information about the defendant, (including criminal history and other relevant historical information, attitudes, substance use and mental health problems; in addition to a final 'risk score'), they were more likely to sentence relatively disadvantaged defendants to a term of imprisonment than they

were for the relatively affluent group. This provides some support for the notion that, in the context of an increasing reliance on risk assessment (Monahan & Skeem, 2015), certain markers of disadvantage, including mental illness, are shifted from being mitigating factors into factors that increase the risk of reoffence and require a harsher response from the CJS.

This tendency to 'criminalise' sources of disadvantage, such as mental illness, rather than identify and attempt to address such unmet needs, misses an opportunity to achieve one of the ultimate goals of the CJS – i.e. to reduce reoffending and thereby protect the public. The provision of mental health court diversion is a clear example of this, since the evidence of its positive effect on reoffending is stronger than many CJS interventions.

2.1.4 Correctional Systems

Correctional systems (i.e. custodial, prison, detention, probation/parole) have long grappled with the need to address the over-representation of people with mental illness and/or cognitive impairment with whose care they are charged. Community rates of mental illness have been reportedly rising in Australia (ABS, 2001; 2006; 2015; 2018) and a higher proportion of those entering custody reporting mental health problems has also been noted (AIHW, 2019). In addition, the negative impact of imprisonment on mental health, particularly amongst those with underlying vulnerability, has long been recognised (Blaauw & van Marle, 2007; Haney, 2003). Additionally, the number of secure forensic beds available across Australia is exceeded by the level of need and wait times for transfer can be long, resulting in many individuals who require detention under mental health legislation being housed in custodial settings for long periods.

The complex needs of those with mental illness and/or cognitive impairment are generally not able to be adequately met in prison settings. By virtue of their diagnosis or symptoms, those with mental health difficulties can experience barriers to accessing therapeutic programs or employment/training opportunities in custody, with some of the former actually being required to demonstrated progress and meet criteria for release under parole conditions. This represents a further example of potential criminalisation of mental illness.

Estimates of unmet mental health need in prison compared to those charged with offences who are managed in secure psychiatric services (Thomas et al., 2009).

Principle 9 of the United Nations' *Basic Principles for the Treatment of Prisoners* (1990) states, 'Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation'. The World Health Organisation endorses the principle of 'equivalence of care' with regard to mental health service provision and access in prison. This means that mental health care is available and accessible in prison and of the same standard as what would be expected in the community. In fact, given the high prevalence of complex mental illness in prisons, this may mean more intensive treatment and services are required than in the community.

However, in a mapping exercise of mental health services in Australian prisons, Davidson et al. (2020) found that when compared to international recommendations only one jurisdiction (the Australian Capital Territory) was funded to provide mental health services at a level equivalent to that available in the community. One of the specific barriers to achieving the principle of equivalency of care in Australia is the exclusion of prisoners from the Medicare Benefits Scheme; instead, healthcare in prison becomes the remit of state and territory government departments only (Davidson et al., 2020; Plueckhan et al., 2015).

The NSW Patients' Experiences and Perceptions Study (PEaPS, Justice Health and Forensic Mental Health Network, 2016) sought patients' perspectives on health care provision in adult correctional and juvenile detention centres across NSW and found that difficulties with accessing consistent health treatment of any kind in custody was commonly reported. Abbott et al.'s (2017) research with incarcerated and newly released women in NSW found that a major issue for women in prison was 'long and unpredictable waits for care', interpreted by some as an indication that their problems were not important. Patients described 'struggling to be seen' as a legitimate patient with problems worthy of health care, both in prison and post-release, and this often resulted in them choosing not to seek care, or, when in the community, not disclosing their history of incarceration. The latter suggests perceptions of stigma and self-stigma may be driving at least some of the poor help-seeking seen amongst those with a history of CJS contact.

The lack of adequate mental health support for those with mental illness in custody is reflected in poorer outcomes for this group. When compared with the general prison population, those with mental illness have a higher risk of suicide and self-harm (Schilders & Ogloff, 2014), are more likely to be physically and sexually victimised (Blitz et al., 2008; Wolff et al., 2007), and are more likely to be disciplined using segregation (Clark, 2018; Stewart & Wilton, 2014).

This lack of support extends to the transition period from custody to community, and to the post-custody period. Adequate discharge planning for those with serious mental illness is often lacking, particularly for unsentenced prisoners who can be released with limited warning, and rates of community mental health contact in the first 12-months post custody are low (Lennox et al., 2012; Thomas et al.,2016). The post-release period is one of high health service need for those with mental illness: there are high rates of physical health problems (Thomas et al., 2015), emergency department attendance and inpatient hospitalisation in this group (Alan et al., 2011; Butler et al., 2019). Individuals recently released from prison with mental illness are also more likely to require an ambulance due to self-harm (Borschmann et al., 2017) and rates of suicide are elevated (Haglund et al., 2014; Kariminia, Law, Butler, Levy et al., 2007). Overall mortality for this group is higher than both the general population and offenders without mental illness (Forsyth et al., 2018; Kariminia, Law, Butler, Corben et al., 2007).

In addition to poorer health outcomes, those released from prison with mental illness have higher rates of recidivism (Stewart & Wilton, 2014), return to prison sooner (Cloyes et al., 2010) and are at substantially increased risk of multiple incarcerations (Baillargeon et al., 2009). Transition support services or interventions have been trialled in a small number of studies but are certainly not widely available. Probation and parole services are increasingly expected to manage those who have been released from custody with mental illness and ensure that they are complying with mental health conditions and treatment, with varying degrees of support from community mental health services. Evidence suggests that individuals released from custody with mental health issues are perceived and treated differently within these services than those without mental illness. Eno Louden & Skeem (2013) found that when estimating risk amongst probationers, the presence of mental illness, and in particular, schizophrenia, led to higher ratings of risk than in those probationers

without mental illness, and had an even stronger effect on risk ratings than substance use problems. Probation officers tended to endorse closer monitoring and enforced mental health treatment for this group in contrast with the non-mentally ill group of probationers. This has important implications when taking into account that those in contact with mental health services post-custody are more likely than those without to be reincarcerated or have their parole revoked, most often for technical (non-offending) reasons (Domino et al., 2019; Green et al., 2016; Stewart & Wilton, 2014). This finding is likely to reflect the complex difficulties faced by those with mental illness in re-integrating with the community, the fact that a higher level of monitoring increases the likelihood of a violation being detected, and the existence of a lower tolerance for violations committed by those with mental illness.

2.1.5 Forensic mental health systems

A number of ethical dilemmas related to the treatment of individuals within the forensic mental health system have been raised in the literature (Adshead, 2000; Völlm et al., 2016). Many of these arise from the dual role of the system to provide care and treatment to individuals whilst also protecting the public. Individuals with mental illness who offend and who are dealt with by the forensic mental health system suffer a lack of autonomy with regard to mental health treatment decisions and may be detained in secure facilities for long periods or subject to restrictions or conditions once released into the community.

In Australia, individuals given a special verdict or found unfit to stand trial may be detained for long periods, or even indefinitely, in prisons or mental health facilities, with a lack of consistency between states and territories in terms of statutory limits on periods of detention (Whelan, 2021). Those detained in secure mental health settings can be detained for periods longer than the prison sentence they would likely have received for the same offence. Decision-makers, such as courts or tribunals, can be very cautious with regard to approving transfers, leave or release of forensic patients. Public perception regarding the potential danger posed by forensic patients in the community is likely to influence these decisions and, in some jurisdictions, registered victims can make submissions to the decision-makers throughout the patient pathway, at stages well beyond what is supported for those without

mental illness subject to CJS oversight. It is important to note that these perceptions exist despite the consistent finding, in Australia and internationally, that forensic patients released to the community have low rates of reoffending, including compared to those released from prison (Hayes et al., 2014).

Whilst progressing through the forensic mental health system, individuals may be subject to restrictive practices such as seclusion, restraint and administration of enforced medication, while progressing through this system is often contingent on the completion of treatment programs that may not be available or suitable for those with serious mental illness, low educational attainment or cognitive impairment. A lack of medium and low secure beds often means that individuals are kept in higher levels of restriction for longer than is required in terms of managing risk, in opposition to the principle of least restrictive care. This lack of autonomy over one's own care and treatment is rarely seen in other areas of healthcare, however it has been argued that less attention has been paid to the ethics of practicing within this field due to the level of stigmatisation against these individuals by virtue of their crimes and perception of risk (Adshead, 2000)

2.1.6 Health Services in the Community

Those in contact with the CJS often describe difficulties associated with obtaining mental health care in the community, as noted above in relation to those in the community on probation. Abbott et al. (2017) interviewed formerly incarcerated women post-release and found that some perceived stigma from their general practitioners who they believed interpreted their requests for mental health care as 'drug seeking' behaviours. Pope et al. (2013) conducted qualitative interviews with providers of mental health services in New York who had treated those who had been in contact with the CJS and identified several barriers to working with this group. Service providers admitted feelings of fear, intimidation and prejudice towards clients with criminal justice histories. There was an assumption that this group did not want treatment or were more difficult to engage if treatment was mandated rather than voluntary. While stigma and discrimination can be at the heart of poor physical

health outcomes for those outside the CJS who suffer with mental illness, the effect can be magnified for those with mental illness combined with CJS contact histories.

2.1.7 Housing

One of the key factors that determines the success of a person staying out of prison after release is the availability of stable housing (Baldry et al, 2006). Those with mental illness who are also homeless have higher rates of contact with the criminal justice system than those with mental illness alone (Roy et al., 2016). A survey of people living with a mental illness in Australia (SANE, 2008) found that 94% had been homeless or without suitable housing at least once in their lifetime, and nearly 90% reported experiencing discrimination while seeking housing, particularly in regard to private rental accommodation.

People with a history of criminal justice contact also face difficulties in securing housing. It is difficult to maintain a private or public housing tenancy when experiencing periods of incarceration and avoiding CJS contact may actually be a written condition of tenancy. Australian Institute of Health and Welfare data (2019) shows that 44% of people nearing the end of their prison term expect to be in short-term or emergency accommodation following release. A recent report, *Exiting prison with complex support needs: the role of housing assistance,* published by the Australian Housing and Urban Research Institute (AHURI; Martin et al., 2021) outlines the difficulties faced by individuals with mental health conditions or cognitive disabilities in securing appropriate accommodation post-release and the potential benefits of providing public housing to this group. They compared criminal justice outcomes for those individuals released from prison who were provided with public housing as opposed to rental assistance alone and found multiple benefits of providing public housing, including reductions over time in police incidents, court appearances, proven offences, time in custody, time on supervised orders, and justice costs. However, with increasing incarceration rates, the need for housing for people released from prison is growing while housing assistance capacity is declining. The demand for public housing outweighs supply and waiting lists are long; some people are excluded from public tenancies due to unsatisfactory past tenancies or debt. Those attempting to secure accommodation in the private rental market face the

problems of affordability, gaps in rental history, discrimination on the basis of their criminal history and are vulnerable to exploitation from landlords. These issues reflect the limited choice those with criminal justice histories have in where they live, a factor that can impact negatively on their ability to achieve successful reintegration and ability to maintain continuity of mental health care and support. All these factors undermine mental health stability and increase the likelihood that people will fall between the gaps in accessing support.

For those with complex needs, including mental health difficulties, stable housing is a prerequisite for recovery: it enables stable engagement with services, and increases likelihood of compliance with mental health and/or correctional orders. In some situations, a lack of stable accommodation in the community can delay release. Some individuals require supported accommodation due to their level of mental health need and those in supportive housing have lower rates of recidivism when compared with those in independent housing; however, because of the scarcity of supported accommodation for this population, individuals may also be kept in custody or secure care for longer than necessary (Salem et al., 2015).

2.3 Vulnerable subgroups

Women

Women represent one of the most disadvantaged groups in contact with the CJS, with much lower levels of education and employment and higher levels of housing instability, compared to women in the general community(AIHW, 2020). In custody, women also report higher rates of mental illness than men (Justice Health and Forensic Mental Health Network, 2017; Sirdifield et al., 2009) as well as a higher prevalence of drug problems or dependence, despite men in the community being twice as likely than women to experience drug problems or dependence (Browne et al., in preparation; Indig et al., 2016). They are also more likely to report a history of physical or sexual abuse (WHO, 2014).

While they make up a much smaller proportion of those in prison, the numbers of women in prison are rising worldwide at a much faster rate than they are for men, such that the gender gap of imprisonment appears to be narrowing (Jeffries & Newbold, 2016). Most prison-based research and development of programs and assessments for offenders are focussed on male populations. Women's services are often under-resourced despite the higher and more complex needs seen in this group.

Women with mental illness are a highly stigmatised group, reporting higher levels of perceived stigma and discrimination related to serious mental illness than men (Morgan et al., 2011). It has also been argued that women suffer a greater burden of stigma relating to incarceration than men due to gender stereotypes: women who commit crimes violate traditional notions of femininity and motherhood, leading to internalised shame and impacting negatively on interpersonal relationships (Gunn et al., 2018). Incarcerated women with mental illness are more likely to suffer from poor health and drug and alcohol problems and to have a history of victimisation prior to incarceration than those without mental illness (Wolff & Shi, 2008); they are more likely to report being physically and sexually victimised in prison (Blitz et al., 2008; Wolff et al., 2007); and are more likely to report being fearful of being physically assaulted or having their property stolen (Wolff & Shi, 2008).

Aboriginal and/or Torres Strait Islander people

There has been a dramatic and persistent overrepresentation of Aboriginal and/or Torres Strait Islander people in contact with the CJS in Australia. The imprisonment rate of Aboriginal and/or Torres Strait Islander people is around 10 times the imprisonment rate of the Australian population as a whole, and as of June 2020, Aboriginal and/or Torres Strait Islander people made up 29% of the prison population in Australia (ABS, 2020) despite making up an estimated 2.8% of the general population in the 2016 census (ABS, n.d). The overrepresentation is even more stark amongst young people, with more than half (53%) of young people in juvenile detention in Australia identifying as Aboriginal or Torres Strait Islander in 2019 (AIHW, 2020). The rates of over-incarceration are also particularly dramatic for women.

There is evidence of potential structural discrimination across all levels of the CJS which contributes to these high rates, including the over-policing of Aboriginal communities and 'adverse use of police discretion' (Blagg et al., 2005), the lower likelihood of diversion (Joudo, 2008; Snowball, 2008), the increasing proportion of Aboriginal and/or Torres Strait Islander people being refused bail and the increasing amount of time spent in prison on remand (Fitzgerald, 2009; Weatherburn & Holmes, 2017). The proportion of Aboriginal and/or Torres Strait Islander people being sentenced to prison terms is also increasing, across the full spectrum of offence types, suggesting that increasing rates of Indigenous imprisonment are more a function of the criminal justice response than of the offending itself (Fitzgerald, 2009).

The high rates of mental illness amongst Aboriginal and/or Torres Strait Islander people in custody are well documented (Heffernan et al., 2012, Indig et al., 2010, Ogloff et al., 2013) and likely reflect a broader problem of mental ill-health amongst those in contact with the CJS. Aboriginal and/or Torres Strait Islander people with mental health disorders or cognitive disability have significantly earlier and more frequent contacts with the criminal justice system than non-Indigenous people (Baldry et al., 2015). Research in NSW has demonstrated that Aboriginal and/or Torres Strait Islander people found to be eligible for mental health diversion are less likely to be granted diversion by magistrates than eligible non-indigenous individuals (Soon et al., 2018), and Aboriginal and/or Torres Strait Islander people with

psychoses are more likely to receive punitive sanctions rather than treatment orders (Albalawi et al., 2019).

Aboriginal and/or Torres Strait Islander people represent a particularly disadvantaged group within custody. According to a NSW prison health survey (Indig et al., 2010), when compared with non-Indigenous people in custody, Aboriginal and/or Torres Strait Islander people had lower levels of formal education, higher rates of unemployment and were more likely to have experienced insecure housing prior to custody. Nearly half of Aboriginal and/or Torres Strait Islander people surveyed had been placed in care prior to the age of 16, around twice the rate of their non-Indigenous counterparts, and a third had experienced parental incarceration, around three times as likely as non-Indigenous people in custody. They were twice as likely to report a history of juvenile detention and significantly more likely to have previous experiences of incarceration and to have been the victims of violence.

Despite high rates of mental ill health, levels of health service utilisation within this population are often poor: Aboriginal and/or Torres Strait Islander people in prison are significantly less likely to have accessed health care prior to custody (Indig et al., 2010) and one study found that a third of Aboriginal and/or Torres Strait Islander men in custody who met the criteria for a current diagnosis of mental illness had not received mental health treatment during their time in custody (Ogloff, Patterson et al., 2013). There are a number of barriers both to accessing services (such as an overburdened mental health system, lack of culturally appropriate services and training, and poor integration of existing services), as well as to seeking services (e.g., the stigma associated with poor mental health, mistrust of institutions and prior experiences of racism and discrimination in healthcare). Even the accurate identification of mental health difficulties in the Aboriginal and/or Torres Strait Islander population may be challenging, with poor understanding of cultural manifestations of mental ill health and a lack of validated culturally appropriate tools for assessing mental health or disability (Ogloff, Patterson et al., 2013).

It is of note that despite high rates of mental illness and striking levels of incarceration, the proportion of forensic patients who are of Aboriginal and/or Torres Strait Islander background is relatively low. There may be particular barriers to accessing forensic mental healthcare and legal provisions that also reflects issues of stigma and discrimination.

Whilst the brevity of the current report is not adequate to explore the complexity underlying the experiences of stigma and discrimination for Aboriginal and/or Torres Strait Islander people with mental illness and CJS contact, the historical context of colonisation in Australia and the resultant trauma of many generations, disconnection from family and country, and layers of disadvantage experienced by Aboriginal and/or Torres Strait Islander people should be noted. The needs of this population are clearly complex, and the failure of systems to respond appropriately or adequately to these needs is repeatedly reflected in poorer health and criminal justice outcomes for this group.

2.4 Mental Illness and criminal victimisation

While much attention is paid to those with mental illness who come into contact with the CJS as a result of offending, an often-ignored group are those who come into contact as a victim or witness of crime. The SHIP survey (Morgan et al., 2011) found that among people with psychosis, a substantial proportion reported any victimisation over the past year, 38.6% reported experiencing any type of victimisation and nearly a quarter (24.8%) reporting being a victim of assault in the past year. Studies conducted in the United Kingdom have also found that people with mental illness are more likely to be victims of crime than those in the general population (Khalifeh, Johnson et al., 2015), are at increased risk of emotional, physical and sexual interpersonal violence, and are more likely to suffer mental or emotional problems as a result of victimisation, including suicide attempts (Khalifeh, Oram et al., 2015). An Australian study by Short et al. (2013) found that, compared to community controls, individuals with a diagnosis of schizophrenia spectrum disorder were significantly more likely to have a record of violent and sexual victimisation, with the rates increasing over time in the mental illness group only. Patients with schizophrenia spectrum disorder diagnoses as well as criminal justice histories were nearly five times more likely than non-offenders with these disorders to have a record of violent victimisation and more than three times more likely in regard to non-violent victimisation.

During qualitative interviews presented in the *At risk yet dismissed* report (Pettit et al., 2013), individuals with mental illness reported feeling specifically targeted by perpetrators due to their mental health problems and vulnerability, both in the community and within psychiatric facilities. The study found that victims with mental health difficulties were less likely to report crimes against them when they had had previous interactions with the police as an offender, victim or for reasons related to their mental health. Victims described not reporting crimes due to fear of a negative response arising from the stigma associated with mental illness: i.e. fears of being blamed, not being believed or taken seriously, or being detained involuntarily under mental health legislation. Victims with serious mental illness who did report their experiences to police reported feeling less satisfied with the process and were less likely to report fair or respectful treatment than victims without mental illness.

Section 4: Summary and Recommendations

The following are some key areas of concern arising from this rapid review of stigma and discrimination experienced by those with mental illness in contact with the Criminal Justice System (CJS); areas that may warrant further investigation and/or recommendations for intervention in order to reduce risk of stigma and discrimination for this group.

- Stigma and discrimination experienced by those with a lived experience of mental illness appears likely to have an intersectional component such that the experiences are compounded if people with mental illness have other potential sources of stigma and discrimination such as contact with the CJS (with the impact further compounded for women, for Aboriginal and/or Torres Strait Islander people)
- Negative public perceptions of those with mental illness, particularly in regard to perceived dangerousness, are well established, as is the self-stigma that can also be generated. These perceptions are based on false or exaggerated information and are repeatedly presented by the lay media. Media reporting guidelines on these topics may be of benefit.
- The fact that those with mental illness are over-represented in criminal justice populations is in itself partly due to the effects of stigma and discrimination related to mental illness (i.e. the 'criminalisation' of mental illness). A number of specific examples of such criminalisation may warrant further investigation/intervention – e.g. reduced access to diversion away from the justice system for those with mental illness, reduced likelihood of bail/release/probation for those with mental illness, reduced access to employment/training/therapy within the justice system for those with mental illness, increased custodial detention for those found unfit to be tried due to mental illness or cognitive impairment, and conflation of need or disadvantage with risk, including with regard to the use of risk assessment tools in assisting judicial and other decision-making.
- The over-representation of individuals with mental illness in the CJS also reflects inadequate availability, resourcing, and capacity of community-based mental health

services at all levels (e.g. individuals with severe mental illness in crisis ending up in contact with police in the absence of appropriate mental health services). The level of over-representation may also be increasing which highlights the urgency of improvement needed in the sector.

- Stigma and discrimination acting to reduce access to healthcare, including mental healthcare, for those with mental illness in contact with the CJS is an urgent problem that requires attention. Healthcare provision, including mental healthcare, in custodial settings is not equivalent to that regarded as necessary for those living in the community, and beyond the custodial environment, people with mental illness who have experienced justice contact face barriers to accessing healthcare. Comparable problems exist with regard to access to public housing and employment/training.
- Legal, judicial and correctional staff and professionals may benefit from a greater provision of mental health training and education, with standards of such articulated clearly.
- Individuals with mental illness in contact with the CJS as victims perceive negative treatment and barriers arising from the stigma associated with their mental health problems. Enhanced mental health training and education for those working within the legal and justice systems, as noted above, may help to address this problem. Individuals with mental illness in contact with the CJS as victims may benefit from support services specifically designed to help them access and navigate the CJS.

References

Abbott, P., Magin, P., Davison, J., & Hu, W. (2017). Medical homelessness and candidacy: women transiting between prison and community health care. *International Journal for Equity in Health*, *16*(1), 1-10.

Adshead, G. (2000). Care or custody? Ethical dilemmas in forensic psychiatry. *Journal of Medical Ethics*, *26*(5), 302-304.

Alan, J., Burmas, M., Preen, D., & Pfaff, J. (2011). 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*, *35*(3), 264-269.

Albalawi, O., Chowdhury, N. Z., Wand, H., Allnutt, S., Greenberg, D., Adily, A., Kariminia, A., Schofield, P., Sara, G., Hanson, S., O'Driscoll, C., & Butler, T. (2019). Court diversion for those with psychosis and its impact on re-offending rates: results from a longitudinal data-linkage study. *BJPsych open*, *5*(1).

Australian Bureau of Statistics. (2001). National Health Survey: Mental Health, Australia. Cat. no. 4811.0, ABS, Canberra.

Australian Bureau of Statistics. (2006). National survey of mental health and wellbeing: summary of results, 2004-05. ABS cat. no. 4364.0. Canberra: ABS.

Australian Bureau of Statistics. (2015). National Health Survey: First Results, Australia, 2014-15. Cat. no. 4364.0.55.001, ABS, Canberra.

Australian Bureau of Statistics. (2018). National Health Survey: First Results, 2017-18. Cat. no. 4364.0.55.001, ABS, Canberra.

Australian Bureau of Statistics. (2020). *Prisoners in Australia.* https://www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia/latest-release

Australian Bureau of Statistics. (n.d). 2016 Census QuickStats. Retrieved on 16 September, 2021 from https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/036

Australian Institute of Health and Welfare. (2019). The health of Australia's prisoners 2018. Cat. no. PHE 246. Canberra: AIHW.

Australian Institute of Health and Welfare. (2020). The health and welfare of women in Australia's prisons. Cat. no. PHE 281. Canberra: AIHW.

Baillargeon, J., Binswanger, I. A., Penn, J. V., Williams, B. A., & Murray, O. J. (2009). Psychiatric disorders and repeat incarcerations: the revolving prison door. *American Journal of Psychiatry*, *166*(1), 103-109.

Baksheev, G. N., Thomas, S. D., & Ogloff, J. R. (2010). Psychiatric disorders and unmet needs in Australian police cells. *Australian & New Zealand Journal of Psychiatry*, *44*(11), 1043-1051.

Baldry, E., McDonnell, D., Maplestone, P., & Peeters, M. (2006). Ex-prisoners, homelessness and the state in Australia. *Australian & New Zealand Journal of Criminology*, *39*(1), 20-33.

Baldry, E., McCausland, R., Dowse, L. and McEntyre, E. 2015 A predictable and preventable path: Aboriginal people with mental and cognitive disabilities in the criminal justice system. UNSW, Sydney. https://www.mhdcd.unsw.edu.au/

Baldry, E., & Russell, S. (2017). *The booming industry continued: Australian prisons, a 2017 update*. http://www. disabilityjustice.edu.au/wpcontent/uploads/ 2015/10/The-Booming-Industry-continued-Australian-Prisons-2017-.pdf

Bales, W. D., Nadel, M., Reed, C., & Blomberg, T. G. (2017). Recidivism and inmate mental illness. *International Journal of Criminology and Sociology*, *6*, 40-51.

Bathurst, T.F. (2020). Demystifying judicial commissions. In Judicial Review: Selected Conference Papers*. Journal of the Judicial Commission of New South Wales, 14*(3), 215-228

Blaauw, E., & van Marle, H.J.C. (2007). Mental Health in Prisons. In L. Møller, H. Stöver, R. Jürgens, A. Gatherer, & H. Nikogosian (Eds), *Health in prisons: a WHO guide to the essentials in prison health* (pp. 133-145). World Health Organisation: Denmark.

Blagg, H., Morgan, N., Cunneen, C., & Ferrante, A. (2005). Systemic racism as a factor in the overrepresentation of Aboriginal people in the Victorian criminal justice system. *Report to the Equal Opportunity Commission of Victoria*.

Blitz, C. L., Wolff, N., & Shi, J. (2008). Physical victimization in prison: The role of mental illness. *International Journal of Law and Psychiatry*, *31*(5), 385-393. https://doi.org/10.1016/j.ijlp.2008.08.005

Blüml, V., Waldhör, T., Kapusta, N. D., & Vyssoki, B. (2015). Psychiatric hospital bed numbers and prison population sizes in 26 European countries: a critical reconsideration of the penrose hypothesis. *PLoS One*, *10*(11), e0142163. https://doi.org/10.1371/journal.pone.0142163

Borschmann, R., Young, J. T., Moran, P., Spittal, M. J., Heffernan, E., Mok, K., & Kinner, S. A. (2017). Ambulance attendances resulting from self-harm after release from prison: a prospective data linkage study. *Social psychiatry and psychiatric epidemiology*, *52*(10), 1295-1305.

Bosland, J., & Bagnall, A. (2013). An empirical analysis of suppression orders in the Victorian courts: 2008-12. *The Sydney Law Review, 35*(4), 671-702.

Browne, C. C., Korobanova, D., Yee, N., Spencer, S.J., Ma, T., Butler, T., & Dean, K. (In prep.) The prevalence of self-reported mental illness amongst those imprisoned in NSW over time, from 2001 to 2015.

Butler, T., Andrews, G., Allnutt, S., Sakashita, C., Smith, N. E., & Basson, J. (2006). Mental disorders in Australian prisoners: a comparison with a community sample. *Australian & New Zealand Journal of Psychiatry*, *40*(3), 272-276. https://doi.org/10.1080/j.1440-1614.2006.01785.x

Butler, A., Love, A. D., Young, J. T., & Kinner, S. A. (2019). Frequent Attendance to the Emergency Department after Release from Prison: a Prospective Data Linkage Study. *The journal of behavioral health services & research*, 1-16.

Carrara, B. S., & Ventura, C. A. A. (2018). Self-stigma, mentally ill persons and health services: An integrative review of literature. *Archives of Psychiatric Nursing*, *32*(2), 317-324.Chang, Z., Larsson, H., Lichtenstein, P., & Fazel, S. (2015). Psychiatric disorders and violent reoffending: a national cohort study of convicted prisoners in Sweden. *The Lancet* Psychiatry, 2(10), 891-900. https://doi.org/10.1016/S2215-0366(15)00234-5

Clark, K. (2018). The effect of mental illness on segregation following institutional misconduct. *Criminal Justice and Behavior*, *45*(9), 1363-1382.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rusch, N., Brown, J.S.L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological medicine*, *45*(1), 11-27.

Cloyes, K. G., Wong, B., Latimer, S., & Abarca, J. (2010). Time to prison return for offenders with serious mental illness released from prison: A survival analysis. *Criminal Justice and Behavior*, *37*(2), 175-187. https://doi.org/10.1177/0093854809354370

Confos v Department of Public Prosecutions [2004] NSWSC 1159

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, *15*(2), 37-70.

Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *The Canadian Journal of Psychiatry*, *57*(8), 464-469.

Court Suppression and Non-publication Orders Act (2010) No 106. https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-2010-106

Covey, R. D. (2008). Criminal madness: cultural iconography and insanity. *Stanford Law Review, 61*, 1375.

Davidson, F., Clugston, B., Perrin, M., Williams, M., Heffernan, E., & Kinner, S. A. (2020). Mapping the prison mental health service workforce in Australia. *Australasian Psychiatry*, *28*(4), 442-447.

Dean, K., Parsons, V., Yee, N., MacKinnon, T., Chaplow, D., & Lines, K. (2013). *The justice system and mental health: A literature review. A report for the Australian Government National Mental Health Commission.* https://www.mentalhealthcommission.gov.au/getmedia/8e26fc6a-da7b-4b34-a724-536f10af375a/Monitoring/The-justice-system-and-mental-health.pdf

Department of Public Prosecutions v El Mawas [2006] 66 NSWLR 93

Domino, M. E., Gertner, A., Grabert, B., Cuddeback, G. S., Childers, T., & Morrissey, J. P. (2019). Do timely mental health services reduce re-incarceration among prison releasees with severe mental illness? *Health services research*, *54*(3), 592-602.

Donnelly, H. (2013). Criminal trial courts bench book substantially revised. *Judicial Officers Bulletin, 25*(5), 39-42.

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

Dvoskin, J. A., Knoll, J. L., & Silva, M. (2020). A brief history of the criminalization of mental illness. *CNS Spectrums*, *25*(5), 638-650.

Eno Louden, J., & Skeem, J. L. (2013). How do probation officers assess and manage recidivism and violence risk for probationers with mental disorder? An experimental investigation. *Law and Human Behavior*, *37*(1), 22.

Eno Louden, J., Gochyyev, P., & Skeem, J. L. (2020). Do specialty programs for justice-involved people with mental illness exacerbate stigma? *Criminal Justice and Behavior*, *47*(10), 1211-1227.

Etter Sr, G. W., Birzer, M. L., & Fields, J. (2008). The jail as a dumping ground: The incidental incarceration of mentally ill individuals. *Criminal Justice Studies*, *21*(1), 79-89. https://doi.org/10.1080/14786010801972738

Evangelista, E., Lee, S., Gallagher, A., Peterson, V., James, J., Warren, N., Henderson, K., Keppich-Arnold, S., Cornelius, L., & Deveny, E. (2016). Crisis averted: How consumers experienced a police and clinical early response (PACER) unit responding to a mental health crisis. *International Journal of Mental Health Nursing*, *25*(4), 367-376.

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys. *The Lancet*, *359*(9306), 545-550. https://doi.org/10.1016/S0140-6736(02)07740-1

Fazel, S., Gulati, G., Linsell, L., Geddes, J. R., & Grann, M. (2009). Schizophrenia and violence: systematic review and meta-analysis. *PLoS Medicine, 6*(8), e1000120. https://doi.org/10.1371/journal.pmed.1000120

Fazel, S., & Seewald, K. (2012). Severe mental illness in 33 588 prisoners worldwide: systematic review and meta-regression analysis. *The British Journal of Psychiatry*, *200*(5), 364-373. https://doi.org/10.1192/bjp.bp.111.096370

Fazel, S., Singh, J. P., Doll, H., & Grann, M. (2012). Use of risk assessment instruments to predict violence and antisocial behaviour in 73 samples involving 24 827 people: systematic review and meta-analysis. *BMJ, 345*.

Fazel, S., Wolf, A., Palm, C., & Lichtenstein, P. (2014). Violent crime, suicide, and premature mortality in patients with schizophrenia and related disorders: a 38-year total population study in Sweden. *The Lancet Psychiatry*, *1*(1), 44-54. https://doi.org/10.1016/S2215-0366(14)70223-8

Fazel, S., Zetterqvist, J., Larsson, H., Långström, N., & Lichtenstein, P. (2014). Antipsychotics, mood stabilisers, and risk of violent crime. *The Lancet*, *384*(9949), 1206-1214.

Fitzgerald, J. (2009). Why are indigenous imprisonment rates rising? *NSW Bureau of Crime Statistics and Research issue paper no. 41.* https://www.bocsar.nsw.gov.au/Publications/BB/bb41.pdf

Forsyth, S. J., Carroll, M., Lennox, N., & Kinner, S. A. (2018). Incidence and risk factors for mortality after release from prison in Australia: a prospective cohort study. *Addiction*, *113*(5), 937-945. https://doi.org/10.1111/add.14106

Godfredson, J. W., Thomas, S. D., Ogloff, J. R., & Luebbers, S. (2011). Police perceptions of their encounters with individuals experiencing mental illness: A Victorian survey. *Australian & New Zealand journal of criminology*, *44*(2), 180-195.Green, B., Denton, M., Heffernan, E., Russell, B., Stapleton, L., & Waterson, E. (2016). From custody to community: Outcomes of community-based support for mentally ill prisoners. *Psychiatry, Psychology and Law*, *23*(5), 798-808.

Goldstein, R. L., & Rotter, M. (1988). The psychiatrist's guide to right and wrong: judicial standards of wrongfulness since M'Naghten. The Bulletin of the American Academy of Psychiatry and the Law, 16(4), 359-367.

Gunn, A. J., Sacks, T. K., & Jemal, A. (2018). "That's not me anymore": Resistance strategies for managing intersectional stigmas for women with substance use and incarceration histories. *Qualitative Social Work*, *17*(4), 490-508.

Haglund, A., Tidemalm, D., Jokinen, J., Långström, N., Lichtenstein, P., Fazel, S., & Runeson, B. (2014). Suicide after release from prison: a population-based cohort study from Sweden. *The Journal of Clinical Psychiatry*, *75*(10), 1047-1053. https://doi.org/10.4088/JCP.13m08967

Hatzenbuehler, M. L., & Link, B. G. (2014). Introduction to the special issue on structural stigma and health. *Social Science & Medicine*, *103,* 1-6 https://doi.org/10.1016/j.socscimed.2013.12.017

Haney, C. (2003). The psychological impact of incarceration: Implications for post-prison adjustment. *Prisoners once removed: The Impact of Incarceration and Reentry on Children, Families, and Communities*, *33*, 66.

Hayes, H., Kemp, R. I., Large, M. M., & Nielssen, O. B. (2014). A 21-year retrospective outcome study of New South Wales forensic patients granted conditional and unconditional release. *Australian & New Zealand Journal of Psychiatry*, *48*(3), 259-282.

Heffernan, E. B., Andersen, K. C., Dev, A., & Kinner, S. (2012). Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland prisons. *Medical Journal of Australia*, *197*(1), 37-41.

Herrington, V., & Pope, R. (2014). The impact of police training in mental health: an example from Australia. *Policing and society*, *24*(5), 501-522.

Honegger, L. N. (2015). Does the evidence support the case for mental health courts? A review of the literature. *Law and human behavior*, *39*(5), 478.

Huppert, D., & Griffiths, M. (2015). Police mental health partnership project: police ambulance crisis emergency response (PACER) model development. *Australasian Psychiatry*, *23*(5), 520-523.

Indig, D., Topp, L., Ross, B., Mamoon, H., Border, B., Kumar, S., & McNamara, M. (2010). 2009 NSW Inmate Health Survey: key findings report. Justice Health, Sydney.

Indig, D., Gear, C., & Wilhelm, K. (2016). Comorbid substance use disorders and mental health disorders among New Zealand prisoners. Wellington: New Zealand Department of Corrections.

Jeffries, S., & Newbold, G. (2016). Analysing trends in the imprisonment of women in Australia and New Zealand. *Psychiatry, Psychology and Law*, *23*(2), 184-206.

Jorm, A. F., Reavley, N. J., & Ross, A. M. (2012). Belief in the dangerousness of people with mental disorders: a review. *Australian & New Zealand Journal of Psychiatry*, *46*(11), 1029-1045.

Joudo, J. (2008). *Responding to substance abuse and offending in Indigenous communities: review of diversion programs*. Canberra: Australian Institute of Criminology.

Justice Health and Forensic Mental Health Network. (2016). *Patients' Experiences and Perceptions Study*. Sydney, Australia: Author

Justice Health and Forensic Mental Health Network. (2017). *2015 Network Patient Health Survey Report.* Sydney, Australia: Author

Kariminia, A., Law, M. G., Butler, T. G., Corben, S. P., Levy, M. H., Kaldor, J. M., & Grant, L. (2007). Factors associated with mortality in a cohort of Australian prisoners. *European Journal of Epidemiology*, *22*(7), 417-428. https://doi.org/10.1007/s10654-007-9134-1

Kariminia, A., Law, M. G., Butler, T. G., Levy, M. H., Corben, S. P., Kaldor, J. M., & Grant, L. (2007). Suicide risk among recently released prisoners in New South Wales, Australia. *Medical Journal of Australia*, *187*(7), 387-390. https://doi.org/10.5694/j.1326-5377.2007.tb01307.x

Kesic, D., Thomas, S. D., & Ogloff, J. R. (2010). Mental illness among police fatalities in Victoria 1982–2007: case linkage study. *Australian & New Zealand Journal of Psychiatry*, *44*(5), 463-468.

Kesic, D., Ducat, L. V., & Thomas, S. D. (2012). Using force: Australian newspaper depictions of contacts between the police and persons experiencing mental illness. *Australian psychologist*, *47*(4), 213-223.

Kesic, D., Thomas, S. D., & Ogloff, J. R. (2013). Use of nonfatal force on and by persons with apparent mental disorder in encounters with police. *Criminal justice and behavior*, *40*(3), 321-337.

Khalifeh, H., Johnson, S., Howard, L. M., Borschmann, R., Osborn, D., Dean, K., Hart, C., Hogg, J., & Moran, P. (2015). Violent and non-violent crime against adults with severe mental illness. *The British Journal of Psychiatry*, *206*(4), 275-282.

Khalifeh, H., Oram, S., Trevillion, K., Johnson, S., & Howard, L. M. (2015). Recent intimate partner violence among people with chronic mental illness: findings from a national cross-sectional survey. *The British Journal of Psychiatry*, *207*(3), 207-212.

Large, M. M., & Nielssen, O. (2009). The Penrose hypothesis in 2004: Patient and prisoner numbers are positively correlated in low-and-middle income countries but are unrelated in high-income countries. *Psychology and Psychotherapy: Theory, Research and Practice*, *82*(1), 113-119. https://doi.org/10.1348/147608308X320099

LeBel, T. P. (2012). If one doesn't get you another one will: Formerly incarcerated persons' perceptions of discrimination. *The Prison Journal*, *92*(1), 63-87.

Lee, S. J., Thomas, P., Doulis, C., Bowles, D., Henderson, K., Keppich-Arnold, S., Perez, E., & Stafrace, S. (2015). Outcomes achieved by and police and clinician perspectives on a joint police officer and mental health clinician mobile response unit. *International Journal of Mental Health Nursing*, *24*(6), 538-546.

Legal Aid NSW. (2016). Fitness and the defence of mental illness in the Local and Children's Court. https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0017/25334/Legal-Aid-Fitness-and-NGMI-in-Local-and-Childrens-Court-27-July-2016.pdf

Lennox, C., Senior, J., King, C., Hassan, L., Clayton, R., Thornicroft, G., & Shaw, J. (2012). The management of released prisoners with severe and enduring mental illness. *The Journal of Forensic Psychiatry & Psychology*, *23*(1), 67-75.

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social science & medicine*, *71*(12), 2150-2161.

Livingston, J. D., Rossiter, K. R., & Verdun-Jones, S. N. (2011). 'Forensic'labelling: An empirical assessment of its effects on self-stigma for people with severe mental illness. *Psychiatry Research*, *188*(1), 115-122.

Livingston, J. D. (2013). *Mental illness-related structural stigma: The downward spiral of systemic exclusion.* Calgary, Alberta: Mental Health Commission of Canada. www.mentalhealthcommission.ca

Martin, C., Reeve, R., McCausland, R., Baldry, E., Burton, P., White, R. and Thomas, S. (2021) *Exiting prison with complex support needs: the role of housing assistance,* AHURI Final Report No. 361, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/final-reports/361,doi: 10.18408/ahuri7124801.

McSherry, B. (1999). Mental impairment and criminal responsibility: Recent Australian legislative reforms. *Criminal Law Journal Sydney, 23*, 135-144.

Mental Health Act (2007). https://legislation.nsw.gov.au/view/html/inforce/current/act-2007-008

Mental Health and Cognitive Impairment Forensic Provisions Act (2020). https://legislation.nsw.gov.au/view/html/inforce/current/act-2020-012

Mental Health (Forensic Provisions) Act (1990). https://legislation.nsw.gov.au/view/html/repealed/current/act-1990-010

Morgan, M. (2021). Police Responses to Persons with Mental Illness: The Policy and Procedures Manual of One Australian Police Agency and 'Procedural Justice Policy'. *Social Sciences*, *10*(2), 42.

Loong, D., Bonato, S., Barnsley, J., & Dewa, C. S. (2019). The effectiveness of mental health courts in reducing recidivism and police contact: A systematic review. *Community mental health journal*, *55*(7), 1073-1098.

Mezey, G. C., Kavuma, M., Turton, P., Demetriou, A., & Wright, C. (2010). Perceptions, experiences and meanings of recovery in forensic psychiatric patients. *The Journal of Forensic Psychiatry & Psychology*, *21*(5), 683-696.

Mezey, G., Youngman, H., Kretzschmar, I., & White, S. (2016). Stigma and discrimination in mentally disordered offender patients–A comparison with a non-forensic population. *The Journal of Forensic Psychiatry & Psychology*, *27*(4), 517-529.

Monahan, J., & Skeem, J. L. (2016). Risk assessment in criminal sentencing. *Annual review of clinical psychology*, *12*, 489-513.

Moore, K., Stuewig, J., & Tangney, J. (2013). Jail inmates' perceived and anticipated stigma: Implications for post-release functioning. *Self and Identity*, *12*(5), 527-547.

Moore, K. E., Stuewig, J. B., & Tangney, J. P. (2016). The effect of stigma on criminal offenders' functioning: A longitudinal mediational model. *Deviant behavior*, *37*(2), 196-218.

Moore, K. E., & Tangney, J. P. (2017). Managing the concealable stigma of criminal justice system involvement: A longitudinal examination of anticipated stigma, social withdrawal, and post–release adjustment. *The Journal of social issues*, *73*(2), 322.

Morgan, W., Jablensky, M., McGrath, C., Bush, C., Cohen, H., Gelletly, S., Stain, H. J., Neil, A., McGorry, P., Hocking, B., Shah, S., & Saw, S. (2011). *People living with psychotic illness 2010. Report on the second Australian national survey*. Department of Health: ACT

New South Wales Law Reform Commission (2010). Consultation paper 5. People with cognitive and mental health impairments in the criminal justice system: an overview. https://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_completed_projects/lrc_peoplewithcognitiveandmentalhealthimpairmentsinthecriminaljusticesystem/lrc_peoplewithcognitiveandmentalhealthimpairmentsinthecriminaljusticesystem.aspx

New South Wales Law Reform Commission (2020). Open Justice Court and Tribunal Information: Access, Disclosure, and Publication. https://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_current_projects/Courtinformation/Project_update.aspx

Ogloff, J., Warren, L., Tye, C., Blaher, F., & Thomas, S. (2011). Psychiatric symptoms and histories among people detained in police cells. *Social psychiatry and psychiatric epidemiology*, *46*(9), 871-880.

Ogloff, J. R., Thomas, S. D., Luebbers, S., Baksheev, G., Elliott, I., Godfredson, J., Kesic, D., Short, T., Martin, T., Warren, L., Clough, J., Mullen, P. E., Wilkins, C., Dickinson, A., Sargent, L., Perez, E., Ballek, D., & Moore, E. (2013). Policing services with mentally ill people: Developing greater understanding and best practice. *Australian Psychologist*, *48*(1), 57-68.

Ogloff, J. R., Patterson, J., Cutajar, M., Adams, K., Thomas, S., & Halacas, M. C. (2013). *Koori prisoner mental health and cognitive function study.* Centre for Forensic Behavioural Science Monash University & Victorian aboriginal community controlled health organisation.

Penrose, L. S. (1939). Mental disease and crime: outline of a comparative study of European statistics. *British Journal of Medical Psychology*, *18*(1), 1-15. https://doi.org/10.1111/j.2044-8341.1939.tb00704.x

Pettitt, B., Greenhead, S., Khalifeh, H., Drennan, V., Hart, T., Hogg, J., Borschmann, R., Mamo, E., & Moran, P. (2013). *At risk, yet dismissed: the criminal victimisation of people with mental health problems.*

Pirkis, J., Blood, R. W., Francis, C., & McCallum, K. (2006). On-screen portrayals of mental illness: Extent, nature, and impacts. *Journal of health communication*, *11*(5), 523-541.

Plueckhahn, T. M., Kinner, S. A., Sutherland, G., & Butler, T. G. (2015). Are some more equal than others? Challenging the basis for prisoners' exclusion from Medicare. *Medical Journal of Australia*, *203*(9), 359-361.

Pope, L. G., Smith, T. E., Wisdom, J. P., Easter, A., & Pollock, M. (2013). Transitioning between systems of care: missed opportunities for engaging adults with serious mental illness and criminal justice involvement. *Behavioral Sciences & the Law*, *31*(4), 444-456.

Potas, I. (2001). The Judicial Commission of NSW: treading a fine line between judicial independence and judicial accountability. Law in Context, 18(1), 102-128.

Prins, S. J. (2014). Prevalence of mental illnesses in US state prisons: A systematic review. *Psychiatric Services*, *65*(7), 862-872. https://doi.org/10.1176/appi.ps.201300166

Pugh, T., Hatzenbuehler, M., & Link, B. (2015). *Structural stigma and mental illness.* Commissioned Paper for Committee on the Science of Changing Behavioral Health Social Norms, Mailman School of Public Health, Columbia University

Reavley, N. J., & Jorm, A. F. (2011). Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey of Mental Health Literacy and Stigma. *Australian & New Zealand Journal of Psychiatry*, *45*(12), 1086-1093.

Riles, J. M., Miller, B., Funk, M., & Morrow, E. (2021). The Modern Character of Mental Health Stigma: A 30-Year Examination of Popular Film. *Communication Studies*, *72*(4), 668-683.

Roy, L., Crocker, A. G., Nicholls, T. L., Latimer, E., Gozdzik, A., O'Campo, P., & Rae, J. (2016). Profiles of criminal justice system involvement of mentally ill homeless adults. *International journal of law and psychiatry*, *45*, 75-88.

Salem, L., Crocker, A. G., Charette, Y., Seto, M. C., Nicholls, T. L., & Côté, G. (2015). Supportive housing and forensic patient outcomes. *Law and Human Behavior*, *39*(3), 311.

Sanders, J. (2021). Criminal law: What's new with section 32?: Mental health, cognitive impairment and criminal law. *LSJ: Law Society of NSW Journal*, *74*, 78-79.

SANE. (2008). *Research Bulletin 7: Housing and mental illness.* https://www.sane.org/images/PDFs/0807_info_rb7_housing.pdf

Schilders, M. R., & Ogloff, J. R. (2014). Review of point-of-reception mental health screening outcomes in an Australian prison. *The Journal of Forensic Psychiatry & Psychology*, *25*(4), 480-494. https://doi.org/10.1080/14789949.2014.933862

Short, T. B., Thomas, S., Luebbers, S., Mullen, P., & Ogloff, J. R. (2013). A case-linkage study of crime victimisation in schizophrenia-spectrum disorders over a period of deinstitutionalisation. *BMC psychiatry*, *13*(1), 1-9.

Short, T. B., MacDonald, C., Luebbers, S., Ogloff, J. R., & Thomas, S. D. (2014). The nature of police involvement in mental health transfers. *Police practice and research*, *15*(4), 336-348.

Sirdifield, C., Gojkovic, D., Brooker, C., & Ferriter, M. (2009). A systematic review of research on the epidemiology of mental health disorders in prison populations: a summary of findings. *The Journal of Forensic Psychiatry & Psychology*, *20*(S1), S78-S101. https://doi.org/10.1080/14789940802594445

Skeem, J., Scurich, N., & Monahan, J. (2020). Impact of risk assessment on judges' fairness in sentencing relatively poor defendants. *Law and human behavior*, *44*(1), 51.

Snowball, L. (2008). Diversion of Indigenous juvenile offenders. *Trends and Issues in Crime and Criminal Justice*, (355), 1-6.

Soon, Y. L., Rae, N., Korobanova, D., Smith, C., Gaskin, C., Dixon, C., ... & Dean, K. (2018). Mentally ill offenders eligible for diversion at local court in New South Wales (NSW), Australia: factors associated with initially successful diversion. *The Journal of Forensic Psychiatry & Psychology*, *29*(5), 705-716.

Stevens, H., Laursen, T. M., Mortensen, P. B., Agerbo, E., & Dean, K. (2015). Post-illness-onset risk of offending across the full spectrum of psychiatric disorders. *Psychological Medicine, 45*(11), 2447-2457. doi:10.1017/S0033291715000458

Stewart, A., Ogilvie, J. M., Thompson, C., Dennison, S., Allard, T., Kisely, S., & Broidy, L. (2020). Lifetime prevalence of mental illness and incarceration: An analysis by gender and Indigenous status. *Australian Journal of Social Issues*, *56*(2), 244 – 268. https://doi.org/10.1002/ajs4.146

Stewart, L. A., & Wilton, G. (2014). Correctional outcomes of offenders with mental disorders. *Criminal Justice Studies*, *27*(1), 63-81. https://doi.org/10.1080/1478601X.2013.873205

Thomas, S., McCrone, P., & Fahy, T. (2009). How do psychiatric patients on prison healthcare centres differ from inpatients in secure psychiatric inpatient units?. *Psychology, crime & law*, *15*(8), 729-742.

Thomas, E. G., Spittal, M. J., Heffernan, E. B., Taxman, F. S., Alati, R., & Kinner, S. A. (2016). Trajectories of psychological distress after prison release: implications for mental health service need in ex-prisoners. *Psychological Medicine*, *46*(3), 611.

Thomas, E. G., Spittal, M. J., Taxman, F. S., & Kinner, S. A. (2015). Health-related factors predict return to custody in a large cohort of ex-prisoners: new approaches to predicting re-incarceration. *Health & Justice*, *3*(1), 1-13.

Turney, K., Lee, H., & Comfort, M. (2013). Discrimination and psychological distress among recently released male prisoners. *American journal of men's health*, *7*(6), 482-493.

United Nations. (1990). *Basic Principles for the Treatment of Prisoners*. https://www.un.org/ruleoflaw/files/BASICP~2.PDF

Völlm, B., Bartlett, P., & McDonald, R. (2016). Ethical issues of long-term forensic psychiatric care. *Ethics, Medicine and Public Health*, *2*(1), 36-44.

Wallace, C., Mullen, P. E., & Burgess, P. (2004). Criminal offending in schizophrenia over a 25-year period marked by deinstitutionalization and increasing prevalence of comorbid substance use disorders. *American Journal of Psychiatry*, *161*(4), 716-727. https://doi.org/10.1176/appi.ajp.161.4.716

Walvisch, J. (2018). "Mental disorder" and sentencing: resolving the definitional problem. *Journal of Law and Medicine*, *26*(1), 159-169.

Weatherburn, D., & Holmes, J. (2017). Indigenous imprisonment in NSW: A closer look at the trend. *NSW Bureau of Crime Statistics and Research issue paper no. 126.* https://www.bocsar.nsw.gov.au/Publications/BB/Report-2017-Indigenous-Imprisonment-in-NSW-BB126.pdf

West, M. L., Yanos, P. T., & Mulay, A. L. (2014). Triple stigma of forensic psychiatric patients: Mental illness, race, and criminal history. *International Journal of Forensic Mental Health*, *13*(1), 75-90.

West, M. L., Vayshenker, B., Rotter, M., & Yanos, P. T. (2015). The influence of mental illness and criminality self-stigmas and racial self-concept on outcomes in a forensic psychiatric sample. *Psychiatric Rehabilitation Journal*, *38*(2), 150.

Whelan, J. (Unpublished). Legal and regulatory contexts of stigma and discrimination

Williams, A., Moore, E., Adshead, G., McDowell, A., & Tapp, J. (2011). Including the excluded: High security hospital user perspectives on stigma, discrimination, and recovery. *The British Journal of Forensic Practice*.

Witt, K., Van Dorn, R., & Fazel, S. (2013). Risk factors for violence in psychosis: systematic review and meta-regression analysis of 110 studies. *PloS one*, *8*(2), e55942.

Wolff, N., Blitz, C. L., & Shi, J. (2007). Rates of sexual victimization in prison for inmates with and without mental disorders. *Psychiatric Services*, *58*(8), 1087-1094. https://doi.org/10.1176/appi.ps.58.8.1087

Wolff, N., & Shi, J. (2009). Victimisation and feelings of safety among male and female inmates with behavioural health problems. *The Journal of Forensic Psychiatry & Psychology*, *20*(S1), S56-S77.

World Health Organisation. (2014). *Prisons and Health.* Copenhagen, Denmark: WHO.

Yee, N., Matheson, S., Korobanova, D., Large, M., Nielssen, O., Carr, V., & Dean, K. (2020). A meta-analysis of the relationship between psychosis and any type of criminal offending, in both men and women. *Schizophrenia Research, 220,* 16-24. https://doi.org/10.1016/j.schres.2020.04.009