CHIEF PSYCHIATRIST
of Western Australia

Ref: NG/SD/BM: OCP16719
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Via Email to neil.morgan@oics.wa.gov.au

Dear Mr Morgan

RE: RESPONSE TO THE OICS REPORT - PRISONER ACCESS TO SECURE MENTAL HEALTH TREATMENT

Thank you very much for sending a copy of the report. It is an excellent and helpful report into an important issue as I am committed to trying to ensure all Western Australians, including prisoners, have access to high quality mental health care.

As you are aware, as Chief Psychiatrist I have a statutory responsibility for overseeing the care and treatment of patients of mental health services. Although prison mental health services are currently not deemed mental health services within the meaning of the *Mental Health Act 2014* (the Act) I am responsible for overseeing the care and treatment of all patients, including those in prison, referred for examination under the Act on Form 1A *Referral for examination by a psychiatrist* and for overseeing the treatment and care they receive from inpatient mental health services if they are admitted. People referred to an authorised unit under Form 1A are the main focus of this report.

The report raises concerning issues about the lack of access that people in prison with acute mental illness have to appropriate inpatient treatment and care. While a referral under the Act is primarily for assessment by a Specialist Psychiatrist, the practical reality is that almost all of Form 1A referrals from prison require care within an authorised hospital- not just assessment. I am extremely concerned that 61% of referrals under the Act did not result in a placement at the Frankland Centre and that almost a third of individuals referred for an inpatient bed were never admitted to the Frankland Centre. In any other health setting, this would be seen as an outrage, and an entirely unacceptable situation by the WA community.

I would like to start by saying that the recommendations are helpful in trying to ensure that prisoners who need it, access appropriate mental health care in a timely manner.

Recommendations 4 and 7 are particularly relevant to my role. I will deal with them first, then discuss the other recommendations.

<u>Recommendation 4- notifying referrals to the Chief Psychiatrist</u>

I was concerned to read that the data about how many referrals lapsed without a bed becoming available and how many people were not admitted to an inpatient bed following referral, were not readily available for monitoring prisoner access to specialist mental health inpatient beds.

As Chief Psychiatrist I need access to this information as it is relevant to my oversight role of standards of treatment and care including access to appropriate care and for my role in holding mental health services and the Mental Health Commission accountable.

I would respectfully suggest however that notifying the Chief Psychiatrist of all individual referrals of prisoners to an authorised hospital and the outcome of the referral would not be the most effective or appropriate way of achieving this. I do not currently receive notifications of individual patients referred to authorised hospitals via emergency departments or from the community and do not have an operational role in managing mental health services. Receiving and tracking details of individual referrals and their outcome is an operational matter for the health service providers to ensure they are finding beds for the referred patients in a timely manner. They need a robust system for tracking referrals that allows them to give the same attention to prisoners waiting for mental health beds as those patients waiting in the community and in emergency departments.

I would therefore suggest in relation to my oversight role, that data is collated on a monthly or at minimum, quarterly basis of numbers of referrals from prison to authorised hospitals including Frankland, how many referrals lapse, how many patients are admitted and how long they waited from first referral to admission and for patients who are not admitted, from the first referral to when their final Form 1A lapses. This data should be sent to the Chief Psychiatrist on at least a quarterly basis. It should also be sent to the Mental Health Commissioner and the Director General of the Department of Health. The data could come from the Department of Justice or the Health Service Providers.

Recommendation 7 – Standards for Clinical Care

I support recommendation 7 that the Department of Justice should establish policy based on the Chief Psychiatrists Standards of Clinical Care for prisoners awaiting transfer to an authorised hospital. However I would suggest that all patients in prison receiving care from the mental health teams in prison should receive care that meets the National Standards for Mental Health Services and Chief Psychiatrist's Standards of Clinical Care and not just those referred for inpatient treatment under the *Mental Health Act 2014*. The principle of equivalence whereby prisoners are entitled to access to the same quality and range of services as people in the community is well established in the Mandela Rules and the National Statement of Principles for Forensic Mental Health. The psychiatric priority rating data shows that there are many people with severe mental illness being managed in prison who have needs very similar to if not more complex than those accessing specialist mental health services in the community. Given that many of these patients are receiving specialist care in prison from psychiatrists and Authorised Mental Health Practitioners, it is a reasonable community expectation that prison mental health services would seek to meet both the National Standards for Mental Health Services and the Chief Psychiatrist's Standards for clinical care.

I have endorsed the National Standards for Mental Health Services 2010 as the overarching standards that mental health services must comply with in addition to the Chief Psychiatrist's Standards for Clinical Care so would recommend that these standards are also adhered to despite the fact that mental health services provided in prisons do not meet the definition of a mental health service for the purposes of the *Mental Health Act 2014*.

The recent ratification by the Australian Government of OPCAT, and the ensuing reporting mechanism to be put in place will likely highlight this issue internationally.

Recommendations 1 - increasing the number of secure inpatient forensic mental health beds

I strongly support the recommendations about the need to increase the number of secure forensic mental health beds. The report documents clearly the serious lack of forensic inpatient beds to meet the needs of the growing prison population.

I would also recommend part of the increase in forensic mental health beds needs to include dedicated forensic youth beds as a matter of urgency (there are none at present); women's beds and rehabilitation beds for patients who are on custody orders or who need a longer admission.

Recommendations 2 and 3 - inpatients options other than the Frankland Centre

I am also supportive of exploring alternative options to the Frankland Centre for patients on hospital orders and prisoners who may not require the level of security provided by the Frankland Centre on condition that this is carefully managed to ensure that staff on such units are appropriately trained and supported and to ensure patients can be provided with therapeutic and safe care. Any such proposals would also need to be considered in the context of availability of inpatient beds for patients coming from the community.

Recommendation 5 - subacute units in prisons

I support the recommendation to establish a subacute unit in the women's and men's prison system. This would allow for more therapeutic management of people who are acutely unwell and have difficulty managing in the prison mainstream. However these should **never** be a substitute for authorised inpatient mental health beds. If a patient needs involuntary treatment they must be transferred to an authorised mental health unit.

Recommendation 6 - improving prison inreach mental health services

I strongly support the recommendations about the need to increase the capacity of mental health services provided in prison in order to be able to provide standards of mental health care equivalent to mental health services in other settings (see recommendation 7).

Recommendation 12 – treating mental illness with the same priority as physical illness

I support the recommendation that mental illness is treated with the same priority as physical illness.

Recommendation 15 – notification of next of kin

Recommendation 15 about notifying the next of kin is very welcome as the involvement of families and carers is a key component of contemporary quality mental health care and a focus of the *Mental Health Act 2014.*

Specialised transport for acute mental illness

I note you have chosen not to make a recommendation about the lack of specialised transport for those suffering acute mental illness despite describing the advantages of systems where prisoners can interact with staff safely during transport making the journey much less traumatic. I am concerned that the vehicles currently used to transport prisoners with mental illness are potentially traumatising and non-therapeutic and would strongly support any recommendation to include

alternative vehicle options for medical transports, pregnant prisoners and people with mental illness as part of the upgrade to the current vehicles.

Thank you very much for the opportunity to comment on this report which I hope will be useful in leveraging access to appropriate mental health care for prisoners who need it, giving them access to the same standards and range of services available to all people with mental illness.

Yours sincerely

Dr Nathan Gibson
CHIEF PSYCHIATRIST

22 November 2018