



OFFICE OF THE INSPECTOR
OF CUSTODIAL SERVICES

Prisoner access to secure mental health treatment

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Inspector's overview

We started this review in mid-2017 because we were concerned by the circumstances in which two women with acute mental health needs were moved from Bandyup Women's Prison to the state's secure forensic mental health facility, the Frankland Centre.

On a positive note, this report finds that these cases were anomalies. There is room for improvement, but movements are generally being conducted appropriately.

However, we kept hitting a much more fundamental question: *do prisoners who need to be in the Frankland Centre actually get there?* The answer is a resounding 'no': it has nowhere near enough beds to meet demand.

Everyone who responded to our draft report agreed with this, but nobody offered a solution with confirmed timelines or funding

The problem has reached such alarming levels that a solution is needed. Prisoners, as a group, have high mental health needs, and it is in the community's interests that they access treatment to improve their mental health, and to reduce the risk that they will re-offend on release.

A double-pronged approach is required, with more hospital beds and improved mental health services in prisons.

Both of these elements are essential. As the Royal Australian and New Zealand College of Psychiatrists says, 'prisons are not hospitals and should never be viewed as such.' Prison-based mental health units must not be seen as a cheaper alternative to inpatient care, but as a supplement and support to hospital-based services.

Too many people are in prison when they should be in a mental health facility

Most prisoners' mental health conditions can be managed in a prison setting provided that mental health services and supports are adequately resourced. But funding for health services in prisons, including mental health, has not kept pace with demand.

There are also some prisoners who are so unwell that they need to be in a forensic mental health facility, not a prison. The Frankland Centre is the only option, and prisoners can only get there if a psychiatrist has made a 'Form 1A' referral under the Mental Health Act. Form 1As are also used in the community when a person is so unwell that they need to be admitted to hospital involuntarily.

We knew that demand for secure forensic mental health beds would outstrip supply, but the situation is worse than we had expected. We found that:

- a third of prisoners referred to the Frankland Centre on a Form 1A never got there
- 20% of those referred multiple times never got there

- 40% of those referred on one occasion never got there
- 61% of all referrals lapsed without a hospital placement.

These figures are disturbing enough, but true demand is even higher. Psychiatrists who work in prisons are so aware of the shortage of forensic beds that they only make referrals in the most urgent of cases where a Form 1A might be clinically justified.

National and international standards state that mental health care in prisons should be equivalent to care in the community. We were informed that it is rare for someone in the community who is placed on a Form 1A not to access a hospital. Care for prisoners is therefore falling well short of community standards.

This is not in the interests of prisoners, or of the families and communities to which they will return. It also creates problems for prisons and their staff. Prisons are not hospitals, but the staff have to manage acutely unwell people in increasingly crowded, stressed and counter-therapeutic conditions.

Practices with respect to mental illness compare badly with practices for physical injuries or illness. If a health professional decides that a prisoner's physical condition is so acute that it requires hospital care, the person *will* be taken there, under appropriate security arrangements. Acute mental illness should be given the same priority.

The problem is clear, action is not

There is a very simple reason why so many referrals to the Frankland Centre are failing: demand for beds has rocketed but supply has been static for 25 years. Based on national and local estimates:

- Half of the 7,000 people in prison in Western Australia have some level of mental health disorder. Of this group:
 - around ten per cent require 'close mental health support'
 - over 200 need, or may need treatment in clinical conditions
 - at least 25 are so unwell that they require 'intensive and/or immediate care in a specialist inpatient mental health bed.'
- The Frankland Centre opened in 1993 with 30 beds. The prison population has tripled since then, but the Frankland Centre still has 30 beds.
- Of all Australian states, Western Australia has the lowest number of forensic beds per 100,000 of the population. We have just 1.9 beds. The national average is 3.4, and Tasmania and New South Wales have over 5.

This is the first report to quantify the gap between prison referrals and actual placements, but the problem has been known for at least fifteen years. Over that time, there has been no shortage of high level inter-agency meetings, in principle commitments, policy documents, and paper bullet points. What has been missing is action.

Plans for more forensic hospital beds are unclear and unfunded

The Frankland Centre is clearly too small to cope with numbers and need. As Western Australia's 'one-stop shop', it must hold adults and sometimes children, males and females, and people from metropolitan, regional and remote areas. In addition to treating people who are too unwell for a prison or detention centre, it must hold people who are referred for psychiatric assessment by a court.

The problems are well-illustrated by the position of young people. Currently, in order to meet the legislative obligation to separate young people from adults, part of the Frankland Centre needs to be emptied if a young person from Banksia Hill Detention Centre is admitted. Because of the strain this places on the centre, it only happens in extreme circumstances. Young people were outside the scope of this review, but we agree with the people who, in response to our draft report, have called for dedicated forensic youth beds.

We have recommended an increase in the number of secure forensic mental health beds. This aligns with the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025, and everyone who responded to the draft report appeared to support this recommendation. But it is unclear what will be done, who will fund it, and when it will happen.

It is not for us to debate who should fund what. Some things just need to be done.

To alleviate pressure in the interim, we have recommended that lower risk people should be diverted to other hospital settings. This is not a new idea, but attempts appear to have failed in the past. The difficulty is addressing security and safety concerns of staff and managing the impact of diversion into facilities that are already under extreme demand. However, we hope that the Western Australian health system, corrections and the courts will work together to address these barriers.

Plans for better mental health services in prisons are unclear and unfunded

The responses to our draft report revealed general agreement with the recommendation for a subacute unit in Bandyup Women's Prison, but different views on where the responsibility for funding lies. To date, applications for funding have failed. Again, it is not for us to debate who should fund what: it just needs to happen.

In December 2017, the government announced that four new accommodation units will be added in to Casuarina Prison by the end of 2019. It is intended that some of the new capacity will be used to provide targeted mental health services, with talk of a 'step-up, step-down' service. However, the Department of Justice has not yet developed a model for delivering these services, including purpose, scope and staffing arrangements.

It must be emphasised that, at best, the Bandyup and Casuarina proposals will service the needs of people who do *not* need hospital treatment. Prison accommodation, especially of

the type to be used at Bandyup and Casuarina, can never displace the need for more hospital beds.

Transports are generally conducted appropriately

The immediate catalyst for this review was the movement of two women from Bandyup Women's Prison to the Frankland Centre in mid-2017 in concerning circumstances. Movements of this sort are conducted by a private contractor, Broadspectrum, under contract with the Department of Justice.

In one case, a very unsettled woman was transported naked. The prison rushed her move without attempting to stabilise her, and without adequate mental health oversight.

In the other case, Bandyup did the opposite. Both the Frankland Centre and the transport contractor were waiting, but Bandyup insisted that she complete the last two hours of a period of 'separate confinement' imposed for a prison offence committed several months earlier. If she had suffered a broken arm, she would have been immediately transferred. Her 'broken mind' was not treated with the same urgency.

On a positive note, we found these cases were anomalies, and that movements between prisons and the Frankland Centre are generally being conducted in an appropriate way by Broadspectrum and the Department of Justice.

I am also pleased to report that when issues were recognised, the Department of Justice and Broadspectrum implemented improvements. The Department has also provided detailed responses to recommendations, and has indicated how they will be actioned. The changes that are flagged will reduce the risk of similar occurrences in the future.

However, there is room to improve processes and coordination. Currently, too much hinges on goodwill and personalities rather than robust processes. This generates inefficiencies and risks.

As the vehicle fleet is upgraded, consideration should be given to commissioning a secure medical transport vehicle. Most transfers to the Frankland Centre take place in standard custodial transport vehicles. These vehicles are 'hard', sterile, isolating and claustrophobic. Mental health patients deserve better.

Information and tracking

There is no tracking of when people are referred to the Frankland Centre from prison and the outcome of the referral. We therefore had great difficulty determining how many people had been moved to the Frankland Centre and how many never made it. Information had to be patched together from multiple sources.

We have made a recommendation to improve record keeping. All agencies agree this is necessary but there was there was no agreement on who is responsible for doing so.

If agreement can't be reached on how to record and track basic information, it is difficult to see how the larger actions discussed in this report will be achieved.

Summary

We must stop placing mentally unwell people in prison, not providing adequate access to treatment, releasing them, and expecting a good outcome.

At a time when mental health services as a whole are under so much pressure, it may be hard to build a case for services to prisoners. But we already spend an enormous amount on incarceration. It costs, on average, \$300 a day, or \$100,000 a year, to keep just one adult in prison. It costs even more to hold people with serious mental health problems.

The additional costs of providing proper mental health treatment are likely to be substantially, or fully offset by improved mental health, reduced risk to the community, and a lower risk of the person returning to prison.

In short, the issues are known, the solutions are known, and progress is desperately needed.

Neil Morgan

21 September 2018

Executive summary

At least ten per cent of prisoners require mental health support

Prisoners are more likely to have experienced risk factors which cause mental illness when compared to the rest of the community. These risk factors include being socially excluded or isolated; poverty, neglect, abuse or trauma; misusing drugs or alcohol; having poor physical health; or having a physical or intellectual disability (COAG, 2012). In 2015, almost half of the people entering prison in Australia (49%) had reported being told by health professional that they had a mental health disorder (AIHW, 2015). This was an increase from 38 per cent in 2012. The report also stated that more than a quarter of people entering prison (27%) were taking medication prescribed for mental health conditions (AIHW, 2015).

In November 2017, the mental health teams in the Department of Justice (the Department) in Western Australia were providing close support to approximately 10 per cent of the prison population (DOJ, 2017). This is over 600 people, 218 of whom require treatment in clinical conditions. To put this in perspective, in total, there are 605 mental health beds in specialised wards run by the Department of Health across Western Australia (DoH, 2018). This means almost the same number of people with mental health conditions are supported in our prisons as are in our hospitals.

These numbers are based on the Department's recently implemented model which assigns a psychiatric risk rating to prisoners with a potential risk or a previous history of a mental health condition. The rating is not a clinical diagnosis, but indicates what services are needed and where they are needed.

The psychiatric risk rating system has four categories. Prisoners can be categorised as:

- P1 – people with serious psychiatric conditions requiring intensive and/or immediate care in a specialist inpatient mental health bed
- P2 – people having significant ongoing psychiatric conditions requiring treatment that may also require a specialist inpatient or subacute mental health bed
- P3 – people with a stable psychiatric condition that required an appointment or continuing treatment
- PA – people who were suspected of having a psychiatric condition but required assessment.

In November 2017, there were 25 people rated at P1 and 193 rated at P2. This means that 218 prisoners were in, or were expected to be in, a clinical state where they would have been admitted to hospital had they been in the community.

There were over 300 people with stable psychiatric conditions requiring treatment, and 67 people who needed an assessment.

Half of the people supported by the Department's mental health teams were at maximum-security metropolitan prisons. A further quarter were at Acacia, a privately run medium-security prison which is the largest prison in the state. A few were held in the larger metropolitan prison facilities, and a substantial proportion (17%) were supported in regional prisons.

The number of women needing support is high. A quarter of the women held at Bandyup Women's Prison are being supported by mental health staff. Melaleuca Remand and Reintegration Facility has a smaller proportion of people needing support, but their needs were higher. Twenty-five women were identified as having serious or significant ongoing psychiatric conditions that does or may require specialist inpatient care. Melaleuca has only four beds for crisis care, which also serve as protection and management units.

Prisoners are supposed to be transferred to the Frankland Centre if involuntary treatment is needed

A person who becomes acutely mentally unwell in Western Australia may be treated without their consent, through an involuntary treatment order. This order is instigated by a doctor or mental health practitioner and issued under the *Mental Health Act 2014*. Strict criteria govern when these orders can be applied. All the following criteria must be met:

- the person has a mental illness requiring treatment
- because of the mental illness there is a significant risk
 - to the health or safety of the person, or to another person; or
 - of serious harm to the person or to another person
- the person does not demonstrate the capacity required to decide about the provision of their treatment
- the person cannot be adequately provided with treatment in a way that would involve less restriction of the person's freedom of choice and movement than making the treatment order.

Outside custody, it is possible for involuntary treatment to be provided in a community setting. Only when treatment in the community cannot be reasonably provided is the person admitted to hospital for treatment. Community treatment orders, particularly to enforce medication, would only be applied to people in prison in rare circumstances. It is a complex issue that is open for abuse without stringent checks and balances, and psychiatrists are reluctant to authorise them. The Royal Australian and New Zealand College of Psychiatrists has produced a consensus statement about involuntary treatment in custodial settings which outlines why this should not occur (RANZCP, 2017). Therefore, prisoners who are acutely unwell, are supposed to be transferred to a hospital to receive clinical care. Almost always this will be the Frankland Centre as this is the only secure forensic mental health facility in the state. The Frankland Centre comes under the responsibilities of the State Forensic Mental Health Service (SFMHS) which is a division of the Department of Health's North Metropolitan Health Service.

Only a psychiatrist can determine if a person needs to be treated involuntarily. A doctor or an authorised mental health practitioner may order a person to a psychiatrist for an examination to begin this process. This order for assessment, a Form 1A referral, is valid for three days, although it can be extended for people who do not live in metropolitan areas.

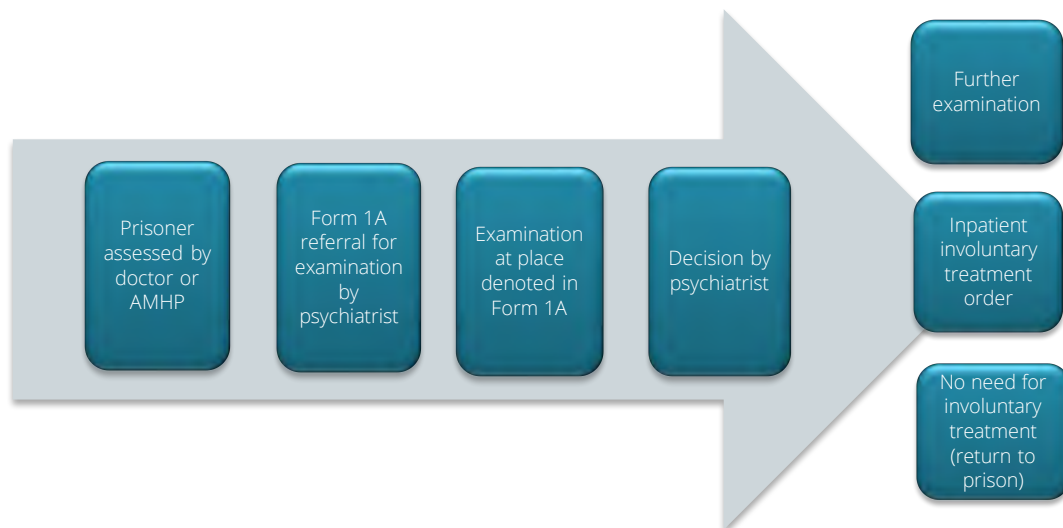


Figure 1 Process for enacting involuntary psychiatric treatment

In practice, prisoners are usually already receiving treatment by a psychiatrist. The referral is to place the person in a clinical rather than custodial setting, which allows for more intensive treatment and enables compliance with medication. Technically, the prison psychiatrist is making a referral as a medical practitioner and the psychiatrist at the Frankland Centre examines the patient to determine if an involuntary treatment order is needed. Given the extensive liaison between the psychiatrists, it is rare that an involuntary treatment order is not needed.

Key findings

Prisoners needing clinical care are not able to access it

The majority of referrals to the Frankland Centre for clinical mental health treatment do not result in a placement. Even after multiple referrals a third of people never access the centre. These people are reliant on clinical care being provided within the prison, but the ability to provide services in these environments is poor. There are no designated therapeutic units and in-reach services fall well short of need. Most management of people with mental health conditions is carried out by custodial staff who have limited training in managing mental health issues and do not have access to full information about the person's needs.

The problems of not accessing care are well known and getting worse, but no action has been taken

The number of beds at the Frankland Centre have not increased since it opened in 1993 when the prison population was a third of the current population. Multiple agencies, including this Office, have drawn attention to the shortage of beds for well over a decade but no change has occurred. The prison population has continued to rise and the volume of people requiring a mental health assessment when they initially come to court also continues to rise. Clinical and judicial decisions are

being compromised by the lack of beds, with unwell people being released early from the Frankland Centre and unwell people not being sent for assessment from court.

Staff are making the system work as best they can despite the severe limitations

Custodial and clinical staff are continually adapting and applying band aid solutions to make the severely under-resourced system provide as much support as they can. Goodwill, perseverance, and good intent are driving service delivery. While this is commendable, it is inefficient and vulnerable to staff movements. Policy and written guidance is lacking, particularly for custodial staff who are mostly responsible for managing prisoners with mental health issues.

Transport between prison and the Frankland Centre is mainly safe, but areas of concern are impossible to track

Most prisoner transfers to the Frankland Centre have been conducted safely and without incident. Almost all transfers between prisons and the Frankland Centre are conducted as a direct transfer between the two facilities with only one person in custody in the vehicle.

However, the reporting of critical incidents during transfer is insufficient and movements of people with mental health conditions, prior to their transfer to the Frankland Centre, are largely impossible to track. The two case studies which triggered the review were not initially reported as critical incidents, with one still not considered an incident. Substantial improvement in recognising and appropriately reporting incidents is needed by both the Department and transport contractors. Safety can also be improved by including specialist vehicles for medical transports in the secure fleet and reducing transports to the Frankland Centre late in the evening.

Conclusion

The State is not meeting the mental health needs of prisoners. The number of beds at the Frankland Centre has been inadequate for over a decade. Access to clinical care in the custodial environment is minimal. Daily management of people with serious mental health needs is left to custodial staff who have limited training, few management options and poor access to information. If a person is able to access a bed at the Frankland Centre, transports to and from the facility are mostly safe but better reporting is needed.

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1 Prisoners needing care in a clinical environment are frequently unable to access it

This review set out to examine the safety of transporting prisoners to a clinical environment when needed. To get a full picture, we chose to look at how people were managed before the transfer and after their return. In doing so, we discovered a larger problem, that many people do not make it to clinical inpatient setting at all. They remain in prison even though they have been identified as needing clinical care in a specialised hospital.

Western Australia only has one secure forensic mental health inpatient facility, the Frankland Centre. It is located at Graylands Hospital in Mount Claremont. It caters for all people needing care in a clinical setting while in custody. Therefore, it is used for men, women and, on the rare occasion, young people in detention. The centre is too small, must balance competing priorities and struggles to cater for the needs of differing age, gender and other health or security issues. The result is that there is often no room for people to access the Frankland Centre when needed, and even those that do make it may have to leave early to free up beds for someone else.

1.1 The capacity of the Frankland Centre falls far short of need

At present, there are simply too few secure mental health beds to effectively manage the identified needs of Western Australia's prisoners. The Frankland Centre was opened in 1993 with the same number of secure beds as exist today; 30 acute beds and eight subacute beds. At that time, the prison population in Western Australia was 1,985. This equated to 19.2 forensic mental health inpatient beds per 1,000 prisoners. Since then the prison population has more than tripled with an average population during 2017 of 6,678 people. This leaves just 5.7 beds per 1,000 prisoners. To restore this to 1993 levels would require an increase of approximately 90 beds.

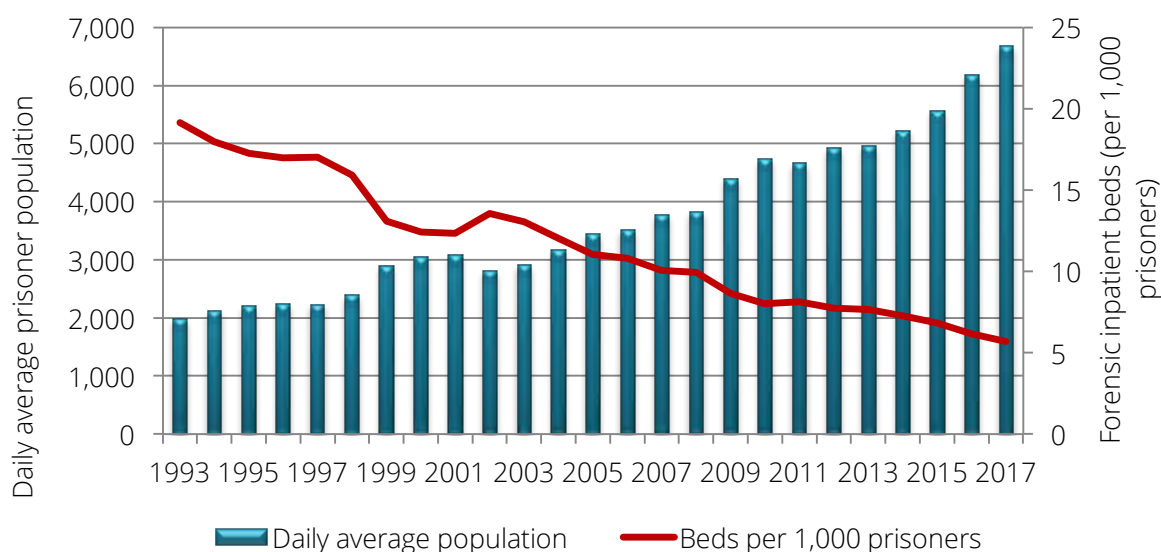


Figure 2 Number of forensic beds in Western Australia per 1,000 prisoners, by year

The underinvestment is not aligned with other states. Western Australia has the lowest number of forensic beds in the country per 100,000 population (1.9), with the exception of the Australian Capital Territory and Northern Territory (neither of which have any forensic beds) (AIHW, 2018). Western Australia falls far short of the national total of 3.4 beds per 100,000 people.

Western Australia and Victoria, were the only jurisdictions that did not increase forensic bed capacity from 2010-2011 (AIHW, 2012). Western Australia's capacity remained unchanged while Victoria reduced its number by two beds although it remained comparable to the national rate.

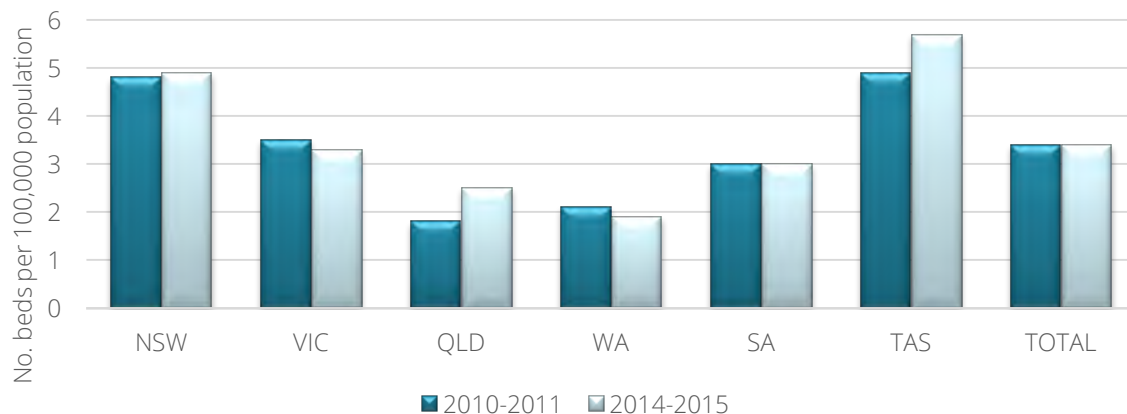


Figure 3 Comparison of public sector forensic beds per 100,000 population, by state and year (AIHW, 2017)

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives., seeks to address the deficiency (MHC, 2015). The plan acknowledges that the current number of forensic inpatient beds is less than half what it should be to meet demand. It states that the forensic inpatient beds are to grow from 30 acute and eight subacute, to 62 acute and 30 subacute by the end of 2025. However, this plan comes with no dedicated funding and therefore, no clear path to implementation.

The bed deficiency is a well-known issue. We drew attention to the scarcity of forensic beds in Western Australia in a thematic review of health services in 2006 (OICS, 2006), in multiple inspection reports over the years, and more specifically in our review of mentally impaired accused on custody orders (OICS, 2014). From 2012 we began specifically highlighting this problem in our annual reports identifying it as one of the top issues affecting custodial services. We have continued to make this same comment over the years (OICS, 2017; OICS, 2015; OICS, 2014; OICS, 2013; OICS, 2012).

We are not alone. The new mental health plan was in response to the July 2012 Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia (otherwise known as the Stokes Review). This recommended urgent consideration for planning and funding a full range of mental health services in Western Australian prisons and detention centre (Stokes AM, 2012).

As far back as 2004 the Mentally Impaired Accused Review Board (the Board) in Western Australia referred to the urgent need to increase the number of beds (MIARB, 2004). The Board has continued to reiterate this statement most recently in its annual report (2016-2017) and many other times in the intervening years (MIARB, 2017; MIARB, 2016; MIARB, 2015; MIARB, 2014).

The Western Australian State Forensic Mental Health Service Review in 2008 drew attention to the shortfall of secure forensic beds (NMAHS, 2008). The deficiency was also raised by the Economic Regulation Authority in a discussion paper published for the Inquiry into the Efficiency and Performance of Western Australian Prisons (ERAWA, 2015). Both the Royal Australian and New Zealand College of Psychiatrists (RANZCP, 2016) and the Western Australian Association for Mental Health (WAAMH, 2016) entered submissions to the Senate Inquiry into the indefinite detention of people with cognitive and psychiatric impairment in Australia highlighting the severe shortage of beds.

Like the new mental health plan, many of the recommendations from these reports calling for an increase in the number of beds have been supported but no action has occurred. As we stated in our last annual report, in the last few years, an enormous amount of energy, time and money has been spent discussing the problem. What is needed now is action (OICS, 2017).

Recommendation 1 – Government to commit funding to increase the number of secure forensic mental health beds

1.2 The limited resources at the Frankland Centre must stretch to meet competing needs

Prisoners in need of acute care are not the first priority for the Frankland Centre. The centre balances the needs of three groups:

- people under hospital orders, where the court has ordered an assessment of an accused person to be undertaken
- people held on custody orders, who are deemed to be not fit to stand trial or were of unsound mind when an alleged offence was committed
- prisoners whose acute care cannot be managed in prison.

Regardless of acuity, referrals by hospital order are given the highest priority for bed allocation. A hospital order is made under the *Criminal Law (Mentally Impaired Accused) Act 1996*. It has the same effect as if the person had been referred for assessment for involuntary treatment under the *Mental Health Act 2014*.

An assessment via hospital order can take up to seven days. Approximately 110 people are admitted to the Frankland Centre on hospital orders each year.

While a hospital order can be made for a person to have a psychiatric assessment at any authorised hospital, in practice, all referrals currently come to the Frankland Centre. An authorised hospital is a hospital or part of a hospital that has been gazetted to admit, assess, and detain involuntary patients under the *Mental Health Act 2014*. Anyone held involuntarily either while in the community or in custody is held in an authorised hospital. The Office of the Chief Psychiatrist maintains a register of these hospitals in Western Australia. As of February 2018, there were 16 hospitals with units or wards able to hold involuntary patients (Chief Psychiatrist of Western Australia, 2018).

To ensure there is room for hospital order admissions, each morning Frankland Centre staff assess the patients currently residing at the centre. They determine who is the least unwell and who will be at the

top of the list to be returned to prison if a bed is needed. The clinical decision of whether a person needs further treatment is therefore compromised by bed availability.

From the opposite perspective, the courts are also influenced by the bed availability as they are aware of the impact of sending someone for assessment. In response to an OICS report discussing this issue in 2014, the Chief Magistrate noted:

There is a constant problem in being able to place someone on a hospital order because of the lack of beds. This means that magistrates may not make the appropriate order because they take this into account and as a result someone in need of treatment ends up in prison (OICS, 2014).

The second group catered for by the Frankland Centre are people with a treatable mental illness who are held on custody orders. The order was applied because they are unfit to stand trial or were acquitted because they were unwell when they committed an offence. For several reasons, there is only a small number of people held on custody orders. Our 2014 review discussed this in detail (OICS, 2014).

Our review concluded that people who were placed at the Frankland Centre fared better than those on custody orders who were placed in prison, particularly in terms of the speed of their release. But again, regardless of the fact that these people have not been found guilty of committing an offence, only people with the highest needs were able to access the centre due to the lack of beds. Our review found that people were penalised for having less severe health needs, because those that did not access the Frankland Centre had a much slower path to release.

The last group vying for a bed in the Frankland Centre are unwell people who are in prison – the subject of this review. On any given day during the review period, this group took up between four and 16 of the 38 beds at the centre.

Our custodial system is designed to house people in prison and move them to clinical care when needed. However, given the severe lack of beds, the person's ability to access clinical care is not only based on the severity of their needs, but also the severity of the needs of others accessing the facility. Risks, such as the behaviours and offending patterns of other already-admitted patients, the need to separate genders, and the additional needs of catering for someone with a cognitive impairment or physical health issues is also considered. After all these factors are taken into consideration, the prisoner with the highest level of need may not be admitted.

Given there is only one secure forensic hospital, the centre must also cater for juveniles. This occurs rarely. Under the general principles of the *Young Offenders Act 1994* and section 303 of the *Mental Health Act 2014*, young people must be kept separate from adults while in custody and while admitted to a mental health service. Therefore, treating a young person at the Frankland Centre and separating them from adults, requires significant logistical effort. It often means part of the facility needs to be vacated.

Under these circumstances, the ability for the Frankland Centre to meet demand is poor. While it remains necessary to increase the number of beds at the centre, a more immediate solution to increase capacity is also needed. One solution is to divert hospital orders for non-serious offenders to an authorised hospital other than the Frankland Centre.

While authorised hospitals are designed to hold people involuntarily, arrangements may need to be established between the Department of Health and the courts to ensure security provisions match the risk of housing these people during their assessment.

Recommendation 2 – Department of Justice to work with judicial officers and the Department of Health to make arrangements to allow non-serious offenders on hospital orders to be diverted to other authorised hospitals and not just the Frankland Centre

1.3 Sixty-one per cent of referrals do not result in a placement at the Frankland Centre, most lapse

Between 1 July 2016 and 31 August 2017 there were 319 Form 1A referrals for hospital assessment made for 147 different prisoners. These referrals were made through the Department's medical database and therefore, can be considered the minimum number submitted as doctors and authorised mental health practitioners can also make a referral through other means. Of the 319 referrals, 61 per cent did not result in a placement at the Frankland Centre (194).

Most referrals lapse past the three-day validity period. However, good relationships between the prisons and the Frankland Centre allow the lapsed cases to still be considered for placement. If a person is deemed to be most suitable for an available bed and their referral has lapsed, another referral is immediately created. While this is commendable, referrals are only valid for three days because the person is in crisis and deemed to need immediate clinical care. The fact that most of the referrals lapse demonstrates the scale of the crisis.

Almost a third of the people referred to the Frankland Centre did not go

Of the 147 distinct prisoners placed on Form 1A referrals, half were referred on multiple occasions throughout our review period. Twenty people were admitted more than once. However, almost a third of the people placed on a Form 1A never made it to the Frankland Centre.

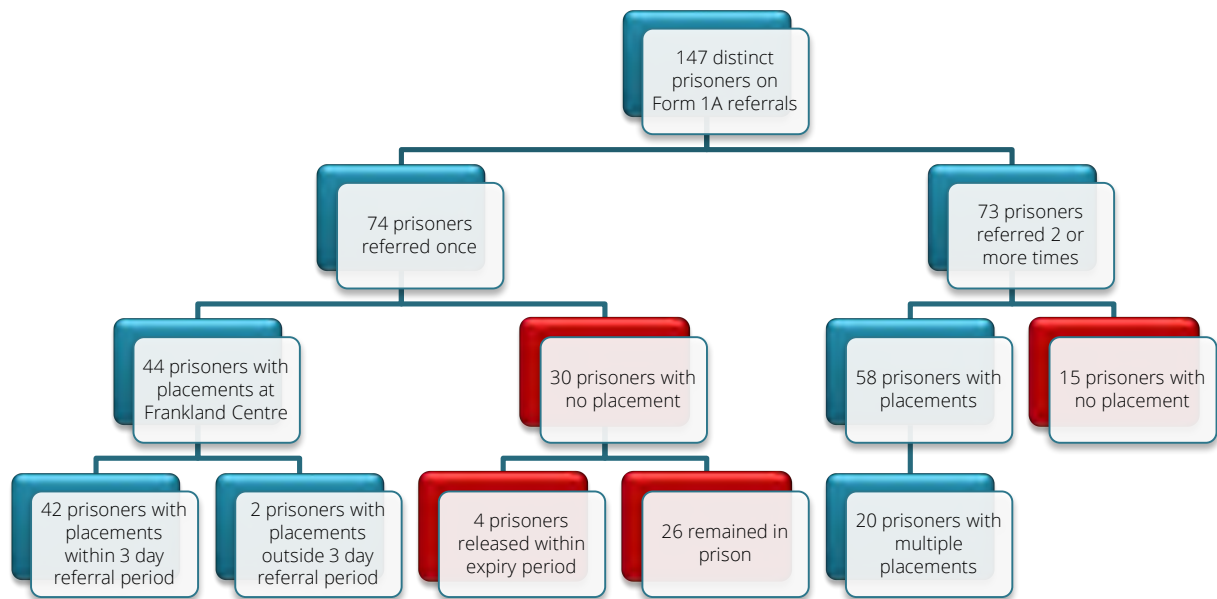


Figure 4 Outcomes for distinct prisoner's referrals to the Frankland Centre

Thirty people who did not access the Frankland Centre did not have a second referral. Four of these people were released within the three-day referral expiry period. When this occurs, the policy is for the authorising clinician to phone the Western Australia Police and the local Emergency Department and advise them of the need for the person to be transported under the *Mental Health Act 2014*. This relies on the police attending before the person leaves the facility. In practice, we found evidence that one of these people was moved via the Department's transport contractor directly to community mental health facilities on release. This was likely driven by good will, and a desire to provide continued care, but does raise questions about the legal authority for the transfer.

The other 26 referrals were for prisoners who remained in custody beyond the expiry period, including one young person at Banksia Hill Detention Centre. Most of these people were being monitored under observation in assisted or crisis care units, or the infirmary at Casuarina Prison.

In addition, 15 people with multiple referrals during the review period, did not access the Frankland Centre. Presumably this was because they were 'less unwell' than others referred at the same time. One person at Hakea Prison had eight referrals within two months but was unsuccessful in obtaining a place.

Table 1 Form 1A referrals made through EchO and subsequent placements at Frankland Centre

No. of referrals	No. of prisoners	No. of prisoners with a placement (within 3days)	No. of prisoners with a placement (outside 3 days)	No. of prisoners with referrals but no placement	% of prisoners with referrals but no placement
1 referral	74	42	2	30	20.4%
2 referrals	32	23	2	7	4.8%
3 referrals	17	14	1	2	1.7%
4 referrals	8	4	0	4	2.7%
5 referrals	6	5	0	1	0.7%
6 referrals	6	6	0	0	0.0%
7 referrals	1	1	0	0	0.0%
8 referrals	2	1	0	1	0.7%
9 referrals	1	1	0	0	0.0%
Total	147	97	5	45	30.6%
% of people with single referral but no placement					40.5%
% of people with multiple referrals but no placement					20.5%

It would be very rare that someone in the community who was placed on a Form 1A would not access a hospital for assessment. Therefore, the current arrangements between the Department of Justice and the Department of Health are not meeting the standard of care that is present in the community.

It also is not the equivalent level of care which is provided for physical injuries or health conditions. If a person in custody is deemed by a health professional that hospital care is required for a physical health condition, the person is taken to hospital. Security is provided via contractor, in what is termed a hospital sit. This is available to every person in custody who has acute physical health care needs. It is also available for the delivery of specialised services, such as dialysis.

To assume that an extension of the hospital sit arrangements can be simply applied for obtaining mental health treatment is optimistic. But this does show that arrangements can be made for prisoners to access community services when the need is high. When 30 per cent of the people referred for acute clinical mental health care are unable to access it, and even more are unable to access care within three days, the need is arguably high and options other than the Frankland Centre should be actively explored and implemented.

This will require coordination with health and mental health service agencies. However, all agencies will benefit from finding ways to increase acute care services to prisoners, given these people will end up in health services after release, particularly if their care has not been sufficient while in custody.

Recommendation 3 - Department of Justice to make arrangements with health and mental health agencies to provide acute clinical care for prisoners in facilities other than the Frankland Centre

The Western Australian Chief Psychiatrist has jurisdiction over anyone placed on a Form 1A, including prisoners. The Chief Psychiatrist is responsible for overseeing the treatment and care of

- all involuntary mental health patients
- all voluntary patients being provided with treatment and care by a mental health service

- all mentally impaired accused required under the *Criminal Law (Mentally Impaired Accused) Act 1996*
- all people referred on a Form 1A

The Chief Psychiatrist must discharge that responsibility by publishing standards for care and treatment and overseeing compliance with the standards. However, due to a strange legislative anomaly, and despite more people in prison receiving mental health services than people in hospital, the Chief Psychiatrist does not have jurisdiction over people with mental health conditions in custody unless they have been placed on a Form 1A. Once referred for treatment these people are under the *Mental Health Act 2014* and are subject to the standards and oversight of the Chief Psychiatrist. However, once the referral lapses, even if the person has not accessed clinical care, they are no longer subject to the oversight of the Chief Psychiatrist. At a minimum, the Chief Psychiatrist should be notified of when the referral has lapsed without the person being transferred to a clinical environment.

Recommendation 4 – Department of Justice to notify the Chief Psychiatrist of all referrals of prisoners to an authorised hospital and the outcome of the referral

1.4 The process of selecting people for placement relies on goodwill rather than good processes

It is unclear who has ultimate responsibility for selecting a person for placement at the Frankland Centre. Goodwill between mental health staff in the Department of Justice, and staff at the Frankland Centre underpins a process of negotiation as to which patient is most in need of the bed.

Frankland Centre staff have responsibility for determining if someone is suitable for placement and if a place is available. Health staff at the Department of Justice are responsible for providing information on the patient so that reasonable decisions about priority can be made. Without shared information systems, the amount of detail available to Frankland Centre staff about the patient varies, particularly the information provided in written documentation. Phone consultation with multiple staff in different prisons on the day a bed becomes available is often necessary.

The goodwill and professionalism of staff make this system work, but it is inefficient and has a high risk of error. While accessing a bed in the community also follows a similar process of negotiation, the difference is the high number of prisoners who never get placed which increases the consequence of the risk.

2 Management of mental health in the custodial environment is inadequate

People who are awaiting transfer to the Frankland Centre, and those who have been referred but never make it, are managed custodially rather than clinically. Rather than treatment, the emphasis is on supervision and monitoring to ensure the person does not physically harm themselves or endanger others. Clinical in-reach may be provided, but day-to-day management of people with significant psychiatric conditions is left to custodial staff who are not trained to manage mental health conditions, have very few options to manage people, and do not have access to sufficient information to make meaningful decisions.

2.1 Access to clinical care is minimal

There are no designated therapeutic units

Currently, there are no subacute beds in any of our prisons, nor any designated therapeutic units in prisons. These facilities would allow mentally unwell people to be accommodated in a therapeutic unit, outside of mainstream custody, with multidisciplinary services available to meet the needs of the prisoners.

These units would serve two purposes:

- To provide intensive clinical treatment and intervention to prevent risk of further deterioration. In some cases, this may eliminate the need for hospital treatment at the Frankland Centre.
- To provide a supportive short-term transition prior to accessing care at the Frankland Centre and on return so people are not placed immediately into a potentially confronting custodial environment.

The lack of these facilities has been recognised in Western Australia's new mental health plan Better Choices. Better Lives (MHC, 2015). This plan recommends that the number of subacute beds in prisons increases from zero to 70 by the end of 2025. In December 2017, the Western Australian government announced a 672-bed expansion project to the prison estate due to be completed by the end of 2019. There are no plans to include subacute beds in this expansion.

The Department of Justice has lodged a submission to the Mental Health Commission to establish a subacute unit at Bandyup Women's Prison. A model of care and proposed staffing has been developed. Nursing staff would be available 12 hours a day, and allied health staff would be available 8.5 hours every day. Custodial staff with an interest in working with women with a mental illness will be rostered into this unit. If this proposal is successful, it will provide a much-needed pilot for how subacute beds in a custodial environment could work in Western Australia. The Department would provide substantial ongoing operational costs, but is seeking additional funding for initial capital works to upgrade the infrastructure and supplement operational costs. The Mental Health Commission has advised the Department that funding cannot be provided by the Commission.

Recommendation 5 – Government support the establishment of the subacute unit in Bandyup Women’s Prison with the intention of expanding subacute care into men’s facilities

Because of the lack of therapeutic facilities, some prisons have improvised alternatives. Prisoners needing additional support and monitoring are identified and brought together to be accommodated in specific units or wings.

- Acacia Prison has an assisted care unit for prisoners requiring additional care with their day-to-day lives. Traditionally, this unit has accommodated elderly patients but the 33-bed unit is increasingly holding prisoners with mental health concerns.
- Casuarina Prison has a wing that homes prisoners considered ‘disturbed and vulnerable’ some of whom have spent time being assessed and treated at the Frankland Centre. The wing has a capacity of 26 but there are plans to move to another unit with more beds.
- Hakea Prison does not have a dedicated wing but in January 2018 was exploring the staff resourcing requirements for a mental health unit. This is a much-needed service given Hakea sends, on average, one prisoner to the Frankland Centre each week.

In-reach does not meet need

Mental health services are provided by the Department’s nurses, in-reach psychiatric services through the State Forensic Mental Health Service (SFMHS) and private psychiatrists. Most services are delivered at metropolitan maximum and medium-security facilities.

The Department has an agreement with the SFMHS to provide an average of 57 hours of psychiatric in-reach per week. Of those hours, a minimum of 44 hours is allocated to:

- Bandyup (14 hours)
- Casuarina (18 hours)
- Hakea (4 hours)
- Karnet (2 hours)
- Wooroloo (2 hours)
- Banksia Hill Detention Centre (4 hours).

An additional 13 hours can be allocated as needed. This agreement took effect on 1 November 2016 as part of a Memorandum of Understanding with the North Metropolitan Health Service – SFMHS (SFMHS and DCS, 2017).

This level of service does not meet need. In November 2017, 626 people were being supported by the Department’s mental health teams, 218 of whom had a significant psychiatric condition which required, or may require specialist inpatient care.

Table 2 Adult mental health patients in custody in Western Australia, by facility (November 2017)

Facility	Daily average population	No. of prisoners being supported as mental health patients					% of population being supported as mental health patients
		P1	P2	P3	PA	Total	
Maximum-security							
Albany	450	4	37	5	6	52	11.6%
Bandyup	214	3	4	46	-	53	24.8%
Casuarina	936	-	54	15	-	69	7.4%
Hakea	997	9	13	63	25	110	11.0%
Melaleuca	230	5	20	4	1	30	13.0%
Medium-security							
Acacia	1,461	1	3	123	25	152	10.4%
Minimum-security							
Boronia	90	-	-	-	-	-	
Karnet	334	-	-	25	7	32	9.6%
Pardelup	88	-	-	-	-	-	
Wandoo	65	-	-	-	-	-	
Wooroloo	369	-	-	20	-	20	5.4%
Multipurpose-security							
Broome	86	-	-	1	-	1	1.2%
Bunbury	352	-	12	16	2	30	8.5%
Eastern Goldfields	283	3	12	3	-	18	6.4%
Greenough	312	-	37	4	-	41	13.1%
Roebourne	195	-	1	11	-	12	6.2%
West Kimberley	212	-	-	5	1	6	2.8%
Total	6719	25	193	341	67	626	9.4%

Currently, there are 53 women supported by the mental health team at Bandyup Women's Prison. If each person was allocated the same amount of psychiatric in-reach, they would receive 32 minutes per fortnight. Within this time the psychiatrist would be required to review previous case notes and prescriptions, see the patient, and write additional notes or prescriptions.

This may be sufficient for people with a stable psychiatric condition, but not for people who require or may require specialist inpatient treatment. Logically, there would be a concentration of services being provided to those requiring the most intensive and/or immediate care. This leaves limited capacity to service those prisoners with a lower priority.

In some cases, even a redistribution of resources away from those with a lower priority, may not make a substantial difference to the amount of resources available for higher priority patients. For example, if Bandyup focused on providing services to the priority one and two patients, they would be able to provide a maximum of four hours of psychiatric care for each priority person over a fortnight. However, at Casuarina, focusing solely on priority patients only would only result in 40 minutes of care per fortnight for priority patients, and means that other patients currently being supported would receive no care.

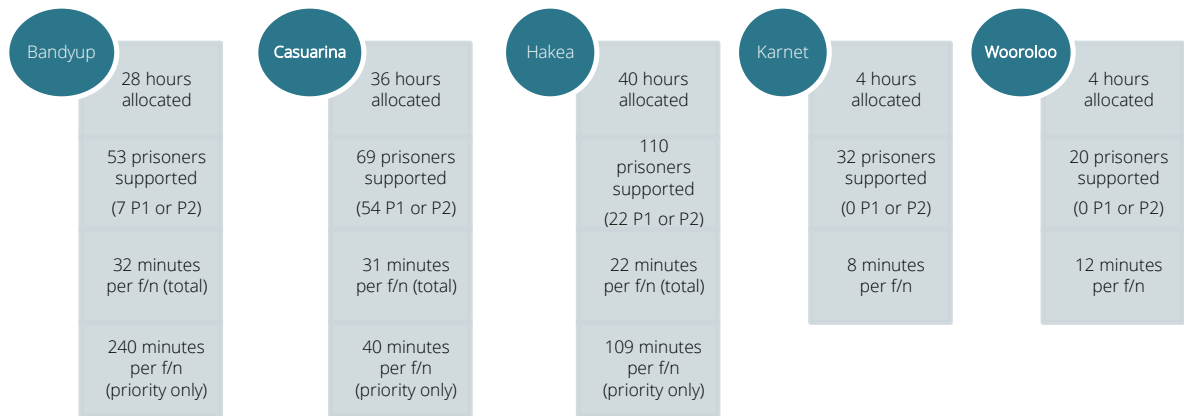


Figure 5 Psychiatric allocation by number of prisoners being supported by prison mental health team (November 2017)

Albany and Greenough regional prisons, who both had a high proportion of priority one and two patients, have a fee for service arrangements with a visiting psychiatrist. In the 2016–2017 financial year, Albany was billed for 330 in-reach hours, and Greenough 112 hours. Averaged over the year, this equates to Greenough providing 7 minutes per fortnight for all mental health patients, or 6 minutes per fortnight if only focusing on priority one and two patients.

Albany provided 15 minutes per fortnight for all patients, or 19 minutes for only priority one or two patients. Since then, our 2018 inspection shows a further reduction in services with the departure of the visiting psychiatrist. Reduced services are now provided via telehealth.

Recommendation 6 – Department of Justice work with Department of Health to increase in-reach services to meet need

2.2 Being referred to the Frankland Centre does not prompt specific action

There is no Departmental policy regarding the management of prisoners once they have been referred to the Frankland Centre but are still awaiting transfer. However, there is an expectation that increased monitoring of the person will be undertaken by using the At-Risk Management System (ARMS) or moving the person to a special purpose unit such as crisis care. ARMS is designed for suicide prevention and reducing the risk of self-harm.

We examined 18 case studies of people who had accessed the Frankland Centre. Together these people had a total of 35 Form 1A referrals during the review period. On the day those referrals were submitted, three prisoners were being managed under ARMS, four were being monitored in special purpose cells, and a further 19 were being managed under a combination of ARMS and specialised cell placements.

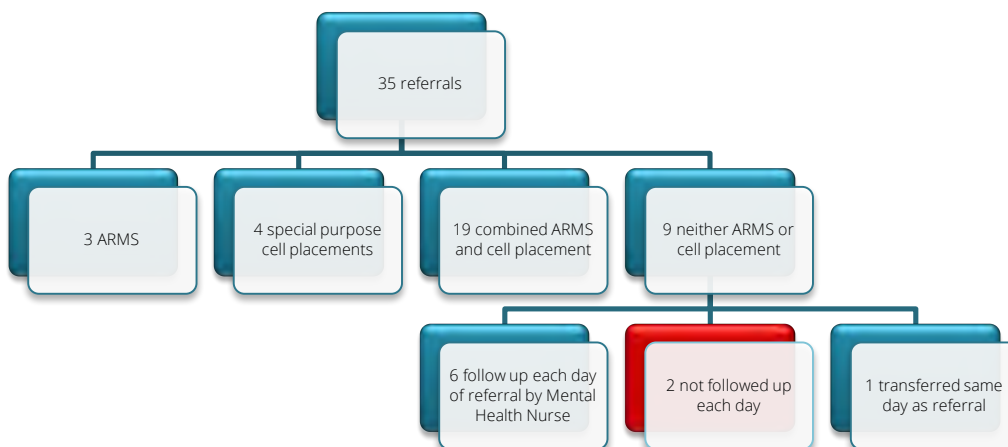


Figure 6 Types of monitoring when placed on a Form 1A

Mental health staff at one prison advised us that these types of supervision maybe appropriate for some prisoners referred for clinical care, but were not always required. For example, a prisoner could be mentally unwell and require involuntary treatment without being such an acute risk to themselves or others that they cannot be managed safely in their unit for a brief period while waiting for a bed. It could also be counterproductive to remove a person from their stable environment to crisis care accommodation. However, clinical psychiatrists at the Frankland Centre disagreed with the idea that prisoners should not be subject to additional monitoring. They explained that people who are acutely unwell have impaired judgement. Therefore, they are automatically at-risk even when they have not voiced a risk to self or to others, the risk is still present so they require closer supervision than usual.

We found two occasions where there was no additional monitoring of the prisoners. Departmental medical records showed that of the remaining nine referrals which were not monitored through the ARMS system or via their cell placement, six were followed up daily by a mental health nurse and another was transferred to the Frankland Centre the same day. This left two prisoners at considerable risk because their management on a Form 1A did not differ from their management in the mainstream prison. If being referred for clinical care prompts no change to their usual management, the potential risks to self and others increases.

Policy providing clear actions for when people have been referred to the Frankland Centre needs to be established. Given the Form 1A directing the person to be assessed for involuntary treatment is issued under the *Mental Health Act 2014*, policy should be aligned with the requirements set out under this Act. A starting point is to align Department policy with the National Standards of Mental Health Services and the Western Australian Chief Psychiatrist's standards for clinical care. These standards provide guidance on risk assessment and management, consumer involvement in individual care, and minimising seclusion and restraint. There is also guidance on the transfer of care which is essential in these situations given the intent is to send these people to the Frankland Centre for further care.

Recommendation 7 - Department of Justice to establish policy based on the Western Australian Chief Psychiatrist's Standards of Clinical Care, to guide the management of prisoners who are awaiting transfer to an authorised hospital

Actions when people return from the Frankland Centre were more consistent. A documented health services procedure does exist for the management of people on return from the centre. It states that all

patients transferring from a psychiatric unit following treatment will initially be admitted to a crisis care unit or safe cell and assessed by a mental health nurse before returning to the general prison population. All 18 case studies, making up 20 returns from the Frankland Centre, were seen by a mental health nurse prior to returning to the mainstream population. We also confirmed that all prisoners, except one, were placed in a crisis care unit or safe cell on the day of their readmission to prison.

However, the procedure also states that all returning patients will initially be placed on ARMS. We found compliance with this aspect of the procedure was less reliable. Only eight prisoners were supervised under ARMS on the day they returned to prison while another was monitored under ARMS from the following day. The remaining 11, which related to prisoners returning to Acacia (2), Casuarina (5) and Hakea (4) prisons, were not monitored in accordance with the procedure.

While supervision under ARMS may be more cumbersome for staff requiring the doubling up of reporting, particularly given the compliance with other parts of the policy regarding cell placement and mental health assessment, it is necessary because custodial staff can access the prisoner's ARMS log to see the prisoner's current and former state. Custodial staff cannot access the medical notes compiled by a mental health nurse.

ARMS is used to identify and manage prisoners who are a risk to themselves. Placing people on ARMS who are not at-risk has the capacity to de-legitimise the importance of the system for staff if it becomes routinely used rather than as necessary. The Department also uses a Support and Monitoring System (SAMS) which may be an appropriate alternative if ARMS is deemed unsuitable. SAMS is a complementary case management system for prisoners who may not be at-risk to themselves, but have been identified as requiring intervention and additional support and monitoring in prison (DCS, 2010). SAMS can be used for people with mental health issues, people with a cognitive impairment or physical disability, or people with other factors that make them vulnerable in custody.

Recommendation 8 – Department of Justice to ensure all prisoners returning from the Frankland Centre are placed on either the At-Risk Management System (ARMS) or Support and Monitoring System (SAMS)

There is also a lack of policy and guidance for the management of prisoners with mental health conditions in custody in general. Two Health Services policies provide guidance around people being referred to the Frankland Centre. These are designed for health staff and provide little reference to custodial staff who are responsible for day-to-day management of prisoners with mental health needs.

Policy Directive 11 governs the placement of prisoners in observation cells and medical observation cells. It is applicable to all public and private prisons. It states that placement should be for the shortest period necessary, never be used in a punitive manner and that a management routine needs to be determined by the Superintendent at the time the prisoner is initially placed there. The policy states placement in an observation cell is to "provide the prisoner with a safe environment that enables the prison to focus on interventions to assist the prisoner." The routine of the person is "to equate as much as possible to a normal management routine" (DCS, 2013a). Prisoners are to be reviewed by Health Services staff as soon as possible but within 24 hours and thereafter a minimum once per day (DCS, 2013b).

At a minimum, some guidance should be provided to staff around managing people with serious mental health issues. If not a formal policy, a charter of principles would provide some guidance. A charter of Mental Health Care Principles by the Office of Mental Health (Office of Mental Health, 2015) already exists and could be used as a basis for establishing a charter within custody.

2.3 Continued effort is needed to ensure mental health issues are understood by all staff

Largely, staff have high levels of tolerance and care for prisoners with mental health concerns. This is evident through reporting. For example, after one incident, a custodial staff member wrote a prisoner 'has significant mental health issues and is now currently housed in the Franklin (sic) Centre Graylands Hospital. There is little to be gained in pursuing a charge due to his current condition. No further action.'

However, we also found some instances where language recorded on prisoners' ARMS records showed the opposite. In particular, a 'demanding female' theme ran through several ARMS records of women returning from the Frankland Centre. This included statements such as:

- '... she has been demanding and impatient'
- '...has been abit (sic) needy this morning'
- 'prisoner has been needy but otherwise behaved'
- '...is becoming a little demanding'.

This language was also found in incident reports. One report stated 'his behaviour was a complete attempt to manipulate his placement within ...[the] Prison. His behaviour was that of a childish adult, to attempt to remain in... [the unit], where he stated that he wants to sleep all day. Recommend that the prisoner be returned to mainstream and receive a formal charge as per the prosecutions officer.' This incident report was submitted the day prior to the prisoner's transfer to the Frankland Centre for two weeks of treatment.

While these examples reflect the minority, we are concerned that people may be more cautious in written communication. Therefore, when this language appears in reports it indicates that the author's day-to-day interaction with people with mental health conditions is inappropriate. These reports are verified by senior staff, so there is an opportunity for intervention when these reports are discovered. There are also opportunities for staff to raise issues with their supervisors if they feel their colleagues do not have a good understanding of the impact of mental health issues on a person's behaviour. When this happens, it is vital this is acted on quickly and appropriately. The Department needs to continually monitor and address issues to drive the right culture.

Mandatory online training is provided for all staff on mental health awareness, reducing the stigma of mental health and creating mentally healthy workplaces. In addition, all custodial staff complete Mental Health First Aid training during their initial training for their roles. Also, 326 custodial staff have completed refresher training in Mental Health First Aid over the last 5 years.

2.4 Record keeping systems are inadequate

Dual record keeping systems fragment management

Custodial staff record information about prisoners in the Total Offender Management Solution (TOMS). This contains information on incidents, placements, and movements. Information about the person is limited to their criminal history and management concerns such as violent history. Alerts about self-harm may be recorded in TOMS to give custodial staff some indication of risk. However, information about health conditions is not available.

Clinical staff use the Electronic Health Online (ECHO) system to record patient notes. This is where information on the person's health conditions and treatment requirements are stored. There is no link between ECHO and TOMS, and no custodial information is kept in ECHO. Therefore, unlike a clinical environment where everyone is using the same system to log information about incidents, reactions and observations, the information is split across two systems. Neither custodial or clinical staff can easily obtain the full information needed to manage the person.

Custodial staff get around the lack of information by developing good relationships with the person in custody. They can learn the stressors and triggers of people and adjust their management practices accordingly. Good relationships and communication between custodial staff and mental health teams also assist in bridging the gap. This is commendable, but it is reliant on good will and vulnerable to staffing changes.

Patient confidentiality is important, but there is a need for a better balance between protecting confidentiality and ensuring those who are predominately managing the person are provided with the right information to do so. Our inspection standards state that mentally ill prisoners must never be punished for behaviour which is a consequence of their illness (OICS, 2007). Therefore, custodial staff responsible for the daily supervision and monitoring of prisoners with mental health concerns must have with sufficient information to ensure they can differentiate the prisoner's actions between those related to their mental illness and those that are behavioural. This does not require custodial staff to know a person's complete medical history or clinical diagnoses. And, as in the community, it can be achieved in many ways within the parameters of confidentiality including via patient consent, specialist training and an alternative records system that allows for limited information sharing between ECHO and TOMS.

While there is often resistance to sharing confidential information, it should be recognised that staff in a prison are already privy to information that would not usually be available in a different environment. For example, custodial officers often know when a person is on a particular type of medication and what the medication is used to treat. Likewise, health staff may become privy to information on a person's custodial history. Ad hoc sharing of information and the processes of piecing together information can arguably lead to a larger breach of confidentiality than a structured approach.

Recommendation 9 – Department of Justice to improve information access for staff managing people with mental health conditions

The Health Services database is not fit for purpose

A Departmental report from 2010 notes 'the deficiencies of [ECHO] are well known and are causing frustration, delays, reduced productivity and possibly errors. [It] was also to be the vehicle through which data on Health Service activity and patient outcomes could be reviewed, but this functionality has not been achieved. It would not now be possible to return to paper-based records so the system must either be improved or replaced' (Stevens, 2010).

However, there is little indication that the system has improved. It has limited ability to extract data to allow trends and outcomes to be examined. It can run some monthly, quarterly and yearly reports but this is limited to just six, although some ad hoc reports can be created within certain guidelines. The system was unable to identify people who had been referred to the Frankland Centre. As part of this review staff attempted to extract this information manually, but this information was later found to be unreliable.

ECHO is a simple system for recording patient notes. It is not the type of sophisticated program which would be expected of a government department that can be used for tracking outcomes and allocating resources. It was supplied to the Department by a company specialising in clinical and practice management software for general practitioners, specialists and community health services (Intrahealth Australia Ltd., 2017).

The Department of Justice is currently working with the Department of Health and the Mental Health Commission on the Justice Health Project to consider options for transferring responsibility for prison health services to Western Australian Health. This has significant implications for the delivery of health services in custody and would improve continuity of care. One of the benefits would be to apply consistent clinical governance, performance and monitoring, which would include improvements in systems for data capture and reporting in custodial health services. This would be welcomed. However, given the size of this project and the substantial change needed, any improvements in reporting may be delayed for several years. A more immediate solution is required.

Recommendation 10 – Department of Justice to ensure medical information is accurately captured to provide the ability to track outcomes and allocate resources

There are no accurate records of transfers to the Frankland Centre from prison

Obtaining the dataset for this review was a challenge. There is no one report available through the Department's offender database (TOMS) that accurately accounts for historical prisoner placements at the Frankland Centre. Instead a combination of TOMS reports, Health Services data and Department of Health data were used to compile our dataset. It was a cumbersome method that required substantial manual data cleaning and the product could still only be considered the minimum number of placements due to missing information.

During our initial discussions with the Department about this review, staff suggested that compiling this list would be straightforward and historical temporary placements would be the most accurate reflection of prisoners placed at the Frankland Centre. However, this report revealed just 48 placements for 41 different prisoners and our preliminary discussions with the Department's Health Services Directorate and Frankland Centre staff led us to consider this number to be too few.

The data was then cross checked against the number of long-term hospital placements which denoted Graylands Hospital (100 hospital placements for 85 distinct prisoners). We combined the temporary placements with the hospital placements and eliminated any duplicate records. However, there were also another 297 long-term hospital placements (for 243 prisoners) recorded where the hospital location was left blank. We manually checked these blank records against another TOMS report, transfers and discharges, to ascertain any further information that would confirm additional placements at the Frankland Centre.

Unsatisfied with this methodology we approached the Department and requested they provide the data. A list of 97 placements for 72 distinct prisoners was supplied compiled from TOMS and ECHO data. Given the different results of each of these datasets, the information was then requested directly from the Frankland Centre. This list (169 placements for 136 distinct prisoners) included some prisoners who were transferred under hospital orders which were outside the scope of our review. Once these records were removed we compared the Frankland Centre data with the other datasets and a final list of 149 placements for 124 distinct prisoners was determined.

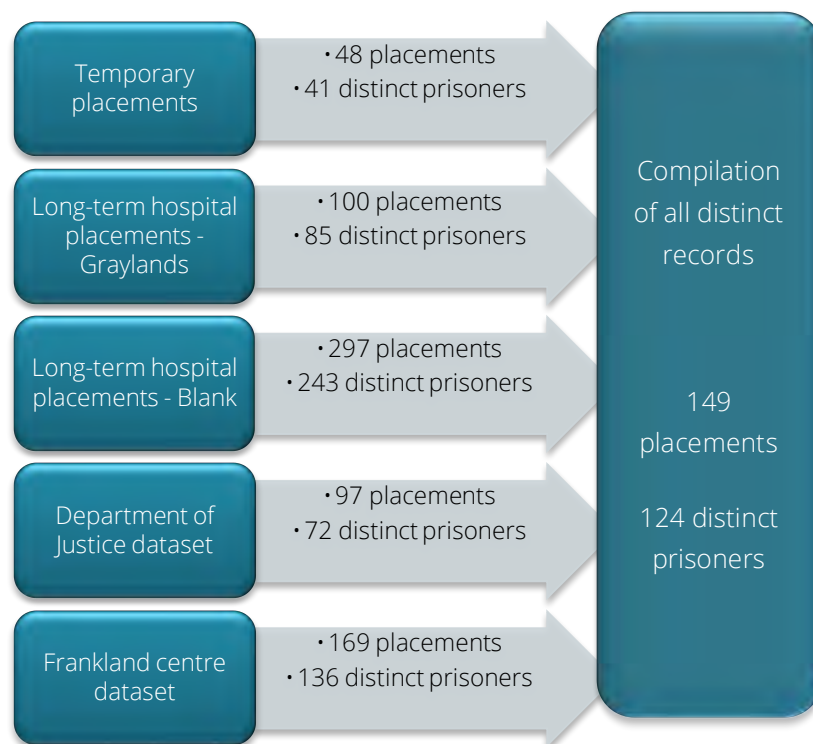


Figure 7 Discrepancies in data sets for prisoners placed at the Frankland Centre (1 July 2016 – 31 August 2017)

Knowing where people are, and have been, while in custody is core Department business. At a minimum TOMS should accurately record where people are residing on any given day.

Recommendation 11 – Department of Justice to ensure records about transfers to and from the Frankland Centre are recorded accurately and consistently

3 Most transfers are safe but gaps in reporting and transport options creates risk

Movements between the Frankland Centre and prisons are routine and generally occur without incident. Transport services for prisoners in Western Australia are largely provided under the Court Security and Custodial Services Contract. The current contract commenced on 24 March 2017 and the provider, Broadspectrum Pty Ltd (Broadspectrum), is contracted until March 2022. Broadspectrum took over from Serco Pty Ltd (Serco) who held the contract between 31 July 2011 and 23 March 2017. Since commencing the new contract, Broadspectrum have conducted almost three-quarters of the transfers to the Frankland Centre. The other transports are conducted by the Department of Justice directly.

Between 1 July 2016 and 31 August 2017 there were only two recorded incidents for prisoners transferring to the Frankland Centre. Both incidents occurred when the prisoners were being escorted from their cells to the vehicles by Departmental staff.

The Frankland Centre does not admit more than one patient at a time. Almost all transfers since Broadspectrum took over the contract occurred as single transfers, with one person moved directly between the prison and the Frankland Centre. There was one occasion when two prisoners were transferred at the same time. This transfer occurred within the first week of Broadspectrum commencing the transport contract and did not occur again during the review period.

Transferring only one prisoner at a time to the Frankland Centre increases the likelihood of a safe journey. It ensures the prisoner spends the shortest possible time in transit, rather than prolonged journeys which can occur when prisoners are picked up from multiple locations before reaching their destination. It also means that staff can focus on continuously monitoring the unwell person, rather than splitting their attention across multiple people.

However, things do go wrong. This review was triggered by two transfers to the Frankland Centre from Bandyup Women's Prison. The incidents reflected two very opposing concepts of the urgency of Frankland Centre transfers. Case Study 1 involved the immediate transfer of a female prisoner without clothes. No time was taken to delay the transfer to stabilise or settle the prisoner to get her dressed. Conversely, Case Study 2 involved the transfer of another female prisoner which was delayed while she completed a period of confinement for assaulting someone several months earlier.

Case Study 1

On 20 June 2017, a female prisoner was transferred to Frankland Centre. She returned to prison 6 July 2017 and was placed in crisis care accommodation. The following day she was placed on a Form 1A referral and when that expired, was referred again on 10 July 2017.

That day a bed at the Frankland Centre became available. The prisoner was very unsettled and had spent more than an hour in her cell without clothes. The transport arrived and prison staff escorted her to the vehicle in a blanket. She was handcuffed from behind. While being secured in the vehicle the blanket was removed but the handcuffs were not.

She was escorted naked, shackled from behind. Broadspectrum advised they were not given any information about her unsettled state prior to the arrival of the male and female escorting staff at the prison.

Only the female officer had a licence to drive the vehicle and so the male officer was required to observe the prisoner through CCTV and conduct welfare checks.

Staff at the Frankland Centre, the Office of the Chief Psychiatrist and several advocacy agencies raised concerns about this transfer.

Case Study 2

On 30 May 2017, a prisoner with an extensive custodial history and multiple prior admissions to the Frankland Centre was given 7-days' confinement by a Visiting Justice for assaulting another prisoner in November 2016. On the final day of this confinement she was placed on a Form 1A referral.

On that day, a bed at the Frankland Centre became available and Broadspectrum were tasked with escorting the prisoner. However, on attending the prison the escort was delayed for two hours so that the prisoner completed her punishment.

Departmental representatives explained that it was always intended that the prisoner would complete the punishment prior to being transferred to the Frankland Centre. We were advised she was not in need of acute care but rather her transfer was to be part of a release plan with her impending release set for 10 June 2017.

3.1 Critical incidents are poorly identified and recorded

We monitor incidents as part of our ongoing oversight of custodial services in Western Australia. Neither case study came to our attention through our usual monitoring processes. External stakeholders alerted us to these incidents which shows failed compliance with reporting requirements both by the Department and the contractor.

Departmental reporting of incidents is governed by Policy Directive 41. It includes various requirements including the classification of incidents as either critical or non-critical depending on the severity. Critical incidents include breaches of security like escapes, attempted escapes and locating contraband that may have a significant impact on the prison. Critical incidents can also include assaults, self-harm and security system failures. There is a final 'other' critical incident category that includes any incident that is not readily classifiable under a specific category that may cause significant public or media scrutiny of staff, policies, procedures, business units or stakeholders (DCS, 2014). Broadspectrum staff must comply with their own Standing Operating Procedure for reporting incidents (BRS, 2017). Broadspectrum's policy is aligned to Policy Directive 41. Given this, the transfer of a person to the Frankland Centre naked

would fall within the Policy Directive 41 definition of a critical incident category 'other' and require critical incident notification. However, this was reported as non-critical, and Case Study 2 was not reported as an incident at all.

One of the explanations for the lack of reporting is a cultural problem, that is staff did not consider these incidents to be unusual, and did not recognise the need for the incident to be reported. This reflects an acceptance of events in a custodial environment, which would not be acceptable to the wider population. Both the Department and the contractors need to actively address this problem and substantially improve reporting.

When issues were recognised, the response was swift and appropriate

Case Study 1, prompted an investigation by both the Department and Broadspectrum. The result was swift changes to practice. It is likely that the individual actions of some staff were not in line with accepted/ expected practice, which is being followed up by other agencies. However, even if this incident was the result of poor decision-making by some individuals, there were not sufficient checks and balances in place to ensure that this incident did not occur. This was recognised in the Department's response to the incident.

In August 2017, the Department issued a Custodial Operations Broadcast to improve the process of getting a prisoner onto an escort vehicle when they are transferred to the Frankland Centre. The broadcast stipulated that the transfer must be timely and not involve force, which includes restraints, unless approved by the Superintendent or their delegate. It also instructed that a member of the mental health team is to be in attendance and participate in the clearance process (a clinical nurse should be involved where a member of the mental health team is unavailable).

The patient is to be escorted to the awaiting vehicle, first passing through the prison's reception area. Any bypassing of reception, such as moving directly from a special purpose unit like crisis care to the vehicle is not permitted unless also approved by the Superintendent or their delegate.

Likewise, Broadspectrum changed its procedures. Instructions were issued so all transfers to the Frankland Centre, regardless of where the person is being transferred from (either prison or court), must be escalated to their Control Centre Manager. Yet within six months, a similar, and unreported, situation occurred. In early November 2017, we were advised that the Frankland Centre had again received a patient from Broadspectrum who was naked. The person had been sent from court on a hospital order. This transfer demonstrated some underlying problems with reporting, compliance and staff training. A misconduct investigation was conducted into why the incident was not reported and Broadspectrum issued a management bulletin with very specific information on the reasons for having timely and accurate reporting. Since then we are not aware of any additional incidents occurring with transfers to the Frankland Centre.

Case Study 2 was not recognised as an incident and therefore no changes have taken place, leaving the likelihood of the same outcome if similar circumstances arise. Mental illness is as serious as physical illness and must be recognised as such. A person in custody needing urgent medical treatment for a broken arm or leg would not be expected to complete isolation punishment prior to receiving

treatment, nor would a medical appointment be delayed. The delay should therefore not be acceptable for a mental illness.

In addition, it is questionable whether a person requiring treatment at the Frankland Centre would have had the capacity to link the punishment to an incident that had occurred several months prior. It is also highly likely isolation would have a negative impact on the condition of someone needing treatment at the Frankland Centre and would increase the resources needed to stabilise the person.

Recommendation 12 – Department of Justice to ensure staff treat mental illness with the same seriousness as physical illness and do not delay treatment for the purposes of punishment

3.2 Regional transfers for mental health treatment are impossible to track

It is rare that a transfer takes place from a regional prison to the Frankland Centre. In the review period, two people were transferred from Bunbury Regional Prison and two were transferred from Roebourne Regional prison. The other 145 were from metropolitan facilities.

We were advised by a visiting psychiatrist that this was by design. Unwell people in regional prisons are transferred to metropolitan prisons, prior to requiring acute care so that they are able to access the Frankland Centre quickly and easily if required. This avoids the difficulties of transferring people from a regional facility in an acute state, which may require transfer using the Royal Flying Doctors Service. On these occasions the prisoner will be anaesthetised during the transfer. The prisoner then needs to be medically cleared prior to being admitted to the Frankland Centre. There were no examples of this found for the review period.

Time in custody, for many prisoners, will involve the transfer from one prison to another. This can occur in response to individual factors such as the prisoner's status changes from remand to sentenced, to participate in programs only available at another prison, or to enable social contact with family and friends who may reside closer to one facility over another. Prison transfers can also occur because of external factors such as population capacity pressures. Unfortunately, a transfer for the purpose of moving a person closer to the Frankland Centre is indistinguishable from the large number of movements between prisons. It is therefore, impossible to determine from records what level of crisis they are in when they are transferred.

However, we examined the full transport history of people from regional areas who accessed the Frankland Centre in our review period. There were no recorded incidents during any prior transfers for these people.

While on the surface this appears to indicate that the system of moving people to metropolitan prisons prior to needing acute care seems to work, it is inconsistent with the Department's psychiatric risk rating system. Half the patients categorised as having serious psychiatric conditions who require or may require specialist inpatient mental health care are located at regional facilities, most at Greenough and Albany. This would suggest that a large volume of transfers of people with serious mental health issues are impossible to track.

Table 3 Location of priority mental health patients in custody (November 2017)

Prison facility	P1	P2	% of all priority patients
Metropolitan facilities			
Acacia	1	3	1.8
Bandyup	3	4	3.2
Casuarina		54	24.8
Hakea	9	13	10.1
Melaleuca	5	20	11.5
Regional facilities			
Albany	4	37	18.8
Bunbury		12	5.5
Eastern Goldfields	3	12	6.8
Greenough		37	17.0
Roebourne		1	0.5
Total	25	193	

One case that was drawn to our attention was the movement of a man from Carnarvon who self-harms during transfer. Since 2002, he had come into custody 23 times. Out of a total of 2,463 days in custody, he spent 79 days in crisis care and another 275 days in management units. He had been to the Frankland Centre once. To get to there, he was transferred from Greenough Regional Prison to Hakea for 13 days, and then to the Frankland Centre. There were no incidents during these transfers. However, two weeks prior, during his initial transfer from Carnarvon police station to Greenough Regional Prison, he had wrapped a seat belt around his neck. After the seatbelt was removed he wrapped his pants around his neck. These were removed. He then defecated in the vehicle. Prior to any transfer of this person, health staff undertake a fitness to travel assessment, but this is predominately related to his physical health issues.

In February 2018, our Office followed a case of another person in custody who had difficulties travelling. This person had a severe cognitive impairment, had been frequently in and out of custody, and was subject to a long transfer from Broome Regional Prison to Perth. There was an adverse outcome with this transfer. When we followed up with the Department about the incident they put several actions in place to improve practices. One of the outcomes was a recognition that the fitness to travel assessment does not address the person's psychological vulnerability. At the time the Department was intending to review the assessment process to include the person's psychological state. This would have a positive impact on all transfers of people with mental health and cognitive issues.

Recommendation 13 – Department of Justice to include the person's psychological state in fitness to travel assessments

3.3 About one in six transfers occur after hours

There are contractual obligations that ensure prisoners arrive in court on time and arrive on time for medical appointments. Therefore, these transfers are prioritised above transfers to and from the Frankland Centre and they are considered unplanned escorts. The result is some transfers (18%) occur outside of standard hours from 8.00 am to 5.59 pm.

Between 1 July 2016 and 31 August 2017, nine transfers occurred after 9.00 pm and before 7.59 am the following morning. Two of these transfers took place just before 8.00 am, six occurred between 9.00 pm and 10.00 pm, and the last was recorded as having returned to prison at 11.00 pm. These times are taken from the Department’s database for prisoner movements in and out of the prison. Therefore, they only reflect one side of the transport and cannot be considered as the accurate arrival or departure time for the Frankland Centre.

Table 4 Gate movement times for prisoners transferring to and from the Frankland Centre (1 July 2016-31 August 2017)

	Transfer to Frankland Centre	Transfer from Frankland Centre
Within standard hours (8 am – 5.59 pm)	137	91
Outside standard hours	11	38
Between 6 pm – 8.59 pm	10	30
Between 9 pm – 7.59 am	1	8
Time of transfer unknown	1	
Discharged from Frankland Centre		11
Still at Frankland after review period ceased		9
Total number of transfers	149	129

Prisons and hospitals offer 24-hour services so it is possible for these transfers to take place. However, it is not ideal. Medication, meals, and sleep can be disrupted by unusual travel hours, all of which may impact the person’s mental health condition. Given this happens so infrequently compared to other transports, a change to the contract to prioritise these transfers will have little impact on the contract, but a large impact on the person’s health and the ability of staff to manage them.

Recommendation 14 – Department of Justice to ensure that mental health transports are prioritised and timely, and amend the Court Security and Custodial Services contract if necessary

3.4 There is no specialist transport for those suffering acute mental illness

Most transfers to and from the Frankland Centre were conducted in a secure escort van. This is the default vehicle for custodial transport in Western Australia. The vehicles have hard moulded plastic seats in secure stainless steel pods. Engagement with staff during transit occurs via an intercom. It can be a sterile, isolating and claustrophobic environment.

Three of the 49 transfers to the Frankland Centre performed by Broadspectrum since assuming the contract were undertaken in ‘soft’ domestic style vehicles where prisoners can be handcuffed to themselves and to an escorting officer in the back seat. These vehicles provide the opportunity for better engagement with the person during transport, but increase the risk of staff assault given the close proximity of staff to the person in custody. If a person is mentally unwell and agitated the risk rises exponentially.

In the United Kingdom, secure ambulance transports are used to transfer forensic mental health patients and other people detained under their Mental Health Act. These vehicles are fitted with security features but are not the pod style vehicles used for standard custodial transport. Staff can be located with the person in custody, but are not sitting beside them. This allows the prisoner to interact with staff during transport while still allowing staff safety and additional security.



Figure 8: Secure medical vehicle (UK) – Image courtesy of Blue Light Services (www.bluelightservices.com)



Figure 9: Standard custodial transport used in Western Australia

Broadspectrum acknowledge the limitations of the fleet. The vehicles were acquired from the previous contractors and are due to be upgraded. Broadspectrum advised us they were researching alternative vehicle options for use in medical escorts, not only for Frankland Centre transfers but in other instances such as transporting pregnant prisoners. The progressive upgrade of the vehicles is to be completed by 2020.

Any upgrade to the fleet must be endorsed by the Department's Infrastructure Branch and align to the Minimum Standards for Secure Escort Vehicles (DCS, 2015). These standards are for 'the escort of maximum-security prisoners on the open road'. They do not specifically outline the transfer of mental health patients, but nor are these transfers specifically excluded. Extensive consultation between Broadspectrum, the Department's Health Services Directorate and other stakeholders should enable the fleet upgrade to effectively meet the needs of all people in custody, particularly with regard to special medical needs. At the time of retendering the contract for transport services the expertise of Health Services was not drawn upon to address the inadequacies of the fleet nor to consider the need for a secure medical vehicle.

The lack of transport options mirrors the community

The lack of vehicle options for people with mental health needs is not confined to those in custody. There are also few options in the community. The Department of Health has developed a transport risk matrix which determines the transport provider when the person requiring mental health care is from the community (DoH, 2016). Low risk transports are conducted by community mental health teams, medium and high risk transports are performed by the statewide ambulance provider, currently St John Ambulance, and the police conduct escorts posing significant risk.

Transport in a police vehicle can have repercussions and the involvement of police in an event that does not otherwise require a criminal justice response can be potentially detrimental to the person's mental health. The Western Australia Police have recognised this and have been trialling a co-response system involving mental health clinicians. While the trial continues, early indications suggest an 80 per cent reduction in the use of restraints during police response (Mearns, 2017).

For those transports conducted by St John Ambulance, we were advised that in many cases an ambulance is not the most appropriate vehicle. Lying down and travelling backwards can increase people's anxiety. There are also restrictions under the *Mental Health Act 2014* regarding restraint practices for transport officers (such as paramedics). A person can only be restrained in prescribed circumstances, and when those circumstances cease the restraint must also cease. This means restraints cannot be applied for custody reasons.

Under the former *Mental Health Act 1996* the State had established its own transport service with secure vehicles conducted by special constables from the police who were trained in mental health. Over the course of conducting this review various stakeholders reflected positively on this arrangement. However, the system was changed under the new *Mental Health Act 2014* and special constables are no longer used. The main benefits of this system were the extensive training in managing mental health issues for people involved in the transports, and the ability for these staff to interact easily with the patient. The Department should consider the later when undertaking the fleet upgrade. Adding secure medical vehicles to the custodial transport fleet would allow for the improved interaction with the patient.

Likewise, the contractor should consider the benefits of extensive training for at least some staff in mental health.

Currently Broadspectrum has fallen behind the training requirements established as part of the contract. By November 2017 only 12 staff had completed a course in Mental Health First Aid. Another 316 staff were still required to complete the training course within 12 months of the contract's commencement. This delay was due to the loss of Broadspectrum's Training and Compliance Officer prior to running the five training courses scheduled in November and December 2017. Despite this, Broadspectrum staff are have received some training in mental health. Staff complete two modules as part of their initial training which cover mental health, illness, and crises. One of the modules looks specifically at the safety and welfare of Aboriginal people in custody. A third online module, covering awareness of mental illness, is also required to be completed by staff.

3.5 Prisoner's next of kin are not notified of medical transfers

According to Departmental policy a person's next of kin is supposed to be notified when the person is removed from prison for medical treatment. We found no evidence this was occurring. We reviewed 18 case studies of people moved to the Frankland Centre and found no record that their next of kin was notified of either their deteriorating health or their transfer to the Frankland Centre.

Concerned that our random sample of case studies was not an accurate reflection of the wider group, we also examined the records of the 11 prisoners who were transferred to the Frankland Centre in November 2017, and another 10 randomly selected general medical emergencies for the same month. None of these records indicated that policy was being adhered to.

The policy allows for security issues to be considered which may delay notification, or provide cause for not notifying next of kin. However, the reason for notifying or not notifying must be recorded by the person making the decision on the prisoner's electronic record. This did not occur in any of the records we examined.

Recommendation 15 – Department of Justice to ensure next of kin are notified when a person in custody is transferred to hospital and that these notifications are recorded

Appendix A Summary of responses to recommendations

As part of our legislatively mandated practice, the draft of this report or relevant sections of the report were sent to several agencies who have been mentioned in the report. General feedback was provided as well as specific feedback on the recommendations.

The following is a summary of the responses to the recommendations. Further information about individual agency responses is available on our website. The response to the recommendations from the Department of Justice has been included in full in Appendix B.

Feedback was sought from:

- Department of Justice
- North Metropolitan Health Services
- Mental Health Commission
- Office of the Chief Psychiatrist
- Department of Health
- Broadspectrum
- Chief Magistrate (section 1.2 only)
- Children's court of Western Australia (section 1.2 only)
- WA Police (section 3.4 only)
- St John Ambulance WA (section 3.4 only)

In general, all agencies with the exception of the Department of Health, were supportive of the recommendations. The main concern from the Department of Health was that the recommendations would place unmanageable pressure on community mental health services and that substantial resourcing, redesign and upskilling is needed to disperse people in custody to other facilities.

Recommendation 1: Government to commit funding to increase the number of secure forensic mental health beds

All agencies who responded to this recommendation were supportive. The Mental Health Commission noted this aligned with the Western Australian Mental Health, Alcohol and Other Drug Services Plan.

The Mental Health Commission, Office of the Chief Psychiatrist and Children's Court of WA also noted the particular problems for youth and called for dedicated forensic youth beds.

Recommendation 2: Department of Justice to work with judicial officers and the Department of Health to make arrangements to allow non-serious offenders on hospital orders to be diverted to other authorised hospitals and not just the Frankland Centre

Agencies supported this recommendation but noted the issues around the safety of staff and other patients at other authorised hospitals would need to be carefully managed. The Chief Magistrate indicated unaddressed safety issues had prevented previous attempts to divert people away from the Frankland Centre from being successful.

The Department of Health stated that beds in other authorised hospitals were already under extreme demand, which was leading to the premature transfer of secure patients to less secure environments. Taking people on hospital orders would add to this pressure.

The Chief Magistrate also raised concerns about a cut back in service on the weekends resulting in no longer having any weekend assistance available to magistrates to assess whether a hospital order is appropriate. Without this, a person may be remanded in custody until an assessment can be made about their ability to be in court.

Recommendation 3: Department of Justice to make arrangements with health and mental health agencies to provide acute clinical care for prisoners in facilities other than the Frankland Centre

As with recommendation two, this recommendation was supported provided safety and support to the facilities where patients would be diverted was addressed.

Recommendation 4: Department of Justice to notify the Chief Psychiatrist of all referrals of prisoners to an authorised hospital and the outcome of the referral

Agencies agreed that there was a need for a robust system for tracking referrals and the outcomes. However there was no common agreement on where this tracking should take place.

The Chief Psychiatrist explained that he does not receive notifications of patients referred to any other hospital in this manner and did not believe this was the most effective or appropriate way of maintaining this information.

The Department of Justice stated it does not capture this information in a way that can be easily collated or reported. The Department expressed an opinion that tracking this information should be part of Assertive Mental Health Bed Management Program which is part of WA Health System reporting.

Recommendation 5: Government support the establishment of the subacute unit in Bandyup Women's Prison with the intention of expanding subacute care into men's facilities

This recommendation was supported by multiple agencies but there were significantly different views about the responsibility for funding these units.

Recommendation 6: Department of Justice work with Department of Health to increase in-reach services to meet need

Agencies generally recognised the need for an increase of in-reach services. The Department of Justice suggests 11 fulltime specialist mental health staff per 550 prisoners, with women's prisons and remand centres having a higher ratio.

Recommendation 7: Department of Justice to establish policy based on the Western Australian Chief Psychiatrist's Standards of Clinical Care, to guide the management of prisoners who are awaiting transfer to an authorised hospital

This recommendation was supported. The Office of the Chief Psychiatrist suggested that this be extended so that the care provided by mental health teams to all patients in prison, meets the National Standards for Mental Health Services and the Chief Psychiatrist's Standards of Clinical Care. The Department of Justice noted the recommendation was part of an existing Departmental initiative which

is developing policy to support national standards. The Department of Justice indicated an intention to work with the Office of the Chief Psychiatrist to do this.

Recommendation 8: Department of Justice to ensure all prisoners returning from the Frankland Centre are placed on either the At-Risk Management System (ARMS) or Support and Monitoring System (SAMS)

The Department of Justice supported this recommendation, confirmed this was current policy and noted there will be a review of compliance, with action taken as required.

Recommendation 9: Department of Justice to improve information access for staff managing people with mental health conditions

The Department of Justice supported this recommendation and stated an intention to improve the Support and Monitoring System (SAMS) module to ensure mental health is included in the custodial care plan.

Recommendation 10: Department of Justice to ensure medical information is accurately captured to provide the ability to track outcomes and allocate resources

The Department of Justice supported this recommendation and is currently working on establishing appropriate ways to measure health outcomes, including mental health outcomes. The Department agreed an appropriate software solution for Justice Health needs to be identified and considered within budgetary constraints.

Recommendation 11: Department of Justice to ensure records about transfers to and from the Frankland Centre are recorded accurately and consistently

The Department of Justice supported this recommendation.

Recommendation 12: Department of Justice to ensure staff treat mental illness with the same seriousness as physical illness and do not delay treatment for the purposes of punishment.

The Department of Justice supported the recommendation and went further by stating an intention to consider developing a mechanism to inform the Visiting Justices of a prisoner's mental health where relevant.

Recommendation 13: Department of Justice to include the person's psychological state in fitness to travel assessments

The Department of Justice supported the recommendation and is taking steps to implement an action.

Recommendation 14: Department of Justice to ensure that mental health transports are prioritised and timely and amend the Court Security and Custodial Services contract if necessary

The Department of Justice supported this recommendation and is considering a contract variation to allow prioritisation of movements to the Frankland Centre.

Recommendation 15: Department of Justice to ensure next of kin are notified when a person in custody is transferred to hospital and that these notifications are recorded

This recommendation was supported. The Department of Justice is considering reviewing policy to move the responsibility for notification to health services rather than custodial staff. The Chief Psychiatrist stressed the importance of notification and notes the Mental Health Act highlights the importance of engaging with families and carers.

Appendix B Department of Justice full response to recommendations



Government of **Western Australia**
Department of **Justice**

Response to the review:

Prisoners access to secure mental health treatment

Response to the review:
Prisoners access to secure mental health treatment

The Department of Justice welcomes the review into Prisoners access to secure mental health treatment and acknowledges the finding that custodial and clinical staff are making the system work as best they can despite severe limitations.

The Department also agrees that there are not enough secure mental health beds to effectively manage the identified needs of Western Australian prisoners and would support an increase to the number of these beds.

The Department has reviewed the report and noted a level of acceptance against the 15 recommendations.

Appendix A contains comments for your attention and consideration.

Response to Recommendations

1 Government to commit funding to increase the number of secure forensic mental health beds.

Response:

Justice Health Services introduced a Psychiatric Ratings system in September 2017. Prisoners with a potential risk or previous history of mental illness are assigned a psychiatric risk rating:

- P1 – serious psychiatric condition requiring intensive and/or immediate care;
- P2 – significant ongoing psychiatric condition requiring psychiatric treatment;
- P3 – stable psychiatric condition requiring appointment or continuing treatment;
- PA – suspected psychiatric condition requiring assessment.

The risk rating system is not a clinical diagnosis; it is intended to highlight high-level mental health needs. The P1-PA rating system has been implemented in all publicly- and privately-operated prisons. Demand for specialist mental health beds has been modelled on the basis that prisoners with a P1 rating require a specialist inpatient mental health bed. P2 classified patients may also require a specialist mental health bed, either inpatient or sub-acute.

The snapshot of WA custodial facilities consistently shows that on average each month there are over 170 individuals (adults and child & youth) that require access to a forensic mental health bed, either acute or sub-acute. There are no mental health facilities (acute and/or sub-acute) within WA custodial facilities and only 30 in-patient beds at the North Metropolitan Health Service (NMHS) State Forensic Mental Health Service (SFMHS) Inpatient Unit, the Frankland Centre. The Department has recently been notified that the 8-bed SFMHS sub-acute unit, Hutchinson Ward, has closed further decreasing access to secure forensic mental health beds. People in custody experience significant delays in accessing, or no access to, appropriate mental health care due to the shortage of secure forensic mental health beds in Western Australia.

The Department would support an increase to the number of secure forensic mental health beds.

Responsible Agency: Mental Health Commission, Department of Health
Level of Acceptance: Supported in Principle, dependant on funding

2 Department of Justice to work with judicial officers and the Department of Health to make arrangements to allow non-serious offenders on hospital orders to be diverted to other authorised hospitals and not just the Frankland Centre.

Response:

The Department of Justice supports this recommendation. Currently, Hospital Orders are prioritised for access to a bed at the Frankland Centre instead of a prioritisation based on clinical acuity resulting in those that most in need have delayed or no access to the necessary inpatient mental health care that they require. The Department will participate in discussions with the Mental Health Commission and WA Health System in relation to the diversion of non-serious adult and youth offenders on hospital orders to other authorised hospitals.

Response to the review:
Prisoners access to secure mental health treatment

Responsible Business Area: Court and Tribunal Services
Proposed Completion Date: 31/03/2019
Level of Acceptance: Supported in Principle

- 3 Department of Justice to make arrangements with health and mental health agencies to provide acute clinical care for prisoners in facilities other than the Frankland Centre.**

Response:

The Department supports this recommendation in principle, noting this recommendation cannot be actioned by the Department. Decisions regarding inpatient mental health facilities are determined by the Mental Health Commission and the WA Health system and written into their Service Level Agreements. A comprehensive project would be required bringing all stakeholders together from WA Health, the Mental Health Commission and the Department.

Responsible Agency: Mental Health Commission
Level of Acceptance: Supported in Principle

- 4 Department of Justice to notify the Chief Psychiatrist of all referrals of prisoners to an authorised hospital and the outcome of the referral.**

Response:

The Department supports this recommendation in principle and acknowledges that the Office of the Chief Psychiatrist should have oversight of referrals and outcomes as per the requirements under the MHA 2014. A Form 1A is a request for psychiatric assessment. All Form 1a are sent through to the appropriate WA Health facility, including the Frankland Centre, who capture this data. The WA Health system report this data to the Office of the Chief Psychiatrist within the Assertive Mental Health Bed Management Program for civil patients. The Department supports the inclusion of forensic patients on this reporting which would meet this requirement. The Department currently does not capture this information in a way that can be easily collated or reported.

Responsible Business Area: Offender Management - Health Services
Proposed Completion Date: 31/03/2019
Level of Acceptance: Supported in Principle

- 5 Government support the establishment of the subacute unit in Bandyup Women's Prison with the intention of expanding subacute care into men's facilities.**

Response:

The Department supports this recommendation for all the reasons stated against Recommendation 1. The Department has submitted a proposal and model of care for a 29 bed sub-acute service at Bandyup Women's Prison to the Mental Health Commission for

Response to the review:
Prisoners access to secure mental health treatment

consideration. The Department is also currently considering a sub-acute facility in the proposed 512 Casuarina expansion.

Responsible Business Area: Offender Management - Health Services
Proposed Completion Date: 31/12/2019
Level of Acceptance: Supported in Principle, dependant on funding

6 Department of Justice work with Department of Health to increase in-reach services to meet need.

Response:

The Department supports this recommendation in principle and will continue to work with the Mental Health Commission, the WA Government agency responsible for commissioning public mental health services. In addition, the Department employs mental health nurses in all metropolitan custodial facilities and larger regional facilities. The Sainsbury Centre for Mental Health estimates that providing mental health services to sentenced males would require 11 fulltime specialist mental health staff per 550 prisoners. For women's prisons and remand centres, the ratio would be higher (Boardman, J. & Parsonage, M. [2007] Delivering the Governments Mental Health Policies).

Responsible Business Area: Offender Management - Health Services
Proposed Completion Date: 31/03/2019
Level of Acceptance: Supported in Principle

7 Department of Justice to establish policy based on the Western Australian Chief Psychiatrist's Standards of Clinical Care, to guide the management of prisoners who are awaiting transfer to an authorised hospital.

Response:

The Department supports this recommendation and will continue to develop policies and processes that support the national standards. The Department will seek opportunities to engage with the Office of the Chief Psychiatrist to audit custodial health services against the Office of the Chief Psychiatrist standards. The Department has already commenced implementation of the WA Health State-wide Standardised Clinical Documentation (SSCD) for mental health services introduced in 2014 following the "Review of admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia" (Stokes, July 2012). The SSCD enable the consistent recording, retrieval and sharing of medical record information at all points of care for the consumer from triage through to discharge. The primary goal is to improve mental health consumer health outcomes by enhancing the clinical information available to inform care decisions.

Responsible Business Area: Offender Management - Health Services
Proposed Completion Date: 31/03/2019
Level of Acceptance: Supported – existing Departmental initiative

8 Department of Justice to ensure all prisoners returning from the Frankland Centre are placed on either the At-Risk Management System (ARMS) or Support and Monitoring System (SAMS).

Response:

The Department supports this recommendation and can confirm this is current Justice Health policy. Compliance with the policy will be reviewed and action taken as required to remind or educate staff as to the requirements.

This will also be included in the respective Policy Directive to inform operational staff.

Responsible Business Area: Offender Management - Health Services
Proposed Completion Date: 31/03/2019
Level of Acceptance: Supported

9 Department of Justice to improve information access for staff managing people with mental health conditions.

Response:

The Department support this recommendation and will improve the SAMS module to ensure the custodial Care Plan includes mental health input.

Responsible Business Area: Offender Management - Health Services
Proposed Completion Date: 31/03/2019
Level of Acceptance: Supported

10 Department of Justice to ensure medical information is accurately captured to provide the ability to track outcomes and allocate resources.

Response:

The Department supports this recommendation. Justice Health is currently working on establishing appropriate KPIs to measure health outcomes, including mental health outcomes.

The Department also agrees that an appropriate software solution for Justice Health needs to be identified and then considered within budgetary constraints.

Responsible Business Area: Offender Management - Health Services
Proposed Completion Date: 31/03/2019
Level of Acceptance: Supported

11 Department of Justice to ensure records about transfers to and from the Frankland Centre are recorded accurately and consistently.

Response:

The Department has an ongoing focus on accurate record keeping and acknowledges the transfer information has not been consistently recorded resulting in inconsistent information being reported. The Department also acknowledges the inherent limitations of administrative data when used for research purposes, which is further complicated when constructing a data set that can account for movements/transfer data without the presence of unique person identifiers in the Department's data holdings.

Staff will be reminded to ensure appropriate recording of these transfers have occurred in TOMS and will also be provided with the necessary guidance to ensure consistency.

Responsible Business Area: Adult Justice Services

Proposed Completion Date: 31/03/2019

Level of Acceptance: Supported

12 Department of Justice to ensure staff treat mental illness with the same seriousness as physical illness and do not delay treatment for the purposes of punishment.

Response:

The Department supports this recommendation. As part of the implementation of this recommendation, consideration will be given to the development of a mechanism that Visiting Justices are informed should the prisoner's mental health have influenced current charges.

This will also be included in the respective Policy Directive to inform operational staff.

Responsible Business Area: Regulation and Operational Services

Proposed Completion Date: 31/03/2019

Level of Acceptance: Supported

13 Department of Justice to include the person's psychological state in fitness to travel assessments.

Response:

The Department supports this recommendation and will enhance awareness of the "Fitness for Travel" processes to ensure that mental health issues are considered in both the approval for travel and the type of vehicle to be used.

Responsible Business Area: Offender Management - Health Services

Proposed Completion Date: 31/03/2019

Level of Acceptance: Supported

14 Department of Justice to ensure that mental health transports are prioritised and timely, and amend the Court Security and Custodial Services contract if necessary.

Response:

Prison Health Centres do not all operate 24 hours, and for those that do there is no mental health nurse on duty overnight. Not all WA mental health in-patient units have staffing capacity to receive admissions and discharges out of hours. The Department supports transfers taking place that prioritise the wellbeing of the prisoner.

A contract variation will be considered to allow the Contractor to prioritise movements to Frankland Centre. Subject to approval by the Commissioner, a Variation Order would need to be drafted together with identifying the quantum of these service requests.

Responsible Business Area: Regulation and Operational Services
Proposed Completion Date: 31/03/2019
Level of Acceptance: Supported

15 Department of Justice to ensure next of kin are notified when a person in custody is transferred to hospital and that these notifications are recorded.

Response:

The Department supports this recommendation and believes, in consideration of security constraints, that Health services would be the most appropriate area to contact next of kin regarding health related emergency transfers to external health services. It should be noted that this currently occurs in other Australian jurisdictions.

Relevant policy documents will be updated to reflect this arrangement once agreed upon.

Responsible Business Area: Offender Management – Health Services
Proposed Completion Date: 31/03/2019
Level of Acceptance: Supported

Appendix C Methodology

Data sets for this review were obtained from the Department of Justice's TOMS through a combination of previously created Departmental reports and standard query language data extraction. These data sets were compared with data supplied from the Department of Justice's Health Service Directorate and the Department of Health's North Metropolitan Health Service – State Forensic Mental Health Service. The combined data was used to determine prisoners with placements at the Frankland Centre during the review period (1 July 2016 to 31 August 2018).

From the cohort, we closely examined the custodial histories of 16 randomly selected prisoners and another two case studies (as outlined in Chapter 3) which were, in part, the trigger for this review. The examinations involved perusal of the prisoners' offender files, and some medical notes relating to their Frankland Centre placement.

We examined both the Department of Justice and Broadspectrum's policy and procedure documents. Other documents were also examined including CCTV footage, in-reach service provision data, and the Memorandum of Understanding between North Metropolitan Health Services and Department of Corrective Services.

We looked at legislation, national principles, and state standards for clinical care. A literature review was also conducted examining the repeated calls for increasing the capacity for secure forensic mental health beds in Western Australia.

We conducted site visits to Bandyup Women's Prison, Melaleuca Remand and Reintegration Facility, and Acacia, Casuarina, and Hakea prisons to speak with both operational and Health Services staff. We observed an escort of a prisoner at Bandyup from her cell to the Broadspectrum vehicle prior to her transport to the Frankland Centre.

We held meetings with the Department of Justice central office staff from the Health Services Directorate, Operational Standards and Procedures Branch, Contracts Management, Infrastructure Services, and the Operations Centre.

We engaged with various external stakeholders including representatives from Broadspectrum, the Frankland Centre, the North Metropolitan Health Services, the Office of the Chief Psychiatrist of Western Australia, the Mental Health Commission, the Western Australian Police Force, and St John Ambulance.

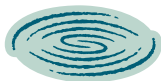
A preliminary findings briefing by this Office was presented in February 2018.

Appendix D Bibliography

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