Ref: 124239

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By email: corporate@oics.wa.gov.au, darian.ferguson@oics.wa.gov.au

Dear Mr Ferguson

**MHAS Response to "Prisoner Access to Secure Mental Health Treatment" report**

Thank you for providing us with an embargoed copy of your report on "Prisoner Access to Secure Mental Health Treatment" and the opportunity to provide a response to the report.

My general comments on the report are set out below.

**Recommendations 1 and 3 – more forensic mental health beds and using other authorised hospital wards**

1. It is clear that people in prison are not getting anywhere near the level of care available for people in the community and, in principle, I support these recommendations.

2. However the mental health system cannot currently cope with an influx of people from prison without an increase in inpatient beds (or other mental health services). Diverting prisoners to other authorised hospitals will impact negatively on other people in the community seeking hospital admission and may not increase access for people in prison in any event:

    a. In the period 1 July 2018 to 13 November 2018, there were 32 days of "code yellow" which means there were 15 or more mental health patients on forms awaiting admission and compulsory assessment by a psychiatrist and no available beds.

    b. This means that on 23.5% of the days there was bed gridlock. This did not count the people waiting in prison for a bed as they are not currently included in the bed flow management process.

    c. Some people including children were waiting in emergency departments for 3, 4 and 5 days.

d. In this regard I refer you to the MHAS Annual reports laid before Parliament for the past two years and particularly pages 7-13 of the 2017-18 report raising these issues. I have attached a copy of the report for your convenience but it can also be accessed at: https://mhas.wa.gov.au/assets/documents/Mental-Health-Advocacy-Service-Annual-Report-2017-18.PDF. There has also been various media publicity and other reports about the issues.

e. In addition to the code yellow days there were five other days where children waiting in emergency departments could not be found a bed.

f. Recent advocacy assisted in getting Frankland patients who are now "civil" and who did not need to be returned to prison moved on to other authorised hospitals thereby freeing up a few beds for people in prison. One of the issues is that such patients tend not to have a home address so there are issues as to which health service provider (HSP) should take them as they work on catchment areas and place of residence.

g. The closure of the eight Hutchinson ward beds on Graylands campus has compromised the ability of the Frankland Centre to move civil and Custody Order patients on and free up beds. It also resulted in a reduction of rehabilitation beds generally as several custody Order patients were moved into Murchison Ward at Graylands Hospital. We have raised this issue with the Minister for Mental Health, the Commissioner for Mental Health and North Metropolitan Health Service.

3. I have advocated for people in prison to be included in the new mental health patient flow process which is due to "go live" in February 2019 but it remains unclear if they will be. If the recommendations in your report are accepted, it will be essential that they are included in that process.

4. There needs to be agreement on the use of prison guards on mental health wards before people from prison are admitted on a regular basis to mental health wards in other authorised hospitals. This was highlighted in a recent case involving a young person from Banksia Hill Detention centre. Prison Guards on a mental health ward will impact on other patients. All acute wards are locked and most are fairly difficult to escape from so it is strongly arguable that "line of sight" observation by a Custodial Officer for people from prison is not necessary. This is particularly so if the crime for which they have been convicted is of a lower level of seriousness. We have recently written to the Commissioner for Corrective Services about this issue and he has agreed to set up a meeting to discuss the issues further.

5. The Justice Health Project Steering Committee was examining the advantages and disadvantages of different custodial health services governance options earlier this year. We have heard nothing since our submissions but another recommendation could be to call on the Government to release their report and recommendations.

**Recommendation 2 – Hospital Order patients going to other authorised hospitals**
Again I support this recommendation in principle but raise the issue of lack of beds across the mental health system as outlined above.

**Recommendation 5 – Sub-acute units at Bandyup and elsewhere**
I strongly support this recommendation and particularly for women. I would go further and ask that it be an acute unit not subacute. MHAS has been raising concerns about the safety of women in the Frankland Centre for some time. There is an inability within the confines of the three wards to care

for women separately from men. Women are usually significantly outnumbered in the Frankland Centre and very vulnerable to sexual and other assault – the same might apply to people from the LGBTQI community, but MHAS experience is mainly in relation to women. Furthermore the experience of being put on a ward where you might be the only woman or one of two or three can be re-traumatising for those who have suffered abuse. There have been a number of incidents despite one-on-one nursing specials on the ward. At times, and for some women, sending them to Frankland is detrimental to their health.

**Recommendation 6 – Increase in inreach services**

Again I strongly support this recommendation but note that further funding will be necessary and suggest that the recommendations of the Justice Health Project be made public. Subject to the recommendations in the Justice Health Project, an addition to the recommendation could be that the Attorney General and Minister for Health ask their respective departments and the Mental Health Commission to work together on a business case to present to Treasury and Cabinet. This has to be a government decision with government commitment.

**Recommendation 7 – Department of Justice to have policy based on the Chief Psychiatrist's standards of care for people awaiting transfer to hospital on a form 1A**

This recommendation is supported. Like the Chief Psychiatrist, mental health advocates have responsibilities in relation to people in prison when they are put on a form 1A. Currently however the function is only triggered by a request for contact from the person in prison. I would like to see another recommendation that Corrective Service staff inform people on a form 1A of their right to seek contact from a mental health advocate. Advocates are increasingly involved in cases involving people on a form 1A, advocating for access to a hospital bed, checking that their rights are being observed and explaining to them what is happening while they wait. The latter often has the benefit of being a calming influence on the patient. This will be particularly important if recommendation 3 is accepted, but people in prison are not included in the new mental health patient flow system.

**Recommendations 12, 13 and 14 - Treating mental illness with the same seriousness as physical illness, not delaying treatment for punishment, including the person's psychological state when assessing travel and ensuring transport is prioritised and timely**

I support all of these recommendations. I also confirm that when we raised case study one with the Department of Justice, the response was swift. The second incident in November is very concerning and, as you are aware, we raised another case with your office in April 2018 about the transport of a young person to the Frankland Centre. That transport was in a domestic vehicle and involved a prolonged restraint. When the car arrived at the Frankland Centre staff advised the mental health advocate that the young person was highly distressed and was being held between two officers, double cuffed, and his head was pushed forward and wedged between the right side of the front driver's seat and the interior of the door.

The lack of an alternative means of transport to the pod style secure escort van or a domestic van would have been welcomed in this case as would a psychological assessment and transport officers trained in mental health and in particular de-escalation techniques.

In response to our complaint, the Director General advised that a full assessment of this incident had been carried out and there was no staff misconduct but, had more information about the young person been communicated to the Deputy Superintendent prior to the transportation, a more thorough assessment would have been undertaken to determine the most appropriate means of transport. Moreover a decision had been taken to no longer use "non-secure vehicles".

I am happy to have this response published.

Yours sincerely

Debora Colvin
**CHIEF MENTAL HEALTH ADVOCATE**

*Enc: MHAS Annual report 2017-18*