PEOPLE IN CUSTODY REQUIRING CRISIS CARE

PRISON MENTAL HEALTH CRISIS NEEDS URGENT ATTENTION

There is no argument about the high rates of mental illness in prisons across Australia (Baksheev et al., 2010; Samele et al., 2021; Adams & Ferrandino, 2008). In Western Australia, around 8% (633) of the adult prison population had a diagnosed, or were awaiting assessment for, a psychiatric condition and were being cared for in prisons across the State. Western Australia's only secure forensic hospital, the Frankland Centre, has a capacity of just 30 beds and can only accommodate 10 or so patients from prisons at any one time, which means that many prisoners with acute mental health issues must be managed within custodial facilities.

Two key elements are critical to how these prisoners are cared for and managed. First, availability of clinical staff, and second access to a therapeutic environment. This review has found that in Western Australian prisons both elements have significant shortfalls.

Clinical mental health staff are in short supply across the country, and prisons around Western Australia are facing significant shortages. A common concern raised with us by clinical staff was that they were overwhelmed by workloads, which required prioritisation of patients with the most acute risk.

Similarly, appropriately designed therapeutic infrastructure is not available across the prison system, and the seven dedicated crisis care units are largely cold sterile facilities that our forensic psychiatric expert advisors have in the past described as untherapeutic and not compatible with community standards. The only exception to this is the specialist Bindi Bindi mental health unit in Bandyup Women's Prison.

With the soaring adult prison population, which stands at just over 8160, the extraordinary demands on mental health staff and crisis care infrastructure are likely to increase rather than diminish. To put this into perspective, in December 2024, the Department's monthly data provided to us shows that there were 31 prisoners at the highest priority rating with a 'serious psychiatric condition requiring intensive and/or immediate care'. These are in addition to the 10 or so patients currently being cared for in the Frankland Centre. In past inspections, our forensic psychiatric experts have told us that prisoners at the highest priority rating would ordinarily require assessment or treatment in an acute hospital setting (i.e., the Frankland Centre or a similar facility if one existed). In the absence of bed capacity in the Frankland Centre, most of these prisoners are managed in prisons, often cycling in and out of crisis care centres.

The clinical and custodial staff we saw working in crisis care centres were doing their best to provide adequate care for prisoners in crisis, but they struggled with inadequate resources and unsuitable infrastructure. Generally, we saw resources focused on the most vulnerable category of prisoners who are at the highest risk of self-harm or suicide. Essentially, this

means prevention of self-harm or suicide more so than offering therapeutic clinical intervention. This is not a criticism of the staff involved, rather a statement of the day-to-day reality they face.

Most, if not all, the prisoners sent to crisis care units are suffering a serious mental health crisis requiring ongoing clinical intervention. They are no less worthy of appropriate specialist care than someone suffering a serious general health issue, such as a broken bone or heart complaint. The difference is the former are sent to a cold sterile untherapeutic environment where the focus is on prevention of self-harm or suicide, whereas the latter would be placed in an ambulance, taken to a hospital, assessed by medical staff, and, if required, admitted for treatment. It begs the question as to why treatment of mental health is somehow seen in a different light to general health.

Just prior to sending the final report to the printers for publication we finally received the Department's response to our draft report, 11 weeks after we sent it to them for comment. Our agreed timeframe for a response is five weeks, but this is now rarely, if ever, met. Our intention was to publish this report without their response as we have done with some recent reports. In the absence of an agreed extension, this will now be our default position.

Our report highlights many concerns and areas where improvement is warranted, and the Department's response acknowledged most, if not all, of these. A constant element of the Department's response is that previous funding requests have been unsuccessful. So, it was pleasing to see additional funding had been approved for badly needed clinical staffing at Hakea Prison, and the plans around improved infrastructure in Casuarina Prison and the intention to bid for adequate resources to staff the expanded facilities. The Department's response could be described as pragmatic, acknowledging the situation and what can be achieved. But pragmatism does not help the people in prisons today who desperately require a therapeutic environment and adequate clinical interventions. The Department and Government must commit to addressing the many mental health shortfalls we have identified in this report that we are seeing across prisons in Western Australia. There is an imperative to address these issues and concerns as a matter of urgency.

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