Tasmanian Government

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TASMANIAN HEALTH SERVICE

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Legislative Council Government Administration Committee 'B'
Email: csjs@parliament.tas.gov.au

Dear Committee,

RE: Inquiry into Tasmanian Adult Imprisonment and Youth Detention Matters

1. This submission specifically relates to Items 3 and 6 of the Terms of Reference of the 'Inquiry into Tasmanian Adult Imprisonment and Youth Detention Matters', with a focus on mental health service provision to Tasmanian adult prisoners.

2. This submission is made in my capacity as the Statewide Specialty Director of the Tasmanian Forensic Mental Health Service (FMHS). I have been in this role since January 2022.

Executive summary:

3. People with mental health issues who are, or have been, in contact with the criminal justice system are amongst Tasmania's most stigmatised and disadvantaged patients. These people experience difficulties accessing appropriate mental health care both in custody and in the community.

4. The Prisoner Mental Health Taskforce (2019; 'Taskforce') and Custodial Inspector's Care and Wellbeing Inspection Report, 2017 (published 2018, 'Custodial Inspector's Report') identified significant issues with mental health service provision to Tasmanian prisoners. The Taskforce and Custodial Inspectorate Report recommendations remain unmet. They cannot be met without commitment to comprehensive service development supported by a sustainable funding model.

5. Mental health services to Tasmanian prisoners remains under-developed and under-resourced compared with other Australian jurisdictions.

6. Despite a significant increase in the prison population in the recent decade, there has been no commensurate increase to already inadequate prison resources.

7. Mental health services to prisoners have not been included in the Tasmanian 'Mental Health Reform', which raises issues in terms of stigma and inequity for this already vulnerable patient group.

Background – mental health problems amongst prisoners:

8. Prisoners experience mental health problems at a disproportionately higher rate than those in the community (e.g. Fazel & Seewald, 2012; Stewart et al., 2021).

9. According to the 5th National Prisoner Health Data Collection (AIHW, 2019), 40% of surveyed prisoners reported a previously diagnosed mental health condition, 21% reported a history of self-harm, and a quarter of prisoners were taking psychotropic medication. Nearly two-thirds used

illicit substances in the preceding 12-months, most commonly methamphetamine (AIHW, 2019). One in four deaths-in-custody were due to suicide or self-inflicted causes (AIHW, 2019). Self-reported rates of a prior mental health diagnosis in a representative sample (N = 1,132) of NSW prisoners were 77.7% for females and 61.8% for males, with nearly half (49.8%) screening positive for current mental health symptoms (Korobanova et al., 2022). In Queensland, 33.6% of a population-based cohort with a history of custodial sentence had an inpatient mental health diagnosis (Stewart et al., 2021).

10. Rates of serious mental illnesses, such as schizophrenia or major depressive disorder, are significantly higher amongst prisoners compared with those in the community (Fazel & Seewald, 2012; Fazel et al., 2016; Stewart et al., 2021).

11. Prisoners with mental health issues are at increased risk of suicide and self-harm, violence, and victimisation (Fazel et al., 2016). Those with serious mental illness are at additional risk of experiencing symptoms which may undermine capacity to make decisions about treatment and/or participate in legal proceeding, which may prolong incarceration even for minor offending.

12. Mentally unwell prisoners may be subjected to periods in segregation to manage associated behaviours and risks while unwell. Without access to timely and specialist mental health assessment and support, symptoms of psychiatric illness may be misrecognised as 'antisocial' or problematic and be inappropriately managed as such.

13. Prison itself can be a stressful, 'counter-therapeutic' environment, deleterious to mental health and well-being (e.g. WHO, 2007). Overcrowding, exposure to violence, enforced solitude, lack of privacy, lack of meaningful activity, monotony, social and familial isolation/dislocation, apprehension about the future, prison dynamics, and difficulties accessing health services, are amongst contributing factors (e.g. Levy, 1997; Sales & McKenzie, 2007; WHO/ICRC, 2005, cited in Fraser et al., 2009; Walker et al., 2014).

'Equivalence of care':

14. The principle of 'equivalence of care' for prisoners is well established and a central concept of prison mental health service planning (e.g. Birmingham et. al., 2006). In summary, '[p]risoners should receive the same level and quality of basic health services as in the community' (WHO, 2007, at p.133; Niveau, 2007).

15. The principle is reflected in the Standard Minimum Rules for the Treatment of Prisoners ('The Mandela Rules', UN General Assembly, 2015) and Convention on the Rights of Persons with Disabilities (UN General Assembly, 2007; see also RANZCP, 2017). According to 'Principle 1' of the UN Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN General Assembly, 1982), '[h]ealth personnel.. charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained' (WHO, 2008, at p.5). 'Principle 9' of the UN Basic Rights for the Treatment of Prisoners (UN General Assembly, 1991) stipulates that '[p]risoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation'.

16. 'Equivalence to the non-offender' was adopted by the Australian Health Ministers Advisory Council (2006) as the first principle of the National Statement of Principles for Forensic Mental Health, and affirmed in a recent National Stakeholder Consultation (Queensland FMHS & QCMHR, 2022; see also RANZCP, 2017).

Tasmanian context:

17. Like other Australian jurisdictions, the Tasmanian prison population has grown significantly over recent years, and along with it, the demands on prison-based mental health services.

18. In Tasmania, there were 514 prisoners in June 2008, 681 in March 2019, and, this March 2023, there were over 720 (Custodial Inspector's Report; Taskforce).

19. There is no unified 'prison mental health service' in Tasmania. Services are fragmented across several service lines, primarily the CPHS and FMHS. Although the CPHS and FMHS are grouped operationally under the 'Forensic Health Service', they are different in their clinical objectives and specialisation, the former being a primary health service, the latter a specialist mental health service, each service being under separate clinical leadership.

20. The Therapeutic Service Unit (TSU) is employed directly by TPS. The TSU provides counselling-type services for prisoners, is involved in suicide and self-harm risk management processes and crisis response, behavioural management, and training for correctional staff. The TSU is not a health service, per se, and thus will not be the focus of this submission.

21. Compared with other jurisdictions, mental health services to Tasmanian prisoner are significantly under-developed and under-resourced

22. Two critical reports remain highly relevant:

    a. The Custodial Inspector's Care and Wellbeing Inspection Report, 2017 (published 2018) which incorporates the report of expert consultant, Professor James Ogloff AM FAPS. (https://www.custodialinspector.tas.gov.au/inspection_reports)

    b. The Prisoner Mental Health Care Taskforce – Final Report (dated May, 2019). (https://www.justice.tas.gov.au/news_and_events/prisoner-mental-health-care-taskforce-final-report2)

23. Concerns and core recommendations outlined in those reports, both now several years old, remain substantially unaddressed.

Custodial Inspectorate Report:

24. The Custodial Inspectorate in Tasmania engaged Professor James Ogloff in the 2017 inspection of mental health services in Tasmanian prisons.

25. While commending the quality, dedication, and commitment of involved health staff, Professor Ogloff found that mental health services were understaffed, highlighting a relative lack of resources (that is, the ratio of mental health staff to detainees) compared with other Australian jurisdictions.

26. Professor Ogloff compared expected versus actual staffing at Risdon Prison (Custodial Inspector, 2017; Appendix 4, at p.6). At the time, available mental health staffing consisting of:

    a. Operating under the Correctional Health Service.

        i. 1.0 'full time equivalent' (FTE) Clinical Nurse Consultant ('CNC') (though not solely dedicated to mental health);

        ii. A full-time 'Psychiatric Liaison Nurse' (PLN) (one nurse working 12-hours per day, seven days per week, which in my calculation equates to approximately 2.2 FTE if all shifts are filled).

    b. Operating under the FMHS:

        i. Although there was no dedicated psychiatrist in prison, it was expected that psychiatrists working elsewhere in the FMHS would 'in reach' to prison for clinics, estimated at that time to amount to up to 0.2 FTE (i.e. two half-day sessions per week).

27. Professor Ogloff commented that the actual total mental health FTE at Risdon Prison was impossible to calculate. In my own calculation considering the above figures, there was at most 3.4 FTE.

28. Considering national averages, Professor Ogloff considered the expected FTE for a prison population of 600 would be 24.6, with extant resources falling well and truly below that level.

29. Professor Ogloff additionally commented on a 'lack of leadership, strategic planning, and coordination of mental health services', noting the provision of services in prison was fractured and lacking strategic direction.

30. While Correctional Health Services had primary responsibility for mental health care of prisoners, Professor Ogloff noted that service provision was shared in an informal way across several involved service lines (i.e. CPHS, FMHS, TPS). Although outside the scope of the review, Professor Ogloff suggested consideration be given to the extent to which the FMHS could play a more formal role in the organisation and delivery of mental health services in Tasmanian prisons.

Prisoner Mental Health Care Taskforce, May, 2019:

31. The Prisoner Mental Health Care Taskforce (Taskforce) was established following the 2016 murder of North Hobart grocer Ms Voula Delios by a recently released prisoner who was subsequently found not guilty by reason of insanity.

32. The Taskforce highlighted:

    a. Tasmania's 'relative lack of resources for delivery of primary and mental health services to prisoners and detainees in comparison with other Australian States and Territories'.

    b. A 'lack of leadership, strategic planning and coordination of mental health services', which were 'fractured by virtue of being provided through separate service arms (CPHS and Forensic Mental Health Services).'

    c. The level of assessment and treatment provided to Tasmanian prisoners was more akin to that of a general practice, with an overall absence of specialist mental health services for people with severe mental illness.

33. I will not reiterate all Taskforce recommendations in this submission, but emphasise 'Recommendation 1', '..that the THS develops and implements a model of care that takes into account current and projected future demand for mental health services from the prison population as a priority. The model of care should be developed taking into account the Custodial Inspector's Report, including [Professor Ogloff's] Report appended to it.'

34. Prisoners with serious mental illness requiring acute hospital care can be referred for admission to the Wilfred Lopes Centre (WLC), Tasmania's only secure forensic mental health unit. While the Taskforce did make recommendations relevant to WLC, importantly, WLC is a health facility, and not part of the prison estate, thus will not be the focus of this submission.

35. I note however that the Taskforce recommended 'the TPS and THS actively investigate options for additional infrastructure and accommodation for prisoners and detainees with mental health needs who do not meet the criteria for transfer to WLC..'.

Progress in meeting key recommendations:

36. In May 2021, CPHS initiated a business plan pursuant to the Custodial Inspector and Taskforce recommendations, for 13.54 FTE (equating to $2,245,000).

37. That business plan was approved by the Deputy Secretary of Community Health and Wellbeing and Clinical Executive Director of the Statewide Mental Health Service in May 2021.

38. The business plan, although approved, was not funded, and thus core recommendations of the Taskforce (particularly, 'Recommendation 1') and Custodial Inspector Report cannot be met at this time.

39. A number of mostly 'ad hoc' resourcing measures have been taken in an effort to improve mental health services to prisoners.

40. The major improvement has been the dedication of a full-time psychiatrist to prison. That is currently an 'unfunded position'.

41. Beyond that, the FMHS have allocated (ad hoc) a mental health nurse (0.8 FTE) to support clinical coordination and transition of care for prisoners. This nurse does not provide direct clinical care to prisoners.

42. Additionally, the FMHS have allocated (ad hoc) a psychiatric registrar (a doctor training to become a psychiatrist) to provide clinical input to prisoners on a limited sessional basis (up to 0.4 FTE).

43. Both the FMHS nurse and psychiatric registrar have been taken from elsewhere in the FMHS; that is, those resources must be forgone by another part of the FMHS and are not formally dedicated to prison mental health. It is unlikely the FMHS can support this ongoingly, given other service demands.

44. A CNC for mental health was allocated by CPHS in mid-2022, again by drawing from resources that would otherwise be for drug and alcohol or physical health programs. It is at time of writing unclear whether (or to what extent) this will be an ongoing funded position. This does not represent an advance on FTE as reflected Professor Ogloff's 2017 review (i.e. 1.0 FTE CNC was already factored in those calculations).

45. There has been no material increase in resources otherwise.

46. With the prison psychiatrist position, and including the ad hoc resources contributed by the FMHS, total FTE available to provide mental health care to prisoners as at March 2023, is, at most, 5.4. This remains significantly below other Australian jurisdictions, and is significantly below the expected resourcing defined by Professor Ogloff in 2017. The prison population, and consequently the number of prisoners requiring specialist mental health support, continued to increase during this period of time (thus expected FTE requirements will have increased since Professor Ogloff's report).

47. Although these increases in resourcing have been modest, they have been 'high yield', translating into a substantial increase in prisoners seen in the psychiatric clinic compared with previous years.

48. In this arrangement, there is an overreliance and inefficient use of medical staff to perform duties which in a developed prison mental health service would be performed by non-medical clinical and administrative staff.

49. There has been no material change otherwise in the model of care for prison mental health services in prison. Services remain fragmented, and depend on the collaborate endeavours of individual clinicians. The fracturing of service provision in this way means that that there is no single person or service responsible for clinical oversight and quality and safety, and no single clinical service responsible for strategic planning of mental health services for prisoners.

50. Despite Professor Ogloff's and the Taskforce recommendations, and despite the recent expansion of the Risdon Prison Complex, there remains no dedicated area in prison suitable to support prisoners with mental health issues who do not meet the criteria for admission to the Wilfred Lopes Centre.

51. The efforts, commitment, adaptiveness, and collaborative endeavour of a small number of individual staff working to deliver mental health care to Tasmanian prisoners is to be highly commended.

Recommendations:

52. The FMHS advocate for 'equivalence of care' for Tasmanian prisoners.

53. There must be appropriate funding to meet the Custodial Inspectorate and Taskforce recommendations. The FMHS advocates that the business plan approved in May 2021, be appropriately funded.

54. We recommend the development of a dedicated 'prison mental health service', operating under the FMHS, as in other Australian jurisdictions.

55. There are a number of service models operating in other Australian jurisdictions which provide reasonable examples. The ACT correctional mental health service, which was visited by myself and several others from our service last year, provides one viable example of community equivalent care for prisoners which could be readily scaled to the Tasmanian context.

56. Support for the re-integration of all prisoners should be a priority, however those with complex mental health needs will often require specialist assistance on release from prison. It is recommended that there be funding allocated to support a post-release care program which can focus on release planning and supporting engagement with community-based health care providers after release.

57. There should be consideration for how prisoners with mental health issues not meeting criteria for admission to WLC could be better supported within the prison estate. This would include the creation of areas in prison which provide additional support (although, to be clear, not intended as a substitute for hospital admission).

58. Further upskilling of correctional staff, and the implementation of something like the 'Psychologically Informed Planned Environments' model (PIPES) in the UK, is recommended.

59. Prisoners should not remain excluded from the Statewide Mental Health Reform.

60. I would welcome the opportunity to appear at the Inquiry to discuss further and answer any questions arising out of this submission.

Yours sincerely,

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