ACT AUDITOR–GENERAL'S REPORT

MANAGEMENT OF DETAINEE MENTAL HEALTH SERVICES IN THE ALEXANDER MACONOCHIE CENTRE

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Audit Team

Katinka Mutandadzi

JRPO Associates Pty Ltd

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ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

PA 20/05

The Speaker
ACT Legislative Assembly
Civic Square, London Circuit
CANBERRA ACT 2601

Dear Madam Speaker

I am pleased to forward to you a Performance Audit Report titled 'Management of detainee mental health services in the Alexander Maconochie Centre' for tabling in the Legislative Assembly pursuant to Subsection 17(5) of the *Auditor-General Act 1996*.

The audit has been conducted in accordance with the requirements of the *Auditor-General Act 1996* and relevant professional standards including *ASAE 3500 – Performance Engagements*.

Yours sincerely

Michael Harris
Auditor-General
2 March 2022

The ACT Audit Office acknowledges the Ngunnawal people as traditional custodians of the ACT and pays respect to the elders; past, present and future. The Office acknowledges and respects their continuing culture and the contribution they make to the life of this city and this region.

Level 7, 5 Constitution Avenue Canberra ACT 2601 PO Box 275 Civic Square ACT 2608
T 02 6207 0833 **F** 02 6207 0826 **E** actauditorgeneral@act.gov.au **W** www.audit.act.gov.au

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GLOSSARY

Abbreviation or Acronym	Full term
ACTCS	ACT Corrective Services
AHS	Aboriginal Health Service
ALO	Aboriginal Liaison Officer
AMC	Alexander Maconochie Centre
ART	Assertive Response Team
CHS	Canberra Health Services
CSU	Crisis Support Unit
Custodial Mental Health	Custodial Mental Health Service – Adult
Draft Operational Guide	*Custodial Mental Health Services Operational Guide*
FMHS	Forensic Mental Health Services
FTE	Full time equivalent
GP	General Practitioner
HRAT	High-Risk Assessment Team
IRMP	Interim Risk Management Plan
JACS	Justice and Community Safety Directorate
JRPO	JRPO Associates Pty Ltd Consulting (subject matter experts assisting with the audit)
MAJICeR	The electronic records management system used by Justice Health for the management of clinical records for detainees
MDT	Multi-Disciplinary Team
MHJHADS	Mental Health, Justice Health, Alcohol and Drug Services
MHS	Mental Health Service
MoU	Memorandum of Understanding
SLA	Service Level Agreement
SVAT	Suicide Vulnerability Assessment Tool
The 'Arrangement'	The Arrangement between the Justice and Community Safety Directorate and ACT Health for the delivery of health services for detainees
ToR	Terms of Reference
Winnunga	Winnunga Nimmityjah Aboriginal Health and Community Services Ltd

SUMMARY

The Alexander Maconochie Centre (AMC) is the ACT's only adult prison. It houses sentenced and remand detainees of all genders.

The AMC's operating philosophy is to meet:

> … the objectives of the 'healthy prison' concept under the four pillars of 'Safety', 'Respect and Dignity', 'Purposeful Activity' and 'Rehabilitation and Release Planning'.

To assist with the achievement of this objective, detainees within the AMC are provided with a range of health services that are delivered via a shared care arrangement between ACT Corrective Services (ACTCS) and Canberra Health Services (CHS).

The audit considered the effectiveness of the delivery of mental health services to detainees within the AMC.

Conclusions

PLANNING FOR THE DELIVERY OF MENTAL HEALTH SERVICES

Planning for the delivery of mental health services is ineffective. There is no Clinical Services Plan that guides the planning for, or delivery of, mental health services to detainees.

Poor data collection practices have hampered the ability of agencies to determine the:

- number of detainees with mental health conditions;
- nature of those conditions; and
- likely treatment requirements.

Under section 53 of the *Corrections Management Act 2007*, the Director-General of the Justice and Community Safety Directorate is required to provide a standard of health care to detainees that is equivalent to that provided in the community. Due to the ambiguous target, coupled with poor data collection practices and a lack of performance information collected by the agency, the Audit Office was unable to establish whether this standard had been met. Nevertheless, it is incumbent on the Director-General of the Justice and Community Safety Directorate to assure the community that it has.

Limited training is provided to Custodial Officers tasked with the day-to-day management of detainees with mental health conditions. This has resulted in a lack of Custodial Officer confidence in their ability to provide effective supervision and support to these detainees.

FRAMEWORK FOR THE DELIVERY OF MENTAL HEALTH TREATMENT

Governance arrangements do not provide clear management linkages between Canberra Health Services and ACT Corrective Services. Documents intended to establish shared care arrangements around the delivery of mental health services have expired and have not been replaced.

The Memoranda of Understanding and funding agreement with Winnunga Nimmityjah Aboriginal Health and Community Services are useful and comprehensive documents to guide the delivery of services by Winnunga. However, Winnunga has not been effectively incorporated into the overarching governance structure.

Governance bodies are not effective in identifying key issues around relationship management, significant gaps in service delivery or performance measurement.

Poor record keeping practices and systems prevent Canberra Health Services from gathering sufficient data to effectively plan for ongoing resource requirements.

SCREENING FOR MENTAL HEALTH ISSUES

Screening processes on admission to the Alexander Maconochie Centre for non-Aboriginal and Torres Strait Islander detainees are effective, and at-risk detainees are effectively triaged and managed.

However, due to a lack of involvement from an Aboriginal or Torres Strait Islander health officer in the screening process, Canberra Health Services does not ensure that Aboriginal and Torres Strait Islander detainees are effectively screened for mental health issues at admission.

The ACT accepts mental health referrals from any source, including self-referrals; this reflects positively on the processes adopted in the Alexander Maconochie Centre. However, the effectiveness of arrangements established to screen detainees already in custody for mental health issues is compromised because of a lack of clear procedures or guidelines.

DELIVERY OF MENTAL HEALTH SERVICES

The delivery of mental health services to non-Aboriginal and Torres Strait Islander detainees under psychiatric or suicide and self-harm ratings is effective.

However, the delivery of culturally sensitive mental health treatment to Aboriginal and Torres Strait Islander detainees with psychiatric or suicide or self-harm risks could be improved by the inclusion of input from an Indigenous service provider.

Detainees with less severe mental health conditions do not receive adequate treatment due to a significant shortage of psychologists within the AMC. The treatment of this cohort could also be strengthened by the development of policies and procedures that guide their care.

Care plans are routinely developed and implemented. However, there are opportunities to improve the quality of these plans, particularly by the inclusion of comprehensive treatment information.

Planning for the release of detainees with mental health conditions could also be improved by the development of guidance material that describes the process for this planning, and the information required to inform that planning.

Key findings

PLANNING FOR THE DELIVERY OF MENTAL HEALTH SERVICES	Paragraph
No strategic planning has been undertaken for the delivery of mental health services at the AMC. Neither CHS nor ACTCS has set objectives, priorities, or goals for the delivery of mental health services in the AMC. No Clinical Services Plan exists that guides the planning for, or delivery of, mental health services to detainees. In the absence of a Clinical Services Plan, and associated objectives, priorities or goals, the responsible agencies are unable to assess their service delivery performance.	2.10
The collection and use of data for the purpose of planning for service delivery is constrained by the MAJICeR system (the electronic records management system used by Justice Health for the management of clinical records for detainees). The system does not readily code for, or allow the extraction of, key data relating to cross-sectional 'service episodes' or 'episodes of care' undertaken by Custodial Mental Health. While data on occasions of service are collected and reported, which shows activity rather than the number of patients receiving treatment, this is not useful for planning purposes because one patient may have many occasions of service or very few. The information demonstrates activity, but it cannot be used as an estimate of met or unmet need for planning purposes.	2.24
There is a significant shortfall in staffing in Custodial Mental Health, which provides direct treatment to those detainees who are experiencing a severe mental illness or disorder. While funded for a total of 16 FTE staff, ranging from Registered Nurses to Forensic Psychologists, the team only has 11.2 current FTEs. The most significant shortfall in staff occurs in the number of psychologists; only two of the four budgeted positions have been filled as of April 2021. The two psychology positions that have been filled are the most junior roles.	2.28
Without a full complement of staff, the 'Stepped Care Approach' identified by CHS in its *Forensic Mental Health Model of Care* cannot be effectively implemented. The 'Stepped Care Approach' is premised on all detainees being provided with entry level mental health care (Step One) that is followed, where required, by stepped-up care	2.32

as necessary. The gap in service provision may not allow ACTCS to provide health care services equivalent to community standards, as required under section 53 of the *Corrections Management Act 2007*, where a broad range of psychological services are available.

ACTCS has established a Specialist Interventions Team, the purpose of which is to provide individual support at a range of levels from short term (six session) strategy-based interventions for high prevalence disorders, through to longer-term approaches to addressing complex needs (including behaviour management, high risk, etc). This service could be expected to address the gap for those with mild to moderate mental health care needs. At the time of audit fieldwork in May 2021, the team was staffed by one psychologist (the team leader) who treated an average of four AMC patients per week. There is funding for an additional FTE counsellor and FTE psychologist, but these positions have remained vacant for 12 months and recruitment attempts to date have been unsuccessful. Even when fully staffed, JRPO considered it unlikely that this team would be able to meet the needs of a prison that holds an average of nearly 450 detainees (which includes a large proportion of detainees on remand and the relatively higher demand female population). 2.37

Section 53 of the *Corrections Management Act 2007* requires the Director-General of JACS to ensure 'detainees have a standard of health care equivalent to that available to other people in the ACT'. There is currently a substantial shortage of psychologists, in both CHS and ACTCS, who can provide treatment to detainees, and neither agency has recruited to its available establishment. This suggests there is a significant service gap in the provision of psychological services for detainees and the ability of the Director-General of JACS to deliver a 'standard of health care equivalent to that available to other people in the ACT' may be compromised. 2.50

Custodial Officers are responsible for the day-to-day management of detainees and have a role in facilitating mental health services to detainees through: identification of escalating mental health issues; referral of detainees to mental health supports; and behavioural management and support for detainees. Training around the management of detainees with mental health conditions is provided to Custodial Officers on commencement with ACTCS, but no refresher training (outside of suicide and self-harm risk) or guidance material is provided after commencement. In 2019 *The healthy prison review* report from the ACT Inspector of Correctional Services identified that 71 percent of Custodial Officers did not feel adequately trained in the management of detainees with mental health issues. The lack of ongoing training and support for Custodial Officers compromises the effective delivery of mental health services and supports to detainees in the AMC. 2.58

FRAMEWORK FOR THE DELIVERY OF MENTAL HEALTH TREATMENT

Paragraph

In 2016 two Memoranda of Understanding were developed between ACT Health and ACTCS. The MoUs provided guidance on the management of detainees subject to mental health or forensic mental health orders and the sharing of information that was reasonably necessary for the safe and effective treatment, care, or support of a detainee. The Memoranda of Understanding expired in 2017 (30 June 2017 and 1 December 2017 respectively). 3.9

In August 2017 the *Arrangement between JACS and ACT Health for the delivery of health services for detainees* was developed, which sought to guide the treatment of detainees and their access to health care services. The Arrangement established the purpose of the relationship between ACTCS and ACT Health, service delivery arrangements and responsibilities as well as resources and governance arrangements. The Arrangement included limited information on how these would be implemented, as it was intended that the Arrangement would be supplemented by a range of schedules that could take the form of guidelines, agreed models of care, governance documentation or descriptions of services. Only the models of care were implemented or developed as planned. The Arrangement expired when ACT Health was split into two entities on 1 October 2018 and CHS took over responsibility for Justice Health. An updated Arrangement document was developed in September 2019 by CHS that reflected the new administrative arrangements and included references to the *Human Rights Act 2004* that were not included in the original document. This document was signed by the Chief Executive Officer of CHS but has not been sighted or signed by ACTCS. In the absence of an updated Arrangement there is no formal arrangement between CHS and ACTCS relating to the delivery of health services for detainees. 3.17

An SLA was intended to be developed under the Arrangement. The SLA was intended to be a high-level schedule as to the services provided by ACT Health (now CHS) and it was noted 'this may be extremely useful as we continue to integrate Winnunga into the Health Service Model'. The development of the SLA remained in progress as at February 2021 and neither a draft version, nor a timeframe for delivery, has been developed. In the absence of an SLA there is no clearly documented definition of the services to be provided by each party along with performance measures that would provide agencies with a mechanism to monitor service delivery. The development of an SLA between ACTCS and CHS would be an important mechanism in defining the relationship between the parties and their service expectations and providing a mechanism that would hold each party accountable for the delivery of the services. 3.22

CHS does not monitor the activities of Winnunga to validate whether the shared care arrangements between CHS and Winnunga are effective, and services are being delivered as planned. This lack of oversight is compounded by a lack of oversight and management of the funding agreement between Winnunga and ACT Health for services delivered in the AMC. 3.32

Winnunga is a key stakeholder for the delivery of mental health services in the AMC. Two key documents govern the relationship between Winnunga and ACT Government agencies: *MoU for the delivery of coordinated health care services to Aboriginal and Torres Strait Islander detainees in the AMC (December 2018)* and service funding agreement (August 2017). The MoU and funding agreement with Winnunga are useful and comprehensive documents to guide the delivery of services by Winnunga. However, there is no formal oversight of the arrangements that provides assurance that they are operating as planned. 3.36

CHS and ACTCS have developed a range of procedures that support the delivery of mental health services to detainees, including procedures that relate to: access to health care; triage and health induction; care of persons subject to psychiatric 3.42

treatment orders; and segregation of detainees subject to health segregation orders. MHJHADS has also developed a draft *Custodial Mental Health Services Operational Guide* (the draft Operational Guide) that seeks to provide an overview of the operational and clinical procedures that are undertaken by Custodial Mental Health within MHJHADS. The guide is expected to be finalised in mid-2021. The draft Operational Guide is a useful document that is expected to guide the activities of the Custodial Mental Health team. Until its finalisation there is a risk that:

- staff lack understanding of their role in the delivery and management of mental health services;
- referral and triage processes are inconsistent or non-existent;
- criteria around the transfer of patients are not understood; and
- consistent approaches to detainee care are not taken.

The ACTCS Health Advisory Group (the Advisory Group) was established to provide high level oversight of the work between ACTCS and ACT Health and to ensure that an integrated approach was taken to the development of health-related policies within the AMC and that joint strategies were progressed effectively. The Advisory Group has been ineffective in achieving these aims. The effectiveness of the Advisory Group was hampered by poor record keeping and a failure to progress key action items, with some remaining incomplete for more than 18 months. Meeting on a bi-annual basis in March and September of each year also reduces the ability of the Advisory Group to effectively provide oversight over key issues such as detainee wellbeing, or the effectiveness of the arrangement for the delivery of health services to detainees and effectively respond to urgent emerging issues. 3.65

The Winnunga Implementation, Operational and Governance Group (the Winnunga Governance Group) was formed to strengthen relationships between Justice Health Services and ACTCS regarding the delivery of health services by Winnunga at the AMC. The Group is primarily focused on operational issues and discussion around these was identified in meeting minutes, as well as robust discussion and escalation of issues to senior decision makers. However, of the eight meetings that took place between September 2019 and September 2020 a representative from ACTCS was only noted at three meetings. Of the six Group meetings planned since October 2020, four had been abandoned, one was postponed, and one was held as planned. Winnunga has advised that it no longer plans to attend the meetings as they had become unhelpful to Winnunga's operations within the AMC. The Group has not achieved its aim of strengthening relationships between CHS, ACTCS and Winnunga. 3.76

While each of the senior governance groups had clearly defined responsibilities, there were gaps in these, particularly around risk management and strategic planning. In addition, the groups naturally addressed and covered some of the same areas of responsibility. This suggests a need for communication channels and reporting between the groups to enable the sharing of information and escalation of important issues. None of the groups had formal mechanisms or pathways to interact with each other or with senior decision makers, which resulted in the ineffective management of important issues, such as the shortfall in psychological staff discussed in Chapter 2. The establishment of clear reporting lines that provide linkages between these groups would help mitigate this risk going forward. It would 3.88

also help to ensure that issues are communicated to senior decision makers who are in the position to effectively address them.

CHS has developed a number of performance indicators that measure the delivery of its services in the AMC, which are identified and articulated in the *Forensic Mental Health Services Model of Care 2019* and MHJHADS divisional plan. Performance indicators and targets associated with assessments, referral times and care plans are appropriate and consistent with practice in other jurisdictions. However, while useful in providing clinical data, some performance indicators are not specifically within its control and do not provide a measure of their performance. These include indicators relating to detainees already linked with Mental Health Services prior to entry; detainees on Psychiatric Treatment Orders; and detainees on long-acting injectable medications. 3.97

Neither CHS nor ACTCS has developed performance indicators that relate to: detainee access to mental health treatments (including against the number of detainees with diagnosed mental health conditions); delivery of mental health treatments: and the development of release plans for detainees with mental health conditions. Neither has CHS or ACTS developed performance indicators related to detainees: access to acute inpatient care; or who have experienced an escalation of psychiatric or suicide risk ratings. In the absence of performance indicators relating to these services, there is a lack of performance information associated with service delivery performance and risks and resource needs. Without relevant performance indicators, it is difficult for either CHS or ACTCS to assess the overall effectiveness of the delivery of mental health services and risks associated with resource allocation. 3.101

SCREENING FOR MENTAL HEALTH ISSUES

Paragraph

Custodial Mental Health screens every individual upon their entry to custody in order to identify those people with mental health needs and refer them for appropriate supports and intervention as required. The mental health screening assessment process, including roles and responsibilities, is well articulated in the draft *Custodial Mental Health Services Operational Guide* and the *Access, Triage and Health Induction Assessment Clinical Procedure*. CHS reported in its *2019-20 Annual Report* that 100 percent of induction assessments had been achieved within the required 24-hour timeframe. Initial mental health screening is based on an adaptation of the *Jail Screening Assessment Tool*, which is a validated measure for mental health screening undertaken in prisons upon reception. The use of clinical FMHS staff to conduct assessments exceeds the practice used by other Australian jurisdictions, where the use of primary health nurses or correctional officers is common. This was considered good clinical practice. 4.17

Indigenous Liaison Officers meet with detainees during the induction process and 'provide information on accessing cultural support, community elders and accessing Aboriginal and Torres Strait Islander cultural programs' and Winnunga may provide comprehensive health checks within seven days of a detainee's induction. However, neither the draft *Custodial Mental Health Services Operational Guide* nor the *Access, Triage and Health Induction Assessment Clinical Procedure* require the presence of a CHS Aboriginal Liaison Officer (ALO), or a representative from Winnunga, during 4.25

induction assessments for Aboriginal and Torres Strait Islander detainees, missing a key opportunity to potentially identify culturally sensitive health care needs.

A SVAT is completed as part of the induction assessment process. The SVAT is the tool currently endorsed for use by MHJHADS across public mental health services in the ACT to help assess a person's suicide vulnerability. The SVAT emphasises an individualised approach, that is meaningful and supported by evidence, that highlights the importance of planning appropriate interventions and follow-up to address specific suicidal thoughts and/or behaviours. While it is positive that a systematic approach to suicide risk is employed (and appropriate that it is consistently used across the ACT), the SVAT has not been validated by the ACT Health Directorate for use with corrections populations (including for Aboriginal and Torres Strait Islander detainees). Suicide and self-harm induction assessment results were routinely communicated to ACTCS in a timely manner via the SVAT. 4.36

Following assessment, Custodial Mental Health clinicians consider a Psychiatric (P) rating for each person. The 'P' rating is an indicator to ACTCS that Custodial Mental Health is assessing and/or treating a person's mental health needs. Psychiatric induction assessment results were routinely communicated to ACTCS in a timely manner via a *Forensic Mental Health Notification Form*. 'P' rating contact timeframes were well met and occurred in accordance with the draft *Custodial Mental Health Services Operational Guide*. 4.40

Mental health concerns often arise during custody for both remand and sentenced detainees. Referrals can arise from detainees self-reporting or from Custodial Officers, health workers or any other worker within the AMC. Along with Queensland, the ACT is the only jurisdiction to accept mental health referrals from any source, including self-referrals. This reflects positively on the processes adopted in the AMC. However, CHS does not collect information on the origin of mental health referrals once a detainee is in custody. Such information would be useful in understanding where there may be gaps in the referral process, or where additional training or guidance information is required to assist individuals making referrals. 4.46

The CHS *Suicide Prevention and Intervention Framework at the AMC* Operating Procedure (the Operating Procedure) and the ACTCS *Management of At-Risk Detainees* Policy require all staff, contractors or volunteers working in the AMC to report risk concerns regarding detainees considered at risk of suicide and/or self-harm whilst detained at the AMC. The documents provide useful information around how detainees should be referred for treatment, although the *Management of At-Risk Detainees* Policy could be improved by the inclusion of information around the typical presentations for detainees at risk. ACTCS staff do not generally have clinical backgrounds and information that helps them to understand the types of behaviours that suggest a detainee may be at risk would improve the likelihood that these behaviours would be identified in a timely manner. 4.52

Limited training around the identification and management of detainees with mental health conditions, including specific units on suicide and self-harm risk, is provided to Custodial Officers on commencement with ACTCS. No refresher training or guidance material is provided once staff have commenced, except around suicide 4.61

and self-harm. ACTCS staff do not have access to material of this type developed by CHS. While procedures exist that provide guidance to Custodial Officers on how to refer detainees identified as at risk of suicide or self-harm, no procedures exist that provide guidance on:

- warning signs for psychiatric or psychological illness; or
- when to assess detainees already in custody for potential mental health issues.

There are opportunities for detainees to self-refer themselves for assistance with mental health issues, including through disclosure to a GP during a primary health visit and/or disclosure to a Custodial Officer. However, these self-referral pathways have not been documented in guidance material outside of the induction handbook provided to detainees on their initial admission into the AMC. This lack of guidance material has led to confusion around: 4.66

- the pathway to self-referral; and
- how self-referrals are managed by either ACTCS or CHS staff.

DELIVERY OF MENTAL HEALTH SERVICES

Paragraph

Collaborative care plans should be developed for all detainees assessed with a 'P' rating. Care plans should include consideration of a detainee's: recovery goals; mental and physical health issues; substance abuse issues; risk and safety issues; and family and carer supports. Basic care plans were developed and implemented for the nine detainees whose health records were reviewed for the purpose of the audit. However, only two of the nine reviewed files showed comprehensive treatment plan notes that would enable an effective handover of care between clinicians. When only basic information is included, it is not possible for CHS to ascertain precisely what treatment a detainee requires without discussing the plan further with the treating clinician. 5.14

At-risk detainees may be managed in the CSU, based upon their needs and operational requirements. Apart from the basic awareness training that is provided to all Custodial Officers at induction, no additional mental health related training is provided to officers who work regularly in the CSU. This presents a risk that the needs of these detainees are not being adequately met and places Custodial Officers managing these detainees at risk. 5.20

The HRAT is a multi-agency decision and intervention planning team involving ACTCS and Justice Health Services that co-ordinates the management of at-risk detainees, specifically S-rated detainees. The HRAT meets each business day and, according to the CHS *Standard Operating Procedure Suicide Prevention and Intervention Framework*, should be attended at a minimum by Custodial Mental Health, ACTCS and Primary Health Services. Minutes of HRAT meetings were extremely brief and only one included sufficient detail around discussions and associated planning. While decisions and actions were recorded, the minutes often contained limited discussion or rationale for these decisions. Without this level of detail, it is unclear whether sufficient attention was paid to the management of S-rated detainees. The effectiveness of these meetings was further weakened by the occasional absence of 5.28

a representative from Justice Health. In addition, no representative from key stakeholder Winnunga was included.

While occurring informally, there is no established process to ensure that advice and support is sought from Winnunga, or any other Aboriginal or Torres Strait Islander health professional, for Aboriginal and Torres Strait Islander detainees at risk of suicide and self-harm. 5.32

In February 2019 a Custodial Mental Health Team Leader observed a trend where 'P' ratings appeared to increase over time rather than decrease, indicating an apparent trend in the deterioration in mental state among detainees on the units. In response, Justice Health undertook a quality improvement activity to identify potential causes of this observed trend and to develop strategies to address it. The Quality Improvement (QI) report identified the need for earlier identification of mental health deterioration and appropriate intervention and a range of changes were implemented to improve clinician response times and reduce inpatient admissions among this group. 5.46

For detainees whose mental health condition requires hospital treatment, two options exist; treatment within the Canberra Hospital or the Dhulwa Mental Health Unit. Dhulwa offers a secure and structured environment for people who can't be safely cared for in other environments and whose complex care needs are not met in the current system. Delays in access to inpatient treatment were frequently experienced due to limited bed access at Dhulwa. While detainees may access hospital beds within the Canberra Hospital as necessary, these hospital beds are not always the type of beds required as they have lower levels of security/safety and are only intended for a relatively shorter length of stay. 5.55

The delivery of treatment to detainees without 'S' or 'P' ratings is hampered by the lack of an operational guide that describes the operational and clinical procedures to be undertaken for detainees who fall outside the criteria for treatment by Custodial Mental Health. At present, their management is at the discretion of individuals rather than a planned approach by the agency. As with detainees with 'S' or 'P' ratings, it is important for CHS to document the arrangements for the management of detainees with less severe mental health conditions to ensure their effective management. 5.58

Winnunga provides a primary health level of mental health care to Aboriginal and Torres Strait Islander detainees but does not have a role in the delivery of mental health treatment at the higher levels of the 'Stepped Care Approach'. Justice Health is specifically responsible for the provision of mental health services to Aboriginal and Torres Strait Islander detainees assessed with either a 'P' or 'S' rating. For the period 1 July 2020 to 31 December 2020, Winnunga reported the development of 42 mental health care plans for 23 detainees under its care and CHS reported that 49 Aboriginal and Torres Strait Islander detainees were subject to a 'S' or 'P' rating and were under its care, with a care plan in place. Only 0.6 of a FTE ALO from CHS is available to assist Custodial Mental Health to provide services to those Aboriginal and Torres Strait Islander detainees who are not receiving treatment from 5.73

Winnunga. This is unlikely to facilitate the delivery of effective culturally sensitive and appropriate treatment to Aboriginal and Torres Strait Islander detainees.

Trauma-informed care frameworks are considered essential in contemporary mental health, and forensic mental health services, to promoting understanding environments that promote health and wellbeing for all detainees and can prevent trauma-based deterioration. However, staff have not undertaken this training. This should be a further area for joint strategy development between CHS and ACTCS. 5.83

Greater attention is required to ensure that release planning is undertaken to address detainees' mental health needs upon release. There are no specific procedures or guidelines in CHS or ACTCS for the development of release plans for detainees, although for CHS staff, the Custodial Mental Health draft Operational Guide provides some guidance for detainees with 'S' and/or 'P' ratings, noting that the detainee's care plan 'must include an initial release plan in the event the person is released from custody'. The draft Operational Guide also includes a Closure Checklist for people released from custody but does not reference engagement of external service providers in the development of release plans, or refer to the clinical services provided by ACTCS. There is no guidance for the development of release plans for detainees with diagnosed mental health conditions who do not have 'S' and/or 'P' ratings. Guidance should be developed with respect to: 5.102

- a description of the release planning process (including the timing of both the development and review of release plans);
- the minimum level of information that should be considered and included in a release plan;
- how ACTCS should be consulted with around detainees receiving mental health treatment from their clinical staff;
- how service providers should be consulted when developing release plans for Aboriginal and Torres Strait Islander detainees.

Recommendations

RECOMMENDATION 1 STRATEGIC PLANNING

Canberra Health Services should, in conjunction with the ACT Health Directorate, develop a Clinical Services Plan for the delivery of mental health services in the Alexander Maconochie Centre. This plan, developed in partnership with Winnunga Nimmityjah Aboriginal Health and Community Services, and other relevant stakeholders, should include explicit embedding of culturally responsive services for Aboriginal and Torres Strait Islander peoples.

RECOMMENDATION 2 RECORD KEEPING SYSTEM

Canberra Health Services should ensure its record keeping system provides the functionality to extract key information, such as demographic and service need data, that supports effective resource planning.

RECOMMENDATION 3 PROVISION OF PSYCHOLOGICAL SERVICES TO DETAINEES

In order to demonstrate that the requirements of section 53 of the *Corrections Management Act 2007* are met the Justice and Community Safety Directorate should:

a) define what an 'equivalent standard of health care to that available to other people in the ACT' means in practice; and

b) ensure the provision of psychological services to detainees meets this standard.

RECOMMENDATION 4 TRAINING FOR CUSTODIAL OFFICERS IN THE CRISIS SUPPORT UNIT

ACT Corrective Services, in conjunction with Canberra Health Services, should:

a) develop and deliver a training package that assists Custodial Officers to provide effective management and support to detainees with mental health conditions. This should be supported by the development of a refresher training package for Custodial Officers to be delivered at regular intervals; and

b) develop and deliver a training package for those staff working within the Crisis Support Unit and provide these staff with ongoing supervision and support.

RECOMMENDATION 5 ESTABLISHMENT OF SHARED CARE ARRANGEMENTS

Canberra Health Services and the Justice and Community Safety Directorate should jointly:

a) establish and document the shared care arrangements for detainees with mental health conditions; and

b) develop a Service Level Agreement.

RECOMMENDATION 6 OVERSIGHT OF WINNUNGA SERVICE DELIVERY ARRANGEMENTS AND FUNDING

To improve the oversight of ACT Government service arrangements with Winnunga Nimmityjah Aboriginal Health and Community Services, ACT Health, in partnership with Canberra Health Services and Winnunga, should establish arrangements for the improved oversight of services described under the Winnunga funding agreement that are provided in the Alexander Maconochie Centre.

RECOMMENDATION 7 CUSTODIAL MENTAL HEALTH SERVICES OPERATIONAL GUIDE

Canberra Health Services should finalise the draft *Custodial Mental Health Services Operational Guide*.

RECOMMENDATION 8 HEALTH ADVISORY GROUP'S TERMS OF REFERENCE

Canberra Health Services and ACT Corrective Services should review and update the Health Advisory Group Terms of Reference.

RECOMMENDATION 9 LINKAGES BETWEEN GOVERNANACE GROUPS

ACT Corrective Services and Canberra Health Services should establish clear reporting lines that provide communication linkages between current governance groups.

RECOMMENDATION 10 KEY PERFORMANCE INDICATORS

Canberra Health Services and ACT Corrective Services should develop, and report against, key performance indicators that measure:

a) access to mental health treatment options; and

b) the delivery of mental health services within AMC.

Additionally, Canberra Health Services should report against a performance measure that relates to the development of release plans.

RECOMMENDATION 11 SUICIDE VULNERABILITY ASSESSMENT TOOL

Canberra Health Services should have the Suicide Vulnerability Assessment Tool, used during the induction assessment process, validated by ACT Health for use in a prison environment.

RECOMMENDATION 12 CUSTODIAL OFFICERS MENTAL HEALTH IDENTIFICATION TRAINING AND GUIDANCE MATERIAL

To improve the timely identification of mental health issues in detainees by Custodial Officers, ACT Corrective Services should provide:

a) on-going mental health identification training to Custodial Officers;

b) guidance material that identifies the warning signs for psychiatric and psychological illness; and

c) guidance material that details the referral process for those detainees not considered at-risk.

RECOMMENDATION 13 SELF-REFERRAL PATHWAY FOR DETAINEES

ACT Corrective Services should develop clear guidance material for detainees that details the self-referral pathways for mental health concerns.

RECOMMENDATION 14 COLLABORATIVE CARE PLANS

Canberra Health Services should improve the comprehensiveness of Collaborative Care Plans for all detainees with psychiatric risk ratings.

RECOMMENDATION 15 HIGH-RISK ASSESSMENT TEAM MEETINGS

Canberra Health Services and ACT Corrective Services should ensure that:

a) sufficient detail is recorded in meeting minutes of the High-Risk Assessment Team to support subsequent decisions and actions;

b) a process is established and documented that ensures advice is sought from an Aboriginal or Torres Strait Islander health professional regarding at-risk Aboriginal and Torres Strait Islander detainees.

RECOMMENDATION 16 OPERATIONAL GUIDE FOR DELIVERY OF TREATMENT OUTSIDE CUSTODIAL MENTAL HEALTH

Canberra Health Services should develop an operational guide that details the operational and clinical procedures to be undertaken for detainees who fall outside the criteria for treatment by the Custodial Mental Health team.

RECOMMENDATION 17 ABORIGINAL LIAISON OFFICER NUMBERS

Canberra Health Services should undertake an assessment of the number of Aboriginal Liaison Officers required to meet service needs, including support during the induction process, of Aboriginal and Torres Strait Islander detainees and recruit to this number.

RECOMMENDATION 18 TRAUMA INFORMED CARE

Canberra Health Services should introduce trauma informed frameworks to inform governance, clinical, and operational processes. This should include the development and implementation of trauma-informed care training for delivery to all clinical staff within Forensic Mental Health Services and Custodial Officers within ACT Corrective Services.

RECOMMENDATION 19 RELEASE PLANNING

Canberra Health Services should develop release planning guidance material that covers all detainees with mental health care plans that:

a) describes the process for release planning;

b) details what information should be contained in a release plan;

c) establishes a consultation process with ACT Corrective Services when planning release for those detainees receiving mental health treatment from ACT Corrective Services clinical staff; and

d) establishes a consultation process with Winnunga Nimmityjah Aboriginal Health and Community Services (or other service providers where necessary) when planning the release of Aboriginal and Torres Strait Islander detainees.

Agencies' responses

In accordance with subsection 18(2) of the *Auditor-General Act 1996*, the Justice and Community Safety Directorate and Canberra Health Services were provided with:

- a draft proposed report for comment. All comments were considered and required changes were reflected in the final proposed report; and

- a final proposed report for further comment.

In accordance with subsection 18(3) of the *Auditor-General Act 1996* other entities considered to have a direct interest in the report were also provided with extracts of the draft proposed and final proposed reports for comment. All comments on the extracts of the draft proposed report were considered and required changes made in the final proposed report.

No comments were provided for inclusion in this Summary chapter.

1 INTRODUCTION

Mental health in prisons

1.1 Research has shown that detainees in Australian prisons have higher levels of mental health issues, alcohol consumption, tobacco smoking, illicit drug use and chronic and communicable diseases than the general population. This often results in significant and complex health needs, which are frequently long-term or chronic in nature.

1.2 According to the Australian Institute of Health and Welfare:

> People in prison usually come from disadvantaged backgrounds, with poorer physical and mental health than the general population. They are less likely to have accessed health care services, and more likely to have a history of risk behaviours. Most people in prison are there for short periods, and many cycle through prison and the community multiple times. So, the health of people in prison is public health.

1.3 Prisons themselves are unhealthy places where living conditions and the environment allow for the spread of disease and worsening of mental health issues. In a fact sheet on mental health and prisons, the World Health Organisation stated:

> **Prisons are bad for mental health:** There are factors in many prisons that have negative effects on mental health, including: overcrowding, various forms of violence, enforced solitude or conversely, lack of privacy, lack of meaningful activity, isolation from social networks, insecurity about future prospects (work, relationships, etc), and inadequate health services, especially mental health services, in prisons.
>
> The increased risk of suicide in prisons (often related to depression) is, unfortunately, one common manifestation of the cumulative effects of these factors.

1.4 Remand detainees (those who are awaiting trial) are a particularly vulnerable group when it comes to the management of health conditions. Much higher numbers of people enter the AMC on remand than will receive a sentence after conviction. The nature of remand means that these detainees are often in prison for an uncertain time period, and this makes the management of their health needs difficult.

1.5 However, if managed correctly, a detainee's entry into a prison environment can provide a key opportunity for health intervention. The ACT Health 2016 *ACT Detainee Health and Wellbeing Survey* (conducted by the University of Melbourne) noted that among those surveyed detainees diagnosed with a mental illness, 63 percent reported that they had been receiving treatment in the community while 74 percent reported that they had been receiving treatment in prison.

Mental health of AMC detainees

1.6 The 2016 *ACT Detainee Health and Wellbeing Survey* reported that 54 percent of surveyed detainees had been diagnosed with a mental illness. Of these detainees, 40 percent reported having their mental illness first diagnosed in prison.

1.7 The most prevalent mental disorders respondents experienced included depression (30 percent), anxiety disorders (22 percent) and substance use disorders (16 percent). Twenty-one percent of respondents indicated that they had been admitted to a psychiatric unit or ward in a hospital and 35 percent reported attempting suicide.

1.8 Addiction to drugs and alcohol is considered a mental illness and is known as 'substance use disorder'. Thirty-five percent of respondents reported injecting illicit drugs at least once a day in the month prior to entering the AMC.

Challenges of mental health treatment in the AMC

1.9 In 2019 the ACT Inspector of Correctional Services released *The healthy prison review* report, which focused on the treatment and care of detainees in the AMC.

1.10 The review found that 72 percent of surveyed AMC detainees reported that it was difficult to obtain psychological services when needed.

1.11 Correctional staff were also surveyed as part of the review and *The healthy prison review* report noted that:

- 71 percent did not feel adequately trained in the management of detainees with mental health issues; and
- 70 percent did not feel adequately trained in the management of detainees with drug issues.

Mental health treatment of Aboriginal and Torres Strait Islander detainees

1.12 Aboriginal and Torres Strait Islander detainees are significantly over-represented in prisons across Australia.

1.13 According to the Productivity Commission's *2021 Report on Government Services*, in 2019-20 the ACT recorded an average daily number of 107 Aboriginal and Torres Strait Islander detainees, representing 24 percent of the AMC's population. The 2016 national Census noted that Aboriginal and Torres Strait Islander people represented 1.6 percent of the ACT's population.

1.14 As a result of this over-representation, arrangements for the provision of culturally appropriate services to Aboriginal and Torres Strait Islander detainees were specifically considered as part of this audit.

Mental health impacts on recidivism

1.15 As part of the 2017 Parliamentary Agreement for the 9th Legislative Assembly between the Leader of the ACT Labor Party and members of the ACT Greens, the ACT Government committed to a target of reducing recidivism (reoffending rates) by 25 percent by 2025.[1]

1.16 A 2019 study conducted by Rutgers University found that poor physical or mental health increases the chance that formerly imprisoned individuals will commit additional crimes and return to prison. These detainees often face additional challenges on their release that contribute to their recidivism. For example, in addition to finding housing and employment, they may also need to find mental health treatment that enables them to maintain a stable lifestyle. A 2020 study of New South Wales prisoners found that there was a threefold increase in the reoffence rates for people with mental illness leaving prison who disengaged from mental health treatment compared to those who continued accessing services.

1.17 The Justice and Community Safety Directorate (JACS) *2018-19 Annual Report* notes that recidivism in the ACT is measured as:

> ACT sentenced detainees released two years earlier than the year being measured who returned to prison with a new correctional sanction within two years.

1.18 The JACS *2018-19 Annual Report* identified that the return to custody rate for detainees in the ACT had decreased by 2 percent from 44 percent in 2017-18 to 42 percent in 2018-19, while the national average has remained steady at around 45 percent). However, the rate of detainees returning to corrective services supervision increased from 70 percent in 2017-18 to 71 percent in 2018-19 (this return rate is the highest in the country, with a national average of around 54 percent). (Recidivism figures for 2019-20 have not been used for comparison due to the impact of the COVID-19 pandemic on incarceration rates).

1.19 Fifty-four percent of respondents to the 2016 *ACT Detainee Health and Wellbeing Survey* reported that they suffered from a mental illness. An improvement in the treatment and management of mental health issues within the AMC would likely result in a reduction in recidivism rates in the ACT.

Provision of health care in the AMC

1.20 State and territory governments are responsible for the provision of health services to detainees. This contrasts with people in the general community for whom both the federal and state and territory governments are the key funders of health care.

[1] Recidivism is a measurement of the rate at which offenders commit new crimes after release from custody or supervision by ACTCS.

1.21 Section 21 of the *Corrections Management Act 2007* states:

> (1) The director-general responsible for the administration of the *Public Health Act 1997* must appoint a doctor for each correctional centre.
>
> (2) The doctor's functions are—
>
> (a) to provide health services to detainees; and
>
> (b) to protect the health of detainees (including preventing the spread of disease at correctional centres).
>
> (3) A doctor appointed for a correctional centre must be available to provide health services at the centre at least once each week.

1.22 The *Corrections Management Act 2007* also requires:

- each detainee admitted to a correctional centre should be assessed as soon as practicable to identify any immediate physical or mental health, or safety or security, risks and needs; and any risks and needs identified by the assessment are to be addressed;
- the assessment of a detainee's physical and mental health needs and risks must be made within 24 hours of the detainee's admission. The health assessment must involve an:
  - initial assessment by a nurse and a review of the nurse's assessment by a doctor appointed under section 21; or
  - assessment by a doctor appointed under section 21; and
- the health assessment must include an assessment of the detainee's risk of self-harm.

1.23 Section 53 of the *Corrections Management Act 2007* states:

> (1) The director-general must ensure that—
>
> (a) detainees have a standard of health care equivalent to that available to other people in the ACT; and
>
> (b) arrangements are made to ensure the provision of appropriate health services for detainees; and
>
> (c) conditions in detention promote the health and wellbeing of detainees; and
>
> (d) as far as practicable, detainees are not exposed to risks of infection.
>
> (2) In particular, the director-general must ensure that detainees have access to—
>
> (a) regular health checks; and
>
> (b) timely treatment where necessary, particularly in urgent circumstances; and
>
> (c) hospital care where necessary; and
>
> (d) as far as practicable—
>
> (i) specialist health services from health practitioners; and
>
> (ii) necessary health care programs, including rehabilitation programs.

Provision of equivalent mental health treatment

1.24 The concept of 'equivalency' is fundamental to the provision of health care services in the AMC and the difference between *equal* and *equivalent* is a key concept for this audit.

1.25 When two things can be measured as identical in all aspects, those two things are considered *equal*. When two things are the same in a particular aspect but not identical, they are considered *equivalent*.

1.26 In practical terms this means that, while in custody, detainees should have access to the range of general mental health services available to the wider ACT Community (*equivalent*) but may not have access to specific treatments or providers that are available to individuals in the ACT Community (*equal*). This recognises the practical limitations around providing treatment options in a secure facility such as a prison.

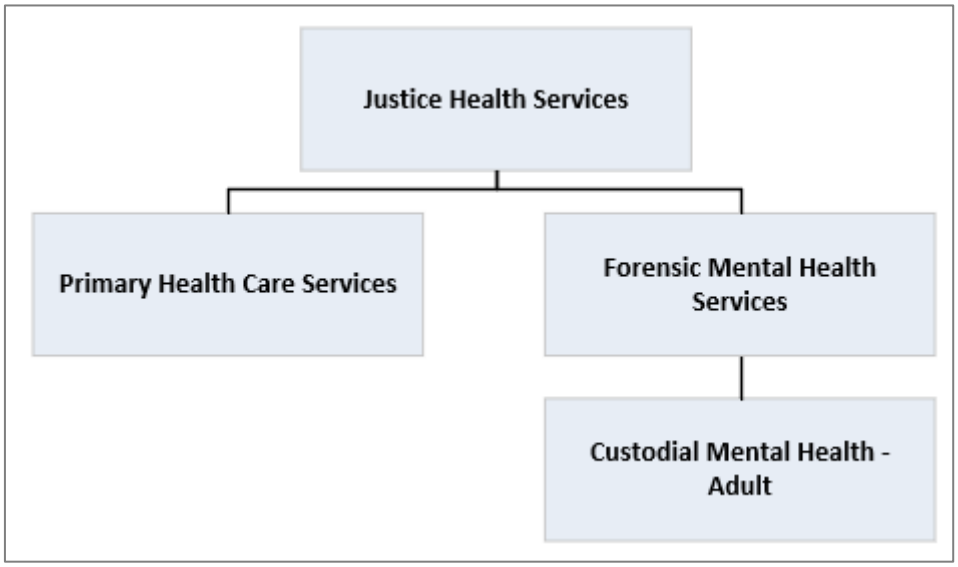
Responsibility for the delivery of mental health services to detainees in the AMC

1.27 A shared governance and care arrangement exists between ACTCS (a branch of JACS) and CHS for the delivery of mental health services in the AMC. ACTCS has over-arching responsibility for the provision of safe and secure facilities and associated infrastructure for custodial and health services, while CHS has primary responsibility for providing health services for detainees.

Justice Health (Canberra Health Services)

1.28 Justice Health, a division of CHS, has overarching responsibility for the delivery of both mental and primary health care services in the AMC. Figure 1-1 shows the organisational structure for Justice Health's delivery of mental health services in the AMC.

Figure 1-1 Justice Health services in the AMC



Source: ACT Audit Office, based on information from Justice Health

Forensic Mental Health Services

1.29 Forensic Mental Health Services (FMHS), a business unit in Justice Health, oversees the delivery of the vast majority of forensic mental health services in the AMC. According to its model of care it is committed to increasing service accessibility to a quality and standard available to other members of the community and to meeting the needs of people experiencing mental illness or disorder and others in a timely manner. This is in keeping with Standard 10.2 of the *National Standards for Mental Health Services 2010* and section 53 of the *Corrections Management Act 2007.*

1.30 The service works in close collaboration with Primary Health Care Services, which supports the physical health needs of detainees with severe mental illness and provides initial care for people with less severe mental health needs.

Custodial Mental Health – Adult

1.31 Custodial Mental Health – Adult (Custodial Mental Health) is a specialist multidisciplinary mental health service that aims for the early identification of mental illness in detainees and the provision of evidence-based treatment and care or referral to appropriate services to improve the mental health and wellbeing of people while in custody. The service aims to reduce the impact of mental ill-health on detainees with a view to supporting their transition back to the community and building their capacity for independent management of their health and social issues.

1.32 Custodial Mental Health also provides specialist mental health advice as requested from Primary Health Care Services, ACTCS and other agencies for detainees not requiring referral for direct psychiatric care and clinical management from a specialist mental health service.

1.33 Following initial referral and screening, Custodial Mental Health offers a range of clinical interventions that are based on the individual needs of the detainee and availability of staffing and other resources. These include (but are not limited to):

- collaborative psychiatric treatment and care, for people requiring specialised mental health treatment, including diversionary processes to inpatient care if required;
- coordination and facilitation of pharmacological treatments, as well as continued monitoring of their efficacy and other effects;
- the provision of various allied health interventions as required. These include evidence based psychological strategies, psychoeducation, skills training and supportive interventions where indicated as part of a holistic biopsychosocial assessment and intervention plan;
- the development and delivery of mental health psychoeducation and intervention programs that support the mental health of detainees;
- consultation and liaison with the Primary Health Service regarding the treatment of less severe mental illness/disorder not requiring specialised treatment;
- health-focused reviews in response to AMC custodial processes, such as segregation;
- preparation for transition to the community in support of continuity of care. This includes the effective liaison with Custodial Officers and other services to identify and support the transition of people into the community and facilitate continuity of care through access to a range of mental health services as required upon release from custody; and
- education and training to key stakeholders regarding the mental health needs of people who are detained in or leaving custodial settings.

1.34 Custodial Mental Health only provides services to detainees who require mental health assessment and/or specialised treatment for a mental illness or disorder. This includes people identified as being at increased risk of suicide. It does not provide services to detainees with less severe mental health conditions.

1.35 The service prioritises care for those experiencing:

- Serious mental illness or disorder

With

- Significant psychosocial functional impairment

And/or

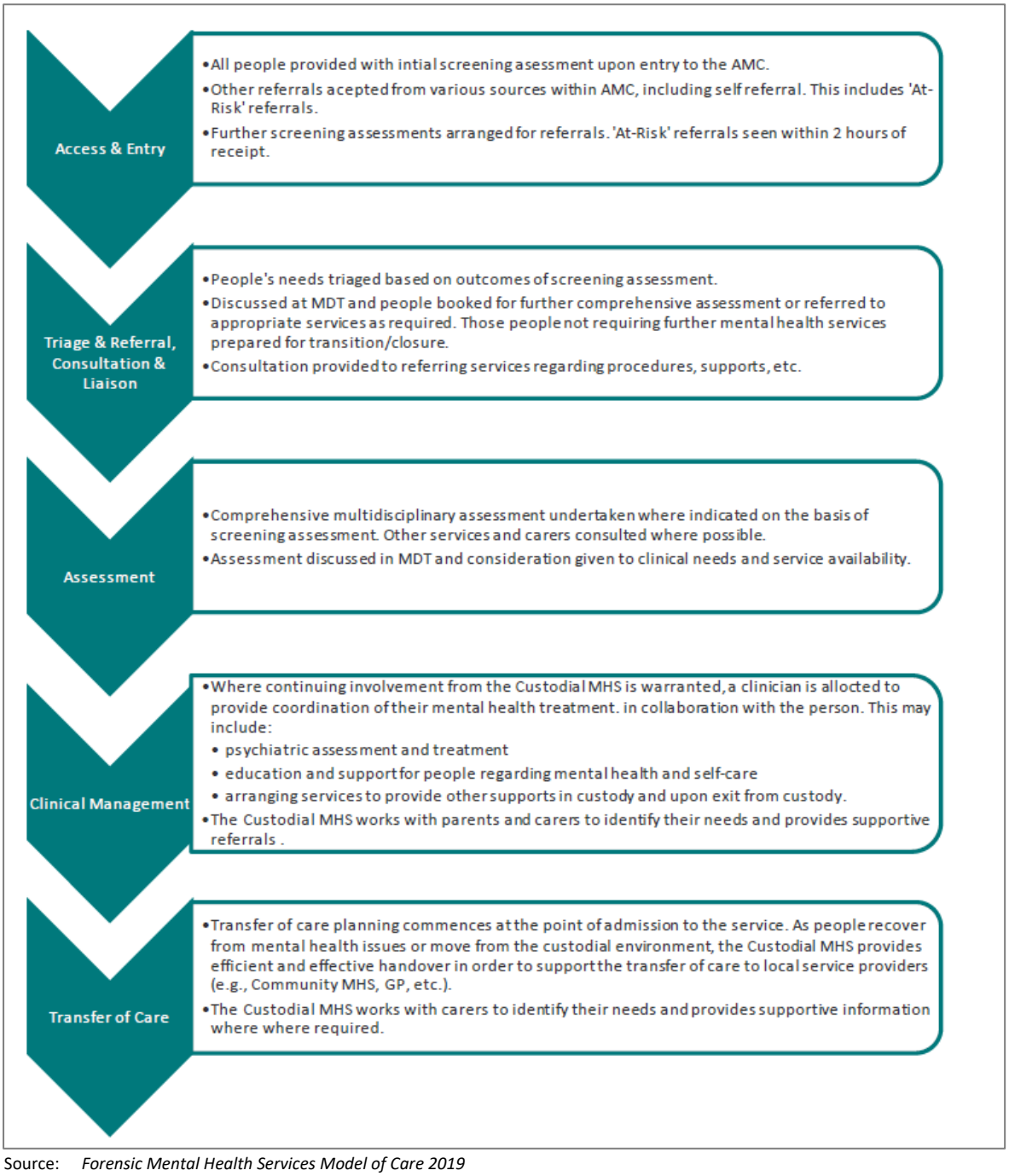
- High risk of harm to self or others, or of misadventure

And have

- Complex needs and intervention requirements that cannot be feasibly provided by a General Practitioner (GP).

1.36 The pathway a detainee's care takes through the mental health system in the AMC is shown at Figure 1-2.

Figure 1-2 Detainee pathway through Custodial Mental Health – Adult



Source: *Forensic Mental Health Services Model of Care 2019*

Primary Health Care Services

1.37 Primary Health Care Services provides general health care and support to detainees in the AMC. In doing so it supports the physical health needs of detainees with severe mental illness and provides initial care for people with less severe mental health needs (those detainees who do not fit the criteria to receive services from the Custodial Mental Health team).

1.38 Primary Health Care GPs play a role in the referral and management of detainees with mental health conditions. Primary Health Care Services does not employ psychiatrists or psychologists.

ACT Corrective Services (Justice and Community Safety Directorate)

1.39 ACTCS has established a Specialist Interventions Team to provide some mental health services and supports. The goal of this team is to provide individual support at a range of levels from short term (six session) strategy-based interventions for high prevalence disorders, through to longer-term approaches to addressing complex needs (including behaviour management, high risk, etc). As at May 2021 the team is staffed by one psychologist (the team leader) and model of service documents are in the process of being drafted. There is funding for an additional counsellor and psychologist, but recent recruitment attempts have been unsuccessful.

Winnunga Nimmityjah Aboriginal Health and Community Services

1.40 Through the establishment of a 2018 Memorandum of Understanding (MoU) between Winnunga Nimmityjah Aboriginal Health and Community Services Ltd (Winnunga) and CHS, Winnunga is responsible for the provision of some mental health and primary health services to approximately 20 to 25 Aboriginal and Torres Strait Islander detainees. However, Aboriginal and Torres Strait Islander detainees with high needs, i.e., those who are assigned either a psychiatric or suicide or self-harm rating, remain under the care of CHS.

ACT Health Directorate

1.41 The ACT Health Directorate is responsible for determining policy settings and the oversight of all funding arrangements for health services delivered by, or on behalf of, the Territory. Through this role it is responsible for setting strategic policy directions and plans for health services at the AMC, in conjunction with CHS.

Previous mental health service reviews

1.42 A number of reviews have been conducted into the delivery of mental health services in the AMC since 2016. Two of these provided recommendations that directly relate to this audit:

- *So much sadness in our lives' - Independent inquiry into the treatment in custody of detainee Steven Freeman* – Phillip Moss (November 2016) (the Moss Review); and
- *Review of mental health arrangements at the AMC* (June 2017) – David McGrath Consulting (the McGrath Report).

So much sadness in our lives' Independent inquiry into the treatment in custody of Steven Freeman – Phillip Moss (November 2016)

1.43 An inquiry completed by Mr Philip Moss AM in November 2016 made findings in relation to the provision of health and custodial services at the AMC. The report made nine recommendations, some of which were directed towards improving the safety, health and care of detainees.

1.44 The Terms of Reference (ToR) for the inquiry included the:

- adequacy of the management, care and custody of detainee Steven Freeman at the AMC and the compliance of this care and custody with human rights obligations;
- overall effectiveness of the application of relevant policies and procedures in the care and custody of Mr Freeman;
- adequacy of induction and risk assessment policies and procedures at the AMC and how these were applied to Mr Freeman;
- adequacy of policies and procedures relating to separation of vulnerable detainees at the AMC and how these were applied to Mr Freeman;
- extent of the consideration given to Aboriginal culture, traditions and beliefs in the management, care and custody of Mr Freeman;
- effectiveness of information sharing arrangements between ACT Policing and ACTCS around new and remand detainees at AMC; and
- accessibility and appropriateness of health and other support services within the AMC for Mr Freeman.

1.45 Table 1-1 details the mental health-related recommendations arising from this report and the action taken to address them. These actions have been undertaken as indicated.

Table 1-1 Health-related recommendations and responses from the Moss Review

No.	Recommendation	Action taken
4	That the arrangements for the provision of health care at the AMC be established, under contract or MoU, to reflect the respective responsibilities of AMC and Justice Health.	In 2017, a Memorandum of Understanding was established between ACT Health and JACS that established the way in which health services are provided to detainees.
5	That Winnunga Nimmityjah Aboriginal Health Service be integrated into the provision of health care at the AMC, in order to introduce its holistic model of care to Indigenous detainees.	In December 2018 Winnunga Aboriginal Health and Community Services (Winnunga), Canberra Health Services and ACT Corrective Services signed a Memorandum of Understanding and three schedules for the delivery of coordinated health care services to Aboriginal and Torres Strait Islander detainees at the centre. The first patient was transferred from Justice Health Services to Winnunga on 18 January 2019, and more than 20 detainees have since transferred to Winnunga for their health care services.

Source: ACT Audit Office, based on documentation from JACS and CHS

Review of mental health service arrangements at the AMC

1.46 In June 2017 the *Review of mental health service arrangements at the AMC* report was prepared by David McGrath Consulting (the McGrath Report). The review was commissioned by JACS and ACT Health and focused on the delivery of mental health services at the AMC.

1.47 The McGrath Report was developed within:

> … the context of several specifically targeted independent reviews over the last eight years commissioned by individual agencies, and concerns about the effectiveness of the policy structures and working relationship between the two agencies. Earlier reviews identified duplication of service delivery, lack of integration of operational mechanisms, dysfunctional interagency and interpersonal relationships and potential for poor detainee mental health outcomes.

1.48 The report included 11 recommendations to improve the delivery of mental health services around issues such as:

- cross agency governance;
- policies and procedures;
- suicide and self-harm assessment processes;
- information sharing; and
- staff supports.

1.49 These recommendations are shown in Table 1-2, along with the agencies' initial responses to the recommendations.

Table 1-2 Recommendations from the McGrath Report

No.	Recommendation	Agency response
1	That a senior level, Deputy Director-General level or higher, time limited, interagency governance mechanism be established to oversee the development of fundamental governance documentation for mental health service provision at the AMC. This group should be chaired by an independent body such as the ACT Health Services Commissioner, Human Rights Commissioner or similar oversight body and should begin work immediately on an interagency MoU, that documents the agreed roles and responsibilities of the two agencies, consistent with the relevant legislation.	Agreed
2	The Director-General of JACS and Director-General of Health must urgently ensure the development, endorsement, promulgation and promotion of a Memorandum of Understanding that identifies: • the roles and responsibilities of each agency. • the agreed model of care for mental health service delivery and suicide risk assessment and management. • a process for development and endorsement of joint policy and procedure documentation with policy force over both sets of staff. • identifies a process for agreement on service standards and endorsement of those standards. • Agreement on measurement processes for meeting of performance standards and associated monitoring practices. • shared strategic and operational planning that drives opportunities for joint business cases. • a process for collaborative input to capital asset management and future site growth to meet the needs of mental health service provision. • a process for establishing collaborative budget submission processes for managing future site growth and the accompanying needs of mental health service provision. • an escalation and dispute resolution mechanism.	Agreed
3	Each agency should develop policy and procedures, operational protocols, assessment guidelines, and job descriptions consistent with the agreed model of care and these documents should be formally lodged with each agency and made available in the working environments of both ACTCS and FMHS.	Agreed
4	That the current practice improvement project underway with the HRAT, and associated independent oversight, be continued until practice and culture change is embedded.	Agreed
5	The CPSS cease undertaking suicide and self-harm assessments at initial induction and that ACT Health commit to provide the outcomes of their initial assessment, required under s 68 of the CMA, to the HRAT for the purpose of contributing to the determination of appropriate risk ratings.	Agreed in principle
6	That a documented protocol for clinical emergency management for mental health conditions be negotiated and agreed between the two agencies.	Agreed
7	That the suicide and self-harm (SASH) assessment accountability return to the FMHS on the proviso that appropriate performance metrics can be agreed between agencies, and that ACT Health can guarantee that clinical resources are available to address any change in the clinical mix of detainees in the CSU.	Agreed in principle

No.	Recommendation	Agency response
8	That integration of service provision with Winnunga Aboriginal Health Service be implemented and a schedule be negotiated to the Health and JACS MoU that recognises this.	Agreed
9	That an information sharing protocol or MoU should be developed between the two agencies to provide the formal framework for culture and practice change.	Agreed
10	ACT Health assess appropriateness of current supports for staff at AMC and develop a retention strategy for staff providing mental health services at AMC.	Agreed
11	ACTCS work in partnership with either a mental health service provider or NSW Police to provide access to appropriate mental health training for custodial staff.	Agreed in principle

Source: ACT Audit Office, based on documentation from JACS and ACT Health

1.50 In August 2017 a working group was established to progress specific action items from the McGrath Report. The working group progressed the implementation of the agreed recommendations until January 2019, when the project to implement the McGrath Report findings was closed. A status report provided to the Minister at that time noted that the implementation status for each recommendation was complete.

1.51 While the status of the implementation of these recommendations as of January 2019 was not audited by the Audit Office, it is worth noting that by January 2019 the Memoranda of Understanding referred to at Recommendations 1, 2 and 9 above had expired and had not been extended or replaced by similar documents.

1.52 The implementation of the recommendations is discussed throughout this report.

Audit objective and scope

Audit objective

1.53 The objective of the audit was to assess the effectiveness of the delivery of mental health services within the AMC.

Audit scope

1.54 The audit considered the services provided, managed or co-ordinated by Justice Health (Canberra Health Services) and ACTCS (Justice and Community Safety Directorate) to detainees in custody in the AMC.

1.55 The audit also considered the effectiveness of:

- the mental health assessment process for detainees:
  - on admission to the AMC; and
  - who are referred for treatment once admitted to the AMC;

- processes to develop and review mental health treatment plans that address identified detainee mental health needs;
- the delivery of mental health services and programs to detainees within the AMC; and
- the transfer and management arrangements in place for detainees on release into the community.

1.56 The audit considered the effectiveness of the management of detainees with identified mental health needs and how the effectiveness of delivered services and programs is measured and reported.

Audit criteria, approach and method

Audit criteria

1.57 To form a conclusion against the objective, the following criteria were used:

- Have effective governance and administrative arrangements been established to deliver mental health services to detainees within the AMC?
- Have effective mental health screening processes been established within the AMC?
- Are detainee mental health treatment plans effectively developed and delivered?
- Have effective systems been developed and applied to monitor and report on the performance of mental health programs delivered within the AMC?
- Are there effective transfer and management arrangements in place, for those detainees with mental health treatment plans, transitioning from custody into the community?

1.58 The audit was performed in accordance with *ASAE 3500 – Performance Engagements.* The audit adopted the policy and practice statements outlined in the Audit Office's *Performance Audit Methods and Practices* (PAMPr) which is designed to comply with the requirements of the *Auditor-General Act 1996* and *ASAE 3500 – Performance Engagements*

1.59 In the conduct of this performance audit the ACT Audit Office complied with the independence and other relevant ethical requirements related to assurance engagements.

Audit approach and method

1.60 The Audit Office engaged JRPO Associates Pty Ltd (JRPO), to provide subject matter expertise. The consultants who provided subject matter expertise to this audit included Distinguished Professor James R. P. Ogloff AM (clinical/forensic psychologist and lawyer), Associate Professor Edward Heffernan (consultant forensic psychiatrist), and Dr Elissa Waterson (psychologist), all of whom have expertise in forensic and correctional mental health.

1.61 JRPO were engaged to examine elements of each of the audit criteria but were primarily tasked with the examination of the delivery of mental health treatment. This included, but was not limited to:

- a review of mental health screening processes;
- interviews with detainees to understand their treatment experience;
- a review of the development and appropriateness of mental health treatment plans;
- assessment of clinical capabilities and required resources; and
- a review of detainee release plans.

1.62 The audit method and approach consisted of:

- reviewing relevant literature, and work undertaken on this subject by other jurisdictions and ACT to identify better practices;
- identifying and reviewing the relevant documentation associated with ACT Government strategies and activities to deliver mental health services to adult detainees;
- identifying and reviewing relevant information and documentation including related policy and procedures, research documents, and relevant reports;
- identifying and documenting internal procedures used to give effect to the policies and guidelines and to ensure compliance and evaluating the effectiveness of these controls;
- interviews and discussions with key staff from Justice Health, Corrections ACT, Winnunga Nimmityjah Aboriginal Health and Community Services and other stakeholders; and
- interviews and discussions with a selection of detainees.

Assumed consent

1.63 Under the *Mental Health Act 2015*, unless subject to a psychiatric treatment order, a person with a mental disorder or mental illness has the right to consent to, refuse or stop treatment, care or support.

1.64 This report, including conclusions, key findings and recommendations, has been written with the assumption that detainees have provided consent for treatment from either an ACT Government agency or external provider.

1.65 Recommendations stemming from this report should only be implemented where a detainee has provided consent for treatment from the relevant service provider.

2 PLANNING FOR THE DELIVERY OF MENTAL HEALTH SERVICES

2.1 This chapter discusses the planning and support arrangements in place for the delivery of mental health services in the AMC.

2.2 Planning for the delivery of mental health services in the AMC is complex. Health services are provided by different service providers and the cohort of patients is ever shifting. The audit considered whether agencies had:

- developed a strategic plan that sets goals and priorities for the delivery of mental health services;
- identified cohorts and their service needs; and
- undertaken workforce planning to ensure the right people are available to deliver these identified services.

Summary

Conclusion

Planning for the delivery of mental health services is ineffective. There is no Clinical Services Plan that guides the planning for, or delivery of, mental health services to detainees.

Poor data collection practices have hampered the ability of agencies to determine the:

- number of detainees with mental health conditions;
- nature of those conditions; and
- likely treatment requirements.

Under section 53 of the *Corrections Management Act 2007*, the Director-General of the Justice and Community Safety Directorate is required to provide a standard of health care to detainees that is equivalent to that provided in the community. Due to the ambiguous target, coupled with poor data collection practices and a lack of performance information collected by the agency, the Audit Office was unable to establish whether this standard had been met. Nevertheless, it is incumbent on the Director-General of the Justice and Community Safety Directorate to assure the community that it has.

Limited training is provided to Custodial Officers tasked with the day-to-day management of detainees with mental health conditions. This has resulted in a lack of Custodial Officer confidence in their ability to provide effective supervision and support to these detainees.

Key findings

	Paragraph
No strategic planning has been undertaken for the delivery of mental health services at the AMC. Neither CHS nor ACTCS has set objectives, priorities, or goals for the delivery of mental health services in the AMC. No Clinical Services Plan exists that guides the planning for, or delivery of, mental health services to detainees. In the absence of a Clinical Services Plan, and associated objectives, priorities or goals, the responsible agencies are unable to assess their service delivery performance.	2.10
The collection and use of data for the purpose of planning for service delivery is constrained by the MAJICeR system (the electronic records management system used by Justice Health for the management of clinical records for detainees). The system does not readily code for, or allow the extraction of, key data relating to cross-sectional 'service episodes' or 'episodes of care' undertaken by Custodial Mental Health. While data on occasions of service are collected and reported, which shows activity rather than the number of patients receiving treatment, this is not useful for planning purposes because one patient may have many occasions of service or very few. The information demonstrates activity, but it cannot be used as an estimate of met or unmet need for planning purposes.	2.24
There is a significant shortfall in staffing in Custodial Mental Health, which provides direct treatment to those detainees who are experiencing a severe mental illness or disorder. While funded for a total of 16 FTE staff, ranging from Registered Nurses to Forensic Psychologists, the team only has 11.2 current FTEs. The most significant shortfall in staff occurs in the number of psychologists; only two of the four budgeted positions have been filled as of April 2021. The two psychology positions that have been filled are the most junior roles.	2.28
Without a full complement of staff, the 'Stepped Care Approach' identified by CHS in its *Forensic Mental Health Model of Care* cannot be effectively implemented. The 'Stepped Care Approach' is premised on all detainees being provided with entry level mental health care (Step One) that is followed, where required, by stepped-up care as necessary. The gap in service provision may not allow ACTCS to provide health care services equivalent to community standards, as required under section 53 of the *Corrections Management Act 2007*, where a broad range of psychological services are available.	2.32
ACTCS has established a Specialist Interventions Team, the purpose of which is to provide individual support at a range of levels from short term (six session) strategy-based interventions for high prevalence disorders, through to longer-term approaches to addressing complex needs (including behaviour management, high risk, etc). This service could be expected to address the gap for those with mild to moderate mental health care needs. At the time of audit fieldwork in May 2021, the team was staffed by one psychologist (the team leader) who treated an average of four AMC patients per week. There is funding for an additional FTE counsellor and FTE psychologist, but these positions have remained vacant for 12 months and recruitment attempts to date have been unsuccessful. Even when fully staffed, JRPO considered it unlikely that this team would be able to meet the needs of a prison that	2.37

holds an average of nearly 450 detainees (which includes a large proportion of detainees on remand and the relatively higher demand female population).

Section 53 of the *Corrections Management Act 2007* requires the Director-General of JACS to ensure 'detainees have a standard of health care equivalent to that available to other people in the ACT'. There is currently a substantial shortage of psychologists, in both CHS and ACTCS, who can provide treatment to detainees, and neither agency has recruited to its available establishment. This suggests there is a significant service gap in the provision of psychological services for detainees and the ability of the Director-General of JACS to deliver a 'standard of health care equivalent to that available to other people in the ACT' may be compromised. 2.50

Custodial Officers are responsible for the day-to-day management of detainees and have a role in facilitating mental health services to detainees through: identification of escalating mental health issues; referral of detainees to mental health supports; and behavioural management and support for detainees. Training around the management of detainees with mental health conditions is provided to Custodial Officers on commencement with ACTCS, but no refresher training (outside of suicide and self-harm risk) or guidance material is provided after commencement. In 2019 *The healthy prison review* report from the ACT Inspector of Correctional Services identified that 71 percent of Custodial Officers did not feel adequately trained in the management of detainees with mental health issues. The lack of ongoing training and support for Custodial Officers compromises the effective delivery of mental health services and supports to detainees in the AMC. 2.58

Strategic planning for the delivery of mental health services

2.3 Strategic planning facilitates the identification of future objectives, priorities and goals and the identification of activities and initiatives to achieve these. Ultimately, strategic planning should improve organisational performance and accountability to deliver more appropriate, efficient, and effective services. Strategic planning is important in the delivery of mental health services as resources are limited and the effects of providing inadequate care can be significant.

2.4 In order to provide effective mental health services to detainees it is important that the responsible agencies have a clear understanding of:

- their goals in delivering mental health treatment;
- the demographics of detainees entering the AMC;
- emerging trends in mental health conditions of detainees; and
- opportunities for service delivery improvements that would increase efficiency and effectiveness.

Strategic planning – Clinical Services Plan

2.5 Neither CHS nor ACTCS has set objectives, priorities, or goals for the delivery of mental health services in the AMC.

2.6 This type of strategic planning would be most effectively articulated via a Clinical Services Plan that identified the priorities and strategic directions for clinical mental health services at the AMC. The plan should:

- summarise the strategic context in which Justice Health operates;
- identify the needs of the AMC population;
- detail service demands;
- outline current services and future service needs; and
- document future directions and actions to meet these objectives (including service developments, important strategies and resource investment).

2.7 While responsibility for the development of this plan would lie primarily with CHS, input would be required from the ACT Health Directorate as the agency responsible for determining policy settings for health services delivered by, or on behalf of, the Territory. The delivery of mental and primary health care services also involves other agencies and service providers, including ACTS and Winnunga, and there is an opportunity to involve these agencies in the planning process.

Governance oversight of strategic planning

2.8 No governance or oversight group has been specifically tasked with overseeing strategic planning for the delivery of mental health services in the AMC. Issues such as goal setting, resource planning, risk management and performance monitoring did not feature in agendas or meeting minutes for various governance and oversight groups that have been established to oversee the delivery of health services (including mental health services) in the AMC including the Health Advisory Group or the Winnunga Implementation, Operational and Governance Group. These groups are discussed from paragraph 3.47.

2.9 A CHS Corporate Governance Committee was established in April 2019 to provide a forum for strategic planning for the Mental Health, Justice Health and Alcohol and Drug Services division (MHJHADS) in the CHS. The functions of the Committee are to:

- develop, monitor and enable the Division's Business Plan;
- develop and enable its workforce;
- develop, monitor and enable access to its services;
- monitor Health Infrastructure (HIP) activities across the Division; and
- monitor health infrastructure and other projects across the Division.

2.10 No strategic planning has been undertaken for the delivery of mental health services at the AMC. Neither CHS nor ACTCS has set objectives, priorities, or goals for the delivery of mental health services in the AMC. No Clinical Services Plan exists that guides the planning for, or delivery of, mental health services to detainees. In the absence of a Clinical Services Plan, and associated objectives, priorities or goals, the responsible agencies are unable to assess their service delivery performance.

RECOMMENDATION 1 STRATEGIC PLANNING

Canberra Health Services should, in conjunction with the ACT Health Directorate, develop a Clinical Services Plan for the delivery of mental health services in the Alexander Maconochie Centre. This plan, developed in partnership with Winnunga Nimmityjah Aboriginal Health and Community Services, and other relevant stakeholders, should include explicit embedding of culturally responsive services for Aboriginal and Torres Strait Islander peoples.

Identifying service needs for mental health services

2.11 Robust data collection processes should assist in planning for the delivery of mental health services. The data should be used to determine service needs and the resources required to deliver against the needs. The service needs of particular cohorts of detainees could be identified through these data collection processes.

2.12 In order to understand the number of staff and the appropriate skills required to deliver treatment, Justice Health needs to collect sufficient data to understand the:

- number of detainees with mental health conditions;
- nature of those conditions; and
- likely treatment requirements.

Identification of cohorts

2.13 CHS and ACTCS have access to data relating to the key demographics of detainees, including data such as Indigenous status and gender. CHS also has data relating to the number of detainees subject to either a psychiatric or suicide or self-harm rating at any given point in time.

2.14 This data is not routinely used for resource planning by either CHS or ACTCS, nor is it used to form assessments around service needs and required resources; for example, how many Aboriginal Liaison Officers (ALO) are required to meet the needs of Aboriginal and Torres Strait Islander detainees.

Episodes of service

2.15 For the purpose of the audit, data on annual and current (cross-sectional) 'service episodes' or 'episodes of care' undertaken by Custodial Mental Health was sought. Cross-sectional refers to data at a given point in time, rather than an observation over an extended period. This information was sought in order to:

- provide details of the number of clients seen across a period of time and proportionally against the AMC population; and
- assess Custodial Mental Health service provision against prevalence estimates for mental illness in custodial environments.

2.16 MAJICeR is the electronic records management system used by Justice Health for the management of clinical records for detainees. It does not readily code for, or allow the extraction of, these key data. During the audit, it was apparent that it was difficult for CHS to extract this data from the system.

2.17 While data on occasions of service are collected and reported, this shows activity rather than the number of patients receiving treatment. This is not useful for planning purposes because one patient may have many occasions of service or very few. The information is useful to demonstrate activity, but it cannot be used as an estimate of met or unmet need, and it is therefore important to regularly capture the number of patients who are provided a service in addition to total episodes of care.

2.18 Data on occasions of service from December 2019 to November 2020 showed that there was a total of 842 episodes of service for the FMHS. Of these, 709 were attributed to the AMC Assertive Response Team (ART) (Induction and At Risk) while 133 were attributed to the AMC Mental Health Service (representing episodes of standard mental health care outside of At-Risk processes). While AMC daily population numbers were readily available, the total number of admissions for that period was not, and it was not possible to calculate the proportion of detainees receiving mental health services. Similarly, cross sectional service episode data could not be provided.

2.19 Routine general health and mental health data is also not routinely collected. This includes variables pertaining to diagnosis, treatment, Mental Health Act status, and the existence of a substituted decision maker.

MAJICeR system replacement

2.20 A contemporary management information system should enable the extraction of data relevant to service delivery and information such as key demographic data, number and timeliness of episodes of care, and relevant clinical and legislative information. This data should be used for service planning and evaluation and can also be used for:

- national benchmarking exercises; and
- measuring and assessing performance.

2.21 The collection and use of data for the purpose of planning for service delivery is constrained by the MAJICeR system. This system is due to be replaced in 2022 with the new ACT wide Digital Health Record system. This project is being led by the ACT Health Directorate.

2.22 In light of this system change, it is important that Justice Health identifies what data it needs ready access to (to enable effective resource planning, patient management and treatment delivery) and communicate this information during consultation around the new system.

2.23 In its response to the draft proposed report CHS advised that:

> … JHS have and will continue to meet with the developers of the Digital Health Record to ensure data collection requirements are met.

2.24 The collection and use of data for the purpose of planning for service delivery is constrained by the MAJICeR system (the electronic records management system used by Justice Health for the management of clinical records for detainees). The system does not readily code for, or allow the extraction of, key data relating to cross-sectional 'service episodes' or 'episodes of care' undertaken by Custodial Mental Health. While data on occasions of service are collected and reported, which shows activity rather than the number of patients receiving treatment, this is not useful for planning purposes because one patient may have many occasions of service or very few. The information demonstrates activity, but it cannot be used as an estimate of met or unmet need for planning purposes.

RECOMMENDATION 2	**RECORD KEEPING SYSTEM**

Canberra Health Services should ensure its record keeping system provides the functionality to extract key information, such as demographic and service need data, that supports effective resource planning.

Workforce planning

Mental health services staffing

2.25 To effectively deliver treatment to detainees with mental health issues, it is critical that an appropriate number of skilled staff are employed. Treatment is provided to detainees by Custodial Mental Health, Primary Health and ACTCS.

2.26 According to staff in ACTCS, Primary Health and Custodial Mental Health there is a lack of staff to provide services to detainees with mild to moderate mental health presentations, i.e. those higher prevalence lower acuity disorders such as anxiety, trauma, distress and depression, for which psychological approaches can be most appropriate. This view was supported by analysis of the roles and staffing profiles of both Custodial Mental Health and the ACTCS Specialist Intervention team.

Staffing for severe mental health presentations

Custodial Mental Health staffing profile

2.27 Custodial Mental Health provides direct treatment to those detainees who are experiencing a severe mental illness or disorder. It does not provide services to those detainees with less severe mental illnesses or disorders that do not require specialised treatment. Table 2-1 compares the planned number of staff in Custodial Mental Health to actual full time equivalent (FTE) staff.

Table 2-1 Custodial Mental Health staffing profile as at April 2021

Position	Budgeted Staffing Level	Current Staffing Level
RN4.1/HP04 Team Manager	1	1
RN3.2 Clinical Nurse Consultant	1	1
Assertive Response Team		
RN 3.1	3	2
RN 2	3	2
Clinical Management		
RN 3.1	1	1.6
RN 2	1	0
SW 3	1	0.8
SW 2	1	0.8
Forensic Psychology Registrar	1	0
Clinical Psychology registrar	1	1
Psychology Intern	1	1
HPO2 Psychologist	1	0
Total	**16**	**11.2**

Source: Forensic Mental Health Services (CHS)

2.28 There is a significant shortfall in staffing in Custodial Mental Health, which provides direct treatment to those detainees who are experiencing a severe mental illness or disorder. While funded for a total of 16 FTE staff, ranging from Registered Nurses to Forensic Psychologists, the team only has 11.2 current FTEs. The most significant shortfall in staff occurs in the number of psychologists; only two of the four budgeted positions have been filled as of April 2021. The two psychology positions that have been filled are the most junior roles.

Stepped care approach for delivery of mental health services

2.29 Justice Health has adopted a 'Stepped Care Approach' for the delivery of mental health services in the AMC. The five-step care approach is outlined in its *Forensic Mental Health Model of Care*. This means that all detainees are provided with entry level mental health

care (Step One) that is followed, where required, by a 'step up' for those with mild to moderate mental illness/disorder accessing primary health care services in combination with more structured psychological services. Higher steps on the care spectrum include specialist mental health service management for more severe and/or complex mental health presentations. These steps are described in Table 2-2.

2.30 The 'Stepped Care Approach' sets out the services that are provided by Custodial Mental Health as opposed to Primary Health. This approach only applies to the treatment of those detainees whose mental health needs are more severe and who fit within the service remit of Custodial Mental Health. Custodial Mental Health does not provide treatment to detainees that have less severe mental illness or disorders that require psychiatric services.

Table 2-2 'Stepped Care Approach' for delivery of mental health services

Focus of the intervention	Nature of the intervention	Role of Custodial MHS – Adult	Role of other services
STEP 1: All known and suspected presentations of mental health concern.	Identification and assessment; psychoeducation and treatment options; active monitoring.	Induction screening Assessment and response based on triage rating. Referral to appropriate supports	Primary Health induction assessment. Primary Health Practitioner treatment formulation first response to suspected mental illness. Winnunga Nimmityjah Aboriginal Health Service (AHS) Health practitioner treatment formulation first response to suspected mental illness.
STEP 2: Diagnosed Mental Illness that has not improved after education and active monitoring in primary care.	Low-intensity psychological interventions: individual non-facilitated self-help, individual guided self-help and psychoeducational groups.	Custodial MHS – Adult Psychiatrist consultation to primary health. Custodial MHS – Adult consultation to custodial agency.	Primary Health Practitioner consultation with Custodial MHS - Adult Psychiatrist. Winnunga Nimmityjah AHS clinician consultation with Custodial Mental Health Service (MHS) – Adult Psychiatrist. ACTCS therapeutic programs and psychological services for suitable participants.
STEP 3: Symptoms with an inadequate response to step 2 interventions or marked functional impairment.	Choice of a high-intensity psychological intervention or a drug treatment.	Custodial MHS – Adult direct psychiatric care and clinical management or other therapies.	Continued Primary Health or Winnunga Nimmityjah AHS for physical health care. Custodial MHS – Adult and ACT Corrective

Focus of the intervention	Nature of the intervention	Role of Custodial MHS – Adult	Role of other services
		Collaborate on joint management planning with custodial agency	Services (ACTCS) joint management plans.
STEP 4: Complex treatment-refractory and very marked functional impairment, such as self-neglect or a high risk of self-harm.	Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, or inpatient care.	Custodial MHS – Adult direct psychiatric care and assertive clinical management. Collaborate on joint management planning with custodial agency.	Continued Primary Health or Winnunga Nimmityjah AHS for physical health care. Custodial MHS – Adult and ACTCS joint management plans.
STEP 5: Complex treatment-refractory and very marked functional impairment, such as self-neglect or a high risk of self-harm, requiring involuntary or inpatient care.	Inpatient care at AMHU or Dhulwa Secure Mental Health Unit depending on presentation and clinical needs.	Ongoing consultation with inpatient setting and ACTCS regarding treatment progress and transfer between settings.	Physical and mental health care needs managed by inpatient unit. ACTCS may provide security support depending on setting.

Source: ACT Audit Office based on the *Forensic Mental Health Services Model of Care 2019*

2.31 JRPO noted that a stepped care model is most successful when the preceding steps of care are also available. It is of note that steps 2, 3 and 4 of the 'Stepped Care Approach' all include references to psychological services. Given the shortfall of psychologists in Custodial Mental Health there is a gap in this service. Primary Health does not employ any psychologists that would address this gap in service provision.

2.32 Without a full complement of staff, the 'Stepped Care Approach' identified by CHS in its *Forensic Mental Health Model of Care* cannot be effectively implemented. The 'Stepped Care Approach' is premised on all detainees being provided with entry level mental health care (Step One) that is followed, where required, by stepped-up care as necessary. The gap in service provision may not allow ACTCS to provide health care services equivalent to community standards, as required under section 53 of the *Corrections Management Act 2007*, where a broad range of psychological services are available.

Staffing for mild to moderate health presentations

ACTCS mental health staffing profile

2.33 ACTCS has established a Specialist Interventions Team. The goal of this team is to provide individual support at a range of levels from short term (six session) strategy-based interventions for high prevalence disorders, through to longer-term approaches to addressing complex needs (including behaviour management, high risk, etc).

2.34 This service could be expected to address the gap for those with mild to moderate mental health care needs. However, at the time of audit fieldwork in May 2021, the team was

staffed by one psychologist (the team leader) who treated an average of four AMC patients per week. Model of service documents (that guide a patient's journey through care) were still being drafted. There is funding for an additional FTE counsellor and FTE psychologist; however, these positions have remained vacant for 12 months and recruitment attempts to date have been unsuccessful due to a low number of suitable applicants.

2.35 Even when fully staffed, JRPO considered it unlikely that this team would be able to meet the needs of a prison that holds an average of nearly 450 detainees (which includes a large proportion of detainees on remand and the relatively higher demand female population). It was not the purpose of the audit to identify the optimum level of psychological expertise in this team, but this could be expected to be influenced by:

- an assessment of service needs and gaps;
- the psychology staffing profile of both agencies; and
- respective roles and responsibilities.

2.36 The shortfall in psychologists and mental health nurses has left a significant gap in care for detainees, particularly those with either high prevalence disorders (such as anxiety, mood or trauma related disorders), substance use disorders or mental health problems in the broader sense who do not meet the referral criteria for Custodial Mental Health.

2.37 ACTCS has established a Specialist Interventions Team, the purpose of which is to provide individual support at a range of levels from short term (six session) strategy-based interventions for high prevalence disorders, through to longer-term approaches to addressing complex needs (including behaviour management, high risk, etc). This service could be expected to address the gap for those with mild to moderate mental health care needs. At the time of audit fieldwork in May 2021, the team was staffed by one psychologist (the team leader) who treated an average of four AMC patients per week. There is funding for an additional FTE counsellor and FTE psychologist, but these positions have remained vacant for 12 months and recruitment attempts to date have been unsuccessful. Even when fully staffed, JRPO considered it unlikely that this team would be able to meet the needs of a prison that holds an average of nearly 450 detainees (which includes a large proportion of detainees on remand and the relatively higher demand female population).

Detainee feedback

2.38 Four out of the six detainees who were interviewed for the purpose of the audit about their mental health care experience identified the need for more psychological services in the AMC. Interviewees were happy with the frequency with which they saw a psychiatrist and generally felt that mental health services were responsive, particularly in response to suicide and self-harm risk. However, JRPO, while interpreting these discussions, also identified that detainees were articulating a need for:

- psychological interventions related to trauma experiences that were focused on emotion regulation skills (such as Dialectical Behaviour Therapy);

- more options outside of medication such as Cognitive Behaviour Therapy; and
- clarity around access and referral processes for psychological services across Custodial Mental Health, ACTCS and external providers.

Recruitment shortages

2.39 CHS representatives advised that it was difficult to recruit psychological staff due to issues around the low renumeration packages offered. Psychologists in private practice can expect higher salaries than those offered within the public service.

2.40 CHS representatives identified that an attempt was made to develop a separate classification and award structure for psychologists within the 2018-2021 *ACT Public Sector Enterprise Agreement*, that would enable more flexibility in renumeration. This attempt was unsuccessful.

2.41 ACTCS representatives identified that position descriptions and required qualifications had been reviewed and amended in an effort to attract a broader range of skillsets, qualifications and experience. Recruitment activities for these positions were expected to occur again from May 2021.

2.42 Neither agency has developed a strategy to attract and retain new clinical staff.

Section 53 of the Corrections Management Act 2007

2.43 Under section 53 of the *Corrections Management Act 2007* the Director-General of JACS must ensure that:

> (a) detainees have a standard of health care equivalent to that available to other people in the ACT; and
>
> (b) arrangements are made to ensure the provision of appropriate health services for detainees; and
>
> (c) conditions in detention promote the health and wellbeing of detainees; and
>
> (d) as far as practicable, detainees are not exposed to risks of infection.

2.44 Recommendation 150 of the 1991 Royal Commission into Aboriginal deaths in Custody stated:

> … the health care available to persons in correctional institutions should be of an equivalent standard to that available to the general public. Services provided to inmates of correctional institutions should include medical, dental, mental health, drug and alcohol services provided either within the correctional institution or made available by ready access to community facilities and services. Health services provided within correctional institutions should be adequately resourced and be staffed by appropriately qualified and competent personnel. Such services should be both accessible and appropriate to Aboriginal prisoners.
>
> Correctional institutions should provide 24 hour a day access to medical practitioners and nursing staff who are either available on the premises, or on call.

2.45 Defining a service provision standard that is equivalent to that available to other people in the ACT is difficult. While data is available that identifies the level of mental health services

provided to the community, this service provision standard is constantly changing. In addition, the mental health care needs of people in custody are significantly higher than those in the general community, suggesting that a simplistic comparison of service provision, such as a comparison of the number of mental health clinicians per 100 000 population, may not be appropriate. JACS does not collate information around access to mental health treatments that could be used to establish whether this standard had been met. This is discussed further at Chapter 3.

2.46 In 2018 the Australian Institute of Health and Welfare (AIHW) released a report on the health of Australia's prisoners which noted that:

> Prison entrants (26%) were twice as likely to score high or very high levels of psychological distress as the general population in 2017–18 (13%).

2.47 This echoed findings from a report released by the AIHW in 2012 that presented the results from the 2010 National Prisoner Health Census and focused on the associations between mental health and a range of characteristics and behaviours reported by prison entrants. The report noted that:

> … 31% of prison entrants reported that they had been told by a doctor, psychiatrist, psychologist or nurse that they had a mental health disorder (including drug and alcohol abuse) in their lifetime. This is about 2.5 times higher than the general population (ABS 2010).

2.48 The 2019 *Healthy Prison Review* report noted that:

> In the detainee survey 72% (*n=166*) reported that it was difficult to get psychological services when needed. Submissions and discussions with detainees indicate the challenge in accessing general psychological services.
>
> … the lack of general psychological support for detainees appears to be a significant gap. .... A prison of commensurate size and detainee profile to the AMC should have in the range of 6-10 psychologists.

2.49 The 2016 *ACT Detainee Health and Wellbeing Survey* reported that the most prevalent mental disorders respondents experienced in the AMC included depression (30 percent), anxiety disorders (22 percent), and substance use disorders (16 percent). There is currently only one psychologist (provided by ACTCS' Specialist Intervention Team) who can provide treatment to detainees with these low acuity disorders. This suggests there is a significant service gap in the provision of psychological services for detainees and the ability of the Director-General of JACS to deliver a 'standard of health care equivalent to that available to other people in the ACT' may be compromised.

2.50 Section 53 of the *Corrections Management Act 2007* requires the Director-General of JACS to ensure 'detainees have a standard of health care equivalent to that available to other people in the ACT'. There is currently a substantial shortage of psychologists, in both CHS and ACTCS, who can provide treatment to detainees, and neither agency has recruited to its available establishment. This suggests there is a significant service gap in the provision of psychological services for detainees and the ability of the Director-General of JACS to deliver a 'standard of health care equivalent to that available to other people in the ACT' may be compromised.

2.51 In its response to the draft proposed report JACS advised that:

> While it is acknowledged that there is a shortage of psychologists in all settings, it is important to note that mental health services are provided by a multidisciplinary team, and not limited to psychologists alone. Social workers, occupational therapists and other allied health professionals work together with psychologists and doctors to provide important mental health supports to detainees at the AMC. Given this, the shortage of psychologists does not necessarily correlate to a "significant gap" in psychological services for detainees.

2.52 The Audit Office notes that, while useful, the provision of these additional services does not negate the need for increased psychological services that would support the agency to meet the requirements of section 53 of the *Corrections Management Act 2007*.

RECOMMENDATION 3 PROVISION OF PSYCHOLOGICAL SERVICES TO DETAINEES

In order to demonstrate that the requirements of section 53 of the *Corrections Management Act 2007,* are met the Justice and Community Safety Directorate should:

a) define what an 'equivalent standard of health care to that available to other people in the ACT' means in practice; and

b) ensure the provision of psychological services to detainees meets this standard.

Custodial Officer support

2.53 While clinical staff hold qualifications that enable them to deliver health treatment, Custodial Officers also play a key role in the delivery of mental health services. Custodial Officers are responsible for the day-to-day management of detainees. In relation to the mental health needs of detainees, this responsibility can include:

- identification of escalating mental health issues;
- referral of detainees to mental health supports;
- behavioural management and support; and
- the maintenance of a safe environment, that promotes health and wellbeing, for all detainees.

Custodial Officer training

2.54 Training around the management of detainees with mental health conditions is provided to Custodial Officers on commencement with ACTCS. Training packages provided to Custodial Officers on their commencement address:

- mental health – provides information on identification and awareness of mental health issues, medications and interventions;
- suicide and self-harm – provides information around warning signs, AMC procedures and self-care for officers; and
- maintaining the health, safety and welfare of offenders.

2.55 No refresher training (outside of suicide and self-harm risk) or guidance material is provided after commencement. ACTCS has not requested that this training be developed or provided by CHS.

2.56 The report that was published in 2019 in relation to *The healthy prison review* from the ACT Inspector of Correctional Services identified that:

- 71 percent of Custodial Officers did not feel adequately trained in the management of detainees with mental health issues; and
- 70 percent did not feel adequately trained in the management of detainees with drug issues.

2.57 Consultation undertaken by JRPO with AMC Area Supervisors working in areas with proportionally high mental health cohorts (Management Unit, Crisis Support Unit, Women's Unit and Accommodation Unit) indicated that they had not had any additional training (compared to other Custodial Officers) to work with complex cohorts. The AMC Area Supervisors also indicated there was no refresher training on identifying and managing detainees with mental illness after their initial recruit training.

2.58 Custodial Officers are responsible for the day-to-day management of detainees and have a role in facilitating mental health services to detainees through: identification of escalating mental health issues; referral of detainees to mental health supports; and behavioural management and support for detainees. Training around the management of detainees with mental health conditions is provided to Custodial Officers on commencement with ACTCS, but no refresher training (outside of suicide and self-harm risk) or guidance material is provided after commencement. In 2019 *The healthy prison review* report from the ACT Inspector of Correctional Services identified that 71 percent of Custodial Officers did not feel adequately trained in the management of detainees with mental health issues. The lack of ongoing training and support for Custodial Officers compromises the effective delivery of mental health services and supports to detainees in the AMC.

RECOMMENDATION 4	TRAINING FOR CUSTODIAL OFFICERS IN THE CRISIS SUPPORT UNIT

ACT Corrective Services, in conjunction with Canberra Health Services, should:

a) develop and deliver a training package that assists Custodial Officers to provide effective management and support to detainees with mental health conditions. This should be supported by the development of a refresher training package for Custodial Officers to be delivered at regular intervals.

3 FRAMEWORK FOR THE DELIVERY OF MENTAL HEALTH TREATMENT

3.1 This chapter focuses on the governance framework for delivering mental health services in the AMC.

Summary

Conclusion

Governance arrangements do not provide clear management linkages between Canberra Health Services and ACT Corrective Services. Documents intended to establish shared care arrangements around the delivery of mental health services have expired and have not been replaced.

The Memoranda of Understanding and funding agreement with Winnunga Nimmityjah Aboriginal Health and Community Services are useful and comprehensive documents to guide the delivery of services by Winnunga. However, Winnunga has not been effectively incorporated into the overarching governance structure.

Governance bodies are not effective in identifying key issues around relationship management, significant gaps in service delivery or performance measurement.

Poor record keeping practices and systems prevent Canberra Health Services from gathering sufficient data to effectively plan for ongoing resource requirements.

Key findings

	Paragraph
In 2016 two Memoranda of Understanding were developed between ACT Health and ACTCS. The MoUs provided guidance on the management of detainees subject to mental health or forensic mental health orders and the sharing of information that was reasonably necessary for the safe and effective treatment, care, or support of a detainee. The Memoranda of Understanding expired in 2017 (30 June 2017 and 1 December 2017 respectively).	3.9
In August 2017 the *Arrangement between JACS and ACT Health for the delivery of health services for detainees* was developed, which sought to guide the treatment of detainees and their access to health care services. The Arrangement established the purpose of the relationship between ACTCS and ACT Health, service delivery arrangements and responsibilities as well as resources and governance arrangements. The Arrangement included limited information on how these would be implemented, as it was intended that the Arrangement would be supplemented by a range of schedules that could take the form of guidelines, agreed models of	3.17

care, governance documentation or descriptions of services. Only the models of care were implemented or developed as planned. The Arrangement expired when ACT Health was split into two entities on 1 October 2018 and CHS took over responsibility for Justice Health. An updated Arrangement document was developed in September 2019 by CHS that reflected the new administrative arrangements and included references to the *Human Rights Act 2004* that were not included in the original document. This document was signed by the Chief Executive Officer of CHS but has not been sighted or signed by ACTCS. In the absence of an updated Arrangement there is no formal arrangement between CHS and ACTCS relating to the delivery of health services for detainees.

An SLA was intended to be developed under the Arrangement. The SLA was intended to be a high-level schedule as to the services provided by ACT Health (now CHS) and it was noted 'this may be extremely useful as we continue to integrate Winnunga into the Health Service Model'. The development of the SLA remained in progress as at February 2021 and neither a draft version, nor a timeframe for delivery, has been developed. In the absence of an SLA there is no clearly documented definition of the services to be provided by each party along with performance measures that would provide agencies with a mechanism to monitor service delivery. The development of an SLA between ACTCS and CHS would be an important mechanism in defining the relationship between the parties and their service expectations and providing a mechanism that would hold each party accountable for the delivery of the services. 3.22

CHS does not monitor the activities of Winnunga to validate whether the shared care arrangements between CHS and Winnunga are effective, and services are being delivered as planned. This lack of oversight is compounded by a lack of oversight and management of the funding agreement between Winnunga and ACT Health for services delivered in the AMC. 3.32

Winnunga is a key stakeholder for the delivery of mental health services in the AMC. Two key documents govern the relationship between Winnunga and ACT Government agencies: *MoU for the delivery of coordinated health care services to Aboriginal and Torres Strait Islander detainees in the AMC (December 2018)* and service funding agreement (August 2017). The MoU and funding agreement with Winnunga are useful and comprehensive documents to guide the delivery of services by Winnunga. However, there is no formal oversight of the arrangements that provides assurance that they are operating as planned. 3.36

CHS and ACTCS have developed a range of procedures that support the delivery of mental health services to detainees, including procedures that relate to: access to health care; triage and health induction; care of persons subject to psychiatric treatment orders; and segregation of detainees subject to health segregation orders. MHJHADS has also developed a draft *Custodial Mental Health Services Operational Guide* (the draft Operational Guide) that seeks to provide an overview of the operational and clinical procedures that are undertaken by Custodial Mental Health within MHJHADS. The guide is expected to be finalised in mid-2021. The draft Operational Guide is a useful document that is expected to guide the activities of the Custodial Mental Health team. Until its finalisation there is a risk that: 3.42

- staff lack understanding of their role in the delivery and management of mental health services;
- referral and triage processes are inconsistent or non-existent;
- criteria around the transfer of patients are not understood; and
- consistent approaches to detainee care are not taken.

The ACTCS Health Advisory Group (the Advisory Group) was established to provide high level oversight of the work between ACTCS and ACT Health and to ensure that an integrated approach was taken to the development of health-related policies within the AMC and that joint strategies were progressed effectively. The Advisory Group has been ineffective in achieving these aims. The effectiveness of the Advisory Group was hampered by poor record keeping and a failure to progress key action items, with some remaining incomplete for more than 18 months. Meeting on a bi-annual basis in March and September of each year also reduces the ability of the Advisory Group to effectively provide oversight over key issues such as detainee wellbeing, or the effectiveness of the arrangement for the delivery of health services to detainees and effectively respond to urgent emerging issues. 3.65

The Winnunga Implementation, Operational and Governance Group (the Winnunga Governance Group) was formed to strengthen relationships between Justice Health Services and ACTCS regarding the delivery of health services by Winnunga at the AMC. The Group is primarily focused on operational issues and discussion around these was identified in meeting minutes, as well as robust discussion and escalation of issues to senior decision makers. However, of the eight meetings that took place between September 2019 and September 2020 a representative from ACTCS was only noted at three meetings. Of the six Group meetings planned since October 2020, four had been abandoned, one was postponed, and one was held as planned. Winnunga has advised that it no longer plans to attend the meetings as they had become unhelpful to Winnunga's operations within the AMC. The Group has not achieved its aim of strengthening relationships between CHS, ACTCS and Winnunga. 3.76

While each of the senior governance groups had clearly defined responsibilities, there were gaps in these, particularly around risk management and strategic planning. In addition, the groups naturally addressed and covered some of the same areas of responsibility. This suggests a need for communication channels and reporting between the groups to enable the sharing of information and escalation of important issues. None of the groups had formal mechanisms or pathways to interact with each other or with senior decision makers, which resulted in the ineffective management of important issues, such as the shortfall in psychological staff discussed in Chapter 2. The establishment of clear reporting lines that provide linkages between these groups would help mitigate this risk going forward. It would also help to ensure that issues are communicated to senior decision makers who are in the position to effectively address them. 3.88

CHS has developed a number of performance indicators that measure the delivery of its services in the AMC, which are identified and articulated in the *Forensic Mental Health Services Model of Care 2019* and MHJHADS divisional plan. Performance indicators and targets associated with assessments, referral times and care plans are appropriate and consistent with practice in other jurisdictions. However, while 3.97

useful in providing clinical data, some performance indicators are not specifically within its control and do not provide a measure of their performance. These include indicators relating to detainees already linked with Mental Health Services prior to entry; detainees on Psychiatric Treatment Orders; and detainees on long-acting injectable medications.

Neither CHS nor ACTCS has developed performance indicators that relate to: detainee access to mental health treatments (including against the number of detainees with diagnosed mental health conditions); delivery of mental health treatments: and the development of release plans for detainees with mental health conditions. Neither has CHS or ACTS developed performance indicators related to detainees: access to acute inpatient care; or who have experienced an escalation of psychiatric or suicide risk ratings. In the absence of performance indicators relating to these services, there is a lack of performance information associated with service delivery performance and risks and resource needs. Without relevant performance indicators, it is difficult for either CHS or ACTCS to assess the overall effectiveness of the delivery of mental health services and risks associated with resource allocation. 3.101

Shared care arrangements

3.2 The delivery of mental health services in the AMC is primarily undertaken by CHS but also involves key inputs from ACTCS and Winnunga. This shared responsibility reflects the different administrative responsibilities of CHS and ACTCS and the involvement of Winnunga as a specialist services provider. Shared care arrangements provide both opportunities and risks. Opportunities derive from the use of specialist service providers, while risks derive from the involvement of multiple providers leading to the potential for duplication or gaps in the delivery of services.

3.3 Given the involvement of multiple entities in the delivery of services it is important that there are relevant and robust governance and administrative arrangements in place.

Arrangements between ACT Government agencies

3.4 Prior to October 2018 ACT Health was responsible for the delivery of mental health services to detainees in the AMC. Responsibility for service delivery shifted to CHS from its establishment on 1 October 2018.

3.5 Governance arrangements were established between ACT Health and ACTCS via two Memoranda of Understanding and an 'Arrangement':

- *The management of detainees subject to the Mental Health Act 2015* (June 2016);
- *Information sharing in the care of detainees subject to the Mental Health Act 2015* (December 2016); and
- *The Arrangement between JACS and ACT Health for the delivery of health services for detainees* (the 'Arrangement') (August 2017).

Memoranda of Understanding

3.6 The purpose of the MoUs was to provide arrangements for:

- the management of detainees subject to mental health or forensic mental health orders; and
- the sharing of information that was reasonably necessary for the safe and effective treatment, care or support of a detainee including:
  - legal status;
  - health information;
  - information which may impact the secure detention or good order of the AMC or secure mental health facility;
  - the nature of any force, restraint, involuntary seclusion, or forcible giving of medication used, when, or in relation to a transfer; and
  - anything else that happened when, or in relation to, a transfer, that may have an effect on the person's physical or mental health.

3.7 Both MoUs were statements of intent and were not intended to create legal obligations between the parties.

3.8 The Memoranda of Understanding expired in 2017 (30 June 2017 and 1 December 2017 respectively). ACTCS representatives advised that they were not aware that the MoUs had expired and were operating as if they were still 'live' documents. CHS representatives advised that they considered the MoUs had expired and had not been replaced by any other MoUs.

3.9 In 2016 two Memoranda of Understanding were developed between ACT Health and ACTCS. The MoUs provided guidance on the management of detainees subject to mental health or forensic mental health orders and the sharing of information that was reasonably necessary for the safe and effective treatment, care, or support of a detainee. The Memoranda of Understanding expired in 2017 (30 June 2017 and 1 December 2017 respectively).

The Arrangement

3.10 The purpose of the Arrangement was to document agreement between ACT Health and JACS as to the way in which health services were to be provided to detainees; whether they were in custody, subject to a community correction or at a health facility.

3.11 The statement of intent of the Arrangement identified that the agencies would:

> … **work together** to ensure detainees have access to regular health checks and timely physical and mental health treatment (including hospital or specialist care) where necessary.

3.12 The Arrangement's statement of intent identifies that the agencies intended that the Arrangement was to constitute an enduring shared commitment to ensuring, as far as practicable, that:

- the right of detainees to be treated in a decent, humane and just way was respected;

- detainees were provided reasonable access to suitable health services and health facilities; and
- the health and wellbeing of detainees was promoted and did not expose them to unnecessary health risks including the spread of disease and infection.

3.13 The Arrangement's guiding principles were that:

- all detainees assessed as having a health issue were considered patients;
- custodial responses to behavioural or health-related issues without appropriate clinical treatment was unlikely to be in the best interests of the detainee - similarly, so is a clinical treatment response that does not have regard for the custodial setting;
- a health care model should recognise the important role of corrections officers in the monitoring of detainees to deliver positive health outcomes;
- the capacity of custodial and health staff to intervene effectively and therapeutically depends on appropriate access to information; and
- staff collaboration is central to managing custodial and health risks, especially those associated with suicide or self-harm.

3.14 The Arrangement included details of the general principles associated with service arrangements and responsibilities as well as resources and governance. However, the Arrangement included limited information on how these would be implemented. To achieve this the Arrangement was intended to be supplemented by a range of schedules that could take the form of:

- guidelines;
- agreed models of care;
- governance documentation; or
- descriptions of services.

3.15 Each of these was developed to some extent, but only the agreed models of care have been completed and endorsed. Key governance documents and guidelines remain in draft. A description of services exists between the ACT Government and Winnunga, but none exists for either CHS or ACTCS.

3.16 The Arrangement expired when ACT Health was split into two entities on 1 October 2018 and CHS took over responsibility for Justice Health. In September 2019 CHS developed an updated Arrangement document that reflected the new administrative arrangements and included references to the *Human Rights Act 2004* that were not included in the original document. This document was signed by the Chief Executive Officer of CHS on 25 September 2019. The document has not been sighted or signed by ACTCS, meaning there is no formal arrangement between CHS and ACTCS that relates to the delivery of health services for detainees.

3.17 In August 2017 the *Arrangement between JACS and ACT Health for the delivery of health services for detainees* was developed, which sought to guide the treatment of detainees and their access to health care services. The Arrangement established the purpose of the relationship between ACTCS and ACT Health, service delivery arrangements and responsibilities as well as resources and governance arrangements. The Arrangement included limited information on how these would be implemented, as it was intended that the Arrangement would be supplemented by a range of schedules that could take the form of guidelines, agreed models of care, governance documentation or descriptions of services. Only the models of care were implemented or developed as planned. The Arrangement expired when ACT Health was split into two entities on 1 October 2018 and CHS took over responsibility for Justice Health. An updated Arrangement document was developed in September 2019 by CHS that reflected the new administrative arrangements and included references to the *Human Rights Act 2004* that were not included in the original document. This document was signed by the Chief Executive Officer of CHS but has not been sighted or signed by ACTCS. In the absence of an updated Arrangement there is no formal arrangement between CHS and ACTCS relating to the delivery of health services for detainees.

Service Level Agreement

3.18 The Arrangement was intended to be supplemented by a range of schedules that could take the form of guidelines, agreed models of care, governance documentation or descriptions of services. One key document that was envisaged to be developed was a Service Level Agreement (SLA).

3.19 With respect to the SLA, meeting minutes from the Health Advisory Group's September 2018 meeting noted that:

> … a number of schedules remained outstanding, the first one being the Service Level Agreement – it was agreed that this needed to be a high level schedule as to the services provided by Health. It was also noted that this may be extremely useful as we continue to integrate Winnunga into the Health Service Model.

3.20 This action item remained in progress as at February 2021 and neither a draft version, nor a timeframe for delivery, has been developed.

3.21 SLAs typically define the services that are to be delivered by each party and how the delivery of those services is expected to be measured. An advantage to the development of an SLA is the clear definition of the services to be provided by each party and the inclusion of performance measures, or indicators, that would provide both agencies with a mechanism to monitor service delivery.

3.22 An SLA was intended to be developed under the Arrangement. The SLA was intended to be a high-level schedule as to the services provided by ACT Health (now CHS) and it was noted 'this may be extremely useful as we continue to integrate Winnunga into the Health Service Model'. The development of the SLA remained in progress as at February 2021 and neither a draft version, nor a timeframe for delivery, has been developed. In the absence of an SLA there is no clearly documented definition of the services to be provided by each party along

with performance measures that would provide agencies with a mechanism to monitor service delivery. The development of an SLA between ACTCS and CHS would be an important mechanism in defining the relationship between the parties and their service expectations and providing a mechanism that would hold each party accountable for the delivery of the services.

RECOMMENDATION 5 ESTABLISHMENT OF SHARED CARE ARRANGEMENTS

Canberra Health Services and the Justice and Community Safety Directorate should jointly:

a) establish and document the shared care arrangements for detainees with mental health conditions; and

b) develop a Service Level Agreement.

Arrangements with Winnunga

3.23 Winnunga is a key stakeholder for the delivery of mental health services in the AMC. Two key documents govern the relationship between Winnunga and ACT Government agencies:

- an MoU between CHS, JACS and Winnunga *for the delivery of coordinated health care services to Aboriginal and Torres Strait Islander detainees in the AMC* (December 2018); and
- a service funding agreement between ACT Health and Winnunga (August 2017).

The Winnunga MoU

3.24 In December 2018 an MoU was signed by the CEO of CHS, the Acting Director-General of JACS and the CEO of Winnunga. The MoU, and its associated Schedules, provides for Winnunga to deliver coordinated health care services to Aboriginal and Torres Strait Islander detainees in the AMC. The MoU seeks to ensure Aboriginal and Torres Strait Islander detainees receive health care at the AMC in a holistic and culturally safe way.

3.25 The MoU is supplemented by a range of schedules that cover:

- services to be provided by Winnunga at AMC;
- information sharing arrangements; and
- medication management.

3.26 The MoU is considered to be a useful and comprehensive document to guide the delivery of services by Winnunga. However, in discussions with operational staff within ACTCS and Justice Health, there was a lack of understanding of the details of the MOU, and its associated schedules, particularly around:

- what mental health treatment options Winnunga had been contracted to provide;
- how information should be shared with Winnunga; and

- the criteria that defined whether detainees were patients of CHS or Winnunga, or a combination of both.

3.27 In their response to the draft proposed report, CHS indicated that the sharing of information was an administrative function rather than clinical. Notwithstanding, this lack of understanding has resulted in reduced confidence from agency staff in their ability to provide effective, co-ordinated, treatment to Aboriginal and Torres Strait Islander detainees.

Winnunga's service funding agreement with ACT Health

3.28 In addition to the Winnunga MoU is a service funding agreement between ACT Health and Winnunga, that was first signed in August 2017 and extended for a period of three years in June 2019.

3.29 In 2018, due to the significant proportion of Aboriginal and Torres Strait Islander detainees in the AMC, and in response to a recommendation from the November 2016 Moss review, the ACT Government identified a need to provide a holistic approach to health care for Indigenous detainees. As a result, an additional schedule (Schedule 2D) was added to the funding agreement in June 2018 that specifically related to the provision of services to detainees in the AMC.

3.30 Schedule 2D notes that in delivering services, Winnunga will aim to:

- provide Health Assessments for Aboriginal and Torres Strait Islander detainees accessing its services in the AMC;
- provide GP Mental Health Care Plans and focused psychological strategies where required for detainees accessing its services in the AMC;
- provide coordination and care planning for chronic conditions where required for detainees accessing its services in the AMC;
- provide standard GP consultations to detainees accessing its services in the AMC;
- provide holistic, multidisciplinary and culturally appropriate care through case conferencing; and
- conduct regular Governance Reference Group meetings with ACT Health and ACTCS.

3.31 In addition, Winnunga is required to ensure that:

- Health Check Assessments are provided to all Aboriginal and Torres Strait Islander detainees accessing its services in the AMC;
- Mental Health Care Plans are in place and implemented for all people assessed as required;
- focused psychological strategies are delivered for all people assessed as required;
- chronic conditions care plans are in place and implemented for all people assessed as required;

- accessible GP consultations are available to all Aboriginal and Torres Strait Islander detainees registered with its services in the AMC;
- all health professionals delivering the service are appropriately trained, qualified and registered;
- services are provided outside operational hours if or when required;
- staff comply with the operational requirements of the AMC and security risk and classification of detainees at all times;
- it advises ACT Health within 10 working days of any changes to the services; and.
- six monthly reports be lodged within the specified timeframe.

3.32 CHS does not monitor the activities of Winnunga to validate whether the shared care arrangements between CHS and Winnunga are effective, and services are being delivered as planned. This lack of oversight is compounded by a lack of oversight and management of the funding agreement between Winnunga and ACT Health for services delivered in the AMC.

Monitoring Winnunga's service delivery performance

3.33 Performance reports were provided by Winnunga to ACT Health every six months as required under its funding agreement (discussed from paragraph 3.28). These reports included information (relevant to this audit) around:

- Health Check Assessments;
- Mental Health Care Plans;
- standard GP consultations;
- chronic conditions care plans; and
- the number of governance group meetings held.

3.34 ACT Health's funding agreement with Winnunga contains no references to CHS, which is primarily responsible for the delivery of health services to detainees. ACT Health had not sought feedback from CHS with respect to the monitoring of performance outcomes for Schedule 2D despite its overarching responsibility for the delivery of these services. This means that ACT Health cannot verify results reported in Winnunga's six monthly performance reports.

3.35 While the funding agreement with Winnunga provides an effective basis for the delivery of services, improvements could be made to oversight of the delivery of mental health services to Aboriginal and Torres Strait Islander detainees. This would enable the ACT Government to assure itself that the requirements of Winnunga's funding agreement are being met. While the ACT Health Directorate is responsible for the funding agreement, CHS, as the agency delivering health services within the AMC, is best placed to provide this oversight.

3.36 Winnunga is a key stakeholder for the delivery of mental health services in the AMC. Two key documents govern the relationship between Winnunga and ACT Government agencies: *MoU for the delivery of coordinated health care services to Aboriginal and Torres Strait Islander detainees in the AMC (December 2018)* and service funding agreement (August 2017). The MoU and funding agreement with Winnunga are useful and comprehensive documents to guide the delivery of services by Winnunga. However, there is no formal oversight of the arrangements that provides assurance that they are operating as planned.

RECOMMENDATION 6	OVERSIGHT OF WINNUNGA SERVICE DELIVERY ARRANGEMENTS AND FUNDING

To improve the oversight of ACT Government service arrangements with Winnunga Nimmityjah Aboriginal Health and Community Services, ACT Health, in partnership with Canberra Health Services and Winnunga, should establish arrangements for the improved oversight of services described under the Winnunga funding agreement that are provided in the Alexander Maconochie Centre.

Operational Procedures

3.37 Procedures that support the delivery of mental health services have been developed by both CHS and ACTCS, including procedures that relate to:

- access to health care;
- triage and health induction;
- care of persons subject to psychiatric treatment orders; and
- segregation of detainees subject to health segregation orders.

CHS Operational Guide

3.38 In addition to these procedures, MHJHADS has developed a draft *Custodial Mental Health Services Operational Guide* (the draft Operational Guide) that seeks to provide an overview of the operational and clinical procedures that are undertaken by Custodial Mental Health. This is expected to be finalised in mid-2021, and procedures outlined in the document are expected to apply to all mental health clinicians working within Custodial Mental Health.

3.39 The draft Operational Guide details:

- roles and responsibilities for staff;
- the stepped care approach for detainee access to mental health treatment options;
- referral and triage processes;
- criteria for the transfer of patients between services; and
- outcome measures and documentation requirements.

3.40 The draft Operational Guide applies to the management of detainees who require specialist mental health treatment or are considered at risk. It does not apply to those detainees diagnosed with less severe mental health conditions such as anxiety or depression.

3.41 The draft Operational Guide is a useful document that is expected to guide the activities of Custodial Mental Health. While the development of the draft Operational Guide is a significant step towards providing a recognised framework for the delivery of mental health services within the AMC, its draft status does not compel clinical or non-clinical staff to follow the procedures it outlines.

3.42 CHS and ACTCS have developed a range of procedures that support the delivery of mental health services to detainees, including procedures that relate to: access to health care; triage and health induction; care of persons subject to psychiatric treatment orders; and segregation of detainees subject to health segregation orders. MHJHADS has also developed a draft *Custodial Mental Health Services Operational Guide* (the draft Operational Guide) that seeks to provide an overview of the operational and clinical procedures that are undertaken by Custodial Mental Health within MHJHADS. The guide is expected to be finalised in mid-2021. The draft Operational Guide is a useful document that is expected to guide the activities of the Custodial Mental Health team. Until its finalisation there is a risk that:

- staff lack understanding of their role in the delivery and management of mental health services;
- referral and triage processes are inconsistent or non-existent;
- criteria around the transfer of patients are not understood; and
- consistent approaches to detainee care are not taken.

RECOMMENDATION 7	CUSTODIAL MENTAL HEALTH SERVICES OPERATIONAL GUIDE

Canberra Health Services should finalise the draft *Custodial Mental Health Services Operational Guide*.

Guidance for the management of detainees outside of Custodial Mental Health

3.43 While significant effort has gone into the development of an operational guide that supports the delivery of treatment to detainees with more severe mental health conditions, or those who are considered at risk, no operational guide has been developed for the management of detainees who fall outside of the criteria that results in an ‘S’ or ‘P’ rating.

3.44 This presents a risk that the treatment of these lower acuity conditions may not be provided in a thorough and consistent manner.

Governance groups

3.45 For governance arrangements to be effective there should be:

- clearly defined oversight responsibilities across areas such as strategic planning, risk management and legislative compliance; and
- a clear reporting structure that defines reporting lines, escalation mechanisms and how each group or forum will interact.

3.46 Decision makers should either be included in governance groups or should be included in reporting lines, to ensure that issues raised are able to be effectively addressed.

3.47 Four main governance groups, each with its own specific focus, have oversight of the delivery of health services within the AMC, including mental health services:

- Corporate Governance Committee (strategic focus);
- AMC Oversight Agencies Collaborative Forum (continuous improvement);
- ACTCS Health Advisory Group (oversight of the working relationship between agencies); and
- Winnunga Implementation, Operational and Governance Group (operational oversight and relationship building between the ACT Government and Winnunga).

ACTCS Health Advisory Group

3.48 In June 2018 an ACTCS Health Advisory Group (the Advisory Group) was established. According to its ToR it was intended to provide high level oversight of the work between ACTCS and ACT Health and ensure that an integrated approach was taken to the development of health-related policies in the AMC and that joint strategies were progressed effectively. The ToR note that the Advisory Group is the peak oversight committee with regard to:

- the Arrangement between ACTCS and ACT Health;
- the two MoUs;
- prisoner wellbeing;
- joint strategy development; and
- performance monitoring.

3.49 The ToR does not include any references to CHS, as it was developed prior to the agency's creation in October 2018, when CHS took over responsibility for Justice Health.

Membership and reporting lines

3.50 The Advisory Group's membership is comprised of senior executives from both ACTCS and CHS including the ACTCS Commissioner and Deputy Commissioner, the Operational Director

of Justice Health, Clinical Director of Primary Health within Justice Health as well as senior clinical staff. This accords with the requirements of the ToR and is considered appropriate for an oversight committee of this nature.

3.51 A representative from Winnunga is also invited to meetings but is not recognised as a member of the Group. This was considered appropriate given Winnunga's role in delivering health services to Aboriginal and Torres Strait Islander detainees.

3.52 While representatives from CHS and ACTCS were noted at each of the four meetings held by the group, a representative from Winnunga has only attended one of the four meetings held and has provided apologies for the remaining three.

3.53 No sub-committees have been established that report to the Advisory Group, and the Advisory Group does not report to any other governance body or Executives within JACS or CHS.

Reporting against standing items

3.54 The key standing agenda items for the Advisory Group, that are relevant to this audit are:

- performance against the MoUs;
- partnership working;
- emerging issues/service gaps; and
- outstanding audit recommendations.

3.55 The Advisory Group reported against its standing agenda items as listed in its ToR. Under the ToR, minutes for the meetings are only required to reflect decisions and actions agreed.

3.56 The overall quality of minutes was poor. The audit team was provided with meeting minutes marked with draft (this was acknowledged as an oversight in process by the secretariat) and shortcomings with the recording of action item numbers were noted on several occasions. For example, an action item marked as complete in the September 2020 meeting minutes noted that:

> … there are a number of recommendations from the Inspector's Healthy Prison Review that are overdue and these need to be prioritised.

3.57 The origin of this action item could not be identified during a review of prior meeting minutes, and it's marking as complete was not accompanied by an explanation of what recommendations had remained outstanding, what work was undertaken to address these recommendations, or whether a report detailing the progress of the implementation was provided to the Committee for review.

3.58 In another example from the April 2019 minutes an item under 'Other business' said 'Forensic mental health from [name] to [name]' but did not explain who these people were or what this meant.

3.59 This lack of detail makes it difficult to determine what issues were raised in these meetings, whether issues received robust attention as well as the information upon which decisions were made.

3.60 Oversight of the two MoUs between ACTCS and CHS was included in the Advisory Group's responsibilities despite their expiration some nine months earlier. In addition, the Advisory Group's ToR have not been updated to reflect the change in administrative responsibility from ACT Health to CHS that occurred three months after the Advisory Group's formation or the expiry of the Arrangement between ACTCS and ACT Health in October 2018. The Advisory Group has not identified these issues and has continued to report against the 'Performance against MoU' agenda item up until the time of this report. This conflicted with advice provided to the Audit Office (as discussed at paragraph 3.8) that CHS representatives considered the MoUs had expired.

3.61 In meeting minutes from September 2018 an action item was raised in relation to the investigation of the recruitment of psychologists to treat detainees with personality and behavioural disorders. This action item was never progressed and by September 2019 the item had been removed from the action item list without explanation.

3.62 The Advisory Group did identify issues around the development of additional schedules to support key MoUs and relationship management issues with Winnunga. However, the meeting minutes from later meetings did not identify whether these issues had been resolved or progressed.

Frequency of meetings

3.63 The Advisory Group is required to meet bi-annually in March and September of each year and met largely as planned (one meeting was moved from March 2019 to early April 2019), other than in March 2020 due to the COVID-19 health emergency. Having only two meetings a year reduces the ability of the Advisory Group to:

- effectively provide oversight over key issues such as detainee wellbeing, or the effectiveness of the arrangement for the delivery of health services to detainees; and
- respond to urgent emerging issues.

3.64 This was evidenced by action items that remained open for more than twelve months. For example, in September 2019 minutes from the Advisory Group recorded an action item relating to the development of an SLA between CHS and ACTCS. This action item remained largely unaddressed in September 2020, where the minutes recorded 'initial discussions' and the development of draft key performance indicators that related to the potential SLA.

3.65 The ACTCS Health Advisory Group (the Advisory Group) was established to provide high level oversight of the work between ACTCS and ACT Health and to ensure that an integrated approach was taken to the development of health-related policies within the AMC and that joint strategies were progressed effectively. The Advisory Group has been ineffective in achieving these aims. The effectiveness of the Advisory Group was hampered by poor

record keeping and a failure to progress key action items, with some remaining incomplete for more than 18 months. Meeting on a bi-annual basis in March and September of each year also reduces the ability of the Advisory Group to effectively provide oversight over key issues such as detainee wellbeing, or the effectiveness of the arrangement for the delivery of health services to detainees and effectively respond to urgent emerging issues.

RECOMMENDATION 8	HEALTH ADVISORY GROUP'S TERMS OF REFERENCE

Canberra Health Services and ACT Corrective Services should review and update the Health Advisory Group Terms of Reference.

Winnunga Implementation, Operational and Governance Group

3.66 The Winnunga MoU states that:

> The principals will put in place a governance structure involving appropriate senior executives and clinicians from their three organisations together for the implementation, administration and coordination of this MoU and its objectives, including the establishment of one or more joint or multi-disciplinary committees …

3.67 The Winnunga Implementation, Operational and Governance Group (the Winnunga Governance Group) was formed to:

> … strengthen relationships between the 3 parties Justice Health Services (JHS), ACT Corrective Services (ACTCS) and Winnunga Nimmityjah Aboriginal Health and Community Services (Winnunga) to the tri-partite Memorandum of Understanding (MoU) regarding the delivery of health service by Winnunga at the Alexander Maconochie Centre (AMC).

Membership and reporting lines

3.68 Under its ToR, membership of the Winnunga Governance Group is to comprise senior staff from ACTCS, Justice Health and Winnunga and should meet monthly. In practice, the group has met on a bi-monthly basis and has not been regularly attended by ACTCS representatives. Of the eight meetings reviewed by the audit team (from September 2019 to September 2020), the presence of a representative from ACTCS was only noted at three meetings, and the ACTCS General Manager, Custodial Operations, did not attend a single meeting, despite being listed as a member under the ToR.

3.69 By not ensuring that a senior officer was present at Winnunga Governance Group meetings, ACTCS has not taken the opportunity to raise or hear key issues relating to the provision of health services to Aboriginal and Torres Strait Islander detainees.

3.70 There are operational issues for Winnunga that require ACTCS attention, particularly around access to detainees. Minutes from a February 2020 meeting note that Winnunga:

> Raised the issue with the lack of clients being brought up to the clinic to see clinicians as well as ways of documenting refusals to appointments, this issue was not resolved due to Corrections not present.

Identification of key issues

3.71 The Winnunga Governance Group is primarily focused on operational issues and discussion around these was identified in meeting minutes.

3.72 The meeting minutes from the Winnunga Governance Group showed there was robust discussion and escalation of issues to senior decision makers. For example, minutes from the September 2019 meeting discussed delays in transfer times for detainees moving from CHS care to Winnunga care and noted the improvement in timeframes since January 2019. Issues around the commencement date for refurbishments to the Hume Health Centre were noted for escalation to an Executive Director in the February 2020 minutes. Action items were regularly followed up and actions taken to address were noted in the meeting minutes.

Meetings since October 2020

3.73 The Audit Office was informed that of the six Winnunga Governance Group meetings planned since October 2020, four had been abandoned, one was postponed, and one was held as planned.

3.74 Winnunga advised that it no longer planned to attend the meetings as they had become unhelpful to Winnunga's operations within the AMC due to difficulties in the management of relationships with staff from both CHS and ACTCS.

3.75 The meetings appeared to the Audit Office to provide a valuable forum for the discussion of issues, and potential solutions, that relate to the management of Aboriginal and Torres Strait Islander detainee health needs. It would be prudent for all parties to re-establish this forum if possible.

3.76 The Winnunga Implementation, Operational and Governance Group (the Winnunga Governance Group) was formed to strengthen relationships between Justice Health Services and ACTCS regarding the delivery of health services by Winnunga at the AMC. The Group is primarily focused on operational issues and discussion around these was identified in meeting minutes, as well as robust discussion and escalation of issues to senior decision makers. However, of the eight meetings that took place between September 2019 and September 2020 a representative from ACTCS was only noted at three meetings. Of the six Group meetings planned since October 2020, four had been abandoned, one was postponed, and one was held as planned. Winnunga has advised that it no longer plans to attend the meetings as they had become unhelpful to Winnunga's operations within the AMC. The Group has not achieved its aim of strengthening relationships between CHS, ACTCS and Winnunga.

Justice Health Services Clinical Governance and Finance Meeting

3.77 The Clinical Governance and Finance Meeting (the Meeting) was established to provide a forum for the overarching clinical governance activities for the Justice Health Services Program. Functions of the meeting include:

- monitoring, managing and leading the various quality and safety activities of the Program;
- maintaining a register and monitoring actions for recommendations arising from CRCs, Coronial, Human Rights Commission and other relevant sources (e.g. internal and external reviews and their recommendations); and
- monitoring trends in service and community feedback.

3.78 The Meeting differs from the governance groups discussed earlier in this report as it is solely a CHS group and does not include representatives from ACTCS or Winnunga. The Meeting covers the full range of activities across Justice Health and is not solely focused on the delivery of services in the AMC. Membership includes Operational and Clinical Directors from across Justice Health.

3.79 Meeting minutes from the period 1 January 2020 to 31 December 2020 were reviewed as part of the audit. Five meetings were held during that period.

3.80 Minutes from these meetings were brief and did not accurately record the types of issues that were discussed. No action items were recorded from the meetings, indicating that it was used solely for the sharing of information.

3.81 Standing agenda items covered a number of issues discussed throughout this report including:

- strategic planning;
- Aboriginal and Torres Strait Islander matters;
- Quality Improvement;
- workforce planning; and
- staff training.

3.82 The issues raised in this report relating to the provision of mental health services to detainees in the AMC, including staff shortages, lack of services for Aboriginal and Torres Strait Islander detainees and training for Custodial Officers, were not raised.

3.83 The Meeting has the potential to share valuable information around issues encountered by Justice Health in the AMC, with a view to sharing the information with relevant decision makers. However, its current operation does not support this.

Other groups

3.84 There are two joint operational governance groups that sit below the Advisory Group that contribute to the operational governance and functioning of mental health service delivery in the AMC:

- ACTCS/Justice Health Operational Governance Meeting; and
- Executive Meeting.

3.85 Neither is required to report formally to the Advisory Group, although members of these groups are also members of the Advisory Group.

3.86 Neither of the groups have ToR that define their membership or described their purpose and only the ACTCS/Justice Health Operational Governance Meeting recorded minutes.

ACTCS/Justice Health Operational Governance Meeting

3.87 A review of minutes from the four meetings held between 1 January to 31 December 2020, identified that the ACTCS/Justice Health Operational Governance Meeting was largely focused on operational issues, rather than governance. However, instances were noted at each meeting where issues such as key performance indicators, relationship management and policy were discussed.

3.88 While each of the senior governance groups had clearly defined responsibilities, there were gaps in these, particularly around risk management and strategic planning. In addition, the groups naturally addressed and covered some of the same areas of responsibility. This suggests a need for communication channels and reporting between the groups to enable the sharing of information and escalation of important issues. None of the groups had formal mechanisms or pathways to interact with each other or with senior decision makers, which resulted in the ineffective management of important issues, such as the shortfall in psychological staff discussed in Chapter 2. The establishment of clear reporting lines that provide linkages between these groups would help mitigate this risk going forward. It would also help to ensure that issues are communicated to senior decision makers who are in the position to effectively address them.

RECOMMENDATION 9	LINKAGES BETWEEN GOVERNANACE GROUPS

ACT Corrective Services and Canberra Health Services should establish clear reporting lines that provide communication linkages between current governance groups.

Monitoring service delivery outcomes

3.89 According to the ACT Government's *Strengthening ACT Government Performance and Accountability Framework* (February 2020):

> Good performance and accountability involves a cycle of continuous review and improvement, with the review stage informing the planning of the next cycle.
>
> The four basic elements of this cycle are:
>
> - planning objectives and actions;
> - managing or delivering services;
> - reporting on the performance of the service provided; and
> - reviewing and evaluating outcomes.

Performance indicators

CHS performance indicators

3.90 CHS has developed a number of performance indicators that measure the delivery of its services in the AMC. These are identified and articulated in the:

- *Forensic Mental Health Services Model of Care 2019*; and
- MHJHADS divisional plan.

3.91 CHS has also developed one Accountability Indicator relevant to the delivery of mental health services in the AMC, which relates to the completion of a health assessment within 24 hours of admission to the AMC (target of 100 percent). This conflicts with the target set for the same measure recorded in the MHJHADS divisional plan of 90 percent. Regardless, the target of 100 percent was achieved in 2019-20.

Forensic Mental Health Services Model of Care performance indicators

3.92 The *Forensic Mental Health Services Model of Care 2019* sets out a range of data to be captured for the purpose of monitoring service outcomes. The first of these outcomes have been allocated targets, which provide a benchmark for performance. These are the number of:

- detainees inducted to the centre (target 100%);
- new referrals triaged and seen within triage guidelines (target 100%);
- 'At-Risk' referrals seen within 2 hours (target 100%); and
- care/recovery plans completed for clinically managed detainees (target 100%).

3.93 Also included in the *Forensic Mental Health Services Model of Care 2019* are four additional measures that have not been allocated targets. These are the number of detainees:

- referred to external services upon release;

- already linked with Mental Health Services prior to entry;
- on Psychiatric Treatment Orders; and
- on long-acting injectable medications.

3.94 Of these four measures only the 'referred to external services upon release' indicator could be considered as a measure of the performance of CHS. However, there is no target for this measure. In the absence of a target the ability of CHS to monitor progress on this measure, and be held to account for its performance, is compromised. The remaining three measures are marginally related to its services and are not specifically within its control.

3.95 As discussed in paragraph 5.95, JRPO did not identify evidence of the development of a release plan in over half the records reviewed. Accordingly, it is important that CHS develop a target for the referral to external services on release measure. This will assist the agency in tracking the number of detainees who are released from custody with the required release plan in place.

MHJHADS divisional plan performance indicators

3.96 The inaugural MHJHADS divisional plan is currently under development. The existing draft includes a set of 39 performance measures that cover a wide range of outputs across the entire division. Of these, four relate directly to the provision of mental health services in the AMC, although only two have identified a proposed target:

- all clinically managed clients have a Care Plan (target 90 %);
- JHS Health assessment completed within 24hrs of induction to AMC and Bimberi (target 90 %);
- management plan for detainees identified as at risk of suicide completed and actioned. Access to Hume Health Centre KPIs developed in partnership with corrections (no target set as this KPI is still under development); and
- collaborate with JACS in determining best practice for JHS including review of service model of primary health and workforce redesign of JHS (increase in detainees and complexity) (no target set).

3.97 CHS has developed a number of performance indicators that measure the delivery of its services in the AMC, which are identified and articulated in the *Forensic Mental Health Services Model of Care 2019* and MHJHADS divisional plan. Performance indicators and targets associated with assessments, referral times and care plans are appropriate and consistent with practice in other jurisdictions. However, while useful in providing clinical data, some performance indicators are not specifically within its control and do not provide a measure of their performance. These include indicators relating to detainees already linked with Mental Health Services prior to entry; detainees on Psychiatric Treatment Orders; and detainees on long-acting injectable medications.

ACTCS performance indicators

3.98 There are no performance indicators for ACTCS relevant to the delivery of mental health services in the AMC.

Gaps in performance indicators

3.99 Neither CHS nor ACTCS has developed performance indicators that relate to:

- detainee access to mental health treatments (against the number of detainees with diagnosed mental health conditions);
- delivery of mental health treatments: and
- the development of release plans for detainees with mental health conditions.

3.100 Furthermore, neither CHS nor ACTS has developed performance indicators related to detainees':

- access to acute inpatient care; or
- who have experienced an escalation of psychiatric or suicide risk ratings.

3.101 Neither CHS nor ACTCS has developed performance indicators that relate to: detainee access to mental health treatments (including against the number of detainees with diagnosed mental health conditions); delivery of mental health treatments: and the development of release plans for detainees with mental health conditions. Neither has CHS or ACTS developed performance indicators related to detainees: access to acute inpatient care; or who have experienced an escalation of psychiatric or suicide risk ratings. In the absence of performance indicators relating to these services, there is a lack of performance information associated with service delivery performance and risks and resource needs. Without relevant performance indicators, it is difficult for either CHS or ACTCS to assess the overall effectiveness of the delivery of mental health services and risks associated with resource allocation.

RECOMMENDATION 10 KEY PERFORMANCE INDICATORS

Canberra Health Services and ACT Corrective Services should develop, and report against, key performance indicators that measure:

a) access to mental health treatment options; and

b) the delivery of mental health services within AMC.

Additionally, Canberra Health Services should report against a performance measure that relates to the development of release plans.

Reporting on service delivery

3.102 Robust data collection practices are necessary to measure and report on the effectiveness of service delivery. As discussed throughout this report, shortcomings in record keeping practices and the functionality of the records management system do not allow either CHS or ACTCS to collate sufficient information to measure the effectiveness of their service delivery.

3.103 Recommendation 2, which recommends that CHS ensures that its record keeping system captures key information, addresses this issue.

3.104 It was evident that the shortcomings of the MAJICER management information system contributes to data quality issues and challenges in regular measurement and reporting. Reviewing records for the purpose of the audit was a manual and labour-intensive process. An electronic management information system that could capture a greater range of variables without having to manually interrogate the content of clinical notes would be of benefit. This would help ensure better care and it would also provide much needed data for the planning of future services.

3.105 Forensic Mental Health also completes the following Outcomes Measures consistent with national standards:

- HONOS (Health of the Nation Outcomes Scale); and
- BASIS-32, Phases of Care, and the LSP (Life Skills Profile).

3.106 A review of clinical records by JRPO indicated that there was inconsistent completion of these measures (even when they appeared to be part of the clinical record - essentially a form had been included without the rating being completed). This may be for a number of reasons including the client refusing to complete the assessment. However, it does mean that it can be difficult to make use of outcomes data at a group level. For example, scores of zero could be genuine or represent a form that has not been fully completed.

3.107 None of the governance bodies considered as part of the audit have been specifically tasked with monitoring performance measures or outcomes. However, the CHS Corporate Governance Committee, attended by Justice Health Executives, is tasked under its ToR with monitoring the Division's business plan (discussed from paragraph 3.90) once it's complete.

3.108 There is no reporting against the targets set in the *Forensic Mental Health Services Model of Care*.

3.109 It is important that mental health service delivery is regularly measured, reported and monitored in order to ascertain its efficiency and effectiveness. For CHS the Corporate Governance Committee is considered an appropriate forum for this reporting. ACTCS should identify a suitable governance committee or similar for the regular reporting of its mental health related performance measures once developed.

4 SCREENING FOR MENTAL HEALTH ISSUES

4.1 This chapter focuses on the mental health screening processes undertaken in the AMC.

Summary

Conclusion

Screening processes on admission to the Alexander Maconochie Centre for non-Aboriginal and Torres Strait Islander detainees are effective, and at-risk detainees are effectively triaged and managed.

However, due to a lack of involvement from an Aboriginal or Torres Strait Islander health officer in the screening process, Canberra Health Services does not ensure that Aboriginal and Torres Strait Islander detainees are effectively screened for mental health issues at admission.

The ACT accepts mental health referrals from any source, including self-referrals; this reflects positively on the processes adopted in the Alexander Maconochie Centre. However, the effectiveness of arrangements established to screen detainees already in custody for mental health issues is compromised because of a lack of clear procedures or guidelines.

Key findings

	Paragraph
Custodial Mental Health screens every individual upon their entry to custody in order to identify those people with mental health needs and refer them for appropriate supports and intervention as required. The mental health screening assessment process, including roles and responsibilities, is well articulated in the draft *Custodial Mental Health Services Operational Guide* and the *Access, Triage and Health Induction Assessment Clinical Procedure*. CHS reported in its *2019-20 Annual Report* that 100 percent of induction assessments had been achieved within the required 24-hour timeframe. Initial mental health screening is based on an adaptation of the *Jail Screening Assessment Tool*, which is a validated measure for mental health screening undertaken in prisons upon reception. The use of clinical FMHS staff to conduct assessments exceeds the practice used by other Australian jurisdictions, where the use of primary health nurses or correctional officers is common. This was considered good clinical practice.	4.17
Indigenous Liaison Officers meet with detainees during the induction process and 'provide information on accessing cultural support, community elders and accessing Aboriginal and Torres Strait Islander cultural programs' and Winnunga may provide comprehensive health checks within seven days of a detainee's induction. However, neither the draft *Custodial Mental Health Services Operational Guide* nor the *Access,*	4.25

Triage and Health Induction Assessment Clinical Procedure require the presence of a CHS Aboriginal Liaison Officer (ALO), or a representative from Winnunga, during induction assessments for Aboriginal and Torres Strait Islander detainees, missing a key opportunity to potentially identify culturally sensitive health care needs.

A SVAT is completed as part of the induction assessment process. The SVAT is the tool currently endorsed for use by MHJHADS across public mental health services in the ACT to help assess a person's suicide vulnerability. The SVAT emphasises an individualised approach, that is meaningful and supported by evidence, that highlights the importance of planning appropriate interventions and follow-up to address specific suicidal thoughts and/or behaviours. While it is positive that a systematic approach to suicide risk is employed (and appropriate that it is consistently used across the ACT), the SVAT has not been validated by the ACT Health Directorate for use with corrections populations (including for Aboriginal and Torres Strait Islander detainees). Suicide and self-harm induction assessment results were routinely communicated to ACTCS in a timely manner via the SVAT. 4.36

Following assessment, Custodial Mental Health clinicians consider a Psychiatric (P) rating for each person. The 'P' rating is an indicator to ACTCS that Custodial Mental Health is assessing and/or treating a person's mental health needs. Psychiatric induction assessment results were routinely communicated to ACTCS in a timely manner via a *Forensic Mental Health Notification Form*. 'P' rating contact timeframes were well met and occurred in accordance with the draft *Custodial Mental Health Services Operational Guide*. 4.40

Mental health concerns often arise during custody for both remand and sentenced detainees. Referrals can arise from detainees self-reporting or from Custodial Officers, health workers or any other worker within the AMC. Along with Queensland, the ACT is the only jurisdiction to accept mental health referrals from any source, including self-referrals. This reflects positively on the processes adopted in the AMC. However, CHS does not collect information on the origin of mental health referrals once a detainee is in custody. Such information would be useful in understanding where there may be gaps in the referral process, or where additional training or guidance information is required to assist individuals making referrals. 4.46

The CHS *Suicide Prevention and Intervention Framework at the AMC* Operating Procedure (the Operating Procedure) and the ACTCS *Management of At-Risk Detainees* Policy require all staff, contractors or volunteers working in the AMC to report risk concerns regarding detainees considered at risk of suicide and/or self-harm whilst detained at the AMC. The documents provide useful information around how detainees should be referred for treatment, although the *Management of At-Risk Detainees* Policy could be improved by the inclusion of information around the typical presentations for detainees at risk. ACTCS staff do not generally have clinical backgrounds and information that helps them to understand the types of behaviours that suggest a detainee may be at risk would improve the likelihood that these behaviours would be identified in a timely manner. 4.52

Limited training around the identification and management of detainees with mental health conditions, including specific units on suicide and self-harm risk, is provided 4.61

to Custodial Officers on commencement with ACTCS. No refresher training or guidance material is provided once staff have commenced, except around suicide and self-harm. ACTCS staff do not have access to material of this type developed by CHS. While procedures exist that provide guidance to Custodial Officers on how to refer detainees identified as at risk of suicide or self-harm, no procedures exist that provide guidance on:

- warning signs for psychiatric or psychological illness; or
- when to assess detainees already in custody for potential mental health issues.

There are opportunities for detainees to self-refer themselves for assistance with mental health issues, including through disclosure to a GP during a primary health visit and/or disclosure to a Custodial Officer. However, these self-referral pathways have not been documented in guidance material outside of the induction handbook provided to detainees on their initial admission into the AMC. This lack of guidance material has led to confusion around: 4.66

- the pathway to self-referral; and
- how self-referrals are managed by either ACTCS or CHS staff.

Mental health screening processes

4.2 Mental health screening processes in the AMC should facilitate the timely identification of detainees with mental health conditions, which in turn should provide a pathway for appropriate diagnosis and treatment. Without effective mental health screening processes, the likelihood that detainees will receive effective mental health treatment is significantly reduced.

4.3 CHS' *Forensic Mental Health Services Model of Care 2019* states:

> High standards of screening at point of entry is paramount so that:
>
> - People with mental health needs are correctly triaged and directed to the appropriate health care setting, minimising the likelihood of people 'falling through the cracks'
> - Direct psychiatric care and clinical management can be targeted to those detainees with high needs, ensuring the Custodial MHS – Adult has the capacity for quality and assertive treatment for people with serious mental illness
> - Recommendations made to ACTCS regarding the mental health needs of detainees can be tailored to the individual.

4.4 The *Standards for health services in Australian prisons*, developed by the Royal Australian College of General Practitioners, state:

> … a prisoner is to be medically examined by a suitably qualified health professional within 24 hours of being received into prison, and thereafter as necessary. This is a clinically important process (as opposed to a routine bureaucratic procedure) for determining whether the prisoner has health concerns (e.g. acute or chronic illness, ongoing medication requirements, potential detoxification issues or suicide risk) that require immediate medical attention and management.

4.5 Section 67 of the *Corrections Management Act 2007* states:

> The Director-General must ensure that—
>
> (a) each detainee admitted to a correctional centre is assessed as soon as practicable to identify any immediate physical or mental health, or safety or security, risks and needs; and
>
> (b) any risks and needs identified by the assessment are addressed.

4.6 The assessment under section 67 of a detainee's physical and mental health needs and risks must be made within 24 hours after the detainee's admission and must involve:

- an initial assessment by a nurse and a review of the nurse's assessment by a doctor appointed under section 21; or
- an assessment by a doctor appointed under section 21.

4.7 The health assessment must also include an assessment of the detainee's risk of self-harm.

Mental health assessments at induction

4.8 Custodial Mental Health screens every individual upon their entry to custody. Custodial Mental Health seeks to identify those people with mental health needs and refer them for appropriate supports and intervention as required.

4.9 The mental health screening assessment process, including roles and responsibilities, is well articulated in the draft *Custodial Mental Health Services Operational Guide* and the *Access, Triage and Health Induction Assessment Clinical Procedure*. The draft Guide references the *Access, Triage and Health Induction Assessment Clinical Procedure* where appropriate. Both these documents were developed by, and aimed at, CHS staff but include references to how staff should engage with ACTCS.

4.10 The ART, which forms part of Custodial Mental Health, is responsible for conducting mental health screening assessments for all people on admission into custody. The team also undertakes suicide and self-harm assessments and implements care plans for people in custody identified as being at-risk of self-harm or suicide.

4.11 The CHS *Access, Triage and Health Induction Assessment Clinical Procedure,* which guides the ART in the screening of detainees, states that mental health screening should be undertaken, as part of an induction assessment, for every detainee within 24 hours of admission into the AMC by a FMHS clinician. CHS reported in its *2019-20 Annual Report* that 100 percent of induction assessments had been achieved within this timeframe.

Assessment process

4.12 The initial mental health screening document, which is used by the ART to assess detainees on admission to the AMC, is based on an adaptation of the *Jail Screening Assessment Tool*, which is a validated measure for mental health screening undertaken in prisons upon reception. This was considered appropriate by JRPO.

4.13 Screening is conducted by a FMHS nurse and results in a detainee being allocated a:

- self-harm/suicide 'S' rating (that establishes whether a detainee requires observation for self-harm risk and the frequency);
- psychiatric illness 'P' rating (frequency of service contact); and
- triage code (relative urgency for psychiatry review).

4.14 The use of clinical FMHS staff to conduct assessments exceeds the practice used by other Australian jurisdictions, where the use of primary health nurses or correctional officers is common. JRPO considered this good clinical practice.

4.15 Triage ratings range from 'Crisis', meaning that current actions are endangering the detainee or others, to 'Advice or Information' meaning that no face-to-face response or referral is required from FMHS.

4.16 Following the induction assessment, the FMHS nurse should complete a *Forensic Mental Health Notification Form*. This form provides a brief summary of the assessment and recommendations regarding the risk, psychiatric and medical observations required. The form is then provided to the ACTCS Admissions Officer for all inductions, regardless of recommended observations.

4.17 Custodial Mental Health screens every individual upon their entry to custody in order to identify those people with mental health needs and refer them for appropriate supports and intervention as required. The mental health screening assessment process, including roles and responsibilities, is well articulated in the draft *Custodial Mental Health Services Operational Guide* and the *Access, Triage and Health Induction Assessment Clinical Procedure*. CHS reported in its *2019-20 Annual Report* that 100 percent of induction assessments had been achieved within the required 24-hour timeframe. Initial mental health screening is based on an adaptation of the *Jail Screening Assessment Tool*, which is a validated measure for mental health screening undertaken in prisons upon reception. The use of clinical FMHS staff to conduct assessments exceeds the practice used by other Australian jurisdictions, where the use of primary health nurses or correctional officers is common. This was considered good clinical practice.

Assessments for Aboriginal and Torres Strait Islander detainees

4.18 Neither the draft *Custodial Mental Health Services Operational Guide* nor the *Access, Triage and Health Induction Assessment Clinical Procedure* require the presence of a CHS ALO, or a representative from Winnunga, during induction assessments for Aboriginal and Torres Strait Islander detainees.

4.19 However, the *Corrections Management (Induction) Policy*, which was developed by ACTCS in 2019, notes that:

> Indigenous Liaison Officers must meet with detainees during the induction process and provide information on accessing cultural support, community elders and accessing Aboriginal and Torres Strait Islander cultural programs.

4.20 While their support is useful and appropriate, the Indigenous Liaison Officers provided by ACTCS are focused on cultural support and do not have the health care expertise and experience that Winnunga or CHS ALOs do.

4.21 Recognising the importance of culturally appropriate care, recommendations arising from the *Independent Inquiry into the Treatment in Custody of Detainee Steven Freeman* led to the engagement of Winnunga to provide health services to Aboriginal and Torres Strait Islander detainees. Winnunga may provide comprehensive health checks within seven days of a detainee's induction, but its MoU with the ACT Government specifically excludes them from involvement in the initial assessment of mental health needs at induction. Responsibility for these assessments falls to the doctor appointed under s21 of the *Corrections Management Act 2007*.

4.22 In theory, this gap could be addressed by a CHS ALO. The role of this officer is to advocate, support and facilitate access to physical health care services for Aboriginal and Torres Strait Islander detainees. However, due to limited resourcing, an ALO may not be available for all Aboriginal and Torres Strait Islander detainee induction assessments. In 2019-20, Aboriginal and Torres Strait Islander detainees comprised 24 percent (a daily average of 107 detainees) of the adult detainee population in the ACT. Despite this high number, only 0.6 of a FTE ALO was available to provide services to the AMC. The allocation of 0.6 of an FTE was a decision made by CHS for reasons unknown to Justice Health. Justice Health has not conducted an assessment of the number of ALOs required to provide an appropriate level of service to detainees.

4.23 A further complication of having only one ALO is that there is no opportunity to provide gender specific care where required. At present, the ALO is male, meaning no female ALOs are available to provide services to female Aboriginal and Torres Strait Islander detainees.

4.24 Reception into custody is a high-risk time for mental health problems and provides an opportunity for early intervention. Given the acknowledged cultural sensitivities in providing treatment to Aboriginal and Torres Strait Islander detainees it is important that the culturally sensitive health care needs of Aboriginal and Torres Strait Islander detainees are recognised at the earliest opportunity.

4.25 Indigenous Liaison Officers meet with detainees during the induction process and 'provide information on accessing cultural support, community elders and accessing Aboriginal and Torres Strait Islander cultural programs' and Winnunga may provide comprehensive health checks within seven days of a detainee's induction. However, neither the draft *Custodial Mental Health Services Operational Guide* nor the *Access, Triage and Health Induction Assessment Clinical Procedure* require the presence of a CHS Aboriginal Liaison Officer (ALO), or a representative from Winnunga, during induction assessments for Aboriginal and Torres Strait Islander detainees, missing a key opportunity to potentially identify culturally sensitive health care needs.

4.26 Recommendation 18 addresses this key finding.

Suicide and self-harm assessments

4.27 The ART considers suicide and self-harm risk as part of the detainee induction assessment.

4.28 Detainees are assigned a rating from 1 to 4 (or nil if no evidence of suicide or self-harm behaviour has been identified). These ratings are explained in Table 4-1.

Table 4-1 Definition of suicide and self-harm ratings

Rating	Definition	Frequency of Contact
S1	Immediate risk of suicide or self-harm	Daily contact (twice daily desirable)
S2	Significant risk of suicide or self-harm	Daily contact
S3	Potential risk of suicide or self-harm	Minimum once per week (bi-weekly desirable)
S4	Previous history of self-harm behaviour	Nil follow up unless clinically indicated
S Nil	No evidence of current or historical suicide or self-harm behaviour	Nil

Source: CHS Suicide Prevention and Intervention Framework at the AMC Operating Procedure

4.29 As long as a detainee is subject to an 'S' rating, they remain under the care of the ART. Treatment needs are considered at the induction assessment and individuals are assigned a triage category (how quickly they should be seen) and an 'S' rating (frequency/intensity of contact).

4.30 By virtue of the Winnunga MoU, Aboriginal and Torres Strait Islander detainees with 'S' ratings do not receive care from Winnunga, but this does not prevent CHS from seeking advice on the treatment of Aboriginal or Torres Strait Islander detainees to assist CHS to provide culturally appropriate health care to these detainees.

Suicide Vulnerability Assessment Tool

4.31 The *Suicide Vulnerability Assessment Tool* (SVAT), developed by ACT Health, is completed as part of the induction assessment process. The SVAT is the tool currently endorsed for use by MHJHADS across public mental health services in the ACT to help assess a person's suicide vulnerability. The SVAT emphasises an individualised approach, that is meaningful and supported by evidence, that highlights the importance of planning appropriate interventions and follow-up to address specific suicidal thoughts and/or behaviours.

4.32 The SVAT assessment is completed face-to-face and the formulation developed from a bio-psycho-social perspective, incorporating strengths and supports as well as vulnerability factors. It is positive that a systematic approach to suicide risk is employed (and appropriate that it is consistently used across the ACT). However, the SVAT has not been validated by ACT Health for use with corrections populations (including for Aboriginal and Torres Strait Islander detainees).

4.33 The increased prevalence of suicide and self-harm within the prison system is related to a combination of individual vulnerabilities, the prison environment, and the person's capacity to manage the stressors that they experience. Factors unique to the prison environment include, for example, stress adapting to prison, separation from supports, shame and embarrassment regarding the charges, withdrawal from substances, and the uncertainty of criminal prosecution. Given there are particular vulnerabilities in prison populations that should be considered during suicide and self-harm assessments, the SVAT should be validated for use in the AMC context to ensure that the clinical processes capture the suicide and self-harm indicators seen in prison settings.

4.34 The SVAT is completed in two parts. The first part provides for a brief overview of a person's suicide vulnerability including space to document a management plan and any consultation that took place as part of the assessment. The second part provides space for clinicians to detail their formulation of a person's suicide vulnerability taking into account static, dynamic, future vulnerability factors, strengths and supports.

4.35 JRPO identified that suicide and self-harm induction assessment results were routinely communicated to ACTCS in a timely manner via the SVAT.

4.36 A SVAT is completed as part of the induction assessment process. The SVAT is the tool currently endorsed for use by MHJHADS across public mental health services in the ACT to help assess a person's suicide vulnerability. The SVAT emphasises an individualised approach, that is meaningful and supported by evidence, that highlights the importance of planning appropriate interventions and follow-up to address specific suicidal thoughts and/or behaviours. While it is positive that a systematic approach to suicide risk is employed (and appropriate that it is consistently used across the ACT), the SVAT has not been validated by the ACT Health Directorate for use with corrections populations (including for Aboriginal and Torres Strait Islander detainees). Suicide and self-harm induction assessment results were routinely communicated to ACTCS in a timely manner via the SVAT.

RECOMMENDATION 11 SUICIDE VULNERABILITY ASSESSMENT TOOL

Canberra Health Services should have the Suicide Vulnerability Assessment Tool, used during the induction assessment process, validated by ACT Health for use in a prison environment.

Psychiatric illness assessments

4.37 Following assessment, Custodial Mental Health clinicians will consider a Psychiatric (P) rating for each person. The P rating is an indictor to ACTCS that Custodial Mental Health is assessing and/or treating a person's mental health needs.

4.38 A 'P' rating can be assigned at the point of induction, a new referral or updated as a person's presentation changes. It provides an indication of the frequency of clinical contact required.

4.39 There are three psychiatric or 'P' ratings in addition to what is called a 'PA' rating. These are explained in Table 4-2. 'P' ratings are likely to change over the course of a detainee's treatment as needs change, are better understood or their condition changes.

Table 4-2 Definition of psychiatric ratings

Rating	Definition	Frequency of Contact
P1	Serious psychiatric condition requiring intensive and/or immediate care and/ or inpatient admission	Daily required
P2	Significant ongoing psychiatric condition requiring psychiatric treatment	Minimum of twice weekly
P3	Stable psychiatric condition requiring continuing treatment or monitoring by Custodial MH	Minimum of fortnightly unless MDTR indicates otherwise (monthly or 3 monthly)
PA	For further full-assessment	Minimum fortnightly
P nil	Nil psychiatric concerns requiring Custodial MH intervention	No further contact

Source: CHS Draft Custodial Mental Health Services Operational Guide

4.40 Following assessment, Custodial Mental Health clinicians consider a Psychiatric (P) rating for each person. The 'P' rating is an indicator to ACTCS that Custodial Mental Health is assessing and/or treating a person's mental health needs. Psychiatric induction assessment results were routinely communicated to ACTCS in a timely manner via a *Forensic Mental Health Notification Form*. 'P' rating contact timeframes were well met and occurred in accordance with the draft *Custodial Mental Health Services Operational Guide*.

Screening processes for those already in custody

4.41 Mental health concerns often arise during custody for both remand and sentenced detainees. Referrals can arise from detainees self-reporting or from Custodial Officers, health workers or any other worker within the AMC. Similar to induction, at-risk referrals are treated separately to those that relate to more general mental health conditions or concerns.

4.42 According to a 2018 study conducted by the Griffith Criminology Institute, *Prison Mental Health Services – A comparison of Australian Jurisdictions*, only the ACT and Queensland accept mental health referrals from any source, including self-referrals. This reflects positively on the processes adopted in the AMC.

4.43 Once received, referrals are triaged by Primary Health and are usually initially assessed by a GP and referred to Custodial Mental Health as required, unless there is an urgent mental health need, in which case the referral may be immediately directed to Custodial Mental Health.

4.44 The origin of these referrals is not collected by CHS. Such information would be useful in understanding where there may be gaps in the referral process, or where additional training or guidance information is required to assist individuals making referrals.

4.45 Once the screening process for detainees already in custody has commenced, it does not differ to that of the induction screening process described from paragraph 4.2. However, the processes for referring detainees already in custody was considered for the purpose of the audit, in order to identify whether detainees who developed mental health issues, or whose pre-existing condition worsened while in custody, were effectively identified for treatment. These processes are discussed further from paragraph 4.47.

4.46 Mental health concerns often arise during custody for both remand and sentenced detainees. Referrals can arise from detainees self-reporting or from Custodial Officers, health workers or any other worker within the AMC. Along with Queensland, the ACT is the only jurisdiction to accept mental health referrals from any source, including self-referrals. This reflects positively on the processes adopted in the AMC. However, CHS does not collect information on the origin of mental health referrals once a detainee is in custody. Such information would be useful in understanding where there may be gaps in the referral process, or where additional training or guidance information is required to assist individuals making referrals.

At-risk referral process

4.47 By virtue of the CHS *Suicide Prevention and Intervention Framework at the AMC* Operating Procedure (the Operating Procedure) and the ACTCS *Management of At-Risk Detainees* Policy all staff, contractors or volunteers working in the AMC are responsible for reporting risk concerns regarding detainees considered at risk of suicide and/or self-harm whilst detained at the AMC.

4.48 Those detainees already in custody, as opposed to those going through the admissions process, who are identified as potentially being 'at-risk', are referred to the ART. The ART is then required to respond and commence an assessment of the individual within two hours.

4.49 For CHS staff, the draft Operating Procedure provides:

- a referral workflow that documents each stage of the referral process, including who is responsible at each stage;
- a referral form for at-risk assessments;
- timelines for clinicians responding to at-risk referrals; and
- limited information on typical presentations (behaviours) for detainees at risk.

4.50 For ACTCS staff the *Management of At-Risk Detainees* Policy provides:

- information around the process for identifying at-risk detainees to supervisors;
- the referral process to FMHS; and

- management of at-risk detainees.

4.51 The ACTCS *Management of At-Risk Detainees* Policy does not include information or guidance around the typical behaviours for detainees at risk. This material is addressed in the CHS draft Operating Procedure, but ACTCS staff were not aware of this document and typically do not have access to CHS information of this type.

4.52 The CHS *Suicide Prevention and Intervention Framework at the AMC* Operating Procedure (the Operating Procedure) and the ACTCS *Management of At-Risk Detainees* Policy require all staff, contractors or volunteers working in the AMC to report risk concerns regarding detainees considered at risk of suicide and/or self-harm whilst detained at the AMC. The documents provide useful information around how detainees should be referred for treatment, although the *Management of At-Risk Detainees* Policy could be improved by the inclusion of information around the typical presentations for detainees at risk. ACTCS staff do not generally have clinical backgrounds and information that helps them to understand the types of behaviours that suggest a detainee may be at risk would improve the likelihood that these behaviours would be identified in a timely manner.

General referral process

Primary Health referrals

4.53 For CHS the draft *Custodial Mental Health Services Operational Guide* (draft Operational Guide) outlines the process for general referrals, which encompasses all those that have not been specifically identified as 'at-risk'.

4.54 Under the draft Operational Guide, Primary Health is required to triage all detainees with mental health concerns before referral to Custodial Mental Health. If an urgent requirement for mental health intervention is identified, the detainee should be sent directly to Custodial Mental Health for assessment. In all other cases, Primary Health should undertake an initial assessment itself, usually by a GP, who can then refer to Custodial Mental Health for specialist psychiatric assessment if required.

4.55 For detainees referred to its care, Custodial Mental Health liaises with primary health care providers, including Winnunga, regarding referrals that may require Custodial Mental Health input and/or further consultation. GP and psychiatrist consultations are organised by Custodial Mental Health as required.

Custodial Officer referrals

4.56 Custodial Officers are responsible for the day-to-day management of detainees. This daily interaction and observation provides the best opportunity, outside of self-referral, for the identification of potential mental health issues in detainees already in custody. This is particularly the case when considering detainees who may not be in a position to self-identify their health concerns.

4.57 Limited training around the identification and management of detainees with mental health conditions, including specific units on suicide and self-harm risk, is provided to Custodial Officers on commencement with ACTCS. No refresher training or guidance material is provided once staff have commenced, except around suicide and self-harm. ACTCS staff do not have access to material of this type developed by CHS, nor has the agency requested that CHS develop or deliver refresher training.

4.58 While procedures exist that provide guidance to Custodial Officers on how to refer detainees identified as at risk of suicide or self-harm, no procedures exist that provide guidance on:

- warning signs for psychiatric or psychological illness; or
- when to assess detainees already in custody for potential mental health issues.

4.59 Custodial Officers were often not made aware as to why a referral to the Custodial Mental Health team had not been actioned, leaving them unsure of any follow up action they may need to take, or what information should be provided to detainees on the status of the referral.

4.60 Ongoing/refresher mental health training for ACTCS staff, including around the mental health care model operating in the AMC, would assist in the:

- effective identification of detainees with mental health conditions; and
- improve the referral pathway to Custodial Mental Health.

4.61 Limited training around the identification and management of detainees with mental health conditions, including specific units on suicide and self-harm risk, is provided to Custodial Officers on commencement with ACTCS. No refresher training or guidance material is provided once staff have commenced, except around suicide and self-harm. ACTCS staff do not have access to material of this type developed by CHS. While procedures exist that provide guidance to Custodial Officers on how to refer detainees identified as at risk of suicide or self-harm, no procedures exist that provide guidance on:

- warning signs for psychiatric or psychological illness; or
- when to assess detainees already in custody for potential mental health issues.

RECOMMENDATION 12	CUSTODIAL OFFICERS MENTAL HEALTH IDENTIFICATION TRAINING AND GUIDANCE MATERIAL

To improve the timely identification of mental health issues in detainees by Custodial Officers, ACT Corrective Services should provide:

a) on-going mental health identification training to Custodial Officers;

b) guidance material that identifies the warning signs for psychiatric and psychological illness; and

c) guidance material that details the referral process for those detainees not considered at-risk.

Self-referral

4.62 Detainees have three primary pathways for self-referral:

1) self-refer to a GP/nurse as part of a primary health visit;
2) submit a Health Centre or Detainee request form; or
3) disclose concerns to a Custodial Officer who can, in turn, initiate a referral.

4.63 Detainees consulted as part of the audit indicated that they were aware of the GP/nurse and Custodial Officer pathways but did not identify the use of either a Health Centre or Detainee Request Form. This suggests that this self-referral pathway may be unclear for some detainees.

4.64 It is important that Custodial Officers can make referrals to Custodial Mental Health, to help ensure that detainees with potential mental health needs are identified. However, given privacy concerns that some detainees may have concerning their mental health, and the lack of trust that often exists between detainees and Custodial Officers, this is unlikely to be the preferred path for referrals. The self-referral to a GP pathway should remain as the primary method for referral.

4.65 When interviewed, detainees expressed some concern around having to go to a Custodial Officer to disclose mental health concerns to obtain help, as well as a lack of clarity around whether such requests had been followed up. This aligned with statements made by Custodial Officers at paragraph 4.59.

4.66 There are opportunities for detainees to self-refer themselves for assistance with mental health issues, including through disclosure to a GP during a primary health visit and/or disclosure to a Custodial Officer. However, these self-referral pathways have not been documented in guidance material outside of the induction handbook provided to detainees on their initial admission into the AMC. This lack of guidance material has led to confusion around:

- the pathway to self-referral; and
- how self-referrals are managed by either ACTCS or CHS staff.

RECOMMENDATION 13 SELF-REFERRAL PATHWAY FOR DETAINEES

ACT Corrective Services should develop clear guidance material for detainees that details the self-referral pathways for mental health concerns.

5 DELIVERY OF MENTAL HEALTH SERVICES

5.1 This chapter focuses on the delivery of mental health services in the AMC. It discusses the:

- development of health care plans;
- the delivery of treatment to detainees with 'S' and 'P' ratings;
- the delivery of treatment to Aboriginal and Torres Strait Islander detainees; and
- planning for release.

Summary

Conclusion

The delivery of mental health services to non-Aboriginal and Torres Strait Islander detainees under psychiatric or suicide and self-harm ratings is effective.

However, the delivery of culturally sensitive mental health treatment to Aboriginal and Torres Strait Islander detainees with psychiatric or suicide or self-harm risks could be improved by the inclusion of input from an Indigenous service provider.

Detainees with less severe mental health conditions do not receive adequate treatment due to a significant shortage of psychologists within the AMC. The treatment of this cohort could also be strengthened by the development of policies and procedures that guide their care.

Care plans are routinely developed and implemented. However, there are opportunities to improve the quality of these plans, particularly by the inclusion of comprehensive treatment information.

Planning for the release of detainees with mental health conditions could also be improved by the development of guidance material that describes the process for this planning, and the information required to inform that planning.

Key findings

	Paragraph
Collaborative care plans should be developed for all detainees assessed with a 'P' rating. Care plans should include consideration of a detainee's: recovery goals; mental and physical health issues; substance abuse issues; risk and safety issues; and family and carer supports. Basic care plans were developed and implemented for the nine detainees whose health records were reviewed for the purpose of the audit.	5.14

However, only two of the nine reviewed files showed comprehensive treatment plan notes that would enable an effective handover of care between clinicians. When only basic information is included, it is not possible for CHS to ascertain precisely what treatment a detainee requires without discussing the plan further with the treating clinician.

At-risk detainees may be managed in the CSU, based upon their needs and operational requirements. Apart from the basic awareness training that is provided to all Custodial Officers at induction, no additional mental health related training is provided to officers who work regularly in the CSU. This presents a risk that the needs of these detainees are not being adequately met and places Custodial Officers managing these detainees at risk. 5.20

The HRAT is a multi-agency decision and intervention planning team involving ACTCS and Justice Health Services that co-ordinates the management of at-risk detainees, specifically S-rated detainees. The HRAT meets each business day and, according to the CHS *Standard Operating Procedure Suicide Prevention and Intervention Framework*, should be attended at a minimum by Custodial Mental Health, ACTCS and Primary Health Services. Minutes of HRAT meetings were extremely brief and only one included sufficient detail around discussions and associated planning. While decisions and actions were recorded, the minutes often contained limited discussion or rationale for these decisions. Without this level of detail, it is unclear whether sufficient attention was paid to the management of S-rated detainees. The effectiveness of these meetings was further weakened by the occasional absence of a representative from Justice Health. In addition, no representative from key stakeholder Winnunga was included. 5.28

While occurring informally, there is no established process to ensure that advice and support is sought from Winnunga, or any other Aboriginal or Torres Strait Islander health professional, for Aboriginal and Torres Strait Islander detainees at risk of suicide and self-harm. 5.32

In February 2019 a Custodial Mental Health Team Leader observed a trend where 'P' ratings appeared to increase over time rather than decrease, indicating an apparent trend in the deterioration in mental state among detainees on the units. In response, Justice Health undertook a quality improvement activity to identify potential causes of this observed trend and to develop strategies to address it. The Quality Improvement (QI) report identified the need for earlier identification of mental health deterioration and appropriate intervention and a range of changes were implemented to improve clinician response times and reduce inpatient admissions among this group. 5.46

For detainees whose mental health condition requires hospital treatment, two options exist; treatment within the Canberra Hospital or the Dhulwa Mental Health Unit. Dhulwa offers a secure and structured environment for people who can't be safely cared for in other environments and whose complex care needs are not met in the current system. Delays in access to inpatient treatment were frequently experienced due to limited bed access at Dhulwa. While detainees may access hospital beds within the Canberra Hospital as necessary, these hospital beds are not 5.55

always the type of beds required as they have lower levels of security/safety and are only intended for a relatively shorter length of stay.

The delivery of treatment to detainees without 'S' or 'P' ratings is hampered by the lack of an operational guide that describes the operational and clinical procedures to be undertaken for detainees who fall outside the criteria for treatment by Custodial Mental Health. At present, their management is at the discretion of individuals rather than a planned approach by the agency. As with detainees with 'S' or 'P' ratings, it is important for CHS to document the arrangements for the management of detainees with less severe mental health conditions to ensure their effective management. 5.58

Winnunga provides a primary health level of mental health care to Aboriginal and Torres Strait Islander detainees but does not have a role in the delivery of mental health treatment at the higher levels of the 'Stepped Care Approach'. Justice Health is specifically responsible for the provision of mental health services to Aboriginal and Torres Strait Islander detainees assessed with either a 'P' or 'S' rating. For the period 1 July 2020 to 31 December 2020, Winnunga reported the development of 42 mental health care plans for 23 detainees under its care and CHS reported that 49 Aboriginal and Torres Strait Islander detainees were subject to a 'S' or 'P' rating and were under its care, with a care plan in place. Only 0.6 of a FTE ALO from CHS is available to assist Custodial Mental Health to provide services to those Aboriginal and Torres Strait Islander detainees who are not receiving treatment from Winnunga. This is unlikely to facilitate the delivery of effective culturally sensitive and appropriate treatment to Aboriginal and Torres Strait Islander detainees. 5.73

Trauma-informed care frameworks are considered essential in contemporary mental health, and forensic mental health services, to promoting understanding environments that promote health and wellbeing for all detainees and can prevent trauma-based deterioration. However, staff have not undertaken this training. This should be a further area for joint strategy development between CHS and ACTCS. 5.83

Greater attention is required to ensure that release planning is undertaken to address detainees' mental health needs upon release. There are no specific procedures or guidelines in CHS or ACTCS for the development of release plans for detainees, although for CHS staff, the Custodial Mental Health draft Operational Guide provides some guidance for detainees with 'S' and/or 'P' ratings, noting that the detainee's care plan 'must include an initial release plan in the event the person is released from custody'. The draft Operational Guide also includes a Closure Checklist for people released from custody but does not reference engagement of external service providers in the development of release plans, or refer to the clinical services provided by ACTCS. There is no guidance for the development of release plans for detainees with diagnosed mental health conditions who do not have 'S' and/or 'P' ratings. Guidance should be developed with respect to: 5.102

- a description of the release planning process (including the timing of both the development and review of release plans);
- the minimum level of information that should be considered and included in a release plan;

- how ACTCS should be consulted with around detainees receiving mental health treatment from their clinical staff;
- how service providers should be consulted when developing release plans for Aboriginal and Torres Strait Islander detainees.

Mental health care plans

Stepped Care Approach

5.2 The *Forensic Mental Health Services Model of Care* 2019 states:

> Whilst all detainees who experience mental health concerns should have timely access to high quality treatment and support, not all will require specialist mental health services. According to the National Institute for Health and Care Excellence (NICE) Guidelines *Mental Health of Adults in Contact with the Criminal Justice System 2011* and *Common Mental Health Problems: Identification and Pathways to Care 2011* all people should be able to access entry level mental health triage and primary health care. This is followed by a 'step up' for those with mild to moderate mental illness/disorder accessing primary health care services in combination with more structured psychological services. Higher steps on the care spectrum include specialist mental health service management for more severe and/or complex mental health presentations.

5.3 A basic outline of this Stepped Care Approach to treatment is shown in Table 5-1.

Table 5-1 'Stepped Care Approach' for delivery of mental health services

Focus of the intervention	Nature of the intervention	Role of Custodial MHS – Adult	Role of other services
STEP 1: All known and suspected presentations of mental health concern.	Identification and assessment; psychoeducation and treatment options; active monitoring.	Induction screening Assessment and response based on triage rating. Referral to appropriate supports	Primary Health induction assessment. Primary Health Practitioner treatment formulation first response to suspected mental illness. Winnunga Nimmityjah Aboriginal Health Service (AHS) Health practitioner treatment formulation first response to suspected mental illness.
STEP 2: Diagnosed Mental Illness that has not improved after education and active monitoring in primary care.	Low-intensity psychological interventions: individual non-facilitated self-help, individual guided self-help and psychoeducational groups.	Custodial MHS – Adult Psychiatrist consultation to primary health. Custodial MHS – Adult consultation to custodial agency.	Primary Health Practitioner consultation with Custodial MHS - Adult Psychiatrist. Winnunga Nimmityjah AHS clinician consultation with Custodial Mental Health

Focus of the intervention	Nature of the intervention	Role of Custodial MHS – Adult	Role of other services
			Service (MHS) – Adult Psychiatrist. ACTCS therapeutic programs and psychological services for suitable participants.
STEP 3: Symptoms with an inadequate response to step 2 interventions or marked functional impairment.	Choice of a high-intensity psychological intervention or a drug treatment.	Custodial MHS – Adult direct psychiatric care and clinical management or other therapies. Collaborate on joint management planning with custodial agency	Continued Primary Health or Winnunga Nimmityjah AHS for physical health care. Custodial MHS – Adult and ACT Corrective Services (ACTCS) joint management plans.
STEP 4: Complex treatment-refractory and very marked functional impairment, such as self-neglect or a high risk of self-harm.	Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, or inpatient care.	Custodial MHS – Adult direct psychiatric care and assertive clinical management. Collaborate on joint management planning with custodial agency.	Continued Primary Health or Winnunga Nimmityjah AHS for physical health care. Custodial MHS – Adult and ACTCS joint management plans.
STEP 5: Complex treatment-refractory and very marked functional impairment, such as self-neglect or a high risk of self-harm, requiring involuntary or inpatient care.	Inpatient care at AMHU or Dhulwa Secure Mental Health Unit depending on presentation and clinical needs.	Ongoing consultation with inpatient setting and ACTCS regarding treatment progress and transfer between settings.	Physical and mental health care needs managed by inpatient unit. ACTCS may provide security support depending on setting.

Source: ACT Audit Office based on the *Forensic Mental Health Services Model of Care 2019*

Development of mental health care plans

5.4 Once detainees with mental health issues have been identified and diagnosed, mental health care plans should be developed to guide their management and treatment.

Development of care plans

Care plans for detainees with 'P' ratings

5.5 By virtue of CHS' draft *Custodial Mental Health Services Operational Guide*, the ART is expected to develop a collaborative care plan for all detainees assessed with a 'P' rating. Care planning should be done in collaboration with the treating team, the detainee and their supports, including carers, community organisations and primary care whenever possible.

5.6 Care plans should include consideration of a detainee's:

- recovery goals;
- mental and physical health issues;
- substance abuse issues;
- risk and safety issues; and
- family and carer supports.

5.7 Under the draft Operational Guide, care plans should be reviewed, at a minimum, every three months.

Development of care plans

5.8 JRPO examined the process and outcomes for the development of treatment plans to meet the needs of detainees with mental illness. This examination included discussions with custodial mental health staff and detainees, as well as a review of a selection of health records for detainees with a 'P' rating. For the purpose of the audit nine detainee health records were considered for review.

5.9 The review of detainee health records, which focused on processes associated with induction screening, through to the development and implementation of treatment plans, showed evidence of:

- information gathering;
- clinical assessment;
- development of treatment plans;
- treatment; and
- clinical review.

5.10 In particular, JRPO's review identified that:

- gathering of collateral information was evident and appropriate across the clinical records reviewed;
- basic clinical treatment and intervention plans were considered appropriate to the diagnosis;
- plans were discussed at Multi-Disciplinary Team (MDT) meetings, which are held four times per week;
- plans included 'P' ratings (frequency of contact) and any applicable 'S' (observations) ratings; and
- initial plans also included triage ratings (relative urgency for psychiatry review).

5.11 Under the draft Operational Guide, collaborative care plans should also be shared with detainees and their supports. Due to issues with the MAJICeR record keeping system, however, it was not clear whether detainees' care plans were shared with them.

Comprehensiveness of mental health care plans

5.12 Although it was apparent that care plans were developed and implemented for the nine detainees whose health records were reviewed, JRPO also identified opportunities to strengthen the quality of these plans, particularly regarding the inclusion of comprehensive information.

5.13 The reviewed files demonstrated appropriate intake assessment notes but relatively brief week to week treatment plan notes were generated by the MDT. While basic care plans existed for all detainees, only two of the nine reviewed files showed comprehensive treatment plan notes that would enable an effective handover of care between clinicians. JRPO did not consider this was good clinical practice.

5.14 Collaborative care plans should be developed for all detainees assessed with a 'P' rating. Care plans should include consideration of a detainee's: recovery goals; mental and physical health issues; substance abuse issues; risk and safety issues; and family and carer supports. Basic care plans were developed and implemented for the nine detainees whose health records were reviewed for the purpose of the audit. However, only two of the nine reviewed files showed comprehensive treatment plan notes that would enable an effective handover of care between clinicians. When only basic information is included, it is not possible for CHS to ascertain precisely what treatment a detainee requires without discussing the plan further with the treating clinician.

RECOMMENDATION 14 COLLABORATIVE CARE PLANS

Canberra Health Services should improve the comprehensiveness of Collaborative Care Plans for all detainees with psychiatric risk ratings.

Delivery of treatment to detainees

5.15 For the period 1 July to 31 December 2020, CHS reported that a total of 180 detainees were subject to an 'S' or 'P' rating and had a care plan in place.

Delivery of treatment to detainees with 'S' ratings

Interim Risk Management Plan

5.16 If a detainee is assessed at induction as requiring further intervention in relation to their risk of suicide or self-harm, the FMHS clinician is required to prepare an *Interim Risk Management Plan* (IRMP) and provide that plan to the ACTCS Admission Officer. IRMPs

include recommendations regarding the required level of observation and whether the person requires placement in the Crisis Support Unit (CSU), as well as information on access to personal items, current support services, daily activities (supported and not supported) and ongoing follow up to be provided by FMHS and any other known significant issues.

5.17 Recommendations from the IRMP are discussed by the HRAT (discussed further from paragraph 5.21) and an SLA is completed and agreed.

Management within the CSU

5.18 At-risk individuals may be managed in the CSU as required, based upon the detainee's needs and operational requirements. The CSU is a 10-bed unit for detainees assessed as being at high risk of self-harm, or of harm to others or at risk from others as the result of a mental illness or other mental health problems. It is staffed 24-hours a day by Custodial Officers, which allows for close supervision of detainees. All cells have cameras to allow for the remote monitoring of detainees and the unit is intended as a short stay environment where detainee safety is the key objective.

5.19 Apart from the basic awareness training that is provided to all Custodial Officers at induction, no additional mental health related training is provided to officers who work regularly in the CSU.

5.20 At-risk detainees may be managed in the CSU, based upon their needs and operational requirements. Apart from the basic awareness training that is provided to all Custodial Officers at induction, no additional mental health related training is provided to officers who work regularly in the CSU. This presents a risk that the needs of these detainees are not being adequately met and places Custodial Officers managing these detainees at risk.

RECOMMENDATION 4	TRAINING FOR CUSTODIAL OFFICERS IN THE CRISIS SUPPORT UNIT

ACT Corrective Services, in conjunction with Canberra Health Services, should:

b) develop and deliver a training package for those staff working within the Crisis Support Unit and provide these staff with ongoing supervision and support.

High-Risk Assessment Team meetings

5.21 Custodial Mental Health staff meet with CSU Custodial Officers each morning to discuss individual patients. Patients are also consulted ahead of the High-Risk Assessment Team (HRAT) meeting.

5.22 The HRAT is a multi-agency decision and intervention planning team involving ACTCS and Justice Health Services that co-ordinates the management of at-risk detainees, specifically S-rated detainees. The HRAT occurs each business day and, according to the CHS *Standard*

Operating Procedure Suicide Prevention and Intervention Framework, should be attended at a minimum by Custodial Mental Health, ACTCS and Primary Health Services.

5.23 For persons identified as 'at risk' outside of standard business hours, ACTCS will transfer the person to the CSU under a default 15-minute observation level. ACTCS will contact the JHS on-call medical officer. The on-call medical officer and/or ACTCS may increase or decrease the observation level and also have the option of placing the person in tear proof clothing and bedding if the risk indicates this mitigation strategy is required. The JHS on-call medical officer will also authorise an interim plan. A referral for an at-risk assessment will be completed by ACTCS. All at-risk triages and assessments are discussed at the HRAT meeting the following business day.

5.24 JRPO observed an HRAT meeting in person and identified that the meeting worked well and that there was good collaboration between Custodial Mental Health, ACTCS officers and Primary Health. The meeting discussed new cases on observations, placement issues, and changes in the status of existing patients. The observed meeting was noted to be relatively brief. There was no discussion about what interventions were occurring to reduce risk, how this was being measured and what outcomes would be expected before a less restrictive placement could commence.

5.25 Minutes from 19 HRAT meetings were reviewed by JRPO. In general, the meeting minutes were noted as extremely brief with only one including sufficient detail around discussions and associated planning. While decisions and actions were recorded, the minutes often contained limited discussion or rationale for these decisions. Without this level of detail, JRPO was unable to establish whether sufficient attention was paid to the management of S-rated detainees.

5.26 While a representative of Primary Health is required to attend the meetings, this is often not the case.

5.27 Patients' reflections about their care during experiences of being at risk were generally very positive. The patients reported that they were responded to promptly and received assessments rapidly and were provided good environmental management and staff support.

5.28 The HRAT is a multi-agency decision and intervention planning team involving ACTCS and Justice Health Services that co-ordinates the management of at-risk detainees, specifically S-rated detainees. The HRAT meets each business day and, according to the CHS *Standard Operating Procedure Suicide Prevention and Intervention Framework*, should be attended at a minimum by Custodial Mental Health, ACTCS and Primary Health Services. Minutes of HRAT meetings were extremely brief and only one included sufficient detail around discussions and associated planning. While decisions and actions were recorded, the minutes often contained limited discussion or rationale for these decisions. Without this level of detail, it is unclear whether sufficient attention was paid to the management of S-rated detainees. The effectiveness of these meetings was further weakened by the occasional absence of a representative from Justice Health. In addition, no representative from key stakeholder Winnunga was included.

Delivery of treatment to 'at-risk' Aboriginal and Torres Strait Islander detainees

5.29 Recommendation 151 from the 1991 Royal Commission into Aboriginal Deaths in Custody highlighted the importance of referring Aboriginal prisoners or detainees requiring psychiatric assessment or treatment 'to a psychiatrist with knowledge and experience of Aboriginal persons':

> … wherever possible, Aboriginal prisoners or detainees requiring psychiatric assessment or treatment should be referred to a psychiatrist with knowledge and experience of Aboriginal persons. The Commission recognises that there are limited numbers of psychiatrists with such experience. The Commission notes that, in many instances, medical practitioners who are or have been employed by Aboriginal Health Services are not specialists in psychiatry, but have experience and knowledge which would benefit inmates requiring psychiatric assessment or care."

5.30 Under the *ACTCS Access to Health Care Policy 2019*, all detainees, including Aboriginal and Torres Strait Islanders, who receive either an 'S' or 'P' rating are automatically under the care of Justice Health Services and do not receive treatment from Winnunga. This arrangement does not prevent Justice Health from seeking treatment advice from an Aboriginal or Torres Strait Islander health professional.

5.31 A key opportunity to seek this advice occurs during HRAT meetings. However, neither Winnunga or any other Aboriginal or Torres Strait Islander health professional attends this meeting. This conflicts with one of the guiding principles within the Winnunga MoU that states:

> Staff collaboration is central to managing custodial and health risks, especially those associated with suicide and self-harm.

5.32 While occurring informally, there is no established process to ensure that advice and support is sought from Winnunga, or any other Aboriginal or Torres Strait Islander health professional, for Aboriginal and Torres Strait Islander detainees at risk of suicide and self-harm.

RECOMMENDATION 15 HIGH-RISK ASSESSMENT TEAM MEETINGS

Canberra Health Services and ACT Corrective Services should ensure that:

a) sufficient detail is recorded in meeting minutes of the High-Risk Assessment Team to support subsequent decisions and actions;

b) a process is established and documented that ensures advice is sought from an Aboriginal or Torres Strait Islander health professional regarding at-risk Aboriginal and Torres Strait Islander detainees.

Delivery of treatment to detainees with 'P' ratings

5.33 'P' ratings are generated for clients of Custodial Mental Health to guide the intensity of review required. The 'P' rating categories and the associated frequency with which the patient should be seen are outlined in the draft Operational Guide.

5.34 In its review of nine detainee health records JRPO noted that all 'P' rated detainees were seen within the required timeframes except where a detainee refused to attend.

5.35 As discussed throughout this chapter, issues with accessing data in the records management system was complicated as the system requires the manual opening and checking of clinical notes associated with occasions of service. It is important that staff accessing the health files can readily see the detainee's 'P' rating to help ensure the appropriate provision of services. This lack of ready access raises the risk that this may not occur.

5.36 Evidence of appropriate handover processes between ART and Custodial Mental Health was identified by JRPO. In the transition process, Case Managers are routinely assigned to each detainee and introduced to individuals to facilitate the handover.

5.37 During interviews with detainees receiving treatment for mental health conditions, one raised concern about frequent changes in the treating team, i.e. the psychiatrist and case manager. This had resulted in the need to rebuild rapport and re-establish trust, in addition to changes in the treatment plan particularly around medication. Justice Health asserted that staff turnover had reduced, but no evidence was supplied to support this statement, and updates provided on the staffing profile of the Custodial Mental Health team suggested significant staff changes for 2020-21.

5.38 In its response to the draft proposed report CHS acknowledged the concerns raised by the detainee and noted that 'the movement of staff within health services is not uncommon'.

5.39 JRPO identified that psychiatry registrars and other intern positions do rotate as a matter of necessity and that there will always be an element of turnover regardless of staff retention. It is therefore important to consider continuity of care processes under these circumstances. This can be enhanced by ensuring data is readily available for treating teams and clinicians to assist in planning for individual patient handover. This would be improved by ensuring care plans are comprehensive and include detailed case notes.

5.40 For detainees who did not meet criteria for involuntary treatment and refuse treatment, there was no clinical evidence of:

- rescheduling of appointments;
- check ins with the patient on the unit; and
- discussion within the MDT when refusal is occurring repeatedly.

5.41 JRPO was not able to identify how frequently this occurred due to shortcomings in the MAJICeR management information system.

Deterioration of mental states

5.42 In February 2019 a Custodial Mental Health Team Leader observed a trend where 'P' ratings appeared to increase over time rather than decrease, indicating an apparent trend in the deterioration in mental state among detainees on the units. In response, Justice Health undertook a quality improvement activity to identify potential causes of this observed trend and to develop strategies to address it.

5.43 The resulting quality improvement report (QI report) identified that of the nine clinically managed cases reviewed (previously relatively stable at PA or P3), six deteriorated and were assigned a P1 rating, suggesting that a deterioration in mental state had not been identified early enough. Of the six, three required transportation out of the AMC to an acute inpatient unit, and three were moved to the CSU within the AMC. Only one of the six patients had appropriate action within 24 hours of the first identification of their deteriorating mental state.

5.44 The QI report identified the need for earlier identification of mental health deterioration and appropriate intervention. The outcome goals of the activity were to improve clinician response times and reduce inpatient admissions among this group. Changes that were implemented included:

- presentation of deteriorating clients to the MDT;
- development of a proforma to prompt consideration of deterioration and appropriate action;
- reviews of 'P' ratings to inform clinical response;
- introduction of triage ratings at each clinical review to inform clinical decision making; and
- increased frequency of psychiatric reviews once deterioration has been identified.

5.45 While a subsequent report indicated the implementation of these changes was relatively successful (a two-month audit of patients between April and May 2020 identified the P1 ratings and admissions had reduced by 50 percent), the quality improvement strategy applied to existing clinically managed cases only. It did not address referral of new or previously closed cases.

5.46 In February 2019 a Custodial Mental Health Team Leader observed a trend where 'P' ratings appeared to increase over time rather than decrease, indicating an apparent trend in the deterioration in mental state among detainees on the units. In response, Justice Health undertook a quality improvement activity to identify potential causes of this observed trend and to develop strategies to address it. The Quality Improvement (QI) report identified the need for earlier identification of mental health deterioration and appropriate intervention

and a range of changes were implemented to improve clinician response times and reduce inpatient admissions among this group.

Access to hospital treatment

5.47 For detainees whose mental health condition requires hospital treatment, two options exist; treatment within the Canberra Hospital or the Dhulwa Mental Health Unit.

5.48 The Dhulwa Mental Health Unit is an ACT Government facility that provides mental health care for people who are, or are likely to become, involved with the criminal justice system. It offers a secure and structured environment for people who can't be safely cared for in other environments and whose complex care needs are not met in the current system. The Unit provides 24-hour treatment and care and has 10 acute care beds and 15 rehabilitation beds.

5.49 Access to hospital beds associated with level of acuity or clinical need (e.g. with respect to commencing Clozapine, an antipsychotic medication that requires medical monitoring on commencement to reduce the likelihood of adverse side effects) is a necessary component of the continuum of care in correctional mental health.

5.50 Staff in Justice Health advised that delays in access to inpatient treatment were frequently experienced. Staff advised that this was due to limited bed access at Dhulwa. While detainees may still access hospital beds within the Canberra Hospital as necessary, JRPO noted that these hospital beds are not always the type of beds required as they have lower levels of security/safety and are only intended for a relatively shorter length of stay.

5.51 At the time of the audit, 17 Dhulwa beds were commissioned and 14 of these were occupied by civil (i.e. mainstream, community-based) patients. This leaves little access for AMC detainees requiring forensic mental health care and represents a deviation from the intended model of service, as it creates bed blockages for mentally unwell detainees who require inpatient care. Justice Health staff estimated that 1 – 2 patients per fortnight (26-52 patients per year) require access to Dhulwa from the AMC.

5.52 Given the difficulty in accessing beds at Dhulwa, those requiring acute admission in the 12 months prior to the audit were generally referred to the Adult Mental Health Unit at the Canberra Hospital instead. Of the 16 referrals from the AMC to Dhulwa Mental Health Unit in the previous year, only 4 admissions occurred. It is of note that 13 of the 16 referrals were for patients on involuntary treatment orders.

5.53 On 29 April 2021, the Operational Director of Justice Health Services advised:

> The issue has been alleviated in the past 2 weeks with the opening of Gawanggal which is a step down unit. Ie a step down from Dhulwa. It is not a secure unit and means that patients can more easily integrate into the community. This has freed up several beds at Dhulwa and we have admitted several custodial patients since then.

5.54 Access to beds within Dhulwa is outside of Custodial Mental Health's control. However, if limited access remains an issue going forward, this issue should be elevated to senior

executives within Justice Health for consideration as there are associated implications regarding access to appropriate treatment and health rights for detainees.

5.55 For detainees whose mental health condition requires hospital treatment, two options exist; treatment within the Canberra Hospital or the Dhulwa Mental Health Unit. Dhulwa offers a secure and structured environment for people who can't be safely cared for in other environments and whose complex care needs are not met in the current system. Delays in access to inpatient treatment were frequently experienced due to limited bed access at Dhulwa. While detainees may access hospital beds within the Canberra Hospital as necessary, these hospital beds are not always the type of beds required as they have lower levels of security/safety and are only intended for a relatively shorter length of stay.

Delivery of treatment to detainees without 'S' or 'P' ratings.

5.56 As discussed from paragraph 2.27, the delivery of treatment to those detainees who suffer from mild to moderate mental health issues has been significantly affected by a shortage of psychologists within both CHS and ACTCS.

5.57 At present, only one psychologist is available to provide treatment to these cohorts. The vast majority of services provided to these cohorts is provided by GPs within Justice Health. Recommendation 3 of this report relates to the increase in psychological services within the AMC.

5.58 The delivery of treatment to detainees without 'S' or 'P' ratings is hampered by the lack of an operational guide that describes the operational and clinical procedures to be undertaken for detainees who fall outside the criteria for treatment by Custodial Mental Health. At present, their management is at the discretion of individuals rather than a planned approach by the agency. As with detainees with 'S' or 'P' ratings, it is important for CHS to document the arrangements for the management of detainees with less severe mental health conditions to ensure their effective management.

5.59 In its response to the draft proposed report CHS advised of its intention to include referral options in the finalised *Custodial Mental Health Services Operational Guide* discussed in Chapter 3.

RECOMMENDATION 16	OPERATIONAL GUIDE FOR DELIVERY OF TREATMENT OUTSIDE CUSTODIAL MENTAL HEALTH

Canberra Health Services should develop an operational guide that details the operational and clinical procedures to be undertaken for detainees who fall outside the criteria for treatment by the Custodial Mental Health team.

Delivery of treatment to Aboriginal and Torres Strait Islander detainees

5.60 The *Forensic Mental Health Services Model of Care* states:

> Delivery of all FMHS services will be sensitive to the social and cultural beliefs, values and practices of Aboriginal and Torres Strait Islander people. Communication with Aboriginal and Torres Strait Islander people and carers will be in a language that they can understand, free from medical jargon and with use of interpreters where required. FMHS also recognise traditional and non-traditional Aboriginal and Torres Strait Islander family structures, elder mentoring, and healers. Specific improvements regarding these elements will be identified in consultation with the community and its representatives and included in policies and procedures as part of the MoC implementation process.
>
> FMHS aims to develop and maintain effective working relationships with local community services including Winnunga Nimmityjah Aboriginal Health and Community Service (AHS), Gugan Gulwan Youth Aboriginal Corporation, the Aboriginal Legal Service, and the Ngunnawal Bush Healing Farm. Service integration, multi-agency intervention coordination, and information sharing practices will support the best outcomes for Aboriginal and Torres Strait Islander people accessing FMHS.

5.61 These statements make clear the intention of the FMHS to work with local community services to ensure that culturally appropriate care is provided to Aboriginal and Torres Strait Islander detainees (who represent more than a quarter of the detainee population of the AMC).

Delivery of services to Aboriginal and Torres Strait Islander

5.62 Outside of services provided by CHS, health services to Aboriginal and Torres Strait Islander detainees are predominately provided by Winnunga. Aboriginal and Torres Strait Islander detainees have a choice as to whether they wish to receive health services from Winnunga, CHS or JACS.

5.63 The Winnunga MoU demonstrates a shared commitment by JACS, CHS and Winnunga to work together to:

> … ensure Aboriginal and Torres Strait Islander detainees have access to comprehensive Aboriginal health checks, chronic conditions care planning and coordination, mental health treatment and care planning capable of recognising trauma experience by Indigenous people at the individual and collection level, and appropriate referrals to and collaboration with specialist and allied health professionals.

5.64 While the MoU between Winnunga, CHS and JACS includes specific references to the provision of mental health services, those individuals who are clients of Winnunga, but who have severe mental illness or are high risk, are referred back into the care of Justice Health. Schedule 1 to the MoU specifically states that only Justice Health may provide services to detainees assessed with either a 'P' or 'S' rating.

5.65 The MoU is clear in considering a detainee as a patient of either Winnunga or Justice Health. While models of shared care are discussed in a number of the documents, usually detainees are patients of either Justice Health or Winnunga and referral would generally occur rather than shared care.

Numbers of Aboriginal and Torres Strait Islander detainees receiving mental health treatment

5.66 Winnunga provides six-monthly performance reports to ACT Health as part of the requirements of its service funding agreement. One element of this reporting relates to the mental health care plans developed by Winnunga for Aboriginal and Torres Strait Islander detainees under its care. For the period 1 July 2020 to 31 December 2020, Winnunga reported the development of 42 mental health care plans for 23 detainees.

5.67 CHS reported that for the same period, 49 Aboriginal and Torres Strait Islander detainees were subject to a 'S' or 'P' rating and were under its care, with a care plan in place.

Delivery of care to Aboriginal and Torres Strait Islander detainees

5.68 The audit considered the extent to which CHS and ACTCS had effective oversight of the treatment of Aboriginal and Torres Strait Islander detainees by Winnunga. It also considered whether Winnunga had been appropriately incorporated into the treatment path for those detainees who had elected to receive their care.

5.69 Winnunga provides a primary health level of mental health care, but it does not have a role in the delivery of mental health treatment at the higher levels of the 'Stepped Care Approach'. Given the critical importance of culturally appropriate intervention, there is a need to engage Winnunga to provide advice to CHS on the treatment of detainees with suicide or self-harm ratings. As discussed from paragraph 5.29, this could be addressed by its inclusion at HRAT meetings.

5.70 Considering the sole responsibility of Custodial Mental Health in treating Aboriginal and Torres Strait Islanders with 'S' or 'P' ratings, as part of the 'Stepped Care Approach', it is important that service delivery is also culturally sensitive and appropriate. All Custodial Mental Health staff have access to cultural capability training (not necessarily at orientation but soon after depending on the training schedule and availability) and all current staff have received this training. While this is an important step towards providing staff awareness of culturally sensitive and appropriate treatment to Aboriginal and Torres Strait Islander detainees, it does not negate the need for CHS to obtain expert advice from Indigenous health service providers.

5.71 For those Aboriginal and Torres Strait Islander detainees who do not choose to receive services from Winnunga, the Custodial Mental Health team also has access to an ALO within Justice Health. The role of the ALO is described as working across MHJHADS within the AMC and the Dhulwa Mental Health Unit and linking in with Indigenous detainees to facilitate engagement across each of these domains. The role promotes engagement, attends complex client meetings to inform care as appropriate, works with Custodial Mental Health in a consultation liaison model, and works with families. Only 0.6 of a FTE ALO is available to provide these services to an average of 107 Aboriginal and Torres Strait Islander detainees.

5.72 CHS staff reported instances of Custodial Mental Health and Winnunga working together in relation to individual clients. In these instances, the Custodial Mental Health psychiatrist consulted with the Winnunga doctor to assist in facilitating care, as well as joint transition planning or complex care planning on a case-by-case basis. However, input from Indigenous service providers does not happen routinely.

5.73 Winnunga provides a primary health level of mental health care to Aboriginal and Torres Strait Islander detainees but does not have a role in the delivery of mental health treatment at the higher levels of the 'Stepped Care Approach'. Justice Health is specifically responsible for the provision of mental health services to Aboriginal and Torres Strait Islander detainees assessed with either a 'P' or 'S' rating. For the period 1 July 2020 to 31 December 2020, Winnunga reported the development of 42 mental health care plans for 23 detainees under its care and CHS reported that 49 Aboriginal and Torres Strait Islander detainees were subject to a 'S' or 'P' rating and were under its care, with a care plan in place. Only 0.6 of a FTE ALO from CHS is available to assist Custodial Mental Health to provide services to those Aboriginal and Torres Strait Islander detainees who are not receiving treatment from Winnunga. This is unlikely to facilitate the delivery of effective culturally sensitive and appropriate treatment to Aboriginal and Torres Strait Islander detainees.

5.74 In its response to the draft proposed report, CHS advised of its intention to undertake benchmarking to support its resourcing outcomes.

RECOMMENDATION 17 ABORIGINAL LIAISON OFFICER NUMBERS

Canberra Health Services should undertake an assessment of the number of Aboriginal Liaison Officers required to meet service needs, including support during the induction process, of Aboriginal and Torres Strait Islander detainees and recruit to this number.

Providing trauma-informed care

5.75 Trauma-informed care was identified by both staff consulted and JRPO as a treatment option need across ACTCS, Primary Health and Custodial Mental Health.

5.76 While there is no universally accepted definition of trauma-informed care, NSW Health considers that:

> Trauma-informed services do no harm i.e. they do not re-traumatise or blame victims for their efforts to manage their traumatic reactions, and they embrace a message of hope and optimism that recovery is possible. In trauma-informed services, trauma survivors are seen as unique individuals who have experienced extremely abnormal situations and have managed as best they could".
>
> Trauma-informed care is based on the understanding that:
>
> - a significant number of people living with mental health conditions have experienced trauma in their lives;
> - trauma may be a factor for people in distress;
> - the impact of trauma may be lifelong; and

- trauma can impact the person, their emotions and relationships with others.

Core trauma-informed principles:

- Safety – emotional as well as physical e.g. is the environment welcoming?
- Trust – is the service sensitive to people's needs?
- Choice – do you provide opportunity for choice?
- Collaboration – do you communicate a sense of 'doing with' rather than 'doing to'?
- Empowerment – is empowering people a key focus?
- Respect for Diversity – do you respect diversity in all its forms?

5.77 The *Forensic Mental Health Services Model of Care* notes that:

> Rates of childhood and adult trauma are high among incarcerated persons and are associated with the risk of developing mental health disorders. Trauma-informed approaches are an integral part of recovery-oriented services and as such are embedded within the FMHS MoC. Trauma is a broad term and includes experiences of personal lived-experiences as well as cultural, inherited (intergenerational) history and collective trauma.

5.78 Under the *Forensic Mental Health Services Model of Care* the Clinical Management Team is responsible for the provision of:

> … recovery oriented, trauma informed care to people in custody who are experiencing an enduring mental illness and/or disorder which is associated with significant psychosocial functional impairment.

5.79 In order to deliver these treatment options to detainees it is critical that staff have training in trauma-informed care. However, staff have not undertaken this training.

5.80 While not employed as clinical staff, trauma-informed care training would also improve Custodial Officers' ability to provide management that aligns with the core trauma-informed principals noted at paragraph 5.76.

5.81 In its response to the draft proposed report JACS advised:

> … in June 2021, training in trauma aware practice commenced. At present, all Offender Reintegration staff have completed training provided by Blue Knot, along with several custodial officers.

5.82 In its response to the draft proposed report, CHS advised that the existing training for MHJHADS staff in trauma informed care had been delayed.

5.83 Trauma-informed care frameworks are considered essential in contemporary mental health, and forensic mental health services, to promoting understanding environments that promote health and wellbeing for all detainees and can prevent trauma-based deterioration. However, staff have not undertaken this training. This should be a further area for joint strategy development between CHS and ACTCS.

RECOMMENDATION 18 TRAUMA INFORMED CARE

Canberra Health Services should introduce trauma informed frameworks to inform governance, clinical, and operational processes. This should include the development and implementation of trauma-informed care training for delivery to all clinical staff within Forensic Mental Health Services and Custodial Officers within ACT Corrective Services.

Planning for release

5.84 Release planning is a complex and wide-ranging exercise of which the development of mental health release plans is just one component. Release planning is co-ordinated by ACTCS rather than Justice Health, as it extends beyond the management of health conditions.

5.85 A detainee's entry into a prison environment can provide a key opportunity for health intervention. However, this intervention may be wasted if, on return to the community, no plan is established for the continuation of care.

5.86 A 2017 University of Sydney paper *From Custody to Community: Transitioning people with mental ill-health from the criminal justice system to the community* highlighted that:

> Mental health care is important during periods of transition back into the community as transition is a time of vulnerability for people experiencing mental ill-health and uptake of support is low.
>
> While all individuals who have recently been released from a correctional facility are at increased risk of homelessness and unnatural death including from suicide and drug overdose, having serious mental ill-health compounds these problems. In addition, mental health conditions may worsen immediately following release, with the burden of additional stresses related to finding accommodation, welfare and other services increasing the likelihood of decompensation and other risks such as suicide.
>
> …Australian figures showed that suicide risk amongst people exiting correctional facilities was highest in the first two weeks following release.

5.87 It is in this context that the development of a transfer plan becomes important in supporting a detainee's health and safety on release from custody.

Development of release plans

5.88 There are no specific procedures or guidelines in CHS or ACTCS for the development of release plans for detainees.

5.89 However, for CHS staff, the Custodial Mental Health draft Operational Guide (which guides the treatment of detainees with 'S' and/or 'P' ratings) states that in the development of a detainee's care plan:

> The care plan must include an initial release plan in the event the person is released from custody. Note it is critical that clinicians collect as much demographic information as possible

> during the initial assessment to help support a successful transfer of care if the person is released from custody.

5.90 The draft Operational Guide does not include further information or guidance around how this release plan should be developed.

5.91 The draft Operational Guide goes on to say that:

> Transfer to community planning occurs in tandem with the care plan and it should be evident at any point in a person's journey through the Custodial Mental Health what the plan is if that person is released.

5.92 The draft Operational Guide also includes a Closure Checklist for people released from custody. This is represented at Table 5-2.

Table 5-2 Release from custody – Closure checklist

Step number	Action
1	Plan discharge with the person and family/carers in conjunction with their care plan.
2	MDT discussion held and decision for closure documented in CHS ECR.
3	Where release date is known and care is to be transferred to Adult Community Mental Health Services referral should be made 4 weeks prior to release. Referral is direct to CRS for involuntary clients and to Access for voluntary clients.
4	ISBAR +SS completed and documented on CHS ECR.
5	SVAT and outcome measures completed.
6	Letter to community GP detailing diagnosis, treatment provided by Custodial MH - Adult, current medications and recommendations.
7	Arrange scripts for medication to be placed in a person's personal effects in Admissions area prior to release or arrange for scripts to be provided to CRS if person and CRS requests same.
8	Activate release supports if such as DECO and/or NDIS supports by advising of upcoming or recent release.
9	Complete closure documentation on CHS ECR and close episode of care with Custodial MH Adult.

Source: CHS draft Operational Guide

5.93 The draft Operational Guide contains no reference to the engagement of external service providers such as Winnunga in the development of release plans. Nor does it contain references to the clinical services provided by ACTCS.

5.94 No guidance has been developed that guides the development of release plans for detainees with diagnosed mental health conditions who do not have 'S' and/or 'P' ratings.

Completeness of release plans

Initial release plans

5.95 In its review of nine detainee health records, JRPO did not identify evidence of the development of a release plan in more than half of the records reviewed. For those records that did contain a release plan, JRPO identified evidence of the collection of demographic information as required under the draft Operational Guide.

5.96 In many correctional settings it is easier to engage in transition planning for sentenced detainees than those on remand due to the associated uncertainty. This is due to greater certainty about the release date, less pressure to make plans rapidly, and a generally more settled population. In terms of effective use of resources, it can take substantial effort to work with individuals, such as detainees on remand, whose release is potential but not certain. However, once detainees are sentenced to a period of incarceration, more certainty exists concerning their possible release date. As such, the release plan can be adapted to the ongoing needs of the detainee at the point of possible release from custody.

5.97 While the efficient management of resources is important it is also important that release plans are developed early for remandees due to the uncertainty of the time that they will remain in custody and the chance that they can be released from custody without much (or any) notice. Failure to do this may result in a detainee being released back into the community without the appropriate planning or support for their mental health condition.

Development of release plans for Aboriginal and Torres Strait Islander detainees

5.98 Winnunga operates in the community as well as in the AMC, and this establishes the potential for good continuity of care. However, the guidance material around release planning contains no information regarding how consultation should be undertaken with Winnunga (or other Indigenous service providers) for Aboriginal and Torres Strait Islander detainees with mental health conditions. This gap may result in the development of a release plan that does not take into account the unique requirements of this cohort of detainees.

Release from custody plans

5.99 For detainees under the care of Custodial Mental Health there was evidence of release planning for a detainee when they were approaching their release date on a case-by-case basis. This included liaison with Mental Health Services in the community, family where appropriate, as well as broader support options. Generally, it appeared that clients were actively involved in these discussions.

5.100 Justice Health is a division of CHS, which makes it easier to have close ties to community mental health services to help facilitate effective transition of mental health services to the community. The file review identified appropriate linkages and referrals made to

community mental health services for those detainees who were patients of Custodial Mental Health.

5.101 In its response to the draft proposed report CHS advised that 'information on the process for release planning for clinical care is being developed' and will be included in the *Custodial Mental Health Services Operational Guide* discussed in Chapter 3.

5.102 Greater attention is required to ensure that release planning is undertaken to address detainees' mental health needs upon release. There are no specific procedures or guidelines in CHS or ACTCS for the development of release plans for detainees, although for CHS staff, the Custodial Mental Health draft Operational Guide provides some guidance for detainees with 'S' and/or 'P' ratings, noting that the detainee's care plan 'must include an initial release plan in the event the person is released from custody'. The draft Operational Guide also includes a Closure Checklist for people released from custody but does not reference engagement of external service providers in the development of release plans, or refer to the clinical services provided by ACTCS. There is no guidance for the development of release plans for detainees with diagnosed mental health conditions who do not have 'S' and/or 'P' ratings. Guidance should be developed with respect to:

- a description of the release planning process (including the timing of both the development and review of release plans);
- the minimum level of information that should be considered and included in a release plan;
- how ACTCS should be consulted with around detainees receiving mental health treatment from their clinical staff;
- how service providers should be consulted when developing release plans for Aboriginal and Torres Strait Islander detainees.

RECOMMENDATION 19 RELEASE PLANNING

Canberra Health Services should develop release planning guidance material that covers all detainees with mental health care plans that:

a) describes the process for release planning;

b) details what information should be contained in a release plan;

c) establishes a consultation process with ACT Corrective Services when planning release for those detainees receiving mental health treatment from ACT Corrective Services clinical staff; and

d) establishes a consultation process with Winnunga Nimmityjah Aboriginal Health and Community Services (or other service providers where necessary) when planning the release of Aboriginal and Torres Strait Islander detainees.

Audit reports

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Report No. 12 – 2021	2020-21 Financial Audits – Financial Results and Audit Findings
Report No. 11 – 2021	Digital Records Management
Report No. 10 – 2021	2020-21 Financial Audits Overview
Report No. 09 – 2021	Annual Report 2020-21
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